Living Our Parents' Trauma:

Effects of Child Abuse and Neglect on the Next Generation

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Abstract

Hurt and complex trauma resulting from childhood maltreatment has serious consequences for the lifespan development of the survivor (Kezelman, Hossack, Stavropoulos, & Burley, 2015; van der Kolk, 2014). Child abuse and neglect involves a betrayal of trust, care and protection within the very relationships upon which the child relies upon for care (Courtois & Ford, 2013). Psychological trauma arising from child abuse and neglect is referred to as complex, or developmental, trauma (Ford et al., 2013). This accounts for the impact of the trauma on the ongoing development of the child into adulthood. Intergenerational continuity research suggests parents' childhood experiences and current psychosocial functioning are expressed in their parenting behaviour (K. Kim, Trickett, & Putnam, 2010). Further to this is the idea that unresolved childhood experiences of loss and trauma are repeated in the next generation (Bowlby, 2005; Egeland & Susman-Stillman, 1996). Childhood maltreatment research into intergenerational functioning and relationship outcomes in adults, however, is lacking.

This thesis comprised a pilot and three studies investigating retrospective reports of childhood experiences and self-reports of current adult functioning outcomes. Participants' categorical responses to four items on childhood sexual and physical abuse, and physical and emotional neglect, were used to identify *any-abused* and *not-abused* groups.

Study 1, *Experiences of Individuals* investigated the relationship and functioning experiences of individuals between groups with, and without, a history of childhood abuse or neglect. Compared to participants without a history of childhood abuse and neglect, *any-abused* participants had poorer adult functioning outcomes including higher separation-individuation disturbances, lower perceived current social support, higher psychopathology and higher current trauma symptoms. An effect of cumulative harm was demonstrated in participants who reported more than one category of abuse or neglect. There was a link between accessing psychotherapy and poorer adult functioning outcomes. Multiple predictor variables, including adult functioning outcomes and childhood experiences of psychological abuse, physical neglect and sexual abuse were associated with current trauma symptoms. The findings of Study 1 add to the body of research in which poorer adult

functioning and relationship outcomes are found in participants reporting a history of childhood abuse and neglect.

Study 2, *Intergenerational Continuity,* examined intergenerational continuity and discontinuity in the relating and functioning of parent–child participant-dyads, with and without a history of child abuse. An intergenerational impact of the effects of childhood abuse and neglect was supported. Regardless of the participant's own child maltreatment history, participants with a maltreated parent had, on average, poorer adult functioning outcomes, compared to participants whose parent was not maltreated. Participants who reported a history of child abuse or neglect in both generations had poorer adult functioning outcomes, compared to those in which neither generation reported a history of childhood abuse or neglect. In this research, children with an abused or neglected parent had more trauma symptoms themselves, than children with a not-abused parent.

A qualitative third study, *Survivors' Experiences of their Parent*, focussed on survivors' lived experiences of their parent. Survivors' experiences of their caregiving relationship were explored with a focus on the terms trust, hurt and healing. Interpretative Phenomenological Analysis (IPA) (Smith, Flowers & Larkin, 2009) provided a forum for survivors to give voice to their experience and explore their understanding of it. Themes included: a) permanent and generalised distrust and disconnection, b) continued expectation of hurt and anticipation of punishment, c) impact of abuse and neglect on memory, relationships, mental health, adult functioning and self-concept, d) self-protective or protective behaviour, e) slow and difficult healing, f) significant relationships with the other parent and siblings, and g) resilience. Several child abuse survivors wrote that they valued being heard. Being heard and having trauma acknowledged, they felt, may support the healing of other survivors.

The lived experience of survivors informs us that, even as adults, their relationship experiences with their parent continue to impact on their relationships with themselves and with others. The current research shows that intergenerational functioning outcomes hold similar implications to outcomes for individuals, and yet has been absent from inclusion in the way we respond, treat and consider complex trauma. The global significance of this research is to shift the focus from the individual effects of childhood maltreatment to a broader understanding of the potential intergenerational effects.

Statement of Sources.

This thesis contains no material published elsewhere or extracted in whole or in part from a thesis by which I have qualified or been awarded another degree or diploma.

No other person's work has been used without due acknowledgment in the main text of the thesis.

This thesis has not been submitted for the award of any degree or diploma in any other tertiary institution.

All research procedures reported in the thesis received the approval of the relevant Ethics/ Safety Committees (where required).

The author presented preliminary findings of this research at the Australian Psychological Society (APS) College of Educational and Developmental Psychologists Conference, 28th March 2014. Post-submission, the author presented findings of this research on 28th November 2015 at the International Society for the Study of Trauma and Dissociation (ISSTD) Regional Conference. The author has made annual presentations of this research within the School of Psychology, Australian Catholic University.

Signed   ....

Date   ....

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Many brave individuals – survivors of childhood maltreatment, adult family members of survivors, and individuals without a history of childhood abuse or neglect – shared of themselves within this research. I am humbled by their generosity. To all of you, I offer my thanks. To survivors and to children of survivors, I hope this research provides a platform for your voices to travel and continue to gather support.

My gratitude goes to my supervisors at Australian Catholic University who allowed me to work autonomously and gave of their time and expertise. To my patient principal supervisor Associate Professor Cecelia Winkelman and co-supervisor Dr Helen Aucote – thank you for enabling the successful completion of this research. To my earlier supervisors – Dr Lisa Eisen (now in Canada) and Professor Barry Fallon (dec.) – thank you for encouraging the expansion of my ideas.

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I have been influenced and inspired by the work of others within the areas of child protection, child maltreatment and complex trauma. My calling to this research has flowed out of my work over the past 14 years with children, young people and their families reported to the child protection service in Victoria, Australia. Families' experiences with protective intervention are mixed. State services and our society as a whole regularly fail our most vulnerable families. Children are often multiply failed. Within this context, many family members have identified burdens of cumulative and intergenerational traumas within their life experiences. These traumas impacted most clearly, not only in

perpetrations of direct maltreatment, but in the relationships and functioning of family members. Recognising these impacts is but a start.

Dedication

I dedicate this thesis to my parents Jean and Ben Leeman. I am not a survivor of childhood abuse or neglect; rather this thesis comes from an experience of parental love, nurture and individuation. My mother and then my father died during the year prior to submission. They were not old, and were passionately full of life. Both Social Workers by profession, their knowledge and experience was a source of inspiration and grounding for my research. With my grief still raw, I keep my sanity free-range. Sometimes I need to look for it, but it seems more wholesome and real that way.

Chapter 1: Introduction to Childhood Maltreatment Research

Research into childhood abuse and neglect has become increasingly complex (Jackson, Gabrielli, Fleming, Tunno, & Makanui, 2014; Sperry & Widom, 2013). Providing context to the varied approaches and conceptual frameworks used to investigate subsequent outcomes, Chapter 1 presents an introduction to childhood maltreatment research. Types of childhood abuse and neglect are discussed. Highlighted in this chapter is the complexity relating to types of maltreatment and their potential differential, clustered, cumulative and intergenerational effects on outcomes. Methodological challenges prevalent in maltreatment research are outlined, including research design, variations in definition and sample, and need for theory-driven research. Research from two epidemiological studies is presented to introduce some of the collective evidence linking childhood maltreatment experiences with adverse risks and outcomes.

Types of Childhood Abuse and Neglect

Child abuse and neglect refers to a range of types of childhood maltreatment. These include sexual abuse, physical abuse, emotional abuse, psychological abuse, physical neglect, emotional neglect, witnessing family violence and exposure to parental substance problems. When children have experienced one type of maltreatment the likelihood is increased that they have experienced other types of maltreatment and adverse experiences (Anda et al., 2006).

Historically, sexual abuse and physical abuse have received more research attention than other types of maltreatment (Egeland, 2009; Yates & Wekerle, 2009). This bias may reflect a belief that emotional abuse and emotional neglect are harder to confirm than physical abuse and physical neglect (Egeland, 2009). Sexual abuse, by contrast, is less ambiguous to define and is easier to study than other forms of abuse and neglect (Chu, 2011). Emotional abuse, however, tends to be poorly delineated from psychological abuse (O'Hagan, 1995; Trickett, Mennen, Kim, & Sang, 2009) and emotional neglect (Shaffer, Yates, & Egeland, 2009). Furthermore, determining severity of emotional abuse, and other abuse types, is complex (Trickett, Kim, & Prindle, 2011).

Research has considered emotional abuse and neglect as having equal or more adverse outcomes than other maltreatment types (Baker & Festinger, 2011; O'Hara et al., 2015).

There is a high level of complexity presented within the research literature in the conceptualisation of maltreatment types and their potential differential, clustered, cumulative or intergenerational effects on outcomes. Describing this complexity, different approaches are outlined below, each using different terminology to investigate potential outcomes associated with maltreatment type and co-occurrence.

Differential Impacts Associated with Maltreatment Type and Subtype

Different types of abuse and neglect may have *differential impacts* on behavioural and functioning outcomes (Hodges et al., 2013). Briere and Runtz (1990) reported a differential relationship between a history of one of three types of childhood abuse and adult psychosocial dysfunction. Childhood sexual abuse was found to be associated with maladaptive sexual behaviour; childhood physical abuse was associated with aggressive behaviour; and psychological abuse was associated with low self-esteem (Briere & Runtz, 1990). Utilizing three analytic approaches, Petrenko, Friend, Garrido, Taussig, and Culhane (2012) investigated the effects of maltreatment type on outcomes in adolescence. Childhood physical abuse was found to be associated with externalising behaviour problems, and both physical abuse and physical neglect were associated with internalizing symptoms (Petrenko et al., 2012). Using bivariate analysis, Shaffer, Yates, et al. (2009) found both emotional abuse and emotional neglect to be associated with social withdrawal and aggression in middle childhood and socioemotional competence in adolescence. However, mediation models found social withdrawal to have a significant negative contribution to adolescent socioemotional competence only with emotional abuse and not emotional neglect.

A history of different types of childhood abuse and neglect has also been reported to have differential effects in adults. In a cohort of adult inpatient substance users, Banducci, Hoffman, Lejuez, and Koenen (2014) found amongst the shared presentation of substance abuse and a history of childhood abuse, types of childhood abuse were associated with different emotional and behaviour outcomes. They found childhood sexual abuse to be uniquely associated with risky sexual behaviours, childhood physical abuse to be uniquely associated with aggressive behaviours and

childhood emotional abuse to be uniquely associated with emotional dysregulation (Banducci et al., 2014).

Different forms of emotional abuse and of physical neglect may not represent a unitary construct (Petrenko et al., 2012). Further, Petrenko et al. (2012) cautioned that functioning outcomes vary depending on maltreatment subtype. In research examining subtypes of emotional abuse, Trickett et al. (2009) organised fifteen emotionally abusive parent behaviours into four *subtypes*: terrorizing, spurning, exploiting/corrupting, and isolating. They found the terrorizing subtype to be the most frequent type of emotional maltreatment, and that most participants had experienced more than one subtype (Trickett et al., 2009).

In addition to impacts related to type of abuse and neglect, Jackson et al. (2014) found that frequency, severity, duration and age at time of maltreatment contributed to outcome. Evans, Steel, and DiLillo (2013) found *maltreatment severity* to be associated with higher levels of trauma symptoms. However, inconsistencies in the magnitude of outcomes across studies focussing on single types of childhood maltreatment has limited the robustness of explanations based upon frequency, severity and duration (Martin, Cromer, DePrince, & Freyd, 2013).

Different types of maltreatment are noted to co-occur (Nurius, Green, Logan-Greene, & Borja, 2015) and to be statistically interrelated, rather than independent, isolated events (Dong et al., 2004). In addition to specific types of abuse being unique predictors of particular outcomes, the number of *co-occurring traumas* has been found to produce cumulative effects, such as increased symptom complexity (Briere, Kaltman, & Green, 2008). Multiple experiences of different types of child abuse, neglect and other forms of harm have been described as *multi-type maltreatment* (Higgins & McCabe, 2000a), *polyvictimisation* (Finkelhor, Ormrod, & Turner, 2007a, p. 149), or *cumulative trauma* (Briere et al., 2008).

Cumulative Trauma

Research suggests childhood experiences of abuse and neglect do not occur in isolation in otherwise well-functioning families (Featherstone, White, & Morris, 2014; Sperry & Widom, 2013). Child maltreatment trauma involves cumulative effects of co-occurring risks (Appleyard, Egeland, van Dulmen, & Sroufe, 2005). Multiple types of

childhood trauma are often experienced within the same time frame, and children who have experienced maltreatment are at increased risk of continued maltreatment by others (Hodges et al., 2013; Martin et al., 2013). Research into multi-type maltreatment suggests cumulative effects are common, and differ from outcomes associated with single abuse types (Finkelhor et al., 2007a; Higgins & McCabe, 2000a). Hazen, Connelly, Roesch, Hough, and Landsverk (2009) found that youth with multiple types of maltreatment had higher internalising and externalising problems than youth with low maltreatment profiles. Compared to frequency of exposure in single-type maltreatment, accumulated exposure to multiple types of trauma predicts poorer outcomes (Hodges et al., 2013).

The *cumulative risk hypothesis* suggests that the greater the number of different types of maltreatment or other adverse childhood trauma experienced by an individual, the poorer the outcome (Appleyard et al., 2005). Reporting a *dose-response relationship*, the number of adverse childhood experiences has been found to be statistically significantly related to poorer adult health outcomes (Felitti et al., 1998b; Flaherty et al., 2013). Briere et al. (2008) reported linear relationships between the number of types of childhood trauma and symptom complexity. Danese et al. (2009) described a *cumulative effect* in which children who had multiple adverse experiences (including childhood maltreatment) had a higher number of age-related disease risks in adulthood.

Supporting, but adding complexity to the cumulative risk hypothesis, *clusters* of co-occurring types of maltreatment were found to lead to differential outcomes (Pears, Kim, & Fisher, 2008; Trickett, Kim, et al., 2011). Pears et al. (2008) found four profiles of co-occurring types of maltreatment in preschool children. Finding similar profiles (or clusters) in adolescents, Trickett, Kim, et al. (2011) also found sex differences. The cluster with the most co-occurring different types of maltreatment (sexual abuse - neglect - emotional abuse - physical abuse) was associated with the highest number of adverse outcomes, with boys in this cluster scoring higher for aggression and depression than girls (Trickett, Kim, et al., 2011). Lower levels of problems were found in the clusters of two types of co-occurring maltreatment: 1) emotional abuse and physical abuse and 2) physical abuse and neglect (Trickett, Kim, et al., 2011). Within the clusters of different types of maltreatment, Trickett, Kim, et al. (2011) analysed subtypes of emotional abuse (spurning, terrorizing, isolating, exploiting/ corrupting). Compared to

the cluster that included all types of maltreatment (including sexual abuse), the emotional abuse - physical abuse - neglect cluster had significantly higher reports of spurning and terrorizing (Trickett, Kim, et al., 2011). Described as being the most seriously emotionally abused, this cluster was reported as having the lowest scores for self-esteem (Trickett, Kim, et al., 2011).

Some experiences of multiple maltreatment types do not lead to poorer outcomes (O'Hara et al., 2015). O'Hara et al. (2015) found neglected-only children had poorer cognitive outcomes than children both neglected and physically abused. Contrary to the cumulative risk hypothesis, O'Hara et al. (2015) suggested children who are neglected-only receive less parental attention than children who are both neglected and physically abused.

These findings suggest the maltreatment profile of the individual can determine differential outcomes (Trickett, Kim, et al., 2011). The complexity of outcomes associated with childhood maltreatment highlight the interplay of multiple risk and protective factors (Cyr, Michel, & Dumais, 2013).

Intergenerational Trauma

There has been a lack of integration between research into outcomes for individuals and research into intergenerational effects of childhood maltreatment. Additional to individual outcomes, childhood trauma has intergenerational consequences (Abrams, 1999). Due to the legacy of early life trauma, parents with their own history of maltreatment face potential challenges in their relationship with their children (Bailey, DeOliveira, Wolfe, Evans, & Hartwick, 2012). Research into the intergenerational effects of child abuse and neglect shows converging, but largely unintegrated findings. This research spans the areas of attachment (Cassidy & Mohr, 2001; Sagi et al., 1997), parenting (Belsky, Jaffee, Sligo, Woodward, & Silva, 2005; Conger, Schofield, Neppl, & Merrick, 2013), continuity of behaviour (Serbin & Stack, 1998), transmission of psychosocial risk (Serbin & Karp, 2004), and transmission of maltreatment (Milner et al., 2010; Widom, Czaja, & DuMont, 2015). Relevant to childhood maltreatment, but more prominent in non-maltreatment trauma research, is the idea of *intergenerational trauma* (Kaitz, Levy, Ebstein, Faraone, & Mankuta, 2009; Rowland-Klein & Dunlop, 1998; van Ee, Kleber, & Mooren, 2012).

Intergenerational child maltreatment research has focussed on transmission mechanisms rather than intergenerational outcomes (Marshall, Huang, & Ryan, 2011). The focus on transmission mechanisms may reflect the complexity of establishing causality of intergenerational effects of trauma (Kaitz et al., 2009). Further, this complexity may be a factor in the interchangeable use within the literature of the terms *intergenerational transmission* and *intergenerational continuity*. Clarifying these terms, Berlin, Appleyard, and Dodge (2011) suggested *intergenerational transmission* refers the direct role of the parent with a history of abuse in perpetrating abuse on (or otherwise failing to protect) the child. *Intergenerational continuity* refers to the experience or outcomes found in both generations (Berlin et al., 2011).

Research into Child Maltreatment

The seminal work of Kempe and his colleagues, "The battered-child syndrome" (Kempe, Silverman, Steele, Droegemueller, & Silver, 1985, p. 143/ 1962) sparked research on child maltreatment (Mudaly & Goddard, 2006). In observing the effects of early care experiences on psychological development, Bowlby, Fry, and Ainsworth (1968) posed the question of how to study the harm done (p.21). Researchers have contributed to the findings linking childhood maltreatment with a range of short and long-term negative outcomes (Frederick & Goddard, 2008; Obadina, 2013; Wegman & Stetler, 2009). Establishing causality between childhood maltreatment and later outcomes, however, is difficult (Foege, 1998). Differences between studies and methodological limitations remain a challenge to the interpretation of these findings (Maniglio, 2009).

Methodological Challenges

Despite decades of research, methodological challenges have been a continual source of debate within the childhood maltreatment literature. These include 1) limitations of study design (Briere, 1992b; Widom, Raphael, & DuMont, 2004), 2)

definitions of maltreatment and estimations of prevalence (Fallon et al., 2010; Goldman & Padayachi, 2000), and 3) a lack of theory-based research (Runyan et al., 1998).

Research design.

Using retrospective reports by adults of events that occurred during childhood has been criticised as a methodology having limitations related to reliability and validity (Widom et al., 2004). Contrasting retrospective to prospective research, Widom et al. (2004) argued retrospective studies are subject to recall bias. Widom et al. noted that, despite concerns about consistency and accuracy of retrospective reports, some researchers inappropriately use retrospective reports of childhood experiences to report causal relationships. Potential confounding effects in retrospective, non-longitudinal research limits causal inferences (Briere, 1992b).

Retrospective research into the long-term effects of childhood maltreatment, however, should not be considered less robust than prospective child maltreatment research (Dube, Williamson, Thompson, Felitti, & Anda, 2004; Kendall-Tackett & Becker-Blease, 2004). Kendall-Tackett and Becker-Blease (2004) suggested that prospective and retrospective studies of childhood maltreatment do not represent the same cohort of abuse and neglect survivors. Experiences of child abuse and neglect that go unreported, they stated, are missed from prospective research studies. Alaggia (2005) found a trend of delayed disclosure of childhood sexual abuse in more than half of interviewed participants, and reported estimates in the literature of between 30% and 80% remaining unreported into adulthood. Unreported abuse and neglect experiences may be more chronic and severe due to inherent secrecy and lack of intervention (Kendall-Tackett & Becker-Blease, 2004).

Retrospective studies currently make up a large section of the research literature into the long-term effects of childhood abuse and neglect. Alongside prospective longitudinal research, findings from retrospective research add to the collective knowledge in this area (Kendall-Tackett & Becker-Blease, 2004). With attention to design sensitivity and control of extraneous variables, studies using retrospective reports contribute to advancing childhood maltreatment research (Briere, 1992b).

Compared to quantitative methods, there has been limited qualitative research into childhood maltreatment (Dittmann & Jensen, 2014; McMahon, 2014). Qualitative methods are purposely appropriate for studying complexity (Rizq, 2012). McMahon (2014) noted qualitative research is needed to provide a person-oriented perspective for

understanding the disturbances in parent-child relationships and long-term consequences of childhood maltreatment.

Variations in definitions of maltreatment and estimations of prevalence.

Definitions of abuse and neglect are frequently inconsistent, creating methodological difficulties in the estimation of prevalence and incidence (Baker, 2009; Goldman & Padayachi, 2000). In a systematic review of studies investigating maltreatment in preschool children, Naughton et al. (2013) observed definitions and categories of abuse and neglect to vary. Despite this variation, Naughton et al. (2013) "caution[ed] against rigid categorization", given many maltreated children are simultaneously subjected to multiple types of abuse and neglect (p.773). To address concerns about construct validity, Herrenkohl and Herrenkohl (2009) recommended that studies examine multiple and operationally-defined types of maltreatment and the correlations between them. This, they stated, would provide more comprehensive information about the overlapping contribution of different types of abuse and neglect (Herrenkohl & Herrenkohl, 2009).

The maltreatment literature varies not only in definitions of maltreatment, but also in the sampling methods employed (Herrenkohl & Herrenkohl, 2009). Population studies using data from child protection services are confounded by legislation-based criteria for the ways maltreatment is defined and reported (Fallon et al., 2010). This means that estimates of the prevalence of childhood maltreatment vary internationally as a result of data collection discrepancies between studies (Fallon et al., 2010).

Because these methodological and definitional differences remain unresolved, comparison between data from different countries is limited (Pereda, Guilera, Forns, & Gomez-Benito, 2009a).

Lack of theory-based research.

Runyan et al. (1998) criticised research in this area as atheoretical and merely descriptive. A gap between research, policy and interventions, they stated, is due to a lack of consistent conceptual theory. Highlighting concerns associated with the interpretation of transactional influences between risk factors, context and maltreatment, Runyan et al. (1998) recommended that maltreatment research integrate an ecological-developmental framework. By using this theoretical framework in the LONGSCAN

(LONGitudinal Studies of Child Abuse and Neglect) research, Runyan et al. (1998) reported that they had addressed many methodological concerns.

Adverse Childhood Experiences Studies

Epidemiological studies into adverse childhood experiences have broadened the focus of maltreatment research to incorporate the impact of children's exposure to multiple adverse family experiences. Research from two widely published epidemiological studies, the ACE Study and the LONGSCAN Study, is presented below. Findings from these studies add to the collective evidence linking childhood maltreatment experiences with multiple adverse risks and negative outcomes.

The ACE study.

The Kaiser Permanente / Centres for Disease Control and Prevention (CDC) Adverse Childhood Experiences (ACE) Study is an epidemiologic study in the USA of over 17, 000 participants (Whitfield, Dube, Felitti, & Anda, 2005). Noting limitations of research into single abuse or neglect types, Felitti et al. (1998b) investigated several types (or categories) of childhood abuse and household dysfunction. Collectively, these have been referred to as *adverse childhood experiences* or "ACEs" (Felitti et al., 1998b; Whitfield, 1998, p. 361). The use of this term implies that childhood maltreatment and related adverse experience are both a developmental and a public health concern (Anda, Butchart, Felitti, & Brown, 2010).

From an initial article by Felitti et al. (1998b), a succession of research papers have used the ACE study data to report on different areas of risk and outcome. These studies report on the relationship between childhood trauma and later health and behavioural outcomes. The ACE study combines prospective data on participants' adult health status with retrospective reports from participants on categories of adverse childhood experience (Felitti, 2002).

ACEs were drawn from themes found in earlier research involving detailed interviews of almost 200 participants in an obesity program (Felitti, 2002). In Wave I of the ACE study, these themes included three categories of personal abuse during childhood, and four (Felitti et al., 1998b) or, subsequently, five categories of dysfunctional household, forming eight categories of ACEs (Anda et al., 1999; Felitti, 2002). The eight categories of ACEs were: 1) physical abuse, 2) emotional (or verbal)

abuse, 3) sexual abuse, 4) living with alcoholic or drug user, 5) incarcerated household member, 6) mental illness in the household, 7) mother was treated violently, and 8) parental separation or divorce. Additional questions were added in Wave II of the ACE study, creating two further categories of ACEs (emotional neglect and physical neglect) and taking the total number of ACEs to ten (Dube, Anda, Felitti, Croft, et al., 2001). The total number of ACEs for each individual provided an ACE score (Dube, Anda, Felitti, Croft, et al., 2001).

Studies using the ACE data have reported a graded relationship between the number of categories of exposure to adverse childhood experiences and multiple health and behavioural risk factors in adulthood (Felitti et al., 1998b). Felitti et al. (1998b) reported ten adult health risks to be significantly associated with experiences of multiple ACEs. These were: suicide attempt, alcoholism, illicit drug use, depressed mood, 50 or more sexual partners, sexually transmitted disease, cigarette smoker, poor self-rated health, obesity (BMI > 35) and physical inactivity (Felitti et al., 1998b). Compared to participants with zero ACEs, the adjusted odds ratios for participants who reported more than four categories of ACEs ranged from 12.2 for suicide attempt to 1.3 for physical inactivity (Felitti et al., 1998b). Adult medical diseases reported to be significantly associated with experiences of multiple ACEs included chronic pulmonary disease, hepatitis or jaundice, ischemic heart disease, any cancer, and skeletal fractures (Felitti et al., 1998b).

The ACE studies have reported significant relationships between the number of adverse childhood experiences and adult mental health outcomes. Anda et al. (2006) reported a graded relationship between the number of ACEs and adult affective disturbances, including depressed affect, hallucinations, panic reactions and anxiety. Risk of mental illness has been reported, including depression (Chapman et al., 2004), lifetime risk of attempted suicide (Dube, Anda, Felitti, Chapman, et al., 2001), and prescriptions of psychotropic medications (Anda et al., 2007).

Linking adolescent and adult health risk behaviours and social problems, ACE study findings have included the initiation of alcohol use by 14 years of age (Dube et al., 2006) and, for boys, impregnating a teenage girl (Anda et al., 2001). Knowledge of these risks, they suggested, can direct prevention efforts (Anda et al., 2001; Dube et al., 2006).

The LONGSCAN studies.

A series of prospective LONGitudinal Studies of Child Abuse and Neglect (LONGSCAN) have investigated the same construction of eight adverse childhood experiences used in the Kaiser Permanente/ CDC ACE studies (Runyan et al., 1998; Thompson et al., 2015). Using data collected from caregivers and their children between ages 4 and 18, the LONGSCAN study investigated eight ACEs during three developmental periods (zero to six years, six to 12 years, 12 to 18 years).

Reporting on the relationship between adverse childhood experiences and health outcomes at age 14, Flaherty et al. (2013) found a graded relationship between the ACE score and categories of poor health, somatic concerns and health problems. Separately reporting on ACEs that occurred in each of the three developmental periods, Flaherty et al. (2013) found differential effects. Although the highest number of ACEs occurred during the first six years of life, these were inconsistently associated with health problems (Flaherty et al., 2013). No significant relationships were found between the number of ACEs occurring during ages six and 12 years and health outcomes. Adverse childhood experiences occurring in the most recent two years (ages 13-14), however, were found to have significant and graded relationships with health and somatic concerns (Flaherty et al., 2013). These differential effects across developmental periods suggest the timing of exposure to ACEs effects outcomes (Thompson et al., 2015). Flaherty et al. (2013) suggested negative consequences for adolescents had previously been overlooked.

Reporting on the final sample of 802 LONGSCAN participants with outcome data at age 18, Thompson et al. (2015) collated ACE data from the three developmental periods to form three trajectory-defined groups. The trajectory groups were 1) chronic ACEs (approximately two or more ACEs at each period), 2) early ACEs only (high ACE score in the first but not subsequent periods) and 3) limited ACEs (with consistently low or zero ACE scores) (Thompson et al., 2015). Group sizes differed with chronic ACEs, early ACEs only and limited ACEs respectively comprising 69%, 7% and 24% of the sample. Comparing exposure to types of ACEs between the three groups, the limited ACEs group had significantly less exposure to any maltreatment (Thompson et al., 2015). The early ACEs only group had significantly more psychological maltreatment than the other groups (Thompson et al., 2015). The chronic ACEs group had significantly more exposure to the four caregiver and household

adverse experiences, and reported more health concerns (Thompson et al., 2015). Rather than being exclusively related to the number of types of ACEs, Thompson et al. (2015) found chronic exposure to adverse childhood experiences significantly affected outcomes.

Commenting on advances in research into child maltreatment inclusive of the ACE studies, Whitfield (1998) expressed hope for the implications this research holds for the next generation:

> In all our history, ours is the first generation to recognize the ravages of child abuse and neglect and begin to do something about it. We are also the first generation to begin to heal ourselves physically and psychologically from the harmful effects of ACEs. Through trial and error and research ...and its publication and then wider dissemination to the public, we can constructively apply our new knowledge and skill to our children. ... if we would raise one generation of healthy children we could go far in eradicating social violence, war, and many other problems of our world (p. 363).

Controversy Related to Causality in Child Maltreatment Research

The study of childhood sexual abuse has navigated through several periods of social and political controversy (Chu, 2011; McNally, 2003). One such period of controversy followed the publication of an article by Rind, Tromovitch, and Bauserman (1998) into the psychological correlates of childhood sexual abuse. The article was publically condemned by the United States Congress, however, the scientific quality of the article and methodology was upheld under independent examination (McNally, 2003).

The article in question by Rind et al. (1998) was a meta-analysis of studies into childhood sexual abuse reporting college student data. Rind et al. (1998) presented findings that "slightly" poorer adjustment in students with a history of childhood sexual abuse [CSA] was better accounted for by family environment than by childhood sexual abuse itself. Explicitly addressing assumptions made in previous research that childhood sexual abuse causes harm that is pervasive, likely to be intense and equal across females and males, Rind and his colleagues argued it appropriate to separate the concept of *abuse* from the concept of *harm* (Rind & Tromovitch, 1997; Rind et al.,

1998). While acknowledging that "in specific cases" childhood sexual abuse can cause "intense harm", Rind et al. (1998) argued that that the negative potential had "been overstated" in clinical research (p.42). Presented as evidence for this position, were findings that 24-37% of male college students "viewed their CSA experiences as positive" (Rind 1998, p.45). Further, Rind et al. argued that the young person's perceived *consent* and *willingness* should be considered as distinct to abuse, and proposed the terms "adult-child sex" and "adult-adolescent sex" to be less value-laden than terms using the words sexual abuse (p.46). This position is strongly refuted within the legal and clinical domains, where children and adolescents are viewed as being under the age of informed consent and abuse experiences as being coloured by shame and self-blame (Briggs, 2011; Courtois, 2014; Dorahy & Clearwater, 2012).

Deliberately investigating non-clinical data, Rind et al. (1998) argued a lack of empirical support for the position that college cohorts typically are better at coping than clinical or community samples. Rather, Rind et al. (1998) suggested that college samples have similar prevalence and severity of childhood sexual abuse; however, undermining this position, they acknowledged, that the college data had substantially lower proportions of close-family perpetrators than that reported in clinical samples. Contrary to the position presented by Rind et al, more recent research using non-clinical cohorts have reported childhood abuse as having long-term negative outcomes not explained by family background (Kendler et al., 2000; Maniglio, 2009).

Summary

Research into childhood maltreatment provides a growing body of evidence linking child abuse, neglect and other adverse childhood experiences with multiple short and long term negative outcomes. There is a separate body of research identifying childhood maltreatment as having intergenerational effects. Cumulative effects of multi-type and chronic maltreatment have been reported to differ from outcomes associated with single abuse types (Finkelhor et al., 2007a). Although unable to make causal attributions related to the aetiology of outcomes, studies using retrospective reports of childhood maltreatment remain prominent in the research literature (Briere, 1992b).

Retrospective research is inclusive of cases, of equal or more severe maltreatment, not reported during childhood and adds to the collective knowledge in this area (Kendall-Tackett & Becker-Blease, 2004). Theory-driven research can support the interpretation of findings on child maltreatment (Runyan et al., 1998).

As outlined in this chapter, research into childhood maltreatment has encompassed a broad spectrum of approaches. Within the diverse body of literature, outcomes related to childhood maltreatment have been reported as complex; not only are there are a diverse range of outcome measures in the literature, there are also a large number of risk and protective factors that contribute to these outcomes. The current research seeks to consider both the potential long-term impacts for the individual and the potential intergenerational impacts of childhood maltreatment. Many potential impacts of childhood maltreatment were considered within the current research. As a result of this broad focus, systematic review was not considered an appropriate literature review methodology. Rather, literature across these areas is reviewed.

As detailed in later chapters, the current research used retrospective self-reporting of childhood experiences including maltreatment. Multiple types of childhood abuse and neglect were investigated, including sexual abuse, physical abuse, physical neglect and emotional neglect alongside reports of witnessing family violence, parental substance abuse problems, and family psychopathology. The theoretical framework for the current research is presented in Chapter 2 and forms the basis for interpretation of the current results.

Chapter 2: The Effects of Childhood Abuse and Neglect on the Lifespan

Development of the Survivor

The trauma of chronic and severe childhood abuse and neglect is far reaching and can hold detrimental consequences for the lifespan development of the survivor (Briere, 1992a; Kezelman et al., 2015; van der Kolk, 2014). Focussed at the individual-level, Chapter 2 presents a summary of past research into the short and long-term impacts of traumatic childhood abuse and neglect. Developmental impacts of childhood maltreatment are described. These include biological impacts on body and brain, disruptions in relationships with self and others, and mental health sequelae. The term *complex trauma* is introduced and is delineated from other traumas. A theoretical framework influenced by the core principles of several conceptual approaches to maltreatment research is presented. The effects of childhood maltreatment on relationships and functioning are presented as transactional, cumulative and influenced by complex and interrelated risk and protective factors.

Developmental Impacts of Child Abuse and Neglect

Childhood maltreatment trauma is a developmental concern. *Trauma* refers not to an event, but rather to the individuals' subjective response to experiences within their relationships and environment (van der Hart, Nijenhuis, & Steele, 2005). Occurring during a vulnerable, formative stage of life, parental maltreatment and overwhelming stressful events can disrupt normal developmental processes in the child (Chu, 2011). Traumas arising from experiences of childhood abuse differ from adult traumas. Experiences of childhood maltreatment potentially disrupt or distort psychological and neurological growth (Perry, 2005), impact on cognitive, social and emotional development (Weitzman, 2005), and disturb relationships with others (Cloitre, Cohen, & Koenen, 2011). Furthermore, as child maltreatment occurs directly or indirectly within the child's care-giving network, these abuses uniquely invade the very relationships that support the child's development of secure attachment, sense of self, and view of the world (Cloitre et al., 2011).

Holding implications for adult survivors, the developmental impacts of severe and chronic childhood maltreatment are pervasive and potentially life-long (Moffitt, 2013; Shonkoff et al., 2012). Converging findings within the maltreatment research literature detail biological and psychological sequelae. These include 1) critical periods of developmental vulnerability, 2) stress-sensitive biological alterations, and 3) interruptions in attachment and the development of self.

Critical Periods of Developmental Vulnerability in Childhood

Traumatic experiences in utero, during infancy, childhood, or adolescence can permanently disrupt normal physiological and psychological development (Cozolino, 2010; Lupien, McEwen, Gunnar, & Heim, 2009). Distinct from the mature adult brain, experiences during childhood, including traumatic experiences of abuse or neglect, are responsible for organising undifferentiated neural systems in the developing brain (Perry, Pollard, Blakley, Baker, & Vigilante, 1995). The timing and duration of exposure to chronic stress is crucial to specific effects on brain, behaviour and cognition (Lupien et al., 2009). *Sensitive periods* in childhood behavioural development reflect sensitive time periods in neural development related to these behaviours (Knudsen, 2004). In normal development, neural circuits are shaped through the selective activation of neural connections (Cozolino, 2010). Within these sensitive periods are *critical periods* of developmental vulnerability, in which social experiences powerfully organise neural connectivity (Knudsen, 2004). Lupien et al. (2009) suggested the presence of *windows of vulnerability* (p.441) within which acute effects of early-life childhood maltreatment on brain organization have protracted effects that emerge during adolescence and adulthood. Traumatic stress during early childhood can disrupt these experience-dependent neurodevelopmental processes; altering the pattern of activation and compromising function (Perry, 2008).

Knudsen (2004) suggested, after the critical period has ended, the effects of traumatic experiences are *permanent* and "cannot be remediated by restoring typical experience later in life" (p.1412). Acknowledging profound effects of childhood maltreatment experiences, Gunnar and Quevedo (2007) provided a different perspective, suggesting neurobiology is *not fixed*. Potential for positive outcomes following childhood maltreatment, they suggested, can be actualised when supported by

enriched home environments and emotion-focussed interventions with children and their caregivers (Gunnar & Quevedo, 2007).

Reports that infants and young children are over-represented in child protection services suggests an overpopulation of the highest risk groups (Australian Institute of Health and Welfare, 2014; MacKenzie, Kotch, Lee, Augsberger, & Hutto, 2011; Putnam-Hornstein & Needell, 2011). In a longitudinal study of infants followed from birth to 5 years old, Brown and Ward (2014) found delays in protective intervention occurred across key developmental stages. These delays meant that very young children either continued to experience maltreatment or lacked permanent care plans (Brown & Ward, 2014). Brown and Ward (2014) found children in their study had high rates of developmental delay and emotional or behavioural difficulties (57%) by age three. Involvement with child protection services prior to turning one was reported to impact on the children's development of attachment, trust, curiosity, communication, reasoning, impulse control, and coping (Brown & Ward, 2014).

Impact of Childhood Maltreatment on Body and Brain

Experiences and behaviours shape, and are shaped by, both the brain and the body (van der Kolk, 2014). This is particularly important when considering the short and long-term effects of child maltreatment (van der Kolk, 2014; van der Kolk, McFarlane, & Weisaeth, 1996). Evidence from neurobiology and epidemiology research suggests childhood maltreatment experiences cause enduring changes to the developing brain (Anda et al., 2006; Lupien et al., 2009). Exposure to childhood maltreatment trauma has been associated with the development of posttraumatic stress disorder (PTSD) (Herman, 1992; Powers, Cross, Fani, & Bradley, 2015). Studies of children with PTSD have reported findings of alterations of biological stress systems (De Bellis, Baum, et al., 1999) and adverse brain development (De Bellis, Keshavan, et al., 1999).

Biological stress systems.

The body's biological stress system is critical for health and adjustment. Neural regulation of stress and coping strategies are on a continuum from survival responses to positive social and emotional experiences (Porges, 2001). The hypothalamic-pituitary-adrenal (HPA) axis, located within the mammalian brain, is central to survival

responses to stress. The hippocampus, involved in learning and memory functions, is an area of the brain sensitive to stress (Anda et al., 2006). Exposure to antenatal stress – through maternal stress or depression, or foetal exposure to glucocorticoids – has been associated with disturbances in child neurological development, cognitive development and behaviour (Lupien et al., 2009). In infancy and early childhood this system is still developing and is strongly shaped by parental caregiving (Tarullo & Gunnar, 2006).

Converging research suggests traumatic experiences of childhood maltreatment disrupt normative neurobiological responses to stress (Alink, Cicchetti, Kim, & Rogosch, 2012; Trickett, Noll, Susman, Shenk, & Putnam, 2010). Stress and trauma impact on the HPA axis and on the central nervous system including functions of the hippocampus and amygdala (van der Kolk, McFarlane, & Weisaeth, 1996). During periods of stress, such as is experienced by the maltreated child, the HPA axis is activated to produce cortisol (De Bellis, Baum, et al., 1999). Stressful experiences of maltreatment produce hypervigilance and physiological alterations in the child's HPA function including chronically elevated cortisol levels (Tarullo & Gunnar, 2006). Continuing research in this area suggests this elevation of cortisol occurs only initially (Alink et al., 2012). When children continue to perceive their environment to be threatening, there is a dysregulation of this process (van der Kolk, 2014).

In a meta-analysis of cortisol research, Miller, Chen, and Zhou (2007) found variability in HPA function to relate to the type of stress and the individual's response to stress. Acute experiences of traumatic uncontrollable stressors have been associated with a high, flat profile of cortisol; however, chronic and severe uncontrollable stress including PTSD has been associated with reduced cortisol (Miller et al., 2007). In a longitudinal comparison of sexually abused and not-abused children, Trickett et al. (2010) found group differences in the developmental trajectory of basal (non-stress) cortisol. In normative development, a linear increase of non-stress cortisol levels was found from middle childhood into early adulthood. In the sexually abused group, after an initial period of elevated cortisol, cortisol was downregulated, leading to an attenuation of non-stress cortisol with time since disclosure of abuse. In adults with PTSD, Simsek, Uysal, Kaplan, Yuksel, and Aktas (2015) found a similar effect of decreased cortisol levels with increased time following trauma.

Biological systems involved in stress regulation and social engagement are interrelated (Porges, 2001). For social engagement to occur, the environment must be

perceived as safe. In appropriate social communication, neurons in the brainstem are regulated by the frontal cortex of the brain (Porges, 2001). When individuals perceive their environment to be threatening, such as during maltreatment, the neural systems involved in social engagement are immobilised (Porges, 2001). During perceived threat, primitive brain systems are activated, producing fight, flight or freeze behaviours (Porges, 2001). This has implications for parent-child attachment and child social competence in contexts of childhood maltreatment (Alink et al., 2012; Bazhenova, Plonskaia, & Porges, 2001).

In a longitudinal study into the relationship between childhood maltreatment, child social functioning and cortisol regulation, Alink et al. (2012) found an indirect effect of maltreatment on cortisol via social functioning. Compared to a matched high-risk, low SES non-maltreated control group, maltreated children showed less prosocial behaviour and more aggressive/ disruptive and withdrawn behaviour (Alink et al., 2012). At 1-year follow-up, Alink et al. (2012) found these difficulties in social functioning in the maltreated children to be related to lower morning cortisol levels (non-stress).

Disruptions in HPA functioning including cortisol dysregulation are considered the mechanisms through which early life stress presents a risk for later physical and mental health problems (Essex et al., 2011). These findings hold implications for the long term well-being of survivors of childhood abuse and neglect (Trickett et al., 2010). However, several studies have found preventative psychosocial interventions following childhood maltreatment can prevent or reverse disruptions in HPA functioning (Brotman et al., 2007; Trickett et al., 2010).

Adverse brain development.

Through the alterations in biological stress systems described above, childhood maltreatment trauma has been found to adversely impact brain development (De Bellis, Keshavan, et al., 1999). De Bellis, Keshavan, et al. (1999) found, compared to matched controls, maltreated children with PTSD had smaller brain volume, alterations in brain structure and altered function.

Maltreatment experiences during early childhood modify epigenetic mechanisms that shape neural circuits in the brain during sensitive periods of development (Roth & Sweatt, 2011). Roth and Sweatt (2011) suggested epigenetic changes play a role in the life-long impacts associated with adverse childhood experiences. These changes in brain

function and structure have lifelong impacts on individuals' cognitive health and their risk for psychopathology (Anda et al., 2006; Roth & Sweatt, 2011). Anda et al. (2006) used the ACE Study as a case study demonstrating convergence of findings between epidemiological and neurobiological maltreatment research. They reported a graded relationship of the ACE score with memory impairment, perceived stress, problems controlling anger and partner violence (Anda et al., 2006).

Impact of Childhood Maltreatment on Attachment and the Development of Self

The quality of the parent-child relationship is central to the infant's ability to develop a sense of security within the attachment relationship (Bowlby et al., 1968). Early attachment care experiences have life-long effects on the development and mental health of the child (Bowlby et al., 1968). Children form representation models of their caregiver, themselves and future relationships based on their primary attachment relationship (Sherman, Rice, & Cassidy, 2015; Toth & Cicchetti, 2013). Secure attachment is formed from warm, sensitive and responsive parental caregiving (Morton & Browne, 1998; Stacks et al., 2014).

Experiences of caregiver maltreatment in infants can disrupt early attachment relationships. Disorganised attachment behaviour in infants has been linked with exposure to severe abuse and neglect (Main, 1996). Associations between infant attachment disorganisation and parental behaviour has been found with parental abusive behaviours that are threatening (Hesse & Main, 2006) or frightening (van Ijzendoorn, Schuengel, & Bakermans-Kranenburg, 1999). Infant attachment disorganisation has also been associated with parent behaviour that is frightened or dissociative (Hesse & Main, 2006). Hesse and Main (2006) suggested these frightened or dissociative parental behaviours reflect unresolved loss or maltreatment trauma in the parent.

Early childhood experiences of threat, fear or unresponsive parental care place children in a paradox in which they are unable to access their caregiver as a source of comfort and coping (Crittenden, 2008). Parental behaviour involving child maltreatment undermines attachment relationships and has been associated with high rates of insecure and disorganised attachment (Cyr, Euser, Bakermans-Kranenburg, & Van Ijzendoorn, 2010; Hesse & Main, 2006). Cyr et al. (2010) found, compared to other high-risk children, maltreated children had less secure attachments and more disorganised

attachments. The behavioural indicators of disorganised attachment reflect unresolved anxiety and stress in children as a result of their parent being simultaneously the source of fright and the only available source of potential safety (van Ijzendoorn et al., 1999). Fonagy (2013) suggested that attachment trauma results from a lack of organised attachment strategy. Disorganised attachment has been shown to persist across time and to be related to later externalizing problem behaviour and dissociative behaviour (van Ijzendoorn et al., 1999).

Attachment processes begin at birth (Brown & Ward, 2014). In the context of child-caregiver attachment experiences, infants develop internal cognitive scripts of the self, others and the world (Sherman et al., 2015). Childhood maltreatment has been associated with the formation of maladaptive schemas in which the individual views "the self as worthless, others as abusive, or the world as threatening and dangerous" (Wright, Crawford, & Del Castillo, 2009, p. 59). In a systematic review, Pacheco, Irigaray, Werlang, Nunes, and Argimon (2014) reported experiences of childhood maltreatment to impact on the child's psychological adjustment through impairments to self-esteem, social competence, academic performance and peer relationships.

The findings within this research show that early traumatic disruptions to attachment and the development of self can have profound negative impacts across the child's development. These developmental disruptions leave the child vulnerable to further difficulties in relationships and seriously undermine their mental health.

Mental Health Symptoms and Disorders Associated with Childhood Maltreatment

Child maltreatment trauma has been found to be a significant risk for a wide range of subsequent mental health symptoms and disorders (Rogosch, Dackis, & Cicchetti, 2011). In childhood and adolescence, psychopathology associated with maltreatment includes major depression, PTSD, attention-deficit/hyperactivity disorder, oppositional defiant disorder and conduct disorder (Cicchetti & Valentino, 2006; Rytilä-Manninen et al., 2014). In adults, a history of childhood maltreatment has been associated with mood disorders, anxiety disorders, personality disorders, impulse control disorders and substance abuse disorders (Green et al., 2010; Herman, Perry, & van der Kolk, 1989; Putnam, Harris, & Putnam, 2013). Within the association between

childhood maltreatment and subsequent adult psychopathology, variations in the characteristics and severity of the maltreatment predict differential outcomes (Collishaw et al., 2007).

Comparing first-onset and lifetime persistence of mental disorder, McLaughlin et al. (2010) found stronger associations between childhood adversities (including maltreatment) and disorder onset than between childhood adversities and disorder persistence. While the associations between childhood adversity and both disorder onset and disorder persistence were statistically significant, the stronger association with onset, they suggested, had more substantive implications for primary intervention (McLaughlin et al., 2010).

Putnam et al. (2013) reported that increased childhood adversity was associated with presentations of more complex adult psychopathology. Complex adult psychopathology reflected the clustering of more than one category of psychopathology, with co-occurring mood disorders, anxiety disorders, impulse control disorders and substance abuse disorders (Putnam et al., 2013). Comparing these four categories of psychopathology, Putnam et al. (2013) found additive and multiplicative synergistic patterns related to eight categories of childhood adversities. Differing from the types of adversity investigated in the ACEs studies, the eight childhood adversities were: childhood sexual abuse, childhood physical abuse, parental substance abuse, single parent or non-biological caregivers, financial hardship, victim of crime and exposure to family violence (Putnam et al., 2013).

In a longitudinal study into the impact of childhood sexual abuse on female development, Trickett, Noll, and Putnam (2011) found negative outcomes across developmental stages from childhood into early adulthood. The negative outcomes reported included stress response alterations, psychopathology (depression, dissociative symptoms, PTSD, self-mutilation), cognitive deficits and school drop-out, higher rates of major illness and obesity, earlier onset of puberty and maladaptive sexual development. Wright et al. (2009) found maladaptive schemas, including defectiveness or shame and vulnerability to harm, mediated the relationship between childhood emotional neglect and symptoms of anxiety, depression and dissociation in young adults.

Depression and Anxiety

Individuals with a history of childhood maltreatment have higher rates of depression and anxiety (Edwards, Holden, Felitti, & Anda, 2003; Salazar, Keller, & Courtney, 2011). In a review of the childhood sexual abuse literature, Maniglio (2010) found childhood sexual abuse to be a significant risk for depression with a small to moderate magnitude. Reporting on the ACE Study data, Edwards et al. (2003) found a dose response relationship between the number of types of maltreatment and depression and anxiety scores. Perception of the family environment being emotionally abusive was found to accentuate these effects (Edwards et al., 2003).

In a 32-year prospective longitudinal study, Danese et al. (2009) found that children who had experienced adverse psychosocial experiences including maltreatment had increased risk in adulthood of depression, inflammation and metabolic risk factors. Miron and Orcutt (2014) found depressive symptoms mediated the relationship between childhood abuse and risk for revictimisation.

Post-Traumatic Stress Disorder

Childhood maltreatment is both a risk and a cause of PTSD (De Bellis, Keshavan, et al., 1999). Prospective and retrospective studies of childhood maltreatment provide strong evidence of PTSD and trauma symptoms both being predicted by maltreatment and being an outcome of a history of childhood maltreatment (Higgins & McCabe, 2000b; Shea, Walsh, Macmillan, & Steiner, 2005; Stovall-McClough & Cloitre, 2006; Yehuda, Halligan, & Grossman, 2001).

Although PTSD is recognised in DSM-5 as a potential consequence of severe single-event traumas (American Psychiatric Association, 2013), not all early life trauma is equally associated with PTSD in adulthood (Pratchett & Yehuda, 2011). Compared to adults with a history of single-event trauma during childhood, PTSD is more common in adults with a history of childhood maltreatment (Pratchett & Yehuda, 2011). Pratchett and Yehuda (2011) suggested that revictimization, together with other individual characteristics, explains differential outcomes in the development of PTSD following early life trauma. Disruptions to early attachment relationships associated with experiences of maltreatment may exacerbate the impact of experiences of chronic

or cumulative childhood maltreatment or subsequent victimization (Pratchett & Yehuda, 2011).

Various terms have been used within the research literature to subcategorise PTSD according to its aetiology and symptomology, including *chronic PTSD*, *complex PTSD* and *dissociative PTSD* (Dorahy et al., 2015; Herman, 1992; Lanius, Brand, Vermetten, Frewen, & Spiegel, 2012). Complex PTSD, alternately termed *disorders of extreme stress not otherwise specified* (DESNOS), has been used to form a more complicated type of PTSD related to early-life chronic interpersonal trauma (Brett, 1996; van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). Complex PTSD or DESNOS is a relational disorder associated with traumatic disruptions in early attachment relationships inclusive of childhood maltreatment (Dorahy et al., 2013). Dissociation has been suggested to have a role in the aetiology of PTSD (Briere, Scott, & Weathers, 2005). Further, both PTSD and dissociation impact on relational functioning (Dorahy et al., 2009; Dorahy et al., 2013).

The core features of PTSD are symptoms of triggered re-experiencing of fear and horror through flashbacks or nightmares (Brewin, Lanius, Novac, Schnyder, & Galea, 2009). PTSD frequently co-occurs with other psychopathology including depression (D. J. Lee, Liverant, Lowmaster, Gradus, & Sloan, 2014) and dissociation (van der Hart et al., 2005). Dorahy et al. (2015) found overlap between the symptom profiles of PTSD and dissociative disorder, with severe psychiatric symptoms discriminating child-abuse related chronic PTSD from child-abuse related severe dissociative disorders.

Dissociation

Dissociation has been associated as a key variable in understanding the connection between complex trauma and subsequent psychopathology in adult survivors (Schimmenti & Caretti, 2014). Dissociations occurring at the time of overwhelming experiences of abuse and neglect "paradoxically protect the traumatised child from a fragmentation of the self through multiple disconnections in the self, occurring at both mental and bodily levels" (Schimmenti & Caretti, 2014, p. 1). In this respect, dissociation can be considered an adaptive coping mechanism in situations of severe

trauma, but problematic in the longer term (Egeland & Susman-Stillman, 1996; Jones, 1996).

van der Hart et al. (2005) described a spectrum or continuum of trauma-related disorders "charcterterized by a structural dissociation of the personality" (p.420-421). They described clusters of trauma-related disorders that cause alterations in consciousness and attention, somatization, affect and impulse dysregulation, self-perception, attachment disorganisation and disruptions to interpersonal relationships, and inconsistencies across the individual's systems of meaning (van der Hart et al., 2005; van der Hart, Nijenhuis, Steele, & Brown, 2004).

Borderline Personality Disorder

Patients diagnosed with Borderline Personality Disorder (BPD) commonly report a history of childhood maltreatment (Herman et al., 1989; Zanarini et al., 2002). BPD is characterised by instability in interpersonal relationships, disturbances in identity, affective instability and frequent intense displays of inappropriate anger (American Psychiatric Association, 2013). Features of BPD include intense fears of abandonment, an unstable sense of self and of others involving splitting good and bad, and recurrent suicidal or self-harm behaviour (American Psychiatric Association, 2013). These features have been theorised to represent continued fragmentation of the self and to reflect attempts to self-regulate following experiences of chronic terror within severe early childhood abuse and neglect (van der Kolk, 1996).

In psychoanalytic terms, borderline personality features of unstable sense of self (or *individuation*) and of others (*separation*) reflect disturbances in separation-individuation processes (Dolan, Evans, & Norton, 1992). Dolan et al. (1992) investigated the association between separation-individuation disturbances and adult personality problems in adult hospital residents with severe personality disorders. A significant positive correlation was found between scores on the Separation-Individuation Inventory (Christenson & Wilson, 1985) and borderline personality characteristics.

Complex Trauma

Pervasive psychological traumatic effects arising from experiences of chronic and severe child abuse and neglect are predominantly referred to as *complex trauma*. Differentiated from other psychological traumas, complex trauma refers to the timing of the trauma as occurring during childhood (Ford & Courtois, 2014). Complex trauma impacts directly on the development of self and disrupts attachment relationships through the betrayal of trust (Ford & Courtois, 2014). Accordingly, the core impacts of complex trauma are in the disruption of self-regulation and interpersonal relationships (Cook et al., 2005).

In defining and categorising childhood traumas, Terr (1991) delineated single event traumas, Type I traumas, from repeated, or Type II traumas. Type I childhood traumatic conditions arise from an experience or witnessing of a single, unanticipated event. Following a Type I trauma, the individual actively recalls and recounts the traumatic event in order to make sense of it (Terr, 1991). Children's recollection and memory of single event trauma is complete, detailed and verbal from as early as three years of age (Terr, 1991). In contrast to this, Terr (1991) described Type II traumas to be uniquely characterised by "denial and numbing, self-hypnosis and dissociation, and rage" (p.10). Following Type II trauma, individuals characteristically deny or avoid talking about their experiences, may have no memory of periods of their childhood, may escape mentally from repeated terrors through dissociating and may enact rage and harm against themselves (Terr, 1991). Building on Terr's research, Solomon and Heide (1999) proposed a Type III trauma to conceptualize severe complex traumas. Also arising from multiple traumatic events, Type III trauma is associated with pervasive, violent events that began at an early age. These experiences were longer-lasting, involved multiple perpetrators including caregivers and were described as unpredictable or involved multiple types of abuse (Solomon & Heide, 1999).

Developmental Trauma Disorder

For survivors of child abuse and neglect, the trauma is developmental, occurring during, and impacting on, the development of the infant, child or adolescent. Developmental Trauma Disorder has been proposed as a diagnostic term describing the

manifestation of complex trauma in abused and neglected infants, children and adolescents. Van der Kolk and others (van der Kolk, 2005; van der Kolk & Courtois, 2005) unsuccessfully lobbied the American Psychiatric Association for inclusion of Developmental Trauma Disorder in the DSM-5. Ongoing support for inclusion of the Developmental Trauma Disorder has identified it as being unaccounted for by other disorders and as having clinical utility for the treatment of traumatised children with complex psychiatric presentations (Ford et al., 2013).

Operational Definitions

Childhood maltreatment. Childhood maltreatment refers to the significant interpersonal perpetration of harm, neglect and boundary violation by adults, centrally involving the traumatic disruption of attachment relationships.

Child abuse and neglect. Child abuse and neglect refers to any report of physical, sexual, emotional child maltreatment or lack of adequate care and protection. All uses of the word *abuse*, *neglect* or *maltreatment* in the current research refer to any type of child abuse and neglect, unless otherwise stated.

Complex trauma. In this thesis, *complex trauma* refers to the early life experience of multiple, severe or persistent interpersonal traumas resulting from child abuse and neglect and subsequent developmentally-based problems in personal and interpersonal functioning.

Abuse. The term *any-abuse* is used to encompass childhood sexual abuse, childhood physical abuse, childhood physical neglect and childhood emotional neglect. Exceptions to this occur when a specific subtype of abuse or neglect is being referred to, e.g. *childhood sexual abuse*.

Survivor. In this thesis, s*urvivor* is used as a shortened term referring to *adult survivors of childhood abuse and neglect*. It refers only to adults, and not to children who have a history of childhood maltreatment. Children and young people who have experienced abuse or neglect are identified as children rather than survivors. The term survivor reflects that the individual has lived through the abuse experience and continues to live after the abuse has stopped (Robinson, 2000). Surviving is not limited to positive, self-protective behaviours. Rather, acts of surviving may include strategies

that undermine safety or perpetuate harm of self, including: "promiscuity, chemical and material addictions, prostitution, denial, control or overachievement" (Robinson, 2000, p. 162). Robinson separated the idea of victimization from the continued experience of surviving, suggesting victims can come to a point of identifying as a survivor, and become empowered to advocate for other survivors.

   Intergenerational continuity. Intergenerational continuity is used to indicate instances in which the subsequent generation reports similarities in their maltreatment status, interpersonal functioning, presence of trauma symptoms, or level of proactive coping.

   Risk factor. A risk factor is any circumstance that increases the likelihood of a negative outcome.

   Protective factor. In contrast to a risk factor, a protective factor is any circumstance that decreases the likelihood or the severity of a negative outcome.

   Resilience. The phenomenon that some people "have a relatively good outcome despite suffering risk experiences that would be expected to bring about serious sequelae" (Rutter, 2007, p. 205). In the current research, resilience in participants who have a maltreated parent refers to reported successes across intergenerational discontinuity of maltreatment and several domains of functioning.

Theoretical Framework

   Research into child maltreatment spans the fields of developmental and clinical psychology, social work, psychiatry, neuropsychiatry, public health and epigenetics. Varied theoretical frameworks in these fields have been used to investigate, model, intervene and influence policy (Shonkoff & Fisher, 2013; Weitzman, 2005). These theoretical frameworks include attachment theory (Morton & Browne, 1998; Pearlman & Courtois, 2005), developmental-psychoanalytic perspectives (Fraiberg, Adelson, & Shapiro, 1975; Schimmenti & Caretti, 2014), neurodevelopmental (Perry, 2009), developmental psychopathology (Cicchetti & Toth, 1995; McMahon, 2014) and ecological/ transactional approaches (Cicchetti & Lynch, 1993).

   Multiple evolving ecological and transactional models have been applied to child maltreatment research. These have included ecological (Belsky, 1980a;

Bronfenbrenner, 1977, 1979; Romano, Babchishin, Marquis, & Frechette, 2015), ecological-developmental (Runyan et al., 1998), bioecological (Bronfenbrenner & Morris, 2007), ecobiodevelopmental (Shonkoff et al., 2012), ecological-transactional (Cicchetti, Toth, & Maughan, 2000; Sameroff & MacKenzie, 2003), cumulative ecological-transactional (MacKenzie, Kotch, & Lee, 2011) and transactional – bioecological approaches (Osofsky & Lieberman, 2011). With the progression of research into childhood abuse and neglect, complexity within these theoretical frameworks has increased (Cicchetti & Valentino, 2006; Institute of Medicine & National Research Council, 2014).

Bronfenbrenner's ecology of human development (Bronfenbrenner, 1977, 1979) conceived children (or persons) as developing in the context of evolving interactions with and within their environment. Combining Bronfenbrenner's focus on the ecology (or context) with ontogenic (or individual parent) development, Belsky (1980a) developed a conceptual framework for an ecological aetiology of child maltreatment. Belsky (1980a) conceptualised child maltreatment as a "social-psychological phenomenon" (p. 320) determined by interacting factors across four levels of the ecosystem. These being the individual developmental history of the parent related to their maltreatment behaviour towards the child (*ontogenic development*); the family (*microsystem*); the community (*exosystem*); and the culture (*macrosystem*).

Belsky (1980b) applied an ecological analysis to explore children's substitute care experiences in child day care settings. Belsky (1980b) concluded that availability of child care outside of the home reflected a cultural shift in attitudes about parenting practices. Further, Belsky drew parallels between this cultural shift in parenting and an increased societal responsibility to protect children from abuse and neglect. In more recent research, Belsky and colleagues used the ecological framework to investigate the intergenerational transmission of parenting (Belsky et al., 2005). Intergenerational research is reviewed in Chapter 3 of this thesis.

Cicchetti and colleagues (Cicchetti & Lynch, 1993; Cicchetti et al., 2000; Cicchetti & Valentino, 2006) integrated Bronfenbrenner's ecological theory and Belsky's ecological framework with developmental psychopathology to form an ecological-transactional perspective on childhood maltreatment. Developmental psychopathology has been used in child maltreatment research to promote understanding of adverse developmental outcomes (Cicchetti & Toth, 1995). In

developmental research, childhood maltreatment is viewed as disturbing the resolution of stage-related developmental tasks across social, emotional, cognitive and behavioural domains underpinning personality functioning (Weitzman, 2005). In situations of childhood maltreatment, disturbances in the child's environment, including the child's experience of parental care and protection, may lead to maladaptive development and psychopathology (Cicchetti & Valentino, 2006). Ecological-transactional perspectives view child development as being organised into hierarchical levels that interact with mutual influence (Cicchetti & Valentino, 2006). Bidirectional interactions are thought to occur between the individual and his or her environment at all levels of development (Cicchetti & Valentino, 2006; Sameroff & MacKenzie, 2003). These interactions include epigenetic modifications in the expression of genes (Moffitt, 2013), neurobiological processes (Ludy-Dobson & Perry, 2010), attachment (Hughes, 2004) and behaviour (Conger, Neppl, Kim, & Scaramella, 2003).

Distinct from models of single causal mechanisms, the cumulative ecological-transactional approach considers complex cumulative risk processes involved in the aetiology of developmental psychopathology (MacKenzie, Kotch, Lee, et al., 2011). The cumulative approach has been used to conceptualise the additive impact of experiences of multiple types of abuse and neglect and other adverse childhood experiences.

There is "a shared conceptual core" (Shonkoff & Fisher, 2013, p. 1640) to the varied theoretical frameworks that have been applied to child maltreatment. The consensus amongst these theoretical perspectives is that the child's emotional and social wellbeing is substantively influenced by the quality of the caregiver-child relationship and the environment (Osofsky & Lieberman, 2011). The core of childhood maltreatment is a traumatic disruption of the parent-child relationship. This disruption negatively impacts the healthy development of the child.

The current research is influenced by the core principles of several conceptual approaches to maltreatment research, taking what I describe as an *eco-transactional psychodevelopmental* approach. This research will consider the effects of childhood maltreatment on relationships and developmental functioning as being transactionally influenced by cumulative, interactive risk and protective factors.

Risk and protective factors refer to child characteristics, parent characteristics, family functioning, community connectedness and socio-cultural factors (Osofsky &

Lieberman, 2011; Runyan et al., 1998). *Child characteristics* include age, genetic influences, temperament, cognitive strengths and weaknesses, social competence and adaptive functioning (Bagley & Mallick, 2000; Schultz, Tharp-Taylor, Haviland, & Jaycox, 2009). *Parent characteristics* include psychological functioning, mental health – particularly severe maternal depression, history of maltreatment, age, resourcefulness, low educational attainment and poverty (K. Kim, Noll, Putnam, & Trickett, 2007; Li, Godinet, & Arnsberger, 2011; Sidebotham, Heron, & Team, 2006). *Family factors* include the quality and quantity of the parent-child relationship, family emotional functioning, single parent families, parental relationship (including presence of family violence), and sibling relationship (abuse or support) (Afifi, Boman, Fleisher, & Sareen, 2009; Appleyard et al., 2005; Scaramella & Conger, 2003; Shen, 2009). *Community connectedness* includes parental social support, child peer relationships, interaction with school, and engagement with social resources (Chapple & Vaske, 2010; Moncher, 1995; Spilsbury & Korbin, 2013). *Socio-cultural factors* (or neighbourhood) include availability of resources, housing quality and levels of crime and violence (Cicchetti & Lynch, 1993; Coulton, Crampton, Irwin, Spilsbury, & Korbin, 2007; Freisthler, Merritt, & LaScala, 2006; Osofsky & Lieberman, 2011).

Healthy development is dependent upon complex transactional processes that are shaped by the presence of multiple risk and protective factors (Osofsky & Lieberman, 2011; Sameroff & MacKenzie, 2003). Child and family functioning and wellbeing is dependent upon both the level of risk and the capacity for the family to deal with ecological adversity (MacKenzie, Kotch, Lee, et al., 2011).

From the theoretical diversity of previous maltreatment research, the eco-transactional psychodevelopmental approach of the current research allows for diversity within the context of risk and protective factors. Amid findings of adverse outcomes following maltreatment, individual survivors of childhood maltreatment have diverse developmental trajectories (Banyard & Williams, 2007; Dube, Felitti, & Rishi, 2013; Pratchett & Yehuda, 2011). The eco-transactional psychodevelopmental approach provides a framework not only for investigating risk and vulnerability, but also for investigating protective factors that contribute to resilience.

Summary

Traumatic experiences of child abuse and neglect can have life-long impacts on the development of the individual survivor. In early childhood, complex trauma has been associated with disruptions in attachment processes and neurological development. Cumulative experiences of fear and horror in the context of direct harm or insufficient care and protection from attachment figures can produce complex trauma. Complex trauma has a developmental impact on the individual's lasting internal working models of self, others and the world.

Childhood maltreatment has been strongly associated with complex presentations of psychiatric symptoms in the child and adolescent. Protracted effects of unresolved trauma related to childhood maltreatment tend to present during adulthood. The research literature provides evidence that a history of childhood maltreatment is a risk for adult psychopathology including depression, anxiety, PTSD, dissociation and BPD.

The current research uses an eco-transactional psychodevelopmental approach to consider the impact of childhood maltreatment on the adult survivor. This research focuses on the functioning and relationships of survivors and the impacts of childhood maltreatment within an intergenerational context. The eco-transactional psychodevelopmental approach is used to consider possible transmission processes in intergenerational continuity of functioning, relating with others, trauma symptoms, and abuse. In Chapters 3 and 4, the focus is on the ecology of transactional psychodevelopmental influences within which the legacy of childhood maltreatment in the parent presents intergenerational risks for the next generation.

Chapter 3: Intergenerational Child Maltreatment Trauma

As outlined in Chapter 2, the potential effects of child maltreatment trauma on the lifespan development of the survivor are serious and complex (Briere, 1992a; Kezelman et al., 2015; van der Kolk, 2014). Moving beyond the level of the individual, the effects of child maltreatment can be intergenerational, impacting on the developmental trajectory of the children of the abused (Leifer, Kilbane, Jacobsen, & Grossman, 2004). There is strong acknowledgement of the presence of an intergenerational transmission of trauma in literature discussing adult children of Holocaust survivors, of Vietnam Veterans (deGraaf, 1998), and of survivors of war (van Ee et al., 2012). There are profound intergenerational effects of trauma on indigenous people including the First Australians (Atkinson, 2011). There is evidence for intergenerational continuity of behaviour and the transfer of psychosocial risk (e.g.Capaldi, Conger, Hops, & Thornberry, 2003; Serbin & Stack, 1998). Despite, this, there has been very little research into the intergenerational effects of child abuse and neglect trauma on the adult functioning of the next generation (Frazier, West-Olatunji, & Goodman, 2009).

Interest in the area of intergenerational child maltreatment trauma can be grouped into three core domains: 1) research focussed on the transmission of child abuse and neglect across generations (e.g.Hurley, Chiodo, Leschied, & Whitehead, 2003; Milner et al., 2010; Newcomb & Locke, 2001; Thornberry & Henry, 2013; Widom et al., 2015), 2) research examining intergenerational continuity of experiences in the attachment and parenting practices of survivors (e.g. Belsky et al., 2005; Capaldi, Pears, Patterson, & Owen, 2003; Fraiberg et al., 1975; Kretchmar & Jacobvitz, 2002), and 3) non-empirical papers addressing the concept of intergenerational trauma relevant to childhood maltreatment (e.g.Cassidy & Mohr, 2001; Frazier et al., 2009; Walker, 1999). Within this body of literature, there is minimal focus on the functioning of adult children of survivors.

The idea of intergenerational impacts of maltreatment is not new. Despite this, advancements in this area are not equivalent to the convergence of findings emerging in the literature on the individual effects of childhood maltreatment. As a result, research reporting on intergenerational child maltreatment currently appears piecemeal, producing fragmented findings across competing hypotheses and approaches. In

presenting what may appear as a piecemeal collection of findings relevant to intergenerational child maltreatment trauma, the links across these findings will be highlighted.

This chapter will first present the concepts of *intergenerational transmission*, *intergenerational continuity* of abuse and neglect, and an *intergenerational cycle of maltreatment*. Previous research will be presented, within which risk factors are identified related to the recurrence of child abuse and neglect across generations. Second, this chapter will address the idea of intergenerational continuity of experiences and outcomes. Research findings will be summarised pertaining to the intergenerational continuity of attachment, childhood experiences and the parenting practices of survivors. Third, the concept of *intergenerational trauma* will be presented, drawing upon literature from within, as well as outside, the area of childhood maltreatment.

Intergenerational Child Maltreatment

The terms *intergenerational transmission*, *intergenerational continuity* and *intergenerational cycle of maltreatment* have been used interchangeably across the research literature (Marshall et al., 2011; Zuravin, McMillen, DePanfilis, & Risley-Curtiss, 1996). These terms refer to the recurrence of childhood abuse and neglect across generations (Marshall et al., 2011). Berlin et al. (2011) provided clarity by delineating *transmission* to imply parental perpetration of maltreatment, and *continuity* to more broadly imply intergenerational child maltreatment related to ecological risks.

Research in this area has focussed on testing the hypothesis of an intergenerational cycle of maltreatment (Newcomb & Locke, 2001; Thornberry, Knight, & Lovegrove, 2012; Zuravin et al., 1996). Thornberry and Henry (2013) described the hypothesis as "predict[ing] that a history of maltreatment victimization is likely to exert a causal influence on the subsequent perpetration of maltreatment" (p.556). This hypothesis has been tested by comparing maltreated parents who have maltreated children with those whose children do not have experiences of maltreatment.

In reviewing five studies testing this hypothesis, Zuravin et al. (1996) noted that in some studies, the younger generation are infants or very young children, and in these cases, reporting intergenerational discontinuity fails to account for the possibility of future maltreatment when the second generation are still children at the completion of

the study. Zuravin et al. (1996) found studies testing the hypothesis of an intergenerational cycle of maltreatment to have considerable variation across the types of maltreatment and childhood relationship experiences investigated. In addition to these variations occurring across the five studies, within each study parent and child measures of maltreatment and childhood relationship experiences also varied (Zuravin et al., 1996). Also using different constructs for measuring maltreatment in parents and their children, Appleyard, Berlin, Rosanbalm, and Dodge (2011) noted this as a limitation and recommended that further research investigate type-to-type maltreatment. Type-to-type maltreatment refers to the parent and child both having experiences of the same type of abuse or neglect, such as a physically abused parent with a physically abused child.

Perry (2009) suggested that maltreated children often have parents with similar developmental traumas; however, the findings regarding type-to-type specific maltreatment are most widely reported for childhood physical abuse. Several studies have reported type-to-type maltreatment across two generations in relation to physical abuse (Berlin et al., 2011; Crouch, Milner, & Thomsen, 2001). Crouch et al. (2001) found a significant direct association between parental histories of childhood physical abuse and adult risk of perpetrating child physical abuse. Berlin et al. (2011) also found a direct association between mothers' history of childhood physical abuse and physical abuse of their infant, but no direct association for neglect. Contrary to these findings, Widom et al. (2015) found support for the intergenerational transmission of neglect and sexual abuse but not of physical abuse.

Ertem, Leventhal, and Dobbs (2000) undertook a systematic review of ten studies investigating intergenerational continuity specifically related to childhood physical abuse. On the basis of eight methodological standards, they found the two were most methodologically robust studies had opposing conclusions about intergenerational continuity of childhood physical abuse. The most methodologically robust study provided support for the intergenerational cycle of maltreatment hypothesis. In comparison, the second most methodologically robust study did not support the hypothesis (Ertem et al., 2000). Ertem et al. (2000) noted that while factors other than parental history of childhood abuse, such as socio-demographic status, may contribute to the risk of abuse, only three of the ten studies controlled for intervening variables.

Methodological weaknesses in this area of research have been suggested to be pervasive (Thornberry et al., 2012). Thornberry et al. (2012) undertook a systematic

review of 47 studies investigating the cycle of maltreatment hypothesis and found most of the studies supported the hypothesis. However, across the nine studies that were identified to be methodologically more robust, mixed support for the hypothesis was identified (Thornberry et al., 2012). Further, they noted, more robust research is needed to better understand the mediating and moderating factors influencing maltreatment and resilience to intergenerational maltreatment (Thornberry et al., 2012).

Acknowledging complexity within the hypothesis for an intergenerational cycle of maltreatment, much research has focussed on possible mechanisms of transmission (Milner et al., 2010; Newcomb & Locke, 2001). Support has been found for several potential mediators of this transmission of childhood maltreatment across generations, with particular attention given to dissociation. Egeland and Susman-Stillman (1996) found dissociation to mediate the intergenerational cycle of maltreatment between maltreated mothers and their infant. Dissociation was also found to mediate the relationship between history of childhood physical abuse and physical child abuse potential in college students (Singh Narang & Contreras, 2000) and in mothers and their children (Singh Narang & Contreras, 2005).

Compared to dissociation, the effect of other potential mediators has been reported to be less robust. Milner et al. (2010) reported trauma symptoms partially mediated the intergenerational transmission of childhood physical abuse. Jungmeen Kim, Talbot, and Cicchetti (2009) found shame did not mediate the intergenerational transmission of abuse. Shame, however, was associated with a history of childhood sexual abuse and significantly mediated the relationship between mothers' history of childhood sexual abuse and adult intimate partner conflict (Jungmeen Kim et al., 2009). Further, investigating intergenerational continuity of multi-type maltreatment, Cort, Toth, Cerulli, and Rogosch (2011) found no evidence that the relationship was mediated by maternal depression, maternal PSTD or intimate partner violence.

Dixon, Browne, and Hamilton-Giachritsis (2005) found three risks (parent under 21 years, parent psychopathology, and presence of a violent adult in the house) to each separately, and in combination, mediate the relationship between parental history of childhood physical or sexual abuse and child maltreatment. To further account for this relationship, Dixon, Hamilton-Giachritsis, and Browne (2005) investigated parenting characteristics of parents with, and without, a history of childhood maltreatment. They found poor quality of caregiving behaviour and parental negative attributions/ unrealistic expectations mediated the intergenerational cycle of maltreatment.

Combining findings across their two studies, Dixon, Hamilton-Giachritsis, et al. (2005) reported the three risks (parent under 21 years, parent psychopathology, and presence of a violent adult in the house) and the caregiving behaviour accounted for 62% of the total effect.

In the LONGSCAN study, Li et al. (2011) found a high level of family social support, as well as two-parent family and high maternal educational level, to be protective against the predicted probability of maltreatment in a cohort of children followed between the ages of four and eight years. Further to this, a high level of social support was found to moderate the relationship between low maternal educational level and probability of child maltreatment (Li et al., 2011). The interaction of multiple factors across the ecology of the family, they suggested, contributes to the risk of child maltreatment, and these factors may differ with respect to the age of the child (Li et al., 2011).

While there is a view that other factors, additional to the parent's maltreatment history, may mediate the intergenerational transmission of abuse and neglect, causality is difficult to establish and research in this area remains a challenge (Widom et al., 2015). In acknowledging that existing models do not fully account for the complexity of factors contributing to intergenerational child maltreatment, Dixon, Hamilton-Giachritsis, et al. (2005) suggested the need to "account for mediating factors from other theoretical perspectives" (p. 66). Intergenerational continuity of maltreatment research needs to be integrated more fully with intergenerational continuity research in other fields related to childhood outcomes. Integration with intergenerational continuity research from developmental psychology and from the field of attachment may increase understanding of the intergenerational processes within child maltreatment trauma. The following section considers developmental and attachment perspectives on intergenerational continuity of experiences. The focus here is on factors related to the parent-child relationship and parenting styles.

Scary "Ghosts in the Nursery": Intergenerational Continuities in Childhood

(Maltreatment) Experiences

In developmental psychology, early and ongoing family relationships and experiences have long been suggested to have a profound impact on later life patterns of adjustment and functioning (Bowlby, 1968; Crosnoe & Elder, 2004). Further to this is the idea that our childhood family experiences not only affect our own life trajectory, but that we reproduce our experiences in our children (Bowlby, 1968; Sroufe & Fleeson, 1988). Serbin and Stack (1998) referred to this phenomenon as "intergenerational continuity" (p. 1159).

In their seminal article "Ghosts in the Nursery," Fraiberg et al. (1975) articulated the idea that all parents brings their past psychological experiences with them as they approach parenting their own child(ren). These past experiences or "ghosts" may be experiences not just of the parent, but also over generations in a family (Fraiberg et al., 1975, p. 387). Fraiberg et al. (1975) presented two case studies of psychoanalysis-in-the-kitchen with at-risk parent-infant couples. The fact that the mother could not acknowledge her own pain of childhood loss and trauma meant that she was not able to be emotionally available to her child.

Intergenerational Transmission of Attachment

In parallel to research into the intergenerational continuity of maltreatment is a separate body of research on the intergenerational transmission of attachment. Within the attachment literature is the idea that parents' recollections of their own early attachment experiences influence their parenting attachment behaviour with their child (Bowlby, 2005).

Hesse and Main (2006) described a "*second-generation effect*" (p.310) in which children of maltreated parents displayed disorganised attachment behaviour. Disorganised child attachment, they found, was not a response to direct maltreatment experiences, but rather was linked to the parental traumatic experience being unintegrated. The parents themselves were in fright due to their unresolved trauma, and in this fright, the parents behaved in both frightened or frightening ways (Hesse & Main, 2006).

In their three-generational study into vulnerability to depression, Besser and Priel (2005) found "significant intergenerational transmission of attachment patterns" (p. 1067). In a separate three-generational study, Leifer et al. (2004) investigated intergenerational childhood sexual abuse and intergenerational attachment relationships. They found mothers' childhood experiences of severe abuse increased problems in their adulthood relationships and functioning, and that these adult problems (trauma symptoms in particular) mediated the relationship with sexual abuse in the next generation (Leifer et al., 2004).

Intergenerational Transmission of Separation-Individuation Disturbances

Unlike adult attachment, which is based upon early childhood experiences, adult separation-individuation has been suggested to relate to the parents' working models of separation-individuation (Charles, Frank, Jacobson, & Grossman, 2001). Investigating separation-individuation disturbances across two adult generations, Charles et al. (2001) found patterns of intergenerational continuity linked to the mothers' memories of their own separation experiences. In this intergenerational "repetition of the remembered past" (p.705), mothers with positive coherent memories of their own individuation, as having been enabled, had individuated daughters (Charles et al., 2001). Negative intergenerational patterns in separation-individuation were found to be related to mothers' incoherence of memory and to mothers' coherent but unresolved separation conflicts (Charles et al., 2001).

Incoherent memories represent a "defensive exclusion" of painful memories and lead to working models of separation-individuation that are "rigid and unintegrated" (Charles et al., 2001, p. 708). Mothers with coherent but unresolved conflicts were noted to have ambivalent feelings in relation to their daughters' independence and separation leading to daughters who were high on independence but low on support and encouragement (Charles et al., 2001).

Susman, Trickett, Iannotti, Hollenbeck, and Zahn-Waxler (1985) identified links between separation-individuation disturbances in depressed mothers with emotional regulation disturbances in the child. They found currently depressed mothers were overprotective, had difficulty with separation from their child, and had difficulty letting their child make decisions (Susman et al., 1985). They also found that the parenting

behaviour of physically abusive parents and of depressed parents were each characterised by high guilt and anxiety induction. They suggested that the experience of guilt in the child, however, would have different effects in children of depressed parents compared to children of abusive parents. Susman et al. (1985) suggested that experiences of abuse link the child's feelings of guilt to fear and anger, whilst experiences of guilt induced by depressed mothers result in the child being sensitised to the negative emotional experiences of others. Experiences of parenting behaviour including depression and abuse has, they suggested, implications for an intergenerational transmission of emotional problems (Susman et al., 1985).

Intergenerational Transmission of Caregiving

Intergenerational continuity research suggests parents' life experiences are expressed in their parenting behaviour (Bailey et al., 2012; K. Kim et al., 2010). When a person experiences catastrophic or complex trauma as a result of childhood abuse, the aftermath of this trauma often continues into adulthood (Mammen, 2006) and parenthood (Bailey et al., 2012). Living with a parent who is struggling with the ongoing impact of this trauma is associated with the presence of multiple and interacting risk factors for the children in this caregiving environment (Leifer et al., 2004; Tomison, 1996). At the critical formative period of infancy and early childhood, the child's own psychological development is influenced and affected by the exposure to the pre- and peri-natal mental health and related environmental problems of their caregivers (Serbin & Karp, 2003). Newcomb and Locke (2001) reported a history of child abuse to be correlated with poor parenting. Cloitre et al. (2011) suggested that the parents of children who are abused potentially have limited emotional regulation and interpersonal functioning. This intergenerational transmission of risk was described by Bowlby (2005) as a "malign circle of disturbed children growing up to become disturbed parents who in turn handle their children in such a way that the next generation develops the same or similar troubles" (p. 29). Similarly, Serbin and Karp (2003) suggested that parenting behaviour is shaped by the modelling of the parent's own parents and by the individual's early social and emotional behaviour.

Empirical support for an intergenerational transmission of caregiving has been shown in a number of studies. For example, Belsky et al. (2005) conducted a longitudinal study into the intergenerational transmission of parenting, measuring

parent-child interactions, and comparing these to earlier collected measures of the parent's childhood experiences of childrearing practices, parent-child relationships, and family climate. Belsky et al. (2005) found that childrearing history had a significant contribution to the prediction of mother's but not father's parenting. Also reporting gender differences, Thornberry, Freeman-Gallant, Lizotte, Krohn, and Smith (2003) found the intergenerational transmission of parenting to be gender-specific with daughters following he parenting of their mothers, and sons following that of their fathers.

When the caregiving relationship is undermined through child abuse trauma, risk for social, behavioural and health problems are created that can be transferred from parent to child (Serbin & Karp, 2004). This can have a critical impact, not only on early development, but also on later life functioning and adaptation (Crosnoe & Elder, 2004; Fonagy, 2003). Cook et al. (2005) noted that parents who have a childhood history of disturbed attachment relationships and complex trauma face increased difficulties in parenting their own children.

Mediators and Moderators of the Relationship between Childhood Maltreatment and Later Sub-optimal Parenting

Research taking a developmental, ecological, and transactional approach to investigating intergenerational continuities of childhood experiences has focused on mediating and moderating factors impacting on parenting (K. Kim et al., 2010; Shaffer, Burt, Obradovic´, Herbers, & Masten, 2009). Serbin and Karp (2004) suggested that "specific parental characteristics or behaviors increase the probability that similar or related problems will occur in the next generation" (p. 337). To demonstrate this stance, Serbin and Karp (2004) presented a generic model of the transfer of risk over two generations in which parenting behaviour and the environmental context may mediate the likelihood of repetition of a particular behaviour in the subsequent generation.

Potential mediators considered in the relationship between childhood maltreatment and parenting behaviour have included dissociation (K. Kim et al., 2010) and child social competence (Shaffer, Burt, et al., 2009). K. Kim et al. (2010) found that mothers' experience of punitive discipline in childhood, current dissociative symptoms, and social support satisfaction predicted mothers' parenting practices. Shaffer, Burt, et

al. (2009) found that social competence in the child generation mediated the intergenerational continuity of parenting quality. In a prospective longitudinal study of children who had become parents by the 20-year follow-up interview, Shaffer, Burt, et al. (2009) used measures of parenting quality that accounted for age-related developmental changes within the parent-child relationship. Early positive parenting experiences were found to support successful social (peer) relationships, and, together, the cumulative effect of parenting quality and social competence predicted intergenerational parenting quality (Shaffer, Burt, et al., 2009).

In addition to the consideration of mediators, potential moderators have been considered to buffer, or reduce the relationship between childhood maltreatment and negative outcomes related to parenting. Bartlett and Easterbrooks (2015) investigated the role of social support on parenting, and found frequency of social support to moderate the relationship between maternal history of neglect and infant neglect. Stable adult relationships, higher maternal education and higher income were investigated by Zvara, Mills-Koonce, Appleyard Carmody, Cox, and Family Life Project Key (2015) as protective buffers between maternal history of childhood sexual abuse trauma and parenting behaviours. Using a propensity matched design and examining parenting behaviours, including sensitive versus harsh-intrusive parenting, boundary dissolution, and parenting efficacy, they found stronger attenuating effects of these three factors in mothers without a history of childhood sexual abuse. Amongst direct effects, Zvara et al. (2015) found maltreated mothers had significantly more harsh-intrusive parenting and boundary dissolution and less sensitive parenting. These group differences on parenting behaviours, they suggested, support the "indirect impact [of child abuse trauma] across multiple generations" (Zvara et al., 2015, p. 96).

Intergenerational Experiences of Trauma

The concept of intergenerational trauma related to child abuse is a relatively new area of research. In the wake of the experiences of Vietnam War Veterans, the effect of trauma on human functioning has drawn public attention and has facilitated systematic research into all types of traumatic stress, including trauma arising from chronic child abuse (Briere & Scott, 2006).

Outside of the direct study of childhood maltreatment, van Ee et al. (2012) found significant correlations between the severity of maternal war-related PTSD symptoms and psychosocial functioning outcomes in the child. Although they did not find support for emotional availability as a mediator of this relationship, they found mothers with PTSD symptoms perceived their child in negative ways. They also found a mirroring of relating behaviour within the parent-infant relationship, observing that mothers with PTSD symptoms were less emotionally available to their child, and that the child was less responsive to the mother (van Ee et al., 2012). Trauma symptoms in the mother, they suggested, impacted on her ability to regulate her own affect and arousal, decreasing the mothers' emotional and functional availability toward the child (van Ee et al., 2012). Further, they reported that the parents' trauma-related emotional dysregulation "impairs the development of the child's self-regulation, and as a consequence, behavioural adaptions may result" (van Ee et al., 2012, p. 464). These findings represent some of the potential impacts of maternal trauma on the parent-child attachment relationship.

In children of Australian Vietnam War veterans with PTSD, Davidson and Mellor (2001) found that young adult children did not have higher PTSD symptoms than comparison groups. Significant group differences were found, however, within domains of family functioning. Davidson and Mellor (2001) noted disturbances in family functioning to be a consistent finding within intergenerational combat PTSD literature. This finding, they suggested, indicates that parental trauma produces heightened vulnerability to dysfunction in the child, rather than a specific transmission of trauma symptoms (Davidson & Mellor, 2001).

Within non-empirical literature, documentation of an intergenerational transmission of trauma and its effect on the relationships and functioning in subsequent generations is found within reports on children and grandchildren of Holocaust survivors (Halasz, 2002; Rowland-Klein & Dunlop, 1998; Scharf, 2007). Abrams (1999) commented that the insidious continuation of trauma-related effects on individual and family functioning is passed on through the stories told within families and through a sharing in the parents' experience of the world as dangerous.

Investigating the intergenerational transmission of trauma, Schwerdtfeger and Goff (2007) found it is not the number of traumatic experiences, but rather the type of trauma that impacts on mothers' attachment behaviour. They found mothers with a history of interpersonal traumas including childhood abuse had higher current trauma

symptoms and lower prenatal attachment compared to mothers with a history of trauma from non-interpersonal sources (Schwerdtfeger & Goff, 2007).

As well as psychiatric symptoms, trauma from childhood abuse can impact on later adult functioning through the "absence of substantive emotional and social competencies" (Cloitre et al., 2011, p. 11), affecting the individual's interpersonal relationships and coping resources. Briere (1992a) identified seven major types of psychological disturbance frequently found in adults who were abused as children: posttraumatic stress, cognitive distortions, altered emotionality, dissociation, impaired self-reference, disturbed relatedness, and avoidance. "Fundamental problems in basic trust, autonomy, and initiative" impair the adult survivors' ability to establish safe and appropriate boundaries with others (Herman, 1997, p. 110). Further, some survivors of childhood abuse re-enact the trauma, either as the perpetrator or the victim, resulting in harm to others, self-destructive behaviour, or revictimisation (van der Kolk, McFarlane, & Weisaeth, 1996).

Unresolved Parental Trauma

Traumatised parents "may avoid experiencing their own emotions, which may make it difficult for them to respond appropriately to their child's emotional state" (Cook et al., 2005, p. 395). Protective effects are strongest when parents are able to reflect on their own childhood experiences (Cook et al., 2005; Egeland & Susman-Stillman, 1996).

In a review of attachment research, Cassidy and Mohr (2001) found that parental unresolved trauma predicted infant disorganised attachment. Egeland and Susman-Stillman (1996) reported increased parental reflection decreased the intergenerational transmission of abuse. Parents who are able to reflect on their own childhood maltreatment experiences are more likely to break the cycle of abuse (Cicchetti & Valentino, 2006). Within this reflection, the ability to assign responsibility for harm to the perpetrator, rather than blaming themselves is crucial (Cicchetti & Valentino, 2006).

Summary

Research into intergenerational child maltreatment provides evidence that parental history of childhood maltreatment is a risk for continuity of maltreatment. Further to this, parental history of childhood maltreatment has been found to be a risk for the continuity of negative experiences and psychosocial outcomes in the next generation. Previous research into the intergenerational sequelae of childhood maltreatment has focussed primarily on continuity of abuse or parenting style. Much of this research has investigated outcomes for infants or young children of maltreated parents, with less research reporting on outcomes for adult children. Separate research into the intergenerational transmission of trauma from sources outside of child maltreatment suggests parental trauma impacts the child through disruptions to family functioning and through a sharing, or a re-living, in the parents' relationship disruptions.

Parents with unresolved trauma continue to experience a disconnection between their recollections of childhood and their affective experiences. Due to their own unmet needs, parents struggling with unresolved traumatic childhood experiences face difficulty in recognising and responding appropriately to the needs of their child. This can impact on the parent-child relationship to disturb the child's attachment and psychosocial development.

Lacking from this research is the investigation of intergenerational functioning and relationship outcomes in adults. Greater links across intergenerational continuity research and intergenerational trauma research are needed to increase our understanding of the intergenerational processes within child maltreatment trauma.

Chapter 4: The Role of Risk and Resilience in Childhood Maltreatment Outcomes

Ecological/transactional theories hold that both maltreatment perpetration and the intergenerational continuity of maltreatment are determined by multiple interacting risk, protective and resilience factors (Thornberry & Henry, 2013). Research paradigms attempting to consider the influence of both the individual and their family environment have inherent complexity (Sameroff & MacKenzie, 2003). Mediation and moderation effects of risk and protective factors on outcomes may explain only part of this complexity (Sameroff & MacKenzie, 2003). Each risk and protective factor may have differential effects or effects that only appear in combination (Bartlett, Raskin, Kotake, Nearing, & Easterbrooks, 2014).

This chapter first considers the role of risk or vulnerability in childhood maltreatment outcomes. Research literature relating to risks of the individual and to additional and cumulative risks of the caregiver and of the family of origin is presented. Potential caregiver and family factors include: quality of caregiving, parents' own history of childhood maltreatment, parental mental illness, family violence, caregiver substance abuse and socio-economic disadvantage. Research findings are presented relating to protective factors including social and professional support.

Second, this chapter explores the role of resilience in childhood maltreatment outcomes. Resilience is described as the presence of positive outcomes amid adversity. The presence of protective factors is considered to promote the potential for resilience. Research literature is discussed relating to resilience of the individual and the ecology.

Risk and Protective Factors of the Individual

As described in Chapter 2, children who are maltreated are at risk across multiple domains of their development and functioning. However, individuals respond to maltreatment and experiences of significant stress in different ways (Jaffee, Caspi, Moffitt, Polo-Tomas, & Taylor, 2007; Rogosch et al., 2011). Risk and protective factors, or *personal resources* of the individual are associated with their level of resilience in the face of maltreatment and other significant adverse experiences (Jaffee et al., 2007). Individual differences within these risk and protective factors – such as temperament, genetic variation and social competence - contribute to differences in an

individual's vulnerability and responses to stress (Gunnar & Quevedo, 2007). An individual's epigenetic history of their physiological responses to environmental stressors leaves a "permanent imprint" or sensitivity for the individual to respond to stress in predictable ways in the future (Gunnar & Quevedo, 2007, p. 162). However, improved family contexts can influence positive outcomes despite this epigenetic history (Gunnar & Quevedo, 2007).

Childhood maltreatment is the significant interpersonal perpetration of harm, neglect and boundary violation by adults, centrally involving the traumatic disruption of attachment relationships. A focus on the individual in isolation of their family and wider environment, therefore, fails to account for transactional and cumulative risk and protective factors within the individual's ecology (Daniel, Wassell, & Gilligan, 2006). Jaffee et al. (2007) found that maltreated childrens' personal resources supported positive (resilient) outcomes only when the family and neighbourhood level of adversity was low. In physiological terms, this reflects the idea of *allostatic load*, in which situations of chronic and severe childhood maltreatment demand frequent biological and psychological adjustments in the individual (Gunnar & Quevedo, 2007). Multiple risks of childhood abuse and neglect, parental substance abuse and maternal depression overwhelm the child's allostatic load, producing "toxic stress" responses (Shonkoff et al., 2012, p. e236). Supportive relationships with parents and other adults can protect children from the damaging effects of toxic stress (Shonkoff et al., 2012). In the absence of sufficient support for recovery, this allostatic load overwhelms individual resources and increases the risk of psychopathology and health problems (Gunnar & Quevedo, 2007; Shonkoff et al., 2012).

The Parent-Child Relationship

Attachment within the parent-child relationship functions to provide safety for the child (Cloitre et al., 2011). Positive parent-child attachments and caregiver support mediate the way children and adolescents adapt in the context of traumatic maltreatment experiences (Cook et al., 2005). Maternal support is a protective mediating factor in supporting positive outcomes for a maltreated child (Cook et al., 2005; Stacks et al., 2014). Despite much less research into paternal support and the influence of a father within the ecology of a maltreated child, fathers are often represented as the perpetrator

of abuse (Dubowitz, 2009; S. J. Lee, Bellamy, & Guterman, 2009). Contrasting this representation, Guterman, Lee, Lee, Waldfogel, and Rathouz (2009) suggested a potential mediating role of positive father-child relationships and paternal education in reducing the risk of child abuse by the mother. The source of abuse or neglect, however, may negate the effects of a supportive parent. Musliner and Singer (2014) found parental support to be significantly associated with lower depression in adult survivors of childhood sexual abuse - only when the abuse was perpetrated by person other than a caregiver.

Good-enough parenting.

Winnicott (1964/1970) introduced the notion of "good enough care" (p.238). In conditions of *good enough care*, the parent is emotionally sensitive to the needs of the child and makes timely and appropriate responses to ensure these needs are met (Gerhardt, 2004). Within an environment of supportive care, the child experiences non-harmful levels of stress that protects the developing brain (Gunnar & Quevedo, 2007). When parents are unable to provide *good enough care*, developmentally appropriate expectations and routines for their children become distorted. Cyr et al. (2013) suggested parent's personal and social resources determine their interpretation of what constitutes good enough care, and that parents with poor emotional regulation and low socio-economic status may increase the child's risk of maltreatment. Bywaters (2015) argued that out-of-home placement of children should only be a consideration when the parents are unable to provide good enough care within the context of adequate supports. When the lack of good enough parental care directly arises from socio-economic risks, it is the responsibility of the State to ameliorate these risks (Bywaters, 2015).

In the absence of good enough care, developmentally inappropriate experiences can manifest in early onset of mental health issues and behavioural problems (Daniel et al., 2006). In a study into parentally set bedtimes for adolescents, Gangwisch et al. (2010) found that adolescents whose parents expect them to be in bed at midnight or later are 24% more likely to experience depression and 20% more likely to express suicidal ideation than adolescents whose parents set their bedtime for 10pm or earlier.

The role of the parent is to provide developmentally-appropriate care, supervision and protection and to nurture and support the child's physical, cognitive, emotional and psychological development (Gewirtz, Forgatch, & Wieling, 2008). The extent to which the parent is emotionally sensitive and attentive to the child, and able to

regulate their own emotional states, is important to achieving good enough care (Gerhardt, 2004). Parents with their own unresolved trauma and loss struggle to shift their focus from continuing to feel that their own needs remain unmet, to being able to consider the vulnerability of their child and to meet their child's needs (Crittenden, 2008). Dysfunction within the family of origin of parents with their own history of childhood maltreatment may limit available models of appropriate caregiving and reduce parental competence (DiLillo, 2001).

Harsh-unresponsive vs warm-stimulating parenting.

The parent-child attachment relationship is shaped by the responsiveness and quality of parenting (Shaffer, Burt, et al., 2009; Tarullo & Gunnar, 2006). Research into supportive versus harsh parenting has focussed on wellbeing outcomes of children and on the intergenerational transmission of parenting (Belsky et al., 2005; Chen & Kaplan, 2001). Belsky et al. (2005) operationalised warm-sensitive-stimulating parenting in parent behaviour that was high on sensitivity, positive regard and cognitive stimulation and low on detachment, intrusiveness and negative regard. Further, supportive parenting has been linked with an authoritative parenting style and a positive family of origin climate (Belsky et al., 2005). Warm-sensitive-stimulating parenting has been associated with positive child outcomes including positive psychosocial development, educational achievement and less behaviour problems (Chen & Kaplan, 2001).

Risks to attachment are found in parenting that is harsh, distant, preoccupied or unpredictable, or when the parent's own distress becomes distressing for the child (Cook et al., 2005). Hesse and Main (2006) described harsh-distant parenting as *frightening*, or "frightened, threatening and dissociative" (p.309). Children who learn not to rely upon their parent for support don't have a model to learn to seek support from others, and instead form assumptions that the world is unpredictable or unsafe (Cook et al., 2005; Herman, 1997).

In a review of the literature investigating children's resilience to harsh and inadequate parenting, Haskett, Nears, Ward, and McPherson (2006) found positive outcomes were limited to discrete areas of functioning or to short periods of time. Harsh or unresponsive parenting was associated with disturbances in the child's development of autonomy, self-regulation and social competence (Haskett et al., 2006).

Caregiver and Family Characteristics

The causes of poor health, social disadvantage and vulnerability are interrelated (Featherstone et al., 2014). In the presence of high levels of ecological adversity, additional and cumulative transactional risks impact on the quality of the parent-child relationship and on overall family functioning (Baumrind, 1994; MacKenzie, Kotch, Lee, et al., 2011). Cumulative caregiver and family risks known to undermine parenting competence, increase the likelihood of abuse and neglect for the child (Brown & Ward, 2014).

MacKenzie, Kotch, Lee, et al. (2011) investigated causal relationships between maltreatment of infants and young children and subsequent child behavioural problems. They found externalising, internalising and overall behavioural difficulties to be predicted by the level of cumulative risk, rather than early maltreatment (MacKenzie, Kotch, Lee, et al., 2011). They concluded, that long-term outcomes were related to the overall level of risk within a family and to the family's capacity to cope with these risks (MacKenzie, Kotch, Lee, et al., 2011). There is little evidence, however, on factors that predict parental capacity for change or the timeframes in which parents address protective concerns (Brown & Ward, 2014).

Experiences of childhood maltreatment increase the likelihood of revictimisation into adulthood (Miron & Orcutt, 2014). How some children come to experience multiple traumas remains unclear (Finkelhor et al., 2007a). Possible explanations have identified the family context including attachment and parenting characteristics to influence the child's development of maladaptive interpersonal expectations (Wright et al., 2009).

Belsky et al. (2005) noted protective effects are most pronounced in at-risk populations. Investigating supportive and harsh parenting practices, Belsky et al. (2005) found that the presence of a current emotionally supportive partner did not moderate the relationship between the parent's own experience of being parented and the quality of their parenting behaviour. Relating this finding to the sample characteristics (not high-risk) of their longitudinal study, Belsky et al. (2005) suggested increased self-control in individuals without a history of childhood maltreatment weakens the role of protective factors in moderating outcomes.

Parental history of childhood maltreatment.

The majority of abuse survivors do not abuse or neglect their children (Bartlett & Easterbrooks, 2015; Herman, 1997), however research has shown that having a parent who has experienced abuse increases the risk that one will experience some form of child maltreatment (Dixon, Browne, & Hamilton-Giachritsis, 2009; Hurley et al., 2003). As discussed in Chapter 3, there is a large body of research testing the hypothesis of an *intergenerational cycle of maltreatment*. In this hypothesis, parents with a history of childhood maltreatment are considered a risk for perpetrating maltreatment against their own children, or having a maltreated child (Thornberry et al., 2012).

Tomison (1996) noted that international estimates of the rate of intergenerational child abuse range from 7 to 70 per cent, and Australian estimates to range from 17 to 79 percent. Pears and Capaldi (2001) reported the rate of transmission of child abuse to vary from 18 to 40 percent. In a review of abuse transmission rates reported in the research literature, Kaufman and Zigler (1987) estimated the rate of intergenerational transmission of abuse to be 30% +- 5%.

Baumrind (1994) found that the strongest predictor of child sexual abuse was having a parent with a history of child sexual abuse. In a prospective 30-year follow-up study, Widom et al. (2015) reported support for an intergenerational risk of childhood sexual abuse and childhood neglect (but not physical abuse). Widom et al. (2015) found that twice as many (16.7%) of the children of maltreated parents self-reported that child protection services were concerned about them compared with 7.4% of comparison children. Widom observed this difference to be somewhat larger for parents with a history three types of maltreatment. Jinseok Kim (2009), however, observed that 60% of parents with histories of three types of childhood maltreatment broke the cycle of maltreatment.

In an investigation of non-offending parents with a history of child sexual abuse Avery, Hutchinson, and Whitaker (2002) found that their children were 1.89 times as likely to be sexually abused, and that most (93%) of the 570 children studied had been exposed to domestic violence, and 41% had been physically abused. Despite these findings, Bartlett and Easterbrooks (2015) found 77% of maltreated mothers did not have maltreated infants, and Thornberry and Henry (2013) found that 77% of parents (aged in their mid-30's) with a history of childhood maltreatment had not maltreated their own children.

Clients of child protection services often present with multiple risk factors in their family of origin (Daniel et al., 2006). Reporting on Australian child protection data, Tomison (1994) found a higher number of family stressors, higher number of presenting problems in the children, and a higher rate of substantiation of child abuse in families in which one or both parents reported their own history of childhood abuse. However, Widom et al. (2015) has called for caution that children of parents with documented child protection histories are subject to detection bias.

Leifer et al. (2004) investigated sexual abuse across three female generations, looking at histories of attachment relationships, a substantiated history of sexual abuse and historical and current functioning. Leifer et al. (2004) found that mothers of sexually abused children reported "more severe histories of childhood abuse and neglect, more serious problems in their family of origin, and less positive relationships with their mothers" (p.670).

In a systematic review of literature testing the intergenerational cycle of maltreatment hypothesis, Thornberry et al. (2012) found most of the studies provided support for an intergenerational transmission of abuse and neglect. Despite this, Thornberry et al. (2012) criticised the body of research for methodological problems, suggesting these methodological concerns weakened the findings. Establishing 11 methodological criteria reflecting quality research, Thornberry et al. (2012) found the majority of studies in their review met less than half of these criteria.

Addressing some of these methodological concerns by using prospective, longitudinal data and substantiated child protection records of maltreatment and perpetration, Thornberry and Henry (2013) found significant support for the intergenerational repetition of maltreatment. They found, that compared to no-maltreatment and childhood maltreatment that occurred prior to adolescence only, maltreatment that occurred during adolescence - either beginning in adolescence or continuing from childhood – significantly increased the odds of subsequent perpetration (Thornberry & Henry, 2013).

Family mental illness.

Psychopathology has been implicated as both an outcome for the individual survivor, and as a risk for childhood maltreatment when present within the child's ecology (Mapp, 2006; Osofsky & Lieberman, 2011). As a risk factor, family mental illness impacts on family of origin functioning and increases family stress (Misrachi,

2012; Radke-Yarrow & Brown, 1993). Maternal depression and trauma symptoms are the most typically cited forms of mental health risks in child maltreatment research (Graham-Bermann, Gruber, Howell, & Girz, 2009; Mapp, 2006). Psychopathology including depression, anxiety and substance abuse impact on healthy functioning and parenting and are associated with difficulties in emotion regulation (Rutherford, Wallace, Laurent, & Mayes, 2015). As a result, parental mental illness, such as depression, impacts on the child through the parent's emotional unavailability, negativity and unpredictability (Radke-Yarrow & Brown, 1993).

Children are vulnerable to direct (genetic) and indirect effects of parental depression, with indirect effects occurring through disruptions of the parent-child relationship and parental relationship (Daniel et al., 2006). Within two-parent households, S. J. Lee, Taylor, and Bellamy (2012) found both maternal and paternal depression and parenting stress to be significantly associated with child neglect. The effects of parental depression in emotional unavailability or neglect have been documented as impacting on the parent-child relationship and the child's development (Shonkoff et al., 2012). These impacts include: disruptions to mother-infant bonding and attachment, both pre-and postpartum (Kent, Laidlaw, & Brockinton, 1997; Muzik, Bocknek, et al., 2013); increased children's stress, measured through cortisol levels (Brennan et al., 2008); and reduced social competence (Shaffer, Yates, et al., 2009).

Compared to the short-term implications, the longer-term impacts of parental mental health-related emotional unavailability on adult psychological functioning has been much less researched (Briere, 1992a). Studies of the psychological functioning of adults with a history of childhood maltreatment have focussed on survivors' parenting of infants or young children. For example, Muzik, Bocknek, et al. (2013) found parental history of abuse to be associated with depression and PTSD in parents of infants.

Highlighting its role as an independent risk factor, maternal depression has been found to mediate the relationship between mother's history of childhood abuse and current parenting problems (Banyard, Williams, & Siegel, 2003). Similarly, Mapp (2006) found while maternal history of childhood sexual abuse was correlated with maternal depression, it was not strongly correlated to risk of perpetrating abuse. Maternal depression and external locus of control (powerlessness), however, were strongly correlated with survivor's risk of perpetrating abuse (Mapp, 2006). Mapp (2006) concluded it was not the mother's history of childhood abuse, but the mother's unresolved trauma that created the risk that she would abuse her child. Corroborating

these findings, Graham-Bermann et al. (2009) found that mother's depression interfered with parental functions. Despite research evidence of maternal depression as risks parenting and child development, this area receives poor child protection-related treatment attention (Shonkoff et al., 2012).

Egeland and Susman-Stillman (1996) reported maternal dissociation to mediate the intergenerational continuity of childhood maltreatment. Mothers with a history of childhood abuse who were abusing their own children scored higher on measures of dissociation than mothers with a history of childhood abuse who discontinued the cycle of abuse (Egeland & Susman-Stillman, 1996). Egeland and Susman-Stillman (1996) reported that the mothers who repeated the abuse had fragmented and disconnected recall of their own childhood experiences of care. Mothers who did not repeat the cycle of abuse to their own children reported having dealt with their own experience of abuse (Egeland & Susman-Stillman, 1996). These mothers also expressed clear beliefs about not repeating abuse within their own caregiving (Egeland & Susman-Stillman, 1996). Egeland and Susman-Stillman (1996) suggested, related to the dissociative process, disturbances in identity and in the development of self are risks for intergenerational continuity of abuse.

Family violence.

Family violence has been identified both as a direct form of child maltreatment and as a secondary risk, through the witnessing of parental violence (Shen, 2009). In this way, family violence impacts not only the well-being of the direct recipient of that violence, but also impacts on the children witnessing that violence (Perry, 2001). As with other risks in the home environment, family violence has been found to overlap with parenting difficulties and child abuse (Barrett, 2010). Further, survivors of childhood abuse are at increased risk of violence in their adult partner relationships (Barrett, 2010; Cort et al., 2011).

Although there are many forms of family violence, including intimate partner violence and child abuse, family violence generally refers to "problems and patterns" of violence within the family ecology (Tolan, Gorman-Smith, & Henry, 2006, p. 560). Intimate partner violence between parents is often bidirectional, and relates to the parent's relationship quality and choice of partner (Tolan et al., 2006). Children's exposure, pre and post birth, to family violence can be fatal (Ackerson & Subramanian, 2009). Owen, Thompson, Shaffer, Jackson, and Kaslow (2009) found exposure to or

witnessing family violence impacts on multiple levels of the family ecology, reducing support for child adjustment. These impacts included reduced family cohesion, relatedness and increased maternal psychopathology (Owen et al., 2009).

In the ACE study, Dube, Anda, Felitti, Edwards, and Williamson (2002) found every category of adverse childhood experience to be significantly associated with growing up with a mother who was treated violently. Frequency of witnessing violence against mother was found to have a graded increase adulthood risks for alcoholism, drug use and lifetime depressed affect (Dube et al., 2002). Brown and Ward (2014) found parental intimate partner violence to be associated with parental criminally aggressive behaviour outside of the home. Witnessing inter-parental violence and violence against other family members can exacerbate the level of fear and feelings of entrapment in the child (Mudaly & Goddard, 2006). Shen (2009) found dual exposure to childhood physical abuse and the witnessing of inter-parental violence to significantly predict adult trauma symptoms and externalising behavioural problems in Taiwanese college students.

Caregiver substance abuse.

Substance abuse by expectant parents impacts directly on the growth and development of the unborn child, impacting neurobiology related to regulation of attachment (Swain, Lorberbaum, Kose, & Strathearn, 2007). Maternal substance abuse during pregnancy increases risks of premature birth, neonatal drug addiction and foetal alcohol syndrome (Brown & Ward, 2014). Postpartum, caregiver substance abuse impairs parenting capacity (Swain et al., 2007). Swain et al. (2007) reported maternal cocaine abuse to reduce parental attention to infant cues through neurobiological alterations in reward perception.

The presence of caregiver substance abuse has been associated with increased risk for other types of childhood maltreatment and adverse experiences. In the ACE study, Dube, Anda, Felitti, Croft, et al. (2001) found a strong association between parental alcohol abuse and the likelihood of co-occurring multiple ACEs. The strongest association with childhood parental alcohol abuse was found with co-occurring family violence (Dube, Anda, Felitti, Croft, et al., 2001). Childhood exposure to mother treated violently was reported to increase between 5 and 12 fold with the presence of caregiver alcohol abuse by one or both parents (Dube, Anda, Felitti, Croft, et al., 2001). Other studies have reported similar findings that caregiver substance abuse and family

violence co-occur at high rates. In an investigation of families in which children were at risk of being placed in out-of-home care due to parental substance misuse, O'Connor, Forrester, Holland, and Williams (2014) reported alcohol or drug use concerns and family violence to co-occur in 80% of the participating families.

De Bortoli, Coles, and Dolan (2013) investigated of the role of parental substance abuse in court-ordered decisions for out-of-home placement of children through the involvement of child protection in Victoria, Australia. Parental substance abuse was a concern in over half of cases in their random sample, indicating parental substance abuse to be a frequent risk in the child protection population (De Bortoli et al., 2013). They found parental substance abuse to be associated with court-proven emotional abuse, less compliance with conditions to address protective concerns, and delays in final court decisions (De Bortoli et al., 2013). Parental compliance and parental substance abuse was significantly associated with decisions for out-of-home placement.

Socio-economic disadvantage.

Baumrind (1994) noted, while child abuse and neglect cannot be fully explained by parental stress, sense of powerlessness or helplessness, social and economic factors hold strong implications in undermining parental ability to provide adequate care and protection. Socio-economic disadvantage is frequently associated with families involved with child protection services, with poverty being a major source of stress for families (Daniel et al., 2006; Goddard, 1996). However, there is complexity involved in adequately measuring children's home and family environments (Bywaters, 2015). The lack of systematic national data on family's financial, housing and neighbourhood circumstances has contributed to paucity of measures of socio-economic factors in maltreatment research (Bywaters, 2015).

Several recent studies have identified childrens' wellbeing and child protection outcomes to be connected to family socio-economic factors (Ssewamala, Stark, Chaffin, Canavera, & Landis, 2014). Bartlett et al. (2014) found neighbourhood median household income to be a contributing factor to mother's neglect of their infants. Barrientos, Byrne, Peña, and Villa (2014) found families in poverty benefit most, in terms of child protection outcomes, when support is targeted at improving household resources, reducing social exclusion, and maximising the child's school attendance.

Brooks-Gunn, Schneider, and Waldfogel (2013) investigated the relationship between economic distress and use of physical discipline by mothers. Physical discipline in the form of spanking was considered a risk indicator for child maltreatment (Brooks-Gunn et al., 2013). Looking at consumer confidence, Brooks-Gunn et al. (2013) used data from the Fragile Families and Child Wellbeing Study, collected during the time of The Great Recession (2007-2009) in the United States. Maternal spanking behaviour was measured at two waves, when the focal child was aged approximately 5 years and again at 9 years. They found worsening consumer confidence to be statistically significantly associated with high frequency spanking (more than 11 times in the past year), but not with low or moderate frequency spanking. The results were unchanged when controlled for unemployment, home foreclosure and spanking frequency at age 5. Differences between socio-economically advantaged and disadvantaged families (as measured by income and maternal educational attainment) were also reported. A statistically significant relationship was found between consumer confidence and high frequency spanking in socio-economically advantaged families, but not in socio-economically disadvantaged families (Brooks-Gunn et al., 2013). This finding of increased high frequency spanking in more affluent, higher educated families was suggested to reflect a greater reaction to and impact of the recession on loss of financial assets (Brooks-Gunn et al., 2013).

De Bortoli, Coles, and Dolan (2015) compared Australian Aboriginal and Torres Strait Islander (ATSI) families to non-ATSI families with children subject to Children's Court protection orders. They found, despite similar profiles across abuse type, one or two-parent status, and parental compliance, there was an over-representation of ATSI children. De Bortoli et al. (2015) explained the overrepresentation of ATSI children subject to child protection involvement, and the finding of higher levels of parental illicit drug use, as being associated to the ongoing social and economic disadvantage experienced by ATSI families.

Social isolation or deprivation has been identified as a risk for childhood maltreatment (Coohey, 1996; Sidebotham, Heron, & Golding, 2002). In addition to limited access to social networks, social deprivation incorporates socio-economic factors, including parental employment status, transience of housing, social class (Sidebotham et al., 2002). Children who experience abuse and neglect do not, however, meet a single profile. For example, Danese et al. (2009) reported that of the 1037 participants in their 32-year prospective longitudinal study, "most of the children

experiencing maltreatment or social isolation did not experience socioeconomic disadvantage" (p.1140).

Social and Professional Support as Protective Factors

Social support has been widely researched as a protective factor. Social support has been associated with 1) reducing the likelihood of childhood maltreatment in at-risk groups (Bartlett & Easterbrooks, 2015; Crouch et al., 2001; Li et al., 2011; Spilsbury & Korbin, 2013) and 2) with moderating maltreatment outcomes (Hill, Kaplan, French, & Johnson, 2010; Sperry & Widom, 2013). Informal social support encompasses the support of family, friends and associates (Spilsbury & Korbin, 2013). Social support is a complex construct, referring to the number of support persons, frequency of contact and perceived level of support (Sidebotham et al., 2002). Crouch et al. (2001) found that perceptions of social support during childhood were directly related to perceptions of current social support in adults.

Social support may reduce the long-term negative sequelae of childhood abuse and neglect through protecting against feelings of loss (Murthi & Espelage, 2005) or by increasing resilience in functioning (DuMont, Widom, & Czaja, 2007). Swain et al. (2007) suggested interpersonal relationships with significant others outside of the parent-child relationship offer a potentially protective contribution to childrens' "genetic, neurobiological and experiential systems" (p.280). However, early life trauma and disordered family functioning limit access to social networks across the life course (Nurius et al., 2015). Further, adults with a history of childhood maltreatment report less social support than matched controls (Sperry & Widom, 2013).

Cohen and Wills (1985) proposed a stress-buffering model in which social support was suggested to buffer, or reduce the negative psychological consequences of overwhelming stress. The buffering effect of social support has been suggested to be more prominent in high-risk groups (Bartlett & Easterbrooks, 2015; Belsky et al., 2005). In high-risk groups, the combination of higher levels of early life stress and limited access to psychosocial resources is more likely to be beyond the individuals' coping resources (Belsky et al., 2005; Hill et al., 2010; Nurius et al., 2015). Bartlett and Easterbrooks (2015) found social support increased parenting empathy, and that this protective effect was strongest for neglected compared to not-maltreated mothers.

Contrary to the suggestion that the buffering effects are more prominent in at-risk samples, research into severe childhood maltreatment suggests there is a limit to the protective effects of social support as the number of types of maltreatment increases (Salazar et al., 2011). Salazar et al. (2011) found, while social support decreased depressive symptoms, this protective effect was stronger in maltreated individuals reporting fewer types of abuse and neglect. Similarly, Evans et al. (2013) found social support to decrease trauma symptoms across several types of maltreatment, however as the severity of maltreatment increased, the protective effects diminished. Social support is often assumed to only promote positive functioning, but may have negative outcomes when it is perceived to be inadequate or intrusive (Spilsbury & Korbin, 2013). Given the complexity of childhood trauma, survivors of multiple or severe maltreatment may have diminished expectations that social support would improve coping (Evans et al., 2013). Furthermore, relational disruptions within maltreatment experiences distort perceptions of others as trustworthy and decrease appropriate judgement, undermining experiences of social connection as a potential coping resource (Mc Elroy & Hevey, 2014).

Amongst the research considering the role of social support in childhood maltreatment outcomes there is a limited number of studies examining the potential role of social support as a moderator or as a mediator of adult mental health symptoms (Hill et al., 2010). Hill et al. (2010) found that current perceived emotional support moderated the effect of childhood physical assault and sexual coercion on current psychological distress in adults. Evans et al. (2013) found that perceived social support from family and friends moderated the interactions between retrospective reports of childhood maltreatment and current adult trauma symptoms. In these studies, higher current perceived social support predicted lower current psychological distress or trauma symptoms.

Sperry and Widom (2013) found social support in adults decreased anxiety and depression both in maltreated and in control participants. Further, they found social support to have significant mediation and moderation effects on the relationship between childhood experiences of maltreatment and adult anxiety and depression, but not on illicit drug use. In addition to investigating total social support, Sperry and Widom (2013) investigated different types of social support: tangible, belonging, appraisal, self-esteem and total support. They found, that while all types of social support mediated the direct effect of childhood maltreatment on anxiety and depression,

different types of social support may have different and gender specific outcomes. Females with a history of childhood maltreatment had less tangible social support, but not less emotional support than not-maltreated females. The opposite was found for maltreated males, who reported less emotional support but not less tangible support than not-maltreated males (Sperry & Widom, 2013). Gender differences were also found in the impact of social support had on depression and anxiety, with social support having a stronger impact for males (Sperry & Widom, 2013).

In young adults, Howell and Miller-Graff (2014) found support from friends, but not family to be associated with higher resilient functioning. This finding, they suggested, may reflect the stage of development of young adults leaving and seeking support outside of the family home. Moreover, for adults with a history of childhood maltreatment, relationships with family members can be potential sources of future trauma rather than support (Howell & Miller-Graff, 2014).

In addition to informal social support, accessing professional supports in the form of therapy or welfare service involvement has protective effects both on preventing the cycle of maltreatment and in reducing maltreatment-related symptomatology (Cicchetti & Valentino, 2006). With appropriate treatment and support, "the impacts of even severe early trauma can be resolved, and its negative intergenerational effects can be intercepted" (Kezelman & Stavropoulos, 2012, p. xxviii).

Ecologically-based therapeutic interventions with parents at risk of maltreating their children have been found to increase parent social support and decrease the risk of child maltreatment (Swenson, Schaeffer, Henggeler, Faldowski, & Mayhew, 2010). However, child welfare professionals working with parents with substance abuse problems often find providing support difficult due to the chronicity of the behaviours (Bromfield, Lamont, Parker, & Horsfall, 2010; Robertson & Haight, 2012).

Interventions that encourage families to seek support from their existing social networks first need to address factors affecting the perceived level of available support (Evans, Steele & DiLillo, 2013). Incorporating social support with education and self-care, Dube et al. (2013) proposed a salutogenic (health promotion) model of intervention to support survivors of childhood maltreatment. Further to this approach, Dube et al. (2013) suggested survivors' own understanding of factors promoting protection and resilience is important. Giving voice to survivors of childhood maltreatment, Cortez et al. (2011) reported social networks promoted feelings of being

heard, validated and of shared experience. Collectively the research suggests that, to be protective, the number, type and quality of the social support is important (Cortez et al., 2011; Dube et al., 2013).

Resilience: Individual and Intergenerational Positive Outcomes

Not all individuals with a history of chronic child abuse or neglect experience psychopathology or problems in personality and social functioning as adults (Collishaw et al., 2007). Despite adversity and traumatic experiences, some individuals have relatively positive outcomes, or at least "may be resilient with respect to some outcomes, but not all" (Rutter, 2007, p. 205). Resilience is being able to adjust to threatening or distressing life circumstances, go against the odds to achieve successful outcomes, and directly address, rather than avoid, difficult situations (Werner-Wilson, Schindler Zimmerman, & Whalen, 2000). Resilience involves 1) the exposure to significant adverse experience(s) and 2) positive adaptation despite these experiences (Luthar, Cicchetti, & Becker, 2000).

Resilience is measured by the presence of positive developmental outcomes, competence and recovery within high-risk individuals (Werner, 1995). Holding implications for research design, individual resilience is neither static nor global, but rather a multidimensional, dynamic process (Luthar et al., 2000). Individuals can have substantial variation in functioning across adjustment domains and over time (Luthar et al., 2000). Traumatised children may function well in one domain (e.g. academically), but struggle in other domains (e.g. self-concept) (Cook et al., 2005). Radke-Yarrow and Brown (1993) found resilience and vulnerability to be related to the combination of risk and protective factors present and the interaction of these factors with the individual's coping competence.

Resilience factors of the individual.

Resilience factors mirror the domains of functioning affected by complex trauma (Cook et al., 2005). Resilience factors of the individual include: positive disposition and adaptable temperament, social competence, emotion regulation and behavioural control, positive self-esteem, internal locus of control, external blame attribution, coping competence, self-reliance, achievement, creativity and spirituality (Cicchetti & Rogosch, 2009; Cook et al., 2005). Cicchetti and Rogosch (2009) referred

to these factors as being "aspects of self-organization" related to "competent coping" (p. 47). Cicchetti and Rogosch (2009) identified biological processes of brain organisation and HPA-axis functioning related to emotional processing to be a factor of genetic-environmental effects on individual-level resilience. Maltreated children who show resilience, they suggested, have different neurobiology to other maltreated children (Cicchetti & Rogosch, 2009).

Resilience in adults with a history of childhood maltreatment was investigated prospectively by McGloin and Widom (2001). Measuring successful resilience as a score of six out of eight domains of functioning, they reported 22% of adult participants with a history of childhood maltreatment to be resilient. Functioning success was scored by: less than six months unemployment in past five years, less than one month of homelessness, high school graduate, social activity several times per week, no mental disorder, no drug or alcohol abuse or dependence, no criminal arrest and no self-reported violent behaviour (McGloin & Widom, 2001).

In a review of the literature, Haskett et al. (2006) described the study by McGloin and Widom as having the highest rate of resilience, with other studies reporting zero to 20% of maltreated children to have shown only some level of resilience. The finding of varied and low-rates of resilience may reflect the focus of research on deficit models of risk and vulnerability, rather than on resilience models tracking positive development (Masten, 2011). There is agreement within the resilience literature that factors of the individual have less of an influence on resilience than the quality of the parent-child relationship and other factors within the child's ecology (Haskett et al., 2006; Masten, 2011). Consideration of both complex ecological interactions and the developmental timing of maltreatment exposure and outcome measurement are important to supporting resilience (Masten, 2011; McLaughlin, Sheridan, & Lambert, 2014).

Resilience factors in the ecology.

Investigating resilience in maltreated children, Jaffee et al. (2007) proposed a cumulative stressors model, where the interaction of risks across the child's ecology reduced resilience in the child. They found that under low, but not high levels of family and neighbourhood stress, individual strengths of the child differentiated resilient from non-resilient children (Jaffee et al., 2007). For children exposed to multiple family and

neighbourhood stressors, personal resources were not sufficient to promote adaptive functioning (Jaffee et al., 2007).

Parental characteristics including depression and anxiety impact on the child's needs being met and places additional demands on the child's adaptive functioning (Radke-Yarrow & Brown, 1993). In a group of children who had a parent with an affective disorder, Radke-Yarrow and Brown (1993) found child-shyness to differentiate troubled- from resilient-children. Reporting a feature of resilient children was having a sustaining relationship with their parent or family, Radke-Yarrow and Brown (1993) suggested more assertive children may be better at getting their needs met from their depressed parent or through support from others.

DuMont et al. (2007) also reported a link between resilience and the presence of sustaining relationships with parents and others. They found, compared to continuously non-resilient participants, continuously resilient participants were more likely to have had lived with both parents or to have had a long first out-of-home placement (of more than 10 years), or were involved in a supportive partner relationship (DuMont et al., 2007).

In a prospective epidemiological sample, Collishaw et al. (2007) found individuals with a history of childhood physical or sexual abuse had higher levels of mental health problems in adolescence compared to midlife. Investigating resilience within a minority of the maltreated group who had reported no adult psychopathology, Collishaw et al. (2007) found resilience to be related to personality and the perceived quality of relationships across the lifespan, including perceived parental care during childhood, adolescent peer relationships, adult friendships and stable adult romantic history. Resilience was related to success in two or more areas of relationship functioning across childhood, adolescence and adulthood (Collishaw et al., 2007). In their longitudinal study into risk and resilience in Black childhood sexual abuse survivors, Banyard, Williams, Siegel, and West (2002) reported that socioeconomic status, education and racism mediated resilience. Howell and Miller-Graff (2014) considered social support, spirituality and emotional intelligence as protective factors associated with resilient functioning.

In a review of research on risk and resilience, Masten (2011) recommended that future research would best promote resilience through inclusion of positive outcome measures rather than focussing on deficits. Despite this, much of the current research into child abuse and neglect, both at the individual and intergenerational level, remains

focussed on risk and adversity (Dube et al., 2013). Further, current resiliency-based practices place the responsibility for positive outcomes on the victim rather than seek political and community efforts to address underlying risks (Davis, 2014). Cortez et al. (2011) suggested survivors of childhood maltreated are best placed to give voice to their experience and to recommend responses and support most helpful to healing trauma.

Summary

Multiple and interacting risk and protective factors are implicated in the vulnerability of the child, and the vulnerabilities within the ecology of the child. Research in this area has taken an ecological perspective to consider risks related to attachment within the parent-child relationship and the role of parenting on child wellbeing outcomes. Caregiver and family characteristics including a parental history of maltreatment, family mental illness, family violence, caregiver substance abuse and socio-economic disadvantage have all been considered as potential risks impacting on risk for maltreatment and on the child's ability to cope with adversity. Social and professional supports have been widely researched as a potential strength or cycle-breaking intervention. The stress-buffering effects of social support have been most widely researched in high-risk samples, however there are mixed findings within the literature in which severe maltreatment may be less protected by social support. Reasons suggested for a weakening of the protective effects of social support in survivors of severe maltreatment trauma include that survivors may perceive the support as inadequate in relation to the extent of their difficulties, may continue to show impaired trust and judgement, or may continue to have a disconnection between their past experience and current coping. With effective professional support, the impacts of trauma can be resolved.

Resilience is shown in the finding that not all survivors of childhood maltreatment have ongoing impacts on their health and wellbeing. Both genetic and environmental characteristics of the individual have been related to resilience; however, these factors are suggested to have less of an influence on resilience than the quality of the parent-child relationship and of relationships with others.

To begin to address intergenerational risk and vulnerability, we need to take a broader view of the causes of poor health, factors that promote good health, and the

social and economic context in which people live. Individual and intergenerational discontinuity of negative outcomes, such as trauma symptoms and problems in interpersonal relationships, and positive outcomes such as proactive coping may inform understanding of positive adaptation or resilience in the context of child abuse and neglect. Complex trauma treatments for children and adolescents need to foster individual, caregiver-child and systems-based strengths (Cook et al., 2005; Kagan & Spinazzola, 2013).

Chapter 5: Child Abuse and Neglect: Overview of Current Studies and

Experiences of Individuals Study

The current research comprised several empirical studies investigating retrospective reports of childhood experiences and self-reports of current adult functioning outcomes. Hurt and complex trauma resulting from childhood maltreatment has serious consequences for the lifespan development of the survivor (Kezelman et al., 2015; van der Kolk, 2014). Previous empirical research into the impact of childhood abuse and neglect has focussed primarily on specific aspects of symptomatology but has largely ignored relational difficulties (Chu, 2011). The current research program seeks to address this through investigating relationships as well as measures of functioning of individuals. Further, previous research has focussed solely on outcomes for individuals and has neglected the outcomes for those in relationships with survivors of abuse. The current research focusses on outcomes both for individuals and across intergenerational pairs of adults and their parent. In clinical literature, previous research has explored the experiences of survivors at the individual level; however, the current research addresses a gap in research into survivor's experiences of their parent and the outcomes for children of survivors.

Overview of Studies in the Present Research Program

The current research investigated relationship and functioning outcomes in three ways: 1) between groups of abused and non-abused adult participants (Study 1: Experiences of Individuals); 2) within parent-child dyads (Study 2: Intergenerational Continuity), and; 3) in survivor accounts of their relationship with their parent (Study 3: Survivor's Experiences of their Parent).

Recruitment was targeted at adults of all ages for both Study 1 and Study 2. This allowed for the recruitment of both generations for the intergenerational sample for Study 2. Due to potential geographical constraints in the participation of two generations of adult participants, a questionnaire design was chosen over face-to-face interview. This allowed for participation of participants whose pair did not reside locally but was able to separately and confidentially complete a pen-on-paper or an

online questionnaire. The survey design also provided a higher level of confidentiality for participants than possible in face-to-face interviews.
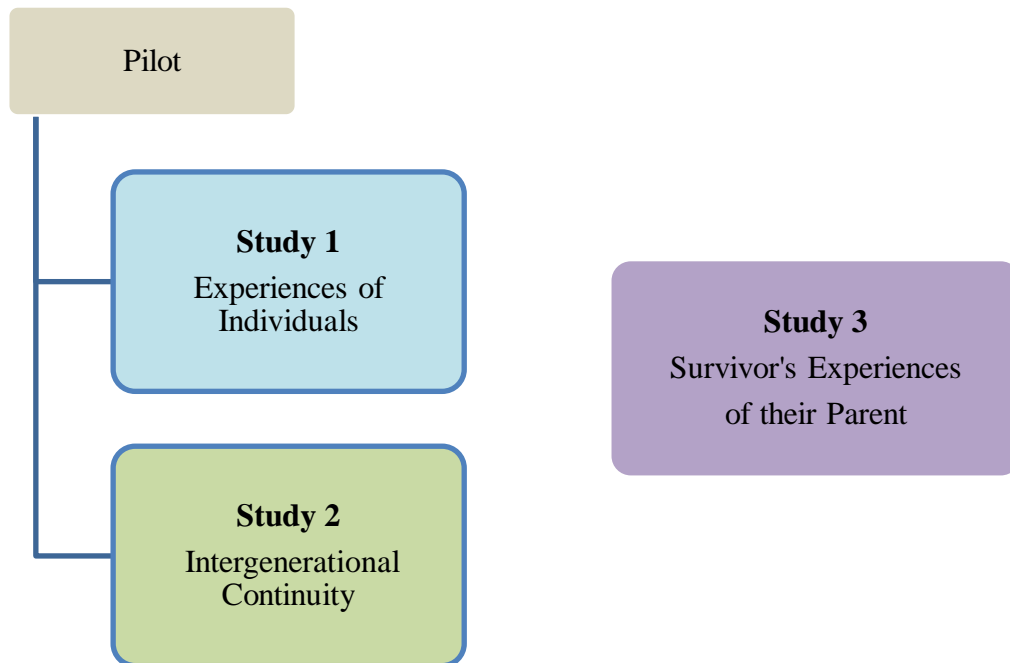
Figure 1. Flowchart of studies in the present research program.

As shown in Figure 1, the current research program comprised a pilot followed by three studies. For Studies 1 and 2, a battery of relationship and functioning measures was piloted. A summary of the pilot is reported within the method of Study 1 in this chapter. The test battery comprised a range of scales and items measuring demographic information, socio-economic indices, childhood family experiences and several current adult functioning outcomes.

Data for Studies 1 and 2 were collected simultaneously and in two waves – from a general population and from a targeted population of adult survivors of childhood abuse and neglect. Data from the two waves of collection were compiled to enable sufficient numbers to form groups of abused and not-abused participants. These data were analysed in two ways. First, the aim of Study 1: Experiences of Individuals was to investigate individual outcomes. Study 1 involved the quantitative investigation of the long-term effects of childhood maltreatment at the level of the relationship and functioning experience of the individual. Presented within the current chapter, Study 1 findings related to seven aims and hypotheses investigating differences in relationship

and functioning outcomes for participants with and without a history of child abuse and neglect.

Second, in order to investigate intergenerational outcomes, intergenerational continuity and discontinuity was explored in a subset of the whole sample comprising parent-child dyads, with and without abuse histories. The intergenerational quantitative investigation of relationships and functioning is reported as Study 2: Intergenerational Continuity in Chapter 6.

In Chapter 7, qualitative findings from Study 3: Survivor's Experiences of their Parent are presented. Study 3 is a follow-up study using a subgroup of Study 1 participants who identified as survivors of child abuse. Study 3 is presented as a qualitative report, exploring themes from survivors' lived-experiences of their parent.

Overall Aims and Hypothesis

There were three overarching aims of this research program. The first aim was to describe the experiences, relationships and functioning of individual survivors of child abuse (Study 1). The second aim was to identify instances of intergenerational continuity and discontinuity in the relationships and functioning of families with a history of child abuse or neglect (Study 2). The third aim was to identify resilience and experiences supportive of healing that minimize the impact of childhood abuse trauma on the subsequent generation (Study 3).

Study 1: Experiences of Individuals

Study 1 Aims and Hypothesis

Study 1: Experiences of Individuals addressed the first overarching aim by investigating group differences in relationship and functioning outcomes for participants with and without a history of child abuse and neglect. Seven aims and hypothesis were made for investigation of groups of *any-abused* and *not-abused* participants in Study 1.

Study 1: Aim 1.

The first aim of Study 1 was to investigate group differences between participants with a history of any type of abuse or neglect (*any-abused* group) and those participants with no history of abuse or neglect (*not-abused* group). Further, to investigate group differences between participants with a history of caregiver drug abuse and witnessing family violence and those participants who were without these adverse childhood experiences

Study 1: Hypothesis 1.1. It was hypothesised that there would be a negative association between maltreatment and adult relationship and functioning outcomes. It was hypothesised that the *any-abused* group would have higher separation-individuation disturbances, less perceived social support, more psychopathology, more current trauma symptoms and lower proactive coping than the *not-abused* group.

Study 1: Hypothesis 1.2. It was hypothesised that there would be a negative association between adverse childhood experiences and adult relationship and functioning outcomes. The two adverse childhood experiences investigated for this hypothesis were: 1) caregiver substance abuse problem and 2) witnessing family violence.

Hypothesis 1.2.1. It was hypothesised that the *carer-any-drug-problem* group would have higher separation-individuation disturbances, less perceived social support, more psychopathology, more current trauma symptoms and lower proactive coping than the *no-carer-drug-problem* group.

Hypothesis 1.2.2. It was hypothesised that the *witnessed-any-family-violence* group would have higher separation-individuation disturbances, less perceived social support, more psychopathology, more current trauma symptoms and lower proactive coping than the *no-family-violence-witnessed* group.

Study 1: Aim 2.

The second aim of Study 1 was to investigate group differences on adult functioning outcomes: 1) between no-abuse and four different types of abuse and neglect (sexual abuse, physical abuse, physical neglect and emotional neglect), 2) between abuse and neglect categories (*Neither*, *Abused*, *Neglected*, *Both*), and 3) between multiple reports of abuse and neglect types (zero to four types).

Study 1: Hypothesis 2.1. It was hypothesized that the group reporting no-abuse would have more positive functioning than any of the four types of abuse and neglect groups: sexual abuse, physical abuse, physical neglect and emotional neglect.

Study 1: Hypothesis 2.2. Comparing abuse and neglect categories, *Neither* (not abused), *Abused* (sexually or physically abused), *Neglected* (physically or emotionally neglected) and *Both* (abused and neglected), it was hypothesized that the *Neither* group would have would have more positive functioning than the *Both* group. No prediction was made about the direction of differences between the *Abused* group and the *Neglected* group, as this analysis was exploratory.

Study 1: Hypothesis 2.3. It was hypothesized that adult functioning outcomes would be poorest for participants reporting all four types of abuse and neglect (four types < three types < two types < one type < no abuse or neglect).

Study 1: Aim 3.

The third aim of Study 1 was to investigate the associations between proactive coping and adult functioning and relationship outcomes.

Study 1: Hypothesis 3. It was hypothesized that higher proactive coping would be associated with more positive adult functioning and relationship outcomes, including: less separation-individuation disturbances, more perceived social support, less psychopathology, and fewer current trauma symptoms.

Study 1: Aim 4.

The fourth aim of Study 1 was to investigate, within the *any-abused* group, the association between psychotherapy and current adult functioning and relationship outcomes: 1) between *ever* and *never* groups and 2) between *currently* and *not-currently* groups.

Study 1: Hypothesis 4.1. It was hypothesised that there would be a positive association between accessing psychotherapy *ever* and adult relationship and functioning outcomes. It was hypothesized that *any-abused* participants who had *ever* accessed psychotherapy would have more positive adult functioning and relationship outcomes (less separation-individuation disturbances, more perceived social support, less psychopathology, and fewer current trauma symptoms) than *any-abused* participants who had *never* accessed psychotherapy.

Study 1: Hypothesis 4.2. It was hypothesised that there would be a negative association between *currently* accessing psychotherapy and adult relationship and functioning outcomes. It was hypothesized that *any-abused* participants who were *currently* accessing psychotherapy would have poorer adult functioning outcomes (more separation-individuation disturbances, less perceived social support, more psychopathology, and more current trauma symptoms) than *any-abused* participants who were *not-currently* accessing psychotherapy.

Study 1: Aim 5.

The fifth aim of Study 1 was to investigate relationship outcomes by looking at 1) whether there is a positive association between childhood family functioning and other relationship outcomes and 2) *any-abused* and *not-abused* group differences on relationship outcomes.

Study 1: Hypothesis 5.1. It was hypothesized that more positive childhood family functioning would be associated with higher parental love and care. For the adulthood relationship outcomes, it was hypothesized more positive childhood family functioning would be associated with lower number of live-in partners, greater duration of longest partner relationship, and more perceived social support.

Study 1: Hypothesis 5.2. It was hypothesised that there would be a negative association between maltreatment and relationship outcomes. It was hypothesised that the *any-abused* group would have less positive childhood family functioning, lower perceived parental love and care, higher number of live-in partners, shorter duration of longest relationship duration and less perceived social support than the *not-abused* group.

Study 1: Aim 6.

The sixth aim of Study 1 was to identify predictors of trauma symptoms.

Study 1: Hypothesis 6.1. This hypothesis was exploratory and considered psychological abuse, physical neglect, physical injury and sexual abuse as predictors of trauma symptoms.

Study 1: Hypothesis 6.2. This hypothesis was exploratory and considered other measures of current functioning (separation-individuation disturbances, perceived social support, and psychopathology) as predictors of trauma symptoms.

Study 1: Aim 7.

The seventh aim of Study 1 was to investigate the association between childhood maltreatment groups and socio-economic outcomes.

Study 1: Hypothesis 7. It was hypothesized that the proportion of *any-abused* group participants would be greater than the proportion of *not-abused* group participants across nine childhood and current adult socio-economic outcomes.

Study 1 Method

Participants

Study 1: Experiences of Individuals comprised 323 adult voluntary participants ($M_{age} = 39.6$ years, age range: 18-90 years). Although recruitment was directed at males and females, the sample was predominately female (275 women, 48 men). Recruitment of participants included individuals (without a participating pair) and parent-child participant-dyads.

Multiple sources of recruitment were used across two waves – the first wave of recruitment targeted the general population, and the second wave of recruitment targeted adult survivors of childhood abuse or neglect. The first wave of recruitment (general population) included emails to all psychology students at Australian Catholic University (ACU), paid advertising for participants on Facebook social media site from 20th August to 12th September 2009 (Facebook advertising was funded using a Student Research Grant. Facebook estimated this advertisement would potentially target 10,611,760 people); recruitment flier insert in New Community Quarterly magazine, September 2009; emails to and fliers at community neighbourhood houses and medical centres in the City of Whitehorse, Victoria, Australia; recruitment fliers at cafés Sensory Lab David Jones and Plantation (Melbourne Central); snowball recruitment via word of mouth and email; letterboxing of recruitment fliers to residential houses local to the researcher in Melbourne, Australia; paid community notice placed in public notices section of Whitehorse Leader Newspaper 3rd March 2010.

The second wave of recruitment used advertising to and distribution of recruitment fliers through organisations involved in the support of adult survivors of childhood abuse or neglect. Organisations used for recruitment in Victoria, Australia included: South Eastern Centre against Sexual Assault (SECASA), welfare agency Doncare, welfare agency UnitingCare (Victoria), Eastern Melbourne Complex Trauma Group of the Mental Health Practitioners Network (MHPN), psychology service Cairnmillar, and Eating Disorders Victoria (EDV). Australian organisations used for recruitment included: Australians Surviving Child Abuse (ASCA; Australia-wide), Australian Psychological Society (APS; Australia-wide), Cowra Neighbourhood Centre (New South Wales, Australia), welfare agency UnitingCare (Tasmania), and Men Affected by Rape and Sexual Abuse (MARS; Queensland, Australia).

Materials

Studies 1 and 2 used a questionnaire battery (the Relationships and Functioning Questionnaire, RFQ) for collection of self-report data on a range of scales and items measuring childhood experiences and current adult relationships and functioning. Prior to Studies 1 and 2, a pilot study was undertaken to explore the application of the RFQ in an adult intergenerational population.

Development of materials via pilot study.

A pilot study was used to assist in shaping Study 1 and Study 2. A total of 42 adult volunteers participated in the pilot study, forming 21 complete participant-dyads of Australian Catholic University (ACU) students (*child* generation) and the person they described as being their primary parent/caregiver when they were growing up (*parent* generation). Primary caregiver was defined as "the parent or parent figure most involved in caring for your basic needs when you were growing up." Recruitment took place through the ACU School of Psychology, via word of mouth and distribution of the information letter. Recruitment of the parent generation occurred though the ACU student participant recruiting their primary caregiver for participation. Both members of the participant-dyad separately completed an identical pen-on-paper questionnaire package (on their own, each in their own time at home or at a location of their own choosing).

Although recruitment was directed at males and females, all pilot study participants were female. All participants were over 18 years of age (child generation M_{age} = 22.6 years, SD = 4.9, Parent generation M_{age} = 52.4 years, SD =6.9). Most (81%) of the pilot participants reported no childhood abuse or neglect. Of the seven participants who reported a history of childhood abuse or neglect, five reported only one type and two reported two types of childhood abuse or neglect. Due to the low numbers of pilot study participants with any history of childhood abuse or neglect, analysis of any-abused and not-abused groups was not useful.

Materials for studies 1 and 2.

As a result of the pilot study, a number of changes were made to the Relationships and Functioning Questionnaire test battery for use in Studies 1 and 2. Ethics approval was granted on 8th July 2009 (Wave 1) and 25th August 2010 (Wave 2) for modifications to the research project.

Measures

Self-report data was collected using a range of scales and items measuring current adult functioning, demographic information and childhood experiences. Wave 1 RFQ is shown in Appendix A-4 and Wave 2 (minor changes) RFQ is shown in Appendix B-5. The measures together with scale internal reliability data from Study 1 are described below.

Current adult functioning.

Participants completed a number of measures pertaining to their current level of functioning in interpersonal relationships and in daily living:

Proactive coping. Proactive coping was assessed using the 14-item Proactive Coping subscale of the Proactive Coping Inventory, (PCI; Greenglass, Schwarzer, Jakubiec, Fiksenbaum, & Taubert, 1999). Derived from Schwarzer's Proactive Coping Theory (1999), proactive coping refers to an individuals' efforts to strive for improvement of their life rather than react to past or anticipatory adversity (Aspinwall & Taylor, 1997; Zambianchi & Ricci Bitti, 2013). It involves the accumulation of resources and skills for the active management of personal goals, in which difficult

future situations are perceived as challenges rather than worrying threats (Katter & Greenglass, 2013; Schwarzer, 2001).

Previous research has shown that scores on the Proactive Coping subscale of the PCI are positively correlated with positive psychological variables such as life satisfaction (Greenglass, 2002; Uskul & Greenglass, 2005), proactive attitude, self-efficacy, preventive coping, and internal control and active coping (Greenglass et al., 1999).The scale is negatively correlated with negative psychological variables such as depression and self-blame (Greenglass et al., 1999). Previous research has reported the scale to be a reliable and valid measure across cultures (Gutierrez-Dona & Schwarzer, 2012). The Proactive Coping subscale has previously been reported to have high internal reliability of .80 and .85 and to have had its factorial validity and homogeneity confirmed by a principal component analysis (Greenglass et al., 1999; Zambianchi & Ricci Bitti, 2013).

Participants in the current study were asked to indicate how true each of the statements is on a 5-point scale from 1 (not at all true) to 5 (completely true). The possible range of Proactive Coping subscale scores was 14 to 70, with higher scores indicating more proactive coping. In the current study, the Proactive Coping subscale had an overall mean of 49.2 (SD= 8.2) and good reliability, with a Cronbach alpha of .84.

Separation-individuation process inventory. The 39-item Separation-Individuation Process Inventory (S-IPI; Christenson & Wilson, 1985) was used as a measure of current interpersonal functioning. Separation-Individuation is a developmental process involving development of an independent sense of self while maintaining connection or relatedness to others (Kins, Beyers, & Soenens, 2012). Separation-individuation disturbances manifest as difficulties coping with dependence, independence or a combination of both (Kins et al., 2012).

In the original scale, Christenson and Wilson (1985) used a 10-point scale and suggested a clinical cut-off based on scores of 190 and above out of a possible 390 to distinguish individuals with separation-individuation disturbances from those without that problem. Christenson and Wilson (1985) reported the S-IPI demonstrated known-groups validity with scores differentiating a sample of individuals with DSM-III diagnoses of Borderline Personality Disorder from a sample of university employees. Dolan et al. (1992) endorsed the clinical cut-off score, but recommended the S-IPI scale be shortened from the original 10-point scale.

Taking into account the S-IPI scale modification suggested by Dolan et al. (1992) , the current study used a five-point scale, and based an equivalent clinical range of scores of 95 or above. Instructions were to rate statements as being "characteristic… [of] people in general" and "characteristic of your feelings about yourself and other people" on a 5-point scale from *not at all characteristic* to *very characteristic*. For example, "When people really care for someone, they often feel worse about themselves". Total S-IPI scores were summed (with three items reverse scored) to give a possible range of 39 to 195, with higher scores indicating more individuation-separation disturbances. In the current study, the S-IPI scale had an overall mean of 85.2 (SD= 25.1) and very good reliability, with a Cronbach alpha of .93.

Social support. A 36-item Social Support scale originally developed by Caplan, Cobb, French Jr, Harrison, and Pinneau Jr (1975) and modified by Terry, Nielsen, and Perchard (1993), Quah and Bowles (2004) and Bowles (2008, personal communication) was used as a measure of current perceived support from others. Terry et al. (1993) reported Cronbach's alpha of .90 to .95.

Participants in the current study were provided with a set of six questions, to which they were asked to respond about six current relationships. The questions were: 1) How much does each of these people go *out of their way* to do things to make your life easier for you? 2) How much can each of these people be *relied on* when things get tough? 3) How much can you count on these people to help you *feel better* when you experience problems? 4) How much can you count on these people to give you *sound advice* when you experience problems? 5) How much can you count on these people to *listen to you* when you need to talk about problems? and 6) How much can you count on the following people to *help you out* in a crisis situation, even though they would have to go *out of their way* to do so? For each of the six questions, participants were asked to respond in relation to friends, spouse/ partner, parent(s), brothers/ sisters, work colleagues and your child/ren, making a total of 36 items. On each of the 36 items, participants could rate their perceived level of support on a scale from 1 (*very much*) to 4 (*not at all*), with the option to choose *no such person at current time*. All items, other than the *no such person at current time* scores, were reverse-scored, with higher scores reflecting higher perceived social support.

The possible range of total Social Support scores was zero to 144, with higher scores indicating more social support. In the current study, the Social Support scale had an overall mean of 100.3 (SD= 30.8) and good reliability, with a Cronbach alpha of .91.

Psychopathology. A set of three items asked about the participant's own mental health and wellbeing. These items were developed by the researcher for this study. The Psychopathology items were: 1) anxiety and depression, 2) addictions, and 3) serious mental illnesses such as schizophrenia, obsessive-compulsive disorder, bipolar disorder, or other. For example, item 1 was, "Have you ever had any symptoms of anxiety or depression (i.e. insomnia, excessive fears or panic attacks, other)? For each item, the response format was: *yes, currently*; *yes, in the past*; *yes, both currently and in the past* (option added in the Wave 2 version of RFQ); or *no*. An open comment section followed the three items, with participants invited to "Feel free to share any additional information about your mental health you feel is relevant."

The possible range of Psychopathology scores was zero to three, with higher scores indicating more psychopathology problems. In the current study, the Psychopathology scale had an overall mean of 2.2 (SD = 1.0) and lower reliability than the other scales, with a Cronbach alpha of .68.

Psychotherapy/ Treatment. One item, with three follow-up questions for participants who answered *yes*, was used to measure whether the participant had received any counselling or psychiatric treatment. This item was developed by the researcher for these studies. The item was, "Are you currently, or have you ever received any counselling or psychiatric treatment?" In the same format as the Psychopathology items, the response format provided the following options: *yes, currently*; *yes, in the past*; *yes, both currently and in the past* (option added in the 2a version of RFQ); or *no*. The three follow-up questions were how many treatment sessions they had attended, the year(s) that the sessions took place, and whether they had found the psychotherapy helpful overall.

Trauma symptoms. The 40-item Trauma Symptom Checklist (TSC-40; Briere; Briere & Runtz, 1989) was used as a measure of trauma symptoms currently experienced by the participant. The TSC-40 is a self-report research instrument measuring symptoms experienced over the prior two months in adults associated with childhood or adult traumatic experiences. Provided with a list of 40 symptoms, instructions were, "How often have you experienced each of the following in the past two months?" A five-point scale was used, with 1 indicating *never* and 5 indicating *often*. Responses were re-coded during analysis to range from zero to four. The total score was used as a measure of current trauma symptoms.

The possible range of total Trauma Symptom Checklist scores was from zero (no trauma symptoms) to 160, with higher scores indicating more current trauma symptoms. In the current study, the Trauma Symptom Checklist scale had an overall mean of 44.4 (SD= 31.8) and very good reliability, with a Cronbach alpha of .96.

The TSC-40 has six subscales: Anxiety, Depression, Dissociation, Sexual Abuse Trauma Index, Sexual Problems, and Sleep Disturbance, as well as a total score. The TSC-40 has previously been found to have good internal consistency, with Cronbach alpha's of .90 for the full scale and .66 to .77 for the subscales (Elliot & Briere, 1992). Past research has shown the scale to have predictive validity for a variety of traumatic experiences including sexual abuse (Elliot & Briere, 1992; Gold, Milan, Mayall, & Johnson, 1994; Zlotnick et al., 1996). The TSC-40 Dissociation subscale is investigated in Study 2.

Demographic information.

Demographic information included questions about the participant's age, sex, living arrangements (who they currently live with), current relationship status, whether they have any children, and which parent or other person was their primary and secondary carers when a child.

Socio-economic status information (SES).

Three indices were used to provide a measure of SES:

Childhood Financial Deprivation. Childhood financial deprivation was measured using retrospective reports of family financial deprivation when the participant was growing up (before age 17). The 17 items were developed from a list of *essentials of life* reported in the research by Saunders (2008) into monetary indicators of deprivation and social exclusion. For example, "When you were growing up, did your family have…Medical treatment if needed? (Yes/ No/ Do not know) If no, was this because your parents/ caregivers couldn't afford it? (Yes/ No). The five follow-up questions were about whether the deprivation of particular items occurred for distinct periods of time, the age of participant during this period, and the possible reason for this period.

The possible range of total childhood financial deprivation scores was from zero to 17, with higher scores indicating more financial deprivation. A categorical score was also used, with scores of two or more indicating childhood financial deprivation. In the

current study, 68.1% of participants reported nil childhood financial deprivation, 11.8% reported one indicator, 5.6% reported two indicators and 14.5% reported three or more indicators of financial deprivation during childhood. The Childhood Financial Deprivation scale had an overall mean of 0.94 (SD= 1.9) and good reliability, with a Cronbach alpha of .82.

Education. Items included 1) the highest level of school and post school qualification they had completed and 2) the highest level of school and post school qualification their primary and secondary carers had each completed.

Employment. The item was current employment and income status (full-time employment; part-time or casual employment; low income or disability based welfare payments; home duties; student; or retired / engaged in unpaid volunteer work).

Childhood family experiences.

Participant's childhood experiences and recollected perceptions of their family relationships and family functioning while they were growing up were recorded using a number of measures:

Family of Origin Scale- Short Form. The Family of Origin Scale-Short Form 2 (FOS Short Form; Ryan, Powel, Kawash, & Fine, 1995) was used as a retrospective measure of the perceived level of healthy functioning within a family. Developed as a short form of the Family of Origin Scale (FOS; Hovestadt, Anderson, Piercy, Cochran, & Fine, 1985), this 15-item scale assesses differentiation dimensions of family intimacy and autonomy from which a total score can be used to measure the perceived overall tone of social-emotional relationships in the family (Hemming, Blackmer, & Searight, 2012; Ryan et al., 1995). Previous research has reported higher scores on the FOS and FOS-SF to be associated with support for more open communication and less conflict, and lower scores to be associated with higher conflict (Hemming et al., 2012) . The FOS –Short Form 2 has previously been reported to have a very high reliability value of .94, and to have high concurrent validity with Short Form 1 (r=.94) and with the total FOS full-scale score (r=.98) (Ryan et al., 1995).

The response format was a five-point scale with a rating from *strongly disagree* to *strongly agree*. Total scores ranged from 15 to 75 as a continuous measure. Higher scores indicate more healthy family of origin functioning (warmth and closeness) and lower scores indicate less healthy family of origin functioning (coldness). In the current

study, the short-form of the Family of Origin scale had an overall mean of 45.6 (SD= 19.5) and acceptable reliability, with a Cronbach alpha of .75.

Family Psychopathology. A set of four items asked about the mental health and wellbeing of participant's family members. These items were developed by the researcher for this study. The Family Psychopathology items were: 1) anxiety and depression; 2) addictions; 3) serious mental illnesses such as Schizophrenia, Obsessive-Compulsive Disorder, Bipolar Disorder, or Other; and 4) Trauma symptoms. For example, "Did/ Does anyone in your family have any symptoms as a result of experiencing trauma (i.e. Flashbacks: reliving the experience, Avoidance: avoiding things that trigger bad memories, Dissociation: i.e. periods when they blank out or lose time)? For each item, the response format was to select from the following options: *yes, currently*; *yes, in the past*; *yes, both currently and in the past* (option added in the Wave 2 version of RFQ); or *no*. An open comment section followed the three items, with the instruction, "Feel free to share any additional information about your family's mental health you feel is relevant."

Child Abuse Survivor Identification. The four child abuse and neglect survivor identification questions were, "To the best of your knowledge, before age 17, were you ever: sexually abused, physically abused, physically neglected, or emotionally neglected." These questions were used to define *any-abused* and *not-abused* groups, to investigate outcomes across types of maltreatment, and across cumulative experiences of abuse and neglect.

Childhood Maltreatment Interview Schedule - Short Form (modified). The Childhood Maltreatment Interview Schedule –Short Form (CMIS-SF; Briere, 1992a) is an 11-item retrospective instrument about potential maltreatment experiences as a child. Briere (1992a) made note that the CMIS-SF can be used in various ways as a research tool, however, that the overall reliability or validity of the scale is not known.

Among the questions are those about adverse childhood experiences of caregiver drug or alcohol problems and witnessing family violence. These two items were used in the current research as additional measures of adverse childhood experiences.

On the CMIS Psychological Abuse subscale instructions are to rank the frequency of experiencing seven types of psychological abuse from 1 (never) to 5 (over 20 times per year). Possible total scores ranged from seven to 35. The Psychological Abuse subscale has previously been reported to show acceptable alpha reliabilities of .75 to .87 (Burgermeister, 2007). In the current study, the total sample Psychological

Abuse subscale had a mean score of 20.4 (SD=9.2) and good reliability, with a

Cronbach alpha of .95.

A CMIS Parental Love and Care subscale was constructed from four CMIS-SF

items, in which instructions were asked how much they felt loved by their mother or

father before age eight and from age eight to 17. The response format was to rate their

answers on a five-point scale from 1 (not at all) to 5 (very much), with the option to

choose *not applicable.* A mean score from the four questions was used as a measure of

total Parental Love and Care. In the current study, the Parental Love and Care subscale

had a total mean score of 4.0 (SD=1.0) and acceptable reliability, with a Cronbach alpha

of .80.

A CMIS Physical Neglect subscale was constructed from five CMIS-SF items

with instructions to rank the frequency (from 1 = never to 4 = over 20 times a year) of

having been without supervision, lunch, breakfast, dinner or medical attention. Possible

total scores ranged from five to 20. In the current study, the total sample CMIS Physical

Neglect subscale had a mean score of 6.2 (SD=2.4) and acceptable reliability, with a

Cronbach alpha of .82.

Procedure

Participants completed an online or pen-on-paper questionnaire package at a

time and location of their own convenience. The questionnaire took approximately 30

minutes to complete.

Studies 1 was initially intended to be only available online, via the survey host

website PsychData (Locke & Keiser-Clark, 2001-2015). Online research has been

suggested to increase self-disclosure and to have similar psychometric properties to

paper-based data collection (Buchanan & Smith, 1999). Online participation removes

some of the time and cost constraints of return postage of questionnaires. It was

anticipated that the online design would free participants from being restricted by

location when recruiting their intergenerational pair. However, informal feedback to the

researcher from participants, and from individuals expressing an interest to participate,

was that some individuals needed or desired a pen-on-paper format. For example, some

Child participants mentioned that their parent was interested in participating, but did not

have ready access to the internet. In response to these requests, the researcher sought a

modification of the ACU Ethics approval, and the addition of a pen-on-paper questionnaire package format of the RFQ was granted. The participants were able to choose for themselves between completing either the online or the pen-on-paper format of the RFQ.

Design sensitivities relating to investigation of childhood abuse and neglect.

As studies investigating the individual and intergenerational impacts of child abuse and neglect, the subject matter of this research was acknowledged a being potentially sensitive for some participants. Australian Catholic University Human Research Ethics Committee approval was obtained for this research project. Careful consideration was given to the design of the study to ensure confidentiality and least risk of harm for participants. These sensitivities were addressed through a number of design features, including: a generic study title and broad focus of recruitment information; data collection via questionnaire rather than interview; and separate completion and return of identical self-report questionnaire for both members of the dyad. The use of a generic study title and broad participant information ensured participants were not primed to items asking about childhood abuse and neglect. Appendix A-1 shows the complete Information Letter to Participants.

Analytic Strategy

The sample for Study 1: Experiences of Individuals included both paired and unpaired individuals. Where possible, a linear mixed model was used in the analyses presented for this study to account for pairing as a random effect.

First, proportions of *any-abused* male and *any-abused* female participants, and proportions of *any-abused* and *not-abused* participants were used to describe the Study 1 data. Percentages were used to describe the frequency of different types of abuse reported by participants.

In describing the results for Study 1, the patterns, directions and magnitudes of mean differences are first considered. The statistical tests are then discussed. Statistical significance of results can depend on sample size, and the extent of variability in the outcomes measured. This avoids relying on statistical significance alone as an indicator

of the importance of results; this strategy is consistent with the recommendations for statistical reporting and interpretation of the American Psychological Association.

For Study 1 Hypothesis 1.1, linear mixed models with estimates of mean differences and 95% confidence intervals were used to compare the *any-abused* and *not-abused* group on measures of adult functioning. Proportions between *any-abused* group and *not-abused* groups were used to describe participants in terms of the clinical range on the Separation-Individuation Process Inventory.

For Study 1 Hypothesis 1.2, linear mixed models with estimates of mean differences and confidence intervals were used to compare the *carer-any-drug-problem* and *carer-no-drug-problem* groups, and the *witnessed-any-family violence* and *no-family-violence* groups on measures of adult functioning.

For Study 1 Hypothesis 2.1, means and standard deviations were used to describe adult functioning outcomes across different abuse and neglect types: sexual abuse, physical abuse, physical neglect and emotional neglect.

For Study 1 Hypothesis 2.2, linear mixed models were used to compare abuse and neglect in four groups: *neither*, *abused* (sexual and physical abuse), *neglected* (physical and emotional neglect), and *both*, on five adult functioning outcomes. Multiple pairwise comparisons (with mean differences and 95% confidence intervals) were also used to describe differences between these four categories of abuse and neglect for five adult functioning outcomes. Linear mixed models were carried out using GenStat software (VSN International, 2011). When undertaking more than one statistical test in analysing the data, some researchers take the stance that adjustment of statistical significance is necessary for methodological rigour. However, Perneger (1998) and Rothman (1990) argue that such adjustments of statistical significance for multiple comparisons can have a negative impact on the interpretation of findings and increase the likelihood of Type II errors and, as such, are not recommended. Therefore, the decision was made not to adjust the statistical significance across these multiple tests. Rather, confidence intervals were used to enable corroboration of the inferences made from the significance tests.

For Study 1 Hypothesis 2.3, linear mixed models were used to compare the five groups (defined according to the number of abuse and neglect types reported: *no abuse or neglect*, *one-type*, *two-types*, *three-types*, *four-types*). Means and standard deviations were used to describe adult functioning outcomes across the number of abuse and

neglect types reported. Pairwise comparisons of adjacent levels were used to describe mean differences between the number of abuse and neglect types reported on five adult functioning variables. Confidence intervals are also reported.

For Study 1 Hypothesis 3, Pearson correlations were used to describe the strength of linear association between Proactive Coping and each of the five adult functioning outcomes.

For Study 1 Hypothesis 4.1, linear mixed models with estimates of mean differences and confidence intervals were conducted on the *any-abused* group to compare participants who had (*ever*), and who had not (*never*), accessed psychotherapy for each of the five adult functioning outcomes.

For Study 1 Hypothesis 4.2, linear mixed models with estimates of mean differences and confidence intervals were conducted across psychotherapy categories: *currently* accessing psychotherapy and *not-currently* accessing psychotherapy for each of the five adult functioning outcomes.

For Study 1 Hypothesis 5.1, Pearson correlations were used to describe the relationship between Family of Origin Scale and four other relationship outcomes: CMIS Parental Love and Care, number of live-in partners, longest relationship and Social Support.

For Study 1 Hypothesis 5.2, linear mixed models, means and standard deviations, mean differences and 95% confidence intervals were used to compare *any-abused* and *not-abused* Groups on the five relationship outcomes: Family of Origin, CMIS Parental Love and Care, number of live-in partners, longest relationship and Social Support.

For Study 1 Hypothesis 6.1, a General Linear Model was used to model Trauma Symptoms in terms of four CMIS sub-scales (Psychological Abuse, Physical Neglect, Physical Injury and Sexual Abuse). Estimates of mean differences and confidence intervals were used to describe the effect of categorical variables CMIS Physical Abuse and CMIS Sexual Abuse with Trauma Symptoms. The effects of continuous independent variables CMIS Psychological Abuse and CMIS Physical Neglect were described using regression coefficients (with 95% confidence intervals and *p*-values) for the predicted change in Trauma Symptom scores.

For Study 1 Hypothesis 6.2, a General Linear Model was used to model Trauma Symptoms in terms of four adult functioning independent variables (Separation-Individuation, Social Support, Psychopathology, and Proactive Coping).

For Study 1 Hypothesis 7, proportions for nine socio-economic outcomes were calculated for *any-abused* and *not-abused* groups.

Study 1 Results

Any-Abused and Not-Abused Groups

Data from all 323 Study 1 participants was used to compare functioning and relationship variables across *any-abused* and *not-abused* groups. Any-abused and not-abused groups were assigned based on participants' responses to a set of questions asking about child abuse and neglect history. The *any-abused* group comprised all participants who answered *yes* to any of the four questions, "Before the age of 17, were you Sexually Abused? Physically Abused? Physically Neglected? [or] Emotional Neglected?" The *not-abused* group comprised participants who answered *no* to all four abuse and neglect questions.

Study 1: Table 1

Frequency of Different Abuse Types

	N	%
Any-Abused	185	57.2
Multiple abuse types:		
0 (or Not-Abused)	138	42.7
1	58	18.0
2	65	20.1
3	43	13.3
4	19	5.9
Sexually abused	91	28.2
Physically abused	105	32.5
Physical neglect	46	14.2
Emotional neglect	151	46.7

Study 1: Table 2

Proportion of Any-Abused Males and Any-Abused Females

Proportion Any-Abused		Proportion Any-Abused (females – males)		
Females	**Males**	**Estimate**	**95% CI**	**p**
0.59 (N = 163)	0.46 (N = 22)	0.14	-0.02, 0.29	.084

Study 1: Table 3

Mean Age Across Any-Abused and Not-Abused Groups

M age		Mean difference (Any-Abused - Not-Abused)		
Any-Abused	**Not-Abused**	**Estimate**	**95% CI**	***p***
40.3	38.6	1.7	-2.17, 5.65	.382
(N = 185)	(N = 138)			

As shown in Table 1, just over half of the participants reported a history of any type of childhood abuse and neglect. As shown in Table 1, childhood abuse and neglect was also explored across *multiple types of abuse and neglect* and across each of the four subtypes (*sexually abused*, *physically abused*, *physically neglected* and *emotionally neglected*). Of the participants reporting maltreatment, the majority reported more than one type of abuse or neglect (68.6%). As shown in Tables 2 and 3, there were no statistically significant differences in sex or mean age between the *any-abused* and *not-abused* groups.

Study 1 Results for Hypothesis 1: Adult Functioning Outcomes across Any-abused, Carer-Drug Problem and Witnessed Family Violence Groups

Study 1 results for hypothesis 1.1: Adult functioning outcomes across any-abused and not-abused groups.

As shown in Table 4 and Table 5, linear mixed models were performed for each of the five adult functioning dependent variables: separation-individuation, social support, psychopathology, trauma symptoms and proactive coping.

Study 1: Table 4

Means and Difference of Means Comparing Any-Abused with Not-Abused Groups for

Five Adult Functioning Outcomes

Outcome	Any-Abused M (SD)	Not-Abused M (SD)	Any-Abused - Not-Abused	
			Mean Difference	95% CI
Separation-Individuation	92.6 (26.7)	77.4 (18.9)	15.2	9.90, 20.48
Social Support	77.9 (22.5)	93.0 (21.0)	-15.1	-19.96, -10.23
Psychopathology	1.4 (0.8)	0.8 (0.8)	0.6	0.43, 0.77
Trauma Symptoms	57.1 (32.4)	28.5 (21.0)	28.7	22.32, 35.00
Proactive Coping	48.8 (9.2)	49.7 (7.0)	-0.9	-2.71, 0.93

Study 1: Table 5

Results from Linear Mixed Models Comparing Any-Abused with Not-Abused Groups for

Five Adult Functioning Outcomes

Outcome	F	df	p
Separation-Individuation	31.95	1, 305	**< .001**
Social Support	36.77	1, 309	**< .001**
Psychopathology	49.14	1, 316	**< .001**
Trauma Symptoms	78.99	1, 314	**< .001**
Proactive Coping	0.93	1, 312	.335

Separation-individuation results for study 1 hypothesis 1.1. As shown in Table 4, participants in the *any-abused* group had more problems with separation-individuation, with average scores 15 points higher than the *not-abused* group. As shown in Table 5, there was a statistically significant difference between *any-abused* and *not-abused* groups on Separation-Individuation.

Study 1: Table 6

Proportion of Any-Abused and Not-Abused Separation-Individuation Scores in the Clinical Range (Scores of >95)

Proportion S-I Scores in Clinical Range		Proportion in Clinical Range (Any-Abused – Not-Abused)		
Any-Abused	**Not-Abused**	**Estimate**	**95% CI**	***p***
0.45	0.18	0.27	0.17, 0.36	**< .001**
(N = 183)	(N = 133)			

Possible total scores on the Separation-Individuation Processing Index ranged from 39-195. Scores above 95 were within the clinical range for separation-individuation disturbances. As shown in Table 6, a statistically significant difference was found between *any-abused* and *not-abused* on separation-individuation scores above 95, with 45% of the *any-abused* participants scoring above the equivalent clinical cut-off score of 95, compared with 18% of *not-abused* participants.

Social support results for study 1 hypothesis 1.1. Possible total scores on the Social Support scale ranged from 0 to144. As shown in Table 4, participants in the *any-abused* group had less total social support, with average scores approximately 15 points lower than participants in the *not-abused* group. As shown in Table 5, there was a statistically significant difference between *any-abused* and *not-abused* groups on Social Support.

Psychopathology results for study 1 hypothesis 1.1. Possible total Psychopathology scores ranged from 0 to 3. As shown in Table 4, participants in the *any-abused* group had more psychopathology on average than *not-abused* participants. As shown in Table 5, there was a statistically significant difference between *any-abused* and *not-abused* groups on Psychopathology.

Trauma symptom results for study 1 hypothesis 1.1. Possible total scores on the Trauma Symptom Checklist ranged from 0 to160. As shown in Table 4, participants in the *any-abused* group had more than twice the average number of recent trauma symptoms, with scores approximately 29 points higher than participants in the *not-abused* group. As shown in Table 5, there was a statistically significant difference between *any-abused* and *not-abused* groups on Trauma Symptoms.

Proactive coping results for study 1 hypothesis 1.1. Possible total scores on the Proactive Coping subscale ranged from 14 to 70. As shown in Table 5, there was no

statistically significant difference between *any-abused* and *not-abused* groups on proactive coping.

Study 1 results for hypothesis 1.2.1: Adult functioning outcomes across carer drug problem groups.

Analysis was conducted on five adult functioning outcomes across carer drug problem groups.

Study 1: Table 7

Means and Difference of Means Comparing Carer Any-Drug Problem with Carer No-Drug Problem Groups for Five Adult Functioning Outcomes

Outcome	Carer Any-Drug Problem (N=53)	Carer No-Drug Problem (N=265)	Carer Any-Drug Problem - Carer No-Drug Problem	
	M	M	Mean Difference	95% CI
Separation-Individuation	99.2	83.9	15.3	8.12, 22.5
Social Support	78.8	85.4	-6.6	-13.39, 0.28
Psychopathology	1.5	1.1	0.3	0.04, 0.51
Trauma Symptoms	65.2	42.1	23.1	14.19, 32.05
Proactive Coping	50.5	48.9	1.6	-0.83, 4.06

Study 1: Table 8

Results from Linear Mixed Models Comparing Carer Any-Drug Problem with Carer No-Drug Problem Groups for Five Adult Functioning Outcomes

	F	Df	*p*
Separation-Individuation	17.57	1, 310	**< .001**
Social Support	3.57	1, 316	.060
Psychopathology	10.02	1, 316	**.002**
Trauma Symptoms	25.94	1, 312	**< .001**
Proactive Coping	1.69	1, 312	.195

Separation-individuation results for study 1 hypothesis 1.2.1. As shown in Table 7, participants in the *carer-any-drug-problem* group had more problems with separation-individuation, with average scores higher than carer-no-drug-problem participants. As shown in Table 8, there was a statistically significant difference between *carer-any-drug-problem* and *carer-no-drug-problem* groups on Separation-Individuation

Social support results for study 1 hypothesis 1.2.1. As shown in Table 8, no statistically significant difference was found between *carer-any-drug-problem* and *carer-no-drug-problem* groups on Social Support.

Psychopathology results for study 1 hypothesis 1.2.1. As shown in Table 7, participants in the *carer-any-drug-problem* group had more psychopathology on average than *carer-no-drug-problem* participants. As shown in Table 8, there was a statistically significant difference between *carer-any-drug-problem* and *carer-no-drug-problem* groups on Psychopathology.

Trauma symptom results for study 1 hypothesis 1.2.1. As shown in Table 7, participants in the *carer-any-drug-problem* group had more trauma symptoms, with average scores higher than participants in the *carer-no-drug-problem* group. As shown in Table 8, there was a statistically significant difference between *carer-any-drug-problem* and *carer-no-drug-problem* groups on Trauma Symptoms.

Proactive coping results for study 1 hypothesis 1.2.1. As shown in Table 8, there was no statistically significant difference between *carer-any-drug-problem* and *carer-no-drug-problem* groups on proactive coping.

Study 1 results for hypothesis 1.2.2: Adult functioning outcomes across carer drug problem groups and witnessing family violence groups.

Analysis was conducted on five adult functioning outcomes across witnessing family violence groups.

Study 1: Table 9

Means and Difference of Means Comparing Witnessed Family Violence with No-Family Violence Groups for Five Adult Functioning Outcomes

Outcome	Witnessed Any-Family Violence (N=118)	No-Family Violence Witnessed (N=200)	Witnessed Any-Family Violence - No-Family Violence Witnessed	
	M	M	Mean Difference	95% CI
Separation-Individuation	91.4	84.3	7.0	1.53, 12.52
Social Support	78.4	87.7	-9.3	-14.54, -4.14
Psychopathology	1.3	1.1	0.3	0.10, 0.45
Trauma Symptoms	53.5	42.4	11.1	4.27, 17.87
Proactive Coping	49.4	49.0	0.3	-1.52, 2.18

Study 1: Table 10

Results from Linear Mixed Models Comparing Witnessed Any-Family Violence with No-Family Violence Groups for Five Adult Functioning Outcomes

	F	df	*p*
Separation-Individuation	6.32	1, 283	**.012**
Social Support	12.46	1, 316	**< .001**
Psychopathology	9.21	1,301	**.003**
Trauma Symptoms	10.27	1, 272	**.002**
Proactive Coping	0.12	1, 308	.730

Separation-individuation results for study 1 hypothesis 1.2.2. As shown in Table 9, participants in the *witnessed-any-family violence* group had more problems with separation-individuation than the *no-family-violence* group. As shown in Table 10, there was a statistically significant difference between *witnessed-any-family violence* and *no-family-violence* groups on Separation-Individuation.

Social support results for study 1 hypothesis 1.2.2. As shown in Table 9, participants in the *witnessed-any-family violence* group had less total social support than participants in the *no-family-violence* group. As shown in Table 10, there was a statistically significant difference between *witnessed-any-family violence* and *no-family-violence* groups on Social Support.

Psychopathology results for study 1 hypothesis 1.2.2. As shown in Table 9, participants in the *witnessed-any-family violence* group had more psychopathology on average than *no-family-violence* group. As shown in Table 10, there was a statistically significant difference between *witnessed-any-family violence* and *no-family-violence groups* on Psychopathology.

Trauma symptom results for study 1 hypothesis 1.2.2. As shown in Table 9, participants in the *witnessed-any-family violence* group had more trauma symptoms, with average scores higher than participants in the *no-family-violence* group. As shown in Table 10, there was a statistically significant difference between *witnessed-any-family violence* and *no-family-violence* groups on Trauma Symptoms.

Proactive coping results for study 1 hypothesis 1.2.2. As shown in Table 10, there was no statistically significant difference between *witnessed-any-family violence* and *no-family-violence* groups on proactive coping.

Study 1 Results for Hypothesis 2: Adult Functioning Outcomes across Abuse and Neglect Categories

For Study 1 Hypothesis 2.1, analysis of adult functioning outcomes was conducted across abuse and neglect categories in two ways: first, descriptive analysis across the four types of abuse and neglect (*sexual abuse*, *physical abuse*, *physical neglect* and *emotional neglect*), second, through comparison of *Neither*, *Abused*, *Neglected* and *Both* groups. For Study 1 Hypothesis 2.2, comparisons were of the outcomes according to the *number of abuse types* (zero to four types).

Study 1 results for hypothesis 2.1: Type of abuse or neglect on adult

functioning outcomes.

Analysis was conducted on five adult functioning outcomes across the four types of abuse and neglect: sexual abuse, physical abuse, physical neglect and emotional neglect.

Study 1: Table 11

Means and Standard Deviations of Five Adult Functioning Outcomes across Different Types of Abuse and Neglect

Outcome		Type of abuse or neglect							
		Sexual Abuse		Physical Abuse		Physical Neglect		Emotional Neglect	
		Yes	No	Yes	No	Yes	No	Yes	No
Separation-Individuation	M	94.6	81.5	95.0	80.4	100.7	82.6	94.1	77.4
	SD	27.25	23.27	27.03	22.71	26.12	24.07	26.82	20.65
	N	90	226	104	212	45	271	149	166
Social Support	M	78.1	86.7	75.7	88.5	78.3	85.2	76.6	91.1
	SD	24.78	22.12	20.60	23.25	22.44	23.19	21.58	22.51
	N	89	229	104	214	45	273	149	168
Psycho-pathology	M	1.6	1.0	1.6	0.9	1.5	1.1	1.4	0.9
	SD	0.78	0.79	0.78	0.77	0.72	0.83	0.77	0.80
	N	91	232	105	218	46	277	151	171
Trauma Symptoms	M	63.9	36.8	63.3	35.1	67.4	40.5	58.9	31.5
	SD	33.53	27.63	33.98	26.12	34.02	29.74	33.31	24.02
	N	89	227	104	212	46	270	149	166
Proactive Coping	M	49.3	49.2	49.7	49.0	48.7	49.3	48.8	49.6
	SD	8.48	8.13	9.32	7.64	9.63	7.97	9.15	7.31
	N	90	229	104	215	46	273	149	170

As shown in Table 11, Separation-Individuation scores were highest, on average, for participants who reported a history of physical neglect, and lowest, on average, for participants who reported emotional neglect. Trauma Symptom scores were highest, on average, for participants who reported physical neglect, and lowest, on average, for participants who reported emotional neglect. Social Support, Psychopathology and Proactive Coping had minimal variation in mean scores across

abuse and neglect types. For all five adult functioning measures, mean scores between sexual abuse and physical abuse were similar.

Study 1 results for hypothesis 2.2: Abuse categories neither, abused, neglected and both.

As shown in Tables 12 and 13 and in Figure 2, analysis was conducted on five adult functioning outcomes comparing *Neither* (not Abused or Neglected), *Abused* (sexual and physical abuse), *Neglected* (physical and emotional neglect) and *Both* (Abused and Neglected). The multiple pairwise comparisons between these categories of abuse and neglect for five adult functioning outcomes are shown in Table 14.

Study 1: Table 12

Means and Standard Deviations across Abuse and Neglect Categories: Neither, Abused, Neglected or Both-Abused-and-Neglected

Outcome	Neither		Abused		Neglected		Both	
	M	*SD*	M	*SD*	M	*SD*	M	*SD*
Separation-Individuation	75.4	19.00	83.9	24.83	88.3	26.29	96.1	26.74
Social Support	93.1	21.22	83.9	25.17	76.0	22.82	76.6	21.33
Psychopathology	0.7	0.77	1.4	0.77	1.0	0.64	1.5	0.77
Trauma Symptoms	27.4	21.37	47.8	26.90	45.2	27.78	63.4	33.71
Proactive Coping	49.6	6.65	49.1	9.55	46.6	8.62	49.6	9.26

Study 1: Table 13

Results from Linear Mixed Models Comparing Abuse and Neglect Categories: Neither, Abused, Neglected or Both-Abused-and-Neglected

Outcome	*F*	df	*p*
Separation-Individuation	13.56	3, 304	**< .001**
Social Support	13.70	3, 314	**< .001**
Psychopathology	21.19	3, 314	**< .001**
Trauma Symptoms	32.11	3, 308	**< .001**
Proactive Coping	14.05	3, 309	.146
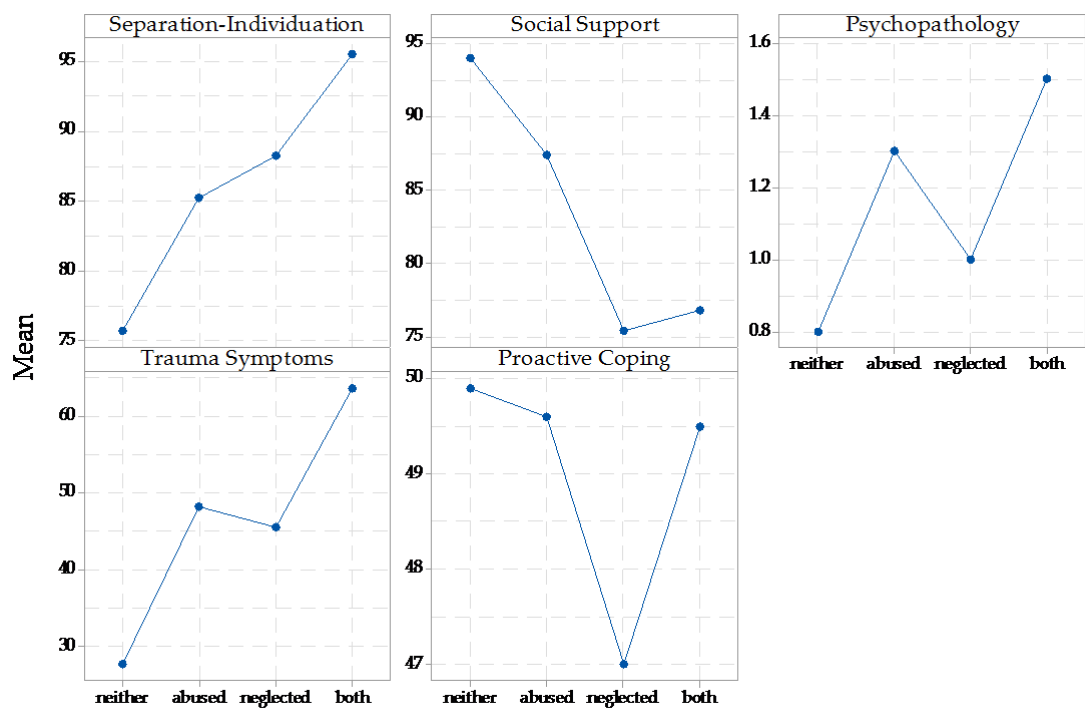
Study 1: Figure 2. Means across abuse and neglect categories: neither, abused, neglected or both-abused-and-neglected.

Study 1: Table 14

Multiple Comparisons between Categories of Abuse and Neglect for Five Adult

Functioning Outcomes

			Level *a* – Level *b*		
Level *a*	Level *b*	Mean difference	95% CI	*p*
Separation-Individuation				
Both	Abused	10.6	1.71, 19.57	**.020**
Both	Neglected	7.6	-1.18, 16.34	.091
Both	Neither	19.2	13.22, 25.14	**< .001**
Abused	Neglected	-3.1	-14.00, 7.88	.584
Abused	Neither	8.5	-0.31, 17.39	.060
Neglected	Neither	11.6	3.05, 20.15	**.008**
Social Support				
Both	Abused	-7.3	-18.35, 3.80	.327
Both	Neglected	0.6	-9.98, 11.25	.999
Both	Neither	-16.5	-23.76, -9.28	**< .001**
Abused	Neglected	7.9	-5.44, 21.26	.421
Abused	Neither	-9.2	-20.11, 1.62	.126
Neglected	Neither	-17.2	-27.55, -6.76	**< .001**
Psychopathology				
Both	Abused	0.2	-0.11, 0.46	.226
Both	Neglected	0.5	0.21, 0.76	**.001**
Both	Neither	0.7	0.56, 0.93	**< .001**
Abused	Neglected	0.3	-0.04, 0.65	.083
Abused	Neither	0.6	0.29, 0.85	**< .001**
Neglected	Neither	0.3	-0.01, 0.53	.058
Trauma Symptoms				
Both	Abused	15.2	4.38, 26.00	**.006**
Both	Neglected	18.4	8.08, 28.70	**.001**
Both	Neither	34.8	27.81, 41.79	**< .001**
Abused	Neglected	3.2	-9.91, 16.31	.633
Abused	Neither	19.6	8.91, 30.31	**< .001**
Neglected	Neither	16.4	6.34, 26.48	**.002**
Proactive Coping				
Both	Abused	1.0	-2.10, 4.08	.531
Both	Neglected	3.2	0.21, 6.25	**.037**
Both	Neither	0.0	-2.07, 2.03	.985
Abused	Neglected	2.2	-1.54, 6.02	.247
Abused	Neither	-1.0	-4.07, 2.05	.519
Neglected	Neither	-3.3	-6.18, -0.33	**.030**

Separation-individuation results for study 1 hypothesis 2.2. As shown Table 12 and Figure 2, the mean score on the Separation-Individuation Processing Index was lowest for the *Neither* group and highest for the *Both* group. Linear mixed models shown in Table 13 confirm there was a statistically significant difference between the *Neither*, *Abused*, *Neglected* and *Both* groups for Separation-individuation. As shown in Table 14, pairwise comparisons between multiple levels confirmed that the largest increases apparent in Figure 2 were statistically significant between *Neither* and *Both,* between *Neither* and *Neglected* and between *Abused* and *Both*. The differences between *Neither* and *Abused*, between *Neglected* and *Both*, and between *Neglected* and *Abused* were estimated to be very small.

Social support results for study 1 hypothesis 2.2. As shown Table 12 and Figure 2, the mean score on the Social Support scale was highest for the *Neither* group and lowest for the *Neglected* group. Linear mixed models shown in Table 13 confirm there was a statistically significant difference between the *Neither*, *Abused*, *Neglected* and *Both* groups for Social Support. As shown in Table 14, pairwise comparisons between multiple levels confirmed that the largest decreases apparent in Figure 2 were statistically significant between *Neither* and *Neglected* and between *Neither* and *Both*. The differences between *Neither* and *Abused*, *Abused* and *Both*, *Neglected* and *Abused* and *Neglected* and *Both* were estimated to be very small.

Psychopathology results for study 1 hypothesis 2.2. As shown in Table 12 and Figure 2, the mean score on the Psychopathology scale was lowest for the *Neither* group and highest for the *Both* group. Linear mixed models shown in Table 13 confirm there was a statistically significant difference between the *Neither*, *Abused*, *Neglected* and *Both* groups for Psychopathology. As shown in Table 14, pairwise comparisons between multiple levels confirmed that the largest increases apparent in Figure 2 were statistically significant between *Neither* and *Both*, between *Neither* and *Abused* and between *Neglected* and *Both*. The differences between *Neither* and *Neglected*, between *Neglected* and *Abused*, and between *Abused* and *Both* were estimated to be very small.

Trauma symptoms results for study 1 hypothesis 2.2. As shown in Table 12 and Figure 2, the mean score on the Trauma Symptoms Checklist was lowest for the *Neither* group and highest for the *Both* group. Linear mixed models shown in Table 13 confirm there was a statistically significant difference between the *Neither*, *Abused*, *Neglected* and *Both* groups for Trauma Symptoms. As shown in Table 14, pairwise comparisons between multiple levels confirmed that the largest increases apparent in Figure 2 were

statistically significant between *Neither* and *Both* and between *Neither* and *Abused*. Statistically significant pairwise comparisons were also found between *Neglected* and *Both*, between *Neither* and *Neglected* and between *Abused* and *Both*. The difference between *Neglected* and *Abused* were estimated to be very small.

      Proactive coping scale results for study 1 hypothesis 2.2. As shown in Table 12 and Figure 2, the *Neither* group had the most Proactive Coping. Participants in the *Neglected* group had the least Proactive Coping with scores lower than those of participants in the *Both* group. These differences, however, were relatively small. As shown in Table 13, there was no statistically significant difference between *Neither*, *Abused*, *Neglected* and *Both* groups for Proactive Coping. As shown in Table 14, pairwise comparisons between multiple levels confirmed that the largest decreases apparent in Figure 2 were between *Neither* and *Neglected* and between *Neglected* and *Both*. Pairwise comparisons between the remaining adjacent levels were smaller and not statistically significant.

Study 1 results for hypothesis 2.3: Multiple abuse types and adult functioning.

      As shown in Table 15 and 16 and Figure 3, analysis was conducted on five adult functioning measures across the number of abuse and neglect types reported: *no abuse or neglect*, *one-type*, *two-types*, *three-types*, *four-types*. The analysis of multiple pairwise comparisons between these categories of abuse and neglect for five adult functioning outcomes are shown in Table 17.

Study 1: Table 15

Means and Standard Deviations across Number of Types of Abuse and Neglect

| Outcome | | **Number of Types of Abuse and Neglect** | | | | |
		0	**1**	**2**	**3**	**4**
Separation-Individuation	M	75.4	86.8	87.9	102.3	102.3
	SD	18.93	24.37	26.52	28.16	22.76
	N	133	57	65	43	18
Social Support	M	93.0	78.8	81.9	70.5	78.0
	SD	21.24	23.72	21.81	20.88	22.21
	N	135	58	64	43	18
Psychopathology	M	0.8	1.1	1.4	1.6	1.8
	SD	0.77	0.69	0.78	0.76	0.71
	N	138	58	65	43	19
Trauma Symptoms	M	27.4	46.2	49.6	75.1	73.1
	SD	21.30	26.66	29.23	33.14	34.96
	N	135	55	64	43	19
Proactive Coping	M	49.6	47.4	50.5	47.7	50.4
	SD	6.65	9.72	8.60	9.56	8.48
	N	136	57	65	42	19

Study 1: Table 16

Linear Mixed Models of Adult Functioning Outcomes Comparing Number of Types of Abuse and Neglect

Outcome	*F*	df	*p*
Separation-Individuation	12.68	4, 305	**< .001**
Social Support	11.15	4, 311	**< .001**
Psychopathology	16.76	4, 314	**< .001**
Trauma Symptoms	36.23	4, 303	**< .001**
Proactive Coping	1.90	4, 306	.111
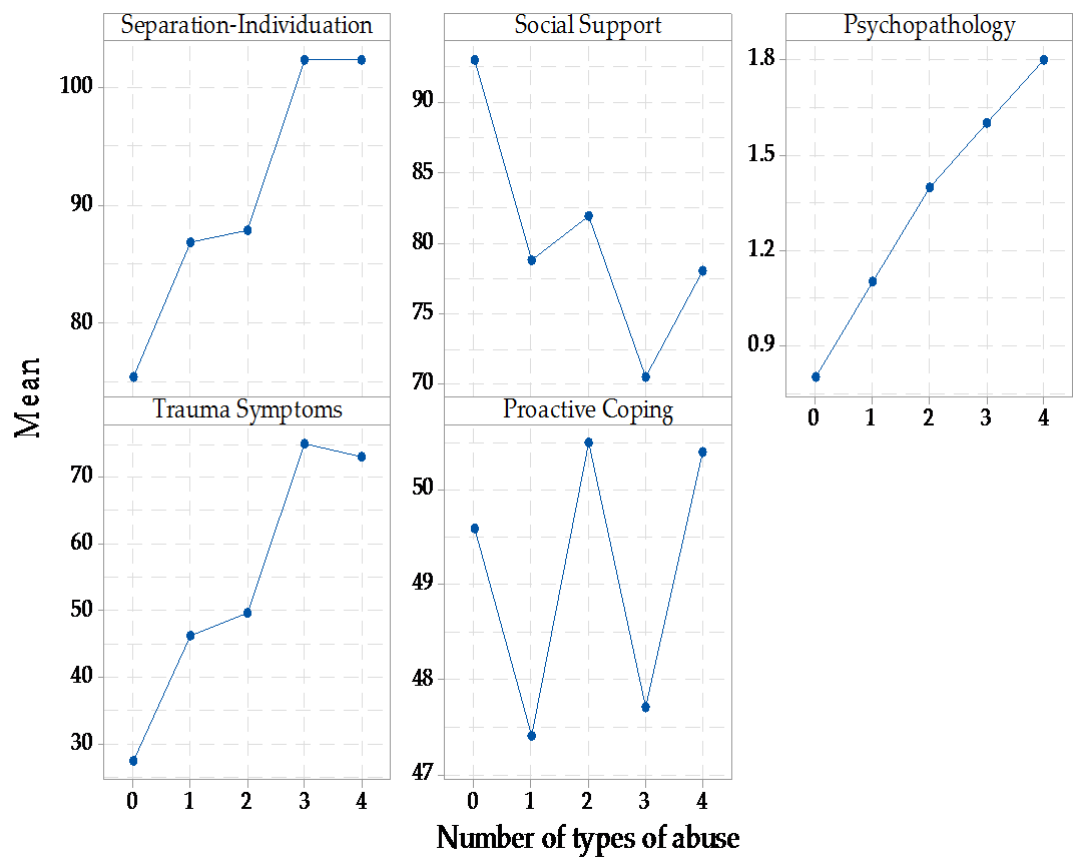
Study 1: Figure 3. Means across number of types of abuse and neglect.

Study 1: Table 17

Means and Difference of Means Comparing Adjacent Levels of Abuse for Five Adult Functioning Outcomes

| Outcome | Level *a* | Level *b* | Level *a* – Level *b* | | |
			Mean difference	95% CI	*p*-value
Separation-Individuation					
	1 type	No abuse	10.9	3.77, 18.09	**.003**
	2 types	1 type	0.2	-7.99, 8.43	.958
	3 types	2 types	14.1	5.27, 22.99	**.002**
	4 types	3 types	0.0	-12.8, 12.74	.996
Social Support					
	1 type	No abuse	-14.1	-20.89, -7.40	**< .001**
	2 types	1 type	3.1	-4.71, 10.87	.437
	3 types	2 types	-11.4	-19.83, -2.29	**.009**
	4 types	3 types	7.5	-4.59, 19.52	.224
Psychopathology					
	1 type	No abuse	0.4	0.14, 0.6	**.002**
	2 types	1 type	0.2	-0.05, 0.48	.110
	3 types	2 types	0.3	-0.03, 0.54	.080
	4 types	3 types	0.1	-0.29, 0.52	.581
Trauma Symptoms					
	1 type	No abuse	18.8	10.37, 27.15	**< .001**
	2 types	1 type	3.5	-6.17, 13.13	.478
	3 types	2 types	25.5	15.17, 35.86	**< .001**
	4 types	3 types	-2.1	-16.54, 12.37	.777
Proactive Coping					
	1 type	No abuse	-2.5	-4.99, -0.03	**.048**
	2 types	1 type	3.2	0.32, 6.02	**.030**
	3 types	2 types	-2.6	-5.68, 0.54	.106
	4 types	3 types	2.9	-1.52, 7.28	.200

Separation-individuation results for study 1 hypothesis 2.3. As shown in Table 15 and Figure 3, the mean score on the Separation-Individuation Processing Index was lowest for *no abuse or neglect* and equal highest for *three-types* and *four-types*. The linear mixed model shown in Table 16 confirmed there was a statistically significant

difference for separation-individuation between the five levels of number of abuse types. As shown in Table 17, pairwise comparisons between adjacent levels confirmed that the largest increases apparent in Figure 3, between *two-types* and *three-types*, and from *no abuse or neglect* and *one-type,* were statistically significant. The differences between *one-type* and *two-types* and between *three-types* and *four-types* were estimated to be very small.

   Social support results for study 1 hypothesis 2.3. As shown in Table 15 and Figure 3, the mean score on the Social Support scale was highest for *no abuse or neglect* and lowest for *three-types* of abuse. The linear mixed model shown in Table 16 confirmed there was a statistically significant difference for social support between the five levels of number of abuse types. As shown in Table 17, pairwise comparisons between adjacent levels confirmed that the largest decreases apparent in Figure 3, from *no abuse or neglect* to *one-type* and from *two-types* to *three-types,* were statistically significant. The differences between *three-types* and *four-types*, and between *one-type* and *two-types* were estimated to be very small.

   Psychopathology results for study 1 hypothesis 2.3. As shown in Table 15 and Figure 3, the mean score on the Psychopathology scale was lowest for *no abuse or neglect* and highest for *four-types*. The linear mixed model shown in Table 16 confirmed there was a statistically significant difference for Psychopathology between the five levels of number of abuse types. As shown in Table 17, pairwise comparisons between adjacent levels confirmed that the largest decrease apparent in Figure 3, from *no abuse or neglect* to *one-type*, was statistically significant. The differences between *two-types* and *three-types*, between *one-type* and *two-types*, and between *three-types* and *four-types* were estimated to be very small.

   Trauma symptoms results for study 1 hypothesis 2.3. As shown in Table 15 and Figure 3, the mean score on the Trauma Symptoms Checklist was lowest for *no abuse or neglect* and highest for *three-types*. The linear mixed model shown in Table 16 confirmed there was a statistically significant difference for Trauma Symptoms between the five levels of number of abuse types. As shown in Table 17, pairwise comparisons between adjacent levels confirmed that the largest decrease apparent in Figure 3, from *two-types* to *three-types* and from *no abuse or neglect* to *one-type*, were statistically significant. The differences between *one-type* and *two-types*, and between *three-types* and *four-types* were estimated to be very small.

Proactive coping results for study 1 hypothesis 2.3. As shown in Table 15 and Figure 3, no pattern of decrease in Proactive Coping was observed over cumulative types of abuse or neglect. As shown in Table 16, the difference for Proactive Coping between the five levels of number of abuse types was not statistically significant. As shown in Table 17, pairwise comparisons between adjacent levels showed the largest mean increase between *one-type* and *two-types*. There was a mean decrease between *no-abuse or neglect* and *one-type*. The differences between *two-types* and *three-types*, and between *three-types* and *four-types* were estimated to be very small.

Study 1 Results for Hypothesis 3: Proactive Coping and Adult Functioning Outcomes

As shown in Table 18, Pearson correlations were used to investigate whether proactive coping average scores correlated with other adult functioning outcomes.

Study 1: Table 18

Results of Pearson Correlations between Proactive Coping and Five Adult Functioning Outcomes

| | | | | Pearson Correlation | | |
Outcome	N	M	SD	Proactive Coping	95% CI	*p*
Proactive Coping	319	49.2	8.2	-		
Separation-Individuation	314	85.2	25.1	-.311	-0.41, -0.21	**< .001**
Social Support	315	84.3	23.2	.145	0.04, 0.25	**.010**
Social Support - No Such Person	319	1.3	1.1	-.083	-0.19, 0.03	.141
Psychopathology	319	1.1	0.8	-.106	-0.21, 0.00	.060
Trauma Symptoms	312	44.4	31.8	-.169	-0.28, -0.06	**.003**

The largest statistically significant correlation (in absolute value) was between higher average Proactive Coping and lower average Separation-Individuation scores. Statistically significant correlations were found between higher average Proactive Coping and higher average Social Support scores, and between higher average Proactive Coping and lower average Trauma Symptom scores. The other correlations were smaller and not statistically significant.

**Study 1 Results for Hypothesis 4: Psychotherapy and Adult Functioning Outcomes
in Any-abused Group**

**Study 1 results for hypothesis 4.1: Comparison of any-abused
psychotherapy ever and never groups.**

As shown in Table 19, Table 20 and Figure 3, linear mixed models were
conducted on the any-abused group comparing participants who had, and who had not
ever accessed psychotherapy across five adult functioning outcomes.

Study 1: Table 19

*Mean Differences and 95% Confidence Intervals for Five Outcomes across
Psychotherapy Ever and Never Categories*

Outcome	Accessed psychotherapy (ever)	Never accessed psychotherapy	Accessed psychotherapy (ever) - No psychotherapy	
	M (SD) N	M (SD) N	Mean Diff.	95% CI
Separation-Individuation	96.2 (26.8) N=128	85.5 (24.7) N=55	10.7	2.49, 18.96
Social Support	75.6 (22.9) N=127	82.9 (20.8) N=56	-7.3	-14.13, -0.47
Psychopathology	1.6 (0.7) N=129	1.0 (0.7) N=56	0.6	0.35, 0.80
Trauma Symptoms	63.9 (32.2) N=126	41.4 (27.3) N=55	22.5	13.25, 31.72
Proactive Coping	48.9 (9.5) N=128	48.3 (8.5) N=55	0.6	-2.25, 3.50

Study 1: Table 20

Results of Linear Mixed Models across Psychotherapy Ever and Never Categories

Outcome	F	df	p
Separation-Individuation	6.61	1, 175	**.011**
Social Support	4.49	1, 115	**.036**
Psychopathology	25.64	1, 177	**<.001**
Trauma Symptoms	23.24	1, 121	**< .001**
Proactive Coping	0.18	1, 172	.670
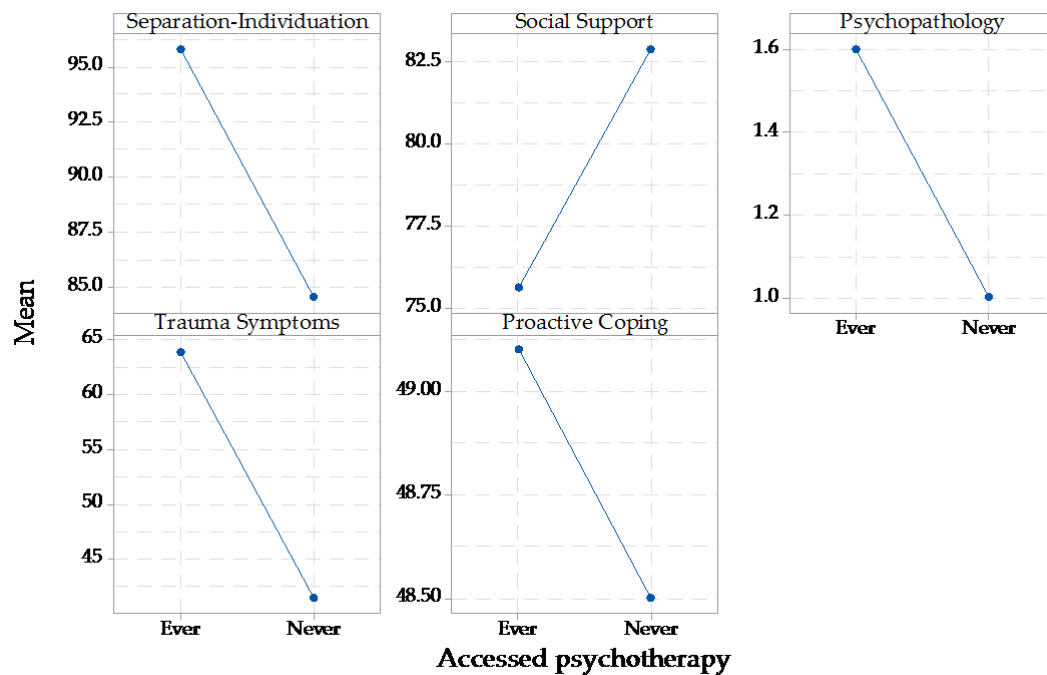
Study 1: Figure 4. Means for psychotherapy ever and never categories.

As shown in Table 19 and Figure 4, *any-abused* participants who had *ever* accessed psychotherapy had poorer adult functioning outcomes. The *ever* group had higher average Separation-Individuation (problem) scores, lower average Social Support, higher average Psychopathology, and higher average Trauma Symptom scores than the *never* group. As shown in Table 20, statistically significant results were found between *any-abused* participants accessing psychotherapy (*ever*) and four adult functioning outcomes: separation-individuation, social support, psychopathology and trauma symptoms. For Proactive Coping, there was no statistically significant difference between the *any-abused* participants in the *ever* and in the *never* accessed psychotherapy group.

Study 1 results for hypothesis 4.2: Comparison of any-abused

psychotherapy current and not-current groups on adult functioning outcomes.

As shown in Tables 21 and 22 and to Figure 5, analysis was conducted on the *any-abused* group comparing participants who were *currently* accessing psychotherapy and participants who were *not-currently* accessing psychotherapy across five adult functioning outcomes.

Study 1: Table 21

Means and 95% Confidence Intervals for Five outcomes across Psychotherapy Current and Not-Current Categories

Outcome	Currently accessing psychotherapy	Not currently accessing psychotherapy	Currently accessing psychotherapy - Not currently accessing psychotherapy	
	M (SD) N	M (SD) N	Mean Diff.	95% CI
Separation-Individuation	99.8 (27.3) N=105	84.0 (22.9) N=78)	15.8	8.26, 23.37
Social Support	73.4 (22.8) N=104	83.7 (20.8) N=79	-10.3	-16.66, -3.87
Psychopathology	1.6 (0.7) N=106	1.2 (0.7) N=79	0.4	0.15, 0.59
Trauma Symptoms	68.1 (32.9) N=105	41.8 (24.9) N=76	26.3	17.83, 34.78
Proactive Coping	48.4 (9.4) N=105	49.1(8.9) N=78	-0.6	-3.37, 2.08

Study 1: Table 22

Results of Linear Mixed Models across Current and Not-Current Psychotherapy Categories

Outcome	*F*	df	*p*
Separation-Individuation	17.05	1, 181	**< .001**
Social Support	10.04	1, 175	**.002**
Psychopathology	11.12	1, 183	**.001**
Trauma Symptoms	37.58	1, 179	**< .001**
Proactive Coping	0.22	1, 181	.640
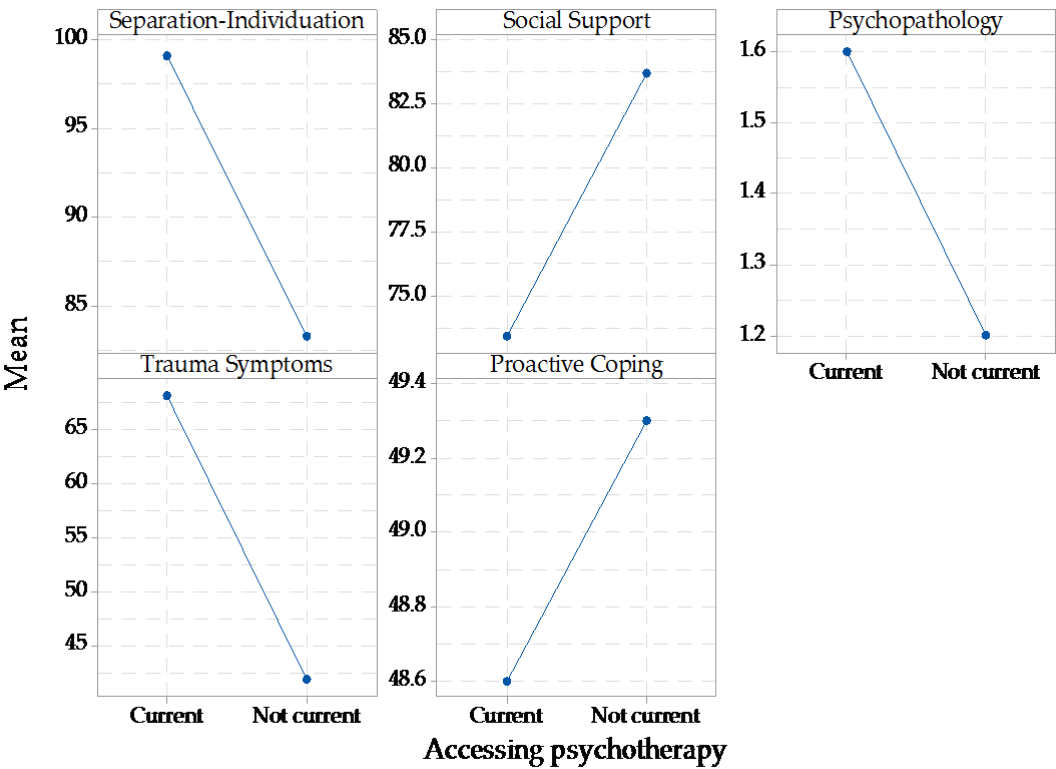
Study 1: Figure 5. Means for psychotherapy current and not-current categories.

Separation-individuation results for study 1 hypothesis 4.2. As shown in Table 21 and Figure 5, *any-abused* participants *currently* accessing psychotherapy reported more disturbances in separation-individuation, with mean scores higher than *any-abused* participants *not-currently* accessing psychotherapy. As shown in Table 22, a statistically significant difference was found for Separation-Individuation between *any-abused* participants *currently* accessing psychotherapy and *any-abused* participants *not-currently* accessing psychotherapy.

Social support results for study 1 hypothesis 4.2. As shown in Table 21 and Figure 5, *any-abused* participants *currently* accessing psychotherapy reported less social support, with mean scores lower than *any-abused* participants *not-currently* accessing psychotherapy. As shown in Table 22, a statistically significant difference was found for Social Support between *any-abused* participants *currently* accessing psychotherapy and *any-abused* participants *not-currently* accessing psychotherapy.

Psychopathology results for study 1 hypothesis 4.2. As shown in Table 21 and Figure 5, *any-abused* participants *currently* accessing psychotherapy reported more

psychopathology, with mean scores higher than *any-abused* participants *not-currently* accessing psychotherapy. As shown in Table 22, a statistically significant difference was found for Psychopathology between *any-abused* participants *currently* accessing psychotherapy and *any-abused* participants *not-currently* accessing psychotherapy.

Trauma symptom results for study 1 hypothesis 4.2. As shown in Table 21 and Figure 5, *any-abused* participants *currently* accessing psychotherapy reported more trauma symptoms, with mean scores higher than *any-abused* participants *not-currently* accessing psychotherapy. As shown in Table 22, a statistically significant difference was found for Trauma Symptoms between *any-abused* participants *currently* accessing psychotherapy and *any-abused* participants *not-currently* accessing psychotherapy.

Proactive coping results for study 1 hypothesis 4.2. As shown in Table 21 and Figure 5, *any-abused* participants *currently* accessing psychotherapy reported less Proactive Coping, with mean scores lower than *any-abused* participants *not-currently* accessing psychotherapy. This difference, however, was estimated to be small. As shown in Table 22, there was no statistically significant difference for proactive coping between *any-abused* participants *currently* accessing psychotherapy and *any-abused* participants *not-currently* psychotherapy.

Study 1 Results for Hypothesis 5: Childhood Family Relationships and Adult Relationships

Childhood family relationship and adult relationship outcomes were investigated for Hypothesis five.

Study 1 results for hypothesis 5.1: Family of origin scale correlations with whole sample childhood and adulthood outcomes.

As shown in Table 23, Pearson correlations were calculated between average Family of Origin Scale scores and four relationship outcomes.

Study 1: Table 23

Results of Pearson Correlations between Family of Origin Scale and Four Relationship Outcomes

Outcome	N	M	SD	Family of Origin Scale	95% CI	*p*
				Pearson correlation		
Family of Origin Scale	320	45.1	16.7	-		
Parental Love and Care	322	4.0	1.0	.67	0.60, 0.72	**< .000**
Number of live-in partners	320	1.0	1.0	-.26	-0.36, -0.15	**< .000**
Longest Relationship (months)	321	173.6	176.5	.05	-0.06, 0.16	.342
Social Support	318	84.3	23.2	.30	0.20, 0.40	**< .000**

As hypothesised and shown in Table 23, a statistically significant correlation was found between higher average Family of Origin Scale scores and three of the four relationship outcomes: higher average CMIS Parental Love and Care scores, lower average number of live-in partners and higher average Social Support scores. The correlation between higher average Family of Origin Scale scores and longer average Longest Relationship scores was not statistically significant.

Study 1 results for hypothesis 5.2: Comparison of outcomes between any-abused and not-abused groups.

As shown in Tables 24, 25, and 26 and Figure 6, differences between *any-abused* and *not-abused* group on relationship outcomes was investigated using means, standard deviations, and linear mixed models for each of the five relationship dependent variables: Family of Origin Scale, CMIS Parental Love and Care subscale, number of live-in partners, longest partner relationship (months) and Social Support.

Study 1: Table 24

Means and Standard Deviations of Childhood and Adulthood Relationship Outcomes

Outcome	Any-abused			Not-abused		
	N	M	SD	N	Mean	SD
Family of Origin Functioning	182	36.8	13.7	138	55.9	13.8
Parental Love and Care	185	3.5	1.0	137	4.7	0.5
Number of live-in partners	182	1.2	1.2	138	0.8	0.8
Longest Relationship (months)	184	171.4	163.9	137	176.7	192.6
Social Support	183	77.9	22.5	135	93.0	21.2

Study 1: Table 25

Results of Linear Mixed Models of Relationship Outcomes across Any-abused and Not-abused Groups

Outcome	F	df	p
Family of Origin Functioning	151.83	1, 294	**< .001**
Parental Love and Care	204.09	1, 282	**< .001**
Number of live-in partners	9.31	1, 318	**.002**
Longest Relationship (months)	0.07	1, 265	.795
Social Support	37.29	1, 298	**< .001**
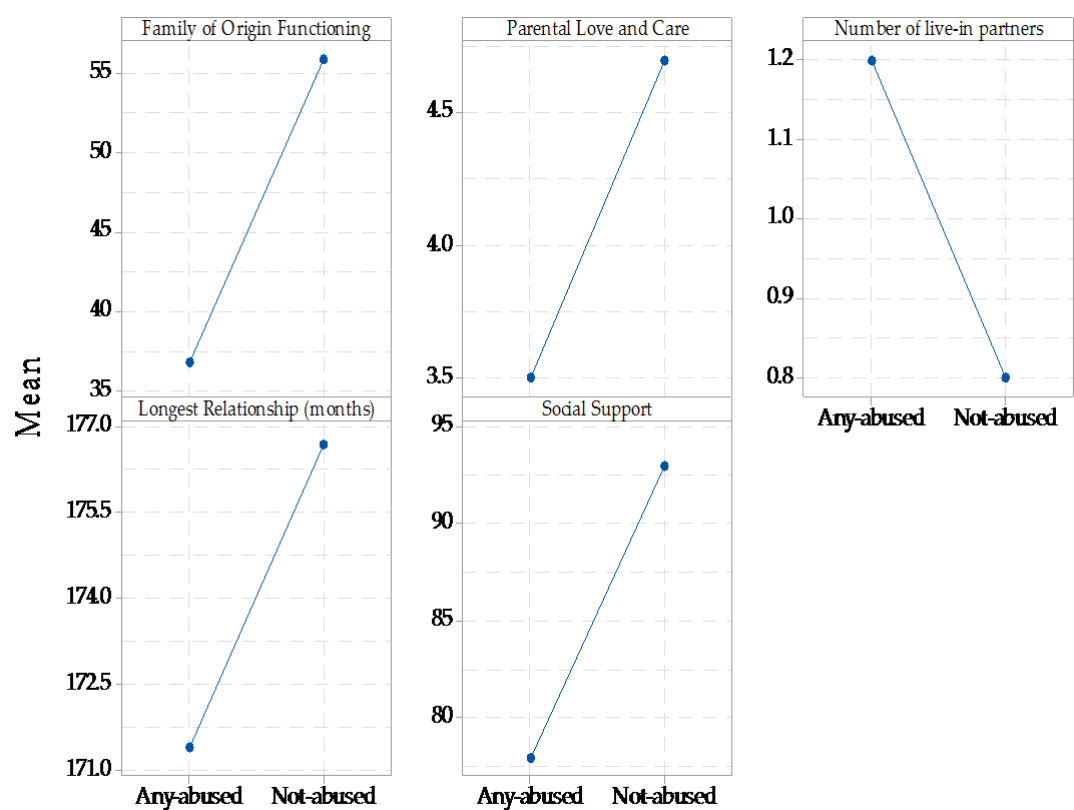
Study 1: Figure 6. Mean relationship outcomes for any-abused and not-abused groups.

Study 1: Table 26

Mean Difference and 95% Confidence Intervals for Five Relationship Outcomes
between Any-abused and Not-abused Groups

Outcome	Any-Abused	Not-abused	Any-abused - Not-abused	
	M	M	Mean Difference	95% CI
Family of Origin Scale	36.8	55.9	-19.1	-22.17, -16.07
Parental Love and Care	3.5	4.7	-1.2	-1.41, -1.07
Number of live-in partners	1.2	0.8	0.4	0.35, 0.35
Longest Relationship (months)	171.4	176.7	-5.3	-45.51, 34.89
Social Support	77.9	93.0	-15.1	-19.96, -10.23

Family of origin results for study 1 hypothesis 5.2. As shown in Tables 24 and 26 and Figure 6, Family of Origin Scale mean scores were higher (more healthy family functioning) in the *not-abused* group than in the *any-abused* group. As shown in Table 25, there was a statistically significant effect of child abuse history on family of origin.

CMIS Parental Love and Care results for study 1 hypothesis 5.2. As shown in Tables 24 and 26 and Figure 6, Parental love and care mean scores were higher (more parental love and care) in the *not-abused* group than in the *any-abused* group. As shown in Table 25, there was a statistically significant effect of child abuse history on Parental Love and Care.

Number of live-in partners results for study 1 hypothesis 5.2. As shown in Tables 24 and 26 and Figure 6, number of live-in partners was higher for the *any-abused* group than the not-abused group. As shown in Table 25, there was a statistically significant effect of child abuse history on number of live-in partners.

Longest relationship results for study 1 hypothesis 5.2. As shown in Tables 24 and 26 and Figure 6, average longest relationship (months) scores had little difference across groups. As shown in Table 25, there was no statistically significant effect of child abuse history on longest partner relationship.

Social support results for study 1 hypothesis 5.2. As shown in Tables 24 and 26 and Figure 6, average social support scores were higher (more social support) for the *not-abused* group than for the *any-abused* group. As shown in Table 25, there was a statistically significant effect of child abuse history on social support.

Study 1 Results for Hypothesis 6: Prediction of Current Trauma Symptoms

Predictors of current trauma symptoms, as measured as total scores on the Trauma Symptoms Checklist, were investigated for hypothesis six. Childhood experiences of abuse and neglect, adult psychopathology and current psychotherapy were explored as potential predictors of current trauma symptoms.

Study 1 results for hypothesis 6.1: Prediction of current trauma symptoms from childhood experiences of abuse and neglect.

The relationships between Trauma Symptoms and childhood experiences of abuse and neglect were explored using four subscales of the Childhood Maltreatment Inventory Scales: CMIS Psychological Abuse, CMIS Physical Neglect, CMIS Physical Injury and CMIS Sexual Abuse. As shown in Tables 27, 28 and 29, Linear Mixed Models were used to model Trauma Symptoms from these continuous and categorical variables. The results of the tests of each of the four childhood experiences of abuse and neglect independent variables considered in the General Linear Model of Trauma Symptoms are shown in Table 27. The effects of the categorical independent variables are shown in terms of mean differences (with 95% confidence intervals and *p*-values) are shown in Table 28. The effects of the continuous independent variables, described in terms of regression coefficients are shown in Table 29.

Study 1: Table 27

Results of General Linear Model[*] of Trauma Symptoms on Four CMIS Sub-scales

Explanatory factor	*F*	**df**	*p*
CMIS Psychological Abuse	35.31	1, 309	**< .001**
CMIS Physical Neglect	10.03	1, 309	**.002**
CMIS Physical Injury	1.48	1, 309	.225
CMIS Sexual Abuse	13.14	1, 309	**< .001**

[*] A linear mixed model was fitted, but when the variance component for pairs was small, a general linear model was fitted and reported.

Study 1: Table 28

Mean Difference and 95% Confidence Intervals for Pairwise Comparisons of CMIS Physical Injury and CMIS Sexual Abuse with Trauma Symptoms

| | **M** | | **Mean difference (abused - not-abused)** | | |
	CMIS Physical Injury yes	CMIS Physical Injury no	**Estimate**	**95% CI**	***p***
Trauma Symptoms	50.0	45.2	4.8	-2.99, 12.64	.225

| | **M** | | **Mean difference (abused - not-abused)** | | |
	CMIS Sexual Abuse yes	CMIS Sexual Abuse no	**Estimate**	**95% CI**	***p***
Trauma Symptoms	53.6	41.5	12.1	-5.54, 18.71	**< .001**

Study 1: Table 29

CMIS Psychological Abuse and CMIS Physical Neglect Regression Coefficients with Trauma Symptoms

| | **Regression coefficient** | | |
Outcome	**Estimate**	**95% CI**	***p***
CMIS Psychological Abuse	1.2	0.80, 1.60	**< .001**
CMIS Physical Neglect	1.6	0.60, 2.57	**.002**

Of the two categorical independent variables shown in Table 27, only the effect of CMIS Sexual Abuse on Trauma Symptoms was statistically significant. As shown in Table 28, the Trauma Symptom mean score was higher for CMIS Sexual Abuse *yes* scores compared with CMIS Sexual Abuse *no* scores. The difference between the effect of CMIS Physical Injury *yes* and the effect of CMIS Physical Injury *no* on Trauma Symptoms was small.

Of the two categorical independent variables shown in Table 27, the effects for both CMIS Psychological Abuse and CMIS Physical Neglect on Trauma Symptoms were statistically significant. As shown in Table 29, when the CMIS Psychological Abuse mean score increased by one point, the Trauma Symptom mean score increased by more than one point. When the CMIS Physical Neglect mean score increased by one point, the Trauma Symptom mean score increased more than one and a half points.

Study 1 results for hypothesis 6.2: Prediction of current trauma symptoms from other current adult functioning variables.

The relationships between Trauma Symptoms and other measures of current adult functioning were explored using Separation-Individuation, Social Support, Psychopathology and Proactive Coping. As shown in Table 30, a General Linear Model was used to model Trauma Symptoms from these continuous variables.

Study 1: Table 30

Results of General Linear Model[*] of Trauma Symptoms on Four Adult Functioning Independent Variables with Regression Coefficients

			Regression coefficient		
IV	**F**	**df**	**Estimate**	**95% CI**	**p**
Separation-Individuation	132.17	1, 300	0.7	0.55, 0.77	**< .001**
Social Support	3.95	1, 300	-0.1	-0.23, -0.00	**.048**
Psychopathology	68.60	1, 300	13.5	10.27, 16.67	**< .001**
Proactive Coping	1.11	1, 300	0.2	-0.14, 0.47	.294

[*] A linear mixed model was fitted, but when the variance component for pairs was small, a general linear model was fitted and reported.

The results of the tests of each of the adult functioning independent variables considered in the General Linear Model of Trauma Symptoms are shown in Table 30. The effect of Psychopathology on Trauma Symptoms was statistically significant. When the Psychopathology mean score increased by one point, the Trauma Symptom Checklist mean score increased by more than 13 points. The effect of Separation-Individuation Processing Index on Trauma Symptoms was statistically significant. When the Separation-Individuation Processing Index mean score increased by one point, the Trauma Symptom Checklist mean score increased less than one point. The effect of Social Support on Trauma Symptoms was statistically significant. When the Social Support mean score increased by one point, the Trauma Symptom Checklist mean score decreased. The difference of Proactive Coping mean scores on Trauma Symptoms was estimated to be small.

Study 1 Results for Hypothesis 7: Childhood Abuse and Neglect and Childhood

and Adulthood Socio-Economic Outcomes

The relationship between childhood abuse and neglect and childhood and current adult socio-economic outcomes was investigated for hypothesis seven. As shown in Table 31, proportions for nine socio-economic outcomes were calculated for *any-abused* and *not-abused* groups.

Study 1: Table 31

Proportions Between Any-abused and Not-Abused Groups on Nine Socioeconomic Outcomes

Outcome	Proportion				Proportion (any-abused – not-abused)		
	Any-abused	N	Not-abused	N	Est.	95% CI	*Fisher's Exact Test p (2-sided)*
Childhood financial Deprivation	0.30	185	0.07	138	0.24	0.16, 0.31	**< .001**
Completed School Yr11	0.84	185	0.91	138	-0.08	-0.15, -0.00	.065
Any qualification	0.76	185	0.72	138	0.04	-0.06, 0.14	.444
Currently in waged employment	0.52	185	0.57	138	-0.05	-0.16, 0.06	.367
Primary carer completed School Yr11	0.49	185	0.65	137	-0.16	-0.26, -0.05	**.006**
Primary carer completed any qualification	0.55	185	0.58	137	-0.03	-0.14, 0.08	.733
Secondary carer completed School Yr11	0.48	166	0.59	129	-0.11	-0.22, 0.01	.078
Secondary carer completed any qualification	0.65	166	0.68	129	-0.38	-0.15, 0.07	.536
Currently receiving welfare payments	0.05	185	0.01	138	0.04	-0.01, 0.08	.077

There was a statistically significant difference between the *any-abused* and *not-abused* groups for childhood Financial Deprivation. The *any-abused* group had more childhood Financial Deprivation than the *not-abused* group. There was a statistically significant difference between the *any-abused* and *not-abused* groups for "Primary carer completed School Yr11." Consistent with the direction of the hypothesis; the *any-abused* group had fewer Primary carers completing School Yr11 than the *not-abused* group. Eight of the nine socioeconomic outcomes were poorer for *any-abused* group. Inconsistent with the direction of the hypothesis, Any Qualification was higher for the *any-abused* group than the *not-abused* group; however, this difference was very small.

Study 1 Discussion

Findings from Study 1: Experiences of Individuals support the evidence from previous research linking childhood experiences of abuse and neglect with a range of poorer relationship and functioning outcomes in adulthood. Supporting Study 1: Hypothesis 1.1, compared to *not-abused* participants, *any-abused* participants had statistically significantly poorer adult functioning on all outcomes measured other than proactive coping.

Supporting Study 1: Hypothesis 1.1; participants with a history of child abuse or neglect had more separation-individuation disturbances than *not-abused* participants. This finding is consistent with previous research. Development of separation and individuation disturbances has been associated with problems in independent sense of self and relatedness to others (Kins et al., 2012). Borderline Personality disorder has previously been associated with higher separation-individuation disturbances (Dolan et al., 1992; Mahler, 1971). Individuals with BPD commonly report a history of childhood maltreatment (Herman et al., 1989; Zanarini et al., 2002) and poor quality of parental care (Sansone, Farukhi, & Wiederman, 2013).

Supporting Study 1: Hypothesis 1.1; participants with a history of child abuse or neglect had less current social support than *not-abused* participants. This finding is consistent with prospective research by Sperry and Widom (2013), in which individuals with a documented history of childhood maltreatment reported less social support as adults. Social support has previously been found to support resilience and to moderate

and mediate the effects of childhood maltreatment in adulthood (Sperry & Widom, 2013).

Supporting Study 1: Hypothesis 1.1; participants with a history of child abuse or neglect had more psychopathology than *not-abused* participants. This finding is consistent with previous research in which childhood maltreatment has been identified as a significant risk for subsequent development of psychopathology in childhood, adolescence and adulthood (Cicchetti & Valentino, 2006; Putnam et al., 2013).

Supporting Study 1: Hypothesis 1.1; participants with a history of child abuse or neglect had more current trauma symptoms than *not-abused* participants. As a retrospective study, causal links between childhood maltreatment and adult trauma symptoms cannot be made, however the current finding is consistent with findings within the prospective research literature (Pratchett & Yehuda, 2011). Pratchett and Yehuda (2011) suggested childhood maltreatment-related disruptions to parent-child attachment relationships may exacerbate trauma symptoms.

In this study, the proactive coping results were predominantly not statistically significant across analyses, and thereby did not provide support for Study 1: Hypothesis 1.1. Previous research has suggested proactive copers experience more positive outcomes (or avoid negative outcomes) because they anticipate future stressful events and act to avoid or minimize them (Aspinwall & Taylor, 1997). The reason for the lack of trend to the proactive coping results across abused and neglected groups in the current study is unclear.

With maltreatment research literature expanding to include a wider range of adverse childhood experiences, poorer child outcomes have been associated with carer drug problems and family violence (Dube, Anda, Felitti, Croft, et al., 2001; Dube et al., 2002). In addition to poorer outcomes for *any-abused* groups, Study 1 also found other childhood adverse experiences to be associated with poorer outcomes. Supporting Study 1: Hypothesis 1.2, *Carer-any-drug-problem* and *witnessed-any-family-violence* were each statistically significantly associated with poorer group adult functioning outcomes on four of the five outcomes measured. Furthermore, the findings in this study showed *carer-any-drug-problem* to impact some outcome scores to a similar degree to that of *any-abused* participants. The findings in Study 1: Hypotheses 1.1 and 1.2 of poorer adult functioning outcomes across abuse categories of *any-abuse* and of other adverse childhood experiences, support the continued use of a more inclusive definition of childhood maltreatment experiences.

Supporting Study 1: Hypothesis 2.1, poorer adult functioning outcomes were found across all four types of abuse and neglect measured: *sexual abuse*, *physical abuse, physical neglect* and *emotional neglect*. Within these findings of poorer outcomes, minimal variation in outcome scores was found between the four types of abuse and neglect.

As hypothesised for the *neither*, *abused*, *neglected* or *both* group comparisons in Study 1: Hypothesis 2.2, there was a general trend of most positive adult functioning outcomes in the *neither* group and least positive in the *both* group. There was no consistent trend across these groups for proactive coping; however proactive coping was lower in the *neglected* category, compared to *both* and to *neither*. Although no directional hypothesis was made in regards to comparisons of outcomes between the *abused* and *neglected* groups, the current findings estimated outcome differences across these categories to be small. For trauma symptoms, other than between *abused* and *neglected*, all comparisons were statistically significant, suggesting differential effects between categories. The majority of research into childhood maltreatment has either looked exclusively at single types of abuse or neglect, or investigated outcomes across a number of different types of maltreatment. The combining of two types of abuse and two types of neglect within the current analysis offered a unique way of considering possible differential effects related to abuse and to neglect.

Supporting Study 1: Hypothesis 2.3, an effect of cumulative harm was demonstrated in participants who reported more than one category of childhood abuse or neglect. This finding is consistent with previous research reporting cumulative exposure to an increasing number of types of childhood maltreatment to be associated with poorer outcomes (Felitti et al., 1998b; Hodges et al., 2013). In Study 1, the linear relationship (for separation-individuation disturbances, social support and trauma symptoms) between *no-abuse to one-type,* and between *two-types to three-types* of abuse and neglect, but not between *three-types* and *four-types* of abuse and neglect, suggests a plateau-effect within the trend of cumulative harm.

Supporting Study 1: Hypothesis 3, proactive coping was associated with more positive adult functioning and relationship outcomes. Higher proactive coping was significantly correlated with lower average separation-individuation, more perceived social support and less trauma symptoms. Despite proactive coping not significantly differentiating *any-abused* and *not-abused* groups in earlier analyses, these results suggest proactive coping is associated with other adult functioning outcomes.

There were mixed results for the hypothesis that psychotherapy would be associated with current adult functioning outcomes in *any-abused* participants. Contrary to Study 1: Hypothesis 4.1, the *ever* versus *never* comparisons showed that those who had never accessed psychotherapy had more positive adult functioning outcomes. Two possible explanations could apply to this finding: 1) *any-abused* participants who *ever* accessed psychotherapy had even poorer functioning prior to psychotherapy, or 2) psychotherapy did not improve functioning. Supporting Study 1: Hypothesis 4.2, *any-abused* participants who reported *currently* accessing psychotherapy had poorer functioning outcomes than *any-abused* participants who reported *not-currently* accessing psychotherapy. This hypothesis was based on a position that that there may be an ongoing role for psychotherapy for *any-abused* participants with poorer functioning.

Supporting Study 1: Hypothesis 5.1, more healthy childhood family functioning was associated with higher levels of perceived childhood parental love and care. Participants who had more healthy family functioning during childhood reported more parental love and care. As hypothesised, more healthy family functioning during childhood was also associated with two of the adult relationship measures. Participants who had higher average healthy family functioning during childhood had, on average, fewer live-in partners and more current social support.

Supporting Study 1: Hypothesis 5.2, these relationship outcomes were more positive in the *not-abused* group compared to the *any-abused* group. These findings suggest childhood maltreatment is associated with disturbances in relationships in both childhood and in adulthood. Previous research has suggested a history of childhood maltreatment and negative perceptions of childhood parental care to be a risk for both childhood and adulthood relationship difficulties (Cyr et al., 2010; Sansone et al., 2013; Wright et al., 2009). Disturbances in intimate partner relationships, including having more than 50 sexual partners, has previously been identified as a risk associated with multiple co-occurring types of childhood maltreatment (Felitti et al., 1998b). In the current study, whilst the *any-abused* group had statistically significantly more live-in partners than the *not-abused* group, results for longest partner relationship were not statistically significant. The mean age of participants in Study 1 was 40 years, with no statistically significant differences between the any-abused and not-abused groups. However, considering participants in the current study ranged of 18-90 years, research involving only older participants may show stronger effects.

The current study investigated potential predictors of trauma symptoms from childhood maltreatment experiences. Giving partial support for Study 1: Hypothesis 6.1, psychological abuse, physical neglect and sexual abuse, but not physical abuse, had a statistically significant effect on trauma symptoms. Experiences of these types of childhood maltreatment increased the number of trauma symptoms. While these findings are not causal, they support previous evidence linking childhood maltreatment experiences with current adult symptoms of trauma (Evans et al., 2013; Higgins & McCabe, 2000b; Milner et al., 2010).

The current study also investigated potential predictors of trauma symptoms from other measures of current adult functioning. Giving partial support for Study 1: Hypothesis 6.1, separation-individuation disturbances, perceived social support and psychopathology, but not proactive coping, had a statistically significant effect on trauma symptoms. Higher separation-individuation disturbances and higher psychopathology scores were associated with an increase in trauma symptoms. Higher perceived social support was associated with a decrease in trauma symptoms. These findings highlight different domains of adult functioning as having an effect on other areas of adult functioning, potentially reducing the individual's capacity for resilience.

This study investigated the relationship between a number of socio-economic outcomes and childhood abuse and neglect. It was a challenge to identify appropriate socio-economic indicators for retrospective reporting across a wide participant age range. The researcher sought informal expert advice about the best way to consider childhood financial deprivation in the current study. The researcher consulted with Dr Janet Taylor, Senior Researcher, Research and Policy Centre, Brotherhood of St Laurence, Fitzroy Victoria and sub-author in the SPRC report (Saunders et al., 2007) in which research for the original financial deprivation scale was reported. In discussion with Dr Janet Taylor (personal communication, 7th May 2013), use of a total score of the 17 items was recommended, with *yes* scores on two or more items as an indicator of financial deprivation. This categorical scoring was employed in the current study.

Sampled broadly across the community, Study 1 differed from childhood maltreatment research using participants from identified low socio-economic groups. Overall, there were very low levels of childhood financial deprivation reported in the current sample. Despite this, the results provided partial support for Study 1: Hypothesis 7. The *any-abused* group had on average higher financial deprivation and fewer primary

carers who had completed Year 11 at secondary school. These findings suggest socio-economic risks to be associated with childhood maltreatment.

Study 1 Limitations

A number of limitations exist regarding the design, cohort and generalizability of the current results. The Relationships and Functioning Questionnaire used in Study 1: *Experiences of Individuals* employed retrospective self-report measures in looking at historical childhood family experiences of an adult sample. These reports are acknowledged by the researcher to be subjective, and no attempts were made in the current research to seek verification from secondary sources. Substantial criticism has been made about the validity of findings from retrospective self-report measures due to potential interference by "selected recall, inaccurate recall, and recall biased by the outcome" (Leifer et al., 2004, p. 671). Leifer et al. (2004) reported that adults' memories of child abuse may be biased by social desirability, unconscious denial or repression of traumatic events, and attitudes toward abuse disclosure. Furthermore, it has been argued that individuals' present relationship with their parent may influence their recall of childhood experiences (Kretchmar & Jacobvitz, 2002).

Indeed, there are three core factors in the current study that may have led some participants to overestimate their maltreatment experiences and other participants to underestimate their maltreatment experiences. First, the length of time since the reported childhood experiences may have reduced the accuracy of participants' recall. As all participants in Study 1 were adults, all of the childhood data collected was retrospective. Further to this, the Study 1 sample varied in age, with a range of 72 years. For older participants, the distance in time between their childhood experiences and participation in the current research was considerably longer than for the younger participants. It is possible that the longer gaps between a childhood experience and the report of that childhood experience may have resulted in more inaccuracies, and that these inaccuracies may be more likely in the reports of older participants than of younger participants.

Second, the participants' mood state when completing the questionnaire may have biased their responses. For example, participants who were depressed at the time of data collection may have shown selective bias for negative recollections of their

childhood. Such negative bias, if reflecting a temporary mental state, could negatively skew participant-responses to questionnaire items in a way that is not robust to re-test.

Third, participants' reports of their childhood experiences, including experiences of abuse and neglect, were potentially biased by the participants' processing of these experiences and their stage of psychological development. Prior to participating in this research, some participants may have undertaken active psychological reflection and exploration of their experiences. Others may have previously had minimal reflection on their childhood relationships and experiences. Participants' prior level of reflection on their experiences may have led to over- or under-reporting of childhood experiences of abuse and neglect. Despite the potential limitations on the reliability of retrospective reports, retrospective methods remain important in researching the long-term effects of childhood maltreatment (Kendall-Tackett & Becker-Blease, 2004). This is because retrospective reports allow for the collection of data where reports were not kept or were not made at the time of the childhood experience. Therefore, to collect this data, retrospective reports were relied upon despite the limitations of this method.

Another limitation of the current study is that of gender imbalance. Given most primary carers are female, the recruitment of primary carers in this research resulted in a higher number of females in the sample. While the gender imbalance is not representative of the general population, in the population of abused people there are mostly females (Barth, Bermetz, Heim, Trelle, & Tonia, 2013; Briere & Elliot, 2003; Spataro, Mullen, Burgess, Wells, & Moss, 2004; Stoltenborgh, van Ijzendoorn, Euser, & Bakermans-Kranenburg, 2011). Given the gender imbalance, these results might reflect a female experience more than a male experience. However, as more females than males experience abuse, this data might be valid for a large proportion of the abused population. This study did not examine gender differences, but future research may consider examination of gender differences in relationship and functioning outcomes.

A further limitation of Study 1 is that the educational and socio-economic measures reported in this research were considered *dependent* variables of interest, rather than *explanatory* variables for other outcomes. Given the correlational nature of the data, it is possible that this data is better suited to explanatory variables than dependent variables. It would be possible to extend the modelling of some outcomes with more complex statistical models, that could, for example, include additional

characteristics of childhood experience as explanatory variables. Any appropriate modelling would consider a range of childhood characteristics, not just those that were statistically significant. Future childhood maltreatment research may be able to extend the current research by investigating socio-economic measures as explanatory variables.

Interpretation of the socio-economic results is also potentially limited as a result of the wide age range of the Study 1 sample. The results of Study 1 show Childhood Financial Deprivation and Primary Carer School Completion to be statistically significantly related to abuse status, and the other educational and socio-economic measures to be non-significant. It is possible these results were limited by the wide age range of the sample and by the cultural effect that the primary carers of younger participants may, on average, be more likely to have completed more years of schooling than those of older participants. Given the continued over-representation of families of lower socio-economic status involved with statutory child protection services (Featherstone et al., 2014), this data holds important implications for policy and support of potentially vulnerable groups. Future research may be able to extend the current research to further investigate particular aspects of socio-economic status found to be related to abuse status.

Study 1 Conclusions

Study 1 investigated outcomes for individuals and found that impacts of child abuse and neglect at the individual level include risks for poorer adult relationship and functioning outcomes. This research found that, when compared to *not-abused* participants, *any-abused* participants had statistically significantly poorer adult functioning. *Any-abused* participants had more separation-individuation disturbances, less current social support, more psychopathology and more current trauma symptoms. Further, Study 1 examined other adverse childhood experiences and found poorer adult functioning outcomes for participants reporting a history of caregiver drug problems and for participants reporting having witnessed family violence.

Outcomes were examined in several ways: across types of maltreatment; across categories of maltreatment; and across cumulative maltreatment types. While poorer outcomes were found across all four types of maltreatment measured, minimal variation in outcome scores was found between *sexual abuse*, *physical abuse, physical neglect*

and *emotional neglect*. Differential effects were found for trauma symptoms between the categories of *neither*, *abused*, *neglected* or *both*. Cumulative exposure to an increasing number of types of childhood maltreatment was found to be associated with poorer outcomes, with a linear relationship between *no-abuse to one-type,* and between *two-types to three-types* of maltreatment. Proactive coping was associated with more positive outcomes, with higher proactive coping found to be significantly correlated with lower average separation-individuation, more perceived social support and less trauma symptoms. Study 1 examined outcomes related to participants' access of psychotherapy. Participants reporting a history of childhood maltreatment who had never accessed psychotherapy had more positive adult functioning outcomes. Further, it was found that current access of psychotherapy was associated with poorer functioning outcomes. In examining relationship outcomes, Study 1 found more-healthy childhood family functioning to be associated with higher levels of perceived childhood parental love and care, fewer live-in partners and more current social support. Participants reporting a history of childhood maltreatment had statistically significantly more live-in partners than those not reporting childhood maltreatment. In examining potential predictors of current trauma symptoms, Study 1 found psychological abuse, physical neglect and sexual abuse to predict trauma symptoms. Higher separation-individuation disturbances and higher psychopathology scores were associated with an increase in trauma symptoms. Higher perceived social support was associated with a decrease in trauma symptoms.

Additional to these individual level factors, is the emerging idea discussed in Chapter 3, that there are intergenerational effects that contribute to relationship and functioning outcomes. In the next chapter, Study 2 sought to investigate intergenerational dyads to address whether, and in what ways, abuse and neglect history in a parent effects the functioning of the next generation.

Chapter 6: Study 2. Intergenerational Continuity - Experiences of

Intergenerational Pairs

In the previous chapter, Study 1: Experiences of Individuals, impacts were identified of abuse and neglect at the individual level. The findings from Study 1 add to the body of evidence within the research literature that having a history of child abuse is a risk for poorer adult relationship and functioning outcomes for the individual (Felitti et al., 1998b; Shonkoff et al., 2012). The impacts on the adult relationships and functioning in offspring of parents with an abuse or neglect history, however, are less clearly understood. Research literature involving the children of abused parents has tended to centre on early parent-child relationships and parenting style (e.g.Conger et al., 2013; K. Kim et al., 2010) or the presence of abuse in the next generation (e.g. Ertem et al., 2000; Hall, 2011; Valentino, Nuttall, Comas, Borkowski, & Akai, 2012).

Yet to be addressed are the intergenerational effects – whether, and in what ways, abuse and neglect history in a parent effects the functioning of the next generation. Understanding ways of relating and functioning that are repeated in subsequent generations of a family may assist in identifying factors that contribute to the discontinuity of dysfunctional relationships and abuse. Research is needed to understand the intergenerational transmission of child abuse trauma and specifically its effects on adult functioning of later generations. Knowledge about the long-term impact of child abuse trauma on transgenerational family functioning is essential to our understanding of human development in the areas of mental illness prevention, intervention, and promotion of well-being (Hurley et al., 2003; Serbin & Karp, 2004). Further research into intergenerational continuity in relationships and functioning in families with and without a history of childhood abuse and neglect is warranted to contribute towards filling a gap in the existing empirical literature. In Study 2: Intergenerational Continuity, patterns of relating and functioning across two generations are explored to investigate intergenerational impacts of abuse and neglect.

Study 2 Aims and Hypotheses

It was the overall aim of Study 2 to investigate intergenerational continuity and discontinuity in relationships and functioning across two generations of a family, with and without histories of abuse and neglect.

Study 2 Aim 1: Intergenerational Continuity of Relationships and Functioning.

The first aim of Study 2 was to investigate whether there are ways of relating and functioning that are repeated in subsequent generations of a family.

Study 2 Hypothesis 1.1: Adult outcomes. It was hypothesised that adult functioning outcomes for the *Child* participants would be similar to the same adult functioning outcomes for their *Parent*, indicating intergenerational continuity. The *Child* group would have similar levels of separation-individuation disturbances, perceived social support, psychopathology, current trauma symptoms and proactive coping to the *Parent* group.

Study 2 Hypothesis 1.2: Childhood outcomes. It was hypothesised that childhood relationship and functioning outcomes for the *Child* participants would be similar to the same childhood relationship and functioning outcomes for their *Parent*, indicating intergenerational continuity. It was hypothesised that the *Child* group would have similar family of origin functioning and perceived parental love and care to the *Parent* group.

Study 2 Aim 2.

The second aim of Study 2 was to investigate intergenerational continuity of abuse and neglect experiences in three ways. The first part of Aim 2 was to investigate whether the *Child* group participants with a history of abuse are more likely to have a *Parent* with a history of abuse than the *not-abused Child* group participants. The second part of Aim 2 was to investigate whether the *Child* group participants who report their own experience of child abuse or neglect have the same types of child abuse or neglect as their parent experienced. The third part of Aim 2 was to investigate whether the *Child* group participants with a history of additional adverse childhood experiences (witnessing family violence or carer drug problem) are more likely to have a *Parent*

with a history of these additional adverse childhood experiences than the *Child* group participants without these adverse childhood experiences.

Study 2 Hypothesis 2.1: Intergenerational continuity of any-abuse. It was hypothesized that child participants with a history of childhood maltreatment would, as a group, have a higher proportion of parent participants with a history of childhood maltreatment than the group of child participants without a history of childhood maltreatment.

Study 2 Hypothesis 2.2: Intergenerational continuity of type of abuse or neglect. It was hypothesized that abuse and neglect types would not be the same across generations.

Study 2 Hypothesis 2.3: Intergenerational continuity of type of witnessing family violence and carer drug problem. It was hypothesized that child participants with a history of witnessing family violence would, as a group, have a higher proportion of parent participants with a history of witnessing family violence than the group of child participants with no history of family violence. It was further hypothesized that child participants with a history of having a caregiver with a drug problem would, as a group, have a higher proportion of parent participants with a history of having a caregiver with a drug problem than the group of child participants with no history of caregiver drug problem.

Study 2 Aim 3.

The third aim of Study 2 was to investigate intergenerational impacts of abuse and neglect on adult relationships and functioning.

Study 2 Hypothesis 3. It was hypothesized that for *Child* participants, both generations having a history of abuse or neglect would be related to less positive adult functioning than neither generation having a history of abuse. For participant-dyads where abuse was only present in one generation, it was hypothesized that adult functioning in the *Child* group would be poorer for participants who had their own history of abuse. This hypothesis was directional with more positive adult functioning outcomes in Group 4 > Group 3 > Group 2 > Group 1. To measure this hypothesis, positive adult functioning outcomes would, on average, be shown by the presence of less separation-individuation disturbances, more perceived social support, less psychopathology, less current trauma symptoms and higher proactive coping.

Study 2 Aim 4.

The fourth aim of Study 2 was to investigate the relationship between parental history of abuse and neglect and adult functioning outcomes in the child.

Study 2 Hypothesis 4.1. Regardless of one's own child abuse history, it was hypothesized that having a parental history of child abuse would be related to less positive adult functioning, as measured by, on average, more separation-individuation disturbances, less perceived social support, more psychopathology, more current trauma symptoms and lower proactive coping.

Study 2 Hypothesis 4.2. It was hypothesized that having a parental history of child abuse would be related to poorer socio-economic outcomes, as measured by, on average, more childhood financial deprivation, more who left school before completing Year 11, more with no post-school qualification, and more welfare recipients.

Study 2 Hypothesis 4.3. It was hypothesized that having a parental history of child abuse would, at the group level, be related to less positive childhood family experiences. Less positive childhood family experiences would be measured by less healthy childhood family functioning, less perceived parental love and care scores, more psychological abuse, more physical neglect scores, more participants who had witnessed family violence, and more participants with parental substance abuse problems.

Study 2 Aim 5.

Using participant-dyads in which the parents all had a history of childhood maltreatment, the fifth aim of Study 2 was to investigate whether children and their parent had more similar functioning to each other when the child also had a history of childhood maltreatment.

Study 2 Hypothesis 5. It was hypothesized that the difference between children and their parent on adult functioning outcome scores (separation-individuation, social support, psychopathology, trauma symptoms, and proactive coping) would be greater in Group 3 (*Parent-abused-only*) than in Group 1 (*Both-generations-any-abused*).

Study 2 Aim 6. Some families show resilience following child abuse and neglect. The sixth aim of Study 2 was to investigate instances of resilience when the *Parent* has a history of childhood maltreatment or of trauma symptoms by exploring potential moderators and mediators of *Child any-abuse* and *Child* functioning outcomes.

Study 2 Hypothesis 6.1. Exploring intergenerational continuity of abuse, it was hypothesised that the relationship between parent history of childhood maltreatment and Child history of childhood maltreatment would be moderated by *Parent* dissociation and *Child's* family functioning.

Study 2 Hypothesis 6.2. It was hypothesised that *Parent* dissociation and disturbances in *Parent's* separation-individuation would mediate the relationship between *Parent any-abuse* and *Child's* trauma symptoms.

Study 2 Hypothesis 6.3. It was hypothesised that *Parent's* perceived social support, *Child's* perceived social support and *Child's* family functioning would moderate the relationship between *Parent any-abuse* and *Child's* trauma symptoms.

Study 2 Hypothesis 6.4. It was hypothesised that *Parent* perceived social support would moderate the relationship between *Parent's* trauma symptoms and *Child's* family functioning.

Study 2 Method

Parent-Child Dyad Participants

Study 2: Intergenerational Continuity used data from complete participant-dyads only. From the 323 Study 1: Experiences of Individuals participants, a subgroup of 70 participant-dyads of child-generation adults (*Child* participants) and the person they described as being their parent/caregiver when they were growing up (*Parent* participants) were identified. These 70 pairs formed the sample for Study 2. All participants were over 18 years of age. The mean age of *Child* participants was 32.5 years (SD= 9.2). The mean age of *Parent* participants was 61.4 years (SD=9.3). *Child* participants were requested to pair with their primary caregiver if possible. Primary caregiver was defined as the parent or parent figure *most involved in caring for your basic needs when you were growing up*. In addition to primary caregiver pairs, the

sample included five pairs with a secondary caregiver and five pairs where the *Child* participant had identified their primary and secondary caregivers as *joint-caregivers* or *equally-involved*. There were no statistically significant differences between primary parent-child dyads and joint or secondary parent-child dyads on abuse history, Fisher's Exact Test, $p = .571$.

The 70 participant-dyads comprised 117 female and 23 male participants. The proportion of *Parent* participants who were female was .90 (63 out of 70) and the proportion of *Child* participants who were female was .77 (54 out of 70). There was a statistically significant sex difference between *Child* and *Parent* groups, McNemar Test, $p = .022$.

Measures

The measures, as they were described in Chapter 5 Study 1, were used in as well Study 2: Intergenerational Continuity.

Procedure

Recruitment of participant-dyads.

Both upward and downward recruitment was utilized, with either a *Child* participant or *Parent* participant recruiting another member of their family to complete their participant-dyad. Both members of the participant-dyad separately completed an identical online or pen-on-paper questionnaire package (on their own, each in their own time). Participants were able to either both participate online, both on pen-on-paper, or one online and the other pen-on-paper. Participants were given a code to allow pairing of the response sets for analysis.

Matching of participant-dyads.

Participant-dyads were formed using identifier information to match *Child* and *Parent* participants. This information was collected from the *Matching of pairs* section at the end of the Relationships and Functioning Questionnaire, as shown in Appendix C-1. Respondents were asked to record their own Respondent ID. For pen-on-paper participants, this was entered by the researcher on the questionnaire prior to distribution. For online participants, a seven-digit number was generated by the survey host program PsychData. Within the questionnaire, participants were asked to respond to the question:

Are you the first or the second person from your family to take this questionnaire? Participants who selected the option: *I am the first. I will be recruiting the second person* were given the instruction *Please provide your Respondent ID (recorded above) to the other person who will be completing this survey. This is so that we can match the information provided.*

Using data from four items in Part 2 of the Relationships and Functioning Questionnaire, the *matching of pairs* information was cross-checked by the researcher. The first matching cross-check item was, "As you know, this study will look at responses from two generations in a family, specifically a primary caregiver and their grown-up child. The other person from your family answering this questionnaire is your: 1) Child (now an adult), 2) Mother, 3) Father, 4) Foster Parent, 5) Grandparent (who was your primary carer), or 6) Other (please specify) _____." The second matching cross-check item was, "Which parent or parent figure was your primary caregiver (the most involved in caring for your basic needs) when you were growing up? 1) Biological mother, 2) Biological Father, 3) Other (please specify) _____." Participants were requested to identify their secondary carer in the same way. To check whether Parent generation participants identified having children, the third matching cross-check used data from the item, "Do you have any children?" For the fourth matching cross-check, participant age data was used to confirm Generation 1 and Generation 2.

Analytic Strategy

For Study 2 Hypothesis 1.1, paired *t*-tests with estimates of mean differences and confidence intervals were used to describe *Child* group and *Parent* group adult functioning. For Study 2 Hypothesis 1.2, paired *t*-tests with estimates of mean differences and confidence intervals were used to describe *Child* group and *Parent* group childhood relationship and functioning.

Study 2 Hypotheses 2.1, 2.2 and 2.3 used estimates of the difference in proportion of abused *Parents* comparing *Child* with abuse and *Child* without abuse; Fisher's exact test was also used.

For Study 2 Hypothesis 3, one-way analysis of variance was used to compare four groups, defined according to intergenerational abuse history, for five different child

outcomes; mean differences were estimated for pairs of adjacent groups: *Both-generations-any-abused* was compared with *Child-any-abused-only*, *Child-any-abused-only* was compared with *Parent-any-abused-only*, and *Parent-any-abused-only* was compared with *Neither-generation-abused*.

For Study 2 Hypothesis 4.1 independent *t*-tests were used to compare two groups, defined according to parent abuse history, for five different child outcomes. For Study 2 Hypothesis 4.2 estimates of the difference in proportion of four different binary deprivation outcomes comparing Child group with abused parents and Child group without abused parents; Fisher's exact test was also used. For study 2 Hypothesis 4.3 independent *t*-tests were used to compare two groups, defined according to parent abuse history, for four different Child relationship and functioning outcomes.

For Study 2 Hypothesis 5, independent *t*-tests were used to compare the *Child-Parent* difference scores for Group 3 (*Parent-abused-only*) to *Child-Parent* difference scores for Group 1 (*Both-generations-any-abused*) on five adult functioning outcomes. For Study 2 Hypothesis 6, PROCESS Procedure for SPSS Release 2.13.1 (Hayes, 2014) was used to produce logistic regression models and linear models to estimate the direct and indirect effects of mediator and moderator variables across a range of outcomes.

Study 2 Results

Study 2 Results for Hypothesis 1: Intergenerational Continuity of Relationships and Functioning

Study 2 results for hypothesis 1.1: Adult outcomes.

Adult relationship and functioning outcomes were investigated for intergenerational hypothesis 1.1. As shown in Tables 1 and 2, these included separation-individuation disturbances, social support, psychopathology, current trauma symptoms and proactive coping.

Study 2: Table 1

Means and 95% Confidence Intervals Showing Paired Differences between Child Group and Parent Group on Five Adult Functioning Outcomes

Outcome	N	Child Group	Parent Group	Child Group - Parent Group Paired Differences	
		M (SD)	M (SD)	Mean Difference	95% CI
Separation-Individuation	64	77.0 (16.8)	71.5 (18.1)	5.5	-0.13, 11.13
Social Support	66	89.6 (19.7)	90.5 (25.3)	-0.9	-9.17, 7.29
Psychopathology	68	1.3 (1.0)	1.6 (1.2)	-0.3	-0.61, -0.04
Trauma Symptoms	63	32.6 (22.9)	30.1 (18.4)	2.5	-4.03, 9.02
Proactive Coping	67	49.9 (6.7)	49.4 (8.1)	0.6	-1.63, 2.73

Study 2: Table 2

Results of Paired Sample t-tests Comparing Child and Parent Groups on Five Adult Functioning Outcomes

Outcome	t	df	p
Separation-Individuation	1.95	63	.055
Social Support	-0.23	65	.820
Psychopathology	-2.24	67	**.028**
Trauma Symptoms	0.76	62	.448
Proactive Coping	0.51	66	.614

As shown in Table 1, the *Child* group had less psychopathology than the *Parent* group. Also shown in Table 1, the *Child* group had more separation-individuation disturbances, on average, than the *Parent* group. The *Child* group had less social support, on average, than the *Parent* group. The *Child* group had more current trauma symptoms, on average, than the *Parent* group. The *Child* group had higher average proactive coping scores than the *Parent* group.

As shown in Table 2, there was a statistically significant mean difference between the *Child* group and *Parent* group on Psychopathology. There were no statistically significant differences between *Child* and *Parent* groups on the other four adult functioning outcomes.

Study 2 results for hypothesis 1.2: Childhood outcomes.

Childhood relationship and functioning outcomes investigated for Study 2 hypothesis 1.2 included Family of Origin Scale functioning and CMIS Parental Love and Care subscale.

Study 2: Table 3

Means and 95% Confidence Intervals Showing Paired Differences between Child Group and Parent Group on Two Childhood Relationship and Functioning Outcomes

Outcomes	N	Child Group	Parent Group	Child Group - Parent Group Paired Differences	
		M (SD)	M (SD)	Mean Difference	95% CI
Family of Origin functioning	69	53.7 (13.7)	49.7 (19.0)	4.0	-1.73, 9.73
Parental Love and Care	70	4.4 (0.9)	4.3 (0.9)	0.2	-0.09, 0.47

Study 2: Table 4

Results of Paired Sample t-tests Comparing Child and Parent Groups on Two Childhood Relationship and Functioning Outcomes

Outcome	*t*	df	*p*
Family of Origin functioning	1.39	68	.168
Parental Love and Care	1.34	69	.185

As shown in Table 3, *Child* group had more positive average family of origin functioning and higher average Parental Love and Care scores than the *Parent* group, however these differences were estimated to be small. As shown in Table 4, there were no statistically significant differences between *Child* group and *Parent* group on the Family of Origin Scale or on CMIS Parental Love and Care scale.

Study 2 Results for Hypothesis 2: Intergenerational Continuity of Abuse and Neglect

Study 2 results for hypothesis 2.1.

As shown in Table 5, the proportion of *Child* group participants with a history of abuse who had an *any-abused Parent* were compared to the proportion of *Child* group participants without a history of abuse and neglect who had an *any-abused Parent*.

Study 2: Table 5

Proportion of Any-Abused Parent for Any-Abused Child versus Not-Abused Child

	Proportion		**Proportion (any-abused – not-abused)**		
	Child any-abused	Child not-abused	Estimate	95% CI	Fisher's Exact Test *p* (2-sided)
Any-abused Parent	0.68	0.47	0.21	-0.05, 0.42	.178

As shown in Table 5, there was no statistically significant difference between the proportion of *any-abused Parents* for *Child* groups with and without abuse. The *any-abused Child* group had proportionately, but not significantly more *any-abused Parents* (13 out of 19) than the *not-abused Child* group (24 out of 51).

Study 2 results for hypothesis 2.2.

As shown in Table 6, for *Parent* group reporting each type of abuse or neglect, comparison was made between the proportion of *Child* group participants reporting the same type, or not reporting the same type of abuse or neglect.

Study 2: Table 6

Proportion of Children Who Have a Parent with a History of the Same Type of Abuse

	Proportion			**Proportion (any-abused – not-abused)**		
	Child sexually abused	N	Child not-abused sexually abused	N	Est.	95% CI	*Fisher's Exact Test p (2-sided)*
Proportion with sexually abused parent	0.25	12	0.22	58	0.03	-0.18, 0.32	>.999
	Child physically abused		Child not physically abused				
Proportion with a physically abused parent	0.63	8	0.23	62	0.40	0.06, 0.65	**.030**
	Child physically neglected		Child not physically neglected				
Proportion with a physically neglected parent	0.00	2	0.06	68	-0.06	-0.14, 0.60	>.999
	Child emotionally neglected		Child not emotionally neglected				
Proportion with an emotionally neglected parent	0.39	13	0.39	56	-0.01	-0.25, 0.28	>.999

As shown in Table 6, *physically-abused Child* group participants were statistically significantly more likely to have a *physically-abused Parent* than *not-abused Child* group participants. The differences between groups for the other abuse and neglect type were not statistically significant and were estimated to be very small.

Study 2 results for hypothesis 2.3.

As shown in Table 7 and 8, for *Parent* with a history of additional adverse childhood experience, comparison was made between the proportion of *Child* group participants with and without that experience.

Study 2: Table 7

Proportion of Parent Witnessed-Any-Family-Violence for Child Witnessed-Any-Family-Violence versus Child No-Family-Violence

	Proportion		**Proportion (witnessed any-family violence – no family violence)**		
	Child witnessed any-family violence	Child no family violence	Estimate	95% CI	Fisher's Exact Test *p* (2-sided)
Parent witnessed any-family violence	0.54	0.37	0.17	-0.11, 0.43	.349

As shown in Table 7, there was no statistically significant difference between the proportion of *witnessed any-family violence Parents* for *Child* groups with and without a childhood history of witnessing family violence. The *witnessed any-family violence Child* group had proportionately, but not statistically more *witnessed any-family violence Parents* (7 out of 13) than the *no family violence Child* group (21 out of 57). The difference in proportions, however, was not statistically significant and was estimated to be small.

Study 2: Table 8

Proportion of Parent Carer-Any-Drug-Problem for Child Carer-Any-Drug-Problem versus Child No-Carer-Drug-Problem

	Proportion		**Proportion (carer any-drug problem – no carer drug problem)**		
	Child carer any-drug problem	Child no carer drug problem	Estimate	95% CI	Fisher's Exact Test *p* (2-sided)
Parent carer any-drug problem	0.50	0.07	0.43	0.01, 0.83	.165

As shown in Table 8, there was no statistically significant difference between the proportion of *carer any-drug problem Parents* for *Child* groups with and without a childhood history of *carer any-drug problem*. The *carer any-drug problem Child* group had proportionally, but not statistically more *carer any-drug problem Parents* (1 out of 2) than the *Child no carer drug problem* group (5 out of 68). One of the groups for this comparison was very small.

Four intergenerational abuse history groups, shown in Tables 9 and 10, were used to investigate the Study 3 Hypothesis 3, Hypothesis 4, Hypothesis 5 and Hypothesis 6.

Study 2: Table 9

Participant-Dyad Intergenerational Abuse History Groups

Group	Parent	Child
1	History of Abuse	History of Abuse
2	No abuse	History of Abuse
3	History of Abuse	No abuse
4	No abuse	No abuse

Study 2: Table 10

Percentage of Participant-Dyads in the Four Intergenerational Abuse History Groups

Group	N	%
1 Both generations any-abused	13	18.6
2 Child any-abused only	6	8.6
3 Parent any-abused only	24	34.3
4 Neither generation abused	27	38.6

As shown in Table 10, more than a third of participants had neither generation abused (Group 4). Group 2, *Child any-abused* only, was the smallest of the four intergenerational abuse history groups, with less than 9% of the total sample. More *Parent* participants (N = 37) were *any-abused* than *Child* participants (N = 19).

Study 2 Results for Hypothesis 3: Intergenerational Impacts of Abuse and Neglect on Relationships and Functioning.

As shown in Tables 11, 12 and 13, mean differences between four abuse history groups (*Both*, *Child-any-abused-only*, *Parent-any-abused-only* and *Neither*) were investigated across five adult functioning outcomes. Positive adult functioning outcomes were measured by the presence of average lower separation-individuation problems, higher perceived social support, lower psychopathology, lower current trauma symptoms and higher proactive coping.

Study 2: Table 11

Means and Standard Deviations across Four Abuse History Groups (Both, Child-Any-Abused-Only, Parent-Any-Abused-Only, Neither) for Five Adult Functioning Outcomes

Outcome	Group	N	M	SD
Separation-Individuation				
	Both generations any-abused	13	85.2	20.4
	Child any-abused only	6	81.0	15.1
	Parent any-abused only	24	75.1	17.1
	Neither generation abused	27	71.9	13.8
Social Support				
	Both generations any-abused	13	85.2	23.5
	Child any-abused only	5	75.8	19.0
	Parent any-abused only	24	96.1	18.4
	Neither generation abused	27	90.7	18.3
Psychopathology				
	Both generations any-abused	13	1.2	0.6
	Child any-abused only	6	1.8	0.8
	Parent any-abused only	24	0.9	0.8
	Neither generation abused	27	0.6	0.8
Trauma Symptoms				
	Both generations any-abused	13	55.9	28.6
	Child any-abused only	5	32.2	19.3
	Parent any-abused only	24	26.8	13.3
	Neither generation abused	27	24.6	18.4
Proactive Coping				
	Both generations any-abused	13	51.2	9.1
	Child any-abused only	6	50.5	5.0
	Parent any-abused only	24	49.0	7.2
	Neither generation abused	27	50.4	5.0

Study 2: Table 12

Means and Difference of Means Comparing Adjacent Levels of Intergenerational Abuse
History for Five Adult Functioning Variables

Outcome		Level *a* – Level *b*		
Level *a*	Level *b*	M diff.	95% CI	*p*
Separation-Individuation				
Both generations any-abused	Child any-abused only	4.2	-12.06, 20.36	.611
Child any-abused only	Parent any-abused only	5.9	-9.12, 20.87	.437
Parent any-abused only	Neither generation abused	3.3	-5.94, 12.49	.481
Social Support				
Both generations any-abused	Child any-abused only	9.4	-11.07, 29.78	.364
Child any-abused only	Parent any-abused only	-20.3	-39.40, -1.25	**.037**
Parent any-abused only	Neither generation abused	5.5	-5.43, 16.35	.320
Psychopathology				
Both generations any-abused	Child any-abused only	-0.7	-1.44, 0.08	.077
Child any-abused only	Parent any-abused only	0.9	0.22, 1.62	**.011**
Parent any-abused only	Neither generation abused	0.3	-0.11, 0.75	.137
Trauma Symptoms				
Both generations any-abused	Child any-abused only	23.7	3.48, 43.97	**.022**
Child any-abused only	Parent any-abused only	5.4	-13.51, 24.32	.570
Parent any-abused only	Neither generation abused	2.2	-8.63, 12.96	.690
Proactive Coping				
Both generations any-abused	Child any-abused only	0.7	-5.86, 7.32	.826
Child any-abused only	Parent any-abused only	1.5	-4.55, 7.64	.615
Parent any-abused only	Neither generation abused	-1.4	-5.16, 2.34	.454

Study 2: Table 13

Results of Five ANOVAs across Four Abuse History Groups (Both, Child-Any-Abused-Only, Parent-Any-Abused-Only, Neither) for Five Adult Functioning Outcomes

Outcome	*F*	df	*p*
Separation-Individuation	2.12	3, 63	.106
Social Support	1.95	3, 65	.130
Psychopathology	4.87	3, 66	**.004**
Trauma Symptoms	8.58	3, 65	**< .001**
Proactive Coping	0.38	3, 66	.769

Separation-individuation results for study 2 hypothesis 3. As shown in Table 11, Separation-Individuation disturbance mean scores were highest in the *Both-generations any-abused* group and lowest in the *Neither generation abused* group; however these differences were estimated to be small. As shown in Table 12, the mean differences between Separation-Individuation scores across the adjacent levels of intergenerational abuse history were estimated to be small. As shown in Table 13, the analysis of variance result for Separation-Individuation comparing four groups (*Both-generations any-abused*, *Child any-abused-only*, *Parent any-abused-only*, *Neither generation abused*) was not statistically significant.

Social Support results for study 2 hypothesis 3. As shown in Table 11, Social Support mean scores were highest in the *Parent any-abused-only* group and lowest in the *Child any-abused-only* group; however these differences were estimated to be small. In the adjacent level contrasts, shown in Table 12, the largest difference on Social Support scores was found between *Child any-abused-only* and *Parent any-abused-only* groups. The mean differences between the other adjacent level contrasts were estimated to be small. As shown in Table 13, the analysis of variance result for Social Support comparing four groups comparing four groups (*Both-generations any-abused*, *Child any-abused-only*, *Parent any-abused-only*, *Neither generation abused*) was not statistically significant.

Psychopathology results for study 2 hypothesis 3. As shown in Table 11, the *Parent any-abused-only* group had, on average, lower Psychopathology scores than *Child any-abused-only* group, and the *Neither generation abused* group had less psychopathology than the *Parent any-abused-only* group. Further, the *Child any-abused-only* group reported, on average, more Psychopathology than *both-generations*

any-abused group. In the adjacent level contrasts shown in Table 12, statistically significant mean differences were found on Psychopathology scores between *Child any-abused-only* and *Parent any-abused-only*. The mean differences between the other adjacent level contrasts were estimated to be small. As shown in Table 13, the analysis of variance result for Psychopathology comparing four groups comparing four groups (*Both-generations any-abused*, *Child any-abused-only*, *Parent any-abused-only*, *Neither generation abused*) was statistically significant.

Trauma symptom results for study 2 hypothesis 3. As shown in Table 11, the *Child-any-abused-only* group had fewer trauma symptoms, on average, than the *Both-generations-any-abused* group. Also shown in Table 11, the *Parent-any-abused-only* group had less trauma symptoms than the *Child any-abused-only* group, and the *Neither-generation-abused* group had less trauma symptoms than the *Parent-any-abused-only* group. In the adjacent level contrasts shown in Table 12, statistically significant mean differences were found on Trauma Symptom scores between the *Both-generations-any-abused* and *Child-any-abused-only* groups. As shown in Table 13, the analysis of variance result for Trauma Symptoms comparing four groups comparing four groups (*Both-generations any-abused*, *Child any-abused-only*, *Parent any-abused-only*, *Neither generation abused*) was statistically significant.

Proactive Coping results for study 2 hypothesis 3. As shown in Table 11, the *Neither-generation-abused* group had higher mean Proactive Coping scores than the *Parent-any-abused-only group*. Also shown in Table 11, the *Both-generations-any-abused* group had higher average Proactive Coping scores than the *Child-any-abused-only* group, and the *Child-any-abused-only* group had higher Proactive Coping scores than the *Parent-any-abused-only* group. However, these differences were estimated to be small. As shown in Table 12, the mean differences between Proactive Coping scores across the adjacent levels of intergenerational abuse history were estimated to be small. As shown in Table 13, the analysis of variance result for Proactive comparing four groups (*Both-generations any-abused*, *Child any-abused-only*, *Parent any-abused-only*, *Neither generation abused*) was not statistically significant.

Study 2 Results for Hypothesis 4: The Impact of Parental History of Abuse and Neglect.

For Study 2 Hypothesis 4, as shown in Table 14, Parental history of abuse and neglect (Group 1 and Group 3) was compared with Parental no abuse history (Group 2 and Group 4).

Study 2: Table 14

Participant-Dyad Abuse History Groups Based on Parental History

Group	Parent	Child
1	History of Abuse	History of Abuse
2	No abuse	History of Abuse
3	History of Abuse	No abuse
4	No abuse	No abuse

Study 2 results for hypothesis 4.1.

Study 2: Table 15

Results of Independent Sample t-tests Comparing Child-with-Any-Abused-Parent and Child-with-Not-Abused-Parent on Five Adult Functioning Outcomes

Outcome	Child-with-any-abused-Parent (Group 1 and 3)			Child-with-not-abused-Parent (Group 2 and 4)			M diff.	95% CI	p
	N	M	SD	N	M	SD			
Separation-Individuation	37	78.6	18.7	33	73.5	14.3	5.1	-2.76, 13.03	.199
Social Support	37	92.3	20.7	32	88.3	18.9	3.9	-5.59, 13.45	.413
Psycho-pathology	37	1.0	0.75	33	0.8	0.92	0.2	-0.22, 0.58	.370
Trauma Symptoms	37	37	24.2	32	25.8	18.4	11.2	0.96, 21.47	**.033**
Proactive Coping	37	49.8	7.9	33	50.4	4.92	-0.6	-3.74, 2.46	.682

As shown in Table 15, the mean difference between groups on Trauma Symptoms was statistically significant. The *Child-with-any-abused-Parent* group (Groups 1 and 3) had, on average, higher current Trauma Symptoms scores than the *Child-with-not-abused-Parent* group (Groups 2 and 4); however, the confidence interval for this difference was wide, indicating the mean difference to be imprecise.

There were no statistically significant mean differences between the *Child-with-any-abused-Parent* and *Child-with-not-abused-Parent* groups on the other four adult functioning outcomes. The *Child-with-any-abused-Parent* group had, on average, higher scores for Separation-Individuation and Psychopathology, and lower proactive coping scores than the *Child-with-not-abused-Parent* group; however the confidence intervals for these differences were wide, indicating the mean differences to be imprecise. The *Child-with-any-abused-Parent* group had, on average, higher Social Support scores than the *Child-with-not-abused-Parent* group; however this difference was not statistically significant.

Study 2 results for hypothesis 4.2.

Study 2: Table 16

Proportion of Any-Abused Parent and Not-Abused Parent across Four Socio-Economic Outcomes

	Proportion				**Proportion (abused – not-abused)**		
	Parent any-abused	N	Parent not-abused	N	Est.	95% CI	Fisher's Exact Test *p* (2-sided)
Any Childhood Financial Deprivation	0.35	37	0.18	33	0.04	-0.12, 0.20	.714
Left school early (before completing Year 11)	0.00	37	0.91	33	-0.09	-0.24, 0.02	.100
No post-school qualification	0.22	37	0.21	33	0.00	-0.19, 0.19	> .999
Welfare recipient	0.03	37	0.00	33	0.03	-0.08, 0.14	> .999

Parental history of child abuse was explored across four negative socio-economic outcomes: Any childhood financial deprivation, Leaving school before completing Year 11, No post-school qualification, and Welfare recipient. As shown in Table 16, there were no statistically significant differences between the proportion of *Parent any-abused* and *Parent not-abused* on *Child* group socio-economic outcomes. The proportions for Any Childhood Financial deprivation, No post-school qualification and Welfare recipient were all higher for *Child* group participants with an *any-abused Parent*; however the differences in proportions were not statistically significant and were estimated to be small. Leaving school before Yr11 was lower for *Child* group participants with an *any-abused Parent*; however, this difference was not statistically significant.

Study 2 results for hypothesis 4.3.

Parental history of child abuse was investigated across four childhood family outcome measures. As shown in Table 17, these outcomes were the Family of Origin scale, the CMIS Parental Love and Care subscale, the CMIS Emotional Abuse subscale, and the CMIS Physical Neglect subscale.

Study 2: Table 17

Results of Independent Sample t-tests Comparing Child-with-Any-Abused-Parent and Child-with Not-Abused-Parent on Four Childhood Relationship and Functioning Outcomes

Outcome	Child with any-abused Parent (Groups 1 and 3)			Child with not-abused Parent (Groups 2 and 4)			M diff.	95% CI	*p*
	N	M	*SD*	N	M	*SD*			
Family of Origin Functioning	37	51.6	13.2	33	56.2	13.9	-4.6	-11.04, 1.92	.165
Parental Love and Care	37	4.3	0.9	33	4.6	0.8	-0.2	-0.63, 0.20	.303
CMIS Emotional Abuse	37	16.3	6.8	33	14.4	6.3	1.9	-1.26, 5.00	.236
CMIS Physical Neglect	37	6.0	3.4	33	5.6	1.7	0.4	-0.90, 1.64	.565

As shown in Table 17, there were no statistically significant differences between *Child-with-any-abused-Parent* (Groups 1 and 3) and *Child-with-not-abused-Parent* groups (Groups 2 and 4) on the four childhood relationship and functioning outcomes. The *Child-with-any-abused-Parent* group had, on average, lower Family of Origin functioning scores and lower CMIS Parental Love and Care scores than the *Child-with-not-abused-Parent* group. The *Child-with-any-abused-Parent* group had, on average, higher CMIS Emotional Abuse scores and higher CMIS Physical Neglect scores than the *Child-with-not-abused-Parent* group. However, these differences were not statistically significant and were estimated to be small.

Study 2 Results for Hypothesis 5.

As shown in Table 18, Study 2 Hypothesis 5 examined participant-dyad groups based on parental history of childhood maltreatment.

Study 2: Table 18

Participant-Dyad Groups Based on Parental History of Abuse

GROUP	Parent	Child
1	History of Abuse	History of Abuse
3	History of Abuse	No abuse

Study 2: Table 19

Means and Standard Deviations Showing Child-Parent Difference Scores for Group 3 and Group 1 on Five Adult Functioning Outcomes

| | Child-Parent Difference Score | | | | | | Group 3 - Group 1 | |
| **Outcome** | **Parent-any-abused only (Group 3)** | | | **Both generations any-abused (Group 1)** | | | **Mean diff.** | **95% CI** |
	N	M	SD	N	M	SD		
Separation-Individuation	23	-0.1	20.9	13	10.0	26.3	-10.1	-27.79, 7.62
Social Support	24	11.1	29.8	13	0.3	28.7	10.8	-9.77, 31.41
Psychopathology	24	0.0	0.8	13	-0.1	0.6	0.0	-0.46, 0.53
Trauma Symptoms	22	-5.7	19.0	12	12.2	38.3	-17.9	-43.13, 7.35
Proactive Coping	23	2.6	9.2	13	-2.9	9.3	5.5	-1.06, 12.13

Analysis was conducted using independent *t*-tests comparing the *Child-Parent* difference scores for Group 3 (*Parent-abused-only*) to *Child-Parent* difference scores for Group 1 (*Both-generations-any-abused*) on five adult functioning outcomes.

Study 2: Table 20

Results of Five Independent t-tests Comparing Child-Parent Difference Scores in Group 3 and Group 1 on Five Adult Functioning Outcomes

Outcome	*t*	df	*p*
Separation-Individuation	-1.19	21	.249
Social Support	1.08	26	.290
Psychopathology	0.15	30	.885
Trauma Symptoms	-1.52	14	.151
Proactive Coping	1.73	25	.096

As shown in Table 19, Group 1 had greater mean intergenerational differences than Group 3 on three of the adult functioning outcomes: Separation-Individuation, Trauma Symptoms and Proactive Coping. However, these differences not statistically significant and were estimated to be small. As shown in Table 20, there were no statistically significant mean differences between intergenerational difference scores in Group 3 and intergenerational difference scores in Group 1 on the five adult functioning outcomes.

Separation-individuation results for study 2 hypothesis 5. As shown in Table 19, in Group 1, *any-abused Child* participants had on average more disturbances in Separation-Individuation than their *any-abused Parent*. In Group 3, *not-abused Child* participants had similar Separation-Individuation scores to their *any-abused Parent*. However, these differences were not statistically significant and were estimated to be small. As shown in Table 20, the mean difference between Group 3 and Group 1 for Separation-Individuation scores was not statistically significant.

Social support results for study 2 hypothesis 5. As shown in Table 19, the difference between *Child* and *Parent* Social Support average scores was greater in Group 3 (*Parent-abused-only*) than in Group 1 (*Both-generations-any-abused*). In Group 1, *any-abused Child* participants had on average similar Social Support scores to

their *any-abused Parent*. In Group 3, the *not-abused Child* participant average Social Support score was higher than the Group 3 *any-abused Parent*. However, these differences were not statistically significant and were estimated to be small. As shown in Table 20, the mean difference between Group 3 and Group 1 for Social Support was not statistically significant.

   Psychopathology results for study 2 hypothesis 5. As shown in Table 19, the difference between *Child* and *Parent* Psychopathology scores was greater in Group 1 (*Both-generations-any-abused*) than in Group 3 (*Parent-abused-only*). In Group 1, *any-abused Child* participants had, on average, lower Psychopathology scores than their *any-abused Parent*. In Group 3, there was no mean difference on Psychopathology scores between *not-abused Child* participants and their *any-abused Parent*. However, these differences were not statistically significant and were estimated to be small. As shown in Table 20, the mean difference between Group 3 and Group 1 for Psychopathology scores was not statistically significant.

   Trauma symptom results for study 2 hypothesis 5. As shown in Table 19, the direction of intergenerational differences was opposite in Group 3 to Group 1. In Group 1, *any-abused Child* participants had on average higher Trauma Symptom scores than their *any-abused Parent*. In Group 3, *not-abused Child* participants had on average lower Trauma Symptoms scores than their *any-abused Parent*. However, these differences were not statistically significant and were estimated to be small. As shown in Table 20, the group mean difference for Trauma Symptoms scores was not statistically significant.

   Proactive coping results for study 2 hypothesis 5. As shown in Table 19, the direction of intergenerational differences was opposite in Group 3 to Group 1. In Group 3, the *not-abused Child* participant average score was higher than the Group 3 *any-abused Parent*. In Group 1 the *any-abused Child* participant average score less than the Group 1 *any-abused Parent*. However, these differences were not statistically significant and were estimated to be small. Although not statistically significant, as shown in Table 20, the largest effect was for Proactive Coping

Study 2 Results for Hypothesis 6.

Potential moderator and mediator variables were explored in Intergenerational hypothesis 6.

Study 2 results for hypothesis 6.1.

For Intergenerational hypothesis 6.1, two potential moderators of intergenerational continuity of abuse were explored: *Parent* Dissociation and *Child* Family of Origin functioning. Using the PROCESS macro for SPSS (Hayes, 2014) logistic regression models were used to investigate this hypothesis.

Study 2: Table 21

Logistic Regression Model of Child Any-Abuse, Using Parent Dissociation as a Moderator of Parent Any-Abuse

Explanatory variable	*b*	SE *b*	*z*	*p*	OR	*95% CI*
Parent Dissociation	0.04	0.10	0.43	.665	1.04	0.86, 1.27
Parent Any-abuse	0.76	0.66	1.15	.252	2.13	0.58, 7.77
Parent Dissociation x Parent Any-abuse	0.02	0.21	0.09	.927	1.02	0.67, 1.54

Note. CI = confidence interval for odds ratio (OR). Predictors were mean centred.

As shown in Table 21, *Parent any-abuse* did not significantly predict *Child any-abuse* and *Parent* Dissociation score did not significantly predict *Child any-abuse*. The interaction between *Parent any-abuse* and *Parent* Dissociation score was not statistically significant in predicting *Child any-abuse*.

Study 2: Table 22

Logistic Regression Model of Child Any-Abuse, using Child Family Functioning as a Moderator of Parent Any-Abuse

Explanatory variable	*b*	SE *b*	*z*	*p*	OR	*95% CI*
Child Family Functioning	-0.07	0.02	-2.86	**.004**	0.94	0.90, 0.98
Parent Any-abuse	0.92	0.67	1.37	.162	2.52	0.68, 9.39
Child Family Functioning x Parent Any-abuse	0.04	0.05	0.83	.406	1.04	0.95, 1.14

Note. CI = confidence interval for odds ratio (OR). Predictors were mean centred.

As shown in Table 22, *Child* Family of Origin functioning significantly predicted *Child any-abuse*. The odds of *Child any-abuse* are shown to increase by 0.94 times for each decrease of one point of the *Child* Family of Origin functioning score. *Parent any-abuse* did not significantly predict *Child any-abuse*, and the interaction between *Parent any-abuse* and *Child* Family of Origin functioning score was not statistically significant in predicting *Child any-abuse*. In both logistic regression models shown in Tables 21 and 22, *Parent any-abuse* did not significantly predict *Child any-abuse*, indicating there was no evidence of intergenerational continuity of abuse.

Study 2 results for hypothesis 6.2.

Mediators of Child Trauma Symptom scores were explored for Study 2 hypothesis 6.2. Two *Parent* measures, *Parent* Dissociation scores and *Parent* Separation-Individuation scores were explored as potential mediators of *Parent any-abuse*. Using the PROCESS macro for SPSS (Hayes, 2014) linear models were used to investigate this hypothesis.

Study 2: Table 23

Linear Model of Child Trauma Symptoms, Using Parent Dissociation as Mediator of Parent Any-Abuse

Path	*b*	SE *b*	*t*	95% CI	*p*
Simple relationship					
Parent any-abuse -> Child Trauma Symptoms	11.47	5.34	2.15	0.04, 0.82	**.035**
Mediated relationship					
Parent any-abuse -> Parent Dissociation	3.09	1.00	3.08	1.08, 5.10	**.003**
Parent Dissociation -> Child Trauma Symptoms	0.94	0.65	1.44	-0.37, 2.25	.156
Parent any-abuse -> Child Trauma Symptoms (Indirect)	2.90	2.25	z = 1.2485	-0.58, 8.84	.212[a]

[a] *p*-value from Normal theory test for indirect effect (Sobel test).

As shown in Table 23, the linear model of *Child* Trauma Symptoms, using *Parent* Dissociation scores as a mediator of *Parent any-abuse* was not statistically significant. As the indirect effect between *Parent any-abuse* and *Child* Trauma

Symptoms was not statistically significant, mediation was not shown to occur. The simple relationship between *Parent any-abuse* and *Child* Trauma Symptoms was statistically significant. Positive values in this relationship indicate that *Parent any-abuse* increases the *Child* Trauma Symptoms score. The interaction between *Parent any-abuse* and *Parent* Dissociation was statistically significant. Positive values in this interaction indicate that *Parent any-abuse* increases the *Parent* Dissociation score.

Study 2: Table 24

Linear Model of Child Trauma Symptoms, Using Parent Separation-Individuation as Mediator of Parent Any-Abuse

Path	*b*	SE *b*	*t*	95% CI	*p*
Simple relationship					
Parent any-abuse -> Child Trauma Symptoms	12.39	5.58	2.22	1.23, 23.55	**.030**
Mediated relationship					
Parent any-abuse -> Parent Separation-Individuation	9.81	4.42	2.22	0.97, 18.65	**.030**
Parent Separation-Individuation -> Child Trauma Symptoms	0.11	0.16	0.69	-0.21, 0.43	.492
Parent any-abuse -> Child Trauma Symptoms (Indirect)	1.09	2.02	z =0.61	-1.91, 6.59	.544[a]

[a] Normal theory test for indirect effect (Sobel test).

As shown in Table 24, the linear model of *Child* Trauma Symptoms, using *Parent* Separation-Individuation scores as a mediator of *Parent any-abuse* was not statistically significant. As the indirect effect was not statistically significant, mediation was not shown to occur. The simple relationship between *Parent any-abuse* and *Child* Trauma Symptoms was statistically significant. Positive values in this relationship indicate that *Parent any-abuse* increases the *Child* Trauma Symptoms score. The interaction between *Parent any-abuse* and *Parent* Separation-Individuation was statistically significant. Positive values in this interaction indicate that *Parent any-abuse* increases the *Parent* Separation-Individuation score.

Study 2 results for hypothesis 6.3.

Predictors of *Child* Trauma Symptoms were explored for Intergenerational hypothesis 6.3. *Parent* Social Support and two *Child* outcomes, *Child* Social Support

scores and *Child* Family of Origin functioning scores were explored as potential
moderators of *Parent any-abuse*. Using the PROCESS macro for SPSS (Hayes, 2014)
linear models, shown in Tables 25, 26 and 27, were used to investigate this hypothesis.

Study 2: Table 25

*Linear Model of Child Trauma Symptoms, Using Parent Social Support as a Moderator
of Parent Any-Abuse*

Explanatory variable	b	SE b	t	95% CI	p
Parent Social Support	0.10	0.12	0.85	-0.14, 0.35	.397
Parent Any-abuse	12.40	5.41	2.29	1.59, 23.21	**.025**
Parent Social Support x Parent Any-abuse	-0.01	0.23	-0.03	-0.47, 0.45	.978

Note. Predictors were mean centred.

As shown in Table 25, *Parent any-abuse* significantly predicted *Child* Trauma
Symptoms. *Parent* Social Support functioning did not significantly predict *Child*
Trauma Symptoms. The interaction between *Parent any-abuse* and *Parent* Social
Support score was not statistically significant in predicting *Child* Trauma Symptoms.

Study 2: Table 26

*Linear Model of Child Trauma Symptoms, Using Child Social Support as a Moderator
of Parent Any-Abuse*

Explanatory variable	b	SE b	t	95% CI	p
Child Social Support	-0.37	0.15	-2.46	-0.67, -0.07	**.017**
Parent Any-abuse	12.71	5.04	2.52	2.64, 22.79	**.014**
Child Social Support x Parent Any-abuse	-0.37	0.29	-1.27	-0.95, 0.21	.210

Note. Predictors were mean centred.

As shown in Table 26, *Parent any-abuse* significantly predicted *Child* Trauma
Symptoms, and *Child* Social Support score significantly predicted *Child* Trauma
Symptoms. The interaction between *Parent any-abuse* and *Child* Social Support was
not statistically significant in predicting *Child* Trauma Symptoms.

Study 2: Table 27

Linear Model of Child Trauma Symptoms, using Child Family Functioning as a

Moderator of Parent Any-Abuse

Explanatory variable	b	SE b	t	95% CI	p
Child Family Functioning	-0.55	0.24	-2.31	-1.03, -0.07	**.024**
Parent Any-abuse	8.36	5.01	1.67	-1.65, 18.36	.100
Child Family Functioning x Parent Any-abuse	0.01	0.47	0.03	-0.92, 0.95	.976

Note. Predictors were mean centred.

As shown in Table 27, *Child* Family of Origin functioning score significantly predicted *Child* Trauma Symptoms. *Parent any-abuse* did not significantly predict *Child* Trauma Symptoms. The interaction between *Parent any-abuse* and *Child* Family of Origin functioning was not statistically significant in predicting *Child* Trauma Symptoms.

Study 2 results for hypothesis 6.4.

Predictors of *Child* Family of Origin functioning were explored for Intergenerational hypothesis 6.4. *Parent* Social Support score was explored as a potential moderator of *Parent* Trauma Symptoms. Using the PROCESS macro for SPSS (Hayes, 2014) a linear model, shown in Table 28, was used to investigate this hypothesis.

Study 2: Table 28

Linear Model of Child Family of Origin Functioning, Using Parent Social Support as a

Moderator of Parent Trauma

Explanatory variable	b	SE b	t	95% CI	p
Parent Social Support	0.18	0.09	2.00	-0.00, 0.35	**.051**
Parent Trauma Symptoms	-0.11	0.09	-1.20	-0.30, 0.74	.235
Parent Social Support x Parent Trauma Symptoms	0.00	0.01	0.17	-0.01, 0.01	.863

Note. Predictors were mean centred.

As shown in Table 28, *Parent* Social Support did not reach statistical significance in predicting *Child* Family of Origin functioning. *Parent* Trauma Symptoms did not significantly predict *Child* Family of Origin functioning. The interaction between *Parent* Social Support and *Parent* Trauma Symptoms was not statistically significant in predicting *Child* Trauma Symptoms.

Study 2 Discussion

Study 2: Intergenerational Continuity investigated intergenerational effects of abuse and neglect between adults and their parent on a range of adulthood and childhood relationship and functioning outcomes. Partially supporting Study 2 hypothesis 1.1, *Child* participants and their *Parent* had similar scores, on average, on the same current adult functioning outcomes of separation-individuation, perceived social support, trauma symptoms, and proactive coping. Against this trend of intergenerational continuity, *Child* participants had, on average, more psychopathology than *Parent* participants. Supporting Study 2 hypothesis 1.2, *Child* participants and their *Parent* had similar scores, on average, for family of origin functioning and parental love and care.

In investigating intergenerational continuity of abuse and neglect, the current study found no support for Study 2 hypothesis 2.1. Maltreated *Child* participants were not statistically significantly more likely to have a maltreated parent than *Child* participants without a history of maltreatment. Further to this, the current study found no support for Study 2 hypothesis 2.3; no statistically significant differences were found in the investigation of intergenerational continuity of witnessing family violence or carer substance abuse. These findings are contrary to previous research supporting an intergenerational transmission of maltreatment (Appleyard et al., 2011; Thornberry et al., 2012). It is acknowledged, however, that this area of research has contradictory findings related to widespread methodological challenges (Thornberry et al., 2012; Widom et al., 2015). Whilst not all maltreated parents have maltreated children, previous research has identified parental history of childhood maltreatment as a risk for child maltreatment (Cort et al., 2011; Dixon, Browne, et al., 2005). The risk to the child is through direct harm, or through parental functioning and behaviour related to the

parent's maltreatment history (Appleyard et al., 2011; Berlin et al., 2011; Dixon et al., 2009; Egeland & Susman-Stillman, 1996). From an eco-transactional psychodevelopmental standpoint, the likelihood of child maltreatment is influenced by both the context of disruptions to attachment relationships, including parenting, and the presence of other risks within the parent-child ecology.

Within the intergenerational continuity of abuse research literature there has been limited investigation of type-to-type maltreatment (Appleyard et al., 2011). Addressing this, the current study investigated type-to-type intergenerational continuity of abuse and neglect. Partially supporting Study 2 hypothesis 2.2, abuse and neglect type was not the same across generations for sexual abuse, physical neglect and emotional neglect. *Child* group participants reporting these abuse and neglect types did not have more *Parent* group participants reporting these abuse and neglect types than *Child* group participants who did not report these types of abuse and neglect. These findings are consistent with previous research that, whilst broadly supporting the intergenerational continuity of childhood maltreatment, has found a lack of type-to-type specific intergenerational continuity (Newcomb & Locke, 2001; Zuravin et al., 1996). In the current study, physically-abused *Child* group participants, however, were more likely to have a physically-abused *Parent* than *not-abused Child* group participants. This finding is consistent with previous research limited to childhood physical abuse, which has found continuity in childhood physical abuse across generations (Berlin et al., 2011; Crouch et al., 2001; Jinseok Kim, 2009).

Intergenerational impact of abuse and neglect on relationships and functioning was explored in the current research by comparing four abuse history groups. Due to a lack of statistically significant findings across the four abuse history groups for separation-individuation disturbances, social support or proactive coping, Study 2 hypothesis 3 was not supported for these three outcomes. Partial support for Study 2 hypothesis 3 however, was found in relation to trauma symptoms and psychopathology. There was a statistically significant difference in trauma symptoms across the four intergenerational history groups. As higher scores indicated more trauma symptoms, higher scores on this outcome indicated poorer adult functioning. The findings related to trauma symptoms support previous research reporting an intergenerational transmission of trauma (Frazier et al., 2009). Following the direction of Study 2 hypothesis 3, trauma symptoms were highest in the *Both-generations-any-abused* group and lowest in the *Neither-generation abused* group. When both generations had history of childhood

maltreatment, trauma symptoms were statistically significantly higher than when only one generation reported a history of maltreatment. The finding that trauma symptoms are highest when both generations were maltreated suggests trauma symptoms are related to more factors than the individual's direct maltreatment experiences alone.

Psychopathology was found to be statistically significantly different across the four intergenerational history groups. As higher scores indicated presence of more types of psychopathology, lower scores on this outcome indicated more positive adult functioning. However, inconsistent with the direction of Study 2 hypothesis 3 across the four groups, psychopathology was highest when only the *Child* had a history of maltreatment, and not when both *Parent* and *Child* were maltreated. This finding suggests psychopathology may be more closely related to the individual's own experiences, than to their parent's maltreatment history. Given there is a lack of previous intergenerational childhood maltreatment research investigating psychopathology in adults, further research is warranted to investigate psychopathology alongside trauma symptoms.

The findings relating to trauma symptoms provided partial support for Study 2 hypothesis 4.1. It was found that, regardless of *Child* participant's own history of abuse and neglect, *Child* participants with a maltreated *Parent* had more trauma symptoms than *Child* participants whose *Parent* was not maltreated. This finding of *Child* trauma symptoms being associated to their parent's history of maltreatment provides further evidence of an intergenerational transmission of trauma. This finding of elevated trauma symptoms in the children of child maltreatment survivors has clinical implications for intervention and treatment of complex trauma. In addition to considering the short and long-term consequences for individuals, the way in which we respond to complex trauma also needs to consider the short and long-term consequences for the next generation.

Support was not found for Study 2 hypothesis 4.1 in respect to the other four adult functioning outcomes. No statistically significant group differences were found between *Child* participants who had an *any-abused Parent* and *Child* participants with a *not-abused Parent* for separation-individuation disturbances, perceived social support, psychopathology or proactive coping.

No support was found for Study 2 hypothesis 4.2, with the current study finding no statistically significant differences across socio-economic outcomes between maltreated and not-maltreated parents. No support was found for Study 2 hypothesis

4.3, with a finding of no statistically significant differences across childhood relationship and functioning outcomes between children with, and children without a maltreated parent. No support was found for Study 2 hypothesis 5, with no statistically significant differences on adult functioning outcomes between dyads in which both generations were abused and dyads in which only the parent had a history of childhood maltreatment.

Parent dissociation and *Child* childhood family of origin functioning were investigated in the current study as potential moderators of parent-child continuity of maltreatment. Failing to support Study 2 hypothesis 6.1, parent history of childhood maltreatment did not predict child history of maltreatment in either model. Contrary to findings in previous research (Egeland & Susman-Stillman, 1996; Singh Narang & Contreras, 2000), the interaction of *Parent* history of maltreatment and *Parent* dissociation were not statistically significant in predicting child maltreatment. The interaction of *Child* childhood family functioning with *Child* history of maltreatment, however, was statistically significant. This finding suggests maltreatment may be more closely related to the overall functioning within the family than to whether the parent had a history of maltreatment (Jones, 1996).

Failing to support Study 2 hypothesis 6.2, neither parent dissociation or parent separation-individuation were found to mediate the association between *Parent* history of childhood maltreatment and *Child* current trauma symptoms. Within both models, the simple relationship between parent history of maltreatment and child current trauma symptoms was statistically significant, but this relationship was not better explained by parent dissociation or parent separation-individuation.

The current study is the first to investigate intergenerational continuity of separation-individuation in adults with and without a history of childhood maltreatment. Previous research has linked separation-individuation disturbances in depressed, abusive parents with emotional regulation disturbances in the child (Susman et al., 1985). Outside of the child maltreatment literature, patterns have been reported of intergenerational continuity in separation-individuation disturbances across two generations (Charles et al., 2001). In the current study, there were no statistically significant intergenerational differences for separation-individuation. The finding within the analysis for Study 2 hypothesis 6.2 of a statistically significant association between *Parent* any-abuse and *Parent* separation-individuation, is consistent with findings in Study 1 of an association between maltreatment and separation-individuation

disturbances at the individual level. Further research is needed to investigate the potential intergenerational impacts of parental separation-individuation disturbances on child outcomes.

Failing to support Study 2 hypothesis 6.3, *Parent* social support, *Child* social support, and *Child* childhood family functioning were each found not to moderate the relationship between *Parent* maltreatment and *Child* trauma symptoms. Failing to support Study 2 hypothesis 6.4, *Child* family functioning was not found to moderate the relationship between *Parent* maltreatment and *Child* trauma symptoms. Also failing to support Study 2 hypothesis 6.4, *Parent* social support was found not to moderate the relationship between *Parent* trauma symptoms and *Child* childhood family functioning. In the current study, *Parent* social support was a measure of current social support and not a retrospective measure of parental social support. In previous research, Bartlett and Easterbrooks (2015) found frequency of social support to moderate the relationship between maternal history of neglect and infant neglect. Further research is needed to understand the impact of parental social support during childhood on the long-term outcomes for the child across different types of abuse and neglect.

Study 2 Limitations

A limitation of *Study 2: Intergenerational Continuity* was that the collection of data relied on retrospective recall. As outlined in Chapter 5, participants may have overestimated or underestimated their experiences due to the problems associated with the accuracy of retrospective reports. However, as noted in Chapter 5, there are currently no other valid means of collecting such information.

In investigating functioning in adults and their parents, *Study 2: Intergenerational Continuity* may be criticized for not accounting for effects related to the different developmental stages of the two generational groups. Thornberry, Hops, Conger, and Capaldi (2003) and Rutter (1998) suggested intergenerational continuity (of certain behaviours) should be assessed at similar developmental stages to allow more accurate examination of differences. In this study, developmental stage was not measured. Because of the longitudinal nature of such measurement, it was not possible to account for effects related to developmental stage in the current study. However, the finding of few statistically significant paired differences on outcome measures in Study

2 suggests that the developmental stage of participants might not be as important as suggested by Thornberry, Hops, et al. (2003).

As a result of the recruitment of primary carers and their adult children, there were a higher number of females in the sample. This is because primary carers were mostly mothers. As discussed earlier, gender imbalance was also a problem in Study 1. The gender imbalance is not representative of the general population, however, in the population of abused people there are mostly females (Barth et al., 2013; Briere & Elliot, 2003; Spataro et al., 2004; Stoltenborgh et al., 2011). The question of gender differences was not a focus of this study. Thus, it is possible that these results might reflect a female, rather than a male experience. Future research may consider examination of potential gender differences in relationship and functioning outcomes.

The intergenerational design of Study 2 resulted in slow recruitment and a small sample size, with 140 participants forming 70 parent-child dyads. The small sample size reduced the power of the statistical analysis, such that potentially significant effects may not have been identified (i.e., Type II error). However, the Study 2 finding of differences between *Child* participants with a maltreated *Parent* and those whose *Parent* was not maltreated, but not between paired *Child* and *Parent* participants, indicates that the study did have sufficient power to detect some differences in functioning outcomes. Further, the use of confidence intervals throughout supports the reader to make direct inferences of the results. The reporting of estimates of mean differences with confidence intervals provides inferential information, and describes the precision of the estimated mean differences for the sample sizes obtained (Lenth, 2001). This focus on estimation is a strategy recommended by the American Psychological Association (American Psychological Association, 2012; Wilkinson, 1999). Hence where differences were not detected, one can consider from the confidence interval whether this was due to poor precision or a relatively small effect.

A further limitation of Study 2 is the uneven group sizes across the four intergenerational maltreatment history groups. As reported above in Chapter 6, the current study considered comparisons of intergenerational groups on psychological outcomes. The *Child any-abused* group comprised less than 9% of the total sample, compared to the *Parent any-abused* which comprised almost 39% of the total sample. This is problematic because small groups are less likely to be representative of the population from which they are drawn. As noted above, the current research faced

challenges in recruiting intergenerational-dyads, and these recruitment challenges may have contributed to the uneven group sizes. Further research with larger overall number of participants and a possibly more even distribution across intergenerational maltreatment history groups would enable more precision in the comparisons and inferences to be made.

Unique Challenges of Continuity Research with Adult Survivors of Child Abuse

The current research involved separate participation by adults and their parent, relying upon one of the participants to recruit their intergenerational pair. Each individual participant completed the questionnaire confidentially on his or her own and returned the completed questionnaire in a separate reply-paid envelope (for pen-on-paper version) or online. Lacking the advantage of co-habitation available to intergenerational research involving children and their caregivers, both of the members within pairs in the current study were adults. As most participants resided separately to their pair, participant recruitment of their intergenerational pair involved some level of active communication.

In the Pilot study and during Wave 1 (general population recruitment), the researcher received informal feedback from several individual participants of an explanation of difficulty recruiting their intergenerational pair. The explanation given was that their intergenerational pair was a busy person, whom they did not wish to burden with time involved in completing the questionnaire. This reason was provided by Parent participants in relation to recruitment of their adult child, as well as by Child participants in relation to recruitment of their parent.

Wave 2 data collection targeted as survivors of childhood abuse and their parent or adult child. As reported earlier, care was taken to present the research as a study of relationships and functioning, with fliers used to recruit survivors being the only identification of this target group. It was anticipated that some *Child* participants with a history of maltreatment may have a difficult relationship or limited current communication with their childhood caregivers. In line with this anticipation, several maltreated *Child* participants gave feedback that they were keen to participate themselves, but were unable to recruit their childhood caregiver and did not have adult children.

As a result of difficulties recruiting intergenerational pairs across both waves of recruitment, a large number of individuals without matched pairs participated. Data from individuals was reported in Study 1. It is acknowledged that the requirement for participants to actively recruit their intergenerational pair may have unintentionally increased the self-selection of pairs with more open parent-child communication.

Study 2 Conclusions

In Studies 1 and 2, the relationships and functioning of abused survivors, and non-abused adults were *quantitatively* investigated. Study 2 found adults and their primary caregiver to have similar scores on adult functioning outcomes of separation-individuation, perceived social support, trauma symptoms, and proactive coping. Maltreated *Child* participants were not statistically significantly more likely to have a maltreated parent than *Child* participants without a history of maltreatment. Consistent with previous research, type-to-type specific intergenerational continuity was found only for childhood physical abuse, with physically-abused *Child* group participants being more likely to have a physically-abused *Parent* than *not-abused Child* group participants. Trauma symptoms were found to be highest in intergenerational-dyads where both generations reported a history of maltreatment. Psychopathology was found to be highest when only the *Child* participant had a history of childhood maltreatment. Significantly, Study 2 found that *Child* participants with a maltreated *Parent* had more trauma symptoms than *Child* participants whose *Parent* was not maltreated.

To further understand the individual-level and the intergenerational effects of child abuse, previous researchers have called for a *qualitative* investigation of survivors' learning from the caregiving experiences they received (Charles et al., 2001; McMahon, 2014). As found in Studies 1 and 2 and in previous research, childhood maltreatment experiences are complex (Cyr et al., 2013; Jackson et al., 2014). Qualitative methods permit the study of this complexity (Rizq, 2012). Unlike quantitative research, qualitative research provides a person-orientated perspective for understanding survivors' learning about disturbances in their relationship with their parent and about their experiences of care and maltreatment (McMahon, 2014). In the next chapter, Study 3 presents a qualitative exploration of child abuse survivors' experiences of their parent with respect to trust, hurt and healing.

Chapter 7: Study 3. Child Abuse and Neglect Survivors' Experiences of their

Parent: Trust, Hurt and Healing

Study 3: Figure 1. An illustration depicting the author's conception of living with the trauma of childhood maltreatment.

Child abuse and neglect involves a betrayal of trust, care and protection within the very relationships that the child relies upon for care (Courtois & Ford, 2013). Despite the important role of the child-parent relationship, there is a lack of empirical research on child abuse survivors' experiences of their parent(s). In Studies 1 and 2, the relationships and functioning of abused survivors, and non-abused adults were *quantitatively* investigated. To further understand the individual-level and the intergenerational effects of child abuse, the need was identified for a *qualitative* investigation of survivors' learning from the caregiving experiences they received.

In responding to this, Study 3 qualitatively explored child abuse survivors' experiences of their parent with respect to trust, hurt and healing. This chapter explains the concepts of trust, hurt and healing in the context of complex trauma. Past qualitative research is discussed, reporting on the perspectives of child abuse survivors. Gaps are identified in research into survivors' experiences of trust, hurt and healing. Interpretative Phenomenological Analysis (IPA) is introduced as a qualitative method and analytic tool best suited to the current research. The method of Study 3 is comprehensively reported. Following this, the results and discussion of the findings are presented in four categories: Trust, Hurt, Healing, and Relationships-and-Functioning. Quotes from Study 3 participants are integral to the results and discussion. They will enable the reader to become familiar with the experiences of individual participants and the group themes. The value to survivors of being heard and having trauma acknowledged is discussed. The authors' conception of living with the trauma of childhood maltreatment is shown in Study 3 Figure 1.

Trust, Hurt and Healing in Complex Trauma

Throughout the growing body of treatment literature for and about survivors of childhood abuse are the concepts of trust, hurt and healing (Chu, 2011; Herman, 1992; Sutton, 2007). These concepts are prominent in the treatment literature, where they have implications for the therapeutic alliance and the way clinicians work with survivors. On the other hand, these three concepts have a low profile in academic studies, where there is little empirical research into child abuse survivors' experiences of trust, hurt or healing.

Furthermore, there has been some debate in the field over how to research the effects of complex trauma. This debate has led to a move away from the Western medical model of deficiency to an inclusive understanding of trauma utilizing the voices and lived experiences of survivors. (Burstow, 2003; Singh, Hays, Chung, & Watson, 2010).

Trust: Theory and Past Research

Trust in close relationships is the expectation of being able to rely with confidence upon a person to meet certain needs and to not violate relationship boundaries (Bowlby, 1968; Erikson, 1963; Simpson, 2007). In infancy and childhood, trust in caregivers comes from the experience of the caregiver actively ensuring that the child's care, protection, and wellbeing needs are met (Winnicott, 1964). The importance of early trust relationships was articulated by Erikson (1963) in his placement of the conflicts of trust in infancy and early childhood as the first psychosocial stage (Basic Trust vs. Basic Mistrust). Erikson described this stage as being critical to identity formation and, subsequently in adolescence and adulthood, to "a sense of being 'all right,' of being oneself, and of becoming what other people trust one will become" (p.249). Further, Erikson linked trust with the strengths "Drive and Hope [*sic*]" (p.274), suggesting that, "the basic sense of trust and the basic sense of mistrust…remain the autogenic source of both primal hope and of doom throughout life" (Erikson, 1963, p. 80). Erikson is clear in both positioning trust as forming in infancy and in its remaining important throughout life.

Similar in many ways to Erikson's "basic trust" is Bowlby et al. (1968) concept of the *secure base* in the attachment relationship between the infant and his or her primary caregiver. John Bowlby in fact attributes the term *secure base* to Mary Ainsworth (Bowlby, 2012). Early trust and attachment experiences during the critical formative periods of infancy and early childhood form the basis for adult relationships and functioning (Crittenden, 2008). Experiences of child maltreatment may be perpetrated within the same relationships upon which children are dependent for care. These are the critical relationships within which the foundations of attachment and trust are formed. As child abuse occurs directly or indirectly within the child's care-giving network, these abuses involve a betrayal of trust within the childhood caregiving relationships (Ford & Courtois, 2014; Martin et al., 2013). Child abuse and neglect experiences uniquely invade the same relationships that support the child's development and view of the world (Cloitre et al., 2011).

Early betrayal of trust by caregivers fosters mistrust in others and in the world (Herman, 1997). Survivors of childhood abuse tend to find it difficult to trust (Browne & Finkelhor, 1986). At school age, "children who have not mastered the stage of basic trust cannot predict the responses of other people" (King & Newnham, 2008, p. 32). In

adults surviving childhood abuse, feelings of betrayal of trust, abandonment and rejection are familiar (Sutton, 2007). Fear and anxiety relating to abuse experiences make it difficult for survivors to form and maintain healthy attachment relationships (Pearlman & Courtois, 2005). Childhood abuse experiences make it difficult for survivors to discern who is trustworthy and who is not (Robinson, 2000). This can result in experiences of social isolation (Haskett & Kistner, 1991) and hamper intimate relationships (Chu, 2011; Colman & Widom, 2004). In therapy, difficulty with trust can rupture the therapeutic alliance (Sutton, 2007). Ruptures to forming a therapeutic alliance impacts commitment to attendance, and can prevent therapeutic focus beyond that of creating safety (Cloitre et al., 2011; Kinsler, Courtois, & Frankel, 2014).

Disturbances in trust have an intergenerational legacy. Extending from the individual-level impact of abuse, children may be exposed to distorted experiences of trust through their parents' own trust legacy and functioning. Children of adults who themselves have survived childhood abuse are vulnerable to exposure to distorted trust experiences. Whether or not directly experiencing abuse or neglect, children living with a parent who is struggling with the ongoing impact of their own trauma may be impacted by the presence of multiple and interacting risk factors in the caregiving environment (Leifer et al., 2004; Tomison, 1996).

With focus on the parent, Conger et al. (2013) reported that in adulthood, survivors' impaired trust may be expressed through harsh and abusive parenting. With focus on the child, Newcomb and Locke (2001) noted that a history of child abuse is correlated with poor parenting. Similarly, Serbin and Karp (2003) found that parenting behaviour is shaped by the modelling of the parent's own parents and by the individual's early social and emotional behaviour.

Hurt: Theory and Past Research

Experiences of child abuse and neglect leave ongoing legacies of hurt (Kezelman et al., 2015; van der Kolk, 2014). Hurt refers to the harm perpetrated, the re-living of that abuse, and the experience of hurt in the continuing impacts of the initial traumas. The literature prefers the term trauma to the term hurt. Both terms are used to indicate objective as well as subjective damage. *Hurt* is more prevalent in survivor accounts and *trauma* in the more formal research. The physician will talk about trauma, the patient of suffering hurt.

Overwhelmingly, research, while not using the term hurt, suggests adverse experiences in childhood do not occur in isolation in an otherwise well-functioning family. Trauma results when child abuse is cumulative and repetitive. Many studies report that multiple types of childhood trauma are experienced within the same time frame, and that children who have experienced maltreatment are at increased risk of continued maltreatment by others (Hodges et al., 2013; Martin et al., 2013).

Healing: Theory and Past Research

Healing is a process rather than an end result. For people who have trauma resulting from child abuse and neglect, healing is an ongoing, sometimes life-long process (Steele, 2003). A leading Australian advocacy and support group for adults with a history of childhood abuse and neglect, Adults Surviving Child Abuse (2009), made a change in its name from *survivors* to *surviving* to better reflect the ongoing process of healing.

Healing involves acknowledgement of hurt and steps towards recovery of oneself. In their study of the views of mothers with a history of childhood abuse, Muzik, Ads, et al. (2013) wrote, "Healing is a journey between ambivalence and hope" (p. 1223). They reported that survivor participants in their study expressed ambivalence about seeking help, mistrust in others and a "sincere desire for healing" (p.1215). Poignantly, the Adverse Childhood Experiences (ACE) study in the United States suggests, "time does not heal" (Felitti, 2002, p. 44).

Healing involves listening to survivor accounts. "Healing and prevention happen together when we listen to the stories that must be told, then share resources and a commitment to peaceful relationships"(Lev, 2003, p. xxvii). Robinson (2000) wrote of two types of healing: *spiritual healing*, in which the survivor moves "from a place of brokenness, emptiness, and feelings of separation from oneself and others, to an awareness of one's infinite connection with a loving and caring Spirit or higher power" (p.162), and *psychological healing*, in which the survivor comes to acknowledge damage to their psyche and "construct out of it a self that is free, self-aware and healthy" (p.163). Cortez et al. (2011) found that survivors of childhood maltreatment were 2.2 times more likely to report they were healing when they felt others had acknowledged the ongoing traumatic impact of their experience.

Past Qualitative Research Reporting on the Perspectives of Child Abuse Survivors

New research is starting to address the paucity of research on the perspectives of child abuse survivors and their experiences of parenting and being parented. Aparicio, Pecukonis, and O'Neale (2015) used Interpretative Phenomenological Analysis (IPA) to explore the lived experiences of motherhood in six American women who had been teenage mothers in foster care. Sub-themes in their study included parental substance abuse, poverty, absence and loss, abuse and neglect, supports, and identity as a mother. Participants described experiences of their parent(s) being "unavailable and had seemingly chosen drugs over taking care of themselves and being present for their children" (p.47).

Singh et al. (2010) investigated resilience strategies used by South Asian immigrant women in the United States in their healing from child sexual abuse. Using a phenomenological method, Singh et al identified five resilience subthemes used by survivor participants in their healing: 1) use of silence, 2) sense of hope, 3) South Asian social support, 4) social advocacy, and 5) intentional self-care.

Although there is support within the non-empirical literature for the importance of trust, hurt and healing to survivors of childhood maltreatment, the researcher is not aware of any previous research addressing these core domains.

Aim of Study 3

The aim of Study 3 was to explore the meaning that child abuse survivors made of their relationship with their parent and what they learnt from their parent about trust, hurt and healing. The research was designed to give voice to participants and provide a forum to explore their understanding of their lived experiences.

Some families show resilience following trauma. This study sought to identify potential buffering factors related to intergenerational discontinuity of disturbances in functioning, relating and abuse.

Study 3 Method

Approach: Interpretative Phenomenological Analysis

Interpretative Phenomenological Analysis (IPA) was used to analyse the Study 3 qualitative data. The use of IPA enabled the analytic focus to be maintained on the "participants' attempts to make sense of their experiences" (Smith, Flowers, & Larkin, 2012, p. 79).

First detailed as an approach to psychological qualitative research by Jonathan Smith (1996), IPA is a theoretical and methodological approach to psychological research (Eatough & Smith, 2008). IPA aims to explore meaning given, rather than explain, thereby providing opportunity for people to tell their story by "giving voice" to and "making sense" of their experience (Larkin & Thompson, 2012, p. 101). The use of IPA as an in-depth ideographic method of analysis allows for experiences to be considered as subjective and shaped within socio-cultural and historical contexts (Smith et al., 2012). Through this person-in-context approach, IPA is purposely appropriate for the inherent complexity within child maltreatment research (Aparicio et al., 2015; Rizq, 2012).

The philosophical epistemological underpinnings of IPA are phenomenology (the study of subjective experiences) and hermeneutics (theory of interpretation). IPA draws on the assumptions of phenomenology posited by Edmund Husserl (1997), inclusive of refinements by subsequent phenomenologists including Martin Heidegger (Smith et al., 2012). Husserl (1997) described phenomenology as both a "descriptive method" and "an *a* priori science… the basic methodological foundation on which alone a scientifically rigorous empirical psychology can be established" (p.159). Husserl (1997) forwarded phenomenology a pure psychology in which mental life could be accessed though both self-experience and the experiences of others.

Distinct from Giorgi's empirical phenomenological psychology, IPA emphasises idiography and cognition (Eatough & Smith, 2008). Expanding from Husserl's concept "living consciousness" (Husserl, 1997, p. 169), IPA considers experience to be subjective, with an individual's sense of reality being shaped by their experiences (Smith et al., 2012). This is referred to as "lived experience" (from the German, "Erlebnis") (Benjamin, Spencer, & Harrington, 1985, p. 49).

Amongst general advice about improving the validity and reliability of qualitative research (e.g.Yardley, 2000), recent criticism of IPA has suggested the analytic procedure lacks scientific rigor necessary for replication (Giorgi, 2010, 2011). In the current study, the researcher strictly followed the procedure for IPA as documented in Smith et al. (2012), which was the same procedure recommended by Smith (2010, in reply to Giorgi, 2011) as a detailed guide to IPA. The methodology is detailed below. Reliability of the current study analysis was enhanced by the inclusion of an independent audit.

As participants of the larger intergenerational relationships and functioning study were spread across Australia (potentially across the world for online participants), the commonly used qualitative technique of face-to-face interviews was not suitable for follow-up with these participants. Instead, an open-answer survey format was employed, with participation either online or pen-on-paper. Support in other research has reported that utilising online participation to have similar reliability and validity to paper-based responding (Collins & Jones, 2004).

Expert Panel (Study 3a)

Feedback was used in the development of the qualitative survey, utilizing feedback from an expert panel of ten professionals who worked in the area of child abuse or complex trauma. The ten professionals were known to the researcher either as existing contacts or contacts made through the recruitment of participants for the larger research study. Contact with these professionals was made via email and post with a letter outlining the aim of the study and the intended use of IPA as a theoretical and methodological approach. The professionals were advised that due to the design of the larger research project being that participants may be naïve to their participant-pair having a history of childhood abuse, the wording of questions avoided specific mention of childhood abuse or trauma. Feedback from professionals showed strong consensus for the key areas of trust, hurt and healing. Neutral wording of questions was supported, as was the focus on the relational experience in participant's learning from their parent.

Recruitment (Study 3b)

Recruitment for this study comprised individuals who had earlier participated in the Relationships and Functioning Questionnaire (RFQ) used in Studies 1 and 2. During their participation in Study 1, participants were invited to complete a follow-up open-answer questionnaire. Study 1 participants included adults who identified as having a history of child abuse, as well as adults who identified themselves as having no history of childhood abuse. As IPA attempts to seek homogenous groups (Smith et al., 2012), the current study reports on a subset of 19 of the 48 respondents who participated in the follow-up questionnaire. These 19 participants were identified as being survivors of childhood abuse or neglect based on their earlier affirmative responses in the RFQ to any of the four abuse and neglect history direct questions. For the purpose of pairing participants in Study 3 to their Study 1 data, Study 3 included instructions to participants to provide the same email address or phone number they had provided when they earlier completed the RFQ.

Sample (Study 3b)

The participants in this study were 19 adults who had previously participated in Study 1 and had reported having a history of childhood sexual abuse, physical abuse, physical neglect or emotional neglect. The participants ranged in age from 19-63 years and were mostly female (18 out of 19 were female). Sixteen out of 19 reported a history of more than one type of abuse and neglect. Eleven out of 19 reported childhood sexual abuse; 11 out of 19 childhood physical abuse; 11 out of 19 childhood emotional abuse/ neglect; and one out of 19 childhood physical neglect.

To protect their identity, participants were given made up names for reporting purposes. These made up names are indicated by an asterisk.

Measures

Using a question style appropriate to the IPA approach to research, the survey contained three open-response questions: (a) TRUST: In the relationship with your parent, what did you learn about trust? (b) HURT: In the relationship with your parent, what did you learn about hurt? and (c) HEALING: In the relationship with your parent, what did you learn about healing? Each of the three questions was presented on its own

web screen-page or, for the pen-on-paper form, on separate paper pages of the survey. Each question was followed with the instructions, "Please write about your experience and the meaning you make of your experience. Write as much as you want." The survey did not prompt to respondents to report on one parent or the other. In referring to "your parent" in the survey questions (see Appendix D), Study 3 was deliberately designed in a way to allow participants to report on one or both parents according to their experiences. Following the three questions there was a space for participants to "Please add any further response you may have in relation to the three questions." The survey was available online using the survey program PsychData (Locke & Keiser-Clark, 2001-2015), or in pen-on-paper format.

Additional qualitative data the participants had previously provided in Study1 comment sections were compiled alongside their open-answer responses. The Study 1 comment sections were optional open response questions asking about social support, the participants own psychopathology, psychopathology in participant's family of origin and the participant's experience of child abuse. These Study 1 comments illuminated some of the Study 3 responses, giving them some important context. Participants wrote as if they assumed that the researchers had matched their two study responses, elaborating further on data they had provided earlier.

Data Analysis (Study 3b)

Individual case documents were created for each participant. Each document comprised the participant's responses to the Study 3b open-answer questionnaire as well as grouping and qualitative data from their optional comment section responses from the Study 1 questionnaire, forming a single "transcript" for each participant. To protect their identity, participants were given number code identifiers and made up names.

Transcripts were analysed one at a time, following the IPA processes and principles described by Smith et al. (2012). The transcript was read several times (Step 1) allowing immersion into the participant's account. Exploratory comments by the researcher (Step 2) were recorded in a table column on the right-hand side of the transcript. These initial notes provided a high level of detail about what the participant had answered (descriptive comments), their specific use of language (linguistic comments) and interrogative or conceptual annotation (conceptual comments). Working primarily from the researcher's exploratory comments, emergent themes (Step 3) were

then identified and recorded as concise phrases, reorganizing discrete fragments of the transcript. Emergent themes attempted to reflect both the essence of the original words of the participant's understandings and the researcher's interpretation of this understanding. Emergent themes were recorded in the order they arose, in a table column to the left-hand side of the transcript.

Step 4 involved exploring patterns and connections to identify clusters of related emergent themes. A super-ordinate theme label was then created for groups of emergent themes by a process of abstraction, or an emergent theme was used to become a super-ordinate theme for related themes (subsumption). A new table was created listing super-ordinate themes and themes in the left-hand column and the relevant transcript line number and transcript key words or phase in the right-hand column, linking the themes back to the original transcript source. Step 5 involved repeating Steps 1-4 for all cases in the group. Step 6 involved looking for patterns across cases in the group. A master table of all themes for the group brought together groupings of themes under super-ordinate themes and illustrated how this theme was expressed by individual participant. The super-ordinate themes were grouped into four sections: Trust, Hurt, Healing and Relationships and Functioning. Separate master tables for each of these four sections were produced. Collectively, these tables incorporated all of the themes and captured the main essence of the transcripts.

From these four master tables, recurrence of themes across the group was also identified for each of these four sections. Four Recurrence of Themes tables were produced (see Appendix F Tables 1-4), providing a quantitative expression of the cases with data relevant to each theme. The Recurrence of Themes tables enable the reader to track which participants made, or did not make, responses across particular themes.

Step 7 was the writing up of a narrative account of the group. Results are presented as case within theme (Smith et al., 2012). The researcher's analytic interpretations of the participant's accounts are presented alongside direct extracts from participants' transcripts. This enables the reader to compare the researcher's interpretations with direct evidence of the lived experience of the participants.

Transcript notation.

*   made up name, to protect participants' identity

…   material omitted

[   ]   explanatory material added by researcher, e.g. [mother]

In accordance with APA style, quotes from participants are reported uncorrected and with original spelling and grammar. Explanatory material was added only when necessary to clarify the meaning obtained from the full transcript.

Independent audit.

Despite an increased popularity in qualitative research approaches, ongoing debate about quality in qualitative research, and in phenomenological research in particular (Yardley, 2000), challenges researchers to present their findings in a way that readers can examine the validity of the research. Smith, Flowers and Larkin (2012) recommend conducting an "independent audit" (p. 183) to assess validity in qualitative research. In keeping with this recommendation, an independent audit of three cases in the current study was conducted. A file containing the method, research questions, de-identified annotated transcripts and tables of themes for each participant, draft reports and the final report were given to an independent researcher to check the validity of the report in terms of the data. The aim of the independent audit was to check the chain of evidence from the transcripts to emergent and super-ordinate themes, and the transparency and coherence of the researcher's interpretative analysis. The Independent Audit had interrater agreement of 82-90%, suggesting good reliability of the findings (refer Appendix E).

Results and Discussion (Study 3b)

IPA analysis of the themes for the whole group fell into four categories: 1) Trust Themes, 2) Hurt Themes, 3) Healing Themes, and 4) Relationships and Functioning Themes. Although this was anticipated due to the specific design of the research questions which asked participants directly about trust, hurt and healing, the participants' accounts endorsed these categories. One participant, Kiah*, wrote, "TRUST HURT HEALING Funny three words aren't they as they probably define where I am at the moment." Each of the four categories contained data from all 19 participants and comprised between five and 14 super-ordinate themes.

All participants were adults, and it is important to note that the participants' ages ranged across 60 years. At the time of data collection, the participants would have

differed in terms of developmental stage. Regardless of age or stage, the participants' accounts refer to their experiences as children. For these participants, their accounts presented as a re-telling, and possibly a re-living, of their childhood experiences of their parent/s or caregivers. For traumatic events, memory is often re-lived by survivors, rather than experienced as being in the past. On this point, van der Kolk (2014) wrote, "unlike normal memories, traumatic memories are more like fragments of sensations, emotions, reactions and images that keep getting re-experienced in the present" (p.372). McWilliams (2011) wrote that "the memory of *being there*" is damaged during a traumatic experience, resulting in the memory being stored in third-person facts, in body experiences, and in "affect connected to triggers" (p.334).

The findings are presented and discussed within the four categories of Trust, Hurt, Healing, and Relationships and Functioning. As these results and discussion may elicit painful experiences, the reader is cautioned to take appropriate self-care.

Participants' Descriptions of Trust

Participants' responses about Trust were grouped into 17 themes falling under five super-ordinate themes: 1) Trust of parents or caregivers; 2) Trust in Others; 3) Trust of Other Parent; 4) Trust in Self; and 5) What Trust is. Table 1 lists the super-ordinate and sub-ordinate Trust themes. The Trust themes are discussed following the table.

Study 3: Table 1

Super-Ordinate and Sub-Ordinate Trust Themes

#	THEME	Total No. (out of 19)
T17	*TRUST*	19
1	**TRUST AND PARENTS/ CAREGIVERS**	**16**
1.1	Could not trust parent.	12
1.2	Parent did not show trust.	4
1.3	Ambivalence in trust of caregivers.	2
2	**TRUST IN OTHERS**	**15**
2.1	Generalized or specific impairments of trust in others, the world is unsafe/ Able to trust in others, the world.	13
2.2	Trust in partners/ relationships.	3
2.3	Trust in sibling, significant others in childhood.	2
3	**TRUST IN OTHER PARENT**	**6**
3.1	Other parent was *not* to be trusted.	4
3.2	Other parent was able to be trusted (even when not protective)	2
4	**TRUST IN SELF**	**5**
4.1	Able to trust in self.	3
4.2	Impaired ability to trust self.	2
5	**WHAT TRUST IS**	**5**
5.1	Trust is a risk and involves discernment.	3
5.2	Different types of trust.	2
5.3	The meaning of trust.	2
5.4	Ongoing impairment of trust.	1

1. Trust and parents/ caregivers.

As shown in Table 1, almost all of the Study 3 participants described a betrayal of trust or care by one or both of their parents. Statements by participants about trust of parents were found to fall into three sub-ordinate themes with participants describing 1) not being able to trust their parent, 2) their parent did not show trust (in them or others), and 3) ambivalence in their statements about trust of their parent.

1.1 Could not trust parent.

Participants wrote extensively about not being able to trust their parent. For some, this was directed at their experiences with one abusive parent. Stella* wrote: "I learned …that I cannot trust [my mother] to care for me, to love me; but can rely on her to punish me even for no reason." Bridget* wrote, "I (and my brothers and sisters) quickly learned never to trust him." Betrayal or lack of trust was most commonly linked to being punished or abused, not protected, or to lies and manipulation. Isabelle* wrote about her abusive parent manipulating trust, "My father would often manipulate to gain trust and if you gave him an inch he would take a mile." As a survivor reporting all four types of abuse and neglect, Isabelle's* experience of manipulation by her abuser describes part of the complex interactions through which her abuser was able to perpetrate his abuse. Also reporting a history of all four abuse types, Donna* did not identify any use of manipulation; rather, she described her parents as being unhelpful, blaming and punitive. Donna* wrote that she had "no trust in the actions of her parents" and "it did not occur to me that they would help – I only believed they would blame me and punish me for it."

While some participants wrote about only one parent, several participants wrote about their experience of being unable to trust either parent. Faye* wrote that she learnt "not to trust them [her parents], I felt they did not have my best interest at heart." Regarding the lack of positive experiences of trust with her parents, Rita* wrote, "there was no trust ever." Describing the abuses by her father and her mother's complicity in that abuse, Rita* explained that her parents' public identities maintained an alternate reality to the abuse and neglect at home. She concluded, "None of it was real, so there was no trust." In labelling her experiences at home as not "real", Rita* described a position in which her abuse experiences lacked recognition and validation by others. Rather than being recognised as abusive, her father had "work…[and] mates" and her complicit mother was publicly "loved by all." Compounding this, Rita* and her siblings were to play the role of "well-dressed, excellent students, beautifully behaved," ensuring that others did not suspect the abuse, which further distorted her reality.

1.2 Parent did not show trust.

Many of the participants described their parent as not showing trust in them or as telling them that they were untrustworthy. Poppy* wrote, "They told me I couldn't be trusted, that they could tell from the look on my face." Faye* wrote, "I can steel [*sic*]

feel the lack of trust she had for me in that moment." Children seek the approval of their parent. When the parent does not show trust in their child, the child is denied this approval. Children become confused when their efforts to be trustworthy are not rewarded. Not being trusted by the person upon whom they rely for care and nurture undermines their knowledge about themselves as being trustworthy.

For other participants, their parent did not model trusting others. Mariah* wrote, "In trusting other people, my mother was a bit suspicious and skeptical of others …a gut sort of feeling that she had." Nina* wrote that her mother, to whom trust was important, "lost full trust in my word" and had a "lack of trust and faith in my abilities." Nina* further identified her Mother as having difficulty trusting others, "My mother sees the world as a dangerous place." Identification of others and the world as untrustworthy or dangerous is seen in individuals who have experienced an overwhelming trauma (Herman, 1997). Perhaps it is possible that Mariah* and Nina's* parents had difficulty showing trust in others due to their own disturbances in early trust experiences. Neither participant had an intergenerational pair in Study 1, but Mariah* identified her mother as being severely depressed.

1.3 Ambivalence in trust of caregivers.

In responding to what they had learnt about trust from their parent(s), participants expressed ambivalence. This ambivalence epitomizes the complex nature of trust. Elle* expressed ambivalence when she wrote, "I trusted my parents without thinking about it. They never knowingly hurt me in any way… I never trust them with my personal thoughts or experiences though…I still don't." This statement by Elle* suggests a number of layers. First, Elle* wrote that she trusted her parents without needing to think about it. As a child, she expected to be able to trust her own parents, and, through this trust, to be able to depend on the actions of her parents. She follows this with a statement that her parents did not deliberately hurt her. In experiencing the hurt as non-malevolent, she expresses hope in being able to continue in the idea (or fantasy) that her parents were able to be trusted. Even as an adult, to believe that her parents are not trustworthy is not within contemplation. Instead, Elle* identified exceptions to what she could not, and still cannot, trust her parent with (personal thoughts or experiences).

Jasmine* expressed ambivalence, identifying "trust was conditional and it depended on circumstances." Jasmine* wrote that she was repeatedly abandoned by her

mother during early childhood: "[Mother] could go away any time and not come back…the hurt of abandonment" but she "can trust [mother] when it comes to being dependent on her for money and having fun." Jasmine* also provided evidence of not being able to trust her grandparent, who had been her primary caregiver during early childhood. Jasmine* wrote that this primary caregiver had ignored her disclosure of abuse and responded without sensitivity when Jasmine* had retaliated against her abuser: "Once I kicked him in the balls while grandma was around and she yelled at me not to hurt him." However, she goes on to acknowledge that, "I can trust her with other things like food and health issues."

2. Trust in others.

Although participants were asked about trust in their relationship with their *parent*, 15 of the 19 participants wrote about trust in *others*. Statements about trust in others were found to fall into three sub-ordinate themes with participants describing; (1) generalized or specific impairments in trust of others (or a view that the world is unsafe), or, being able to trust in others or the world; (2) trust in partners or relationships; (3) trust in sibling(s) or significant others in childhood.

2.1 Generalized or specific impairments in trust of others, the world is unsafe / able to trust in others or the world.

Experiences of child abuse were reported as not only impacting on trust within the caregiving relationship, but in trust more globally. Participants described difficulties trusting others as an ongoing problem. Kiah* wrote, "I have enormous trouble trusting people". Several participants described not being able to trust others at all: Georgia* wrote, "Don't trust anyone." Similarly, Camira* wrote, "I choose to live on my own." Isabelle* described her mistrust in others as leading to difficulties in relating to others, "I learned that I can't trust a lot of people. Often in social circles I often wonder if people are only being nice to me on the surface and if they're bitching about me." These are descriptions of the world being perceived as unsafe. Feeling connected to and safe around others is vital to psychological wellbeing (van der Kolk, 2014). In childhood maltreatment, overwhelming experiences in which boundaries are broken, shatter the development of a sense of security in relationships (McWilliams, 2011).

Three participants expressed an opposite position to those above; they were *able* to trust in others or the world. Libby* found that, despite not being able to trust her parents, she "felt more comfortable with strangers" and was able to trust in others. Libby* wrote that, during her childhood, "I trusted my kindy teacher." This ability to trust in others outside of her family may have enabled Libby* to develop trust in her therapist; "After years of therapy I trust my therapist who has proved over and over again that no matter what happens our relationship can be trusted."

Despite describing being "devastated" when, as a child, his trust was "betrayed" not only through his parents' abuse, but also by his best friend stealing some money from him, Hugo* insisted that he was still able to trust in others. Hugo* and Mariah* each described themselves as "a [very/pretty] trusting person." Hugo* explained, "interestingly I learned that trust is an individual occasion, meaning that even though I could not trust my parents (father in particular) I did not generalize that to the total population. Later I formed relationships based on trust quite well." Mariah compared her own ability to trust with that of her mother, writing "I am more trusting than my mother I think."

For others, their particular abuse experiences led them to report specific impairments of trust in authority figures or men. It is within the family that children are taught to obey and respect authority. When caregivers and family members abuse a child, the concept of the family being a place of safety and nurture is altered. Donna* wrote, "I learned that you actually can't trust other people - particularly those in authority." Donna*, who disclosed having multiple abusers including her mother, further specified her ongoing impairments in her ability to trust "…parents and female authority figures particularly." Olivia* identified ongoing issues regarding trust of authority figures stemming from her experience of authoritarian parenting. Trust in authority figures is not in the self-interest of people who have suffered maltreatment by the very people who were supposed to protect them (McWilliams, 2011).

Isabelle*, who identified her father as her abuser, wrote, "I often find it hard to trust men." In contrast to her "very abusive" father, Isabelle's* experience of her mother was positive. She wrote, "my mother and God are the only reason I am here." Like Isabelle*, survivors of abuse may continue to associate fear and threat with the gender position of power or authority.

2.2 Trust in partners or relationships.

Impairment of trust was given particular importance in participants' references to adult romantic relationships. Participants in partner relationships described having to work on establishing the ability to trust in their long-term partners. Isabelle* wrote, "I have been in a stable relationship for 4 years and it has taken me three years to cry in front of him." She also wrote "even-though I have opened myself to my partner, I am often preparing myself for that day when he'll leave me."

2.3 Trust in sibling, significant others in childhood.

Participants' trust in siblings and significant others during childhood revealed mixed experiences. Experiences relating to siblings identified them either as being subject to the same abuse and supporting each other, or being co-abusers. Bridget* wrote about a supportive sibling relationship, "growing up, my closest ally was my brother…we had and still have a great relationship and totally trust each other." Elle* wrote about her sibling abusing her, "I was not so lucky with one of my brothers, he never forced me to have sex with him but somehow he got his way even though I never wanted to do it." The presence of significant others, such as grandparents, also permitted a contrast to the experience of betrayal by parents. Bridget* wrote "fortunately, I also had an excellent relationship with my mother's parents…and my Pop served as my male role model. We grew up knowing he loved us unconditionally and he was always supportive of us. We definitely trusted him."

3. Trust in Other Parent.

For individual reasons, not all participants described their experience with more than one parent figure. Those who did write about a second caregiver differentiated between an abusive parent and a non-abusive, or less abusive, parent (referred to here as the *other parent*). Participants' trust in their other parent revealed mixed experiences.

3.1 Other parent was not to be trusted.

Several participants identified that they could not trust their other parent. For Alice* this was based on a general feeling of "mis-trust within the family." For Rita* this came from experiences that she could not trust the other parent to protect her from the abusive parent. Qiana* reflected extensively on her experience of not being able to trust her mother. Although identifying her mother as sharing a fear of her abusive father, this did not unite them or provide support. Qiana* wrote, "I learned that trust

does not come from shared suffering… the fear that caused the shared suffering was stronger than loyalty." Her mother betrayed opportunities for trust; "I hid her secrets from him but she didn't hide my secrets from him." Being a child, Qiana* had relied upon her mother for safety. When her mother was not consistent in meeting this need, she learned trust is "often not worth the risk." Unable to rely on her mother for safety, Bridget* wrote, "my mother's approach was to turn a blind eye to what went on."

3.2 Other parent _was_ able to be trusted (even when not protected by them).

In contrast to the experiences, detailed above, of Alice*, Qiana*, Rita and Bridget*, Camira* wrote that her other parent _could_ be trusted, "even if they didn't agree with me or respond in the way that I wanted." Camira* holds her other parent -her father -- as non-maleficent. Even when he disclosed confidential information about her, he was still idealized without loss of trust.

Stella* wrote about being able to trust her father, even though he was unable to protect her. Stella* wrote, "I could trust my father…we [could] feel safe when he's around." There were times that her father "would defend us," but he was unable to protect Stella* and her siblings from her mother's abuse: "he would take off, as he does not know how to back chat my mother. He never …attempted to…physically stop her." Stella* noted her father's absenteeism, "we hardly saw him," explaining his absence due to being preoccupied by "work" and "stud[y] at night all his mature life." Rather than focussing on his lack of protection, in writing, "we would wait for him outside work and we [would] feel safe," Stella* focussed on the feeling of safety she had when with her father.

4. Trust in self.

4.1 Able to trust in self.

Participants' trust in themselves revealed mixed experiences. In a similar way to several other participants, Hugo* wrote that he could only trust in himself: "the only person I can truely [sic] and really trust though is myself." Having trust in oneself requires a level of identity integration and sense of initiative formed through successful integration of Erikson's first two developmental stages, Basic Trust and Basic Autonomy (McWilliams, 2011). Not all of the participants indicated successful integration of this developmental stage, as discussed in section 4.2.

4.2 Impaired ability to trust self.

Two participants reported that as a result of the abuse they were unable to trust even themselves. Olivia* wrote, "I learnt from an early age that I could not trust them or myself for that matter." Nina* wrote she, "…lost trust in myself." On the impaired ability to trust oneself, Freud (1966) wrote about this being a defensive mechanism and a turning against the self. In turning threatening experiences of an undependable parent against the self, the maltreated child acts in self-preservation, gaining a sense of being in control over the negative experience by redirecting the negative affect inwardly (McWilliams, 2011).

5. What trust is.

Participants differentiated between different types of trust, what trust means to them, and ongoing impairment of trust.

5.1 Trust is a risk and involves discernment.

Trust was identified to be a risk, and trusting others a necessary risk that one can choose to take. Mariah* wrote, "being aware of the risk of trust, and finding often the risk is worth it -- finding great friendships and relationships at the end of it." Qiana* weighed up the risk differently, expressing caution that trust was often not worth the risk: "if the consequences of that trust being broken is too high, then even if the chance of the trust being broken is low, it is not worth the risk."

Trust is not an all-or-nothing position, but, rather, involves discernment and evaluation around whom and what to trust. Mariah* wrote, "I am good at discerning who is trust worthy and who isn't," and "it did teach me to listen to my own intuition with people." Alice* wrote about trust having layers, "on the surface there can be a certain level of trust but underneath there is danger." Experiencing trust only in the "factual information that my parents told me," Alice* described being unable to tolerate ambiguity. Limiting trust to that which can be assessed on the basis of fact, Alice* wrote, "My expectations now are that people should tell the truth unambiguously…I can tend to take this demand for 'accuracy' to extremes." The interpersonal nature of the childhood maltreatment means that survivors can feel disconnected from those around them and not be able to connect current interpersonal difficulties with their maltreatment experiences (van der Kolk, 2014).

5.2 Different types of trust.

Trust was described as contextual or conditional; they could trust their parent for some basic needs, but not for other needs. Olivia* describes this inconsistency of trust in caregivers, "I could trust that I would be looked after for the basics of life (e.g. Food, shelter, clothes etc.) but when it came to emotional issues I learnt not to trust." Mariah* delineated emotional trust, "sharing emotions," from her parents' reliability in practical matters, such as "not trust[ing] them to pick me up after school because they are unreliable."

5.3 The meaning of trust.

Several definitions were offered for trust. Stella* wrote that trust means being able to rely on someone for care: "I cannot trust [mother] to care for me." Stella* defined trust as feeling safe from harm, writing that she would "feel safe when [her non-abusive father was] around." Qiana* noted that trust can be broken.

5.4 Ongoing impairment of trust.

Alice* noted, that, like hurt, trust was a "big" issue of "unresolved" impairment. When the conflict of trust/ mistrust remains unresolved, the survivors' ability to navigate trust relationships is tenuous and effortful. Trauma that is unresolved continues to impact on the survivor through a disconnection of past experience, and current affect and behaviour (Cassidy & Mohr, 2001). The capacity to connect with and regain a sense of trust in others is important to recovery (Herman, 1997).

Summary: Participants' Descriptions of Trust

Trust in parents and others was described as being impaired through the child abuse experiences. Participants described difficulty trusting others as having an on-going impact on their family, social and close relationships. Varied experiences of being able to trust one parent or a significant other whilst growing up was reflected in participants' ability to trust in adult relationships. Participants had mixed experiences of having either no one to trust during childhood or at least some trust in the other parent. The impact for some participants of not even being able to trust themselves highlights the disruption of Erikson's (1963) developmental stage of basic trust versus mistrust. Having not successfully traversed the basic trust versus mistrust stage weakens one's capacity to develop autonomy and, later, identity (McWilliams, 2011).

Participants' Descriptions of Hurt

Participants wrote about and described their experiences of hurt more than any other category. This resulted in 10 superordinate themes about Hurt: 1) Hurt described; 2) Description or type of the abuse and neglect; 3) Impact of abuse and neglect; 4) Age of abuse experiences; 5) Protections: self-protective/ protective behaviour; 6) Explaining hurt or abuse; 7) Powerlessness and vulnerability; 8) Responses to abuse and neglect; 9) Blame and Shame; and 10) Addressing the hurt. Table 2 lists the super-ordinate and sub-ordinate Hurt themes. The Hurt themes are discussed following the table.

Study 3: Table 2

Super-Ordinate and Sub-Ordinate Hurt Themes

#	THEME	Total No. (out of 19)
T36	*HURT*	19
1	**HURT-DESCRIBED**	17
1.1	Descriptions of hurt.	8
1.2	Hurts were silenced, hidden, ignored, minimized or suppressed.	8
1.3	Anticipation of abuse, hurt.	6
1.4	Description of abuser.	4
1.5	Blamed and not believed.	4
1.6	Abuser hid the abuse/ abuser used shame, fear and secrets to hide the abuse.	3
1.7	Failure of others to protect.	3
2	**DESCRIPTION/ TYPE OF THE ABUSE AND NEGLECT**	16
2.1	Emotional and psychological abuse.	9
2.2	Physical abuse.	7
2.3	Sexual abuse.	7
2.4	Emotional neglect.	7
2.5	Multiple abusers.	7
2.6	Cumulative abuse and neglect.	5
2.7	Family violence - witnessed abuse of sibling/s, other parent or extended family.	4
2.8	Other forms of abuse.	1
3	**IMPACT OF ABUSE AND NEGLECT**	
3.1	**IMPACT OF ABUSE AND NEGLECT: MEMORY**	11
3.1.1	Impact of Abuse – MEMORY: Impaired, incomplete, repressed memory of abuse experiences or of childhood.	9
3.1.2	Impact of Abuse – Lost, unhappy childhood.	4
3.2	**IMPACT OF ABUSE AND NEGLECT: SOCIAL EFFECTS, RELATING, ISOLATION**	11
3.2.1	Impact of abuse – Impaired relating with others, relationship difficulties.	8
3.2.2	Impact of abuse – Isolation, feeling alone.	5
3.3	**Impact of abuse – MENTAL HEALTH**	9
3.3.1	Impact of abuse – Participant mental health problems.	7
3.3.2	Impact of abuse – Sibling mental health problems.	2

3.4	**IMPACT OF ABUSE AND NEGLECT: ONGOING EFFECTS IN ADULTHOOD**	**8**
3.4.1	Ongoing impact of abuse (into adulthood).	6
3.4.2	Impact of abuse and neglect on functioning in adulthood.	4
3.5	**IMPACT OF ABUSE AND NEGLECT: SELF-CONCEPT, OTHER**	**7**
3.5.1	Impact of abuse and neglect – other.	5
3.5.2	Impact of abuse and neglect – self-concept.	4
4	**AGE: Age of abuse experiences**	**11**
5	**PROTECTIONS: Self-protective/ protective behaviour.**	**10**
6	**EXPLAINING HURT, ABUSE**	**8**
6.1	Parenting/ relationship with parent	6
6.2	Excusing the abuser/ the abuse.	4
7	**POWERLESSNESS & VULNERABILITY**	**5**
7.1	Powerlessness and vulnerability to abuse by others as an impact of abuse.	5
8	**RESPONSES TO ABUSE AND NEGLECT**	**7**
8.1	Self-destructive behavioural responses to abuse	4
8.2	Enacting hurtful, abusive behaviour to others.	4
8.3	Disclosure of abuse and neglect.	2
9	**BLAME AND SHAME**	**6**
9.1	Feelings of guilt, fault, and blame.	4
9.2	Shame at being abused.	2
9.3	Shame at failing own parenting expectations.	1
10	**ADDRESSING THE HURT**	**4**
10.1	Addressing/ dealing with the hurt.	3
10.2	Abuse and forgiveness.	2

1. Hurt described.

1.1 Descriptions of hurt.

As shown in Table 2, eight of the 19 participants wrote descriptions of hurt. Libby* described the abuse as a recurring nightmare that only stopped when the abuser died. Kiah* described the abuse as a "sickness." Mariah* described hurt as "rage…raw and sad…[an] injustice [and] damaging." Rita* wrote, "there was no fun, no play, no pleasure, no kindness, no love, only hurting. I learned all about hurt. I was physically beaten. I was emotionally blackmailed. I was mentally damaged. Sexually abused. I was lied to and let down." Alice* provided descriptions of cumulative hurts, "only some of which have been resolved."

1.2 Hurts were silenced, hidden, ignored, minimized or suppressed.

Family scripts reported by participants were that it was not allowed for children to show hurt, and that hurt was to be made light of, buried or borne without comfort or complaint. Family scripts included, "keep the 'stiff upper lip' as my mother used to say" (Libby*), and "chin up" (Oliva*). Qiana* wrote that talking about the abuse was going "outside the culture."

About being silenced, Kiah* wrote, "silence was my life." Libby* wrote that as a child her hurts were ignored with a "there, there," and she was silenced to the point that "I lost the power of speech at one point in my life (6yo)." For Libby*, her childhood family expectation was that she not complain. In adulthood, Libby* reported this expectation continues to prevent her from expressing and sharing her experiences of hurt, even with those closest to her.

In experiencing abuse from both of her parents, Poppy* was placed in a situation where showing hurt was dangerous and not going to lead to her being protected. Poppy* wrote, "hurt wasn't an ok emotion to have. I was not going to be comforted if I was hurt and I needed to hide it." Stella* wrote, "we never complained of feeling hurt or pain because we were brought up to suffer pain, hurt and sorrow." Olivia* wrote, "I buried my feelings surrounding any hurt" and "emotions…were not discussed."

Participants also wrote about hurt making them vulnerable, and that hurt should be suppressed or minimized. Donna* wrote, "Emotional Hurt: that you never, ever show it – it makes you vulnerable and open to ridicule and bullying. Overall, don't ever show you're hurt – physically or emotionally." Camira* appeared to endorse the position that hurt must be suppressed and minimized in her writing, "don't sweat the small stuff" and "I…like to start afresh quickly which doesn't always need acknowledgement of the hurt issue."

Descriptions were also given of how their parents' modelled coping with hurt. Qiana* wrote, "my parent shut down when hurt," and Stella* wrote that her parents were silent about their own traumatic past experiences.

1.3 Anticipation of abuse or hurt.

After the initial event, subsequent experiences of harm create a "sense of anticipation" (Terr, 1991, p. 15). Survivors in this study described developing an expectation of being hurt by their parent(s), and that this expectation of hurt continued into adulthood in their social relationships. Participants wrote that they anticipated

abuse or hurt. Stella* wrote, "the exact feeling was anticipating punishment." The anticipated hurt was unpredictable: "brutal, but we never knew when it would happen," (Hugo*) and "inevitable" (Nina*). Expressing a global expectation of being hurt, Georgia* wrote, "people will hurt you. Keep your mouth shut and stay out of the way and maybe you won't get hurt."

1.4 Description of abuser.

Participants gave descriptions of their abuser, including**:** "a psychopath…cunning" (Bridget*), "brutal" (Hugo*), "a liar" (Nina*), "the not-good-person in my life" (Qiana*). These abusers were also the participants' parent(s), and the person(s) whom they as children would have been fully or partially dependent upon for protection, care, love and nurture.

1.5 Blamed and not believed.

As shown in Table 2, four of the 19 participants described being blamed and not believed in relation to their abuse. Libby* wrote,

> I was 3y.o. when my mother's uncle assaulted me, he had been drinking and I managed to get away and hide under my bed; my dad came in and I was blamed for being a naughty girl…but uncle was believed. I learnt then that all children are seen as liars and no point saying anything about what happened.

Jasmine* wrote that her disclosure of abuse was ignored by her caregiver, "I cannot trust her with telling her that I was abused… once I told [my primary caregiver] and she ignored me…she yelled at me." Elle* wrote that upon discovering the abuse by non-relatives, rather than protecting her from further vulnerable encounters, her mother punished her: "she [mother] would give me a belting…, but she would not explain why I was in trouble and they weren't."

Qiana* wrote about a denial of hurt, where the hurt itself, rather than the abusive act, was not believed, and where her less abusive parent viewed her expression of hurt as a psychiatric illness.

1.6 Abuser hid the abuse or abuser used shame, fear and secrets to hide the abuse.

As shown in Table 2, three of the 19 participants described the abuser hiding the abuse and the abusive acts being hidden. Bridget* wrote that her abusive father "carried out his abuse behind closed doors." Her abuser wanted to keep the abuse secret or hidden as, "he didn't want anyone to know what went on in our house." Further, her

father had advocated to her violent uncle the benefits of hiding child abuse, telling him "that when he beat up his children he should do it in a way that couldn't be seen."

The abuse was kept hidden from the other parent, neighbours and teachers. Bridget* wrote, that, despite living in the same house, her abusive father had hidden the abuse from her mother: "my father was also careful to not be violent towards us in her presence as she would not have allowed that." Rita* wrote that she and her siblings were presented in such a way that the abuse was completely hidden from those outside her family: "no one would have ever suspected what severe severe [*sic*] abuses were going on. We were well-dressed, excellent students, beautifully behaved."

Being hidden and secret allowed the abuse to continue and the perpetrator(s) of the abuse to not be brought to account. Olivia* wrote that her abuser used secrets, threats of harm and fear to hide the abuse: "I was told to keep the secret otherwise my family would be harmed in some way…fear became my friend."

1.7 Failure of others to protect.

Several participants wrote about the failure of others to protect them. Elle* described inadequate parental protection from abuse, both from adults whom her mother had residing in the family home and from her brothers. Elle* suggested that avoiding abuse was a matter of luck, and that she was "not so lucky." Hugo* wrote that his mother had tried but failed to protect him from abuse, and that even when the abuse was flaunted in front of neighbours by his abusive father, they had failed to protect him: "I screamed and screamed, so he [father] opened the windows so all the neighbours could hear me scream. NO ONE came to help, NO ONE!!"

Rita* described her mother's failure to protect her as being worse than the abuse itself: "my father's abuses hurt me but my mother's complete alliance with him over me has killed me especially since I became a mother" and "[the fact] that she did not step in to shield us hurts beyond words." Becoming a mother influenced Rita's* understanding of her own abuse experiences regarding the failure of her mother to protect her.

2. Description or type of the abuse and neglect.

Nearly all of the participants described the acts or types of abuse and neglect. Participants described their experiences of child abuse to be that of multiple perpetrations of abuse or neglect by one or several persons. Participants described experiences of Emotional and Psychological Abuse, Sexual Abuse, Physical Abuse, and

Emotional Neglect. One participant described experiences of Satanic Ritual Abuse. Participants also reported experiences of family violence. Faye* wrote, "the examples [of abuse] go on and on all through my childhood."

2.1 Emotional and psychological abuse.

Experiences of emotional and psychological abuse were reported. Survivors described feeling manipulated, humiliated, ridiculed, put down, lied to, threatened and verbally abused. Isabelle* wrote, "I was always humiliated…he would just tell me that I had nothing worth looking at anyway." Rita* wrote, "he would ridicule me all the time about my physical self, tell me men preferred women who looked the way I didn't. He would tell me how men thought." Rita* described receiving threats of harm and false retractions of threats of harm, of "being lied to and let down," "emotionally blackmailed" and subjected to "traumatising" silences lasting "as long as 7 days."

Qiana* described her abuser using love and hurt as a "manipulation." Bridget* wrote that, due to her father being "manipulative," she "learned never to trust him and never give him anything…knowing that he could, and would, use it against us if it suited his purpose." Poppy* was told by her abusive parents that she was untrustworthy and hurtful. Faye* described repeated messages from her mother of being "bad," commenting "it must be true because she kept telling me it was true." Kiah* wrote of her mother's "continuous misunderstanding of me and often making fun of me" and of being "laughed at." Stella* described the physical and mental hurt as being "intertwined." Rita* wrote that her father abused her whilst smiling, and that this had a lasting psychological impact: "some smiles I see today terrify me."

2.2 Physical abuse.

Experiences of physical abuse were reported. Survivors described acts of violence and aggression, severe physical punishment and harsh physical discipline. Physical abuse was perpetrated by fathers, mothers and siblings. Physical abuse was inflicted using "hands" (Bridget*) and objects, including "her strap" (Donna*), "belting" (Elle*), "garden hose" (Hugo*), "coat hangers" (Rita*) and "machette" (Stella*). Hugo* described injuries he had sustained from his father's physical abuse: "til [sic] I bled", "I often had the imprint" and "bruise on my buttocks, legs and back." Nina* wrote of fearing physical discipline by her mother: "I would get disciplined physically by my mother a lot and feared this." Stella* wrote of being physically attacked by her mother and physically punished "for no reason" and that her mother was

"always angry and I just happened to be near to vent her anger." Donna* wrote that her mother used physical punishment as "a way to solve problems." Many of the participants' references to physical abuse were graphically descriptive, and several participants recounted specific event(s) of physical abuse to describe what they had learnt from their parent about hurt.

2.3 Sexual abuse.

Experiences of sexual abuse were reported. Survivors described incest, sexual assault and rape. Identified perpetrators included "brother(s)," "uncle," "grandfather," "neighbour," and "men." Several participants recounted specific event(s) of sexual abuse, naming the location "bed," "front verandah," or their age (or age range) at the time(s) of these sexual attacks. Several participants described the setting of their sexual assault. Libby* wrote, "he had been drinking and I managed to get away and hide under the bed" and of a rape that occurred "when my parents were out." Stella* wrote, "he came to where I was sleeping, got on top of me and penetrated me" and that he had "laughed about it." Elle* explained the complexity of her experience of incest by her brother, writing "he never forced me to have sex with him but somehow he always got his way even though I never wanted to do it."

2.4 Emotional neglect.

Experiences of emotional neglect were reported. Survivors described their emotional needs not being met by their parent(s), a lack of parental warmth, comfort or reassurance, and emotional isolation. Alice* wrote that she was "distressed," did not feel listened to or believed by her parents, and her "emotional well-being became completely irrelevant." Donna* described her mother as "neglectful" and lacking in parental warmth, "not through love, or a hug, or a chat." Libby* described feeling ignored, abandoned and uncared for by her mother. Mariah* and Libby* each identified their mother's emotional needs as having priority over their own, with Mariah* describing this as "parentalisation…I was my mother's emotional support." Olivia* and Poppy* wrote of their experiences with their parents involving emotional isolation and absence of comfort. Olivia* wrote that her parents "did not share anything on an emotional level." Poppy wrote she was "not going to be comforted…[or] reassured when hurt either physically or emotionally."

2.5 Multiple abusers.

Experiences of abuse and neglect from multiple abusers were reported. Seven of the 19 survivors described their abuse experiences as being perpetrated by more than one person. Identified abusers included, "mother," "father," "grandmother," "grandfather," "males," "male boarders," "brother," "big brother," "younger brother," "neighbour(s)" and "strangers." Of the number of her abusers, Alice* wrote, "I don't know the exact numbers." Many participants wrote about separate abusers inflicting different types of abuse. For example, Elle* wrote that she was physically abused by her mother, and sexually abused by her brother and male boarders.

2.6 Cumulative abuse and neglect.

Several participants described their experiences of child abuse and neglect as cumulative. They had experienced multiple perpetrations of abuse or neglect by one or several persons. Hugo* wrote, "I might have forgiven them the first time…but not subsequent times…." Faye* wrote, "each time," and "over and over as I was growing up," and "the examples [of hurt] go on and on all through my childhood." Nina* wrote that she had been surrounded by hurt her whole life. Rita* described repeated experiences of threat and harm, "every single time, every single day, all day, of every single year." The experience of hurt was described as constant. Of constant hurt, Rita* wrote, "I hurt continually…I lived, breathed, smelt, ate hurt;" and Stella* wrote, "hurt is expected – it happens all the time" and "all those abuses as a child."

Survivors of childhood abuse and neglect are likely to have experienced multiple traumas (Cloitre et al., 2009). Cloitre et al. (2009) found that, unlike adulthood trauma, childhood experiences of cumulative trauma predicted increasing symptom complexity, where symptoms are not simply more severe but "are qualitatively different in their tendency to affect multiple affective and interpersonal domains" (p.405). Similarly, Putnam et al. (2013) found the interaction of two or more adverse childhood experiences (referred to as synergistic ACES) have a combined effect greater than the sum of their individual effects.

2.8 Family violence: witnessed the abuse of sibling(s), other parent or extended family.

Four of the 19 participants described witnessing family violence. This included: abuse perpetrated towards siblings, "the violence…witnessed towards my brothers and

sisters" (Bridget*); or by one parent toward the other, "I was physically hurt by my father; as was my mother" (Nina*). Nina* reflected further on the hurt her mother felt as a result of parental conflict in her statement, "I also saw the hurt caused by arguing and constant court battles my mother had due to my father."

2.9 Other forms of abuse.

One participant, Alice*, described experiencing a further form of abuse, Satanic Ritual Abuse (SRA). Only barely mentioning this abuse, Alice* wrote, "I was involved in SRA, as well as abuse by neighbours and strangers" and, that "in my other lives my mother gave me over to the Satanists." It is possible that Alice* had previously found disclosing more about her experiences unhelpful. Children and adults who have been subjected to Satanic ritual abuse often face disbelief upon disclosure (Sinason, 2005). Ritual abuse is not contained to Satanists, but also occurs within Christian, Jewish and Muslim faiths (Sinason, 2005).

It is also possible that Alice* could not recall the details. Fuelled by survivors' presentations of dissociative identities and recovered memories, the mid 1980's – 1990's was a time of heated division over the validity of disclosures of ritual abuse (Chu, 2011). However, organised ritual abuse is acknowledged to be real, and "not rare" (Chu, 2011, p. 263).

In addition to SRA, Alice's* disclosure of abuse by unknown "numbers" of perpetrators including "neighbours and strangers" suggests organised abuse. *Organised abuse* refers to childhood sexual abuse perpetrated by multiple adults who conspire together to abuse multiple children (Salter & Richters, 2012). Limited detail in Alice's* statement, however, means it remains not known whether the perpetrators were aware of one another or if there were more child victims. Alice* wrote, "I don't know the exact numbers."

3. Impact of abuse and neglect.

The abuse and neglect were described as impacting on memory, social relationships, mental health, adulthood, and self-concept. These subordinate themes are discussed below.

3.1 Impact of abuse and neglect on memory.

3.1.1 Impact of abuse: impaired, incomplete, repressed memory of abuse experiences or of childhood.

Survivors described impact of the abuse and neglect on memory as including impaired, incomplete, repressed memories of abuse experiences or childhood. In her addition of the words, "never insertion…not that I can remember," Jasmine* gives the suggestion her recollection of her abuse experiences are incomplete or uncertain. Similarly, Kiah* wrote, "the actual abuse which I remember bits of." Stella* wrote that she did not recall some of her abuse experiences and "my [sisters] had to tell me about beatings I couldn't remember." Libby* describes her struggle with childhood memories of abuse, noting "I still have trouble with these memories" and "all my siblings have issues relating to childhood memories." Libby* is clear that her experiences impacted on her even when she was grappling with difficult remembering: "for many years I did not remember my past but it still affected me." Nina* wrote, "I've suppressed majority of my childhood" and "I really don't remember". Nina* also second-guesses herself, writing; "can't remember the details or won't?"

3.1.2 Impact of abuse: lost, unhappy childhood.

Several participants described a lost or unhappy childhood. That the abuse or neglect meant they had missed out on a childhood. Olivia* wrote, "I lost my childhood." About her lost childhood, "Stella" wrote, "my mother's abuse meant we missed out on our childhood. Faye* described having memories of an unhappy childhood from an early age. Rita* wrote that her childhood experience was one of hurt, and was without pleasure or nurture: "I was never a little girl, a teenager. I just lived to fight to live and keep my brothers alive." In writing she "never enjoyed" family events, Rita* provided an example of her unhappy childhood.

3.2 Impact of abuse and neglect on social effects, relating or isolation.

3.2.1 Impact of abuse: impaired relating with others or relationship difficulties.

Relationship difficulties and impaired relating with others was described by almost half of the survivor participants. Participants wrote that their experiences of abuse and hurt led them to become emotionally guarded: "in terms of emotional trust, I was much more guarded" (Alice*); or, rejecting of new relationships, "I don't try to make friends anymore" (Isabelle*). Other participants described wanting, but being unable to make lasting friendships and relationships as a result of their abuse

experiences: "[the abuse] affected me, my ability to make lasting friendships and relationships" (Libby*).

Nina* described feelings of being socially excluded at the time of her abuse and neglect, "I felt the pain of being excluded from my people at school as no one was experiencing what I was… I ended up trusting the wrong people and misread situations" and "I lost majority of my friends." Nina* also described not learning how to form and maintain friendships, "personally felt I've always had problems/ anxiety in terms of relationships and feeling like I don't know what I'm doing" and that it was "even more difficult to keep friendships."

Qiana* described her social experiences in adulthood as being limited, writing, "I don't have relationships…I don't have many friends – they are mostly acquaintances." And that, to date, these difficulties with relationships had prevented her from having a boyfriend or even "a date." Rita* identified that past messages and manipulations used during childhood abuse by her abuser were still affecting her ability to form relationships: "he would tell me how men thought…still in my head and affect all my relationships." Rita* wrote that the effect of her abuse experiences on diminishing her self-concept continues to impact on her relationships in adulthood: "relationships with EVERYONE are difficult. Constantly feel ugly, unlovable, alone" and, "[you] don't enjoy your own sexuality."

3.2.2 Impact of abuse: isolation or feeling alone.

Feelings of isolation or feeling alone as a result of abuse and neglect experiences were commented on by several participants. Alice* wrote that she was alone in her hurt: "I was alone in mine." Donna* wrote she had "no one to talk to." Stella* described that as a child, she was rejected by others due to the abuse she experienced: "nobody was allowed to play with us…We were rejects." Olivia* described an experience of isolation: "I became a loner." Libby* described this isolation extending through her adult life and preventing relationships: "I have spent most of the last 10 years living on my own and do not go out to meet men socially, am too shy and unwilling to put myself out there."

3.3 Impact of abuse on mental health.

3.3.1 Impact of abuse: participant mental health problems.

Mental health problems were identified as an impact of the abuse and neglect experiences, with many of the participants making references to symptoms of trauma

including flashbacks, reliving the abuse, splitting, self-harm, suicidal thoughts or attempts. Participants also reported diagnosed or undiagnosed mental illness, including Post-Traumatic Stress Disorder, Borderline Personality Disorder, Dissociative Identity Disorder, Anxiety, Depression, Bipolar, Eating Disorders, and Post-Natal Depression. Camira* wrote, "I was diagnosed with Borderline Personality Disorder… I used to self-harm regularly (cutting arms) and have had multiple serious suicide attempts. I have also had a fluctuating eating disorder." Olivia* wrote, "I had undiagnosed dissociation which was borderline D.I.D." and "I…often had suicidal thoughts." Donna* wrote, "I was diagnosed…with PTSD" and treated with "antidepressants."

3.3.2 Impact of abuse: sibling mental health problems.

Two participants, who did not write about their own mental health, described the mental health of their siblings. Bridget* wrote, "the impact of childhood violence at the hands of our father has had a significant impact on the mental health of some of my brothers and sisters." Similarly, Libby* wrote that her siblings had been treated for depression. Siblings may have all experienced similar childhoods, or had different experiences of their parents and others for any number of reasons, such as gender or age. The brief comments made about siblings' mental health by participants in this study suggests the impact of abuse and neglect may have different outcomes across siblings.

3.4 Impact of abuse and neglect: ongoing effects in adulthood.

3.4.1 Ongoing impact of abuse (into adulthood).

Participants reported ongoing negative effects in adulthood attributed to their abusive childhood experiences, including daily intrusions, triggers and reliving the abuse. Bridget* wrote, "[the abuse] has caused me significant stress and anxiety which still has an impact on me to this day." Rita* wrote that her abuse experiences had caused "lifelong effects" and that she lives in ongoing fear of attack and harm: "I still live with fear –fear of attack even (and especially) in my own home." Rita* does not actually experience ongoing attacks: "it doesn't happen but I still feel fearful". Rita's* fear, however, -- arising from her childhood experiences -- makes her anticipate harm in daily interactions with others: "I still wonder…what are they going to do next?"

Elle* and Nina* both described the hurt of abuse as lasting into adulthood: "hurts from my childhood linger still" (Elle*). Kiah* described ongoing emotional triggers, of being "easily triggered," and that these triggers return her to the emotional

state of when she was being abused: "there are so many emotional triggers which send us back into child behaviour's [*sic*] mode – the victim or the pleasing or the peace maker etc." Libby* described ongoing efforts to overcome the impact of painful experiences in both her childhood and adult relationships, that she is "trying to forget…until a trigger reminds me."

3.4.2 Impact of abuse and neglect on functioning in adulthood.

The lasting effects described had significant implications for the participants daily functioning. Rita* shared her experience of the sequelae of childhood trauma on adult relationships and daily functioning:

> I am 50 and still need counselling. It has been very difficult raising children... Emotional abuse is so devastating it wrecks chances of happiness... Relationships with EVERYONE are difficult. Constantly feel ugly, unlovable, alone. I've attempted suicide. You feel VERY GUILTY if you hate your parents... I still live with fear …Wrecks physical health - sleeplessness, insomnia, ... Lifelong effects.

Libby* wrote that the childhood and abuse experiences in her "dysfunctional family of origin" negatively affected the functioning and relationships of her whole family. Libby* also wrote that her trauma history led her to "an abusive marriage" and "very bad lifestyle choices". Mariah* described the hurt damaging and impairing her functioning ("each person hurts because there is a part of them that has been damaged or is not functioning properly"). Mariah* describes herself as "crippled by hurt" and "walking wounded". Stella* describes grief over her "inability to work in paid employment", "a loss of destiny", and feelings of "uselessness and helplessness". These effects on adult functioning described by survivor participants are pervasive and profound, impacting their relationship with themselves and the way they are able to relate with and to others, as well as their daily lives.

3.5 Impact of abuse and neglect: self-concept or other themes.
3.5.1 Impact of abuse and neglect – other themes.

Other, varied, impacts of abuse and neglect were described, including "distress" (Alice*), or hypersensitivity to violence: "I am still overly sensitive to violence of any kind" (Hugo*). Qiana* noted that she had resided for a period of her childhood in state

care. Hugo* and Kiah* wrote that due to their experience of abuse they had left home at a young age, "I left home as soon as I could" (Hugo*). Libby* wrote that, due to her hurts in childhood being ignored, she had difficulty triaging her own hurts: "I have had the same difficulty forever about knowing exactly when it was ok to say that I'd been hurt, or was I just whinging? What is important?" Hugo* wrote that his sister had suffered and died in adulthood "as a result of our stupid violent upbringing."

3.5.2 Impact of abuse and neglect on self-concept.

The experience of abuse, for some, became internalized, disrupting identity formation and undermining self-concept. Faye* wrote, "Could I really be that bad? I didn't think that I was that bad but it must be true because she kept telling me it was true." This was earlier also detailed as a report of emotional and psychological abuse. Impacting her self-concept, the repeated messages Faye* heard from her mother about being bad were internalized to the point she was unsure of herself. As if to prove herself, Faye* provided examples from her early childhood, writing also that she seeks to have these memories be "confirmed" by others.

The concept of being a "bad girl" was continued in Olivia's* account. Olivia* internalised blame for her abuse experiences, writing, "I hated myself…I was a bad girl." Olivia's* messages from her parents "'do not feel,' 'do not think'" further contributed to a loss of self in which she "could not trust" herself. Olivia* described a complete loss of self in experiences of "dissociation" and later in Dissociative Identity Disorder, "D.I.D."

Rita* described feeling "ugly," "bad," self-hating and a loss of self and identity, "who am I? What do I like to do?" Rita's* experiences of abuse impacted on her body image, "I feel ugly around women, ugly around men," and enjoyment of her own body, "don't enjoy your own body, don't enjoy your own sexuality." Libby* wrote, "my childhood experience has left me unfinished and on the border of childhood and adulthood."

4. Age of abuse experiences.

More than half of the participants included references to their age (or age range) at the time of some of their abuse experiences. Ages mentioned included: "about 2 years old," and "nearly 3 years old" (Faye*); "from age 5 to10 (approx.)" (Jasmine*); "I was

6" (Libby*); "I would have been just eight" (Stella*); "I was 8 or 9…very very [*sic*] young" (Hugo*); "I was abused from 12-18 years of age (Olivia*); "at the age of 14" (Donna*, in reference to additional abuse). Age of abuse experiences appears in participants' statements as important to describing the position they had held, being children exposed to abusive or neglectful adults. Alice* goes into detail of periods of time when particular abuse, and reactions to the abuse, were experienced, for example "small child. (I did much splitting at this time)." Bridget* comments that the "childhood violence" had stopped when she was older: "[he] only backed off when we became old enough." For Nina*, the abuse did not stop as she got older, and her exposure to hurt was "pretty much my whole life."

5. Protections: self-protective or protective behaviour.

Instances of self-protective behaviours at the time of the abuse included, suppressing emotions, restricting sharing of information, keeping quiet, becoming passive, "splitting" (Alice*), or "pretend[ing] to be someone else" (Hugo*). Both Hugo* and Nina* described seeking to avoid punishment as a child through lying. Rita* wrote that she not only protected herself, but also her siblings: "I just lived to fight to live and keep my brothers alive." Bridget* wrote she had suppressed her emotions to avoid being manipulated by her abuser: "I learned never to allow him to hurt me…emotionally…by never showing any emotion that he could use to get at me in any way." Bridget* also described standing up to her abuser "as a teenager" when she "became old enough to stand up to him physically" and sophisticated enough to "threaten to raise my voice so neighbours would hear what was happening."

Participants described protective behaviours they now employ as adults, including having no contact with the abuser, restricting sharing of information with parents, distancing self from close family, blocking out the trauma, avoiding further opportunities for abuser to re-abuse. Mariah* used preventing further opportunities for abuse by the realization that "some people are simply not very trustworthy" and that it would have been "ridiculous and foolish" for her mother to have left "us alone in his care [again]." Mariah* described how her mother (also a survivor of child abuse and neglect) had acted protectively of her own children. Mariah* used the psychological defence of blocking out trauma during childhood: "I learnt the power of the human brain to block out trauma in early childhood in order to preserve self," but commented

that, "hurt, if suppressed, will always re-surface." As an adult, Bridget* described having set herself protective boundaries by having "no contact with my father." Bridget* protected herself in placing the responsibility for childhood harm with the abuser: "I am not responsible for my father or his behaviour." This placement of blame with the abuser negates false ideas of self-blame for any part of the abuse, reaction or lack of reaction to the abusive events, and highlights the complex nature of the relationship with the abuser (Courtois, 2014).

6. Explaining hurt or abuse

Many excuses were offered for the abuser and the abuse. These are detailed below.

6.1 Parenting or relationship with parent.

Participants described their experience of being parented to explain the hurt or abuse. Bridget* described not-good-enough parenting. Hugo* wrote that the abuse had ended his relationship with his parents. Hugo* described not being able to confront his parents about their abuse, but also not being able to dismiss it in terms of different societal expectations of parenting. Nina* described hurt from her mother's parenting, which had included "disapproval, disowning, doubt, lack of trust and faith in my abilities." Rita* wrote that she felt unloved by her parents and that in her family love was pain. Kiah* wrote of a lack of relationship with her mother, "the relationship I never had with my mother." For Kiah* this lack of relationship is confounded by her inability to communicate with her mother about her sexual abuse by an extended family member: "I could not tell her anything and she never gave me an opportunity to talk." Kiah's* statements identify her mother as emotionally abusive, but focus on the hurt and regret at this lack of relationship: "if only she had asked the question to open my heart, but she never did."

6.2 Excusing the abuser or the abuse.

Excuses were given for either the abuser or the abuse. Several participants referred to one or both of their parents as having their own child abuse history or other trauma or mental health problem that affected them as individuals and as parents. For Hugo* and Stella*, the knowledge of their parent's war experiences provided an explanation of their parent's behaviour towards them. Mariah* wrote of her mother's own abuse and post-natal depression. Elle* and Stella* both wrote that their abusive

parent had not meant to hurt them. Nine separate entries on this topic came from Stella*'s account, including Stella's* minimization of the abuse from her mother: "it happens all the time. It was character building. Helped me develop resilience, courage and strength to save myself from feeling pain." Stella* also provided excuses for and minimized the harsh parenting she had provided her own children.

7. Powerlessness and vulnerability.

7.1 Powerlessness and vulnerability to abuse by others as an impact of abuse.

Several participants described powerlessness and vulnerability as a result of the abuser being a family member or caregiver and of being a child abused by adults. Olivia* wrote that she was vulnerable to abuse, "I was a child in need and believe I was preyed upon," and she wrote that her abuser was in a position of power. Isabelle* described continued feeling of vulnerability to hurt from others: "if you open yourself up to people you could get very badly hurt." Jasmine* described being unable to retaliate: "I cannot hurt them back because that would mean I am a bad person." Stella* described being powerless due to feeling owned by her abusive parent. Stella* described her vulnerability to abuse by others, noting multiple other abusers.

In their longitudinal study into childhood re-victimisation patterns, Finkelhor, Ormrod, and Turner (2007b) looked at multiple types of adverse experiences (or victimization exposures) including child maltreatment. The researchers found that children who have been "victimized" have a 1.9 - 6.8 times higher risk of "re-victimization" (p. 489). Finkelhor et al. (2007b) also found that victimization of one type can "create a vulnerability to other kinds of victimization" (p.489). A history of childhood maltreatment is a risk for further childhood maltreatment, adult victimisation and vulnerability to poorer psychological wellbeing (Anda et al., 2006; Miron & Orcutt, 2014; Nurius et al., 2015).

8. Responses to abuse and neglect

8.1 Self-destructive behavioural responses to abuse

Self-destructive behavioural responses to abuse were reported by several participants. Acting out was used both as a cry for help and to express oneself. Seeking her mother's attention and assistance, Kiah* wrote, "I wish she had confronted me and

asked me why I was acting out but it never happened." Kiah* wrote that she "wasn't believed – I started to lie about everything." In the face of abuse and neglect, Kiah* described difficulty regulating own emotions and behaviour as a child, and that she had "learnt to behave inappropriately." Acting out was used in the absence of other options: "acting out was the only way of expression but it did not really work either" (Kiah*).

Olivia* and Mariah* describe self-destructive behaviours arising from their own or their mother's experience of child abuse. These behaviours included promiscuity, seeking validation from men, and binge drinking. Robinson (2000) described strategies that undermine safety or perpetuate harm of self as being acts of surviving. These, and other self-destructive risk behaviours are not uncommon for survivors of childhood maltreatment (Mammen, 2006). van der Kolk (2014) noted that these behaviours may be an attempt to feel better, to a separation of awareness within physical sensations in the body, or attempts at trauma symptom reduction.

8.2 Enacting hurtful or abusive behaviour to others.

As shown in Table 2, four participants described hurtful or abusive behaviour to others. Hugo* wrote that his sibling responded differently to the abuse they both experienced from their parents, and that his sister had "followed their lead" becoming abusive. Nina* wrote that she learnt from her parents to hurt people you get close to. Mariah* and Kiah* reflected more generally on survivors of childhood abuse, commenting that abused people abuse others. Kiah* wrote that victims hurt others through sexual promiscuity, or hurting family or friends, concluding "one victim and an exponential number of people being hurt."

Hurtful acts by individuals towards others in the wake of their own trauma have previously been recorded elsewhere. Writing about his work with Vietnam War Veterans suffering with PTSD, van der Kolk (2014) recounted disclosures by veterans of acts of brutal and uncharacteristic violence following exposure to overwhelming situations of trauma.

8.3 Disclosure of abuse and neglect.

Following disclosure of abuse or neglect, supportive responses by the non-maltreating parent has been identified as protective of subsequent negative psychosocial outcomes (Godbout, Briere, Sabourin, & Lussier, 2014). Only two participants mentioned disclosure of abuse and neglect. Kiah* wrote extensively about her experience of disclosure. Kiah* wrote that, as a child, after disclosing to her father

abuse perpetrated by a member of her wider family, she had felt let down that he did not act on or pass on her disclosure. Kiah* wrote that this silence following her disclosure significantly impacted on her relationship with both of her parents into adulthood: "I have mixed feelings about what was worse – the actual abuse…or the lack of validation and discussion about it with my parents."

Elle* wrote that her participation in this research was the first she had told anyone of her childhood abuse and neglect. There are multiple reasons that can lead to disclosures of abuse being delayed or withheld. For example, disclosure may be prevented when the perpetrator is a significant caregiver. Issues of attachment and maintaining the family unit confound the child's capacity to seek protection (Alaggia, 2004).

9. Blame and Shame.

9.1 Feelings of guilt, fault and blame.

Participants used words that expressed feelings of guilt, fault or blame. Rita* expressed guilt at hating her abusive parents. Donna* wrote about feeling at fault and blamed by her parents during childhood. Libby* expressed guilt about her use of lying, which had arisen in response to not being believed: "I felt guilty about lying but also guilty about telling the truth." Elle* ascribed self-blame for not taking better care of her abusive mother, scolding herself and referring to herself as "Bad daughter!"

9.2 Shame at being abused.

Two participants described shame at being abused. Olivia* wrote, "I hated myself and always thought I had done something wrong…I was a bad girl. I was shame [*sic*]…it felt good yet I knew it was wrong." Stella* wrote that she felt shame and embarrassment at her abuse being overheard. Neighbours and others knew of her mother's abuse, and Stella* wrote, "…we grew up ashamed of ourselves. We walked with heads down."

9.3 Shame at failing own parenting expectations.

Shame at failing her own parenting expectations was referred to several times by Stella*. Stella* described shame when she did not meet her expectations of herself and uphold her promise to parent her own children differently: "I was ashamed I was smacking because I remembered my promise to protect my children and not to ill treat them."

10. Addressing the hurt.

10.1 Addressing or dealing with the hurt.

Addressing or dealing with the hurt was described. Participants wrote that pain is "to be avoided" (Donna*), but once hurt has occurred, holding onto hurt is "destructive" (Camira*) and impedes "healing" (Mariah*). Mariah* wrote that hurt resurfaces if suppressed and "is harder to deal with the second time around." Mariah* also wrote, "hurts can be healed" and "hurt people often just need to be heard…[and] validated."

10.2 Abuse and forgiveness.

Two participants wrote extensively about abuse and forgiveness, expressing some contrasting messages – Hugo* wrote, "repeated abuse cannot be forgiven." Mariah* wrote about forgiveness being essential, supporting healing, but that forgiveness does not equal trust.

Summary: Participants' Descriptions of Hurt

Hurt was the most written about theme. The large number of statements made by participants in this study about hurt signifies the importance of hurt to survivors. The traumatic effect of abuse was described as being maintained through the abusers' use of power, threats, manipulation or fear of further abuse.

Sexual and physical abuse is more studied in the empirical literature than other types of abuse, but the participants regarded all types of abuse and neglect as having a negative effect on their lives. Emotional neglect seemed to be still a live issue with participants who were struggling with why that should be so. They seemed less distant from the past emotional neglect and preoccupied by the question of what is it about me? Why me? They seemed unable to move from this point.

Parental responses to the hurt, whether it be disclosure or missed opportunities for protection, remain with the participants as alive and present responses. The hurt was not just the abuse, but incorporated the response of parents and others to the abuse.

Abuse was described as impacting across multiple domains of functioning and relating with others. Participants were active in their attempts to describe their experiences and appeared troubled by incomplete memories of parts of childhood or of the abuse, whether resulting from the suppression of traumatic events or young age.

Participants' Descriptions of Healing

Participants' responses about Healing were grouped into 16 themes falling under six super-ordinate themes: 1) Support in healing; 2) Did not learn from parent about healing; 3) Healing is slow, difficult and ongoing; 4) Healing is possible, signs and messages about healing; 5) Healing, forgiveness and the parent-child relationship; and 6) Age and healing. Table 3 lists the super-ordinate and sub-ordinate Healing themes. Refer to Appendix G for further detail. The Healing themes are discussed following the table.

Study 3: Table 3

Super-Ordinate and Sub-Ordinate Healing Themes

#	THEME	Total No. (out of 19)
T16	*HEALING*	19
1	**SUPPORT IN HEALING**	**12**
1.1	Professional support in healing.	9
1.2	Support from others in healing.	5
1.3	God/ religion/ spirituality in healing.	4
2	**DID NOT LEARN FROM PARENT ABOUT HEALING**	**11**
2.1	Did not learn anything from parent(s) about healing.	9
2.2	No role for the abuser in healing.	2
3	**HEALING IS SLOW, DIFFICULT AND ONGOING**	**10**
3.1	Healing is slow, takes time.	7
3.2	Healing is difficult, takes effort, (and is not always possible).	6
3.3	Healing is a journey, and ongoing process.	6
4	**HEALING IS POSSIBLE- SIGNS OF AND MESSAGES ABOUT HEALING**	**9**
4.1	Things that promote / assist healing.	8
4.2	Signs of healing.	3
4.3	Healing is possible	2
4.4	Conflicting messages about healing.	2
5	**HEALING, FORGIVENESS AND THE CHILD-PARENT RELATIONSHIP**	**7**
5.1	Forgiveness and healing	4
5.2	Attempts to heal relationship with caregiver.	2
5.3	Healing was not permitted.	1
6	**AGE AND HEALING**	**3**
6.1	Healing can take place in adulthood.	3
	TRUST, HURT, *and* HEALING	1

1. Support in healing.

1.1 Professional support in healing.

Almost half of the participants reported having accessed psychotherapy in relation to their abuse experiences. These nine participants all reported therapy with professionals had supported them in healing. Nina* and Olivia* wrote that their

experience of counselling was "healing and "very helpful." Kiah* wrote, "I was lucky to find a good psychologist and we focussed on re-training. Identifying triggers, putting things in context, letting go of emotions - grieving in a lot of ways - becoming aware, and moving on." Kiah* also wrote about the timing of therapeutic intervention, recommending that therapy needs to occur as soon as possible to bring better outcomes. Libby* wrote about developing trust in a long-term therapist and also having a positive experience of therapy as a "safe place." Libby* noted that although she is "taking medication still," "psychotherapy has been invaluable in keeping me out of hospital and helping me to manage my issues." Stella* wrote that she attends regular long-term psychotherapy and has less trauma "due to great psychologist/ medical team."

Donna* wrote about having "decades of" difficulty getting good professional help: "some psychs [*sic*] are arrogant idiots who shouldn't be allowed to practice – others are just incompetent." Despite her negative experience with professionals, Donna* eventually found competent professionals to support her healing: "I have received fantastic support from a strong [*sic*], intelligent psychologists and my GP since then."

In supporting individuals' healing from abuse, Robinson (2000) advised that "counsellors need to be well, psychologically and emotionally" (p. 175). Treatment for complex trauma requires specific knowledge that is not necessarily within the skills set of generalist professionals. Professionals in this area require competent understanding of the developmental impact of complex trauma and up to date knowledge of best practice therapeutic interventions. In Australia, the support and advocacy service, Adults Surviving Child Abuse (ASCA) have published practice guidelines for the treatment of complex trauma (Kezelman & Stavropoulos, 2012). These guidelines raise awareness about complex trauma and inform policies, programs and interventions.

1.2 Support from others in healing.

Other types of support for healing described include support and understanding from a partner. Pets provide a source of meaning in life. Faye* wrote of "some very understanding and wonderful people who have stood by me." Similarly, Nina* wrote that "talking to trusted friends" supported her healing. Isabelle* wrote that her non-abusive parent assisted in her healing. Stella* wrote of having significant others witness her healing. Kiah* wrote of accessing local resources for healing and support: "as a

society I think it is important to help the victim." For Kiah*, "rather than try to rehabilitate the paedophile", support needs to be for the child victim and the family.

1.3 God, religion or spirituality in healing.

Several participants described their faith in God as being a part of their healing journey. "Mariah" wrote, "God plays a big role in the healing process." Libby* wrote that she found "comfort in church." Isabelle* wrote that her faith in "God helped me heal." Expressing a different view, Hugo* wrote that religion does *not* support healing: "to heal – the superficiality of religion is no use…so hypocritical…!!!" Coming from a violent upbringing, Hugo* explains his position thus: "the Catholic religion celebrates and glorifies violence every day!!"

2. Did not learn from parent(s) about healing.

2.1 Did not learn anything from parent(s) about healing.

In response to the question, what did you learn from your parent about healing, almost half of the participants wrote that they did not learn anything about healing from their parent(s). Georgia* kept her response short, writing only, "nothing at all." Other participants expressed a similar view: "I learned nothing about healing" (Rita*); "I did not learn much about healing at all" (Faye*); and, "I am not sure I can think of anything in relation to healing and my parents" (Poppy*). Jasmine* explained that she had "not learnt healing," as her early caregivers had moved overseas and her abusive caregiver was "long dead." Nina* wrote that she learnt not to rely on her mother for healing: "I wasn't satisfied with turning to my mother for help with resolving issues." Libby* wrote about the absence of healing: "there was none." For Libby*, growing up in her family, nothing was healed or resolved: "No one said 'sorry' or 'please forgive me' in our house; as kids we weren't allowed to fight or solve our grievances – nothing was healed or resolved. As I said before: it was all swept under the carpet!"

2.2 No role for the abuser in healing.

Two participants wrote that there was no role for the abuser in healing. Bridget* wrote that her relationship with her abuser cannot be healed or repaired: "The relationship between myself and him has never been repaired and never will." In response to the question about healing, Bridget* wrote that she had "no need to attempt to have any kind of relationship with him," indicating that her healing does not need to involve her abuser. Stella* described her attempt to involve her abusive mother in her

healing as an adult. Stella* wrote that confronting her abuser was not healing, as her abusive mother trumped her with an account of her own abuse experiences: "I wrote one letter telling mother how she hurt me when we were young. I did this because my sister told me she's being victimized by mother again. This thought was short-lived – when I heard about her own experiences."

3. Healing is slow, difficult and ongoing.

3.1. Healing is slow and takes time.

That healing is slow and takes time was the message of participants who described their healing journey. Words used to describe healing included, "it took me ages to heal" (Hugo*), and "it has taken a long time" (Faye*). Olivia* wrote, "emotions take longer to heal…only as an adult could I begin to process issues from my childhood." Two participants wrote about slow healing involving years of counselling: "I have gone to counselling for 20 years…I am 50 and still need counselling" (Rita*); and "I am in recovery – 12 years in therapy and counting" (Libby*). Kiah* wrote, "it's been 20 years now since the disclosure" and "the changes are slow." Isabelle* wrote that once she was safe, her healing had been incremental: "It has been 8years since the DVO, every-year I have improved." Isabelle* refers to a DVO, or Domestic Violence Order. This is a Protection Order, known by varied terms in different states in Australia – in Victoria, this type of order is known as a Family Violence Intervention Order (Commonwealth of Australia, 2009). Protection Orders are made by a Court of Law, and commonly have conditions to restrict the respondent (abusive party) from having contact with, or otherwise harming, the aggrieved family member (Commonwealth of Australia, 2009). Isabelle* indicates that the order was made against her father, whom she described as "abusive" and "manipulative".

Safety from threat and fear of future harm, such as the "DVO" referred to by Isabelle*, is a necessary prerequisite for healing (Courtois, 2014; van der Kolk, McFarlane, & van der Hart, 1996). Complex trauma therapeutic treatment models start with establishing safety and self-care before any work on traumatic memories (Chu, 2011; Kezelman & Stavropoulos, 2012). Survivors and therapists desire to speed through the first stage (Herman, 1997). However, this first stage of therapy takes time: "recovery, like a marathon, is a test of endurance, requiring long preparation and repetitive practice" (Herman, 1997, p. 174).

3.2 Healing is difficult or takes effort (and is not always possible).

Time was reported to allow, but not necessarily produce healing. Olivia* wrote, "time does not necessarily heal." Participants described healing as difficult, "[healing] is really difficult for a lot of people," (Nina*) or as taking effort, "effort in healing…I made some conscious effort" (Alice*).

Alice's* statements about healing were conflicting messages about it never being too late to heal: "it is never too late to start facing and dealing with such things," and not to hope too much for healing, "I also learned to not hope too much." Libby* wrote about giving up hope for healing (by being able to cry), "I've given up hope of them ever being shed."

Several participants wrote that healing – for *other people* - is not always possible. Nina* wrote that her mother was unable to heal: "I don't think it is possible for my mother to heal the wounds my father made." Alice* wrote that her mother had made effort to heal, but did not achieve healing: "she died without making a great deal of headway (or so it seems) after years of struggling." Hugo* wrote about a girlfriend who had never healed from her childhood abuse experiences: "she [girlfriend] never healed…from her early defining abuse experiences…20 years later…she was in an abusive relationship."

3.3. Healing is a journey or an ongoing process.

Participants wrote about healing being a "journey" or an ongoing process. Olivia* wrote, "I sought help and began a journey of counselling." Mariah* wrote, "the healing continues, in small little things, as layers of hurt are revealed they are healed." Kiah* wrote that disclosing her abuse, "was the beginning of my journey…this first step was the most important step," also that, "healing is a journey." Libby* described healing as a "long journey" and expressed "hope" for the future, and that, with healing, she would form positive relationships and friendships. Rita* wrote about her healing involving both progress and lapses, "getting better i.e. coming out of Dissociation but keep going back in."

4. Healing is possible: signs and messages about healing.

4.1 Things that promote or assist healing.

Participants wrote about things that promote or assist healing. Nina* described moving away from healing strategies "of the medical or psychological kind," in order

"to find other ways that provided me to get or feel better." Nina's* "other" healing strategies included music: "music was healing for me as it made me happy and distracted." She used emotional eating: "I emotionally ate, which indirectly was healing – whatever helped me relax."

Space from parents and boundaries with family members were described as assisting healing. Qiana* and Camira* identified that "separating myself from my parent" and "space from communicating with a parent" assisted their healing. For Alice, healing was promoted by establishing boundaries: "relationships can improve if you stand firm and insist on accountability to some extent…I have refused to put up with angry and rude outbursts." She was "open" with family members. Presenting a different view, Jasmine* wrote that her healing was assisted by significant others "understanding" her and being able to "understand my pain." Stella* wrote that empathizing with her abuser's own history of abuse and trauma brought "healing." Stella* wrote that her counsellors had encouraged her to use "volunteering" as a positive use of energy.

Hugo* wrote that listening to survivors of abuse assists their healing. Isabelle* wrote that identifying herself as a survivor promoted healing: "the thing that healed me the most is the greatest decision I made, which was to stop acting like a victim and start acting like a survivor."

4.2 Signs of healing.

As shown in Table 3, three participants described some of their signs of healing. Healing was described by Isabelle* as meaning that she has fewer flashbacks, less anxiety and fear, and can start "to live life without fear." Kiah* wrote that healing is feeling "stronger within and much better armed to put myself in vulnerable situations," and being "less paranoid." Stella* wrote that healing (during childhood) was the temporary relief felt when her other (non-abusive) parent was present. For Stella* a sign of healing (as an adult) was decreased trauma: "trauma – not so much in the past 2 years due to a great psychologist/ medical team."

4.3 Healing is possible.

Statements about healing being possible were made by Hugo* and Mariah*. Mariah* wrote, "I know that hurts can be healed" and "healing is always possible." Hugo* wrote, "People can and will heal…I can and have."

4.4 Conflicting messages about healing.

Statements by Stella* and Camira* provided conflicting messages about healing. Camira* wrote that she had recovered, but retains suicide as an option: "I…now consider myself recovered although I always remember that option B (suicide) is there if needed." Stella* wrote, "I learned that hurt could heal" through behaving in ways that were "appreciated" by her abuser, and "I healed by being obedient…"

5. Healing, forgiveness and the child-parent relationship.

5.1 Forgiveness and healing.

Participants wrote about forgiveness in the context of healing. Libby* was clear that she was seeking to forget rather than forgive: "I won't ever forgive but am trying to forget, until a trigger reminds me." For some participants, forgiveness was necessary for healing: "you have to forgive to heal" (Elle*), or "I had forgiven her…I am healed" (Stella*). In addition to writing about forgiveness by her mother, Stella* wrote that she was seeking forgiveness from her children: "I started plying my four children (now adults) with messages of apologies for any mis-or maltreatment they received from me." Kiah* wrote that she needed to be forgiven by her mother: "I panicked but when I finally talked to her and realised **…** She understood my behaviour then and forgave me. I could not have asked for anything better." Nina* wrote about forgiveness being important, but not always possible: "forgiveness is important and I feel I do and have done my best to do so," and "I know my mother can't [forgive]."

5.2 Attempts to heal relationship with caregiver.

Alice* and Jasmine* wrote about their attempts to heal their relationship with their parent. Jasmine* wrote that her relationship with her mother had changed as she had become and adult, allowing for healing: "I did most healing with my mother…she was able to understand my pain as opposed to before when I thought she did not understand at all." Alice* made a distinction between healing (of herself) and repairing of the relationship with her parents, "healing can be thought of as being at a personal level and at a relational level." Alice* expressed a self-expectation that repairing her relationship with her parent was "the right thing to do."

5.3 Healing was not permitted.

Qiana* wrote several statements indicating that her experience was one where healing was not permitted. Qiana* wrote that healing requires acknowledgment of hurt,

and no such acknowledgment was made: "I couldn't acknowledge hurt so how could healing be attempted or acknowledged? Healing would imply hurt had taken place." Qiana* wrote that her other parent had viewed Qiana's* help-seeking as a personal attack: "like I was attacking her…and accusing her of not doing anything to help me." Qiana* wrote that as a result she had sought healing in secret, "So I also hid healing" and "I felt like I had to get help in secret."

6. Age and healing.

6.1 Healing can take place in adulthood.

Age or adulthood was linked with healing, with three participants writing that healing can take place in adulthood. Alice* wrote about healing, "…when I was nearly 30. I learned that it is never too late to start facing and dealing with such things." Olivia* and Faye* wrote about healing "as an adult." Olivia* described adulthood as bringing a freedom to "express" hurt and "process issues from…childhood."

Summary: Participants' Descriptions of Healing

The participants' experiences of healing were varied. Some identified healing as possible, but more likely to occur in adulthood. Participants, who accessed supports for their healing, whether they were professional, social or spiritual, described a more positive stance towards their own healing. Healing did not need to involve a repairing of the relationship with the abuser or, with some, the other parent.

Nobody used the word *hope*, but statements about healing seemed to embody a sense of hope. Healing might be difficult, but they were not shut off from the possibility of achieving it.

Participants' Descriptions of Relationships and Functioning

Participants' responses about Relationships and Functioning were grouped into 16 themes falling under six super-ordinate themes: 1) Family relationships; 2) Resilience/ positive outcomes; 3) Family of origin mental health; 4) Intergenerational continuity; 5) Other; and 6) Family functioning. Table 4 lists the super-ordinate and sub-ordinate Relationship and Functioning themes. Refer to Appendix F for further detail. The Relationship and Functioning themes are discussed following the table.

Study 3: Table 4

Super-Ordinate and Sub-Ordinate Relationship and Functioning Themes

#	THEME	Total No. (out of 19)
T26	*RELATIONSHIPS & FUNCTIONING*	19
1	**FAMILY RELATIONSHIPS**	**12**
1.1	Relationship with other parent.	6
1.2	Love, warmth and affection.	5
1.3	Relationship with siblings.	5
1.4	Relationship with abusive parent(s).	4
1.5	Excusing, explaining other parent/ defending parent behaviour.	3
1.6	Family-of-origin dynamics	2
1.7	Parent continues not to recognize, acknowledge the abuse and neglect.	2
1.8	Boundary issues impair ability to make and retain friendships	1
1.9	Splitting good and bad	1
1.1	Separation/ individuation	1
1.11	Conflicting messages about current support from family.	1
2	**RESILIENCE/ POSITIVE OUTCOMES**	**12**
2.1	Resilience	7
2.2	Positive relationships in adulthood	5
2.3	Presence of positive significant others in childhood (& absence of support)	4
2.4	Identifying as a survivor of child abuse	4
2.5	Helping other survivors of abuse/ comments on other survivors	3
3	**FAMILY OF ORIGIN MENTAL HEALTH**	**11**
3.1	Caregiver mental health.	9
3.2	Cultural taboos about mental illness.	1
3.3	Abuser had mental illness.	1
4	**INTERGENERATIONAL CONTINUITY**	**9**
4.1	Intergenerational abuse, functioning, parenting.	6
4.2	Intergenerational discontinuity	5
5	**OTHER**	**8**
5.1	The questioning self/ search for meaning	4
5.2	Age/ time periods	3
5.3	Telling experience/ being listened to/ participation in this research project	2
6	**FAMILY FUNCTIONING**	**6**
6.1	Adverse family functioning – adulthood	6
6.2	Comment on functioning	1

Super-Ordinate and Sub-Ordinate Relationship and Functioning Themes

1. Family relationships.

1.1 Relationship with other parent.

Participants wrote about their relationship with their other (non- or less-abusive) parent. Several participants wrote about the hurt of abandonment by the non-abusive parent. Olivia* wrote of the absence of her other parent as he was "away [with work] most of the time" and of feeling "devastated" when he had "died when I was 16." Libby* expressed abandonment at her other parent dying when she was a child, "my father let me down badly when he died prematurely – I was just beginning to get to know him."

Both Nina* and Qiana* acknowledged that their other parent was hurt by their abusive parent. Qiana* wrote of her childhood relationship with her mother, during which time both she and her mother had lived with abuse from Qiana's* father. Her experience included providing for and protecting her mother from her abusive parent, seeking allegiance with her mother, and eventually escaping together with her mother. Qiana* gave examples of her actions to care and protect her other parent, including: "getting food for us and hiding it in my room," and "sometimes I had to protect my parent and I actively got involved (eg pushing them apart…)"

Qiana's* experience was that her other parent fell apart emotionally during the abuse, leaving her wishing for her mother to be collected and strong: "I wanted to do everything to put the parent back into one solid strong piece." Qiana* sought allegiance with her other parent, "I thought this made my [other] parent and I unified against…the bad one." Her mother was unable to reciprocate, instead "complying always" with the abuser. From her statements, it could be suggested that Qiana's* mother, as well as her abusive father, became a source of distress or fear, unable to emotionally or physically provide safety for Qiana*. When attachment figures are both the necessary providers for survival and the source of fear, the child is faced with the dilemma of being unable to choose closeness or to avoid their parent. This pattern is described by attachment researchers as "disorganised attachment" (Main, 1996). Exposure to family violence during infancy can impair the development of trust and secure attachment (Owens & Cox, 1997).

Within families, the parent-parent relationship and the parent-child relationship do not occur in isolation; these family subsystems are interdependent (Minuchin, 1985). Family violence disrupts family relationships and parent-child interactions. Margolin,

Gordis, and Oliver (2004) found a link between father-mother conflict and aggression and negative affect in mother-child interactions. Hibel, Granger, Blair, Cox, and Family Life Project Key (2011) found sensitive parenting by mothers to moderate the effects of intimate partner violence.

Kiah* and Qiana* wrote about feeling let down by their other parent. Kiah* wrote that she felt let down by her father over his lack of action in response to her disclosure, "I felt my father let me down." Qiana* expressed hurt that, even once out of the abusive situation, her mother was unable to provide nurture. Focusing on her own victimization, her mother was unable to notice Qiana's* hurt and need for healing: "my [mother] treated healing like something she did because something negative, external had happened to her…[and] I was nonexistent, was not hurt, did not need healing." Qiana* wrote that her other parent recognized only her own hurt and need for healing, "she would make it about her and I had to take care of her."

The above responses focused on a relationship with the other parent during childhood. Bridget*, however, aged 60 years, wrote about her adult relationship with her elderly other parent. Bridget* wrote about her regret at her lack of relationship with her other parent in adulthood: "while I would like to have had the opportunity to develop a relationship with her, it isn't going to happen." Bridget* described her role as an adult in caring for and protecting her now vulnerable other parent from the abusive parent, "I play a role in ensuring she is well cared for and safe from my father (who has started to mistreat her…)"

1.2 Love, warmth and affection.

Participants wrote about love, warmth and affection. Stella* wrote that she envied the love and care she saw in other families: "they loved their children, they took good care of them, fed them.…We envied them. We were drawn to them." Kiah* wrote that she needed to feel loved, recognised and forgiven by her mother: "I knew then she loved me and I needed this recognition. She…forgave me." Faye* wrote that she felt "never really important to her [mother]" and felt her mother was "embarrassed" of her. Elle* wrote that her parents "loved their children" but "I can't remember getting a hug…. they never actually showed it physically." Elle* wrote that her mother's love favoured her brothers over her, even in adulthood: "my mother loved me less than she did my brothers…she is 91 years old now and stills [*sic*] favours her boys!" Camira* wrote that her other parent, her father, had "taught me the true meaning of unconditional

love in constant and ongoing respect." Camira's* idealizing of her other parent, suggests it was important to her to contrast this relationship with the one she had with her abusive parent.

1.3 Relationship with siblings.

Participants wrote about their relationship with their siblings. Alice* wrote about having a positive relationship with her brother in adulthood: "my brother has just opened the doors of communication with me." Camira* wrote about a limited relationship with her sister in adulthood. Other participants wrote about their sibling relationship during childhood. Bridget* described the birth order of herself and her siblings and identified one of her brothers as being her "closest ally." Stella* wrote about differential survival strategies used within her sibling group. Elle* wrote about restrictions on her "simply because I was a girl" and contrasted her experience of her parent with that of her brothers: "my mother did to me as a child that she did not do to her sons."

1.4 Relationship with abusive parent(s).

Participants wrote about their relationship with their abusive parent. About her abusive father, Bridget* wrote that she had "no need to attempt to have any kind of relationship with him" and queried whether she had ever had a relationship with him: "in fact I consider that I've never had a relationship with my father." Libby* wrote that she "never came to reconcile" with her abusive mother, as there "did not seem to be any point" in doing so. Alice* wrote that her childhood family relationship with her abusive father was "often the case of the family vs Dad." Alice* wrote that, in adulthood, her relationship with her father had shown limited improvement, but that "this only goes as far as the other person is willing to move" and "he still is very self-absorbed." She contrasted this with her relationship with her mother in adulthood, about which she wrote, "I learned that attitudes can change." Mariah* provided a positive reflection on her mother, writing that her mother was able to "admit when she had made a mistake and hurt us…emotionally" and that "this modelled what I view as a healthy part of conflict resolution."

1.5 Excusing, explaining other parent or defending parent behaviour.

Participants provided excuses and explanations in defence of their other parent. Bridget* excused her other parent as having no power to stop the abuse, "My mother, a kind nurturing woman, was totally under his control." Bridget* explained that her mother was a "good…person" and a "lovely person" who did not directly cause hurt: "she was never hurtful to anyone anyway." Bridget* explained that her mother was not at fault for the abuse, but had simply made a bad choice: "she just made a really bad choice of husband!" Bridget* also explained that her other parent did "the best she could for us," even if she did not know how to provide protection for her children: "my mother's approach was to turn a blind eye to what went on as I don't think she knew what to do about it." Bridget* defended her mother as an "honest, hardworking person" and wrote that, although she did not learn trust from her mother, her mother "did impart other values."

Providing context to her own abuse experiences, Kiah* was inclusive of her parents as victims of abuse: "my father, my mother and I were all victims of my uncle's sickness." Kiah* explained that her parents "did not have the…skills" to provide her with protection from abuse from an abusive extended family member or to respond appropriately to her "acting out" behavior. In defending her parents' limitations and explaining her emotional neglect, Kiah* wrote, "both my parents are good people with faults and qualities but expressing emotions is not their strength." Kiah* and Stella* wrote about their parents' own adverse childhood experiences and hinted at the impact of this on their functioning as adults, or (for Stella*) as a parent.

1.6 Family-of-origin dynamics.

Giving context to their experience, participants wrote about the dynamics within their family-of-origin. Nina* described her family-of-origin as stressful: "my family was so stressful." Nina* wrote that her abusive father drew other family members into taking his side against her mother's, and successfully involved her brother in directing hostility towards her mother and herself. Alice* wrote of varied experiences of her parents across her childhood and of her mother as "extremely changeable."

1.7 Parent continues not to recognize or acknowledge the abuse and neglect.

Participants wrote that their parent continued not to recognize or acknowledge the abuse and neglect. Nina* wrote that her abusive father continues to deny his abusive behaviour: "he continues to deny things of the past." Alice* wrote that her abusive

father does not recognize his children's hurts: "[hurt] – Dad doesn't know the meaning of the word, unless he feels upset."

1.8 Boundary issues impair ability to make and retain friendships.

Nina* wrote about her own and her mother's boundary issues having impaired her ability to make and retain friendships. Nina* wrote that due to her mother's own impaired trust, her mother was overprotective of her, and "when I told/they saw how protective my mother was, I lost a lot of friends." Nina* wrote that "boundary issues" are part of the reason for her difficulties in retaining friendships. Nina* provided examples of this occurring as a child: "I lost majority of my friends due to disclosing information backfiring…and the other kids being scared of that," and as an adult: "I still have problems…in repairing friendships."

1.9 Splitting good and bad

Camira* wrote about herself and her parents with statements that indicated a split between *good* and *bad*. Camira* wrote, "people are very different." Camira wrote about her mother as being bad or dangerous, "I am wary of my mother," and her father as being good, "my [father] has taught me the true meaning of unconditional love." She also wrote about herself as good, "I …always take responsibility" and about her relationship with her father as being "close;" they "share good and challenging things." Camira* reported that she has been "diagnosed with Borderline Personality Disorder."

1.10 Separation and individuation.

Camira's* responses suggests that she continued to grapple with issues of separation and individuation. Camira* began her statement about what she learnt from her parents about trust with a comment that hinted at her being troubled by the presence of differences, that her other parent trusted her: "even if they didn't agree with me or respond in the way that I wanted." Camira* wrote that her other parent (her father) had respected and allowed differences: "my parent always respected my views even if it differed from theirs [*sic*]." Camira* contrasts this with her experience of her abusive parent being intrusive: "my [mother] made judgements [*sic*] and intruded on personal boundaries such as going through my room and trying to find out things from other people."

1.11 Conflicting messages about current support from family.

Stella* provided conflicting messages about her current support from family. Stella* identified her own children as caring for her: "my children would early help me

out…They care; they call." Following this, Stella* undoes the impression that she actually receives support, writing that her children are "limited by distance and family commitments" and "I hardly avail of those offers."

2. Resilience or positive outcomes.

2.1 Resilience.

Participants described their resilience. Many participants identified themselves as "survivors" rather than "victims" and gave value to this identification as supporting their ongoing process of healing. Isabelle* wrote "the thing that healed me the most is the greatest decision I made, which was to stop acting like a victim and start acting like a survivor." Hugo* and Elle* expressed positive views of life despite their childhood experiences of abuse: "having said that I feel very content, happy and fulfilled in my life" (Hugo*) and "I think the good from my life far outweighs the bad…I am very fortunate" (Elle*). Stella* expressed a positive outlook, describing "enjoy[ment]." Bridget* wrote about herself as being strong, "I am a very strong person," and self-determined, "I decided as a teenager that the best revenge I could ever get on my father was to be happy." Bridget* identified her happiness as success, "to be happy – I've succeeded!" In addition to noticing her own resilience, Bridget* commented on resilience within her sibling group: "I must say that I am very proud of how most of my brothers and sisters have turned out."

Kiah* wrote that being self-aware enables positive outcomes. Mariah* wrote that she had "not lost hope" and that some of her strengths, "empathetic…good listening skills [and] easy to talk to," had come out of her exposure to hurts. Libby* counted herself as "blessed to be alive." Libby* identified herself as being "in recovery" and showing improvements in "coping with daily stressors of life that…years ago, I could not have imagined."

2.2 Positive relationships in adulthood.

Participants wrote about the presence of current positive relationships in adulthood. Nina* wrote that her healing was supported by "talking to…trusted friends." Bridget* wrote about having multiple positive relationships: "I have other people in my life (husband, daughter, brothers & sisters, friends) that I love, respect and care about and prefer to put my energies into them." Bridget* wrote about her pets as "important to me" and a "source of meaning in my life." Elle* wrote about positive adult relationships

with "great friends" and family: "I am part of a large family and I love my family. We have many get togethers and love every one of them." Hugo* wrote about a long-term intimate relationship he has: "I am in a wonderful, respectful, equal relationship and have been for over 10 years. That's the way relationships are supposed to be… :)" Acknowledging other survivors are not always able to have positive adult relationships, Kiah* wrote, "I am one of the lucky ones as I recently re-married in a truly loving relationship."

2.3 Presence of positive significant others in childhood (and absence of support).

Participants wrote about positive significant others who had played an important role during their childhood. Bridget* wrote about having a trusting, loving relationship with her grandparents, describing her grandfather as a "male role model…[who] loved us unconditionally …was always supportive of us. We definitely trusted him." Bridget* wrote that she has a trusting relationship with her "brother…we totally trust each other." Libby* wrote that she had a positive relationship with her sister and brother: "my sister is my best friend" and "nobody except my brother noticed – he still remembers."

Participants wrote about non-relatives being significant others during childhood. Libby* identified her kindergarten teacher as a trusted relationship: "I trusted my kindy teacher; she never let me down or lied to me or made me feel small & insignificant!" Qiana* identified feeling safe with some of her childhood support workers: "there were some workers at group homes and shelters with whom I felt safe." Identifying a lack of positive significant others, Mariah* wrote about limited social supports during childhood: "we had a very small/ no support network."

2.4 Identifying as a survivor of child abuse.

Several participants identified themselves as *survivors* of child abuse and neglect. Isabelle* wrote that identifying as a survivor promotes healing: "the thing that healed me the most…was to stop acting like a victim and start acting like a survivor."

Showing herself to have an internal locus of control, Camira* wrote, "you can't change the past except for how you yourself deals [*sic*] with it and interacts [*sic*] with others in the future." Together with his statement, "people can and will heal…I can and have", Hugo* wrote about identifying with, relating to and "helping" other survivors of abuse: "I realised that many were in a similar situation than [*sic*] me" and "I…can relate

well with people who are 'stuck.'" Rita* wrote that she survived: "I…am alive today because of my own efforts."

2.5 Helping other survivors of abuse or comments on other survivors.

Participants wrote about other survivors of abuse. Kiah* and Hugo* wrote about helping other survivors. Kiah* wrote of her goal "to help others" and to "keep on working towards helping people heal at all ages." Hugo* wrote of his need to rescue others, "I turned into a bit of a 'rescuer' [sic] I gravitated to people who had issues and problems." Hugo* identified himself as a healer of other abuse survivors; "through my coaching and teaching – I am helping people to heal." Rita* wrote about her involvement in this research helping other survivors: "I can't do much to help other sufferers but this I can do."

Acknowledging difficulties that survivors of child abuse face in achieving lasting non-abusive relationships, Kiah* wrote, "It also hurts to know that so many of us [survivors] have been denied love for so long."

3. Family of origin mental health.

3.1 Caregiver mental health.

As shown in Table 4, half of the participants described problems in the mental health of one or both of their caregivers. Faye* and Nina* wrote that their abusive parent had a "mental illness." Rita* wrote that her abusive parent was "a…violent mentally ill man" who had "suffered from bi-polar as well as alcoholism" and had been "in mental hospitals a few times." Rita* wrote that because her abusive father "chose not to heal" his mental health, she and her sibling are "the nightmare results." Hugo* described his parents as emotionally unstable: "their emotional instability did not make it safe for me."

Participants reported their parent's mental health to be a long-term issue. Donna* wrote, "my father… has been clearly depressed for decades…I also believe my mother was depressed." Camira* wrote that her mother had "always shown subtle symptoms of BPD". Libby* wrote that her "mother had a breakdown when I was very small & was never the same again."

Participants reported parental depression. Mariah* wrote that her mother had "post-natal depression" and "battled depression." In addition to writing about her father's depression, Donna* wrote, "I also believe my mother was depressed." Stella*

wrote that her "father was depressed" and speculated that "perhaps my mother had bipolar."

3.2 Cultural taboos about mental illness.

One participant, Jasmine*, wrote that in her family there were cultural taboos about mental illness. Jasmine* wrote: "Chinese culture do not recognise mental illness…look down on mental illness…[and] in China, mental illness can get you into trouble so no one did anything about it."

3.3 Abuser had mental illness.

One participant, Kiah*, who reported abuse from a non-caregiving extended family member, wrote that her abuser's mental health was questionable, particularly "after 9 years in jail." Kiah* uses the word "sickness" in relation to the abuser: "my father, my mother, and I were all victims of my [abuser's] sickness." It is unclear from the context whether Kiah* uses "sickness" to refer to the abuser having mental health problems, or to the abuser's "paedophil[ic]" acts being sick. Colloquially, this distinction is characterized as "mad or bad" (Court, Simpson, & Webster, 2014; Tucker, 1999). Whether an act is mad or bad remains contentious in psychiatric and legal arenas (Court et al., 2014). Tucker (1999) described the mad-bad distinction as relating to different paths for intervention: "for the mad they provided protection and treatment, and for the bad, deterrence and punishment" (p.221). From a child welfare or moral context, *bad* appears appropriately protective of the child when describing paedophilic behavior (refer to Featherstone & Lancaster, 1997). The term *bad* refers to the behaviour: it places the responsibility and accountability for harm with the abuser. Morse (2008) appears to dismiss this, suggesting that "actions can be just mad, just bad, or mad and bad" (p.47) and that classification of mental disorder does not excuse the behaviour.

Paedophilia is listed as a mental disorder in the ICD-10 (World Health Organization, 1992) and a paraphilic disorder in the DSM-5 (American Psychiatric Association, 2013). Clarifying the distinction between vice and mental disorder, First (2008) (a text-editor of the DSM-IV-TR) advised that the DSM requires "there be an underlying internal psychological dysfunction that is driving the vice behaviour" (p.37). Sadler (2008), dismissing this requirement for internal psychological dysfunction as arbitrary, criticized the DSM classification of Pedophilia as "impoverished [and]

indicator-deficient" (p.52). Sadler suggested we find ourselves drawn to classify "into the 'sick' category" (p.52) actions or symptoms that are morally contentious.

4. Intergenerational continuity.

4.1 Intergenerational abuse, functioning or parenting.

Several participants reported that child abuse in their family had occurred in several generations. Alice* wrote, "my mother was also extensively abused as a child." Kiah* wrote, "Mother [had] history of sexual abuse in the family – two generations at least," and "both my parents… we were all victims of pretty sick people." Rita* reported a "family history [of] violence and depression on father's side." Rita* wrote that her experience of abuse had impacted her own parenting: "it has been v. [*sic*] difficult raising children esp [*sic*] as they get to teenage years and have their own anger issues." Nina* wrote that her childhood had been impacted upon by her mother's abuse experiences. Stella* wrote about intergenerational abuse having occurred across four generations in her family. Stella* identified herself as being abused by her mother, her children being abused by both herself and her mother, and one of her sons abusing his sons. Stella* wrote about her abusive mother having her own history of childhood abuse: "Mother's family…were punitive disciplinarians ... Mother's punishment received as a child were used on us kids and more." Stella* wrote about how her abuse experiences "influenced [her] treatment of [her] own children". Stella* wrote that she had made a promise to herself to parent her own children better that her own experience of parenting. Her children would "never [be] treated in the way we were treated." In admitting to her abuse of her own children, Stella* wrote, "perhaps it's my mother in me." Stella* noticed intergenerational patterns in functioning in her family. She suggests abuse is "in the blood" rather than learned through experience: "so I question myself, is this an instinct to discipline to be good and acceptable innate in me and my son, and now this son's boys?"

4.2 Intergenerational discontinuity.

Several participants reflected on their attempts and desire to parent their own children differently. Of her desire to parent without abuse, Stella* wrote, "I was ashamed I was smacking because I remembered my promise to protect my children and not to ill-treat them." Stella* commented that she has been "making up for my mistakes" and that grandchildren provide her with a second chance "to make up for

what I have neglected [or] failed in their parent's upbringing." Stella* commented on instances where abuse had not continued in the following generation: "my other son…is doting, protective, loving[,] no expectations, open, [and] empowering."

Bridget* explained she was choosing to be different to her abuser: "from my father I learnt what not to do and how not to be and vowed to live my life very differently to the way I was brought up." Hugo* demonstrates discontinuity from his violent parents in his statement that power in relationships, status or religion is "distasteful" and something he "did not want to…be a part of." Elle* wrote, "I have always made a point of hugging my children and telling them that I love them. That is the most important thing that is different from the way I was brought up." Alice* wrote that her abusive parent was not abusive as a grandparent: "my mother…later became a great (as in fantastic) grandmother."

The wish expressed in these statements is to provide a future for the next generation that is freer of the impact of their parents' traumatic legacy. It is a wish to break the cycle of abuse; a wish expressed by other survivors of child abuse and neglect (Atkinson, 2011; Kezelman, 2010).

5. Other.

5.1 The questioning self or search for meaning.

Participants wrote about their own search for meaning. Nina* wrote that she was hurt by not being able to "understand why [the abuse] had happened." Olivia* posed the question, "was there any meaning to this?" Elle* wrote about having difficulty finding insight: "I don't know why that is…I still do not know why." Kiah* wrote about seeking causes for her own lack of trust in the world: "I can't really tell whether it is simply from the sexual abuse… or the silence from my father or the [lack of positive] relationship…with my mother." Kiah* searched for a solution to her mother's behaviour: "if only she had..." and wrote that "hindsight" offers her the ability to reflect on her experiences.

5.2 Age or time periods.

In writing about their experiences, several participants gave weight to a particular period in their life. Teenage years were a critical time of change for Bridget*, who wrote: "I decided as a teenager" and "as a teenager." Nina* wrote that she had a period of loss of friendships in "primary school where I lost [the] majority of my

friends"… and "the transition from high school to university" and "during…university." Nina* wrote that "high school" was a period during which she looked for independence from her mother. Nina* described that "as I got older" she had directed her own search for healing.

5.3 Telling experience, being listened to, or participation in this research project.

Two participants wrote that telling their experience through participation in this research project was useful to them. Libby* wrote, "thank you for listening." Rita* wrote, "thanks for doing this [research]." Commenting on the methodology being questionnaire rather than interview-based, Rita* wrote, "I'd be no good in person but answering questionnaires is fine."

6. Family functioning.

6.1 Adverse family functioning in adulthood.

Participants described adverse family functioning in adulthood. Descriptions included: sibling "marriage breakup" (Alice*), "divioces [sic], fractured relationships, child/parent estrangements; abusive partners (Libby*), sibling "alcohol abuse" (Bridget*), and sibling "mental illness" (Faye*). To describe her family dysfunction Bridget* wrote that she has a "very screwed up family." Libby* sums this up in her statement: "dysfunctional family of origin leading to current dysfunctional relationships."

6.2 Comment on functioning.

Alice* commented on functioning, describing functioning as being non-polar with suffering: "'functioning' people who 'contribute to society' can still suffer and struggle greatly at times."

Summary: Participants' Descriptions of Relationships and Functioning

Participants wrote about a complex relationship with their other parent, relaying feelings of regret, loss, lack of support or role confusion. Explanations for the other parent and her or his role in the family dynamic were varied and included the idea that, while the other parent had shortcomings, she or he had done her or his best. Ongoing

difficulty in relationships with others was attributed to dysfunction in their family of origin. Some participants had difficulty with all social relationships; others highlighted their particular difficulty with starting or maintaining romantic relationships. Whilst still noticing their own relationship struggles, participants who identified a more positive childhood relationship with their other parent (such as Isabelle* and Kiah*), had been able to maintain a romantic relationship in adulthood.

Participants described the functioning of others in the context of caregiver mental health and in reports of adverse outcomes for family members in adulthood. Noticing intergenerational continuity of abuse, functioning or parenting, participants used this to provide context for the behaviour of their parent or themselves. Resilience was present in reports of discontinuity of abuse, of improved parent-child and grandchild relationships and in the wish to be different to the abuser. Powerfully, participants described instances of resilience within themselves in the form of self-determination and acknowledgment of positive aspects of their lives or through identifying as a survivor rather than a victim.

Participants described the impact of abuse and neglect on their relationships and functioning. Discussed above under the category 'Hurt' the "Impact of abuse and neglect" themes (memory, social, mental health, ongoing effects, self-concept), are also relevant to the category of Relationships and Functioning.

Study 3 Discussion

Study 3 qualitatively explored the meaning that adult survivors of childhood abuse and neglect made of their relationship with their parent(s). Interpretative Phenomenological Analysis was used to examine participants' responses to open-answer questions. Themes arose from the data in four categories: trust, hurt, healing and relationships-and-functioning. Participants described global and ongoing disturbances in trust. Hurt was overwhelming in its ongoing significance to survivors in adulthood. The other or less abusive parent's failure to protect was identified as being "worse than the abuse itself." Healing was identified as possible, but slow and difficult even with psychotherapy. Abuse and neglect experiences were identified as having long-term and intergenerational impacts on relationships and functioning.

Several participants wrote that they valued being heard. Being heard and having trauma acknowledged, they felt, may support the healing of other survivors. There is a zeitgeist in Australia to hear their voices: Note that currently the Australian Royal Commission into Institutional Responses to Child Sexual Abuse is hearing accounts from survivors. This research raises awareness of the long-term and intergenerational impacts of a history of childhood maltreatment. The lived experience of survivors within this study provides a forum to inform intervention and support the recovery of other survivors.

Study 3 Limitations

Study 3: Survivors' Experiences of their Parent had a sample size of 19 participants. While this sample size is large for the qualitative data methodology used, the small size of this sample means that caution should be taken when trying to apply the results to child abuse survivors and the broader community.

Study 3 comprised participants who identified as survivors of sexual abuse, physical abuse, physical neglect and emotional neglect. As such, the sample was more heterogeneous in their experiences of abuse and neglect than a sample of one type of abuse or neglect. This may have resulted in the current themes being more broad than if the sample were less heterogeneous, and the current study may include themes that do not relate to singular maltreatment types. As discussed in Chapter 1, current research literature identifies investigating multiple and cumulative types of adverse childhood experiences as highly relevant to the survivor population. Survivors report having experienced co-occurring different types of abuse and neglect (Nurius et al., 2015) and such co-occurring traumas have been reported to produce cumulative effects (Briere et al., 2008). As Interpretative Phenomenological Analysis is best suited to homogeneous samples, this potential heterogeneity may have increased the breadth of themes found within the current study. Understanding these broader themes is, however, consistent with the broader focus of this thesis as a whole. Future research could use the themes identified in the current study to examine whether they apply to all types of child abuse and neglect or whether some themes are linked to specific types of maltreatment.

Gender imbalance is a limitation of Study 3, with the sample including only one male. This may mean that the Study 3 data reflects a more female, rather than male

experience. As noted previously, future research could investigate gender differences in the experiences of survivors of childhood maltreatment.

Study 3 relied upon Interpretative Phenomenological Analysis from written statements rather than face-to-face interview. The use of written statements rather than interview prevented prompting and clarification of participants' experiences. This is a limitation, given prompts and clarifications may have enabled a deeper exploration of participants' experiences and the meaning they ascribed to their experiences. However, as Study 3 was a follow-up study to Studies 1 and 2, the use of written statements was deliberately chosen to be consistent with the questionnaire design of Study 1 and Study 2. The questionnaire design of Study 1 and Study 2 had been chosen for the potential that online questionnaires may have in eliciting self-disclosure (Buchanan & Smith, 1999).

A further limitation of Study 3 was the use of set questions. The methodological design of using specific questions in Study 3 imposed a structure to participants' written statements which led to the formation of the superordinate themes of trust, hurt and healing. It is possible the themes arising from the data may have been broader or more diverse if participants had not been asked set questions, but rather described their relationship with their parent and their learning from this relationship. Future qualitative research into survivors learning from their experiences of their parent may consider approaches without the use of set questions.

A triangulation process was considered in which feedback would be sought from participants on the data analysis. Use of triangulation would have provided opportunity for participants to reflect on and respond to the themes gathered from their data. Although it could be considered a limitation of Study 3 that triangulation was not undertaken, studies using IPA methodology most commonly collect data from participants only once (Smith et al., 2012). The period of time from data collection to completion of the IPA analysis of the 19 participants' statements was longer than anticipated. As a result, a triangulation feedback process was not pursued. Future research using smaller samples may consider incorporating a triangulation feedback design.

Chapter 8: Summary and Conclusions

Previous research provides evidence that having a history of child abuse is a risk for poorer adult functioning and relationship outcomes for the individual (Felitti et al., 1998a; Godbout et al., 2014). Yet to be fully addressed are the longer-term intergenerational effects -- whether, and in what ways, abuse and neglect history in a parent effects the functioning of the next generation. This thesis comprised a pilot and three studies investigating retrospective reports of childhood experiences and self-reports of current adult relationship and functioning outcomes.

Study 1: Experiences of Individuals

Study 1, *Experiences of Individuals,* adds to the growing body of research in which poorer adult functioning and relationship outcomes are associated with a history of child abuse and neglect. In a sample of 323 adults, Study 1 investigated retrospective reports of childhood experiences including abuse and neglect, family functioning, perceived parental love and care and financial deprivation. Also investigated were current self-reported adult social support, separation-individuation disturbances, psychopathology, trauma symptoms, proactive coping, partner relationship, and psychotherapy.

Participants' categorical responses to four items on childhood sexual and physical abuse, and physical and emotional neglect, were used to identify *any-abused* and *not-abused* groups. Just over half of the sample reported at least one of these four types of abuse or neglect, with childhood emotional neglect the most frequently reported maltreatment type. Significant group differences were found for four of the five adult functioning outcomes, with maltreated participants reporting, on average, more separation-individuation disturbances, less social support, more psychopathology and more trauma symptoms. These findings are consistent with previous research and indicate that adults with a history of childhood maltreatment, regardless of type of maltreatment, have impairments in adulthood across multiple domains of relating and functioning (Shonkoff et al., 2012).

This study also investigated the additional adverse childhood experiences of having a caregiver with a drug or alcohol problem or witnessing family violence. Similar to the findings for the maltreated group, participants with either of these adverse childhood experiences had, on average, more separation-individuation disturbances, less social support, more psychopathology and more trauma symptoms. These findings support the direction taken by recent maltreatment research in being more inclusive of a broader range adverse childhood experiences and their collective (Felitti et al., 1998b) and differential impacts on adult outcomes (Briere & Runtz, 1990).

Comparing outcomes between the four types of abuse and neglect, Study 1 found physically neglected participants had, on average, the highest separation-individuation disturbances and the highest trauma symptoms. Previous separation-individuation research has linked separation-individuation disturbances with problems in relatedness and sense of self (Kins et al., 2012), disturbances that are characteristic of Borderline Personality Disorder (Dolan et al., 1992; Mahler, 1971). The researcher is not aware of any previous research investigating differential effects on separation-individuation disturbances related to type of maltreatment. Given the current findings of significantly higher separation-individuation disturbances in maltreated, and particularly in physically neglected participants, further research in this area is warranted.

Study 1 investigated outcomes related to categories of abuse and to neglect, comparing participants who were neither-abused-nor-neglected, abused-but-not-neglected, neglected-but-not-abused, and both-abused-and-neglected. Significant group differences were found for separation-individuation, social support, psychopathology, and trauma symptoms. Across these comparisons, significant differences were not found between the abused and the neglected categories. Differential effects found in these comparisons related to whether the individual had any history of either abuse or neglect, and whether the individual had a history of both abuse and neglect. Due to a lack of previous research examining the differential effects of several types of abuse versus several types of neglect, the researcher made no prediction about the direction of differences between the abused group and the neglected group. The finding in the current research of a lack of differential effects related to whether participants were abused or were neglected appears to be the first comparison of this kind. Future research comparing abuse and neglect across a range of outcomes would allow further examination of potential differential effects.

Of those who reported maltreatment, the majority reported more than one type of childhood abuse or neglect. Cumulative effects of co-occurring types of abuse and neglect were found to be associated with poorer adult functioning outcomes including more separation-individuation disturbances, less social support, more psychopathology and more trauma symptoms. This finding of increasingly more adverse outcomes with increasing number of types of childhood abuse and neglect is consistent with previous research. The current results partially support the cumulative risk hypothesis (Appleyard et al., 2005), with a positive linear relationship between number of types of abuse and neglect and psychopathology, in which the psychopathology score increased with each additional type of maltreatment. The positive linear relationship in separation-individuation disturbances and trauma symptoms, however, discontinued between three-types and four-types. Further, the negative linear relationship in social support discontinued between both one-type and two-types and between three-types and four-types. The researcher is not aware of previous research reporting adjacent level contrasts across the number of types of abuse and neglect. As a consequence, comparison of the current finding of discontinuation across the linear relationship with previous findings is not yet possible.

Proactive coping was not found to be significantly different in the various maltreated group comparisons. While coping, as a concept, has been connected to resilience within the childhood maltreatment literature (Cicchetti & Rogosch, 2009), the researcher is not aware of previous research investigating proactive coping as an outcome across maltreated and not-maltreated groups. The current research found proactive coping to be significantly correlated with other adult functioning outcomes including separation-individuation, social support, and trauma symptoms. Given these significant correlations with proactive coping, further research could investigate proactive coping as a potential moderator of adult functioning outcomes.

An unexpected and disturbing of finding of Study 1 was that participants who had accessed psychotherapy, both ever and currently, had statistically significantly poorer adult functioning outcomes that those who had not accessed, or were not currently accessing psychotherapy. This finding has implications for treatment. Is it that individuals with the most problems in adult functioning access psychotherapy? Or that adult functioning difficulties surface more, or are reported more, by individuals who have or are accessing psychotherapy? Further research is needed to answer these

important questions to ensure that psychotherapy is supportive towards positive outcomes for survivors and is enabling of healing.

The current research found significant correlations between childhood family functioning and other childhood and adulthood relationship outcomes. Healthier family functioning was correlated with higher perceived parental love and care, suggesting social-emotional experiences with family and with parents is related. Healthier family functioning was correlated with higher current social support, suggesting early positive relationship experiences are related to later levels of perceived social support. Healthier family functioning was correlated with a lower number of live-in partners, but not with the length of longest partner relationship. Further, the current research found that maltreated participants had, on average, less healthy childhood family functioning, less perceived parental love and care, less current social support and more live-in partners. This is consistent with previous research, which has linked adverse childhood experiences with a risk for multiple sexual partners (Felitti et al., 1998b), less perceived social support (Sperry & Widom, 2013) and with difficulties in achieving stable adult partner relationships (Colman & Widom, 2004).

Experiences of childhood maltreatment have the potential to produce trauma symptoms in the adult survivor (Wright et al., 2009). Study 1 found experiences of childhood psychological abuse, childhood physical neglect, and childhood sexual abuse increased the number of current adult trauma symptoms. Furthermore, higher separation-individuation disturbances and higher psychopathology were found to be associated with an increase in the number of current adult trauma symptoms. Consistent with previous research identifying social support to have protective effects, higher perceived social support was found to be associated with a decrease in current adult trauma symptoms (Hill et al., 2010).

Study 1 participants reported, overall, low levels of childhood financial deprivation and are not considered to represent an at-risk population. Despite this, the current research found maltreated participants had, as a group, statistically significantly more childhood deprivation and statistically significantly less primary carers who had completed school to Year 11. These findings are consistent with previous research in which socio-economic risks during childhood have been associated with higher rates of childhood maltreatment (Daniel et al., 2006; Ssewamala et al., 2014).

Study 1 supported previous evidence, at the individual level, that a history of childhood maltreatment is a risk for adult functioning outcomes. The impact of maltreatment across generations of a family, and specifically intergenerational continuity of adult functioning and relating, has been much less studied. These intergenerational effects were investigated in Study 2.

Study 2: Intergenerational Continuity - Experiences of Intergenerational Pairs

Study 2, *Intergenerational Continuity,* investigated intergenerational continuity and discontinuity in the relationship and functioning outcomes across two generations of a family, with and without a history of childhood maltreatment. Study 2 participants were a subgroup of Study 1 participants who formed intergenerational pairs of child-generation adults and the person they described as being their parent or caregiver when they were growing up.

The results of Study 2 suggest an intergenerational continuity in relationships and functioning. It was the first aim of Study 2 to investigate whether there are ways of relating and functioning that are repeated in subsequent generations of a family. Comparing paired samples of adult child and parent participants, Study 2 found child group participants had statistically significantly less psychopathology than parent group participants. For all of the other adulthood and childhood relationship and functioning outcomes investigated, no statistically significant child-parent paired differences were found. The finding of no statistically significant difference in the child and the parent outcomes, implies, but does not confirm intergenerational continuity.

Study 2 investigated whether maltreated child participants were more likely, as a group and as compared to not-maltreated child participants, to have a maltreated parent. Proportionally, but not statistically significantly more of the maltreated child group had a maltreated parent. This finding was mirrored in the investigation of additional adverse childhood experiences of witnessing family violence and having a caregiver with a drug or alcohol problem. Proportionally, but not statistically significantly more of the witnessed any-family violence child group had a parent who had witnessed family violence during childhood. And, proportionally, but not statistically significantly more

of the child group who had a caregiver with a drug or alcohol problem had a parent who had the same type of experience during childhood.

Comparing type-to-type maltreatment across children and their parent, only physically abused children were statistically significantly more likely to have a parent with the same type of childhood maltreatment. This finding is interesting, in that it highlights that the cycle of maltreatment, proposed and debated in the research literature (Thornberry et al., 2012), may have limited type-to-type specification. The finding in the current research, and in previous research, is type-specific only in relation to childhood physical abuse (Berlin et al., 2011; Crouch et al., 2001; Jinseok Kim, 2009).

Study 2 investigated the intergenerational impacts of abuse and neglect on adult relationships and functioning by comparing four intergenerational maltreatment history groups. These groups comprised of participant-dyads in which both generations were maltreated, only the child-generation was maltreated, only the parent-generation was maltreated, or neither generation was maltreated. There were significant differences across these groups on psychopathology and on trauma symptoms. The group in which only the child-generation was maltreated had the highest psychopathology, and this was statistically significantly higher than the group in which only the parent was maltreated. This finding provides an interesting contrast to the earlier finding in child-parent paired differences, within which it was found that the parent group had significantly more psychopathology than the child group. Together these findings suggest that while the parent had more psychopathology than their child, when only one generation had a history of maltreatment the maltreated child only group had more psychopathology than the maltreated parent only group. The pattern across groups for trauma symptoms was different to the pattern found for psychopathology. The group in which both generations had a history of childhood maltreatment had substantially higher trauma symptoms than the other three intergenerational maltreatment history groups, and this was significantly higher than the group in which only the child-generation was maltreated. This finding suggests there may be cumulative effects of trauma in which trauma symptoms are highest when both generations have a history of maltreatment.

Previous research has investigated moderators and mediators within maltreated-related outcomes (e.g. Bartlett & Easterbrooks, 2015; K. Kim et al., 2010; Zvara et al., 2015). The current research investigated a number of moderators and mediators, however failed to find support for any moderating or mediating effects within the

relationships explored. Parent dissociation and child family functioning were investigated as potential moderators of intergenerational continuity of abuse, but, contrary to findings in previous research (Egeland & Susman-Stillman, 1996; Singh Narang & Contreras, 2000), the current research failed to find support for either model. Parent dissociation and parent separation-individuation were explored as possible mediators between parental history of maltreatment and child trauma symptoms. Significant direct relationships were found between parent history of maltreatment and child trauma symptoms, between parent history of maltreatment and parent dissociation, and between parent history of maltreatment and parent separation-individuation. Neither mediation model, however, was supported. Three predictors of child trauma symptoms were explored as potential moderators of the relationship with parental history of abuse. Parental social support, child social support and child family functioning were all not supported within the current research as moderators of this relationship. Parental social support was also not found to mediate the relationship between parent trauma symptoms and child family functioning.

The most important finding of Study 2 was that, regardless of their own maltreatment status, child-generation participants with a maltreated parent had more trauma symptoms themselves, than child-generation participants whose parent was not maltreated. The finding of elevated trauma symptoms in the child generation when their parent has a history of maltreatment has implications for the way we respond to complex trauma. This finding highlights the importance that protective and therapeutic support be inclusive of generations within a family, rather than continuing to focus efforts at the level of the individual.

Study 3: Survivors' Experiences of their Parent

The impacts of additional risks and protective factors are given context within the lived-experience reports of survivors of childhood maltreatment. A qualitative third study, *Survivors' Experiences of their Parent*, focussed on child abuse and neglect survivors' relationship with their caregiver(s). The study was designed to give voice to participants who had earlier participated in Study 1, and to provide a forum to explore their understanding of their experiences. An expert panel was used in the development

of the Study 3 qualitative survey. The professionals' feedback showed agreement on the terms *trust*, *hurt* and *healing* as being important to issues of complex trauma. Interpretative Phenomenological Analysis (IPA) was used to examine participants' responses to three open-answer questions. An independent audit of the qualitative analysis was conducted and had an inter-rater reliability of between 82-90%. Participants were given made up names to protect their identity. Four categories of themes arose from the data: 1) trust themes, 2) hurt themes, 3) healing themes, and 4) relationship and functioning themes.

Participants' responses about trust were grouped into 17 themes falling under five super-ordinate themes. Most participants described a betrayal of trust or care by one or both of their parents, linked to being punished or abused, not protected, or to lies and manipulation. Participants described difficulties trusting others as an ongoing problem, where they were not able to trust others at all, or had specific impairments of trust in authority figures or men. Several participants wrote they could not trust their non-abusive, or less abusive, parent. Other participants wrote about trusting their other parent, even though he (referring to their father) was unable to protect them.

Overwhelmingly, participants wrote about and described their experiences of hurt. This resulted in 14 superordinate themes about hurt. Hurts were anticipated, silenced, hidden, ignored, minimized, and suppressed. The abuser used shame, fear and secrets to hide the abuse. The other parent's failure to protect was described as being worse than the abuse itself. Nearly all of the participants described the acts or types of abuse and neglect. Participants described their experiences of child maltreatment to be that of multiple perpetrations of abuse or neglect by one or several persons. Participants also wrote about the impact of abuse and neglect on memory, impaired social relationships, mental health and ongoing negative effects in adulthood, and self-concept.

Instances of self-protective behaviour at the time of the abuse were described, and included: splitting, suppressing emotions, restricting the sharing of information, keeping quiet, lying, becoming passive, and pretending to be someone else. Participants also described current protective behaviours they employ as adults. Many of the participants described powerlessness and vulnerability as a result of the abuser being a family member or caregiver and of being a child abused by adults. Several participants identified their own development of self-destructive behaviours as being connected to the abuse. These behaviours may initially have been self-protective strategies. Reported

self-destructive behaviours included acting out and hurting others. "Olivia" wrote, "I became promiscuous, rebellious, and a binge drinker. I later became dissociative." Many excuses were offered for the abuser and the abuse.

Of healing, half of the participants wrote that healing is possible, and can take place in adulthood. Participants referred to healing as being slow, difficult and ongoing. Healing was described by Isabelle* as meaning she has fewer flashbacks, anxiety and fear, and can start "to live life without fear." Most of the participants reported having accessed psychotherapy in relation to their abuse experiences and to have found it supportive.

Participants also wrote extensively about relationships and functioning, describing family relationships and some instances of resilience. Disruptions within the family centred on the fracturing of interpersonal relationships. Libby* sums up statements about family functioning, saying, "dysfunctional family of origin leading to current dysfunctional relationships…divorces, fractured relationships, child-parent estrangements; abusive partners." Many participants identified themselves as survivors rather than victims and gave value to this identification as supporting their ongoing process of healing. Child maltreatment was also reported as having occurred in several generations in participant's families. Participants reflected on their attempts and desire to parent their own children differently. Survivor participants expressed an awareness of the trauma impacting several generations in their family. It was the expressed wish of several survivor participants with children, that maltreatment experiences not be repeated in the next generation.

In summary, Study 3 participants described their relationship experiences with their parent as continuing to impact on their relationships with themselves and others. These survivors described global and ongoing disturbances in trust. Hurt was overwhelming in its ongoing significance to survivors in adulthood. The other or less abusive parent's failure to protect was identified as being "worse than the abuse itself." Healing was identified as possible, but slow and difficult even with psychotherapy. Abuse and neglect experiences were identified as having long-term and intergenerational impacts on relationships and functioning. Participants wrote of the value of being heard and having trauma acknowledged.

Conclusions

The current research took an *eco-transactional psychodevelopmental* approach to maltreatment research. The effects of childhood maltreatment on relationships and developmental functioning were considered as being transactionally influenced by cumulative, interactive risk and protective factors. As discussed in Chapter 1, literature into childhood maltreatment has historically considered one or two types of abuse or neglect; however, more recent research has highlighted the importance of considering the cumulative effects related to the co-occurrence of multiple maltreatment types and other adverse childhood experiences (Finkelhor et al., 2007a; Hodges et al., 2013). Examination of these cumulative and interactive risks is consistent with an *eco-transactional psychodevelopmental* approach. Utilising this theoretical framework, the current research examined outcomes for participants reporting childhood sexual abuse, physical abuse, physical neglect or emotional neglect, as well as the potential cumulative effects related to a history of being multiply abused and neglected. This research also investigated outcomes related to groups reporting adverse childhood experiences of carer drug problem and witnessing family violence. Using this approach has provided a greater level of context for outcomes relating to experiences of childhood maltreatment.

This research adds, firstly, to the body of research in which poorer adult functioning and relationship outcomes are found in participants reporting a history of childhood abuse and neglect. Study 1 found that, regardless of type of childhood abuse or neglect, adults with a history of childhood maltreatment have, as a group, more impairments in adulthood across multiple domains of relationships and functioning than adults without this history. As discussed in Chapters 1 and 2, these findings are consistent with previous research on individuals (Kezelman et al., 2015; Shonkoff et al., 2012).

Second, this research, while being unable to draw causal conclusions due to being retrospective in its measurement of childhood experiences, provides evidence of intergenerational effects on relationships and functioning. As discussed in Chapters 3 and 4, previous research into the intergenerational sequelae of childhood maltreatment has looked at a narrower range of outcome measures, such as continuity of abuse (Berlin et al., 2011) or parenting style (Shaffer, Burt, et al., 2009). To date, no previous

childhood maltreatment research has investigated intergenerational functioning outcomes in adults. This is the first study to investigate the intergenerational impact of child abuse and neglect on multiple measures of adult functioning.

Study 2 of this research found it is not the maltreatment itself that has continuity between children and their parents, but that the ways of relating and functioning are similar for children and their parents. A critically important finding of this research, Study 2 found that children with an abused or neglected parent had more trauma symptoms themselves, than children with a not-maltreated parent. Providing an in depth exploration of relating and functioning experiences between children and their parent, the lived experience of survivors was detailed in Study 3 of this research. The voices of survivors in Study 3 inform us that, even as adults, their relationship experiences with their parent continue to impact on their relationships with themselves and others.

Identification of resilience and protective factors within maltreatment research provides for support of survivors to be focussed on wellbeing (Dube et al., 2013). As discussed in Chapter 4, it was acknowledged that not all individuals with a history of childhood maltreatment experience relationship or functioning problems as adults. In Study 3, survivor statements offer a wealth of insight into factors that were found to be protective and factors that have increased resilient outcomes and healing. During childhood, these included the presence of positive transactions between children and their other (less abusive parent) or sibling and the application of self-protective behaviours. In adulthood, the role of professionals, friends and significant others was identified as supporting healing, as was establishing boundaries with family members. Resilience was shown in statements identifying that healing is possible and in statements reflecting on parenting experiences in the context of a wish for the next generation. Participants statements were grounded both in the meaning they were able to bring to their experiences and were held within their transactions with others and the world. This research suggests that, just as risk factors are transactional and have cumulative psychodevelopmental effects, so too do protective and resilience factors.

Limitations

The current research has six main limitations. The first of these is that the small sample sizes of the three studies limits the precision of the findings. The second

limitation is the homogeneity produced as a result of the same or a subset of the same participants being involved in all three studies. This means that interpretation of findings within this research is limited to the one sample. These participants may not be representative of the general population.

A third limitation is that the current research relied on retrospective recall for measures of childhood experiences. The accuracy of retrospective recall may be compromised by the length of time since childhood and by the participants' level of functioning and mental state at time of reporting.

Fourth, the use of a single item to define maltreated and non-maltreated groups is a limitation of all three studies. The independent variable of abuse was formed from dichotomous responses on a single item that spanned four types of maltreatment (e.g., "…before age 17, were you ever: sexually abused, physically abused, physically neglected, emotionally neglected?"). The item was self-rated and participants were not provided with a definition of each type of abuse or neglect. While this approach allowed for participants to report on their subjective self-identification of their experiences, methodologies in which participants are provided with definitions and clear operationalization of abuse and neglect have been recommended (Finkelhor, Turner, Shattuck, & Hamby, 2015; Stoltenborgh et al., 2011). Despite this, previous research has found no difference in prevalence rates when using a broad and a narrow definition of abuse (Pereda, Guilera, Forns, & Gomez-Benito, 2009b). It is further noted that while self-reports of abuse and neglect experiences are "probably closer to the true" experience than substantiated child protection service data, biases in self-reporting may lead to under- rather than over-reporting of abuse (Gilbert et al., 2009, p. 69). The use of a single, undefined item in the current research may have meant that some participants overestimated their experiences as being that of maltreatment and that other participants underestimated their experiences as being that of non-maltreatment. This would have increased the heterogeneity of experiences within the maltreated and the non-maltreated groups, making it harder to identify differences across the groups.

The fifth limitation is gender imbalance. Participants in the current research were mostly female. This is potentially a problem because gender differences were not accounted for in the current research. As a result, the current research describes a female experience more than a male experience. In the population of abused people, there are substantially more females than males (Briere & Elliot, 2003; Stoltenborgh et

al., 2011). Some research has suggested gender differences in the long-term impact of childhood abuse and neglect (Kendler et al., 2000; Rind et al., 1998), however, other research has reported no significant gender differences (Nelson et al., 2002). While the current research was not designed to investigate potential gender differences and this may be the focus of future research.

A sixth limitation relevant to all three studies is the wide age range of the samples. There has been a cultural shift in the general population towards the experience of childhood abuse and neglect. This cultural shift includes an increase in the reporting of abuse and neglect, and the viewing of perpetration of childhood maltreatment as a crime. As a result of this cultural shift, younger people might be able to report and discuss experiences of childhood abuse and neglect more than older people. The current research had a wide range of ages and this could have masked generational differences that may have existed.

Clinical Relevance and Implications

Research at the individual level has led to the development of specific treatment guidelines (e.g. Kezelman & Stavropoulos, 2012). Previous research has modelled the financial cost of the effects of childhood abuse and neglect on the lifespan of the individual in order to influence government and public policy (Kezelman et al., 2015). My research shows that intergenerational functioning outcomes hold similar implications to outcomes for individuals, and yet this area has been absent from inclusion in the way we respond, treat and consider complex trauma.

The global significance of this research is to shift the focus from exclusively looking at the individual effects of childhood maltreatment, to being inclusive of a broader understanding and response to the potential intergenerational effects of complex trauma. Furthermore, this research draws attention to the need for a convergence of findings from research on individuals and families and research inclusive of the lived-experiences of survivors.

Suggestions for Future Research

The current research found similar outcomes across groups of maltreated individuals (relating to a history of any childhood sexual or physical abuse, or physical or emotional neglect) and groups of individuals reporting additional adverse childhood experiences of having a caregiver with a drug or alcohol problem or witnessing family violence. These findings support the continued inclusion of multiple types of childhood maltreatment and other adverse experiences during childhood in future research.

Disturbances in separation-individuation are implicated in the functioning of adult survivors of childhood maltreatment; however minimal research has investigated separation-individuation outcomes in adult survivors of childhood abuse and neglect. The current research found separation-individuation disturbances were highest, on average, in individuals with a history of childhood physical neglect. In the absence of previous research into differential effects of types of childhood abuse and neglect on separation-individuation outcomes, further research in this area is needed.

In the current research, childhood physical neglect was reported least of the four abuse and neglect types by Study 1 participants. This may be related to the low levels of childhood financial deprivation also reported in the current sample; however, the relationship between financial deprivation and childhood physical neglect was not investigated within the scope of the current research. Future studies comprising both low and high socio-economic groups would enable further investigation of the relationship between financial deprivation and childhood physical neglect.

The investigation, within Study 2 of this research, of adult intergenerational outcomes within families with and without a history of maltreatment provides a start for filling a gap in the current child maltreatment literature. The majority of previous research investigating relationship and functioning outcomes across maltreated and not-maltreated groups is focussed at the level of the individual. Intergenerational maltreatment research investigating functioning outcomes has focussed on parent-with-infant or parent-with-child outcomes, and there has been a paucity of research investigating intergenerational adult outcomes across multiple domains of relationships and functioning. Extending the current research, further childhood maltreatment research investigating intergenerational adult relationship and functioning outcomes is needed to provide a more complete understanding of the potential long-term effects of maltreatment on the next generation. Optimally, future research would include long-

term prospective studies of intergenerational cohorts and focus on relationship and functioning outcomes at both the individual and intergenerational levels.

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Appendices.

Appendix A   Studies 1 and 2 - Participant Recruitment, Informed Consent and Questionnaire (Wave 1: General Population Sample)

Appendix A – 1   Studies 1 and 2 (Wave 1) - Expression of Interest.

Survey participants wanted
for an intergenerational PhD study into
Relationships and Functioning

I am a PhD student seeking adults from the general population to participate in an intergenerational study into relationships and functioning. This study involves intergenerational, paired research and we are looking for two generations of a family to both, separately and confidentially, participate.

- ○   Please note: **All participants (both generations) need to be 18+ years old**

AND

- ○   **One of the participants is to have been the primary caregiver** (the person *most* involved in caring for the basic needs) **of the other when the other was growing up.**

This study has been approved by the Human Research Ethics Committee at Australian Catholic University. Your responses are confidential and you are not asked to provide any fully identifying information in completing the survey.

The survey is available online or in paper form. Paper questionnaire forms with reply paid envelopes are available on request (see contact details below).

For the online version, participants may access the survey by going to the following web link: **https://www.psychdata.com/s.asp?SID=129809**

Your participation would be greatly appreciated!

Kind regards,

Joanna Menger Leeman, PhD Candidate ACU
Phone: **0431 941 035**   Email: **joleem001@myacu.edu.au**

Under the supervision of registered psychologists:
Dr. Lisa Eisen and Prof. Barry J. Fallon, Australian Catholic University.

Appendix A – 2   Studies 1 and 2 (Wave 1) - Information Letter.
INFORMATION LETTER TO PARTICIPANTS

TITLE OF PROJECT: Intergenerational relationships and adult functioning.
STAFF SUPERVISOR: Dr. Lisa Eisen and Professor Barry Fallon
STUDENT RESEARCHERS: Ms. Joanna Menger Leeman

Dear Participant,

You are invited to participate in research into family relationships and adult functioning. The purpose of this study is to examine childhood and adult experiences, looking at how people adapt to life experiences and develop in their interpersonal relationships. This study will look at similarities or differences across generations in a family. Therefore, we are specifically seeking participation from adults and, separately, the same participation from the person who was their primary caregiver when they were growing up. Due to being an intergenerational study, participation will be based on completion of questionnaires from two participating generations of the one family. All participants are asked to complete a questionnaire, taking approximately 30 minutes to complete. The questionnaire is available in pencil-on-paper format or available online by going to the following link: **https://www.psychdata.com/s.asp?SID=129809.** If you are able to complete the survey online, this would be preferable.

The questionnaire asks you about your experiences as a child growing up in your family and about yourself as an adult, including about the ways you approach life tasks, your health and wellbeing, and the ways you relate to others and how you are supported by family and friends. All of the information you provide is important and will assist in understanding how people cope with life experiences and develop in their relationships.

As a part of the research, we will also be inviting a sub-group of interested participants who have completed the questionnaire to participate in a follow-up study. Participants who indicate a wish to participate in the further research will be contacted by email or phone.

Completing the questionnaire may prompt you to consider in greater detail your family and life experiences. The consequences of this are expected to be positive and help you to reflect upon some important aspects of your interpersonal and family relationships. However, if answering the questionnaire made you feel distressed or uncomfortable in any way, feel free to contact Dr. Cecelia Winkelman, a Registered Psychologist working in the School of Psychology at ACU on Ph: (03) 9953 3112, who will refer you to an appropriate counselling service.

All information obtained from the questionnaires will be kept confidential and kept in a securely locked file cabinet in room 2.29 in the School of Psychology at the Australian Catholic University, St. Patrick's campus for the statutorily required period of time (currently 5 years). The information obtained from the questionnaires will be the basis of the Combined Masters/PhD thesis of Joanna Menger Leeman, a student at the Australian Catholic University.

None of the reports will identify you or your individual responses. The results may be published in professional journals or reported at conferences. Records may be

inspected for purposes of data audit by persons within the institution (such as Ethics Committee members) or outside regulatory bodies.

Participation in this research project is voluntary. Participants can withdraw from the study at any stage without giving a reason. Any withdrawal from the research by students will not prejudice their academic progress. Confidentiality will be maintained during the study and in any report of the study. All participants will be given a code and names will not be retained with the data. Individual participants will not be able to be identified in any reports of the study, as only aggregated data will be reported.

If you have any questions about the project, before or after participating, please contact Joanna Menger Leeman on Ph: (03) 9953 3171, at the Australian Catholic University, School of Psychology, St Patrick's Campus at 115 Victoria Parade, FITZROY 3065. Alternatively, you are welcome to contact the Supervisors of the study, Dr. Lisa Eisen, on Ph: (03) 9953 3119, or Professor Barry Fallon on Ph: (03) 9953 3108, at the same address as above.

This study has been approved by the Human Research Ethics Committee at Australian Catholic University. In the event that you have any complaint or concern about the way you have been treated during the study, or if you have any query that the Principal Investigator has not been able to satisfy, you may write to:

Chair, Human Research Ethics Committee
C/o Research Services
Australian Catholic University
Locked Bag 4115
FITZROY VIC 3065   Tel: 03 9953 3157   Fax: 03 9953 3315

Any complaint will be treated in confidence and fully investigated fully. The participant will be informed of the outcome.

If you are willing to participate please sign the attached informed consent forms. Please retain one copy for your records and return the other copy to the researchers. Your participation in the project will be highly valued and appreciated.

Yours sincerely,

Ms. Joanna Menger Leeman   Dr. Lisa Eisen   Professor Barry Fallon
    Student Researcher   Principal Supervisor   Supervisor

Appendix A – 3   Studies 1 and 2 (Wave 1) - Consent Forms.

Appendix A – 3.1   Studies 1 and 2 (Wave 1) - Copy for Participant (Pen-on-Paper Version).

INFORMED CONSENT FORM
Copy for Participants to Keep

TITLE OF PROJECT: Intergenerational relationships and adult functioning (1b)

STAFF SUPERVISOR: Dr. Lisa Eisen & Professor Barry Fallon

STUDENT RESEARCHER: Ms. Joanna Menger Leeman

COURSE: Combined Masters of Psychology, Child and Family/ PhD

Participants section

I _____ (*the participant*) have read and understood the information in the letter inviting participation in the research, and any questions I have asked have been answered to my satisfaction. I agree to participate in this questionnaire, realizing that I can withdraw at any time.

I agree that research data collected for the study may be published or provided to other researchers in a form that does not identify me in any way. I agree to be contacted by *email/ phone* if needed to arrange a mutually convenient time to complete the research task. I am over 18 years of age.

I *wish to/ do not want to*   also participate in a follow-up study. (please indicate your choice)
(Participants wishing to participate in a follow-up study will be contacted via email or phone.)

Name of participant: ……………….…………… Email/Phone: ……………………
                          (block letters)   *Can a message be left for you?*   Yes / No

Signature: _____   Date: …………………

Research Student: Ms. Joanna Menger Leeman

Signature: _____   Date: _____

Staff Supervisor: Dr. Lisa Eisen

Signature: _____   Date: _____

Staff Supervisor: Professor Barry Fallon

Signature: ………………………………………   Date: …………………

Appendix A – 3.2   Studies 1 and 2 (Wave 1)- Copy for Researcher (Pen-on-Paper Version).

INFORMED CONSENT FORM
Copy for Participant to Submit

TITLE OF PROJECT: Intergenerational relationships and adult functioning (1b)

STAFF SUPERVISOR: Dr. Lisa Eisen & Professor Barry Fallon

STUDENT RESEARCHER: Ms. Joanna Menger Leeman

COURSE: Combined Masters of Psychology, Child and Family/ PhD

Participant section

I _____ (*the participant*) have read and understood the information in the letter inviting participation in the research, and any questions I have asked have been answered to my satisfaction. I agree to participate in this questionnaire, realizing that I can withdraw at any time.

I agree that research data collected for the study may be published or provided to other researchers in a form that does not identify me in any way. I agree to be contacted by email if needed to arrange a mutually convenient time to complete the research task. I am over 18 years of age.

I *wish to/ do not want to*   also participate in a follow-up study. (please indicate your choice)
(Participants wishing to participate in a follow-up study will be contacted via email or phone.)

Name of participant: _____Email/ Phone:…………………
                (block letters)   *Can a message be left for you?*   Yes / No
Signature: _____   Date: …………………

Research Student: Ms. Joanna Menger Leeman

Signature: _____   Date: _____

Staff Supervisor: Dr. Lisa Eisen

Signature: _____   Date: _____

Staff Supervisor: Professor Barry Fallon

Signature: _____   Date: _____

Appendix A – 4   Studies 1 and 2 (Wave 1): Relationships and Functioning Questionnaire (Pen-on-Paper Version).

Relationships and Functioning Questionnaire

Please fill in all information as accurately and honestly as possible. All responses will remain confidential.

PART ONE
The following statements deal with reactions you may have to various situations. Indicate how true each of these statements is depending on how you feel about the situation. *Please circle your answers on the scale below from 1 (not at all true) to 5 (completely true).*

		1	2	3	4	5	
I am a "take charge" person.	Not at all true	1	2	3	4	5	Completely true
I try to let things work out on their own.	Not at all true	1	2	3	4	5	Completely true
After attaining a goal, I look for another more challenging one.	Not at all true	1	2	3	4	5	Completely true
I like challenges and beating the odds.	Not at all true	1	2	3	4	5	Completely true
I visualize my dreams and try to achieve them.	Not at all true	1	2	3	4	5	Completely true
Despite numerous setbacks, I usually succeed in getting what I want.	Not at all true	1	2	3	4	5	Completely true
I try to pinpoint what I need to succeed.	Not at all true	1	2	3	4	5	Completely true
I always try to find a way to work around obstacles; nothing really stops me.	Not at all true	1	2	3	4	5	Completely true
I often see myself failing so I don't get my hopes up too high.	Not at all true	1	2	3	4	5	Completely true
When I apply for a position, I imagine myself filling it.	Not at all true	1	2	3	4	5	Completely true
I turn obstacles into positive experiences.	Not at all true	1	2	3	4	5	Completely true
If someone tells me I can't do something, you can be sure I will do it.	Not at all true	1	2	3	4	5	Completely true
When I experience a problem, I take the initiative in resolving it.	Not at all true	1	2	3	4	5	Completely true
When I have a problem, I usually see myself in a no-win situation.	Not at all true	1	2	3	4	5	Completely true

In this section, you are asked to rate how characteristic the following statements are about the family you grew up in. *The rating is on a scale from 1 (strongly disagree) to 5 (strongly agree). Your rating is your opinion, so there are no right or wrong answers. Please answer all the questions as best you can. Answer them fairly quickly, circling the first response that pops into your head without over thinking it.*

In my family, we encouraged each other to develop new friendships.	Strongly Disagree	1	2	3	4	5	Strongly Agree
Conflicts in my family never got resolved.	Strongly Disagree	1	2	3	4	5	Strongly Agree
I found it difficult to understand what other family members said and how they felt.	Strongly Disagree	1	2	3	4	5	Strongly Agree
In my family, I expressed just about any feeling I had.	Strongly Disagree	1	2	3	4	5	Strongly Agree
My family was receptive to the different ways various family members viewed life.	Strongly Disagree	1	2	3	4	5	Strongly Agree
I often had to guess at what other family members thought or how they felt.	Strongly Disagree	1	2	3	4	5	Strongly Agree
My family members rarely expressed responsibility for their actions.	Strongly Disagree	1	2	3	4	5	Strongly Agree
Sometimes in my family I did not have to say anything, but I felt understood.	Strongly Disagree	1	2	3	4	5	Strongly Agree
I found it easy to understand what other family members said and how they felt.	Strongly Disagree	1	2	3	4	5	Strongly Agree
I found it difficult to express my own opinions in my family.	Strongly Disagree	1	2	3	4	5	Strongly Agree
In my family, no one cared about the feelings of other family members.	Strongly Disagree	1	2	3	4	5	Strongly Agree
In my family, certain feelings were not allowed to be expressed.	Strongly Disagree	1	2	3	4	5	Strongly Agree
My family members usually were sensitive to one another's feelings.	Strongly Disagree	1	2	3	4	5	Strongly Agree
In my family, people took responsibility for what they did.	Strongly Disagree	1	2	3	4	5	Strongly Agree
I remember my family as being warm and supportive.	Strongly Disagree	1	2	3	4	5	Strongly Agree

In this section, you are asked to rate how characteristic the following statements are about **people in general**. Your rating is your opinion of how people in general feel about themselves and others, so there are no right or wrong answers. Since people's attitudes about themselves and others vary considerably, the questions vary considerably; some questions may seem a little strange or unusual to you. Please answer all the questions as best you can. Answer them fairly quickly, circling the first response that pops into your head without over thinking it.

When people really care for someone, they often feel worse about themselves.	Not at all characteristic	1	2	3	4	5	Very characteristic
When someone gets too emotionally close to another person, he/she often feels lost.	Not at all characteristic	1	2	3	4	5	Very characteristic
When people get really angry at someone, they often feel worthless.	Not at all characteristic	1	2	3	4	5	Very characteristic
It is when people start getting emotionally close to someone that they are most likely to get hurt.	Not at all characteristic	1	2	3	4	5	Very characteristic
People need to maintain control over others to keep from being harmed.	Not at all characteristic	1	2	3	4	5	Very characteristic

In this section you are asked to rate whether you think the following statements are characteristic of **your feelings about yourself and other people**. Again, these are your opinions so there are no right or wrong answers. As different people often have very different thoughts about themselves and others, the statements vary considerably. Some of them may seem strange or unusual to you, but please answer all of them the best you can. Rate each statement fairly quickly indicating the first response that pops into your head without over-thinking it.

I find that people seem to change whenever I get to know them.	Not at all characteristic	1	2	3	4	5	Very characteristic
It is easy for me to see both good and bad qualities that I have at the same time.	Not at all characteristic	1	2	3	4	5	Very characteristic
I find that people either really like me or they hate me.	Not at all characteristic	1	2	3	4	5	Very characteristic
I find that others often treat me as if I am just there to meet their every wish.	Not at all characteristic	1	2	3	4	5	Very characteristic
I find that I really vacillate between really liking myself and really disliking myself.	Not at all characteristic	1	2	3	4	5	Very characteristic
When I am by myself, I feel that something is missing.	Not at all characteristic	1	2	3	4	5	Very characteristic
I need other people around me to not feel empty.	Not at all characteristic	1	2	3	4	5	Very characteristic

I sometimes feel that part of me is lost whenever I agree with someone else.	Not at all characteristic	1	2	3	4	5	Very characteristic
Like others, whenever I see someone I really respect and to whom I look up, I often feel worse about myself.	Not at all characteristic	1	2	3	4	5	Very characteristic
I find it easy to see myself as a distinct individual.	Not at all characteristic	1	2	3	4	5	Very characteristic
Whenever I realize how different I am from my parents, I feel very uneasy.	Not at all characteristic	1	2	3	4	5	Very characteristic
In my experience, I almost always consult my mother before making an important decision.	Not at all characteristic	1	2	3	4	5	Very characteristic
I find it relatively easy to make and keep commitments to other people.	Not at all characteristic	1	2	3	4	5	Very characteristic
I find that when I get emotionally close to someone, I occasionally feel like hurting myself.	Not at all characteristic	1	2	3	4	5	Very characteristic
I find that either I really like someone or I can't stand them.	Not at all characteristic	1	2	3	4	5	Very characteristic
I often have dreams about falling that make me feel anxious.	Not at all characteristic	1	2	3	4	5	Very characteristic
I find it difficult to form mental pictures of people significant to me.	Not at all characteristic	1	2	3	4	5	Very characteristic
I have on more than one occasion seemed to wake up and find myself in a relationship with someone, and not be sure of how or why I am in the relationship.	Not at all characteristic	1	2	3	4	5	Very characteristic
I must admit that when I feel lonely, I often feel like getting intoxicated.	Not at all characteristic	1	2	3	4	5	Very characteristic
Whenever I am very angry with someone, I feel worthless.	Not at all characteristic	1	2	3	4	5	Very characteristic
If I were to tell my deepest thoughts, I would feel empty.	Not at all characteristic	1	2	3	4	5	Very characteristic
In my experience, people always seem to hate me.	Not at all characteristic	1	2	3	4	5	Very characteristic
Whenever I realize how similar I am to my parents, I feel very uneasy.	Not at all characteristic	1	2	3	4	5	Very characteristic
Often, when I am in a close relationship, I find that my sense of who I am gets lost.	Not at all characteristic	1	2	3	4	5	Very characteristic
I find it difficult for me to see others as having both good and bad qualities at the same time.	Not at all characteristic	1	2	3	4	5	Very characteristic
I find that the only way I can be me	Not at all	1	2	3	4	5	Very

		1	2	3	4	5	
is to be different from other people.	characteristic						characteristic
I find that when I get emotionally too close to someone, I sometimes feel that I have lost a part of who I am.	Not at all characteristic	1	2	3	4	5	Very characteristic
Whenever I am away from my family, I feel very uneasy.	Not at all characteristic	1	2	3	4	5	Very characteristic
Getting physical attention itself seems more important to me that who gives it to me.	Not at all characteristic	1	2	3	4	5	Very characteristic
I find it difficult to really know another person well.	Not at all characteristic	1	2	3	4	5	Very characteristic
I find that it is important for me to have my mother's approval before making a decision.	Not at all characteristic	1	2	3	4	5	Very characteristic
I must admit that whenever I see someone else's faults, I feel better.	Not at all characteristic	1	2	3	4	5	Very characteristic
I am tempted to try to control other people in order to keep them close to me.	Not at all characteristic	1	2	3	4	5	Very characteristic
I must admit that whenever I get emotionally close to someone, I sometimes want to hurt them.	Not at all characteristic	1	2	3	4	5	Very characteristic

PART 2

The following section asks you some general questions about yourself.

Your sex:
☐ Male
☐ Female

Your Age: _____ (years)

What is the *highest* level of school you completed? *(please tick one)*
☐ Year 12 or equivalent
☐ Year 11 or equivalent
☐ Year 10 or equivalent
☐ Year 9 or equivalent
☐ Year 8 or equivalent
☐ Year 7 Secondary school or equivalent
☐ Grade 6 Primary school or below

What is the level of the highest qualification you have completed? *(please tick one)*
☐ University Bachelor degree or above
☐ Advanced diploma / Diploma
☐ Certificate I to IV (including trade certificate)
☐ No qualification

Which of the following best describes your current employment and income status? *(please tick one):*

☐ In full-time paid employment
☐ In part-time or casual paid employment
☐ Recipient of low income or disability based welfare payments
☐ Home duties
☐ Student
☐ Retired or engaged in unpaid / volunteer work

Who do you currently live with? *(please choose the option that best describes your household)*

☐ Your Partner/ Spouse only
☐ Your Partner/ Spouse and child(ren)
☐ Your child(ren) only
☐ Your Parent(s) only
☐ Your Parent(s) and siblings
☐ Grandparent(s) or other relatives
☐ Family group (spouse or nuclear family plus other relatives)
☐ Share-house with mostly non-relatives
☐ I live alone

What is your current marital/ relationship status?

☐ Single
☐ Dating (in relationship more than 2 weeks)
☐ Defacto/ married
☐ Divorced
☐ Widowed

How many different partners have you been married to or lived with in a defacto relationship?   _____ partners

What is the length of your longest partner relationship? *(if less than 2 years, please indicate in terms of number of months, if less than a month, indicate in terms of days).*

_____ years
_____ months
_____ days

Do you have any children?

☐ Yes
☐ No, I cannot due to physical reasons
☐ No, I chose not to have children
☐ No, I am too young/ I plan to have children in future
☐ No, I want to have children, but do not have a partner
☐ Other (Please specify)

_____
_____

Did your children reside out of your care for anytime while they were growing up (under 18 years of age)? (Or if you have any children currently under 18 years, do they now or did they ever reside out of home?)

☐ No, they reside/ resided with me fulltime
☐ Yes, shared residency with other parent
☐ Yes, some due to Child Protection involvement
☐ Other (Please specify)

_____
_____

Did you grow up with both of your biological parents for all of your childhood?

☐ Yes
☐ No

Which parent or parent figure was your primary caregiver (the most involved in caring for your basic needs) when you were growing up?

☐ Biological Mother
☐ Biological Father
☐ Other (Please specify)

_____

As you know, this study will look at responses from two generations of a family, specifically a primary caregiver and their grown-up child.
The other person from your family answering this questionnaire is your:

☐ Child (now an adult)
☐ Mother
☐ Father
☐ Foster Parent
☐ Grandparent (who was your primary carer)
☐ Other (Please specify)

What is the highest level of school your **primary carer** completed? (if you are not sure, please make your best guess)

☐ Year 12 or equivalent
☐ Year 11 or equivalent
☐ Year 10 or equivalent
☐ Year 9 or equivalent
☐ Year 8 or equivalent
☐ Year 7 Secondary school or equivalent
☐ Grade 6 Primary school or below

What is the level of the highest qualification your **primary carer** completed? (if you are not sure, please make your best guess)

☐ University Bachelor degree or above
☐ Advanced diploma / Diploma
☐ Certificate I to IV (including trade certificate)
☐ No qualification

Who was your **secondary carer** (the person next most involved in caring for your basic needs) when you were growing up?

- ☐ Biological Mother
- ☐ Biological Father
- ☐ I did not have a secondary carer
- ☐ Other (Please specify)

    _____

What is the highest level of school your **secondary carer** completed? (if you are not sure, please make your best guess)

- ☐ Year 12 or equivalent
- ☐ Year 11 or equivalent
- ☐ Year 10 or equivalent
- ☐ Year 9 or equivalent
- ☐ Year 8 or equivalent
- ☐ Year 7 Secondary school or equivalent
- ☐ Grade 6 Primary school or below

What is the level of the highest qualification **secondary carer** completed? (if you are not sure, please make your best guess)

- ☐ University Bachelor degree or above
- ☐ Advanced diploma / Diploma
- ☐ Certificate I to IV (including trade certificate)
- ☐ No qualification

PART 3

The following section asks you some general questions about your current relationships.

How much does each of these people go <u>out of their way</u> to do things to make your life easier for you?

	Very much	Somewhat	A Little	Not at all	No Such Person
Your Friends	1	2	3	4	9
Your spouse/ partner	1	2	3	4	9
Your Parent/s	1	2	3	4	9
Your Brothers/Sisters	1	2	3	4	9
Your Work Colleagues	1	2	3	4	9
Your Child/ren	1	2	3	4	9

How much can each of these people be <u>relied on</u> when things get tough?

	Very much	Somewhat	A Little	Not at all	No Such Person
Your Friends	1	2	3	4	9
Your spouse/ partner	1	2	3	4	9
Your Parent/s	1	2	3	4	9
Your Brothers/Sisters	1	2	3	4	9
Your Work Colleagues	1	2	3	4	9
Your Child/ren	1	2	3	4	9

How much can you count on these people to <u>help you feel better</u> when you experience problems?

	Very much	Somewhat	A Little	Not at all	No Such Person
Your Friends	1	2	3	4	9
Your spouse/ partner	1	2	3	4	9
Your Parent/s	1	2	3	4	9
Your Brothers/Sisters	1	2	3	4	9
Your Work Colleagues	1	2	3	4	9
Your Child/ren	1	2	3	4	9

How much can you count on these people to <u>give you sound advice</u> when you experience problems?

	Very much	Somewhat	A Little	Not at all	No Such Person
Your Friends	1	2	3	4	9
Your spouse/ partner	1	2	3	4	9
Your Parent/s	1	2	3	4	9
Your Brothers/Sisters	1	2	3	4	9
Your Work Colleagues	1	2	3	4	9
Your Child/ren	1	2	3	4	9

How much can you count on these people to <u>listen to you</u> when you need to talk about problems?

	Very much	Somewhat	A Little	Not at all	No Such Person
Your Friends	1	2	3	4	9
Your spouse/ partner	1	2	3	4	9
Your Parent/s	1	2	3	4	9
Your Brothers/Sisters	1	2	3	4	9
Your Work Colleagues	1	2	3	4	9
Your Child/ren	1	2	3	4	9

How much can you count on the following people to <u>help you out</u> in a crisis situation, even though they would have to go <u>out of their way</u> to do so?

	Very much	**Somewhat**	**A Little**	**Not at all**	**No Such Person**
Your Friends	1	2	3	4	9
Your spouse/ partner	1	2	3	4	9
Your Parent/s	1	2	3	4	9
Your Brothers/Sisters	1	2	3	4	9
Your Work Colleagues	1	2	3	4	9
Your Child/ren	1	2	3	4	9

The following section asks you about things you had or did not have when you were growing up (before age 17).

When you were growing up, did your family have…
(If you had it *most of the time*, please select 'Yes')

Medical treatment if needed?
☐ Yes
☐ No, because my parents/ carergivers couldn't afford it
☐ No, for other reasons

Warm clothes and bedding if it was cold?
☐ Yes
☐ No, because my parents/ carergivers couldn't afford it
☐ No, for other reasons

A substantial meal at least once a day?
☐ Yes
☐ No, because my parents/ carergivers couldn't afford it
☐ No, for other reasons

Heating in at least one room of the house if needed?
☐ Yes
☐ No, because my parents/ carergivers couldn't afford it
☐ No, for other reasons

Dental treatment if needed?
☐ Yes
☐ No, because my parents/ carergivers couldn't afford it
☐ No, for other reasons

A home?
☐ Yes
☐ No, because my parents/ carergivers couldn't afford it
☐ No, for other reasons

A separate bed for each child?
- ☐ Yes
- ☐ No, because my parents/ carergivers couldn't afford it
- ☐ No, for other reasons

Ability to buy medicines prescribed by a doctor?
- ☐ Yes
- ☐ No, because my parents/ carergivers couldn't afford it
- ☐ No, for other reasons

A telephone?
- ☐ Yes
- ☐ No, because my parents/ carergivers couldn't afford it
- ☐ No, for other reasons

A hobby or leisure activity for children?
- ☐ Yes
- ☐ No, because my parents/ carergivers couldn't afford it
- ☐ No, for other reasons

A washing machine?
- ☐ Yes
- ☐ No, because my parents/ carergivers couldn't afford it
- ☐ No, for other reasons

Presents for family or friends at least once a year?
- ☐ Yes
- ☐ No, because my parents/ carergivers couldn't afford it
- ☐ No, for other reasons

Children in family able to participate in school activities or outings?
- ☐ Yes
- ☐ No, because my parents/ carergivers couldn't afford it
- ☐ No, for other reasons

Up-to-date school books and new or good condition school clothes for children?
- ☐ Yes
- ☐ No, because my parents/ carergivers couldn't afford it
- ☐ No, for other reasons

Use of a car if needed?
- ☐ Yes
- ☐ No, because my parents/ carergivers couldn't afford it
- ☐ No, for other reasons

A weeks holiday away from home each year?
- ☐ Yes
- ☐ No, because my parents/ carergivers couldn't afford it
- ☐ No, for other reasons

A separate bedroom for children of different genders aged over 10?
- ☐ Yes
- ☐ No, because my parents/ carergivers couldn't afford it
- ☐ No, for other reasons

In this section, you are asked about mental health and wellbeing. Please answer all the questions as best you can.

Have you ever had any symptoms of anxiety or depression (e.g. insomnia, excessive worrying, excessive sadness, excessive fears or panic attacks, other)?
- ☐ Yes, I currently have these symptoms
- ☐ Yes, in the past
- ☐ No

Have you ever had any addictions (e.g. gambling, drug or alcohol abuse, other)?
- ☐ Yes, I currently have these symptoms
- ☐ Yes, in the past
- ☐ No

Have you ever had any serious mental illness (e.g. Schizophrenia, Obsessive-Compulsive Disorder, Bipolar, other)?
- ☐ Yes, I currently have these symptoms
- ☐ Yes, in the past
- ☐ No

Are you currently, or have you ever received any counseling or psychiatric treatment?
- ☐ Yes, currently
- ☐ Yes, in the past
- ☐ No

Approximately how many treatment sessions have/did you attend? _____
 What year(s) did these sessions take place? _____

Did/do you find it helpful?
- ☐ Yes
- ☐ No

Feel free to share any additional information about your mental health you feel is relevant:

_____
_____
_____

The following questions ask about the mental health and wellbeing *of your family other than yourself* (e.g. your mother, father, sister, brother, aunt, uncle, grandparent, cousin, child or spouse). Please answer all the questions as best you can.

Does /did anyone in your family have any symptoms of anxiety or depression (e.g. insomnia, excessive worrying, excessive sadness, excessive fears or panic attacks, other)?

☐ Yes, currently
☐ Yes, in the past
☐ No

Does/did anyone in your family have any addictions (e.g. gambling, drug or alcohol abuse, other)?

☐ Yes, currently
☐ Yes, in the past
☐ No

Does/did anyone in your family have any serious mental illness (e.g. Schizophrenia, Obsessive-Compulsive Disorder, Bipolar, other)?

☐ Yes, currently
☐ Yes, in the past
☐ No

Does/did anyone in your family have any symptoms as a result of experiencing trauma (e.g. Flashbacks: reliving the experience, Avoidance: avoiding things that trigger bad memories, Dissociation i.e. periods when they blank out or lose time)?

☐ Yes, currently
☐ Yes, in the past
☐ No

Feel free to share any additional information about your family's mental health you feel is relevant.

_____
_____
_____

The following section asks you about **your current health and wellbeing**.

How often have you experienced each of the following in the last two months?

Headaches	Never	1	2	3	4	5	Often
Insomnia (trouble getting to sleep)	Never	1	2	3	4	5	Often
Weight loss (without dieting)	Never	1	2	3	4	5	Often
Stomach problems	Never	1	2	3	4	5	Often
Sexual problems	Never	1	2	3	4	5	Often
Feeling isolated from others	Never	1	2	3	4	5	Often
"Flashbacks" (sudden, vivid distracting memories)	Never	1	2	3	4	5	Often
Restless sleep	Never	1	2	3	4	5	Often
Low sex drive	Never	1	2	3	4	5	Often
Anxiety attacks	Never	1	2	3	4	5	Often
Sexual overactivity	Never	1	2	3	4	5	Often
Loneliness	Never	1	2	3	4	5	Often
Nightmares	Never	1	2	3	4	5	Often
"Spacing out" (going away in your mind)	Never	1	2	3	4	5	Often
Sadness	Never	1	2	3	4	5	Often
Dizziness	Never	1	2	3	4	5	Often
Not feeling satisfied with your sex life	Never	1	2	3	4	5	Often
Trouble controlling your temper	Never	1	2	3	4	5	Often
Waking up early in the morning and can't get back to sleep	Never	1	2	3	4	5	Often
Uncontrollable crying	Never	1	2	3	4	5	Often
Fear of men	Never	1	2	3	4	5	Often
Not feeling rested in the morning	Never	1	2	3	4	5	Often
Having sex that you didn't enjoy	Never	1	2	3	4	5	Often
Trouble getting along with others	Never	1	2	3	4	5	Often
Memory problems	Never	1	2	3	4	5	Often
Desire to physically hurt yourself	Never	1	2	3	4	5	Often

Fear of women	Never	1	2	3	4	5	Often
Waking up in the middle of the night	Never	1	2	3	4	5	Often
Bad thoughts or feelings during sex	Never	1	2	3	4	5	Often
Passing out	Never	1	2	3	4	5	Often
Feeling that things are "unreal"	Never	1	2	3	4	5	Often
Unnecessary or over-frequent washing	Never	1	2	3	4	5	Often
Feeling of inferiority	Never	1	2	3	4	5	Often
Feeling tense all the time	Never	1	2	3	4	5	Often
Being confused about your sexual feelings	Never	1	2	3	4	5	Often
Desire to physically hurt others.	Never	1	2	3	4	5	Often
Feelings of guilt	Never	1	2	3	4	5	Often
Feelings that you are not always in your body	Never	1	2	3	4	5	Often
Having trouble breathing	Never	1	2	3	4	5	Often
Sexual feelings when you shouldn't have them	Never	1	2	3	4	5	Often

PART 4

The following section asks about things that may have happened to you in the past. Please answer all of the questions that you can, as honestly as possible.

To the best of your knowledge, before age 17, were you ever:

Sexually abused?	Yes	No
Physically abused?	Yes	No
Physically neglected?	Yes	No
Emotionally neglected?	Yes	No

Before age 17, did any parent, step-parent, or foster-parent ever have problems with drugs or alcohol that led to medical problems, divorce or separation, being fired from work, or being arrested for intoxication in public or while driving?

☐ Yes
☐ No

Before age 17, did you ever see any older family member (e.g. parent, grandparent, elder sibling, uncle/aunt) hit or beat up your other family member?

☐ Yes
☐ No

Did one or more of these times result in someone needing medical care or the police being called?

☐ Yes
☐ No

	Not at all	1	2	3	4	5	Very much	N/A
On average, **before age 8**, how much did you feel that your **father**/step-father/foster-father loved and cared about you?	Not at all	1	2	3	4	5	Very much	**N/A**
On average, **before age 8**, how much did you feel that your **mother**/ step-mother/ foster-mother loved and cared about you?	Not at all	1	2	3	4	5	Very much	**N/A**
On average, from **age 8 through age 17**, how much did you feel that your **father**/step-father/foster-father loved and cared about you?	Not at all	1	2	3	4	5	Very much	**N/A**
On average, from **age 8 through age 17**, how much did you feel that your **mother**/ step-mother/ foster-mother loved and cared about you?	Not at all	1	2	3	4	5	Very much	**N/A**

When you were 17 or younger, how often did the following happen to you in the average year? *Answer in terms of your parents, step-parents, foster-parents, or any other adult in charge of you as a child, including teachers and babysitters. Please tick the closest answers.*

	Never	Once or twice a year	3 to 5 times a year	6 to 20 times a year	Over 20 times a year
Yell at you	1	2	3	4	5
Insult you	1	2	3	4	5
Criticise you	1	2	3	4	5
Try to make you feel guilty	1	2	3	4	5
Ridicule or humiliate you	1	2	3	4	5
Embarrass you in front of others	1	2	3	4	5
Make you feel like you were a bad person	1	2	3	4	5

Before you were 8, how often did the following happen to you in the average year? (please tick the closest answers)

	Never	Once or twice a year	3-20 times a year	Over 20 times a year	I do not remember
You were left without supervision by an adult or responsible babysitter/ minder for more than 2 hours.	1	2	3	4	5
You went to school without any lunch.	1	2	3	4	5
There was nothing to eat for breakfast at home and you had to go without.	1	2	3	4	5
There was nothing to eat for dinner/tea at home and you had to go without.	1	2	3	4	5
You required medical attention but did not get it.	1	2	3	4	5

Before age 17, did a parent, step-parent, foster-parent, or other adult in charge of you as a child ever do something to you on purpose that made you bleed or gave you bruises or scratches, or that broke bones or teeth? (for example, hit or punch or cut you, or push you down)

☐ Yes
☐ No

If Yes, were you ever hurt so badly by your carer that you had to see a doctor or go to the hospital?

☐ Yes
☐ No

Before age 17, did any of the following persons ever kiss you in a sexual way, or touch your body in a sexual way, or make you touch their sexual parts?

A family member?	Yes	No
A non-family member who was five or more years older than you?	Yes	No

Overall, how many people did this to you?

How many members of your family?	_____
How many non-family members (who were five or more years older than you)?	_____

Before you were age 17, did any of the following persons ever have oral, anal, or vaginal intercourse with you, or insert a finger or object in your anus or vagina?

A family member?	Yes	No
A non-family member who was five or more years older than you?	Yes	No

Overall, how many people did this to you?

How many members of your family?	_____
How many non-family members (who were five or more years older than you)?	_____

Feel free to share any additional information about any abuse that you feel is relevant.

_____
_____
_____
_____
_____

Matching of pairs

This study asks for two members of the same family to each separately and confidentially complete the same questionnaire. The first family member to complete the questionnaire is asked to recruit the second person. It is important to the design of this study to be able to match the two family members, using their Respondent ID , so that we can look at similarities and differences in family responses. This is for analysis purposes only. All of your responses will remain confidential and the other person will NOT be able to see any of your responses to this questionnaire.

Are you the first or the second person from your family to take this questionnaire?

☐ I am the first. I will be recruiting the second person.

(Your Respondent ID is: _____. Please provide it to the other person who will be completing this survey. This is so that we can match the information provided.)

☐ I am the second. The other person gave me their Participant ID, for matching purposes, it is: _____.

Thank you for completing this questionnaire.
Your time and input are considered very valuable and are appreciated.

Again, should you feel upset or worried as a result of undertaking this questionnaire, please contact the numbers provided on the covering page.

Appendix B   Studies 1 and 2 Participant Recruitment, Informed Consent and Questionnaire (Wave 2: Targeted Population: Child Abuse Survivors and their Participant-Pair)

      Appendix B – 1   Studies 1 and 2 (Wave 2) - Expression of Interest.

ACU
AUSTRALIAN CATHOLIC UNIVERSITY

Relationships survey
Participants wanted!

If you identify as
surviving childhood abuse
you are invited to take part.

The survey is for adults and parents. Your other family participant only needs to know it is a study of relationships.

The survey is available at
https://www.psychdata.com/s.asp?SID=136939

Or paper survey forms with Confidential reply paid envelopes are available on request.
Contact: Joanna Menger Leeman, PhD Candidate
joleem001@myacu.edu.au or Ph: (03) 9953 3106

Appendix B – 2   Studies 1 and 2 (Wave 2) - Information Letter.
INFORMATION LETTER TO PARTICIPANTS

TITLE OF PROJECT: Intergenerational relationships and adult functioning (2a).
STAFF SUPERVISOR: Associate Professor Cecelia Winkelman and Dr. Helen Aucote
STUDENT RESEARCHERS: Ms. Joanna Menger Leeman

Dear Participant,
You are invited to participate in research into family relationships and adult functioning. The purpose of this study is to examine childhood and adult experiences, looking at how people adapt to life experiences and develop in their interpersonal relationships.

This study will look at similarities or differences across generations in a family. Therefore, <u>we are specifically seeking participation from adults and, separately and confidentially, the same participation from the person who was their primary caregiver when they were growing up</u>. For example, the other family member participating could either be your child (who is now grown up, *and* assuming you were their primary carer) or your primary parent figure. As this study will look at similarities or differences across generations in a family, we seek that you AND another adult member of your family both participate. You will be prompted within the questionnaire how to do this.

Due to being an intergenerational study, participation will be based on completion of questionnaires from two participating generations of the one family. All participants are asked to complete a questionnaire, which takes approximately 20 to 30 minutes to complete. The questionnaire is available in pen-on-paper format or available online by going to the following link: https://www.psychdata.com/s.asp?SID=136939 . If you are able to complete the survey online, this would be preferable.

The questionnaire asks you about your experiences as a child growing up in your family and about yourself as an adult, including about the ways you approach life tasks, your health and wellbeing, and the ways you relate to others and how you are supported by family and friends. All of the information you provide is important and will assist in understanding how people cope with life experiences and develop in their relationships.

As a part of the research, we will also be inviting a sub-group of interested participants who have completed the questionnaire to participate in a follow-up study. Participants who indicate a wish to participate in the further research will be contacted by email or phone.

Completing the questionnaire may prompt you to consider in greater detail your family and life experiences. The consequences of this are expected to be positive and help you to reflect upon some important aspects of your interpersonal and family relationships. However, if answering the questionnaire made you feel distressed or uncomfortable in any way, feel free to contact Dr. Barbara Jones, a Registered Psychologist working in the School of Psychology at ACU on +613 9953 3464, who will refer you to an appropriate counselling service.

All information obtained from the questionnaires will be kept confidential and kept in a securely locked cupboard in the storage room 2.29 of the School of

Psychology at the Australian Catholic University, St. Patrick's campus for the statutorily required period of time (currently 5 years). The information obtained from the questionnaires will be the basis of the Combined Masters/PhD thesis of Joanna Menger Leeman, a student at the Australian Catholic University.

None of the reports will identify you or your individual responses. The results may be published in professional journals or reported at conferences.

Participation in this research project is voluntary. Participants can withdraw from the study at any stage without giving a reason. Any withdrawal from the research by students will not prejudice their academic progress. Confidentiality will be maintained during the study and in any report of the study. All participants will be given a code and names will not be retained with the data. Individual participants will not be able to be identified in any reports of the study, as only aggregated data will be reported.

If you have any questions about the project, before or after participating, please contact Joanna Menger Leeman by email: joleem001@myacu.edu.au or phone message, Ph:+613 9953 3106, at the Australian Catholic University, School of Psychology, St Patrick's Campus at 115 Victoria Parade, Fitzroy, Victoria, AUSTRALIA 3065. Alternatively you are welcome to contact the Supervisors of the study, A/Professor Cecelia Winkelman on +613 9953 3112, or Dr. Helen Aucote on +613 9953 3013, at the same address as above.

This study has been approved by the Human Research Ethics Committee at Australian Catholic University. In the event that you have any complaint or concern about the way you have been treated during the study, or if you have any query that the Principal Investigator has not been able to satisfy, you may write to:

Chair, Human Research Ethics Committee
C/o Research Services
Australian Catholic University
Locked Bag 4115
FITZROY
VICTORIA AUSTRALIA   3065   Tel: +613 9953 3157 Fax: +613 9953 3315

Any complaint will be treated in confidence and fully investigated fully. The participant will be informed of the outcome.

Your participation in the project will be highly valued and appreciated.
Yours sincerely,

Ms. Joanna Menger Leeman   A/ Professor Cecelia Winkelman   Dr. Helen Aucote
   Student Researcher   Principal Supervisor   Co-Supervisor

Appendix B – 3   Studies 1 and 2 (Wave 2) - Consent Forms.

Appendix B – 3.1   Studies 1 and 2 (Wave 2) - Copy for Participants (Pen-on-Paper Version).

INFORMED CONSENT FORM
Copy for Participants to Keep

TITLE OF PROJECT: Intergenerational relationships and adult functioning (2a)

STAFF SUPERVISORS: A/Professor Cecelia Winkelman & Dr Helen Aucote

STUDENT RESEARCHER: Ms. Joanna Menger Leeman

COURSE: Combined Masters of Psychology (Child and Family)/ PhD

Participants section

I .... (*the participant*) have read and understood the information in the letter inviting participation in the research, and any questions I have asked have been answered to my satisfaction. I agree to participate in this questionnaire, realizing that I can withdraw at any time.

I agree that research data collected for the study may be published or provided to other researchers in a form that does not identify me in any way. I agree to be contacted by email or phone if needed to arrange a mutually convenient time to complete the research task. I am over 18 years of age.

I *wish to/ do not want to*   also participate in a follow-up study. (please indicate your choice) (Participants wishing to participate in a follow-up study will be contacted via email or phone.)

Name of participant: ....Email/ Phone: ………………..
                      (block letters)   *Can a message be left for you?* Yes / No

Signature: ....   Date: …………………

Research Student: Ms. Joanna Menger Leeman

Signature: ....   Date: ....

Staff Supervisor: A/Professor Cecelia Winkelman

Signature: ....   Date: ....

Staff Supervisor: Dr Helen Aucote

Signature: ....   Date: ....

Appendix B – 3.2   Studies 1 and 2 (Wave 2) - Copy of Researcher (Pen-on-Paper Version).

INFORMED CONSENT FORM
Copy for Participant to Submit

TITLE OF PROJECT: Intergenerational relationships and adult functioning

STAFF SUPERVISORS: A/Professor Cecelia Winkelman & Dr Helen Aucote

STUDENT RESEARCHER: Ms. Joanna Menger Leeman

COURSE: Combined Masters of Psychology, Child and Family/ PhD

Participants section

I _____ (*the participant*) have read and understood the information in the letter inviting participation in the research, and any questions I have asked have been answered to my satisfaction. I agree to participate in this questionnaire, realizing that I can withdraw at any time.

I agree that research data collected for the study may be published or provided to other researchers in a form that does not identify me in any way. I agree to be contacted by email or phone if needed to arrange a mutually convenient time to complete the research task. I am over 18 years of age.

I *wish to/ do not want to*   also participate in a follow-up study. (please indicate your choice) (Participants wishing to participate in a follow-up study will be contacted via email or phone.)

Name of participant: _____ Email/ Phone: …………………
                         (block letters)   *Can a message be left for you?* Yes / No

Signature: _____   Date: …………………

Research Student: Ms. Joanna Menger Leeman

Signature: _____   Date: _____

Staff Supervisor: A/Professor Cecelia Winkelman

Signature: _____   Date: _____

Staff Supervisor: Dr Helen Aucote

Signature: _____   Date: _____

Appendix B – 4   Studies 1 and 2 (Wave 2) Additional Participant Instructions.

PLEASE PASS ON THIS IDENTICAL PAPER COPY OF the
Intergenerational Relationships and Functioning Questionnaire
TO THE OTHER PARTICIPATING GENERATION IN YOUR FAMILY.

Alternatively, either one or both members of the pair can confidentially complete this same questionnaire online:
https://www.psychdata.com/s.asp?SID=136939

Appendix B – 5   Studies 1 and 2 (Wave 2): Relationships and Functioning Questionnaire (Pen-on-Paper Version).

Relationships and Functioning Questionnaire (2a: Wave 2)

Please fill in all information as accurately and honestly as possible. All responses will remain confidential.

PART ONE
The following statements deal with reactions you may have to various situations. Indicate how true each of these statements is depending on how you feel about the situation. *Please circle your answers on the scale below from 1 (not at all true) to 5 (completely true).*

I am a "take charge" person.	(*Not at all true*)	1	2	3	4	5	(*Completely true*)
I try to let things work out on their own.	(*Not at all true*)	1	2	3	4	5	(*Completely true*)
After attaining a goal, I look for another more challenging one.	(*Not at all true*)	1	2	3	4	5	(*Completely true*)
I like challenges and beating the odds.	(*Not at all true*)	1	2	3	4	5	(*Completely true*)
I visualize my dreams and try to achieve them.	(*Not at all true*)	1	2	3	4	5	(*Completely true*)
Despite numerous setbacks, I usually succeed in getting what I want.	(*Not at all true*)	1	2	3	4	5	(*Completely true*)
I try to pinpoint what I need to succeed.	(*Not at all true*)	1	2	3	4	5	(*Completely true*)
I always try to find a way to work around obstacles; nothing really stops me.	(*Not at all true*)	1	2	3	4	5	(*Completely true*)
I often see myself failing so I don't get my hopes up too high.	(*Not at all true*)	1	2	3	4	5	(*Completely true*)
When I apply for a position, I imagine myself filling it.	(*Not at all true*)	1	2	3	4	5	(*Completely true*)
I turn obstacles into positive experiences.	(*Not at all true*)	1	2	3	4	5	(*Completely true*)
If someone tells me I can't do something, you can be sure I will do it.	(*Not at all true*)	1	2	3	4	5	(*Completely true*)
When I experience a problem, I take the initiative in resolving it.	(*Not at all true*)	1	2	3	4	5	(*Completely true*)
When I have a problem, I usually see myself in a no-win situation.	(*Not at all true*)	1	2	3	4	5	(*Completely true*)

In this section, you are asked to rate how characteristic the following statements are about the family you grew up in. *The rating is on a scale from 1 (strongly disagree) to 5 (strongly agree). Your rating is your opinion, so there are no right or wrong answers. Please answer all the questions as best you can. Answer them fairly quickly, circling the first response that pops into your head without over thinking it.*

In my family, we encouraged each other to develop new friendships.	*(Strongly Disagree)*	1	2	3	4	5	*(Strongly Agree)*
Conflicts in my family never got resolved.	*(Strongly Disagree)*	1	2	3	4	5	*(Strongly Agree)*
I found it difficult to understand what other family members said and how they felt.	*(Strongly Disagree)*	1	2	3	4	5	*(Strongly Agree)*
In my family, I expressed just about any feeling I had.	*(Strongly Disagree)*	1	2	3	4	5	*(Strongly Agree)*
My family was receptive to the different ways various family members viewed life.	*(Strongly Disagree)*	1	2	3	4	5	*(Strongly Agree)*
I often had to guess at what other family members thought or how they felt.	*(Strongly Disagree)*	1	2	3	4	5	*(Strongly Agree)*
My family members rarely expressed responsibility for their actions.	*(Strongly Disagree)*	1	2	3	4	5	*(Strongly Agree)*
Sometimes in my family I did not have to say anything, but I felt understood.	*(Strongly Disagree)*	1	2	3	4	5	*(Strongly Agree)*
I found it easy to understand what other family members said and how they felt.	*(Strongly Disagree)*	1	2	3	4	5	*(Strongly Agree)*
I found it difficult to express my own opinions in my family.	*(Strongly Disagree)*	1	2	3	4	5	*(Strongly Agree)*
In my family, no one cared about the feelings of other family members.	*(Strongly Disagree)*	1	2	3	4	5	*(Strongly Agree)*
In my family, certain feelings were not allowed to be expressed.	*(Strongly Disagree)*	1	2	3	4	5	*(Strongly Agree)*
My family members usually were sensitive to one another's feelings.	*(Strongly Disagree)*	1	2	3	4	5	*(Strongly Agree)*
In my family, people took responsibility for what they did.	*(Strongly Disagree)*	1	2	3	4	5	*(Strongly Agree)*
I remember my family as being warm and supportive.	*(Strongly Disagree)*	1	2	3	4	5	*(Strongly Agree)*

In this section, you are asked to rate how characteristic the following statements are about **people in general**. Your rating is your opinion of how people in general feel about themselves and others, so there are no right or wrong answers. Since people's attitudes about themselves and others vary considerably, the questions vary considerably; some questions may seem a little strange or unusual to you. *Please answer all the questions as best you can. Answer them fairly quickly, circling the first response that pops into your head without over thinking it.*

When people really care for someone, they often feel worse about themselves.	*(Not at all characteristic)*	1	2	3	4	5	*(Very characteristic)*
When someone gets too emotionally close to another person, he/she often feels lost.	*(Not at all characteristic)*	1	2	3	4	5	*(Very characteristic)*
When people get really angry at someone, they often feel worthless.	*(Not at all characteristic)*	1	2	3	4	5	*(Very characteristic)*
It is when people start getting emotionally close to someone that they are most likely to get hurt.	*(Not at all characteristic)*	1	2	3	4	5	*(Very characteristic)*
People need to maintain control over others to keep from being harmed.	*(Not at all characteristic)*	1	2	3	4	5	*(Very characteristic)*

In this section you are asked to rate whether you think the following statements are characteristic of **your feelings about yourself and other people**. Again, these are your opinions so there are no right or wrong answers. As different people often have very different thoughts about themselves and others, the statements vary considerably. Some of them may seem strange or unusual to you, but please answer all of them the best you can. Rate each statement fairly quickly indicating the first response that pops into your head without over-thinking it.

I find that people seem to change whenever I get to know them.	*(Not at all characteristic)*	1	2	3	4	5	*(Very characteristic)*
It is easy for me to see both good and bad qualities that I have at the same time.	*(Not at all characteristic)*	1	2	3	4	5	*(Very characteristic)*
I find that people either really like me or they hate me.	*(Not at all characteristic)*	1	2	3	4	5	*(Very characteristic)*
I find that others often treat me as if I am just there to meet their every wish.	*(Not at all characteristic)*	1	2	3	4	5	*(Very characteristic)*
I find that I really vacillate between really liking myself and really disliking myself.	*(Not at all characteristic)*	1	2	3	4	5	*(Very characteristic)*
When I am by myself, I feel that something is missing.	*(Not at all characteristic)*	1	2	3	4	5	*(Very characteristic)*
I need other people around me to not feel empty.	*(Not at all characteristic)*	1	2	3	4	5	*(Very characteristic)*

I sometimes feel that part of me is lost whenever I agree with someone else.	*(Not at all characteristic)*	1	2	3	4	5	*(Very characteristic)*
Like others, whenever I see someone I really respect and to whom I look up, I often feel worse about myself.	*(Not at all characteristic)*	1	2	3	4	5	*(Very characteristic)*
I find it easy to see myself as a distinct individual.	*(Not at all characteristic)*	1	2	3	4	5	*(Very characteristic)*
Whenever I realize how different I am from my parents, I feel very uneasy.	*(Not at all characteristic)*	1	2	3	4	5	*(Very characteristic)*
In my experience, I almost always consult my mother before making an important decision.	*(Not at all characteristic)*	1	2	3	4	5	*(Very characteristic)*
I find it relatively easy to make and keep commitments to other people.	*(Not at all characteristic)*	1	2	3	4	5	*(Very characteristic)*
I find that when I get emotionally close to someone, I occasionally feel like hurting myself.	*(Not at all characteristic)*	1	2	3	4	5	*(Very characteristic)*
I find that either I really like someone or I can't stand them.	*(Not at all characteristic)*	1	2	3	4	5	*(Very characteristic)*
I often have dreams about falling that make me feel anxious.	*(Not at all characteristic)*	1	2	3	4	5	*(Very characteristic)*
I find it difficult to form mental pictures of people significant to me.	*(Not at all characteristic)*	1	2	3	4	5	*(Very characteristic)*
I have on more than one occasion seemed to wake up and find myself in a relationship with someone, and not be sure of how or why I am in the relationship.	*(Not at all characteristic)*	1	2	3	4	5	*(Very characteristic)*
I must admit that when I feel lonely, I often feel like getting intoxicated.	*(Not at all characteristic)*	1	2	3	4	5	*(Very characteristic)*
Whenever I am very angry with someone, I feel worthless.	*(Not at all characteristic)*	1	2	3	4	5	*(Very characteristic)*
If I were to tell my deepest thoughts, I would feel empty.	*(Not at all characteristic)*	1	2	3	4	5	*(Very characteristic)*
In my experience, people always seem to hate me.	*(Not at all characteristic)*	1	2	3	4	5	*(Very characteristic)*
Whenever I realize how similar I am to my parents, I feel very uneasy.	*(Not at all characteristic)*	1	2	3	4	5	*(Very characteristic)*
Often, when I am in a close relationship, I find that my sense of who I am gets lost.	*(Not at all characteristic)*	1	2	3	4	5	*(Very characteristic)*
I find it difficult for me to see others as having both good and bad	*(Not at all characteristic)*	1	2	3	4	5	*(Very characteristic)*

qualities at the same time.							
I find that the only way I can be me is to be different from other people.	*(Not at all characteristic)*	1	2	3	4	5	*(Very characteristic)*
I find that when I get emotionally too close to someone, I sometimes feel that I have lost a part of who I am.	*(Not at all characteristic)*	1	2	3	4	5	*(Very characteristic)*
Whenever I am away from my family, I feel very uneasy.	*(Not at all characteristic)*	1	2	3	4	5	*(Very characteristic)*
Getting physical attention itself seems more important to me that who gives it to me.	*(Not at all characteristic)*	1	2	3	4	5	*(Very characteristic)*
I find it difficult to really know another person well.	*(Not at all characteristic)*	1	2	3	4	5	*(Very characteristic)*
I find that it is important for me to have my mother's approval before making a decision.	*(Not at all characteristic)*	1	2	3	4	5	*(Very characteristic)*
I must admit that whenever I see someone else's faults, I feel better.	*(Not at all characteristic)*	1	2	3	4	5	*(Very characteristic)*
I am tempted to try to control other people in order to keep them close to me.	*(Not at all characteristic)*	1	2	3	4	5	*(Very characteristic)*
I must admit that whenever I get emotionally close to someone, I sometimes want to hurt them.	*(Not at all characteristic)*	1	2	3	4	5	*(Very characteristic)*

PART 2
The following section asks you some general questions about yourself.

Your sex:
☐ Male
☐ Female

Your Age: _____ (years)

What is the *highest* level of school you completed? *(please tick one)*
☐ Year 12 or equivalent
☐ Year 11 or equivalent
☐ Year 10 or equivalent
☐ Year 9 or equivalent
☐ Year 8 or equivalent
☐ Year 7 Secondary school or equivalent
☐ Grade 6 Primary school or below

What is the level of the highest qualification you have completed? *(please tick one)*
☐ University Bachelor degree or above
☐ Advanced diploma / Diploma
☐ Certificate I to IV (including trade certificate)
☐ No qualification

Which of the following best describes your current employment and income status? *(please tick one):*

- ☐ In full-time paid employment
- ☐ In part-time or casual paid employment
- ☐ Recipient of low income or disability based welfare payments
- ☐ Home duties
- ☐ Student
- ☐ Retired or engaged in unpaid / volunteer work

Who do you currently live with? *(please choose the option that best describes your household)*

- ☐ Your Partner/ Spouse only
- ☐ Your Partner/ Spouse and child(ren)
- ☐ Your child(ren) only
- ☐ Your Parent(s) only
- ☐ Your Parent(s) and siblings
- ☐ Grandparent(s) or other relatives
- ☐ Family group (spouse or nuclear family plus other relatives)
- ☐ Share-house with mostly non-relatives
- ☐ I live alone

What is your current marital/ relationship status?

- ☐ Single
- ☐ Dating (in relationship more than 2 weeks)
- ☐ Defacto/ married
- ☐ Divorced / separated
- ☐ Widowed

How many different partners have you been married to or lived with in a defacto relationship?   _____ partners

What is the length of your longest partner relationship? *(if less than 2 years, please indicate in terms of number of months, if less than a month, indicate in terms of days).*

_____ years   _____ months   _____ days

Do you have any children?

- ☐ Yes
- ☐ No, I cannot due to physical reasons
- ☐ No, I chose not to have children
- ☐ No, I am too young/ I plan to have children in future
- ☐ No, I want to have children, but do not have a partner
- ☐ Other (Please specify)

_____
_____

Did your children reside out of your care for anytime while they were growing up (under 18 years of age)? (Or if you have any children currently under 18 years, do they now or did they ever reside out of home?)

- ☐ No, they reside/ resided with me fulltime
- ☐ Yes, shared residency with other parent
- ☐ Yes, some due to Child Protection involvement
- ☐ Other (Please specify)

_____
_____

Did you grow up with both of your biological parents for all of your childhood?

- ☐ Yes
- ☐ No

As you know, this study will look at responses from two generations of a family, specifically a primary caregiver and their grown up child.
The other person from your family answering this questionnaire is your:

- ☐ Child (now an adult)
- ☐ Mother
- ☐ Father
- ☐ Foster Parent
- ☐ Grandparent (who was your primary carer)
- ☐ Other (Please specify)

Which parent or parent figure was your **primary caregiver** (the most involved in caring for your basic needs) when you were growing up?

- ☐ Biological Mother
- ☐ Biological Father
- ☐ Other (Please specify)

_____

What is the highest level of school your **primary carer** completed? (if you are not sure, please make your best guess)

- ☐ Year 12 or equivalent
- ☐ Year 11 or equivalent
- ☐ Year 10 or equivalent
- ☐ Year 9 or equivalent
- ☐ Year 8 or equivalent
- ☐ Year 7 Secondary school or equivalent
- ☐ Grade 6 Primary school or below

What is the level of the highest qualification your **primary carer** completed? (if you are not sure, please make your best guess)

- ☐ University Bachelor degree or above
- ☐ Advanced diploma / Diploma
- ☐ Certificate I to IV (including trade certificate)
- ☐ No qualification

Who was your **secondary carer** (the person next most involved in caring for your basic needs) when you were growing up?

- ☐ Biological Mother
- ☐ Biological Father
- ☐ I did not have a secondary carer
- ☐ Other (Please specify)

_____

What is the highest level of school your **secondary carer** completed? (if you are not sure, please make your best guess)

- ☐ Year 12 or equivalent
- ☐ Year 11 or equivalent
- ☐ Year 10 or equivalent
- ☐ Year 9 or equivalent
- ☐ Year 8 or equivalent
- ☐ Year 7 Secondary school or equivalent
- ☐ Grade 6 Primary school or below

What is the level of the highest qualification **secondary carer** completed? (if you are not sure, please make your best guess)

- ☐ University Bachelor degree or above
- ☐ Advanced diploma / Diploma
- ☐ Certificate I to IV (including trade certificate)
- ☐ No qualification

PART 3
The following section asks you some general questions about your current relationships.

How much does each of these people go <u>out of their way</u> to do things to make your life easier for you?

	Very much	**Somewhat**	**A Little**	**Not at all**	**No such person at current time**
Your Friends	1	2	3	4	9
Your spouse/ partner	1	2	3	4	9
Your Parent/s	1	2	3	4	9
Your Brothers/Sisters	1	2	3	4	9
Your Work Colleagues	1	2	3	4	9
Your Child/ren	1	2	3	4	9

How much can each of these people be <u>relied on</u> when things get tough?

	Very much	**Somewhat**	**A Little**	**Not at all**	**No such person at current time**
Your Friends	1	2	3	4	9
Your spouse/ partner	1	2	3	4	9
Your Parent/s	1	2	3	4	9
Your Brothers/Sisters	1	2	3	4	9
Your Work Colleagues	1	2	3	4	9
Your Child/ren	1	2	3	4	9

How much can you count on these people to <u>help you feel better</u> when you experience problems?

	Very much	**Somewhat**	**A Little**	**Not at all**	**No such person at current time**
Your Friends	1	2	3	4	9
Your spouse/ partner	1	2	3	4	9
Your Parent/s	1	2	3	4	9
Your Brothers/Sisters	1	2	3	4	9
Your Work Colleagues	1	2	3	4	9
Your Child/ren	1	2	3	4	9

How much can you count on these people to <u>give you sound advice</u> when you experience problems?

	Very much	**Somewhat**	**A Little**	**Not at all**	**No such person at current time**
Your Friends	1	2	3	4	9
Your spouse/ partner	1	2	3	4	9
Your Parent/s	1	2	3	4	9
Your Brothers/Sisters	1	2	3	4	9
Your Work Colleagues	1	2	3	4	9
Your Child/ren	1	2	3	4	9

How much can you count on these people to <u>listen to you</u> when you need to talk about problems?

	Very much	Somewhat	A Little	Not at all	No such person at current time
Your Friends	1	2	3	4	9
Your spouse/ partner	1	2	3	4	9
Your Parent/s	1	2	3	4	9
Your Brothers/Sisters	1	2	3	4	9
Your Work Colleagues	1	2	3	4	9
Your Child/ren	1	2	3	4	9

How much can you count on the following people to <u>help you out</u> in a crisis situation, even though they would have to go <u>out of their way</u> to do so?

	Very much	Somewhat	A Little	Not at all	No such person at current time
Your Friends	1	2	3	4	9
Your spouse/ partner	1	2	3	4	9
Your Parent/s	1	2	3	4	9
Your Brothers/Sisters	1	2	3	4	9
Your Work Colleagues	1	2	3	4	9
Your Child/ren	1	2	3	4	9

Feel free to share any additional information about your current relationships you feel is relevant:

_____
_____
_____

The following section asks you about things you had or did not have when you were growing up (before age 17).

When you were growing up, did your family have…
(If you had it *most of the time*, please select 'Yes')

Medical treatment if needed?
- ☐ Yes
- ☐ No, because my parents/ carergivers couldn't afford it
- ☐ No, for other reasons

Warm clothes and bedding if it was cold?
- ☐ Yes
- ☐ No, because my parents/ carergivers couldn't afford it
- ☐ No, for other reasons

A substantial meal at least once a day?
- ☐ Yes
- ☐ No, because my parents/ carergivers couldn't afford it
- ☐ No, for other reasons

Heating in at least one room of the house if needed?
- ☐ Yes
- ☐ No, because my parents/ carergivers couldn't afford it
- ☐ No, for other reasons

Dental treatment if needed?
- ☐ Yes
- ☐ No, because my parents/ carergivers couldn't afford it
- ☐ No, for other reasons

A home?
- ☐ Yes
- ☐ No, because my parents/ carergivers couldn't afford it
- ☐ No, for other reasons

A separate bed for each child?
- ☐ Yes
- ☐ No, because my parents/ carergivers couldn't afford it
- ☐ No, for other reasons

Ability to buy medicines prescribed by a doctor?
- ☐ Yes
- ☐ No, because my parents/ carergivers couldn't afford it
- ☐ No, for other reasons

A telephone?
- ☐ Yes
- ☐ No, because my parents/ carergivers couldn't afford it
- ☐ No, for other reasons

A hobby or leisure activity for children?
- ☐ Yes
- ☐ No, because my parents/ carergivers couldn't afford it
- ☐ No, for other reasons

A washing machine?
- ☐ Yes
- ☐ No, because my parents/ carergivers couldn't afford it
- ☐ No, for other reasons

Presents for family or friends at least once a year?
- ☐ Yes
- ☐ No, because my parents/ carergivers couldn't afford it
- ☐ No, for other reasons

Children in family able to participate in school activities or outings?
- ☐ Yes
- ☐ No, because my parents/ carergivers couldn't afford it
- ☐ No, for other reasons

Up-to-date school books and new or good condition school clothes for children?
- ☐ Yes
- ☐ No, because my parents/ carergivers couldn't afford it
- ☐ No, for other reasons

Use of a car if needed?
- ☐ Yes
- ☐ No, because my parents/ carergivers couldn't afford it
- ☐ No, for other reasons

A weeks holiday away from home each year?
- ☐ Yes
- ☐ No, because my parents/ carergivers couldn't afford it
- ☐ No, for other reasons

A separate bedroom for children of different genders aged over 10?
- ☐ Yes
- ☐ No, because my parents/ carergivers couldn't afford it
- ☐ No, for other reasons

In this section, you are asked about mental health and wellbeing. Please answer all the questions as best you can.

Have **you** ever had any symptoms of anxiety or depression (e.g. insomnia, excessive worrying, excessive sadness, excessive fears or panic attacks, other)?
- ☐ Yes, I currently have these symptoms
- ☐ Yes, in the past
- ☐ Yes, both currently and in the past
- ☐ No

Have **you** ever had any addictions (e.g. gambling, drug or alcohol abuse, other)?
- ☐ Yes, I currently have these symptoms
- ☐ Yes, in the past
- ☐ Yes, both currently and in the past
- ☐ No

Have **you** ever had any serious mental illness (e.g. Schizophrenia, Obsessive-Compulsive Disorder, Bipolar, other)?
- ☐ Yes, I currently have these symptoms
- ☐ Yes, in the past
- ☐ Yes, both currently and in the past
- ☐ No

Have **you** ever had any symptoms as a result of experiencing trauma (e.g. Flashbacks: re-living the experience; Avoidance: avoiding things that trigger bad memories; Dissociation i.e. periods when you blank out or lose time)?
- ☐ Yes, currently
- ☐ Yes, in the past
- ☐ Yes, both currently and in the past
- ☐ No

Are **you** currently, or have you ever received any counseling or psychiatric treatment?
- ☐ Yes, currently
- ☐ Yes, in the past
- ☐ Yes, both currently and in the past
- ☐ No

Approximately how many treatment sessions have/did you attend? _____
What year(s) did these sessions take place? _____

Did/do you find the counseling or treatment helpful?
- ☐ Yes
- ☐ No

Feel free to share any additional information about your mental health you feel is relevant:
_____
_____
_____

The following questions ask about the mental health and wellbeing *of your family other than yourself* (e.g. your mother, father, sister, brother, aunt, uncle, grandparent, cousin, child or spouse). Please answer all the questions as best you can.

Does /did anyone in your family have any symptoms of anxiety or depression (e.g. insomnia, excessive worrying, excessive sadness, excessive fears or panic attacks, other)?

☐ Yes, currently
☐ Yes, in the past
☐ Yes, both currently and in the past
☐ No

Does/did anyone in your family have any addictions (e.g. gambling, drug or alcohol abuse, other)?

☐ Yes, currently
☐ Yes, in the past
☐ Yes, both currently and in the past
☐ No

Does/did anyone in your family have any serious mental illness (e.g. Schizophrenia, Obsessive-Compulsive Disorder, Bipolar, other)?

☐ Yes, currently
☐ Yes, in the past
☐ Yes, both currently and in the past
☐ No

Does/did anyone in your family have any symptoms as a result of experiencing trauma (e.g. Flashbacks: re-living the experience; Avoidance: avoiding things that trigger bad memories; Dissociation i.e. periods when they blank out or lose time)?

☐ Yes, currently
☐ Yes, in the past
☐ Yes, both currently and in the past
☐ No

Feel free to share any additional information about your family's mental health you feel is relevant.

_____
_____
_____

The following section asks you about **your current health and wellbeing**.

How often have you experienced each of the following <u>in the last two months</u>? *The rating is on a scale from 1 (never) to 5 (often).*

Headaches	(Never)	1	2	3	4	5	(Often)
Insomnia (trouble getting to sleep)	(Never)	1	2	3	4	5	(Often)
Weight loss (without dieting)	(Never)	1	2	3	4	5	(Often)
Stomach problems	(Never)	1	2	3	4	5	(Often)
Sexual problems	(Never)	1	2	3	4	5	(Often)
Feeling isolated from others	(Never)	1	2	3	4	5	(Often)
"Flashbacks" (sudden, vivid distracting memories)	(Never)	1	2	3	4	5	(Often)
Restless sleep	(Never)	1	2	3	4	5	(Often)
Low sex drive	(Never)	1	2	3	4	5	(Often)
Anxiety attacks	(Never)	1	2	3	4	5	(Often)
Sexual overactivity	(Never)	1	2	3	4	5	(Often)
Loneliness	(Never)	1	2	3	4	5	(Often)
Nightmares	(Never)	1	2	3	4	5	(Often)
"Spacing out" (going away in your mind)	(Never)	1	2	3	4	5	(Often)
Sadness	(Never)	1	2	3	4	5	(Often)
Dizziness	(Never)	1	2	3	4	5	(Often)
Not feeling satisfied with your sex life	(Never)	1	2	3	4	5	(Often)
Trouble controlling your temper	(Never)	1	2	3	4	5	(Often)
Waking up early in the morning and can't get back to sleep	(Never)	1	2	3	4	5	(Often)
Uncontrollable crying	(Never)	1	2	3	4	5	(Often)
Fear of men	(Never)	1	2	3	4	5	(Often)
Not feeling rested in the morning	(Never)	1	2	3	4	5	(Often)
Having sex that you didn't enjoy	(Never)	1	2	3	4	5	(Often)
Trouble getting along with others	(Never)	1	2	3	4	5	(Often)
Memory problems	(Never)	1	2	3	4	5	(Often)
Desire to physically hurt yourself	(Never)	1	2	3	4	5	(Often)

Fear of women	*(Never)*	1	2	3	4	5	*(Often)*
Waking up in the middle of the night	*(Never)*	1	2	3	4	5	*(Often)*
Bad thoughts or feelings during sex	*(Never)*	1	2	3	4	5	*(Often)*
Passing out	*(Never)*	1	2	3	4	5	*(Often)*
Feeling that things are "unreal"	*(Never)*	1	2	3	4	5	*(Often)*
Unnecessary or over-frequent washing	*(Never)*	1	2	3	4	5	*(Often)*
Feeling of inferiority	*(Never)*	1	2	3	4	5	*(Often)*
Feeling tense all the time	*(Never)*	1	2	3	4	5	*(Often)*
Being confused about your sexual feelings	*(Never)*	1	2	3	4	5	*(Often)*
Desire to physically hurt others.	*(Never)*	1	2	3	4	5	*(Often)*
Feelings of guilt	*(Never)*	1	2	3	4	5	*(Often)*
Feelings that you are not always in your body	*(Never)*	1	2	3	4	5	*(Often)*
Having trouble breathing	*(Never)*	1	2	3	4	5	*(Often)*
Sexual feelings when you shouldn't have them	*(Never)*	1	2	3	4	5	*(Often)*

PART 4

The following section asks about things that may have happened to you in the past.
Please answer all of the questions that you can, as honestly as possible.

To the best of your knowledge, before age 17, were you ever:

Sexually abused?	Yes	No
Physically abused?	Yes	No
Physically neglected?	Yes	No
Emotionally neglected?	Yes	No

Before age 17, did any parent, step-parent, or foster-parent ever have problems with drugs or alcohol that led to medical problems, divorce or separation, being fired from work, or being arrested for intoxication in public or while driving?

☐ Yes
☐ No

Before age 17, did you ever see any older member of your family (e.g. parent, grandparent, elder sibling, uncle/ aunt) hit or beat up another family member?

☐ Yes, and on one or more of these times, this resulted in someone needing medical care or the police being called.
☐ Yes, but no medical care was sought/ required and police were never contacted.
☐ No

Please answer the following questions, giving a rating on the scale from 1 (not at all) to 5 (very much). Please only answer N/A (not applicable) if, at that age, there was no such person in your life, or if that person was no longer alive.

	(Not at all)	1	2	3	4	5	*(Very much)*	N/A
On average, **before age 8**, how much did you feel that your **father**/step-father/foster-father loved and cared about you?	*(Not at all)*	1	2	3	4	5	*(Very much)*	N/A
On average, **before age 8**, how much did you feel that your **mother**/ step-mother/ foster-mother loved and cared about you?	*(Not at all)*	1	2	3	4	5	*(Very much)*	N/A
On average, from **age 8 through age 17**, how much did you feel that your **father**/step-father/foster-father loved and cared about you?	*(Not at all)*	1	2	3	4	5	*(Very much)*	N/A
On average, from **age 8 through age 17**, how much did you feel that your **mother**/ step-mother/ foster-mother loved and cared about you?	*(Not at all)*	1	2	3	4	5	*(Very much)*	N/A

When you were 17 or younger, how often did the following happen to you in the average year? *Answer in terms of your parents, stepparents, foster-parents, or any other adult in charge of you as a child, including teachers and babysitters. Please tick the closest answers.*

	Never	Once or twice a year	3 to 5 times a year	6 to 20 times a year	Over 20 times a year
Yell at you	1	2	3	4	5
Insult you	1	2	3	4	5
Criticize you	1	2	3	4	5
Try to make you feel guilty	1	2	3	4	5
Ridicule or humiliate you	1	2	3	4	5
Embarrass you in front of others	1	2	3	4	5
Make you feel like you were a bad person	1	2	3	4	5

Before you were 8, how often did the following happen to you in the average year? *(please tick the closest answers)*

	Never	Once or twice a year	3-20 times a year	Over 20 times a year	I do not remember
You were left without supervision by an adult or responsible babysitter/ minder for more than 2 hours.	1	2	3	4	5
You went to school without any lunch.	1	2	3	4	5
There was nothing to eat for breakfast at home and you had to go without.	1	2	3	4	5
There was nothing to eat for dinner/tea at home and you had to go without.	1	2	3	4	5
You required medical attention but did not get it.	1	2	3	4	5

Before age 17, did a parent, step-parent, foster-parent, or other adult in charge of you as a child ever do something to you on purpose that made you bleed or gave you bruises or scratches, or that broke bones or teeth? (for example, hit or punch or cut you, or push you down)

☐ Yes, I was hurt so badly by my carer that I had to see a doctor or go to the hospital

☐ Yes, but I was not hurt so badly that I needed any medical attention.

☐ No

Before age 17, did any of the following persons ever kiss you in a sexual way, or touch your body in a sexual way, or make you touch their sexual parts?

A family member?	Yes	No
A non-family member who was five or more years older than you?	Yes	No

Overall, how many people did this to you?

How many members of your family?	_____
How many non-family members (who were five or more years older than you)?	_____

Before you were age 17, did any of the following persons ever have oral, anal, or vaginal intercourse with you, or insert a finger or object in your anus or vagina?

A family member?	Yes	No
A non-family member who was five or more years older than you?	Yes	No

Overall, how many people did this to you?

How many members of your family?	_____
How many non-family members (who were five or more years older than you)?	_____

Feel free to share any additional information about any abuse that you feel is relevant.

_____
_____
_____

Matching of pairs

This study asks for two members of the same family to each separately and confidentially complete the same questionnaire. (One of the participants is to have been the primary carer of the other when the other was growing up.) The first family member to complete the questionnaire is asked to recruit the second person. It is important to the design of this study to be able to match the two family members, using their Respondent ID, so that we can look at similarities and differences in family responses. This is for analysis purposes only. All of your responses will remain confidential and the other person will NOT be able to see any of your responses to this questionnaire.

Your Respondent ID is: _____

Are you the first or the second person from your family to take this questionnaire?

☐ I am the first. I will be recruiting the second person.

(Please provide your Respondent ID (recorded above) to the other person who will be completing this survey. This is so that we can match the information provided.)

☐ I am the second. The other person gave me their Participant ID, for matching purposes, it is:

_____.

Thank you for completing this questionnaire.
Your time and input are considered very valuable and are appreciated.

Again, should you feel upset or worried as a result of undertaking this questionnaire, please contact the numbers provided on the covering page (Information letter to participants).

Appendix C   Study 3a - Expert Panel Invitation and Survey.
　　　　　Appendix D – 1   Study 3a – Email Invitation to Professionals.

Dear _____,

Thank you for your support and assistance for my PhD research into the intergenerational effects of child abuse.

I would greatly value your comment and feedback, as a professional in this area of work, on the proposed final study (Study 3).

Study 3 is a brief three-question open answer online survey. It is a follow-up study for people who participated in the Relationships and Functioning questionnaire and who gave their details to participate in a further study.

I am asking for feedback on the three questions from 10 professionals including yourself. Please find attached a letter detailing this request. I will also send a hardcopy to you by post.

Kind regards,
Jo

Joanna Menger Leeman
Student, ACU Combined Psychology Masters (Child & Family) / PhD Candidate

Appendix C – 2   Study 3a: Expert Panel Survey.

Professional feedback re: Relationships and Functioning, follow-up study

Thank you for your support and assistance for my PhD research into the intergenerational effects of child abuse.

I would greatly value your comment and feedback, as a professional in this area of work, on the proposed final study.

The final study (Study 3) is to be a qualitative follow-up survey of a sub-set of individuals who participated in my Relationships and Functioning Questionnaire. These individuals provided their contact details and indicated their interest in being involved in a further study.

The aim of Study 3 is to explore specific aspects of people's experience of their caregiving relationship with respect to three terms important to complex abuse: trust, hurt, and healing.

Following this current page you will be taken through the proposed Study 3 survey as you would see it if you were a participant. I ask participants only three open answer questions. However, **I invite you to please use the open text response sections of these questions to make your own professional comment**. The wording of these questions has been given particular thought, but perhaps you may have alternate suggestions about the wording or focus of the questions?

Qualitative studies commonly use face-to-face interviews, but can also take other forms, such as this open-answer survey. I plan to conduct detailed analysis of each individual's responses using Interpretative Phenomenological Analysis (IPA). IPA is a theoretical and methodological approach to psychological research that permits 'detailed examination of individual lived experience and how individuals make sense of that experience' (Eatough & Smith, 2008, p.179). IPA aims to explore rather than explain, thereby providing opportunity for people to tell their story; 'giving voice' and 'making sense' (Larkin & Thompson, 2012, p. 101).

Comment sections in my earlier Relationship and Functioning Questionnaire have achieved some rich detailed comment from some participants. I hope to get rich and full responses to these three follow-up questions. One limitation of using an online survey design is in forming a rapport that invites the participant to want to answer fully. The wording of the questions and the overall look of the survey is, therefore, very important.

Please note, a deliberate design strategy in my earlier intergenerational-paired studies means that participants may be naive to their participant-pair having a history of childhood abuse. Therefore, the wording of questions Study 3 avoids specific mention of childhood abuse or trauma.

You will be seeing the survey as if you were a participant. This means that once you have left a question, you will not be able to return to it. There is a place for further comment at the end, or should you wish it, you are welcome to repeat the survey once seeing it in full.

It would be helpful if you could please identify yourself somewhere in your response and provide your email address, so that I can contact you, if necessary, for further clarification or discussion in regard to your comments.

After incorporating feedback, I hope to open Study 3 to participants as soon as possible. Could you please make your comments available before **20th December 2011?** This survey link will be closed after that date. Participants for Study 3 will be given a new survey weblink.

Thank you again. Your time and feedback are much appreciated.

Regards,

Jo

Joanna Menger Leeman, PhD Candidate & student researcher, Australian Catholic University, email: joleem001@myacu.edu.au

Under the supervision of: A/Professor Cecelia Winkelman, Principal Supervisor & Registered Psychologist email: Cecelia.Winkelman@acu.edu.au and Dr. Helen Aucote, Co-Supervisor, email: Helen.Aucote@acu.edu.au

PS. Due to slow recruitment, my intergenerational-paired Study 2a Relationships and Functioning Questionnaire will remain open alongside Study 3 until June 2012. I am still seeking participants for Study 2a. Study 2a has a target population of people who identify as a survivor of childhood abuse. Should you know of anyone who might be interested in participating, please email me and I can send out flyers or paper copies as appropriate. Thank you.

You are invited to participate in follow-up research into intergenerational family relationships and adult functioning.

 As a follow-up study, this survey is only intended for people who earlier completed the Relationships and Functioning questionnaire. Welcome back! Your participation in the project is highly valued and appreciated.

This study asks three questions.

This study has been approved by the Human Research Ethics Committee at Australian Catholic University.

Full participant information about this study is available below.

By participating in this study, it is assumed that you have read the full participant information and give your informed consent to participate.

*1) I wish to read full participant information about this study

   Yes, show me full participant information   No, I am satisfied I have enough information and wish to continue

Question Logic
If [Yes, show me full participant information...] is selected, then skip to question [No logic applied]
If [No, I am satisfied I have enough information and w...] is selected, then skip to question [#2]

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INFORMATION LETTER TO PARTICIPANTS

TITLE OF PROJECT: Intergenerational relationships and adult functioning (Study 3)

STAFF SUPERVISORS: A/Professor Cecelia Winkelman and Dr. Helen Aucote

PhD STUDENT RESEARCHER: Ms. Joanna Menger Leeman

Dear Participant,

Thank you for your earlier participation in the Relationships and Functioning Questionnaire. We appreciate both your commitment of time and generous sharing of your experiences.

You are now invited to participate in a smaller qualitative study into intergenerational family relationships and adult functioning. The current study asks only three open-response questions. The purpose of this study is to examine in greater depth particular experiences and the meaning you give to these experiences.

Completing the questionnaire may prompt you to consider in greater detail your family and life experiences. The consequences of this are expected to be positive and help you to reflect upon some important aspects of your interpersonal and family relationships. However, if answering the questionnaire made you feel distressed or uncomfortable in any way, feel free to contact Dr. Barbara Jones, a Registered Psychologist working in the School of Psychology at Australian Catholic University, Melbourne Australia on +613 9953 3464, who will refer you to an appropriate counseling service. As this study is online and participants may live around the world, referral to an appropriate counseling service local to you can be accessed via the link to national psychology associations that are displayed when you complete the study.

All information obtained from the questionnaires will be kept confidential and kept in a securely locked cupboard in the storage room 2.29 in the School of Psychology at the Australian Catholic University, St. Patrick's campus for the statutorily required period of time (currently 5 years). The information obtained from the questionnaires will be the basis of the Combined Masters/PhD thesis of Joanna Menger Leeman, a student at the Australian Catholic University. None of the reports will identify you. The results may be published in professional journals or reported at conferences.

The responses you give will be examined closely so that we can identify, firstly, the things that are important to you about your experience, and secondly, so that we can see what connections there are between your experience and other people's. In the final report, which will be publicly available, but mainly read by scientists and health professionals, we will quote from your survey responses, and from other surveys that we have collected. People will be able to see what you said, but they won't know that it was you who said it. We will give you a made-up name, and will change any references that you make to other people's real names or other potentially identifying details. Furthermore, if we think that there is a risk that readers of the work might be able to identify you from any of the quotes that we wish to use, we will check them with you

before using them.

If you have any questions about the project, before or after participating, please contact Joanna Menger Leeman, email: joleem001@myacu.edu.au or Ph: +613 9953 3106 at the Australian Catholic University, School of Psychology, St Patrick's Campus at 115 Victoria Parade, FITZROY VICTORIA AUSTRALIA 3065. Alternatively, you are welcome to contact the Supervisors of the study, A/Professor Cecelia Winkelman, email: Cecelia.Winkelman@acu.edu.au Ph: +613 9953 3112 or Dr. Helen Aucote, email: Helen.Aucote@acu.edu.au Ph: +613 9953 3013, at the same address as above.

This study has been approved by the Human Research Ethics Committee at Australian Catholic University. In the event that you have any complaint or concern about the way you have been treated during the study, or if you have any query that the Principal Investigator has not been able to satisfy, you may write to: Chair, Human Research Ethics Committee, C/o Research Services, Australian Catholic University, Locked Bag 4115 FITZROY VICTORIA AUSTRALIA 3065 Tel: +613 9953 3157 Fax: +613 9953 3315

If you are willing to participate, please press the "Continue" button below. By continuing, it will be assumed that you are over 18 years of age, have read and understood the above participant information, and any questions you may have asked have been answered to your satisfaction. You are able to withdraw at any time. By continuing with this study, you are agreeing that research data collected for the study may be published or provided to other researchers in a form that does not identify you in any way. Your participation in the project is highly valued and appreciated.

Yours sincerely,

Ms. Joanna Menger Leeman, PhD Researcher email: joleem001@myacu.edu.au

 A/Professor Cecelia Winkelman, Principal Supervisor & Registered Psychologist email: Cecelia.Winkelman@acu.edu.au

Dr. Helen Aucote, Co-Supervisor, email: Helen.Aucote@acu.edu.au

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*1) TRUST: What is your experience of your parent in terms of learning about trust?

(This is the first of three questions. Please write about your experience and the meaning you make of your experience. Write as much as you want.
Once you submit your response (by pressing 'Continue' or 'Save and Exit'), you won't be able to return to this question to add or edit.)

(NOTE FOR PROFESSIONALS: This is the format for the proposed Study 3* survey as you would see it if you were a participant. I ask participants only three open answer questions. However, **I invite you to please use the open text response sections of these questions to make your own professional comment**. You can write your comment here and post it to me in the reply-paid envelope provided, or put your comments in the online survey: **https://www.psychdata.com/s.asp?SID=144525.** The online survey is currently only open to professionals for feedback. *Thanks.)*

(28000 characters remaining)

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*2) HURT: What is your experience of your parent in terms of learning about hurt?

(This is the second of three questions. Please write about your experience and the meaning you make of your experience. Write as much as you want.)

(28000 characters remaining)

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*3) HEALING: What is your experience of your parent in terms of learning about healing?

(This is the last question. Please write about your experience and the meaning you make of your experience. Write as much as you want.)

(28000 characters remaining)

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4) Thank you very much for your valued contribution to this research.

Please add any further response you may have in relation to the three questions.

(NOTE FOR PROFESSIONALS: Please also provide your name and email address here, so that I can contact you, if necessary, for further clarification or discussion in regard to your comments. Thanks.)

(28000 characters remaining)

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(Your professional feedback on 3 questions) Relationships and Functioning follow-up study

Thank you!

Completing this online questionnaire may have prompted you to consider in greater detail your family and life experiences. The consequences of this are expected to be positive and help you to reflect upon some important aspects of your interpersonal and family relationships. However, if answering the questionnaire made you feel distressed or uncomfortable in any way, feel free to contact Dr. Barbara Jones, a Registered Psychologist working in the School of Psychology at Australian Catholic University, Melbourne Australia on +613 9953 3464, who will refer you to an appropriate counselling service.

As this study is online and participants may come from around the world, referral to an appropriate counselling service local to you can be accessed via the links to national psychology associations below:

Links for finding a psychologist

Australia: http://www.psychology.org.au/FindaPsychologist/Default.aspx?Mode=Quick

New Zealand: http://www.psychology.org.nz/Find_a_Psychologist

America: http://locator.apa.org or http://www.findapsychologist.org

United Kingdom: http://www.bps.org.uk/e-services/find-a-psychologist

If you do not reside in one of the above listed countries, you can access a local service directory by contacting your closest psychological association http://www.apa.org/international/natlorgs.html

For maximum confidentiality, please close this window.

Appendix D   Study 3b Participant Recruitment and Informed Consent.
Appendix D– 1   Study 3b - Information Letter.

INFORMATION LETTER TO PARTICIPANTS

TITLE OF PROJECT: Intergenerational relationships and adult functioning (Study 3b*)

STAFF SUPERVISORS: A/Professor Cecelia Winkelman and Dr. Helen Aucote

STUDENT RESEARCHER: Ms. Joanna Menger Leeman

PROGRAMME IN WHICH ENROLLED: Combined M/Psych (Child & family)/ PhD

Dear Participant,

Thank you for your earlier participation in the Relationships and Functioning Questionnaire. We appreciate both your commitment of time and generous sharing of your experiences.

You are now invited to participate in a smaller qualitative study into intergenerational family relationships and adult functioning. The current study asks three open-response questions and has a space at the end for your comments. The purpose of this study is to examine in greater depth particular experiences and the meaning you give to these experiences. This study is also available online: https://www.psychdata.com/s.asp?SID=146393.

Completing the questionnaire may prompt you to consider in greater detail your family and life experiences. The consequences of this are expected to be positive and help you to reflect upon some important aspects of your interpersonal and family relationships. However, if answering the questionnaire made you feel distressed or uncomfortable in any way, feel free to contact Dr. Barbara Jones, a Registered Psychologist working in the School of Psychology at Australian Catholic University, Melbourne Australia on +613 9953 3464, who will refer you to an appropriate counseling service. As this study is online and participants may live around the world, referral to an appropriate counseling service local to you can also be accessed via the link to national psychology associations that are displayed when you complete the study.

You are free to refuse to participate in this study without having to justify that decision. You are able to withdraw consent and discontinue participation in the study at any time without giving a reason.

All information obtained from the questionnaires will be kept confidential and kept in a securely locked cupboard in the storage room 2.29 in the School of Psychology at the Australian Catholic University, St. Patrick's campus for the statutorily required period

of time (currently 5 years). The information obtained from the questionnaires will be the basis of the Combined Masters/PhD thesis of Joanna Menger Leeman, a student at the Australian Catholic University. None of the reports will identify you. The results may be published in professional journals or reported at conferences.

The responses you give will be examined closely so that we can identify, firstly, the things that are important to you about your experience, and secondly, so that we can see what connections there are between your experience and other people's. In the final report, which will be publicly available, but mainly read by scientists and health professionals, we will quote from your survey responses, and from other surveys that we have collected. People will be able to see what you said, but they won't know that it was you who said it. We will give you a made-up name, and will change any references that you make to other people's real names or other potentially identifying details. Furthermore, if we think that there is a risk that readers of the work might be able to identify you from any of the quotes that we wish to use, we will check them with you before using them.

If you have any questions about the project, before or after participating, please contact Joanna Menger Leeman, email: joleem001@myacu.edu.au or Ph: +613 9953 3106 at the Australian Catholic University, School of Psychology, St Patrick's Campus at 115 Victoria Parade, FITZROY VICTORIA AUSTRALIA 3065. Alternatively, you are welcome to contact the Supervisors of the study, A/Professor Cecelia Winkelman, email: Cecelia.Winkelman@acu.edu.au Ph: +613 9953 3112 or Dr. Helen Aucote, email: Helen.Aucote@acu.edu.au Ph: +613 9953 3013, at the same address as above.

This study has been approved by the Human Research Ethics Committee at Australian Catholic University. In the event that you have any complaint or concern about the way you have been treated during the study, or if you have any query that the Principal Investigator has not been able to satisfy, you may write to: Chair, Human Research Ethics Committee, C/o Research Services, Australian Catholic University, Locked Bag 4115 FITZROY VICTORIA AUSTRALIA 3065 Tel: +613 9953 3158 Fax: +613 9953 3315. Any complaint or concern will be treated in confidence and fully investigated. The participant will be informed of the outcome.

If you agree to participate in this project, you should sign both copies of the Consent Form, retain one copy for your records and return the other copy to the Principal Supervisor or Student Researcher.

Yours sincerely,

Ms. Joanna Menger Leeman   A/ Professor Cecelia Winkelman   Dr. Helen Aucote
   PhD Student, Researcher   Principal Supervisor   Co-Supervisor

Appendix D - 2   **Study 3b - Consent Forms.**

Appendix D- 2.1   *Study 3b - Copy for Participants.*

CONSENT FORM
Copy for Participant to Keep

TITLE OF PROJECT: Intergenerational relationships and adult functioning (Study 3)

STAFF SUPERVISORS: A/Professor Cecelia Winkelman and Dr. Helen Aucote

STUDENT RESEARCHER: Ms. Joanna Menger Leeman

I .... *(the participant)* have read and understood the information provided in the Letter to Participants. Any questions I have asked have been answered to my satisfaction. I agree to participate in this follow-up study, which asks three open-answer questions, realising that I can withdraw my consent at any time without adverse consequences. I agree that research data collected for the study may be published or may be provided to other researchers in a form that does not identify me in any way. I am over 18 years of age.

NAME OF PARTICIPANT: ....

SIGNATURE: ....   DATE: ....

Signature: _____   Date: _____
PhD Research Student: Ms. Joanna Menger Leeman

Signature: _____   Date: _____
Principal Supervisor: A/Professor Cecelia Winkelman

Signature: _____   Date: _____
Co-Supervisor: Dr. Helen Aucote

Appendix D– 2.2   Study 3 - Copy of Researcher.

CONSENT FORM
Copy for Researcher

TITLE OF PROJECT: Intergenerational relationships and adult functioning (Study 3)

STAFF SUPERVISORS: A/Professor Cecelia Winkelman and Dr. Helen Aucote

STUDENT RESEARCHER: Ms. Joanna Menger Leeman

I .... *(the participant)* have read and understood the information provided in the Letter to Participants. Any questions I have asked have been answered to my satisfaction. I agree to participate in this follow-up study, which asks three open-answer questions, realising that I can withdraw my consent at any time without adverse consequences. I agree that research data collected for the study may be published or may be provided to other researchers in a form that does not identify me in any way. I am over 18 years of age.

NAME OF PARTICIPANT: ....

SIGNATURE: ....   DATE: ....

Signature: ....   Date: ....
PhD Research Student: Ms. Joanna Menger Leeman

Signature: ....   Date: ....
Principal Supervisor: A/Professor Cecelia Winkelman

Signature: ....   Date: ....
Co-Supervisor: Dr. Helen Aucote

Appendix D -3   Study 3b: Qualitative Questionnaire.

**Relationships and Functioning
follow-up study**

**You are invited to participate in follow-up research into intergenerational family
relationships and adult functioning.**

**As a follow-up study, this survey is only intended for people who earlier completed
the Relationships and Functioning questionnaire. Welcome back! Your
participation in this project is highly valued and appreciated.**

**This study asks three questions and has further space at the end for your
comments.**

**This study has been approved by the Human Research Ethics Committee at
Australian Catholic University.**

Full participant information about this study is attached.

_____

Optional

Draw to win iPod Shuffle

Study 3b: Relationships and Functioning follow-up study

Enter Draw Here:
Participants of this follow-up study are invited to enter a draw to win an iPod Shuffle.
Entries close 1st June 2012. The winner will be notified by email or phone. If you wish
to enter the draw, enter your email address or phone number below:

Email or phone number: _____
_____

Q 1.*
TRUST: In the relationship with your parent, what did you learn about trust?

(This is the first of three questions. Please write about your experience and the meaning you make of your experience. Write as much as you want. There will be a space at the end of the questionnaire for further comment.)

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Q 2.*
HURT: In the relationship with your parent, what did you learn about hurt?

(This is the second of three questions. Please write about your experience and the meaning you make of your experience. Write as much as you want.)

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Q 3.*
HEALING: In the relationship with your parent, what did you learn about healing?

(This is the last question. Please write about your experience and the meaning you make of your experience. Write as much as you want.)

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Thank you for your contribution to this research. Please add any further response you may have in relation to the three questions.

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* For the purpose of pairing your responses to your previous survey, please enter the email address or phone number you provided for follow-up contact:

Email or phone number: _____

[***** Questions marked with an asterisk in the Psychdata online version of the Relationships and Functioning Follow-up Survey required a participant response.]
_____
Study 3: Relationships and Functioning follow-up study
Thank you!

Your contribution to this study is valued.

Completing this questionnaire may have prompted you to consider in greater detail your family and life experiences. The consequences of this are expected to be positive and help you to reflect upon some important aspects of your interpersonal and family relationships. However, if answering the questionnaire made you feel distressed or uncomfortable in any way, feel free to contact Dr. Barbara Jones, a Registered Psychologist working in the School of Psychology at Australian Catholic University, Melbourne Australia on +613 9953 3464, who will refer you to an appropriate counselling service.

As this study is also online and participants may come from around the world, referral to an appropriate counselling service local to you can be accessed via the links to national psychology associations below:

Links for finding a psychologist

Australia: http://www.psychology.org.au/FindaPsychologist/Default.aspx?Mode=Quick

New Zealand: http://www.psychology.org.nz/Find_a_Psychologist

America: http://locator.apa.org or http://www.findapsychologist.org

United Kingdom: http://www.bps.org.uk/e-services/find-a-psychologist

If you do not reside in one of the above listed countries, you can access a local service directory by contacting your closest psychological association: http://www.apa.org/international/natlorgs.html

Appendix E   Study 3b Independent Audit

Appendix E – 1   Independent Audit 1.

"Isabelle"								
Researcher's Themes	Line #	Key words	Independent Reviewer's (IR) Themes	Line #	IR - Match	IR-Agree-ment	Missing in Original	Missing in IR
Limited capacity for trust			**Relationship with abuser damages person's capacity to trust**			√1		
Insecure trust in others	1-3	i learned that I cant trust a lot of people. often in social circles I often wander if people are only being nice to me on the surface and if they're bitching about me.	Others are untrustworthy & Feeling insecure in social situations	1 2-3		√2		
Building trust takes time	3-5	I have been in a stable relationship for 4 years and it has taken me three years to cry in front of him.	Building trust is a long/slow process.	3-5	√1			
Abusive parent manipulated trust.	5-7	My father would often manipulate to gain trust and if you gave him an inch he would take a mile.	Past boundary violations (abuser) impair ability to trust	5-7		√3		
Trust involves being vulnerable	9-10	… I have opened myself to my partner, …	Opening up/ being vulnerable	9-10		√4		
Specific	SS3	I often find it hard to trust	Men can be a source of pain					

impairment of trust in men		men				√5		
Expectation of future hurt			Preparing for inevitable hurt and abandonment	9-10		√6		
Feeling vulnerable to hurt.	8-9	if you open yourself up to people you could get very badly hurt.	**Constantly feeling vulnerable**	8-9	√2			
Anticipating hurt.	9-11	Even-though I have opened myself to my partner, I am often preparing myself for that day when he'll leave me.	Anticipating abandonment – the ultimate hurt	9-11		√7		
Rejection of new relationships.	11	I dont try to make friends anymore.	Avoiding anticipated hurt	11		√8		
Healing			**Healing is possible**			√9		
Non-abusive parent assisted healing.	12 SS1-2	my mother and God helped me heal. my mother and God are the only reason I am here.	Support from non-abusive parent aids healing & Reasons for living	12 & SS 1-2		√10		
Faith in God assisted healing.	12 SS1-2	my mother and God helped me heal. my mother and God are the only reason I am here.	Spiritual beliefs aids healing. & Reasons for living	12 & SS1-2		√11		

Identifying as a survivor.	12-15	…the thing that healed me the most is the greatest decision i made, which was to stop acting like a victim and start acting like a survivor.	Identification as Survivor	14	√3			
Healing is incremental and takes time	PP1-2	It has been 8yrs since the DVO, every-year I have improved.	Improvements in wellbeing over time			√12		
Healing means having less flashbacks, anxiety and fear	PP2-3	The flash backs, and anxiety has lessened every year. I am starting to live life without fear.	less trauma symptoms			√13		
			Restored sense of agency (new beginning - no longer controlled by fear	PP3			√1	
Experience of Abuse			**Impact of abuse**			√14		
			Disempowered by abuser	CA3-5			√2	
Humiliated by abuser	CA1	I was always humiliated	Shame and humiliation	CA1 & CA6-7		√15		
Siblings' experiences of abuse	CA7-8	He did this to my brothers too.	Abuser demeans, degrades all of his children	CA8-9		√16		
TOTAL	#21				3	16	2	0
19/21 = 90%								

Appendix E – 2   Independent Audit 2.

"Jasmine"								
Researcher's Themes	**Line #**	**Key words**	**Independent Reviewer's (IR) Themes**	**Line #**	**Match**	**Agree-ment**	**Missing in Original**	**Missing in IR**
Ambivalence in trust of caregivers			**Ambivalence regarding trusting caregivers**		√1			
Inconsistent caregiver trustworthiness.	1-2	*trust was conditional. and it depended on circumstances*	Trust in others is fragile/ unstable	1-2, 3-4		√1		
			Trusted that basic needs would be met.	4-5			√1	
Abandonment by caregivers	7-8	*she could go away any time and not come back*	Abandoned, betrayed by family members. &	2-3, 5-7		√2		
	13	*the hurt of abandonment*	Hurt: Abandonment is painful.	12-13				
Abuse disclosure ignored by caregivers	3-4 CA3-4	*i cannot trust her (grandmother/ primary carer) with telling her that i was abused by my grandfather* *once i told grandma and she ignored me*	Could not rely upon adults around her to protect her.	CA3-4		√3		
Insensitive caregiver responses	CA5	*she yelled at me*	Adults thwarted her efforts to protect herself.	CA4-6		√4		
Hurt			**Hurt**		√2			

Hurt by multiple caregivers.	10-11 12-13	*my grandmother and grandfather can hurt me i learnt from my mother the hurt of abandonment.*						√1
Unable to retaliate	11-12	*i cannot hurt them back because that would mean i am a bad person*	Retaliation not allowed	10-11 11-12		√5		
Unresolved hurt prevents healing	14-16	*she (grandmother/ primary carer) has been back in china since i was young*	Unresolved hurt	14-16		√6		
Describing the abuse	CA1-3	*my step-grandfather touched me in a sexual way from age 5 to 10 (approx) and flash his privates at me. never insertion*	27. Sexually abused - grandfather (Middle childhood)	CA1-3		√7		
Impact of Abuse			**Impact of Abuse**		√3			
Memory – recollection of abuse incomplete/ uncertain	CA3	*never insertion... not that i can remember.*	27. Sexually abused - grandfather (Middle childhood) – wondering about further abuse	CA1-3		√8		
Resilient outcomes			**Possibility of healing**			√9		
Developing trusting relationships (mother)	16-18	*i did most healing with my mother. i learnt that i can trust her with my feelings.*	Developed trusting relationship with Mother.	16-18	√4			

Developing trusting relationships (partner)	SS2-4	*... the relationship [with current boyfriend] is full of trust, love, respect, communication, understanding*	**Supportive intimate relationship**- Support from current boyfriend; new experience	SS1-2, SS4-5		√10		
Being understood	18-20 SS4	*and that she [mother] was able to understand my pain as opposed to before when i thought she did not understand at all.* *...understanding,...[by boyfriend]*	Understanding another's pain facilitates healing.	18-19		√11		
Cultural taboos about mental illness.	FP1-3, FP5-6	*A) chinese culture do not recognise mental illness, B) chinese culture look down on mental illness[...] in china, mental illness can get you into trouble so no one did anything about it etc.*	**Cultural taboos around mental illness** – Mental illness does not exist; Stigma, shame associated with mental illness; Psychological distress is concealed/ unaddressed.	FP 1-2, FP3, FP5-6	√5			
TOTAL # 18					**5**	**11**	**1**	**1**
16/18 = 89%								

Appendix E - 3   Independent Audit 3.

"Olivia"									
Researcher's Themes	**#**	**Line #**	**Key words**	**Independent Reviewer's (IR) Themes**	**Line #**	**Match**	**Agree -ment**	**Missing in Original**	**Missing in IR**
Trust has parts	1	1-4	*Trust has both positive and negative connotations. I could trust that I would be looked after for the basics of life (eg food, shelter, clothes etc) but when it came to emotional issues I learnt not to trust.*	Mixed associations with trust.(1)	1-4		√1		
Could trust basic physical needs would be met.	2	1-3	*I could trust that I would be looked after for the basics of life (eg food, shelter, clothes etc)*	Material survival needs taken care of. (2)	1-3		√2		
Could not trust emotional needs would be met.	3	3-4	*when it came to emotional issues I learnt not to trust.*	Emotional needs not taken care of. (3)	3-4		√3		
Not safe to trust self or others	4			**Not safe to trust self or others**		√1			
Learnt not to trust my parents	5	9-10	*so I learnt from an early age that I could not trust them [parents] …*	Can't trust others.	9-10		√4		
Learnt not to trust myself	6	9-10	*so I learnt from an early age that I could not trust them [parents] or myself for that matter.*	Can't trust self (7)	9-10		√5		
Ongoing issues	7	10-11	*Trust remains an area today*	Ongoing low trust -	10-11				

regarding trust of authority figures.			*regarding authority figures.*	authority figures (8, 22)	CA1-3	√2			
Hurt was minimized, suppressed , silenced, ignored	**8**			**Hurts must be concealed/ suppressed**		√3			
Hurt was minimized	9	12-13	*If you hurt in any area (physically or emotionally) these were made light of.*	Hurt minimized or not acknowledged.(9, 16)	12-13		√6		
Family attitude: Don't show hurt	10	14-16	*I had no-one to talk to and was told "chin up".* *A very stoic attitude existed in our family regarding hurt.*	Family script: To show hurt is a sign of weakness.(11)	15-16		√7		
Learnt to suppress hurts in childhood.	11	17-18 21-22 22-23	*I **buried** my feelings surrounding any hurt.* *Emotions take longer to heal & were **not discussed*** *pushed [my emotions] down*	Learned to suppress pain (12, 17, 30)	16-18 21-22 22-24 CA10	√4			
Abuse was ignored, not acknowledged	12	CA10-12	*He went to jail. During the time my mother didn't ask me anything about what had happened.*	Parental betrayal/ failure to acknowledge abuse (25, 29)	CA4 CA11 -12		√8		

Impact of Abuse	13			**Impact of abuse**		√5			
Loss of self	14	5 10 PP1-3 CA3-4	*'do not feel' 'do not think'. could not trust ... myself ... dissociation ...D.I.D. Trauma counselling & healing was very helpful in this area where my identities were integrated. I hated myself...I was a bad girl.*	Spoiled identity, blames self. (38)	CA3-5		√9		
Lost childhood	15	CA3	*I lost my childhood.*	Lost innocence. (23)	CA3-4		√10		
Isolation	16	CA14	*I became a loner.*	Isolated by abuser (33)	CA14		√11		
Dissociation and DID	17	PP1-3 CA17	*... dissociation ...D.I.D. Trauma counselling & healing was very helpful in this area where my identities were integrated. I later became dissociative*	Dissociation (20, 35)	PP1-2 CA17	√6			
Suicidal ideation	18	CA13	*often had suicidal thoughts*	Suicidal ideation (31)	CA13-	√7			
Self-destructive behaviour- promiscuity, acting out,	19	CA16	*I became promiscous, rebellious & a binge drinker.*	self-destructive behavior (34)	CA16	√8			

alcohol abuse									
Flashbacks	20	CA18-19	*Memories began to surface during sex with my husband*	Flashbacks.(36)	CA18-19	√9			
Healing	21			**Healing as a journey**			√12		
Adulthood brings freedom to express hurt	22	18-19	*As an adult I am free to express how I feel regarding this issue.*	Giving self-permission to express pain (13)	18-19		√13		
Healing not achieved by time alone	23	20	*Time does not necessarily heal.*	Healing not connected with time (14)	20		√14		
Healing made possible in adulthood	24	23-24	*only as an adult could I begin to process issues from my childhood.*	Childhood hurts processed in adulthood (18)	22-24		√15		
Supports in healing - professionals	25	PP2	*counselling & healing was very helpful*	Counselling process helped with self-integration .(21)	PP2-3		√16		
Healing is slow	26	21-22 CA19-20	*... Emotions take longer to heal ...* *... I sought help & began a journey of counselling ...*	Time	20 21-22 CA19-20 22-24		√17		
Power and Vulnerability	27								√1
	28		*... No opinions could be entered into and authority (parental) had the final say on matters which was usually my mother...*	Children voiceless (5); adults abuse power	6-8			√1	

Vulnerable to abuse	29	CA7	*I was a child in need & I believe I was preyed upon*	Vulnerable, groomed by abuser	CA7		√18		
Abuser was in position of power	30	CA1-2	*The person who abused me was an elder in a church*	22. Clergy abuse, betrayed by neighbour.	CA1-3		√19		
Shame, fear and secrets	31								√2
Shame, self-loathing and psychological conflict	32	CA3-5	*I hated myself & always thought I had done something wrong ... I was a bad girl. I was shame ... it felt good yet I knew it was wrong.*	Shame and psychological conflict.	CA5	√10			
Abuser used secrets, threats of harm, fear	33	CA14-16	*I was told to keep the secret otherwise my family would be harmed in some way ... fear became my friend.*	Secrets. Threatened and isolated by abuser.	CA14-15 CA14-16		√20		
Deprivation of emotional wellbeing	34								√3
Emotional needs not met	35	8-9	*[parents] did not share anything on an emotional level*	Emotional needs not taken care of - deprivation, emotional isolation.(**3, 6,** 10)	4-5, 8-9		√21		
Emotional isolation	36	14 17	*I had no-one to talk to and was told "chin up".* *...I hated it.*	[Emotional needs not taken care of - deprivation]	14		√22		

			emotional isolation.(3, 6, **10**)					
Search for meaning	37	16	*Was there any meaning to this?*						√**4**
Age of abuse	38	CA1	*I was abused from 12-18 years of age.*						√**5**
Absence / loss of non-abusive parent	39	CA6 13-14	*My father was in the Navy & away most of the time.* *My dad died when I was 16…* I was devastated						√**6**
TOTAL #	**39**					**10**	**22**	**1**	**6**
32/39 = 82%								

Appendix F   Study 3b Recurrence of Themes

Appendix F – 1   Recurrence of Themes - Trust.

#	THEME	Participants who wrote about this	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	Total No. (out of 19)
T17	*TRUST*	all	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	19
1	**TRUST OF PARENTS/ CAREGIVERS**	**ABCDEFIJLMNOPQRS**	1	1	1	1	1	1	0	0	1	1	0	1	1	1	1	1	1	1	1	16
1.1	Could not trust parent.	ABCDFILNORS P* (*P= trust as an expectation of abuse)	1	1	1	1	0	1	0	0	1	0	0	1	0	1	1	1*	0	1	1	12
1.2	Parent did not show trust.	FMNP	0	0	0	0	0	1	0	0	0	0	0	0	1	1	0	1	0	0	0	4
1.3	Ambivalence in trust of caregivers.	EJ	0	0	0	0	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	2
2	**TRUST IN OTHERS**	**CDFGHIJKLMNOPRS**	0	0	1	1	0	1	1	1	1	1	1	1	1	1	1	0	1	1	15	
2.1	Generalized or specific (DIO) impairments in trust of others, the world is unsafe (G) / able to trust in others, the world (HLM).	CDFGHIKLMNOPRS	0	0	1	1	0	1	1	1	1	0	1	1	1	1	1	1	0	1	1	14
2.2	Trust in partners/ relationships.	IJL	0	0	0	0	0	0	0	0	1	1	0	1	0	0	0	0	0	0	0	3
2.3	Trust in sibling, significant others in childhood.	BE	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
3	**TRUST IN OTHER PARENT**	**ABCQRS**	1	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	1	6
3.1	Other parent was *not* able to be trusted.	ABQR	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	4
3.2	Other parent was able to be trusted (even when not protected	CS	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	2

#	THEME	Participants who wrote about this	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	Total No. (out of 19)
	by them).																					
4	**TRUST IN SELF**	**FHNOS**	0	0	0	0	0	1	0	1	0	0	0	0	0	1	1	0	0	0	1	5
4.1	Able to trust in self.	FHS	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	1	3
4.2	Impaired ability to trust self.	NO	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	2
5	**WHAT TRUST IS**	**AMOQS**	1	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	1	0	1	5
5.1	Trust is a risk and involves discernment.	AMQ	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	0	3
5.2	Different types of trust.	MO	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0	2
5.3	The meaning of trust.	QS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	2
5.4	Ongoing impairment of trust.	A	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1

Appendix F – 2 **Recurrence of Themes – Hurt.**

#	THEME	Participants who wrote about this	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	Total No. (out of 19)
	HURT	All 19	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	**19**
1	**HURT-DESCRIBED**	**ABCDEFGHKLMNOPQRS**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**0**	**0**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**17**
1.1	Descriptions of Hurt.	ADFKLMQR	1	0	0	1	0	1	0	0	0	0	1	1	1	0	0	0	1	1	0	8
1.2	Hurts were silenced, hidden, ignored, minimized or suppressed.	CDKLOPQS	0	0	1	1	0	0	0	0	0	0	1	1	0	0	1	1	1	0	1	8
1.3	Anticipation of Abuse, Hurt.	DGHNRS	0	0	0	1	0	0	1	1	0	0	0	0	0	1	0	0	0	1	1	6
1.4	Description of abuser.	_BHNQ_	0	1	0	0	0	0	0	1	0	0	0	0	0	1	0	0	1	0	0	4
1.5	Blamed and not believed.	EJLQ	0	0	0	0	1	0	0	0	0	1	0	1	0	0	0	0	1	0	0	4
1.6	Abuser hid the abuse/ Abuser used shame, fear and secrets to hide the abuse.	BOR	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1	0	3
1.7	Failure of others to protect from abuse.	_EHR_	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0	1	0	3
2	**DESCRIPTION/ TYPE OF THE ABUSE AND NEGLECT**	**_ABDEFHIJKLNOPQRS_**	**1**	**1**	**0**	**1**	**1**	**1**	**0**	**1**	**1**	**1**	**1**	**1**	**0**	**1**	**1**	**1**	**1**	**1**	**1**	**16**
2.1	Emotional and Psychological Abuse.	_BEFIKPQRS_	0	1	0	0	1	1	0	0	1	0	1	0	0	0	0	1	1	1	1	9
2.2	Physical Abuse.	_BDEHNRS_	0	1	0	1	1	0	0	1	0	0	0	0	0	1	0	0	0	1	1	7
2.3	Sexual Abuse.	_DEJKLRS_	0	0	0	1	1	0	0	0	0	1	1	1	0	0	0	0	0	1	1	7
2.4	Emotional Neglect.	_ABDLMOP_	1	1	0	1	0	0	0	0	0	0	0	1	1	0	1	1	0	0	0	7
2.5	Multiple abusers.	_ADEJLNS_	1	0	0	1	1	0	0	0	0	1	0	1	0	1	0	0	0	0	1	7

	THEME	Participants who wrote about this	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	Total No. (out of 19)
2.6	Cumulative Abuse and Neglect.	AFNRS	1	0	0	0	0	1	0	0	0	0	0	0	0	1	0	0	0	1	1	5
2.7	Family violence - Witnessed Abuse of Sibling/s, other parent or extended family.	BHIN	0	1	0	0	0	0	0	1	1	0	0	0	0	1	0	0	0	0	0	4
2.8	Other Forms of Abuse.	A	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
T36	THEME	Participants who wrote about this	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	Total No. (out of 19)
3	IMPACT OF ABUSE AND NEGLECT																					
3.1	IMPACT OF ABUSE AND NEGLECT: MEMORY	ACFJKLMNORS	1	0	1	0	0	1	0	0	0	1	1	1	1	1	1	0	0	1	1	11
3.1.1	Impact of Abuse – MEMORY: Impaired, Incomplete, repressed Memory of Abuse Experiences or Childhood.	ACJKLMNRS	1	0	1	0	0	0	0	0	0	1	1	1	1	1	0	0	0	1	1	9
3.1.2	Impact of Abuse –Lost, unhappy c'hood.	FORS	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1	0	0	1	1	4
3.2	IMPACT OF ABUSE AND NEGLECT: SOCIAL EFFECTS, RELATING, ISOLATION	ADHIKLNOQRS	1	0	0	1	0	0	0	1	1	0	1	1	0	1	1	0	1	1	1	11
3.2.1	Impact of abuse – Impaired Relating with Others, relationship difficulties.	AHIKLNQR	1	0	0	0	0	0	0	1	1	0	1	1	0	1	0	0	1	1	0	8
3.2.2	Impact of abuse – Isolation, feeling alone.	ADLOS	1	0	0	1	0	0	0	0	0	0	0	1	0	0	1	0	0	0	1	5

	THEME	Participants who wrote about this	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	Total No. (out of 19)
3.3	**Impact of abuse – MENTAL HEALTH**	*ABCDHLORS*	1	1	1	1	0	0	0	1	0	0	0	1	0	0	1	0	0	1	1	**9**
3.3.1	Impact of abuse – Participant Mental Health Problems.	ACDHORS	1	0	1	1	0	0	0	1	0	0	0	0	0	0	1	0	0	1	1	7/19
3.3.2	Impact of abuse – Sibling Mental Health Problems.	BL	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	2/19
3.4	**IMPACT OF ABUSE AND NEGLECT: ONGOING EFFECTS IN ADULTHOOD**	**BEKLMNRS**	0	1	0	0	1	0	0	0	0	0	1	1	1	1	0	0	0	1	1	**8**
3.4.1	Ongoing impact of abuse (into adulthood).	BEKLNR	0	1	0	0	1	0	0	0	0	0	1	1	0	1	0	0	0	1	0	6
3.4.2	Impact of abuse and neglect on functioning in adulthood.	LMRS	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	1	1	4
3.5	**IMPACT OF ABUSE AND NEGLECT: SELF-CONCEPT, OTHER**	*AHKLOQR*	1	0	0	0	0	0	0	1	0	0	1	1	0	0	1	0	1	1	0	**7**
3.5.1	Impact of abuse and neglect – other.	*AHKLQ*	1	0	0	0	0	0	0	1	0	0	1	1	0	0	0	0	1	0	0	5
3.5.2	Impact of abuse and neglect – self-concept.	FLOR	0	0	0	0	0	1	0	0	0	0	0	1	0	0	1	0	0	1	0	4
	THEME	*Participants who wrote about this*	*A*	*B*	*C*	*D*	*E*	*F*	*G*	*H*	*I*	*J*	*K*	*L*	*M*	*N*	*O*	*P*	*Q*	*R*	*S*	*Total No. (out of 19)*
4	**AGE: Age of abuse experiences**	*ABDEFHLNORS*	1	1	0	1	1	1	0	1	0	0	0	1	0	1	1	0	0	1	1	**11**
5	**PROTECTIONS: Self-protective/ protective behaviour.**	**ABCEGHKMNR**	1	1	1	0	1	0	1	1	0	0	1	0	1	1	0	0	0	1	0	**10**

6	EXPLAINING HURT, ABUSE	*BEFHKNRS*	0	1	0	0	1	1	0	1	0	0	0	0	0	1	0	0	0	1	1	8
6.1	Parenting/ Relationship with Parent	*BFHKNR*	0	1	0	0	0	1	0	1	0	0	1	0	0	1	0	0	0	1	0	6
6.2	Excusing the abuser/ the abuse.	*EHMS*	0	0	0	0	1	0	0	1	0	0	0	0	1	0	0	0	0	0	1	4
7	POWERLESSNESS & VULNERABILITY	DIJOS	0	0	0	1	0	0	0	0	1	1	0	0	0	0	1	0	0	0	1	5
7.1	Powerlessness and vulnerability to abuse by others as an impact of abuse.	DIJOS	0	0	0	1	0	0	0	0	1	1	0	0	0	0	1	0	0	0	1	5
8	RESPONSES TO ABUSE AND NEGLECT	EHKLMNO	0	0	0	0	1	0	0	1	0	0	1	1	1	1	1	0	0	0	0	7
8.1	Self-destructive behavioural responses to Abuse	KLMO	0	0	0	0	0	0	0	0	0	0	1	1	1	0	1	0	0	0	0	4
8.2	Enacting hurtful, abusive behaviour to others.	HKMN	0	0	0	0	0	0	0	1	0	0	1	0	1	1	0	0	0	0	0	4
8.3	Disclosure of Abuse and Neglect.	EK	0	0	0	0	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0	2
9	BLAME AND SHAME	DELORS	0	0	0	1	1	0	0	0	0	0	0	1	0	0	1	0	0	1	1	6
9.1	Feelings of guilt, fault, and blame.	*DELR*	0	0	0	1	1	0	0	0	0	0	0	1	0	0	0	0	0	1	0	4
9.2	Shame at being abused.	OS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	2
9.3	Shame at failing own parenting expectations.	S	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
10	ADDRESSING THE HURT	CDHM	0	0	1	1	0	0	0	1	0	0	0	0	1	0	0	0	0	0	0	4
10.1	Addressing/ dealing with the Hurt.	*CDM*	0	0	1	1	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	3
10.2	Abuse and Forgiveness.	HM	0	0	0	0	0	0	0	1	0	0	0	0	1	0	0	0	0	0	0	2

Appendix F – 3   Recurrence of Themes – Healing.

#	THEME	Participants who wrote about this	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	Total No. (out of 19)
T16	HEALING	all	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	19
1	SUPPORT IN HEALING	DFHIKLMNOQRS	0	0	0	1	0	1	0	1	1	0	1	1	1	1	1	0	1	1	1	12
1.1	Professional support in healing.	DKLMNOQRS	0	0	0	1	0	0	0	0	0	0	1	1	1	1	1	0	1	1	1	9
1.2	Support from others in healing.	FIKNS	0	0	0	0	0	1	0	0	1	0	1	0	0	1	0	0	0	0	1	5
1.3	God/ religion/ spirituality in healing.	HILM	0	0	0	0	0	0	0	1	1	0	0	1	1	0	0	0	0	0	0	4
2	DID NOT LEARN FROM PARENT ABOUT HEALING	ABFGJLNPQRS	1	1	0	0	0	1	1	0	0	1	0	1	0	1	0	1	1	1	1	11
2.1	Did not learn anything from parent(s) about healing.	AFGJLNPQR	1	0	0	0	0	1	1	0	0	1	0	1	0	1	0	1	1	1	0	9
2.2	No role for the abuser in healing.	BS	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	2
3	HEALING IS SLOW, DIFFICULT AND ONGOING	AFHIKLMNOR	1	0	0	0	0	1	0	1	1	0	1	1	1	1	1	0	0	1	0	10
3.1	Healing is slow, takes time.	FHIKLOR	0	0	0	0	0	1	0	1	1	0	1	1	0	0	1	0	0	1	0	7
3.2	Healing is difficult, takes effort, (and is not always possible).	AHKLNO	1	0	0	0	0	0	0	1	0	0	1	1	0	1	1	0	0	0	0	6
3.3	Healing is a journey, and ongoing process.	AKLMOR	1	0	0	0	0	0	0	0	0	0	1	1	1	0	1	0	0	1	0	6
4	HEALING IS POSSIBLE- SIGNS OF AND MESSAGES ABOUT HEALING	ACHIKMNQS	1	0	1	0	0	0	0	1	1	0	1	0	1	1	0	0	1	0	1	9
4.1	Things that promote / assist healing.	ACHIKNQS	1	0	1	0	0	0	0	1	1	0	1	0	0	1	0	0	1	0	1	8
4.2	Signs of healing.	IKS	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	1	3
4.3	Healing is possible	HM	0	0	0	0	0	0	0	1	0	0	0	0	1	0	0	0	0	0	0	2

#	THEME	Participants who wrote about this	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	Total No. (out of 19)
4.4	Conflicting messages about healing.	*CS*	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	2
5	**HEALING, FORGIVENESS AND THE CHILD-PARENT RELATIONSHIP**	**AEJLNQS**	1	0	0	0	1	0	0	0	0	1	0	1	0	1	0	0	1	0	1	7
5.1	Forgiveness and healing	*ELNS*	0	0	0	0	1	0	0	0	0	0	0	1	0	1	0	0	0	0	1	4
5.2	Attempts to heal relationship with caregiver.	*AJ*	1	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	2
5.3	Healing was not permitted.	*Q*	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1
6	**AGE AND HEALING**	**AFO**	1	0	0	0	0	1	0	0	0	0	0	0	0	0	1	0	0	0	0	3
6.1	Healing can take place in adulthood.	*AFO*	1	0	0	0	0	1	0	0	0	0	0	0	0	0	1	0	0	0	0	3
	TRUST HURT & HEALING	*K*	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1

Appendix F – 4 **Recurrence of Themes – Relationships and Functioning.**

#	THEME	Participants who wrote about this	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	Total No. (out of 19)
T26	RELATIONSHIPS & FUNCTIONING	all	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	19
1	FAMILY RELATIONSHIPS	ABCEFKLMNOQS	1	1	1	0	1	1	0	0	0	0	1	1	1	1	1	0	1	0	1	12
1.1	Relationship with other parent.	BKLNOQ	0	1	0	0	0	0	0	0	0	0	1	1	0	1	1	0	1	0	0	6
1.2	Love, warmth and affection.	CEFKS	0	0	1	0	1	1	0	0	0	0	1	0	0	0	0	0	0	0	1	5
1.3	Relationship with siblings.	ABCES	1	1	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	5
1.4	Excusing, explaining other parent/ defending parent behaviour.	BKS	0	1	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	3
1.5	Relationship with abusive parents/ caregivers.	ALM	1	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	3
1.6	Family-of-origin dynamics	AN	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	2
1.7	Parent continues not to recognize, acknowledge the abuse and neglect.	AN	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	2
1.8	Boundary issues impair ability to make and retain friendships	N	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1
1.9	Splitting good and bad	C	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
1.10	Separation/ individuation	C	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
1.11	Conflicting messages about current support from family.	S	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1

	THEME	Participants who wrote about this	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	Total No. (out of 19)
2	RESILIENCE/ POSITIVE OUTCOMES	BCEHIKLMNQRS	0	1	1	0	1	0	0	1	1	0	1	1	1	1	0	0	1	1	1	12
2.1	Resilience	BEHKLMS	0	1	0	0	1	0	0	1	0	0	1	1	1	0	0	0	0	0	1	7
2.2	Positive relationships in adulthood	BEHKN	0	1	0	0	1	0	0	1	0	0	1	0	0	1	0	0	0	0	0	5
2.3	Presence of positive significant others in childhood (& absence of support)	BLQ (M)	0	1	0	0	0	0	0	0	0	0	0	1	1	0	0	0	1	0	0	4
2.4	Identifying as a survivor of child abuse	CHIR	0	0	1	0	0	0	0	1	1	0	0	0	0	0	0	0	0	1	0	4
2.5	Helping other survivors of abuse/ comments on other survivors	HKR	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0	0	0	1	0	3
3	FAMILY OF ORIGIN MENTAL HEALTH	CDFHJKLMNRS	0	0	1	1	0	1	0	1	0	1	1	1	1	1	0	0	0	1	1	11
3.1	Caregiver mental health.	CDFHLMNRS	0	0	1	1	0	1	1	1	0	0	0	1	1	1	0	0	0	1	1	9
3.2	Cultural taboos about mental illness.	J	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1
3.3	Abuser had mental illness.	K	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1
4	INTERGENERATIONAL CONTINUITY	ABHKLMNRS	1	1	0	0	0	0	0	1	0	0	1	1	1	1	0	0	0	1	1	9
4.1	Intergenerational abuse, functioning, parenting.	AKMNRS	1	0	0	0	0	0	0	0	0	0	1	0	1	1	0	0	0	1	1	6
4.2	Intergenerational discontinuity	ABHLS	1	1	0	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	1	5
5	OTHER	BEKLNOQR	0	1	0	0	1	0	0	0	0	0	1	1	0	1	1	0	1	1	0	8
5.1	The questioning self/ search for	EKNO	0	0	0	0	1	0	0	0	0	0	1	0	0	1	1	0	0	0	0	4

	meaning																						
5.2	Age/ time periods	*BNQ*	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1	0	0	3
5.3	Telling experience/ being listened to/ participation in this research project	*LR*	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	2
6	**FAMILY FUNCTIONING**	***ABFLMNR***	**1**	**1**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**1**	**1**	**1**	**0**	**0**	**0**	**1**	**0**	**7**
6.1	Adverse family functioning - adulthood	*ABFLMNR*	1	1	0	0	0	1	0	0	0	0	0	1	1	1	0	0	0	1	0	7
6.2	Comment on functioning	*A*	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1