

# Understanding the Cycle of Maternal Intergenerational Child Maltreatment

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Hannah Stone

Doctorate in Forensic Psychology Practice

The Centre for Forensic and Criminological  
Psychology

University of Birmingham  
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## **Abstract**

Familial child maltreatment continues to be an area of concern in child protection proceedings which often involves the psychological assessment of parents. Research has demonstrated that a significant number of parents assessed in child protection proceedings report experiences of victimisation in their own childhoods. While the consequences of childhood maltreatment are well known, few studies have focused on the intergenerational patterns of child maltreatment amongst mothers involved in child protection proceedings. This thesis attempts to explore the transmission of maternal child abuse and neglect.

Chapter Two presents a systematic literature review on maternal intergenerational child maltreatment. Although sampling and methodological procedures vary between studies, it was found that individuals with a childhood history of victimisation demonstrated a heightened risk of engaging in maladaptive parenting behaviours. A small number of studies found a direct link between types of maltreatment experienced in childhood and perpetrated in adulthood. Factors thought to be instrumental in the process of intergenerational maltreatment include substance misuse, exposure to violence, mental health difficulties, low maternal age and rejection of therapeutic support.

To explore the relevance of types of maltreatment perpetrated by mothers in child protection proceedings, Chapter Three compares abusive mothers with neglectful mothers in a sample of 278 mothers who had been referred for psychological assessment as part of childcare proceedings. Although there was no significant difference between maltreatment in childhood and perpetration of maltreatment in adulthood, significant differences were found between neglectful mothers in terms of

conflict in current relationships (including domestic violence), substance misuse, self-harm, financial difficulties and self-reported feelings of isolation. Neglectful mothers obtained significantly higher scores on psychometric assessment relating to coping styles and parental stress and displayed significantly more traits associated antisocial and sadistic (aggressive) personality types. The process of intergenerational maltreatment in neglectful mothers may differ from those who perpetrate abuse which may have implications for treatment.

Chapter Four discusses the use and value of psychometric measures of personality, in particular the Millon Clinical Multiaxial Inventory–Third Edition (MCMI-III; Millon, 1994), in parents involved in child protection proceedings. Despite its popularity and strong psychometric properties, there are a number of limitations of the MCMI-III including underrepresentation of ethnic minorities in its normative sampling and gender bias in item responding. Issues of gender bias are particularly relevant for mothers involved in child protection proceedings as interpretation of personality profiles inform opinions and decisions regarding childcare outcomes.

Understanding interpersonal differences in intergenerational neglectful and abusive mothers involved in childcare proceedings may lead to the development of effective interventions which may disrupt the generational transmission of child maltreatment.

## **Acknowledgements**

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Undertaking this work has meant total immersion in the cognitive, behavioural and psychological processes of child abuse and neglect, as well as the consequences of such adverse experiences. It has highlighted my fortunate position to have come from such a supportive background, including family, friends, fellow trainees and Adam.

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So fathers be good to your daughters/  
Daughters will love like you do/  
Girls become lovers who turn into mothers/  
So mothers be good to your daughters too

(Mayer, 2003, track 8)

## **Chapter One**

### **Introduction to Thesis**

A recent report published by the National Society for the Prevention of Cruelty to Children (NSPCC; Radford et al., 2011) presented new research findings on the incidences of child maltreatment and victimisation in the United Kingdom, specifically focusing on the prevalence of severe maltreatment. The definition of severe maltreatment included 'severe physical and emotional abuse by any adults, severe neglect by parents or guardians and contact sexual abuse by any adult or peer' (p. 7). A large portion of the report focused on maltreatment within the family context, reporting that just over 1% of children aged 11 years or under and almost 4% of children aged 11 – 17 years experienced maltreatment from a parent or guardian in 2011. Neglect was the most prevalent form of familial maltreatment, characterised as an absence of physical care, closely followed by physical punishment and exposure to physical violence. Children who are neglected by a caregiver account for almost two thirds of cases of child maltreatment that comes to the attention of child authorities (Meadows et al., 2011).

According to the NSPCC, the proportion of children on child protection registers is 31 per 10,000 children in England, 26 per 10,000 in Scotland, 40 per 10,000 in Wales and 57 per 10,000 in Northern Ireland (Meadow et al., 2011). Although relatively low in comparison to the United States (121 children per 10,000) or Canada (187 children per 10,000), these numbers have steadily increased and continue to place greater strain on child protection resources.

The extensive literature in this field demonstrates that abuse and neglect generally occur when 'adverse circumstances in relation to the child, the family and the wider social and

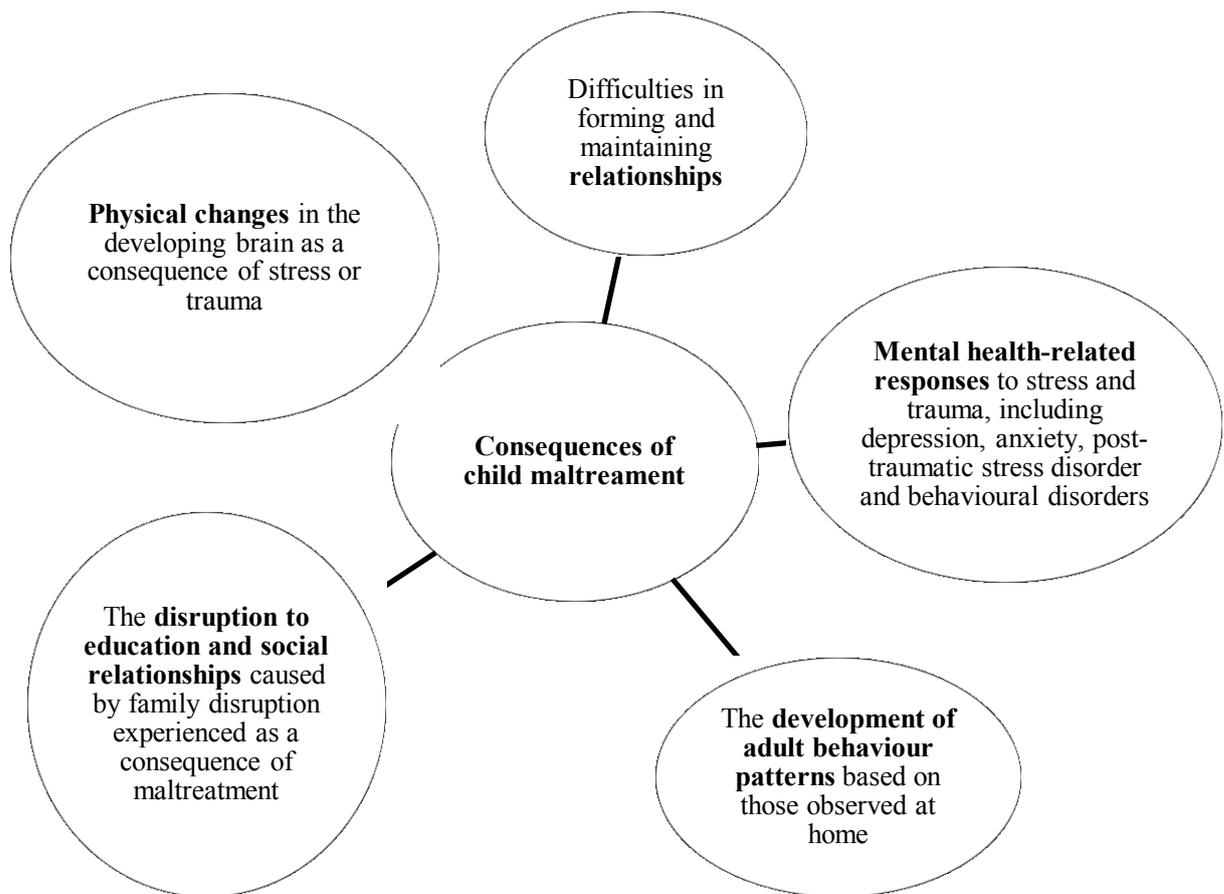
economic environment coincide' (Meadows et al., 2011, p. 9). These include, but are not limited to, a lack of parenting skills, parental learning and developmental disabilities, parental mental health problems, parental substance misuse, domestic violence, socioeconomic status and social isolation (Barnard, 2003; Booth, Booth & McConnell, 2005; Browne & Herbert, 1997; Cassell & Coleman, 1995; Eastmann & Moran, 1991; Kroll, 2007; McGraw, 2008; Newman & Stevenson, 2008; Ostapiuk, Bailey, & Basra, in press; Scaife, 2008; Seaman, Turner, Hill, Stafford, & Walker, 2005; Thorburn, Wilding, & Watson, 2000).

Although not the focus of this thesis, child variables have also been identified as risk factors for maltreatment, such as having a physical or developmental disability or health problems (Sullivan & Knutson, 2000; Svensson, Eriksson, & Janson, 2013). Whilst it may be controversial to suggest that a child's physical or psychological condition may incite deliberate maltreatment, there is argument that these situations test the parents' ability to cope (Frude, 1988; Glaser & Prior, 2002) and that their capacity to deal with such challenges may lead to negative interaction with the child or unintentional neglect.

Focusing particularly on familial child maltreatment (i.e., the abuse or neglect of a child perpetrated by a parent or close relative), risk factors for maltreatment within the family include those listed above as well, as the young age of parents, large family size and parents with childhood experiences of abuse and neglect (Connelly & Straus, 1992; MacKenzie, Kotch, & Lee, 2011; Meadows et al., 2011; Stith et al., 2009), the latter of which will be the focus of this thesis and explored later in further detail.

## **The consequences of adverse childhood experiences**

Having identified the variables that are associated with familial child maltreatment, subsequent research has attempted to understand how these variables relate to each other and if the presence of one variable affects the presence or absence of another. Herrenkohl and Herrenkohl (2007) identified the problems in determining the effects of overlapping, thus making it unclear whether some factors have more weighting on behavioural, emotional and mental outcomes than others. Radford et al.'s (2011) report for the NSPCC described all forms of maltreatment were found to be associated with 'poorer emotional wellbeing, self-harming and delinquent behaviour among children and young people' (p.66). It is undeniable that adverse experiences in childhood, such as abuse and neglect, can have a lasting effect on a child's physical, emotional and mental development. The trajectories by which maltreatment affect a child are complex but significant research within the field has, in essence, identified five main routes (see Figure 1).



*Figure 1.* The five main routes from child maltreatment, as identified by the NSPCC (Meadows et al., 2011)

Although not wholly exhaustive of the catalogue of consequences, the pathways from child maltreatment in Figure 1 provide an overview of the areas in which an individual is affected by childhood abuse and neglect. Interestingly, Meadows et al. (2011) argue that physical injury or illness as a result of maltreatment is often not as significant as the lasting damage on a child's mental and emotional well-being. Although the experience of maltreatment is unique to each child and can sometimes be modified by the existence of protective factors, such as the presence of a non-abusive adult or the child's resilience, there is undoubtedly argument for the impact on the child's emotional and

mental development following such experiences, in particular, the development of their personality.

### **Childhood maltreatment and personality**

The effect of childhood abuse and neglect in the development of emerging personality disorder etiology is well documented, particularly amongst adults with borderline and antisocial personality disorder (Lobbestael & Arntz, 2010; Perepletchikova, Ansell, & Axelrod, 2012; Shi, Bureau, Easterbrooks, Zhao, & Lyons-Ruth, 2012). However, it is important to consider how abuse and neglect impact on a child's developing personality and psychosocial functioning. Early experiences of maltreatment and trauma have been found to have long-term impact on core personality domains including a stable sense of identity, the ability to form and maintain secure relationships as well as 'affect regulation and the ability to tolerate stress and anxiety' (Perepletchikova et al., 2012, p. 183). Maltreatment has been shown to severely impact on a child's adaptive ability as well as 'major detrimental effects on behavioural and cognitive regulatory systems across the life span' (Oshri, Rogosch, & Cicchetti, 2013, p. 288). Therefore, the experience of maltreatment begins to shape a child's understanding of themselves and their connection to other people and the world around them.

From a schematic approach, abusive and neglectful experiences have been associated with 'powerful and enduring psychological sequelae' (Roemmele & Messman-Moore, 2011, p.60) including feelings of worthlessness, humiliation, anger and shame. Experiences of victimisation may be interpreted by the child as a reflection of themselves, they are unwanted, unloved, worthless or only of value when satisfying the

needs of others. These in turn affect the development of enduring negative schemas which undoubtedly become triggered once the individual is faced with situations which generate feelings linked to the original experiences of maltreatment. There is also evidence for schemas being triggered by significant periods of change or development, such as entering higher education and facing academic pressure, adult relationships and conflict, marriage and parenthood (Carbone, 2010; Roemmele & Messman-Moore, 2011). For an individual who has experienced childhood maltreatment perpetrated by a parent, the prospect of becoming a parent themselves may feel more daunting and unfamiliar. The core domains of personality may be triggered by the event of parenthood itself; an individual's sense of self and interpersonal skills may be defined by their connection and relationship with their child, and thus difficulties in this parent-child bond are interpreted as a reflection of their own – or their own child's – failures.

According to attachment theory (Bowlby, 1988), children form representations of attachment both to self and others based on their relationships with the primary caregivers. Therefore, when the caregiver responds in a caring and consistent manner, the child internalises a sense that they are worthy of that attention and that others can be relied upon to provide such love and care. Conversely, if a child's interpersonal experiences are hostile, frightening and rejecting, abuse and neglect may internalise negative beliefs about the self and others (Wright, Crawford, & Costillo, 2009). Wright et al. (2009) argue that instead of developing a working internal model of the self being worthy of love and positive attention, 'negative models of the self as unworthy, incompetent, powerless or bad may result' (p. 61). Similarly, Kwako, Noll, Putnam and Trickett's (2010) research suggested that unresolved insecure attachments to their own

parents may increase the risk of individuals exhibiting neglectful and abusive behaviours towards their children. Furthermore, the experience of abuse or neglect may hinder an individual's ability to interpret and manage stressful situations. They may resort to coping strategies deemed effective in childhood, such as emotional and behavioural inhibition, which become maladaptive when trying to manage the stressors of parenting and may place their child at risk of physical harm. Furthermore, they may engage in alcohol or substance misuse behaviours as a way of coping, which may inhibit their ability to parent safely, thus exposing their children to more risky behaviours that have their own lasting effect on the child's development.

Dixon, Browne and Hamilton-Giachritsis' (2005) research into the intergenerational continuity of child abuse and neglect suggested that a childhood history of victimisation may heighten the risk of transmission. Their results indicated that 6.7 % of families where at least one parent had experienced psychological and/or sexual abuse as a child were referred for maltreating their own child in comparison to 0.4% of parents with no childhood history of maltreatment. Furthermore, their mediational analysis demonstrated three significant risk factors for the maltreating families: parenting under 21 years of age, living with a violent adult and a history of mental illness or depression. Dixon, Hamilton-Giachritsis and Browne's (2005) extension of this initial research explored the mediational properties of parenting styles and their interplay with the risk factors. During assessment, health visitors made a number of important observations concerning the parenting behaviours of individual with childhood histories of maltreatment; they noted these parents were more likely to demonstrate poor quality care-giving and have negative or unrealistic perceptions of their child. Dixon, Hamilton-

Giachritsis and Browne's (2005) noted that an abusive childhood may account for difficulties in "parental bonding and relationship with the child" (p.65). Child abuse was also more likely within these families if there was the presence of an abusive adult and the parent had experienced mental health problems or depression. Although their research demonstrates that adverse early experiences may increase the likelihood of perpetuating the cycle of familial child maltreatment, Dixon et al. (2005b) noted that just over 93% of parents with a childhood history of maltreatment did not maltreat their own child. Despite a higher incidence of risk factors and poor parenting styles being present in such families, the process of transmission was very low suggesting the importance of parents who are able to break the cycle of transmission and the presence of protective factors within these families.

### **Protective factors and resilience against maltreatment**

Whilst risk factors for transmission warrant close study, it is also crucial to consider factors which mitigate such risk. As Dixon et al.'s (2005b) study notes, not all victimised children become maltreating parents. Whilst the demand for research that underpins the processes of transmission helps inform practice and intervention, it can also highlight how certain personal, social and environmental factors can support the individual in breaking the cycle of maltreatment, attributes that undoubtedly should also be the focus of intervention.

Howe, Brandon, Hinings, & Schofield (1999) argue that a family context defined by cohesion and absence of discord operates as a protective factor. As highlighted earlier, even within a cultural context which is documented as a precursor for child

maltreatment, such as socioeconomic status, financial difficulties and single parenthood (Seaman et al., 2005), the characteristics of the family can act provide an obstacle to neglect and abuse. The framework of ‘family’ is also relatively fluid – parents, siblings, grandparents and extended family members can interchange in their presence, roles and significance with regard to the provision of child care.

With regards to relationships between parents, Howe et al. (1999) also argue the following:

It is generally recognised that a powerful source of protection for children derives from parents enjoying close, supportive relationships with other adults. Mothers who enjoy satisfactory, stable relationships, particularly with their partners display more competent care giving.

(p.268)

This implies that parents who have secure and gratifying attachment experiences with each other can apply these schemas to their relationships with their children. . It also implies that social support is necessary is positive child-rearing and that if this is with a supportive partner, it is even more effective. Despite single parenthood frequently being identified as a risk factor, Rowlingson and McKay (2002) argue that often any negative experiences of lone parenthood are the result of financial struggle from a single income, as opposed to being an ‘undesirable family state’ (p.160). Furthermore, maintaining in a conflicted or abusive relationship to remain financially secure may not always be in the best interest of the child. Indeed, Chan’s (2011) research into the exposure of child

abuse and intimate partner violence (IPV) in childhood suggests that not only will the perpetrators of IPV initiate abuse towards a child but their use of violence to manage or solve spousal conflict may ‘spill over into the parent-child relationship’ (p.533).

Whilst there is much argument for the detrimental effects of an abusive parental relationship (Browne & Herbert, 1997), there is also recognition for the protective capacity of the non-abusive parent. The key element is that this parent has the capacity to not only recognise that their child is being abused but to protect their child over the relationship with the abusive partner (Wilson & James, 2003).

Resilience is a term that appears consistently throughout research into protective child variables, and is applied as counteractive to many different predictors of maltreatment including substance and alcohol misuse, mental illness, depression and domestic violence (Humphreys & Mullender, 2002; Luthar, 2003). Holt et al. (2008) argue that whilst self-esteem is at risk of being damaged by an abusive perpetrator, children may find they have confidence in other domains outside of the family, such as school. This provides an area where they can escape the abusive environment and become competent in their strengths, thus buffering against the long-term effects of abuse. However, Mersky and Topitzes’ (2010) research found that competence and resilience in adults – who were maltreated as children – were contextually specific to economic and social circumstances. Indeed, resilience was relatively uncommon amongst the non-maltreated sample due to being able to engage in post-secondary education and gainful employment. In their review of resilience literature, Afifi and MacMillan (2011) argue that resilience is a dynamic factor and whilst an individual maybe robust in one area of

functioning, this may not extend to other areas of functioning. However, they also argue that resilience is a dynamic factor and varies over time and developmental periods.

Howe et al. (1999) argue that 'secure attachments predict many of the characteristics of the resilient child' (p.234). Furthermore, secure attachment to an individual or within a family framework is suggested as a protective influence when the child is faced with adversity (Howe et al., 1999). Howe (1996) suggests that in working with maltreating families, the quality of the emotional relationships between family members requires consideration, as the insecure attachment in children can be a result of the absence of 'attachment producing behaviours' (p.43) from the parents.

### **The cycle of intergenerational child maltreatment**

Within the scope of familial child maltreatment, an early intergenerational child maltreatment hypothesis stated that 'maltreated children are likely to become abusive parents' (Kaufman & Zigler, 1987, p. 186). Indeed, Engel (2004) describes the cycle of maltreatment as the following:

'abuse and neglect never occurs in a vacuum ...when a child is emotionally, physically or sexually abused it not only damages the child but it damages the offspring of that child'.

(p. 1)

In exploring the incidence of maltreatment in childhood and its diverse effects on the individual, it is understandable how child maltreatment becomes cyclical in nature,

particularly within families where it has occurred throughout the generations. Within families where child maltreatment is particularly entrenched, it becomes harder to see where such abusive and neglectful behaviours have started, thus presenting a chicken-and-egg conundrum. Although it would be unwise to assume that all victimised children become maltreating parents, Dixon, Browne and Hamilton-Giachritsis (2009) noted that parents who were abused or neglected as children were still at risk of inadequate parenting. However, acknowledgment of their abusive childhood history may adjust their parenting decisions accordingly in an effort to reduce repeating the cycle of maltreatment.

One cannot disregard the increasing amount of media coverage on this subject, particularly as child maltreatment perpetrated by family members generates such strong public response. Over the last 20 years, prominent cases of child abuse and neglect have heightened public awareness of familial child maltreatment, both in the UK and internationally, as well as the notoriety of offenders such as Marie-Thérèse Kouao (great aunt of Victoria Climbié), Karen Matthews (mother of Shannon Matthews), Tracey Connelly (mother of Peter 'Baby P' Connelly), Mick Philpott, Stuart Hazell (step-grandfather of Tia Sharp), and Magdalena Luczak and Mariusz Krezolek (mother and step-father of Daniel Pelka). More recent press coverage of the above cases and others has demonstrated a prevalence for legal defence teams in bringing the offender's own childhood experiences of maltreatment into the trial proceedings. It can be speculated that this is not done to minimise or excuse the actions committed by the individual (although this is not wholly inconceivable in some cases) but instead to highlight the incidence of child maltreatment within the family dynamics and how this

may have influenced the individual's behaviour towards their own children. Whilst this may not generate public sympathy towards the defendant, it creates speculation concerning a parent's capacity to harm their own child, particularly and most interestingly, when that parent is female.

Following the well-publicised Plymouth case of Vanessa George's sexual abuse of toddlers under her care, Easton (2009) wrote how incidents such as this 'challenge our understanding of human nature ... not simply the idea that people can find pleasure in the sexual abuse of very young children but the revelation that women were involved'. Although females who sexually abuse children are described as 'society's last taboo' (Philby, 2009), it is not just sexual abuse that challenges public and professional perceptions of women who maltreat children. The recent investigation into the physically abusive and neglectful treatment of Daniel Pelka by his mother Magdalena Luczak, resulting in his death aged four, generated significant concerns regarding fitness to care. These were not only limited to the continued failure of professional provision of Daniel's care but also the extent to which his mother had perpetrated 'unimaginable acts of cruelty and brutality', as described by the trial's presiding judge (Peachey, 2013).

### **The 'bad mother' – why is it taboo?**

Historically, the role of the mother has been viewed as 'within the family' (Hoare, 1967, p.79) and specifically, someone who ensures the 'relational and logistical work of child rearing' (Medina & Magnuson, 2011, p.90). Motherhood is also subject to social construction; standards for mothering have been, and continue to be, socially

determined (Arendell, 2000) based on the social context within which they are manifested. Hays (1996) researched the social construction of motherhood from the 1980s, creating the term ‘intensive mothering’. This ideology implied that:

‘mothers are the ideal, preferred caretakers of children. Intensive mothering is expert guided, emotionally absorbing, and labour intensive. Children are considered to be sacred and their price immeasurable’.

(Medina & Magnuson, 2011, p. 91).

Douglass and Michaels (2004) identified attachment parenting techniques within intensive mothering ideology: mothers are ‘encouraged to be emotionally available and completely attuned to their infants’ needs’ (Median & Magnuson, 2011, p. 91). This then leads to speculation, how can a mother, subject to damaging or detrimental parenting in her own childhood, be able to effectively recognise and meet the needs of her own offspring? Given the socially-constructed qualities and characteristics that have been placed on the mother-figure, it is understandable that the notion of a woman defying her role as a mother, particularly by abusing or neglecting her own child, generates such public response. The names Tracy Connelly, Vanessa George and most recently, Rebecca Shuttleworth and Amanda Hutton, are all heavily labelled with assumptions on their capacity as appropriate and safe mothers. Interestingly, a high proportion of these women have well-documented childhood histories of abuse and neglect which supports the potency of Engel’s (2004) intergenerational child maltreatment hypothesis.

## **Aim of Thesis**

The aims of the thesis are as follows:

1. To explore the literature which demonstrates the link between childhood experiences of maltreatment and subsequent parenting behaviours, including the perpetration of similar abusive and/or neglectful behaviours.
2. To explore the role of risk and protective factors which influence the process of transmission from victim to perpetrator.
3. To compare the childhood experiences, risk factors and personality profiles of mothers who abuse and mothers who neglect.
4. To explore the role of psychometric testing in understanding child maltreatment and its role in parenting assessment and intervention.

In order to achieve these aims, the thesis is presented in five chapters:

Chapter Two presents a conceptual literature review using a systematic approach that offers an indication of the available literature examining the incidence of intergenerational maltreatment between mothers who have a childhood history of maltreatment (abuse or neglect) and the subsequent maltreatment of their own children. The main objectives of the review are to gain an understanding of intergenerational child maltreatment between mothers with a childhood history of maltreatment and the maltreatment of their own children, to determine if mothers who are maltreated in

childhood perpetuate the same maltreatment behaviours with their own children, and to determine the risk and protective factors for intergenerational child maltreatment between mothers and their children.

Having identified the lack of current literature on maternal intergenerational child maltreatment, Chapter Three presents a research study exploring the incidence of child maltreatment amongst a sample of British mothers. Although it can be assumed that the results of this study may not differ greatly from previous research undertaken predominantly using North American samples, this study goes into further detail with regards to the significance of developmental variables and psychometric scoring on both maltreatment in childhood and adulthood. The main objectives of the research are to determine if a childhood history of abuse or neglect perpetrated by the participants' mothers predicts similar maltreatment behaviours in adulthood, and the differences in risk and personality and parenting profiles between the two groups.

Given the potential role of personality difficulties and disorders with childhood histories of maltreatment and their influence on parenting styles, it is essential to measure the strength of these traits in mothers convicted of child maltreatment. One of the most commonly utilised tools in parenting capacity assessments is the Millon Clinical Multiaxial Inventory – Third Edition (MCMI-III; Millon, 2006). Therefore, Chapter Four presents a critique of the MCMI-III and its validity with this specific forensic population. The critique gives a summary of the psychometric measure and its' properties, including validity, reliability and also outlining its' limitations.

Overall, it is hoped that by exploring the significance of childhood maltreatment for women perpetrating abusive and neglectful parenting behaviour, effective interventions can be offered to reduce the likelihood of intergenerational transmission and also assist in the treatment of women engaging in such harmful parenting behaviours.

## **Chapter Two**

### **Maternal Intergenerational Child Maltreatment: A Systematic Approach**

## Abstract

The aim of this systematic review was to assess the incidence of intergenerational maltreatment between mothers who had a childhood history of maltreatment (abuse or neglect) and the subsequent maltreatment of their own children. Scoping searches were conducted to assess the requirement of the current review. Using a systematic approach, a literature review was conducted to find articles of relevance to the area of research. Literature that was identified as relevant to the review was then screened using pre-determined inclusion and exclusion criteria and then assessed further for quality (e.g., methodological quality, bias and validity). Ten studies were included in the review, three of which found a direct link between a maternal history of childhood abuse and the perpetration of abusive behaviours towards their own children. These studies found that although the behaviours may not be exactly replicated, punitive behaviour and discipline in parenthood were greatly affected by exposure to childhood abuse. Findings suggest that women with histories of childhood maltreatment are at significant risk of perpetrating the abusive behaviour towards their own children. This is particularly prevalent in women with childhood exposure to psychological abuse who demonstrated more punitive behaviour towards their children. Other factors appear to impact on the risk of intergenerational abuse including parenting stress, substance misuse, post-traumatic stress disorder and maternal partner choice. Research has suggested that women who have been maltreated in childhood must recognise their experiences as abusive in order to break the cycle of familial maltreatment and that therapeutic intervention is critical in this process.

## **Introduction**

The belief that maltreatment can be transmitted across generations, or that a cycle of maltreatment could progress through generations, was one of ‘the earliest and most widely accepted theories of the causation of maltreatment’ (Egeland, 1993, p.197). Briere, Berliner and Bulkley (1996) stated that ‘maltreatment is a family problem’ (p.158), and that the occurrence of such behaviours is entrenched in the functioning of the family. The intergenerational perspective is supported by consistent evidence for the recurrence of abuse in maltreating families but this is not to say that every mistreated child will develop into a maltreating adult (Browne, Hanks, Stratton, & Hamilton, 2002).

### **Defining child maltreatment**

The World Health Organisation (2010) defines child maltreatment as the following:

‘child maltreatment, sometimes referred to as child abuse and neglect, includes all forms of physical and emotional ill-treatment, sexual abuse, neglect, and exploitation that results in actual or potential harm to the child’s health, development or dignity. Within this broad definition, five subtypes can be distinguished – physical abuse, sexual abuse, neglect and negligent treatment, emotional abuse, and exploitation’.

Naylor, Petch and Ari (2011) argue that exposure to intimate partner violence between adults in the home is an additional form of maltreatment, a concept which they term as ‘domestic bullying’ (p.88). This is not exclusive to a child being physically injured

during a domestic incident, such as in an attempt to protect a parent from the perpetrator or being the subject of separate incidences of physical abuse initiated by the abusive parent, but extends to the effect of exposure to domestic violence and the threat of physical punishment from the victimised partner (Humphreys & Mullender, 2002).

Tomison (1996) highlighted a recurrent theme in child abuse literature; the prevalence of maltreated children who become abusive parents. Dixon et al. (2005b) maintain that 'an abusive childhood may result in an increased likelihood of maltreatment being transmitted from one generation to the next' (p.65). Browne and Herbert's (1997) research into domestic violence found that children become socialised to abusive behaviour, basing their findings on Bandura's (1978) social learning theory. Bandura (1978) suggested that parents, particularly those who are the same gender as the child, are the primary resources for a child's social learning, as they are the most available role models with high status and authority. Through the parent's behaviour, children learn how to conduct themselves, based on the consequences of the observed behaviours. With regards to abusive behaviour within a domestic context, Jennings, Park, Tomsich, Gover and Akers (2011) suggested that although aggressive and violent behaviour has negative outcomes, children observe and internalise this behaviour to be an effective tool of control. Conversely, Kaufman and Zigler (1993) propose that some children may have a genetic predisposition for aggressive behaviour which translates into child maltreatment when they become a parent. The abusive perpetrator becomes a role model for the child and behaviour learnt in childhood can be triggered by significant events in adulthood, such as parenting.

Early research by Herman (1981) demonstrated the significant parenting problems of women with self-reported histories of child sexual abuse. Herman's (1981) psychotherapy with these women explored their fear of becoming incompetent mothers and high expectations for their parenting which led to feelings of hostility and frustration directed towards their children. Furthermore, Cole, Woolger, Power and Smith's (1992) study of a community sample of women with histories of incest abuse highlighted a prevalence of hostile and punitive interactions between these mothers and their children. What is apparent in this field of research is that traumatised mothers with child abuse histories may not be known through adult healthcare services but through their own children who are referred to mental health services for treatment for abuse and trauma (Cross, 2001). In parallel with the research findings of Dixon et al. (2005a), earlier research by Langeland and Dijkstra (1995) found that an individual's childhood history of abuse was not an automatic prerequisite for maltreatment in adulthood and subsequent parenting behaviour. Their research identified a number of protective factors at individual, familial and community levels which served to limit the risk of perpetuating the cycle of maltreatment including strong social networks, supportive spouses and, most significantly, acknowledgement of their experience of abuse.

### **Current review**

The current review attempts to provide some understanding of the prevalence of intergenerational maltreatment between mothers and their children, as well as the risk and protective factors that affect the transmission of maltreatment. By reviewing the data systematically, it attempts to minimise limitations acknowledged in previous studies and increase the possibility to generalise the findings.

### **Existing review assessment**

Searches for previous systematic reviews and meta-analyses of intergenerational child maltreatment were conducted on the 16<sup>th</sup> April 2011 using the Cochrane Library, the Campbell Collaboration, DARE, PsycINFO, MEDLINE, Web of Science, ASSIA, Ingenta Connect and Science Direct. Systematic reviews were found on the impact of child maltreatment, such as disturbed emotional and behavioural development ('Emotional and behavioural sequelae of childhood maltreatment', Perepletchikova & Kaufman, 2010; 'Child maltreatment and adolescent development', Trickett, Negruff, Ji & Peckins, 2011) and cognitive deficits and developmental delay ('Developmental traumatology: The psychobiological development of maltreated children and its implications for research, treatment and policy', De Bellis, 2001; 'Three decades of child maltreatment research: Implications for the school years', Veltman & Browne, 2001).

Interestingly, several systematic reviews that were identified in the scoping search considered the link between child maltreatment and intimate partner violence in adulthood ('Transmission of sexual violence: Description of the phenomenon and how to understand it', Collin-Vezina & Cyr, 2003; 'Childhood precursors of adult interpartner violence', Feldman, 1997; 'Unhealthy parenting and potential mediators as contributing factors to future intimate violence: A review of the literature', Schwartz, Hage, Bush & Burns, 2006). Johnson-Reid (1998, 'Youth violence and exposure to violence in childhood: An ecological review') in particular highlighted the significance of child maltreatment and exposure to violence in childhood as combined precursors for

domestic violence in adulthood, focusing particularly on the differences between intergenerational transmission and social learning contexts.

In linking with this, one meta-analysis examined the physical enforcement of discipline ('Parental physical negative touch and child non-compliance in abusive, neglectful and comparison families: A meta-analysis of observational studies', Wilson, Shi, Tirmenstein, Norris & Rack, 2006), which suggested that the use of physical discipline could escalate into dangerous and/or violent situations and affect the quality of the parent-child relationship. Physical discipline was also explored in a review on childhood attachment in relation to the intergenerational transmission of maltreatment ('Theory and observation of attachment and its relation to child maltreatment: A review', Morton & Browne, 1998).

Finally, a significant proportion of the literature reviews and meta-analyses were found to focus on the prevention of intergenerational child maltreatment through effective parenting programmes ('Preventing child abuse: A meta-analysis of parent training programs,' Lundahl, Nimer & Parsons, 2006; 'Programs for the promotion of family wellness and the prevention of child maltreatment: A meta-analytic review', MacLeod & Nelson, 2000; 'Intergenerational transmission of abuse', Powell, Cheng & Egeland, 1995; 'Ten year research update review: Child sexual abuse', Putnam, 2003).

Throughout the scoping search, the only review which looked specifically at mothers and/or motherhood in intergenerational child maltreatment was Hassan and Paquette's (2004) literature review on the control behaviours of adolescent mothers ('Control

behaviours of adolescent mothers: Critical review of the empiric documentation’). This reviewed the determinants of behaviours employed by adolescent mothers when enforcing discipline. Hassan and Paquette (2004) noted that the mother’s control behaviour could be predicted by a set of determinants belonging to three categories – the mother’s psychosocial conditions (such as perceived stress, support, conflict), their personal and developmental characteristics (including age, history of maltreatment, parental attitude and knowledge), and the child’s characteristics (such as temperament). The only other review that touched upon the link between childhood maltreatment and motherhood was Collin-Vezina and Cyr’s (2003) literature review on the transmission of sexual violence in which they note that half of sexually abused children’s mothers recalled being sexually abused in their own childhoods.

It is evident from the scoping search that there are a significant amount of systematic reviews and meta-analyses which explore intergenerational child maltreatment and the link to future parenting. However, there is a clear lack of literature reviews on mothers who are maltreated in childhood and the risk of abuse and neglect of their own children. Taking the previous reviews into consideration, in conjunction with the scoping search, it is apparent that further exploration of the prevalence of maltreatment in motherhood is required. The current review is therefore a warranted addition to the existing literature of intergenerational child maltreatment, as it differs in its focus on mothers who have been maltreated in their childhood.

## **Aims and objectives**

The aim of this systematic review is to assess the incidence of intergenerational child maltreatment in a population of mothers who had a childhood history of maltreatment.

The objectives of this systematic review were as follows:

- To gain an understanding of intergenerational child maltreatment between mothers with a childhood history of maltreatment and the maltreatment of their own children (the term ‘maltreatment’ refers to sexual, verbal, physical and emotional abuse and neglect).
- To determine if mothers who are maltreated in childhood perpetuate the same maltreatment behaviours with their own children.
- To determine the risk and protective factors for intergenerational child maltreatment between mothers and their children.

## **Method**

### **Sources of literature**

In order to identify existing reviews, searches of the gateways Cochrane Library, the Campbell Library and DARE were conducted on the 16<sup>th</sup> April 2011 but yielded no results for the keyword searches. In order to identify primary studies that would address the aims of the review, a search of electronic databases was conducted on 2<sup>nd</sup> and 4<sup>th</sup> May 2011. Databases that were searched included: PsycINFO (1987 to January Week 1 2014), Web of Science (1990-2014) and Applied Social Sciences Index and Abstracts - ProQuest (ASSIA; 1990 - 2014), Ovid MEDLINE® (1948 to January Week 1 2014) and EMBASE (1988 to 2014). The literature search on ASSIA included a database

search of PILOTS, National Criminal Justice Reference Service (NCJRS) Abstracts Database, ProQuest Dissertations & Theses A&I: Social Sciences, ProQuest Dissertations & Theses A&I: Health & Medicine, Sociological Abstracts, Social Services Abstracts and Educational Research Information Centre (ERIC).

### **Search strategy**

In May 2011 (re-reviewed and updated in January 2014), an initial scoping search of the databases was employed to obtain an understanding of the literature that was available in this area of research. All of the databases were accessed electronically which allowed limits to be placed, such as English language only and specific publication years, therefore conducting more specific searches in each database. Where possible, limits were also placed on the population subtype (e.g. human, animal, male, female, etc) due to a significant amount of articles on attachment styles and maternal characteristics in rhesus monkeys being detected in the literature searches.

The same search terms and process of searching were applied to all of the electronic databases. In each database, initial searching for articles using the keywords '*child abuse*' and '*child neglect*' was carried out followed by a search combining the keywords for '*maltreatment*' and '*child*'. These two searches were then merged in an '*OR*' combination search so as to identify as many relevant articles as possible and to ensure that the concept of 'child maltreatment' had been covered thoroughly. Breaking down the search this way also allowed for international discrepancies in the child maltreatment literature to be identified. The following keyword searches

(‘*intergeneration*’ and ‘*mother*’) were then applied to create a final number of relevant articles. Table 1 presents the keywords utilised in the search:

Table 1

*Keywords utilised in literature search*

Intergenerational	Child	Maltreatment	Mother
Transgeneration*	Child*	Verbal* abus*	Mother*
Intergeneration*	Infant	Emotional*	Female parent
Transition* patterns	Adolescen*	abus*	Maternal
Family Relation*	Teen*	Sexual* abus*	Mother child relation*
	Baby	Physical* abus*	Parent child relation*
	Babies	Neglect	

*Note:* see Appendix 1 for search syntax.

These terms were entered into the search as follows:

*(child abuse) OR (child neglect) OR (physical abuse) OR (verbal abuse) OR (emotional abuse) OR (sexual abuse)OR (physical neglect) OR (verbal neglect) OR (emotional neglect)*

AND

*(child) OR (infant) OR (adolescent) OR (teen) OR (baby) OR (babies)*

AND

*(transgeneration) OR (intergeneration) OR (transition patterns) OR (family relations)*

AND

*(mother) OR (female parent) OR (maternal) OR (mother child relation) OR (parent child relation)*

An effective measure of searching for specific articles involves mapping to subject headings. However, using keywords in these searches ensured that the minimal amount of studies was overlooked through inaccurate coding. As commented on previously, this was certainly a more effective search strategy for the subject heading of ‘child maltreatment’ which encompasses many keywords, some of which may not have been detected under a singular subject heading. Exploding these subject headings in databases such as PsycINFO allows for the generation of keywords that may not have been thought of originally, alternative spellings, international synonyms or historical terms. For example, the search on PsycINFO was extended when ‘exploding’ the term ‘*transgenerational patterns*’ highlighted ‘*mother child relation*’ and ‘*parent child relation*’ as additional subject headings. This increased the number of hits on PsycINFO and became an additional keyword when searching other databases. Appropriate use of truncation and word adjacency were also taken into consideration when searching keywords.

There was some variation in how the search tools were applied for each database which created some disparity in the output, in particular, MEDLINE and EMBASE. The search strategy utilised in PsycINFO was conducted within the MEDLINE and EMBASE databases and did not generate any results (see Appendix 1). MEDLINE did not produce any articles relating to intergenerational patterns of abuse and only had articles for sexual abuse, producing no results for the other forms of abuse. The search

in EMBASE produced similar findings; it also did not recognise the keyword '*transgenerational*'. Both of these databases appeared to have a more medical focus – child maltreatment was contextualised in terms of malnourishment, mothers with substance abuse problems and alcohol dependence, and an infant's failure to thrive. On review of the articles produced in these databases, there was no relevant literature to the current review and thus these search results were not filtered.

All of the initial search results from PsycINFO, Web of Science and ASSIA were then filtered by hand using the article titles and abstracts to eliminate articles that were not relevant to the current review as well as duplicates of the included literature.

## **Study Selection**

### **Inclusion criteria and Participants, Interventions, Comparisons and Outcomes (PICO)**

The literature titles and abstracts identified through the searches were reviewed for relevance to the review aim. Duplications of literature were also removed at this stage. The remaining studies were reviewed using the following inclusion and exclusion criteria:

**Population** – mothers and their biological children.

**Study design** – observational studies, case control studies, case series studies and cohort studies.

**Exclusions** – studies where the child(ren) had been abused by another parent or caregiver (e.g. biological father, step-father, maternal boyfriend/partner, elder sibling, extended family member), fathers/male-only/both parent studies, non-English papers, unpublished papers, reviews, commentaries, editorials and opinion papers.

Although the PICO was taken into consideration, the current review did not deem the following inclusion and exclusion criteria appropriate for the literature search: intervention, comparator and outcome. This was due to the literature search not being specific to certain types of study or interventions. Indeed, the initial scoping searches demonstrated a significant lack of intervention studies based around mothers with a history of child maltreatment who perpetuate abuse and neglect of their own children, which can be identified as intervention research in this area being in its' infancy (Cross, 2001). Some of the literature in the current review includes comparative studies involving both maltreating and non-maltreating mothers with histories of childhood maltreatment and control groups of mothers with no maltreatment history. However, screening the literature with this comparator criterion would have dramatically reduced the number of articles and subsequently jeopardised the quality of the current review.

The inclusion/exclusion criteria form used at this stage of the review is provided in Appendix 2. A selection of eliminated studies can be found in Appendix 3 to demonstrate how they were unsuitable for selection. These studies were originally marked as relevant to the current review but upon further examination and application of inclusion and exclusion criteria, they were removed. Once the initial results had been searched by hand to leave only potentially relevant literature, the inclusion and

exclusion criteria were applied. In the incidences where the articles' abstracts did not provide enough information to effectively apply the inclusion and exclusion criteria, or the author was unsure of its suitability, the full text article was accessed and reviewed. All articles which met the inclusion criteria were downloaded as full text articles through electronic journal databases. Any articles that could not be accessed in this format were sourced from the Main Library at the University of Birmingham and reviewed by hand. Eight articles were unable to be retrieved either electronically or by hand; the author contacted the various journal databases but was unable to access the full text without payment to or consent of the author. This was particularly problematic for three academic pieces of literature (dissertations and theses) which were completed at universities in the United States.

### **Quality Assessment**

Following the screening of articles using the inclusion and exclusion criteria, each included study was then quality assessed using the appropriate appraisal tool for the study design (see Appendix 4). The key variables that were assessed during this process were research design, sampling, data collection, reflexivity (recognition of researcher bias), ethical issues, data analyses, findings and overall value of the research.

Each item on the quality assessment sheet was rated as either 'yes', 'no' or 'partially', depending on its' presence and/or documentation in the study. If the study was unclear or had not documented evidence of any item, it was marked 'unknown'. A numerical value was given to each item: 2 for 'yes', 1 for 'partially' and 0 for 'no' or 'unknown', which were aggregated to give a total quality score of 64 for qualitative studies, 46 for

cohort studies and 54 for case control studies. For the purpose of inter-rater reliability, a small sample (n = 3) of the included studies was assessed by a second reviewer. One of the studies received the same score given by the primary reviewer (author) and the remaining two had a discrepancy of one point, thus providing an acceptable level of agreement between the two reviewers on the quality assessment process.

Any studies that received a total score lower than 60% of the total possible score were excluded from the final review. Studies that had met the outlined inclusion and exclusion criteria but rated poorly in the quality assessment (i.e. significant number of items marked 'no' or 'unknown') were excluded from the final review. As presented in Table 3, studies which received a final score between 60-80% of the possible total score were marked as 'good' whereas studies which scored between 80-100% of the possible total score were marked as 'very good'. Although excluding some studies may have resulted in a level of selective bias, it was the intention of the author that by using only studies deemed to be of the highest quality, any conclusions that were made could be generalised to the population as a whole and recommendations for future research would be more applicable.

### **Data extraction and synthesis**

A pre-defined data extraction form (see Appendix 5) was designed by the author and used to extract relevant data from each study included in the current review. This form allowed for both general and specific information in each study to be considered, and to enable an unbiased and reliable approach to reporting of conclusions. Information from the data extraction process can be found in Table 3. All included studies were

considered from a qualitative perspective instead which allowed for the heterogeneity both within the various aspects of each study individually and between all the studies together. As a result, the quality of each included study was assessed by considering the individual qualitative aspects of each study, as shown in Table 3. An attempt was made by the author to synthesise the results from all included studies but, as highlighted above, this proved to be problematic due to the diversity of study aims, objectives, methods and results. Therefore, data synthesis has explored only a few aspects of the 10 studies.

Figure 2 depicts the process of study selection and elimination for the review.

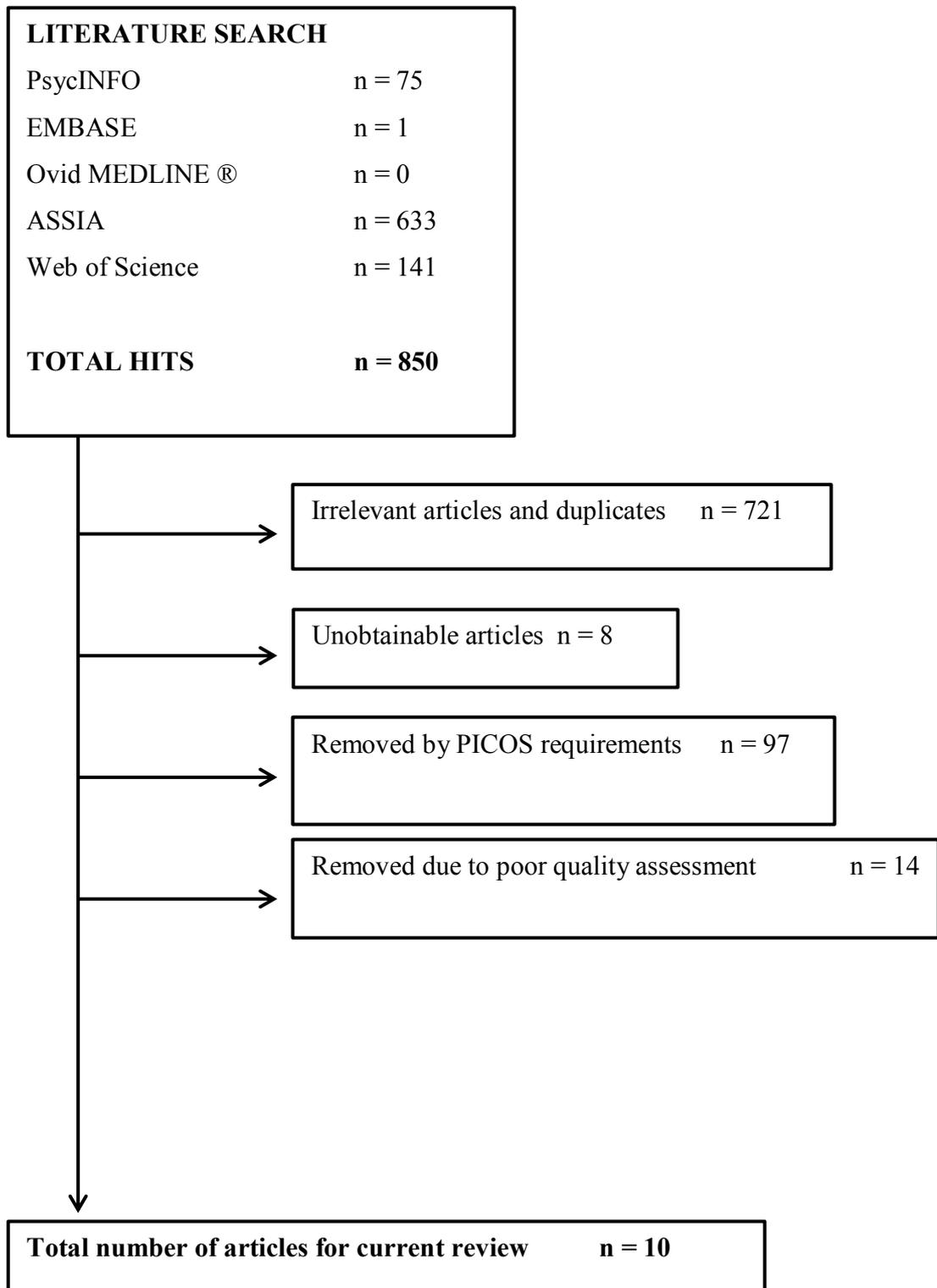


Figure 2. Study selection process.

## **Results**

Initial searches of the electronic databases using the specified search terms yielded a total of 850 studies. On reviewing the titles and abstracts of these studies, 721 were found to be irrelevant or duplicates of other studies already viewed and were therefore excluded for those reasons. Eight studies were also unable to be retrieved within the search due to issues contacting authors or unavailability of either electronic or paper copies. The remaining 121 studies were hand searched and checked against the inclusion and exclusion criteria, according to the PICO process, and 97 studies were excluded at this point. The remaining 24 studies were then quality assessed using the quality assessment tools, dependent on the research type, excluding 14 at this point due to the author's assessment of poor quality. The selection process yielded 10 final studies which met both the inclusion criteria and were also considered to be of highest quality (Table 2).

Table 2

*Overview of the included research studies*

<b>Author(s) &amp; Year of Publication</b>	<b>Hypothesis/Aims/Research Questions</b>	<b>Participants</b>	<b>Methodology</b>	<b>Results</b>
<b>Baker (2001)</b>	To explore how the development of cognitive self-understanding can be affected by childhood sexual abuse and the affect this can have on a woman's ability to parent her children.	Nine women aged 35-49 years all who were in therapy dealing with the sexual abuse of their own children.  Children's age range: 5-29 years ( $M = 15.94$ ).	All women were interviewed and content themes were identified. Data narrowed down to two themes: 'self-reflection' and 'multigenerational patterns'. Data was coded and scored by the author using content analysis.	1. Victimization experiences made it more difficult to recognise their daughters being abused. 2. Low self-esteem originated from childhood abuse and had connections with becoming a single parent and being in relationships with abusive partners. 3. Recognition that the multigenerational patterns of abuse needed to be changed but participants struggled to see how, thus relying on 'luck or circumstances beyond their control'.
<b>Bartlett &amp; Easterbrooks (2012)</b>	1. Childhood history of physical abuse would increase the risk of neglect. 2. Childhood history of positive care would decrease the odds of neglect. 3. Some adolescents would experience both positive care and physical abuse in childhood relationships with their mothers. 4. Positive care-receiving experiences would moderate the relation between a maternal childhood history of abuse and risk for child neglect.	92 adolescent mothers aged 14.0-16.9 years ( $M = 16$ years)  Children aged 6.6-9.4 years ( $M = 7.9$ years)	Mothers assessed on their own histories of maternal care and childhood physical abuse using psychometric data. Neglect of their own children was assessed using CPS records and data involving participation in a parenting programme was also recorded.	1. According to CPS records, every count of maltreatment was substantiated by neglect, either as the only form of maltreatment or in combination with physical abuse. 2. 26% of mothers neglected their children. 3. In 70% of families where the mother was neglectful, the child was also being victimised by another caretaker. 4. 45% of participants had experienced abuse in childhood and just under half were assessed as neglectful mothers. 5. 78% reported positive care in childhood, as assessed by psychometrics. 6. The odds of being neglectful were four times greater for mothers with a childhood history

<b>Bert, Guner &amp; Lanzi (2009)</b>	<ol style="list-style-type: none"> <li>1. What is the incidence of exposure to childhood abuse among a sample of first-time, adult low-resource and adult high-resource mothers?</li> <li>2. Does having a history of emotional, physical or sexual abuse affect maternal parenting knowledge and behaviour for the different types of first-time mother?</li> </ol>	<p>681 teen, adult low-resource and adult high-resource mothers (age range: 14-36 years, <math>M = 19.8</math> years)</p>	<p>Interviews with mothers six months after birth of their first child and use of psychometrics.</p>	<p>of abuse.</p> <ol style="list-style-type: none"> <li>1. Exposure to childhood emotional and physical abuse were associated with 6-month parenting behaviour but not with parenting knowledge.</li> <li>2. As opposed to adult mothers, teen mothers had higher mean scores for exposure to childhood emotional and physical abuse.</li> <li>3. For the total sample of mothers, as past exposure to emotional and physical abuse increased, maternal responsivity decreased and opinions towards and propensities for, abusive behaviour increased.</li> </ol>
<b>Estes &amp; Tidwell (2002)</b>	<ol style="list-style-type: none"> <li>1. The influence of a mother's experience of sexual abuse on the sexual abuse behaviours experienced by her child.</li> <li>2. Examine child behaviour as it relates to the type of sexual abuse and to gender.</li> <li>3. To explore indicators of family functioning in incestuous and non-incestuous families.</li> </ol>	<p>104 sexually abused children (52 males and 52 females) and their 104 mothers (50 with a history of sexual abuse and 54 without such histories).</p>	<p>Self-report assessment measures and semi-structured interview.</p>	<ol style="list-style-type: none"> <li>1. Intrafamilial abused children displayed significantly more sexualised behaviour than children molested outside of the home.</li> <li>2. Sexually abused male children displayed significantly more sexualised behaviour than females.</li> <li>3. Mothers who had histories of incest abuse reported significantly more substance abuse and more physical abuse in their families.</li> </ol>
<b>Haapsalo &amp; Aaltonen (1999)</b>	<ol style="list-style-type: none"> <li>1. To examine the differences between the two groups of mothers in their reports of childhood maltreatment experiences.</li> <li>2. To test whether the mothers' self-reported childhood experiences could explain maltreatment directed at their</li> </ol>	<p>25 mothers who had children under the supervision services (CPS) and 25 mothers who had no</p>	<p>Completion of basic information sheet, structured interview and review of case files. Data analysis included descriptive statistics and correlations. Multiple</p>	<ol style="list-style-type: none"> <li>1. CPS mothers had experienced more childhood psychological abuse.</li> <li>2. Regression analyses showed that mother's childhood abuse experiences predicted their abuse of their own child.</li> </ol>

	own children and their punitiveness.	contact with CPS.  CPS mothers' <i>M</i> age: 40.84 years. Non-CPS mothers' <i>M</i> age: 39.12 years.  CPS children's <i>M</i> age: 12.68 years. Non-CPS children's <i>M</i> age: 11.88 years. 11 girls and 14 boys in each group.	regression analysis with maternal childhood abuse experiences.	
<b>Jaffee et al. (2013)</b>	Mothers with a childhood history of maltreatment who did not maltreat their children ('cycle breakers') would have more socially supportive relationships and fewer contextual negative factors than mothers who did maltreat their children ('cycle maintainers').	1,116 mothers and their same-sex twins born between 1994-1995. Participants split into 562 'younger mothers' (age at birth < 20 years, <i>M</i> = 18.5 years) and 554 'older mothers' (age at birth > 20 years, <i>M</i> = 28.4 years).	Mothers interviewed on their childhood experiences of maltreatment using the Childhood Trauma Questionnaire (CTQ). Children assessed for maltreatment using standardised clinical interview protocol. Prospective reports of the child's maltreatment were collected repeatedly up to 12 years.	Longitudinal results demonstrated continuity of maltreatment – the odds of a child experiencing physical maltreatment were 3-5 times higher among women who reported being abused or neglected in their own childhoods.  'Cycle breakers' demonstrated supportive and trusting relationships with intimate partners, high levels of maternal warmth towards their children and low levels of violence between adults compared with 'cycle maintainers'.
<b>Macias (2004)</b>	1. Examine the prevalence of intergenerational transmission of abuse. 2. Identify the characteristics that differentiate mother-child dyads where the mother was abused in childhood from mother-child dyads where the	85 mothers and their children that had been referred to a child abuse agency for treatment due to physical or sexual	Use of checklists to document mother's childhood abuse history, current parenting stress scores, current parenting behaviours and involvement in family	1.68% of mothers reported a childhood history of abuse. 2. 20% of mothers had perpetrated the abuse on their child, 47% of children were abused by another family member and 33% were abused by a non-family member. 3. Mothers with an abuse history reported

	<p>mother reported no childhood history of abuse.</p> <p>3. Differences between mother with an abuse history who were the perpetrators of abuse and abused mothers who did not perpetrate were also explored.</p>	abuse.	therapy and treatment.	<p>significantly more total parenting stress and stress due to child factors than mothers with no childhood abuse history.</p> <p>4. Mothers' report of total problem behaviours in their children was significantly greater for children of abused mothers than for children of non-abused mothers.</p>
<b>McCloskey &amp; Bailey (2000)</b>	<p>1. Whether domestic violence is a risk factor for child sexual abuse to be perpetuated within the family.</p> <p>2. Parental history of abuse as a risk factor for sexual abuse in daughters.</p> <p>3. Daughters of battered women would have higher rate of victimization.</p>	179 preadolescent girls (M age = 9 years) and their mothers.	<p>Mothers and children were interviewed, interpreters supplied if needed.</p> <p>Interview narratives were coded and compared.</p>	<p>1. 18% of girls were victims of sexual abuse.</p> <p>2. Risk factors for sexual abuse included interparental violence, family isolation, presence of stepfather, maternal problems including drug use, psychopathology and a history of sexual abuse.</p> <p>3. Girls in the sample whose mothers were sexually abused were 3.6 times more likely to be sexually victimised.</p> <p>4. Maternal sexual abuse history combined with maternal drug use placed daughters at the most elevated risks.</p> <p>Maternal sexual abuse history indicated a strong potential for the intergenerational transmission of child sexual abuse.</p>
<b>Noll, Trickett, Harris &amp; Putnam (2009)</b>	Maternal histories of childhood abuse place children at risk for various forms of adversity.	<p>1. 84 sexually abused females, their non-abusing caregivers and their children - three generations:</p> <p>G2: Median age at onset of abuse: 7.8 years.</p> <p>G3: 5 months – 11 years 10 months (<math>M = 4.60</math> years).</p>	Interviews and ANCOVA of variables identified.	<p>1. Children of abused females were more likely to have been involved with child protection services.</p> <p>2. Children of abused mothers were most likely to be unplanned or the result of teen pregnancy.</p>

		2. Comparison sample of 82 non-abusing parents/caregivers and their children (children's <i>M</i> age: 3.56 years).		
<b>Valentino, Nuttall, Comas, Borkowski &amp; Akai (2012)</b>	<p>Hypothesis 1: Mothers with a history of childhood abuse (physical, sexual, and/or emotional) would be more likely to have children who reported experiences of childhood abuse than mothers without a history of abuse.</p> <p>Hypothesis 2: Among mothers with a history of childhood abuse, exposure to community violence and authoritarian attitudes about harsh parenting would predict intergenerational continuity of childhood abuse.</p> <p>Hypothesis 3: The effect of authoritarian parenting on childhood abuse would be moderated by race, such that higher authoritarian parenting among African American families would operate as a protective factor, rather than conferring risk compared to Caucasian American families.</p>	<p>70 mother-child dyads</p> <p>Mother's age (at time of birth): 14.5-19.5yrs (<i>M</i> = 17.95), children were all aged 18 years</p>	<p>Mothers completed questionnaires and information was taken from birth-related medical records.</p>	<ol style="list-style-type: none"> <li>1. Mothers with childhood histories of abuse were more likely to have children who reported abuse prior to age 18 (54.3%) than mothers with no reported abuse history.</li> <li>2. Maternal authoritarian parenting attitudes was a significant predictor of child abuse status at age 18 - low levels of authoritarian parenting were associated with membership in the abuse continuity group.</li> <li>3. Among African American families, Authoritarian parenting was a strong predictor of children's abuse status - such that lower authoritarian parenting was associated with membership in the abuse continuity group.</li> </ol>

Table 3

*Data extraction of included studies*

<b>Author(s) &amp; Year of Publication</b>	<b>Sampling Methods</b>	<b>Assessments Used</b>	<b>Limitations</b>	<b>Quality Assessment Score</b>
<b>Baker (2001)</b>	Non-random sample of nine women recruited who were currently in therapy. Six recruited through therapy group, one referred by a colleague and two other women contacted through this referee.	1. Experience Recall Test 2 (ERT2) 2. Parental Awareness Interview – Learning and Evaluating Parenting	1. Cognitive capabilities of participants – participants who had completed tertiary education where able to move more easily through the self-knowledge stages.	Good (67.3%)
<b>Bartlett &amp; Easterbrooks (2012)</b>	Participants were enrolled in an evaluation of a state-wide prevention home visiting programme for first time young parents (age < 21 years). Mothers participating in the programme were interviewed and complete questionnaires after enrolment and every six months thereafter for a period of 18 months.	1. The Parental Bonding Instrument (PBI) 2. Conflict Tactics Scale – Parent-Child version (CTSPC)	1. Limited sample size. 2. Reported missing data on maternal history variables.	Very Good (86.4%)
<b>Bert, Guner &amp; Lanzi (2009)</b>	Participants were drawn from the Parenting for the First Time Project. Mothers were asked to participate on the basis that it was their first birth and they met the age and education requirements.	1. Childhood Trauma Questionnaire (CTQ) 2. Knowledge of Infant Development Inventory – Short Form (KIDI) 3. Child Abuse Potential Inventory (CAPI)	1. Maternal reports were the sole source of information. Multiple informants may have provided more accurate information on life events and current level of functioning. 2. Retrospective measure of exposure to abuse – may be confounded by participants' age, memory capacity and/or intelligence.	Very Good (88.1%)

		4. Parenting Style Expectations Questionnaire	3. Did not account for the effect of other variables on their exposure to abuse such as race, gender, culture, psychopathology and child's temperament.	
<b>Estes &amp; Tidwell (2002)</b>	Participants were receiving psychotherapeutic assistance at a local community mental health centre specialising in the assessment and treatment of childhood sexual abuse. Assigned to one of two groups based on their experiences of incest childhood abuse.	1. Child Abuse Prevention/Intervention Services Interview 2. Child Behaviour Checklist (CBCL) 3. Child Sexual Behaviour Inventory (CSBI)	1. All of the children in the study were victims of sexual abuse. This limits the ability to examine intergenerational factors influencing sexual abuse. A control group that includes mothers who were incest victims and whose children have not been sexually abused would allow for better understanding of how individuals break through cycles of abuse.	<b>Very Good (89.5%)</b>
<b>Haapsalo &amp; Aaltonen (1999)</b>	Mothers in the CPS group were recruited through social welfare authorities. Non-CPS mothers were recruited among parents of school-age children through letters sent by their teacher.	1. Basic information sheet- education and employment, family situation, socioeconomic status, etc. 2. Structured Interview – experiences of childhood physical and sexual abuse, substance abuse, psychiatric problems in adulthood, use of punishment in child-rearing, and physical and psychological violence used against their own child.	1. Sample size was small due to ethical considerations and effective recruitment of participants. 2. Reliability of self-report – the experiences of abuse are retrospective so reports could be biased or distorted. 3. Maternal self-reports did not correlate with file information e.g. information on reporting abuse or identity of the perpetrator. 4. Interpretation of 'abuse' as an act or a 'less-acceptable child-rearing practice'.	<b>Very Good (81%)</b>
<b>Jaffee et al. (2013)</b>	National Office of Statistics invited parents of all twins born between 1994-5 to join the Twins Early Development Study (TEDS).	Childhood Trauma Questionnaire (CTQ)	1. Mothers reported retrospectively on their own history of maltreatment. 2. Sample composed of twins and therefore unsure	<b>Good (65.6%)</b>

	71% of parents joined the TEDS register.		if results can be generalised to individual children. 3. Children's experiences of abuse were reported via mothers and may be prone to bias. 4. Study did not assess all children in the family, only twins therefore other cases of maltreatment within the family may have been overlooked.	
<b>Macias (2004)</b>	85 mother-child dyads that had been referred for treatment due to physical or sexual abuse. Non-random sample.	1. Parenting Stress Index (PSI) 2. Child Behaviour Checklist (CBC Scores) 3. Trauma Symptom Checklist.	1. All participants involved in child abuse agencies so population may be skewed in terms of maltreatment type.	Very Good (87%)
<b>McCloskey &amp; Bailey (2000)</b>	179 families drawn from a pool of 363 families who were interviewed during 1990-1991. Recruitment methods included posters and public announcements in the community and approaching women's shelters.	1. Narrative on child sexual abuse from interviews 2. Conflict Tactics Scale (CTS) 3. Brief Symptom Inventory (BSI) 4. Sexual Experiences Survey 5. Diagnostic Interview for Children and Adolescents (DICA)	1. Inclusion of many variables jeopardised strength of measurement, e.g. some variables rely on only one or two questions to ascertain important constructs such as parental sexual abuse history or maternal drug or alcohol use.	Good (72.3%)
<b>Noll, Trickett, Harris &amp; Putnam (2009)</b>	Original sample was referred by child protection services (CPS) agencies. Comparison sample was recruited via advertisements in community newspapers and posters in welfare, day care and community facilities in the same neighbourhood where the abused participants lived.	1. Comprehensive Trauma Interview 2. Domestic Conflict Inventory 3. Diagnostic and Statistical Manual of Mental Disorders – 4 <sup>th</sup> Edition (DSM-IV) 4. Childhood Depression	1. Sample of offspring born to women participating in a longitudinal study is a convenience sample and was not randomly obtained from a larger population potentially limiting generalisability. 2. Relying on maternal family-of-origin socioeconomic status as a demographic control and have not accurately matched the sample of children with non-abused mothers.	Good (62%)

		Inventory 5. Beck Depression Inventory (BDI) 6. Dissociative Experience Scale 7. Scheduled Clinical Interview for DSM Diagnoses (SCID)		
<b>Valentino, Nuttall, Comas, Borkowski &amp; Akai (2012)</b>	70 mother-child dyads drawn from the Notre Dame Adolescent Parenting Project. School-aged mothers were recruited from school-age mothers' programmes, hospital clinics and social services.	1. The Parent Attitude Questionnaire (PAQ) 2. The neighbourhood subscale of the Recent Exposure to Violence scale (EVS). 3. Childhood Trauma Questionnaire (CTQ)	1. Child abuse data was collected via self-report. 2. Small sample size.	<b>Very Good (85.4%)</b>

## **Study populations**

In considering sample size first, the total number of participants varied considerably, ranging from nine (Baker, 2001) to 1,116 participants (Jaffee et al., 2013). However, most of the studies had fewer than 200 participants. The total number of participants included in this review is 2552 with an average number across all studies calculated as 255.2. Of the 10 studies included in the review, seven were conducted in the United States, one in Canada, one in Finland and one in the United Kingdom. Therefore, there is an over-representation of a North American population.

Methods of recruitment differed across all 10 studies; therapy groups, public announcements in community facilities including medical and health centres, child protection service (CPS) agencies, child abuse agencies, social welfare authorities and local community mental health centres. Whilst Bartlett and Easterbrooks (2012) and Valentino et al. (2012) recruited mothers already involved in a parenting programme, Jaffee et al.'s (2013) sample was taken from a twin development study where parents had already been recruited. In studies where comparator groups were considered, the samples of mothers were recruited from the same community as the target sample through local advertisements in nursery and leisure facilities (Noll et al., 2009) and teachers from the local schools (Haapsalo & Aaltonen, 1999). All the studies used a non-random sampling method.

The ethnic distribution of participants varied greatly between the included studies. In some, there were a higher percentage of Caucasian participants (Estes & Tidwell, 2002; Macias, 2004; McCloskey & Bailey, 2000; Noll et al., 2009), whereas Bert et al. (2009)

and Valentino et al. (2012) had a significantly higher percentage of African American participants (68.5% and 57%, respectively) compared to European American (14.4% and 36%) and Hispanic (14.3% and 7%). Other ethnicities were significantly underrepresented across these studies, with Noll et al. (2009) having only 1% of Asian participants in their sample and Estes and Tidwell (2002) noted that only 1% of their sample were 'Pacific Islanders' (p.38). Interestingly, Bartlett and Easterbrook's sample consisted mainly of Latina mothers (48%) with 'according to self-report, 29% White, 11% Black and 12% "other"' (p.2166). Baker (2001) did not report the ethnic representation of her sample; however, she did state that all the mothers in her research were from rural New England towns. Jaffee et al. (2013) also did not explicitly report the ethnic groups in their sample; their participant demographics were described in Moffitt et al.'s (2002) Environmental Risk (E-Risk) Longitudinal Twin Study, from which Jaffee et al.'s (2013) data was used. However, this paper gives little information on participant ethnicity, describing the sample as predominantly 'white' with 19.1% of the sample documented as 'non-white ethnicity' (p.733) without further clarification.

The ages of the mothers in the included studies varied greatly; two studies included women between the ages of 31 years and 40 years (Estes & Tidwell, 2002; Haapsalo & Aaltonen, 1999). In contrast, Bartlett and Easterbrooks (2012), Macias (2004), Noll et al. (2009) and Valentino et al. (2012) looked at younger mothers (< 18 years). In Noll et al.'s (2009) sixth assessment across the 18-year study period, the average age of participants spanned from 18.12 years to 32.14 years. Bert et al. (2009) and Jaffee et al. (2013) also looked at younger participants as adolescent mothers were one of their sample groups. Overall, Bert et al.'s (2009) sample age range was between 14 years and

36 years whilst Jaffee et al.'s (2013) spanned 19 – 48 years of age. Baker's (2001) research looked at slightly older mothers; the eldest participant being 49 years old and the youngest at 35. McCloskey and Bailey (2000) did not report the ages of their participants.

With such diversity amongst the ages of participants, it may be more challenging to generalise the results of the included studies to a specific population of mothers with childhood histories of abuse. There is particular bias in Bert et al.'s (2000) research as their sample of teen mothers (mean age: 19.8 years) was highlighted in particular for their childhood histories of abuse and the significant correlation with '6-month parenting opinions and a propensity for abusive behaviour' (p.183). Bert et al. (2000) fail to mention that the relatively young age of this sample of mothers may be responsible for their parenting knowledge and abilities, and not just the exposure to childhood abuse. Despite their results demonstrating that emotional abuse did not differentially predict parenting outcomes separately for separate classifications of mothers, the researchers do not consider age as a factor in parenting aptitude, a factor which has been highlighted before (Connelly & Straus, 1992).

Of the 10 included studies, seven had a sample representing women from middle to low socioeconomic groups, categorised mainly by the assessment of monthly income (both individually and household) or the reliance of financial support from the state. Two studies did not define the socioeconomic status of their participants and only one study used family monthly income as a comparator variable across three groups of mothers. Bert et al. (2009) categorised their sample groups as 'adult high-resource mothers

(\$16,666+)', 'teen mothers (\$8,336 - \$12,500)' and 'adult low-resource mothers (\$4,166-\$5,000)' (p.179).

In examining the demographics of the children in the included studies, their ages vary greatly. Across all 10 studies, the age of participant offspring ranged from 5 months to 29 years with five studies reporting the full range and medium ages (Baker, 2001; Bartlett & Easterbrooks, 2012; Estes & Tidwell, 2002; Noll et al., 2009; Valentino et al., 2012) and two reporting just the mean ages of children (Haapsalo & Aaltonen, 1999; McCloskey & Bailey, 2001). Jaffee et al. (2013) and Macias (2004) did not report the age of participant offspring. Whilst Bert et al. (2009) did not explicitly mention the age of their participants' offspring, part of the participant criteria was that their child had to be their first-born and, as the study was looking at parenting behaviour and knowledge at six months, it can be assumed that all the children were six months old at the time of assessment.

Gender was also significantly underreported across the literature; five studies did not cite the gender of the mother's children (Baker, 2001; Bartlett & Easterbrooks, 2012; Bert et al., 2009; Macias, 2004; Valentino et al., 2012). A number of studies were split fairly evenly across gender; Estes and Tidwell (2002) reported the same number of children of mothers with histories of incest abuse (25 sexually abused boys and 25 sexually abused girls) and the same number of children of mothers without a childhood history of abuse (27 boys and 27 girls). Haapsalo and Aaltonen (1999) had slightly more female than male children (14 and 11 respectively) but both groups (mothers known and unknown to CPS) had the same number and gender split of children. Although numbers

were not explicitly reported, Jaffee et al. (2013) and Noll et al. (2009) reported approximately even splits of male and female children. McCloskey & Bailey's (2001) participant offspring were all female.

### **Assessment method**

A variety of assessments were used in the studies and most of these were psychometric assessments administered in the form of or as part of structured and semi-structured interviews. For studies where the population sample was recruited from CPS agencies or social welfare authorities, case files were also used for data collection and as a form of corroborating information from the participants' self-report (Bartlett & Esterbrooks, 2012; Haapsalo & Aaltonen, 1999; Noll et al., 2009; Valentino et al., 2012). Only one study used case files as a singular method of data collection and did not involve active participation of the sample (Macias, 2004). A vast array of psychometric testing was employed more than once across the studies. Whilst some studies used standardised psychometrics to gauge the incidence, type, duration, and frequency of childhood maltreatment amongst their samples of mothers (Bert et al., 2009; McCloskey & Bailey, 2000), others used semi-structured interviews and open questioning for data collection (Baker, 2001; Haapsalo & Aaltonen, 1999; Jaffee et al., 2013).

Approaches to assessment remained similar across all 10 studies, predominantly the North American studies, which had a significant proportion of participants for whom English was not their first language. Researchers endeavoured to match non-English speaking participants (Hispanic and Latina mothers in particular) with interviewers who could speak their mother tongue (Estes & Tidwell, 2002; McCloskey & Bailey, 2000).

Studies involving interview procedure lasted approximately 2-3 hours and researchers cited the experience and training of their interviewers (Baker, 2001; Estes & Tidwell, 2002; Haapsalo & Aaltonen, 1999; Jaffee et al., 2013; McCloskey & Bailey, 2000; Noll et al., 2009). Only one study mentioned their follow-up procedure with the participants; Estes and Tidwell (2002) reported that all of the mothers and their children in the sample were offered on-going psychological treatment which included a sexual abuse evaluation, psychological testing, individual treatment, family treatment, group treatment and medication evaluation.

## **Discussion**

### **Main findings**

The main findings of the current review will be discussed with their relevance to the three objectives stated at the start of the review. The aim of this systematic review was to assess the incidence of intergenerational child maltreatment in a population of mothers who had a childhood history of maltreatment, and identify risk and protective factors associated with the transmission of abuse and neglect. Three main objectives were identified:

*Objective 1: To gain an understanding of intergenerational child maltreatment between mothers with a childhood history of maltreatment and the maltreatment of their own children (the term 'maltreatment' refers to sexual, verbal, physical and emotional abuse and neglect).*

All of the included studies support the initial objective of this review. All 10 studies reported an association between a history of childhood maltreatment and the impact of this experience on parenting in adulthood, whether the maltreatment was perpetuated or not. Previous research has suggested that female children are more likely to be the victims of abuse and neglect (Fluke, Shusterman, Hollinshead, & Yuan, 2008) and that this experience can have significant effects on their development in adulthood, resulting in physical problems, psychiatric disorders, stress, substance misuse and even offending behaviour (Briere & Jordan, 2009; Sachs-Ericsson, Cromer, Hernandez, & Kendall-Tackett, 2009). Dixon et al.'s (2009) research noted that adults who are victimised in childhood face particular problems when coping with parenthood. Indeed, Kim, Talbot and Cicchetti (2009) noted in their research that the intense feelings of guilt and shame in adult survivors of childhood maltreatment often resulted in higher levels of conflict within the home, towards both their partners and their children. Kim et al. (2009) linked these feelings with an undermined ability for these women to deal with conflict resolution and interpersonal problem-solving.

With regards to Objective 1, it is also important to consider studies which commented on the rates of child maltreatment in mothers with no childhood history of childhood maltreatment. Of the 10 studies included in the review, three included a control group of mothers with no history of maltreatment but only one study commented on the rate of maltreatment amongst the children of women in these groups. Estes and Tidwell (2002) found that maternal childhood history of sexual abuse bore no significance on the risk of offspring sexual abuse; women who had experienced sexual abuse within their family were just as likely to have a child who experienced sexual abuse (84%) as were mothers

with no such experience (76%). Although Jaffee et al.'s (2013) control group was compared against cycle maintainers and breakers of intrafamilial maltreatment, it consisted of 646 families where neither mother nor child had experienced maltreatment and thus no analysis could be conducted on parents who initiate child abuse and neglect with no childhood history of maltreatment. The third study to include a control group, Noll et al. (2009), did not conduct any exploration on the presence of child maltreatment in their comparison group of mothers with no childhood history of maltreatment.

Although their studies did not include an explicit control group, two studies reported the rates of child maltreatment amongst mothers with no childhood history of abuse or neglect. Bartlett and Easterbrooks (2012) found that of the mothers who neglected their children, 9% did not report being physically abused in childhood. Furthermore, of the mothers who reported a childhood history of positive care, as measured by the Parent Bonding Instrument (Parker, Tuping, & Brown, 1979), 15% neglected their children. Similarly, Valentino et al. (2012) found that 29.2% of the mothers in their sample with no abuse history had children who reported experiencing abuse. These are important issues to consider with regards to the impact of childhood experiences of maltreatment on the perpetration of abuse and neglect in adulthood.

*Objective 2: To determine if mothers who are maltreated in childhood perpetuate the maltreatment behaviours with their own children.*

Three of the included studies supported this second objective – each of these studies found a clear link between mothers who had been exposed to maltreatment in childhood and had subsequently proceeded to abuse and/or neglect their own children, although not always in the same form of maltreatment. Macias' (2004) research documented the strongest evidence for this hypothesis; 20% of mothers in their study had perpetrated the abuse they had experienced in childhood on their own child. This ranged from neglectful behaviour (lack of attention, actively distancing themselves from the child, etc) to contact abusive behaviours such as smacking, slapping, hair-pulling and pinching. In almost all cases where abuse had been perpetrated, the behaviours were similar to the maltreatment type experienced by the mother in childhood.

The second study which found a strong maltreatment type-to-type link was Bert et al. (2009). They found that mothers in their sample exposed to childhood abuse scored higher in punishment and authoritarian scores. This research reported that higher levels of exposure to physical abuse decreased maternal responsiveness thus increasing the propensity for abusive and neglectful behaviour of their own children. Macias' (2004) research found that mothers with a history of abuse who perpetrated the abuse reported significantly more parenting stress, a risk factor that has been highlighted before as a predictor of intergenerational abuse (Leigh & Milgrom, 2008).

However, two studies reported observable differences in the appearance of maltreatment. Haapsalo and Aaltonen (1999) found that punitive behaviour was best predicted by maternal psychological abuse; these women had experienced repeated rejection, accusations from their parents, being terrorised, and admitted to being

corrupted and manipulated on a regular basis. The researchers found a direct link between maternal childhood psychological abuse and psychological abuse in parenthood; these women were more likely to inflict psychological abuse on their own children. Mothers whose child had been under the supervision of child protection services demonstrated a lesser extent of punitive behaviour<sup>1</sup> which reflected that they were neglecting as opposed to being punitive or abusive. Indeed, Crittenden (1988) argued that neglecting mothers are observed to be typically unresponsive to their children whereas abusing mothers are more hostile and controlling. Interestingly, Haapsalo and Aaltonen (1999) found that mothers whose children were not known to the CPS reported as much physical and psychological abuse as the mothers whose children were known to the CPS. An explanation for this could be that CPS mothers attempted to minimise the extent of their abusive parenting or that non-CPS mothers had no reason to distort their responses and may therefore have been more truthful.

Similarly to Haapsalo and Aaltonen (1999), Bartlett and Easterbrooks' (2012) research that childhood experiences of maltreatment were particularly high in neglectful mothers and, interestingly, of the mothers who reported experiencing physical abuse in childhood, 44% of them were neglectful.

Two studies found that a childhood history of victimisation was more likely to be found in mothers whose children had also been identified (either by self-report or professional assessment) to have experienced maltreatment. Although the type of maltreatment

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<sup>1</sup> Punitive behaviour is defined by Haapsalo and Aaltoen (1999) as the following: rap on the fingers, slapping or smacking, tugging hair, spanking with an object, forcing the child to eat soap, locking the child somewhere, tying the child to a chair, forbidding a favourable activity, grounding, sending the child out of the home, denying pocket money, reproaching, scolding and demanding an apology.

experienced by both the mother and her child was not identified so as to make a direct type-to-type comparison, Jaffee et al. (2013) and Valentino et al. (2012) reported that child maltreatment was more likely amongst mothers with a personal history of childhood victimisation. Valentino et al. (2012) found that mothers with a childhood abuse history were more likely to have children who reported experiencing abuse by the age of 18 years. However the perpetrator of the children's maltreatment was not identified, a study limitation acknowledged by the authors. Emotional abuse was the most frequently reported form of maltreatment for both mothers and their children. Similarly, Jaffee et al. (2013) reported that of the 259 mothers who reported experiencing childhood maltreatment, over half had physically abused at least one of their twin children.

Three of the included studies found a more secondary link between maternal childhood maltreatment and parenting behaviour. These studies found that the exposure to abuse in childhood had significant repercussions for mothers, such as teenage pregnancy, involvement with child protection agencies or local authorities, experience of psychiatric problems, substance misuse and exposure to domestic violence in relationships (Estes & Tidwell, 2002; McCloskey & Bailey, 2000; Noll et al., 2009). In turn, these were noted as significant risk factors for child maltreatment, as their presence denotes an environment or situation that is not congruent to stable childhood development. Substantial research has been undertaken in exploring these risk factors and how they interplay with the cycle of abuse (Browne and Herbert, 1997; Newman and Stevenson, 2008; Scaife, 2008).

Baker's (2001) research did not find any evidence for intergenerational child maltreatment although her results displayed the effects of abuse at completely the opposite end of the parenting spectrum. Baker's (2001) participants displayed heightened anxious parenting behaviour, continually checking their child's whereabouts and teaching them self-protective behaviours. Previous research has certainly demonstrated that exposure to childhood abuse can often lead to women questioning their own parenting ability and thus compensating by being cautious and over-protective (Ungar, 2009).

*Objective 3: To determine the risk and protective factors for intergenerational child maltreatment between mothers and their children.*

As mentioned previously, the risk factors for intergenerational child maltreatment have been well researched and documented. Dixon, Browne and Hamilton-Giachritsis (2005) found that parents who had been maltreated as children had a higher prevalence to being a parent under 21 years of age, having a history of mental illness and living with a violent partner. In addition, they argued that this increased the likelihood of poor parenting styles and perpetuating the cycle of familial abuse. Six studies identified several risk factors including post-traumatic flashbacks which manifest in aggressive or hostile behaviour (Haapsalo & Aaltonen, 1999), substance misuse (McCloskey & Bailey, 2000), lack of self-knowledge development (Baker, 2001), rejection of therapeutic intervention (Macias, 2004), exposure to community violence (Valentino et al., 2012) and low maternal age, mother's or partner's mental health problems,

socioeconomic disadvantage, domestic violence and low social support (Jaffee et al., 2013; Valentino et al., 2012).

In comparison, four studies acknowledged a range of protective factors that may be instrumental in reducing the risk of maltreatment continuation. Jaffee et al. (2013) listed a number of protective factors including healthy intimate and sibling relationships, socioeconomic advantage and strong social support. Furthermore, Haapsalo and Aaltonen (1999) noted that mothers who recognise their experience of abuse as victimisation are more likely to behave differently to their own parents and not to abuse their own children. In contrast, a parent who sees their experience of abuse as a reflection of or punishment for their childhood temperament may identify with the abusive perpetrator and model their behaviours. Interestingly, Valentino et al. (2012) found a significant relationship between authoritarian parenting and abuse continuity. Their research indicated that women with a childhood history of victimisation and who demonstrated low levels of authoritarian parenting were more likely to have children who reported abuse at age 18, contrary to Valentino et al.'s (2012) expectation.

It can be argued, however, that the responsibility falls to professional services to intervene. Indeed, Bert et al. (2009) and Noll et al. (2009) argue that a significant protective factor would be the responsibility of public health services to provide appropriate intervention and prevention strategies aimed at improving the parenting skills and behaviours, particularly for mothers who have been exposed to childhood maltreatment. Macias (2004) found that mothers who participated in family therapy were far more likely to successfully complete treatment for their maladaptive parenting

behaviours than mothers who did not participate in family therapy. Bert et al.'s (2009) research provides significant implications for clinical practice and policy-making in order to prevent problems before they begin to surface.

In considering risk and protective factors, it is important to acknowledge studies which compared mothers with childhood histories of maltreatment who broke the cycle of continuation and those who did not. This issue was explored explicitly in just one study; Jaffee et al. (2013) compared families in which mothers but not children experienced maltreatment (cycle breakers) with families in which both mothers and children experienced maltreatment (cycle maintainers). In their analysis, Jaffee et al. (2013) found that cycle maintainers were more likely to experience domestic violence whereas mothers who were cycle breakers had positive personal relationships and demonstrated high maternal warmth towards their child.

Jaffee et al.'s (2013) results compliment the research undertaken by Dixon et al. (2009) in determining the difference in risk factors and parenting styles between families who initiate, maintain and break the cycles of abuse and neglect. Dixon et al. (2009) found that, in comparison to a control group of families with no evidence of child maltreatment, initiators, maintainers and cycle breakers had a higher prevalence of mental illness, substance dependency, serious financial difficulties and the presence of a violent adult within the home. In assessing families where the patterns of maltreatment had continued across the generations, they found that these families felt more isolated and had more financial problems than families who broke the cycle of continuation. However, it is also important to note that of the 135 families with a parent who did

report childhood maltreatment, only 6% maintained the cycle of abuse. Whilst there is evidence for the intergenerational mechanisms of child maltreatment, Dixon et al.'s (2009) study demonstrates a very low rate of transmission.

### **Strengths and weaknesses**

In reviewing all 10 included studies, a wide spectrum of mothers has been addressed in terms of age as opposed to just adolescent mothers. Therefore the population is clinically relevant to that being studied, which allows for generalisability across mothers of all ages. Five of the 10 studies use a comparator of non-abusive mothers which allowed for comparison to be made between mothers with a childhood history of maltreatment and mothers without such history. The remaining five studies looked at one target sample which allowed for further exploration of their parenting behaviours in relation to childhood exposure. The combination of all these studies thereby allowed a more coherent understanding of the incidence of intergenerational child maltreatment in relation to childhood exposure to maltreatment and the implications for parenting behaviours.

Limitations in this review may arise due to over-representation of certain demographics in the sample populations. Only two studies were representative of a European population (Haapsalo & Aaltonen, 1999; Jaffee et al., 2013) and the over-representation of North American populations meant a distinctive lack of particular ethnic minorities.

Bias can be found in the case control studies (Estes & Tidwell, 2002; Haapsalo & Aaltonen, 1999; Macias, 2004) as they used mothers who were known by child

protection services and local authorities. The referral of their cases to such services suggests a degree of severity in the maltreatment, which may be misrepresentative of the type of abuse or neglect which may be more frequent in this population. Whilst the results of these studies are pertinent to the field of research, data collection using this form of recruitment means a significant proportion of abusive/non-abusive mothers are undetected and thus further understanding of the risk and protective factors is hindered. In addition, the repeated focus of mothers in low socioeconomic situations may have reduced the efficacy of the current review by limiting the generalisability of the findings.

The reliability of the findings is also limited by a significant reliance on self-report from the participants. Reports of exposure to abuse as well as the degree of maltreatment inflicted on their own children mean that the validity of the research findings are compromised, particularly as additional sources of information were either unavailable or not utilised to confirm narrative accounts. Due to the sensitivity and the legal repercussions of the issues being discussed, it is possible that mothers may distort their version of events as a means of self-protection from shame, guilt or further legal ramifications.

### **Methodological considerations**

Comprehensive and inclusive search strategies were utilised in this review alongside effective quality assessment tools. The involvement of a secondary reviewer also helped ensure fair quality assessment and inter-rater reliability. These enabled the researcher to highlight specifically relevant information, such as sampling procedures, attrition rates,

specific psychopathologies and assessment tools used within the studies. The inclusion and exclusion criteria and quality assessment tools were reviewed by an Information Specialist to ensure all items were clear and relevant. However, time constraints limited the methodological quality of this review; the researcher was unable to contact authors resulting in some information being recorded as unknown. The researcher was also unable to search references of specifically relevant journals by hand; eight articles were unable to be retrieved within the time frame and articles not written in English were excluded due to the time constraints of interpreting the information.

A further methodological weakness is the heterogeneity of statistical analyses used in the studies due to the observational nature of both the population and the recorded data. As a result, no quantitative analyses could be conducted, which reduces the ability to report overall statistical significance.

These studies were included in the review as they were considered to be the most methodologically robust of those identified from the search procedure. The majority of included studies were quality assessed as 'very good', thus suggesting their methodological strength during quality assessment. However, it is important to consider that none of the included studies achieved a full score (100%) of quality assessment and consequently there may be procedural weaknesses in the review sample. It is possible that valuable data from lower quality studies may have been lost, although conversely the review is less prone to other forms of bias introduced by including methodologically weak studies and thereby drawing misleading conclusions. In addition, all systematic

reviews have the possibility of publication bias, although this is reduced by addressing this within the report.

It is also important to note that the review has only included studies which focus exclusively on mothers and has purposefully excluded studies where maltreatment has been perpetrated by both mothers and fathers. The literature search acknowledged that this selection criterion dramatically reduced the number of papers available for review and, indeed, over 800 papers were excluded on the basis of participant gender (in addition to other exclusion conditions). It was the intention of the author to analyse only studies that matched the aims of the review as closely as possible. However, it is possible that studies which include male and female participants but still contain valuable maltreatment data have been overlooked, as a result of this strict selection process. For example, Newcomb and Locke's (2001) comparative study of the parenting behaviours in men and women who experienced childhood victimisation demonstrated significant differences between mothers and fathers who were abused or neglected in childhood. For mothers in particular, sexual abuse in childhood precipitated more aggressive parenting behaviours in adulthood and experiencing neglect 'led to poor parenting above and beyond the general influence of child maltreatment' (p.1234).

Similarly, Kim's (2009) study on the continuity of type-specific maltreatment offered some interesting results concerning the prevalence of young parents who demonstrated specific maltreatment behaviours in adulthood that they themselves had experienced in childhood. Although this study was excluded due to using both male and female parents, Kim's (2009) data showed a strong link between the type of maltreatment

experienced and subsequently perpetrated; parents who experienced neglect in childhood were 2.6 times more likely to report neglecting their own children compared with those who physically abuse. Conversely, parents who reported being physically abused in childhood were five times more likely to physically abuse their children than those who neglected their children. Results specific to the mothers in the sample demonstrated that being female, White-Caucasian, experiencing lower rates of depression and having fewer children would make you less likely to neglect your child if you had been neglected yourself. An improvement on the current review may be to lift data relevant to mothers from mixed-sample studies as the results may still hold significance to understanding the process of intergenerational child maltreatment. Data of prevalence in European mothers is lacking and it is therefore recommended that future research consider this population.

### **Applicability of findings**

The findings of this review are applicable to the population of mothers with a childhood history of maltreatment as some large sample sizes were used in the studies. The heterogeneity of age amongst the participants also allows for generalisability amongst this population. Furthermore, some of the participants were recruited from local authority and child protection services and can therefore be generalised to women who have come into contact with public health services due to abusive or neglectful parenting. This is an important factor as there is often debate into what contact and non-contact behaviour constitutes child maltreatment, particularly around disciplinary behaviours (Ateah & Durrant, 2005). The samples that have come into contact with professional services suggest that the nature and severity of the behaviour has prompted

the involvement of child welfare agencies, and cannot be misconstrued as subjective. In addition, the range of maltreatment behaviours perpetrated by the sample allows for comparison to further populations. However, a significant proportion of the included studies were conducted in North America, suggesting that had more studies been conducted in Europe or another continent, different findings may occur in such a population.

### **Conclusions and recommendations – Implications for practice and future research**

Knowledge of parenting skills, or more importantly knowledge of ‘dysfunctional parenting skills’ (Ostapiuk et al., in press, p.7-8), combined with child maltreatment, are most likely to prompt the involvement of child welfare agencies. Ostapiuk et al. (in press) describe these dysfunctional attitudes and behaviours as encompassing ‘unrealistic expectations of their children ... and perceive their children to be more irritable and demanding’ (p.11). Browne and Herbert (1997) found these attitudes reflected in physically and sexually abusive parents who forced their children to ‘behave in a manner that is beyond the child’s developmental limitations’ (p.124).

Findings from the current review suggest the need for significant intervention work from child protection and social services to assist in breaking the cycle of transmission. It is not uncommon that children who come into contact with professional agencies, as a result of maltreatment, are assessed in adulthood as a result of their own adverse parenting behaviours. Families that are targeted by social services as ‘at risk’ are the most obvious recipients of such intervention but what does appear critical is the capacity for change in parents who have maltreated their children. Furthermore, a

willingness to cooperate with professionals is also key to the proceedings (Wilson & James, 2003); frequent involvement with professionals often leaves parents defensive, an issue that continually arises within child protection services (Ostapiuk et al., in press).

When considering the recommendations and indeed the current financial status of social health care, it can be argued that the cost of such involvement and development would be high. However, the exposure to child maltreatment comes at a significant cost itself; the impact of abuse and neglect can sometimes lead to offending which may result in financial loss, increased workloads of youth justice workers and societal fear. The risk of teen pregnancy and abuse-related health problems, resulting in an increased workload for health workers, the cost to individuals of self-harm and harm to others, particularly their own children, would also consequentially be high. In addition, it is important to consider women who do not come into contact with professional services and yet still have a need for therapeutic intervention in order to recover from their childhood exposure. Adult mental health and psychiatric facilities need to consider how they promote their services to encourage these women to come forward and support them in acknowledging their experiences. Therefore the benefits of providing specialised treatment and addressing the issues that face mothers who have been exposed to childhood maltreatment would far outweigh the costs if further transmission of abuse and neglect is prevented or minimised.

The risk of intergenerational child maltreatment between mothers with a childhood history of maltreatment and their own children has been ascertained in this review.

Fundamentally, the studies provide support for the intergenerational hypothesis for child maltreatment, albeit a modest relationship between having a childhood history of victimisation and perpetrating abuse or neglect in adulthood. Whilst certainly not unanimous, this is the typical conclusion from studies on the subject. Other factors may also be important and this review provides clear systematic evidence that intergenerational transmission of maltreatment can manifest itself in this population and presents a platform to develop this research further.

However, a number of studies have also highlighted the onset of abuse and neglect in families where child maltreatment has not been a feature of the childhoods of previous generations. Dixon et al. (2009) breach this in their study of parents who initiate, maintain and break the cycles of child maltreatment. Within the sample of 4,351 families investigated for child maltreatment, 96.9% did not have parents with a childhood history of abuse and neglect. However, 18 of these families were reported for maltreatment of their own child within the first 13 months of parenting. Despite a low rate of initiation, Dixon et al. (2009) noted interesting comparison between these families and those that break the cycle. Although no significant differences emerged between initiators and cycle maintainers, as both groups maltreated their children regardless of their own victimisation history, those who initiated child maltreatment reported a higher prevalence of single parenthood and financial difficulties. Furthermore, in comparison with families where there was no child maltreatment in current parenting and parental childhood history (control group), the parents who had initiated child maltreatment demonstrated a higher prevalence of mental illness, cohabiting with a violent partner and feelings of indifference towards their infant as

well as much fewer positive parenting styles, such as ‘infant responding to caregiver’s voice with pleasure’ or ‘mother’s attribution regarding infant’ (p. 117). In the light of these results, Dixon et al. (2009) generated a conceptual model of maltreatment transmission which suggested that despite not experiencing abuse or neglect in childhood, parents who had a mental illness, substance dependency, poor parenting styles and living with a violent partner were all risk factors for the initiation of child maltreatment. In developing a similar risk profile to those who maintain and break the cycle, it highlights that a history of maltreatment is not the only means by which children can be at risk of abuse and neglect.

This raises questions concerning the appearance of such incidents and thus how they can be managed, particularly in families who may not be ‘at risk’ or under the attention of social care services. Although some studies do acknowledge the incidence of maltreatment in families where parents have not been abused or neglected themselves, this is certainly an area for expansion, particularly with regards to early identification of abuse and neglect, and not dismissing families because a history of child maltreatment is not present as an identifiable risk factor for transmission.

Research can also be expanded in comparison studies of women with abusive childhood histories who do not perpetuate the cycle, as this could have considerable practical implications focusing on protective factors. From the considerable lack of studies in this field of research documented in the original literature search, it is clearly a subject for expansion, particularly as it has such significant implications for research, treatment and policy.

## **Chapter Three**

### **The Incidence of Maternal Intergenerational Child Maltreatment in a British Sample**

## **Abstract**

Maternal intergenerational child maltreatment is still in its infancy regarding research. There is argument in the literature that gender bias exists within the professional response to child abuse and neglect; men are more frequently linked to physical and sexual abuse whereas women are more likely to be the perpetrators of neglect. The current research is an extension of a previous study (Stone, unpublished Master's dissertation, 2012) which identified significant gender differences between British men and women assessed for child abuse and neglect, the latter of which was more frequently perpetrated by females in the research sample who had a childhood history of maternal neglect. The aims of the study were to compare the childhood maternal maltreatment histories of 278 British mothers assessed for child abuse and neglect, as well as compare differences in a number of risk variables associated with child maltreatment. Analysis of the data found that no significant associations between experiences of maternal childhood abuse and neglect, and the perpetration of the same maltreatment in adulthood. However, significant associations were found between child maltreatment and conflict in current relationships including domestic violence, substance misuse, both in adulthood and adolescence, self-harm, financial difficulties and self-reported feelings of isolation. Furthermore, women assessed specifically for child neglect were found to score significantly higher than women assessed for child abuse on a number of psychometrics which measured personality traits, coping styles and parental stress. The implications of this distinction between maltreatment types for future research and practice are discussed.

## Introduction

Whilst risk and protective factors for child abuse and neglect have been extensively researched, the literature which focuses on the comparative experiences and consequences of childhood histories of maltreatment remains limited. Some studies have attempted to explore this variable; Wilson, Rack, Shi and Norris' (2008) review of the literature comparing abusive, neglectful and non-maltreating parents distinguished maltreated parents from non-maltreated parents in terms of the aversive parenting behaviours they displayed towards their children. However, their research did not determine if a childhood experience of abuse or neglect was a precursor for the maltreating behaviour demonstrated by the individuals as parents themselves. Thornberry, Knight and Lovegrove (2012) published a recent systematic literature review which tested the validity of the intergenerational maltreatment hypothesis: 'whether a history of maltreatment victimisation is a significant risk factor for the later perpetration of maltreatment' (p. 135). Whilst they found that the 47 identified studies reported findings consistent with the hypothesis, Thornberry et al. (2012) found that few met the criteria for effectively testing the hypothesis. This criterion included 'such basic standards as using representative samples, valid and reliable measures, prospective designs, and different reporters for each generation' (p. 135). The authors argued that although a positive association was frequently reported in the literature, these were based on 'methodically weaker designs' (p. 135). Thornberry et al. (2012) argued that a more robust and methodically acceptable assessment of the hypothesis was required in order to more effectively inform the development of intergenerational maltreatment prevention programmes.

## **Previous research**

In the light of such absences in research literature reviews, it was evident that intergenerational maltreatment through commission (abuse) and omission (neglect) needed further exploration. Therefore, an initial study was conducted (Stone, unpublished Master's dissertation, 2012) to compare the experiences of childhood maltreatment of parents who abuse their children (emotionally, sexually and physically) and parents who neglect their children (physically and emotionally). This research was designed to test the hypotheses that individuals would be more likely to perpetuate the type of maltreatment experienced in their own childhoods towards their own children. Analysis of the data found that both parent groups had experienced same-type maltreatment in their own childhoods, with the association of neglectful experiences and neglectful parenting being particularly strong. In particular, there was a significant association between females who neglected their children and reported being neglected by their own mothers in childhood. Significant relationships were also found between substance misuse and childhood experiences of neglect. Furthermore, both parent groups were at risk of substance misuse in adulthood and demonstrated elevated scores on histrionic personality disorder scales.

The research also presented an interesting gender split; parents assessed for child neglect were more likely to be female, lack insight into their behaviour and demonstrated elevated scores on a number of personality disorders. In comparison, parents assessed for child abuse were more likely to be male and lack empathy towards their children. Although there is argument for this phenomenon occurring within this

particular sample, previous literature has demonstrated the incidence of gender bias when considering perpetrators of child abuse and neglect. Dutton (2006) argued that the literature on child physical abuse present males as the primary perpetrator although data from meta-analytic studies report otherwise, thus allowing for child safety to be compromised if child protection professionals are focused solely on the possibility of abuse by a man.

Furthermore, using vignettes of sexually abusive interactions between adults and children, Hetherington and Beardsall's (1998) research into the professional response to female perpetrators of child sexual abuse found that social workers and Police officers were more likely to believe the child's account of abuse when the perpetrator was male. If the perpetrator was female, participants were more likely to believe the adult's account of the incident and reject the child's version. Allen (1990) argued that the notion of female sexual perpetrators deviates grossly from the social and cultural norms of the role of women and that these belief systems 'may actually prime professionals not to see female sexual abuse where it exists' (Hetherington & Beardsall, p. 1266). Similarly, the social construction of women being the primary care-providers may have allowed for bias when considering the main perpetrator of child neglect. It is possible that when faced with assessing child neglect, child protection professionals may be more inclined to suspect the mother, given their beliefs around who the primary care-giver may be within a household with two parents. Given this preconception towards gender roles within the family, it is possible that a gender split in the results may have arisen from original assessment bias.

The results of this study suggested a need for further research exploring childhood experiences of maltreating mothers, the comparative risk factors between those who abuse and those who neglect as well as the implications for intervention and treatment. As a result of this and findings from the systematic literature review which demonstrated a lack of studies using a European sample of mothers, the current research focuses on British mothers with childhood histories of maltreatment who are subject to legal proceedings concerning child abuse or neglect. Although a European sample of mothers may not differ greatly in characteristics to other samples, it is important to consider the professional response to child maltreatment in the UK and the role of research in informing practice and policy-making.

### **Maternal intergenerational child maltreatment: Evidence from current literature**

The literature on women with childhood histories of abuse and neglect who maltreat their own children is steadily becoming more prevalent; research focused solely on females has only become evident in the last few years and the available studies that have attempted to explore female intergenerational child maltreatment are still limited. These studies appear to be one-dimensional, focusing on one particular form of maltreatment and including maternal childhood histories of this single maltreatment type as a perpetuating factor.

Bartlett and Easterbrooks' (2012) research on neglectful parenting behaviours of young mothers (< 17 years old) demonstrated neglect to be four times as likely if the mother reported a childhood history of physical abuse. However, the authors appear to argue the mothers' ages as the main causal factor for child maltreatment, despite any reported childhood maltreatment from the participants. The significant commentary on 'limited

cognitive maturity, emotional maturity and knowledge of child development' and adjustment to the expectancies of motherhood 'may overwhelm a young mother's personal resources and lead to insensitive or neglectful parenting' (p. 2164) suggests that Bartlett and Easterbrooks (2012) find the mothers' ages to be a more weighty variable for perpetuating cycles of child maltreatment.

In addition to choosing to focus on adolescent mothers, Valentino, Nuttall, Comas, Borkowski and Akai's (2012) study widened the scope for variable interplay by exploring childhood histories of physical, sexual and emotional abuse as well as the impact of parenting styles and exposure to community violence. This 18-year longitudinal study demonstrated that a child's risk of experiencing abuse was significantly higher if the mother had also reported experiencing abuse as a child. A previous 18-year longitudinal multigenerational study also focused on the impact of childhood histories of abuse on abusive and neglectful parenting behaviours. Although Noll, Trickett, Harris and Putnam (2009) focused only on childhood histories of sexual abuse, they identified a number of individual variables for both the children and their mothers. Females with substantiated histories of childhood sexual abuse were assessed six times over 18 years; they were found to be 'high-school dropouts, obese, teen mothers and have experienced psychiatric problems, substance dependence, and domestic violence' (p. 424). Their children were more likely to be born pre-term and involved with child protection services.

Maternal histories of childhood sexual abuse were also included in Robboy and Anderson's (2011) study of maladaptive coping in second-generation childhood sexual

abuse survivors. Adolescent girls aged between 12 and 17 years who were being seen for forensic evaluation for sexual abuse were assessed on their coping strategies following experiences of abuse. In assessing the risk of victimisation, maternal histories of sexual abuse were also taken into account. Regression analyses demonstrated that maternal childhood history of sexual abuse was significantly associated with their child's own experiences of sexual abuse.

Despite a number of studies focusing only on one type of maltreatment, two recent studies were identified as exploratory of several types of child maltreatment. Using the History of Maltreatment and Trauma measure (HMTF; Wolfe, 2001), Bailey, DeOliveira, Wolfe, Evans and Hartwick's (2012) study assessed a range of maltreatment experiences including 'sexual abuse, physical abuse, exposure to family violence, physical neglect, lack of supervision and emotional maltreatment' (p. 239). Their research found that childhood maltreatment experiences, specifically neglect, emotional maltreatment and witnessing domestic violence, were 'significantly associated with mothers' observed hostility towards their children' (p. 236). Bailey et al. (2012) also found that childhood histories of sexual abuse were associated with 'self-reported concerns regarding parenting competence' (p. 239). Similarly, Perepletchikova, Ansell and Axelrod (2012), used the Childhood Trauma Questionnaire (CTQ; Bernstein et al., 2003) to assess a range of child abuse and neglect experiences in mothers with borderline personality disorder (BPD) whose children had been removed from the home by child protection services (CPS). In comparison with a control group of mothers whose children had not been involved with CPS, 'CPS-involved mothers scored significantly higher on measures of childhood maltreatment history and BPD features

... of which the highest BPD scores were associated with the most severe histories of mothers' childhood maltreatment' (p. 182). In addition to using the CTQ as an extensive measure of maternal childhood maltreatment, one study goes further in using a measure of parenting behaviour to determine the impact of childhood maltreatment on current parenting practice. Using the Parenting Stress Index – Short Form (PSI-SF; Abidin, 1995), Pereira et al. (2012) hypothesised that 'parenting stress mediates the relation between maternal maltreatment history and parenting' (p. 433). Their findings pointed towards parenting stress as a facilitator between maternal childhood maltreatment and current parenting behaviours, demonstrating that mothers who reported higher rates of maltreatment in childhood and current parenting stress were less sensitive towards their children's needs.

### **Literature on type-to-type maltreatment continuity**

One of the key difficulties in the intergenerational transmission of child maltreatment hypothesis is maintaining methodological consistency in studies which explore the cyclical process (Ertem, Leventhal & Dobbs, 2000). Although supported by numerous studies, the hypothesis has been criticised for its 'methodological weakness and data inconsistencies' (Kim, 2009, p.762). Indeed, Kaufman and Zigler's (1987) review of literature on intergenerational child maltreatment concluded that many of the studies lacked evidentiary confirmation of the hypothesis due to weaknesses in sampling, methodology and statistical analysis. Although Kaufman and Zigler (1987) believed such a transmission existed, they questioned the evidentiary support offered by research. A later systematic review of the intergenerational maltreatment literature conducted by Ertem et al. (2000) used methodological standards to test study validity and found only

one out of ten met all eight standards and that calculated variance of risk varied from 1.05 to 37.80.

A further methodological problem with intergenerational studies is the ‘failure to account for differences between the types of child maltreatment’ (Kim, 2009, p.762). Whilst some studies may focus on one particular type of maltreatment, others may group abusive or neglectful behaviours together to create a single construct of child maltreatment without critical consideration of the heterogeneity among different types of maltreatment (Heller, Larrieu, D'Imperio, & Boris, 1999). In the light of this, studies focusing on differences as well as similarities in the etiologies of various types of maltreatments are still needed. Only a small number of studies have examined whether parents who are physically abused in childhood are more likely to perpetrate physical abuse in parenthood and not more likely, for example, to sexually abuse or neglect or sexually abuse their own children. For example, Pianta et al. (1989) reported that, among 47 mothers who reported experiencing physical abuse as children, 17% were physically abusive and neglectful to their children at 6 years of age. Among a small number of mothers who experienced neglect as children, 33% were physically abusive and 44% were neglectful to their 2-year-old children.

### **Overview of the current study**

The purpose of the current research is to compare the experiences of childhood maltreatment of British mothers who abuse their children (emotionally, sexually and physically) and mothers who neglect their children (physically and emotionally). This research will examine the following hypotheses:

1. Women who report having an abusive childhood (sexual, physical and/or emotional abuse; non-accidental injury; witnessing and/or trying to prevent domestic violence) perpetrated by their mothers will be more likely to abuse their own child(ren) than women who report having a neglectful childhood.
2. Women who report having a neglectful childhood (failure from parents/care givers to meet a child's basic needs in a way that affects their health, development or safety) perpetrated by their mothers will be more likely to neglect their own child(ren) than women who report having an abusive childhood.

No control group is used as the research is conceptualised as exploratory in comparing two groups of participants.

In addition to the above hypotheses, this study will also examine identified risk factors linked with intergenerational continuation of child maltreatment and determine if they are associated with either abusive or neglectful parenting in adulthood. Differences in psychometric testing are also explored between women assessed for child abuse and women assessed for child neglect.

## **Method**

### **Sample**

The data set was obtained over a ten-year period (historical data) and consisted of information collected from parenting assessment reports which have been completed by

psychology staff at a private psychology practice between April 2000 and June 2010. These assessments were completed on women subject to legal child care proceedings within and across the United Kingdom. The assessment work had been completed and there had been no subsequent contact between the psychologist(s) who undertook the assessment and the clients. Participant information for this research was selected from a wider sample of parents (fathers and mothers) referred for psychological assessment. Information from any other type of assessment conducted by the practice was excluded (e.g. capacity, probation, parole hearings or risk assessments). The systematic literature review demonstrated that previous studies have relied on advertising as a method of recruitment for research. This research differs in that this study used actual individuals involved in child care proceedings, thus ensuring as representative a sample as possible.

Participants aged below 18 were excluded to ensure the data set was reflective of an adult sample. Furthermore, the data set was reduced by excluding participants with a Full Scale Intelligence Quotient (FSIQ)  $\leq 69$ . FSIQ information was obtained using the Wechsler Abbreviated Scale of Intelligence (WASI; Wechsler, 1999) or Wechsler Adult Intelligence Scale III (WAIS-III; Wechsler, 1997) and some studies have indicated that parents with intellectual disabilities, i.e. an FSIQ score  $< 69$ , are at an increased risk of neglecting their children through omission rather than commission. Azar, Robinson and Proctor (2012) argue that an individual's capacity to parent effectively is determined by their ability to learn from their environment and previous experience coupled with appropriate problem-solving skills, which may be compromised by low-functioning IQ or cognitive deficits. Individuals with intellectual disabilities may struggle to demonstrate these abilities and thus incompetent care-giving may be viewed as a

characteristic of child neglect. Furthermore, there is some evidence that individuals with intellectual disabilities tend to have higher rates of reported incidents of childhood histories of physical and/or sexual abuse (Lindsay, Steptoe, & Haut, 2011) and thus by removing individuals from the sample with an FSIQ score  $\leq 69$ , the chance of skewed results is limited. Following exclusion, the sample's FSIQ ranged between 70 and 145 ( $M = 89.86$ ,  $SD = 13.69$ ).

This left a final sample which consisted of 278 female participants aged between 18 and 68 years ( $M = 30.6$  years,  $SD = 9.30$ ) who had been assessed for perpetrating either child abuse or child neglect. Within the '*child abuse*' group, there were 185 females and within the '*child neglect*' group, there were 93 females. With regards to the children central to the maltreatment assessment, 149 were male (100 in the '*child abuse*' group and 49 in the '*child neglect*' group) and 128 were female (85 in the '*child abuse*' group and 43 in the '*child neglect*' group). It was considered to only use participants whose children were female in order to explore gender in the process of female maltreatment but this would have considerably reduced the sample size and thus decreased generalisability of results. Therefore, mothers of male and female children were included in the final sample.

Unfortunately, information on participant ethnicity was only recorded for 73 women in the sample: 69 were identified as 'white British', two as 'Asian', two as 'mixed race' and one as 'Afro Caribbean'. Therefore, it is not possible to report on the ethnic diversity of the entire sample. However, population estimates during the time period of assessments (2001 – 2007) reported that the largest ethnic group documented in

England and Wales was White British (83.8%), followed by Indian Asian (2.6%), Indian Pakistani (1.8%) and Black African (1.5%) (Office for National Statistics, 2011).

Figure 3 shows the referral regions for the sample across the UK:

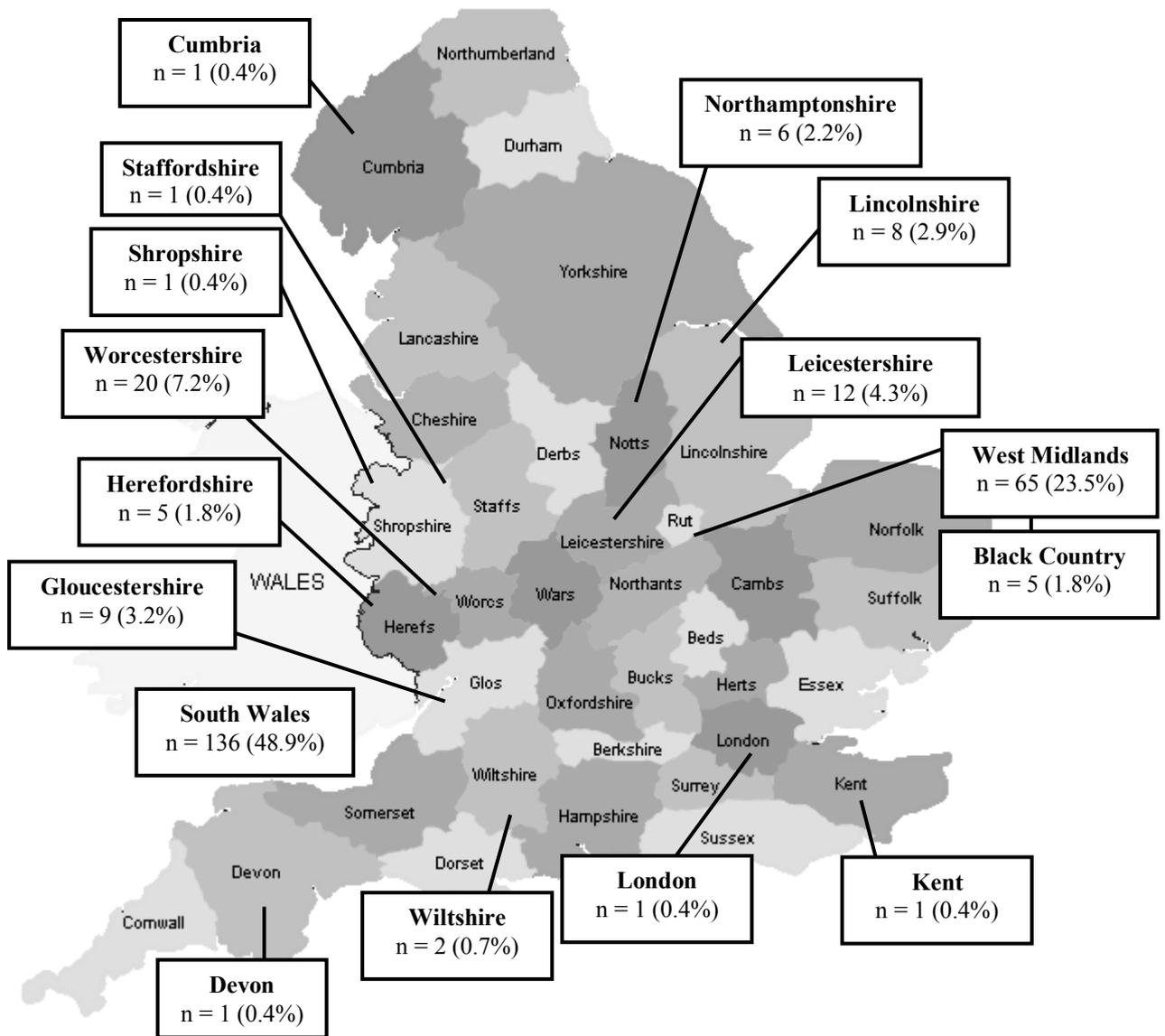


Figure 3. Location and frequencies of research sample participants across England and South Wales.

## **Procedure**

As the data set had already been created and was based on information from previous assessments, no further data collection was required for the research process. The information in the database included a number of comprehensive variable categories for each participant:

- Referral background information: maltreatment type coded '1' for 'abuse' or '2' for 'neglect'
- Early childhood history of assessed parent (developmental factors, siblings, witness of spousal/partner abuse, subject to emotional, physical or sexual abuse and/or physical or emotional neglect by mother and/or father)
- Education and employment history
- Relationship history including domestic violence and unidirectional/reciprocal abusive/neglectful behaviour
- Substance misuse history (alcohol, illegal substances)
- Criminal history (charge/convictions, offence type, YOI and HMP custodial sentences)
- Mental health issues (depression/anxiety, diagnosis of conduct or personality disorder, admission to hospital, suicide/self-harm attempts)
- Risk factors checklist (under 21 years of age, feelings of isolation, financial difficulties, substance dependency, mental illness, single parent, presence of violent adult in home, complications during birth, child having physical/mental disabilities, lack of insight/empathy)
- Results from psychometric testing – cognitive functioning, personality traits,

maladaptive interpersonal behaviour, parenting behaviours, coping responses, alcohol and substance misuse, mental and physical health, and domestic violence.

Following finalisation of the research sample, several variables were removed from the original data set as they were of no benefit to the objectives of the research, or removed due to missing data. These included information on education and employment history, sibling maltreatment and selected psychometric data.

Risk factors were selected on the basis of identification from previous research within the field of child maltreatment, including data taken from papers subject to the systematic literature review in Chapter 2. A significant body of literature exists on the presence of particular factors and are repeatedly identified, notably young parental age, mental illness, substance dependency, social isolation, cohabiting with a violent partner, financial difficulties and feelings of indifference towards the child(ren) (Brown, Cohen, Johnson, & Salzinger, 1998; Dixon, Browne & Hamilton-Giachritsis, 2005; Dixon et al., 2009; Pears & Capaldi, 2001; Schumacher, Slep, & Heyman, 2001; Sidebotham & Golding, 2001). Therefore, from the data available, the risk factors listed above were included in the checklist in order to identify possible differences between women who abuse and women who neglect their children.

## **Measures**

Overall, 131 variables were analysed<sup>2</sup>. Variables were coded as '0' if 'no/not present'

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<sup>2</sup> Sample variable names from the data set are identified using apostrophes, e.g. 'mother-figure physically abusive', 'feels partner is not supportive'.

and '1' as 'yes/present'. No further details were available within the data set. In addition to these variables, results from specific psychometric testing pertinent to parenting behaviours were examined. The following self-report psychometric data was analysed:

*1) Millon Clinical Multiaxial Inventory – Third Edition (MCMI-III; Millon, 1994)*

The MCMI-III is a 175-item measure of the presence and degree of personality disorders or other mental health problems as defined in the Diagnostic and Statistical Manual of Mental Disorders' (4th ed.; DSM-IV; American Psychiatric Association [APA], 1994) classification system, using three modifying indices, 14 personality scales and 10 clinical syndrome scales. Participants are required to rate each item's applicability to themselves on a "true/false" basis. Frequently used in parenting assessments to understand the capacity to parent, the context in which maltreatment has taken place and to inform treatment options for those involved in child protection proceedings (Cloninger & Svrakic, 2008; Moran & Weinstock, 2011), the MCMI-III has been rigorously researched for its testing properties. It demonstrates strong content, face, concurrent, predictive and content validity (Craig, 2008; Hsu, 2002; Millon, 2006; Retzlaff, 2000), as well as high internal consistency and test-retest reliability (Butcher et al., 2002; Wise, Streiner & Walfish, 2010).

*2) Coping Response Inventory (CRI; Moos, 1994)*

The CRI is a 48-item inventory designed to measure an individual's capacity to cope with distressing life events and their typical behavioural, cognitive and emotional response styles in problem situations. In particular, it assesses whether an individual approaches problems in a positive way or whether they use avoidance strategies as a

means of coping. The protocol comprises of four scales measuring ‘approach’ coping styles (Logical Analysis, Positive Re-appraisal, Seeking Guidance and Support and Problem Solving) and four scales measuring ‘avoidance’ coping styles (Cognitive Avoidance, Acceptance, Seeking Alternative Rewards and Emotional Discharge). Participants are required to base their responses on a traumatic stressor they have experienced and rate their reliance on each of the 48 coping items using a four-point Likert scale ranging from “not at all” to “fairly often”. These subscales are reported to have high internal consistency (Hack & Degner, 2004) and strong face and construct validity (Frederickson & Joiner, 2002).

### *3) State Trait Anger Expression Inventory – 2 (STAXI-2; Spielberger, 1999)*

This 57-item inventory is designed to assess how an individual experiences and expresses anger. It measures two dimensions, ‘state’ and ‘trait’ anger. ‘State’ anger refers to the emotional state experienced as anger, while ‘trait’ anger refers to the disposition to perceive a wide range of situations as annoying or frustrating. ‘Trait’ anger also refers to the tendency to respond to such situations with more frequent elevations in ‘state’ anger. Anger expression has four major components: the expression of anger towards other people or objects (anger expression-out), anger directed inwards and the suppression of angry feelings (anger expression-in), the individual differences in the extent to which an individual attempts to monitor and prevent an outward expression of anger (anger control-out), and the extent to which a person tried to calm down and reduce their anger (anger control-index). Participants are required to rate each item’s applicability to themselves on a 4-point Likert scale from “not at all” to “almost

always”. It reports high internal consistency as well as strong concurrent validity with other measures of anger and hostility (Martin & Dahlen, 2005).

#### *4) Parenting Stress Index – Standard Form (PSI; Abidin, 1995)*

The PSI is a 101-item inventory assessing degrees of stress experienced in parenting within two domains – child-related and parent-related stress. This measure provides a total parenting stress score based on the sum of subscales that broadly cover numerous aspects of parenting stress including parent characteristics, child characteristics and life/demographic stress. It is also used for early identification of dysfunctional parent-child interactions. Scores are given on a 5-point Likert scale ranging from “strongly agree” to “strongly disagree” on which higher scores represent more stress. Research on the testing properties of the PSI demonstrates it has adequate internal consistency (Gutermuth Anthony et al., 2005; Reitman, Currier, & Stickle, 2002) and test-retest reliability (Haskett, Ahern, Ward, & Allaire, 2006).

### **Ethical Considerations**

All participants at the time of original assessment consented to the assessment and storage of assessment results under the Caldicott Guidelines, which specifies consent requirements for the storage and use in research of data (the Memorandum of Understanding can be found in Appendix 6). The sample data provided to the author did not include any identifiable details of the participants such as names and dates of birth. Ethical approval was also sought from the University of Birmingham’s Ethics Committee (see Appendix 7) and Legal Services, and from the Family Operations Team, HM Courts and Tribunal Service.

## **Treatment of Data**

Analysis of the sample data was conducted using the Statistical Packages for Social Sciences, version 19 (SPSS 19). Chi-square analysis was used to test the hypotheses in the data as well as explore any relationships between identified variables and childhood histories of maltreatment. These analyses included using Cramer's  $V$  as an index of effect size, which was measured in accordance with Abbott and McKinney's (2013) definition of 'small' ( $\leq 0.10$ ), 'medium' ( $\leq 0.30$ ) and 'large' ( $\leq 0.50$ ). Total percentages were also interpreted in order to explore the origin of significant results between the two maltreatment types (Field, 2009). ANOVA analyses were run to examine the effect of maltreatment type on psychometric scoring on the MCMI-III, CRI and STAXI-2. ANOVA analysis was chosen over t-tests as the assumptions are more robust and ANOVA protects against Type I errors. Post-hoc tests were unable to be conducted on the ANOVA analyses as there were less than three maltreatment types.

It is important to note that when running multiple comparison analyses, it increases the risk of Type I error (i.e. the incorrect rejection of a null hypothesis), which may lead to incorrect conclusion that a relationship between two variables exists. In order to manage this, the Bonferroni correction is often applied when conducting multiple comparisons (Field, 2009). However, a significant criticism associated with this procedure is its reduction of statistical power when overcorrecting for Type I errors (Nakagawa, 2004). Furthermore, the Bonferroni procedure also increases the risk of Type II errors (i.e., a false negative) and thus the possibility of missing important results which indicate an association between two variables. As a result, the Bonferroni technique was deemed

inappropriate for this study and in order to counteract the problems of multiple comparisons whilst allowing for potentially significant associations to be examined, the significance level was maintained at .01.

Within the research sample, only 113 participants had scores on the PSI; 74 in the '*child abuse*' group and 39 in the '*child neglect*' group. However, ANOVA analyses were still run to explore the effect of maltreatment type on PSI scale scores. As age is continually identified as a risk factor for child maltreatment and a frequent feature of the limited research within motherhood and child maltreatment, Pearson's correlations were conducted to explore the relationship between age and scores on PSI scales, as the PSI is an explicit measure of parenting behaviours. And a linear regression was also run to see if age predicted scores on the PSI scales.

## **Results**

### **Frequencies**

Table 4 demonstrates the descriptive information for the achieved sample within this study.

Table 4

*Frequencies of maltreatment type and reported childhood experiences of maternal abuse and neglect by sample participants*

Maltreatment Type	Mother was physically abusive		Mother was emotionally abusive		Mother was sexually abusive		Mother was physically neglectful		Mother was emotionally neglectful	
	<i>Yes</i> ( <i>N</i> )	<i>No</i> ( <i>N</i> )	<i>Yes</i> ( <i>N</i> )	<i>No</i> ( <i>N</i> )	<i>Yes</i> ( <i>N</i> )	<i>No</i> ( <i>N</i> )	<i>Yes</i> ( <i>N</i> )	<i>No</i> ( <i>N</i> )	<i>Yes</i> ( <i>N</i> )	<i>No</i> ( <i>N</i> )
Abuse (n = 185)	29	156	24	161	1	184	21	164	30	155
%	15.6	84.4	12.9	87.1	0.5	99.5	11.3	88.7	16.2	83.8
Neglect (n = 93)	16	77	16	77	3	90	12	81	25	68
%	17.2	82.8	17.2	82.8	3.2	96.8	12.9	87.1	26.8	73.2
Total	45	233	40	238	4	274	33	245	55	223

As demonstrated in Table 4, there appears to be no significant differences between the two groups of mothers and their reported childhood experiences of maltreatment. It is interesting to note, however, that despite not being statistically significant, more women in the 'child abuse' group reported being physically abused (n = 29) and emotionally abused (n = 24) than women in the 'child neglect' group. However, when asked if they experienced neglect in childhood, more women from the 'child abuse' group responded affirmatively (n = 51) than in the 'child neglect' group (n = 37). Subsequent analyses using chi square found no significant relationships ( $p > .01$ ) between maltreatment type in adulthood and the reported childhood experiences of abuse and neglect, as demonstrated in Table 5. This table also indicates the effects sizes using Cramer's  $V$  as an index of effect size.

Table 5

*Chi square values and effect size for maltreatment type and childhood experiences of abuse and neglect by sample participants*

	Mother was physically abusive	Mother was emotionally abusive	Mother was sexually abusive	Mother was physically neglectful	Mother was emotionally neglectful
$\chi^2$	.107	.900	3.14	.142	4.43
$p$	.744	.343	.07	.706	.03
Cramer's $V$	.02	.05	.10	.02	.12

In exploring patterns of gender within intergenerational child maltreatment, it is also important to consider the number of participants who were maltreated in childhood by their mother alone, their mother and father or their father alone. Table 6 presents the frequencies of maltreatment reported by participants and identified perpetrators. Within the both groups of participants, there were more self-reports of paternal physical, emotional and sexual abuse than perpetrated by the participants' mothers whereas maternal emotional and physical neglect were more frequently reported when compared with paternal neglect. Frequencies of childhood maltreatment perpetrated by both mothers and fathers did not demonstrate any significant differences both within and between sample groups apart from paternal emotional abuse and emotional neglect which were over-reported by participants in the '*child abuse*' group (n = 18 and n = 14, respectively) compared to women in the '*child neglect*' group (n = 5 and n = 4, respectively).

Table 6

*Frequencies of maltreatment type and reported childhood experiences of paternal and maternal abuse and neglect by sample participants*

Maltreatment type experienced in childhood and perpetrator(s)	'Child abuse' group (n = 185)		'Child neglect' group (n = 93)	
	<i>N</i>	%	<i>N</i>	%
PA – Mother alone	13	7.0	5	5.3
PA – Mother and father	14	7.5	11	11.8
PA – Father alone	25	13.5	17	18.2
EA – Mother alone	13	7.0	12	12.9
EA – Mother and father	9	4.8	4	4.3
EA – Father alone	18	9.7	5	5.3
SA – Mother alone	0	-	2	2.1
SA – Mother and father	1	0.5	1	1.0
SA – Father alone	15	8.1	11	11.8
PN – Mother alone	11	5.9	7	7.5
PN – Mother and father	9	4.8	5	5.3
PN – Father alone	4	2.1	3	3.2
EN – Mother alone	17	9.1	11	11.8
EN – Mother and father	12	6.4	12	12.9
EN – Father alone	14	7.5	4	4.3

*Note.* PA = physically abused by, EA = emotionally abused by, SA = sexually abused by, PN = physically neglected by, EN = emotionally neglected by

### **Variables of child maltreatment**

Significant relationships were found within the following variables, as demonstrated in Table 7. This shows the number of participants in the '*child abuse*' and '*child neglect*' groups who responded 'yes' or 'present' to a number of variables within the data set.

Table 7

Percentage discrepancies of sample participants who responded 'yes' or 'present' to variable and chi-square results

Variable	'Child abuse' group		'Child neglect' group		$\chi^2$
	n	%	n	%	
Either parent (of the participants) suffered physical or sexual abuse as a child	<b>4</b>	<b>66.7</b>	2	33.3	9.56*
Feels current partner is not supportive (participants in a relationship, n = 82)	13	39.4	<b>20</b>	<b>60.6</b>	14.04**
Feels current partner does not provide enough care (participants in a relationship, n = 82)	15	39.4	<b>23</b>	<b>60.6</b>	15.92**
Reciprocal physical violence in current relationship (participants in a relationship, n = 82)	9	42.8	<b>12</b>	<b>57.2</b>	10.41
Misuse of cannabis as an adolescent	<b>37</b>	<b>56.3</b>	35	43.7	8.03
Misuse of amphetamines as an adolescent	9	40.9	<b>13</b>	<b>59.1</b>	11.33**
Misuse of alcohol as an adolescent	24	50.0	24	50.0	11.57**
Misuse of cocaine as an adult	12	44.4	<b>15</b>	<b>55.6</b>	6.56
Misuse of heroin as an adult	13	46.4	<b>15</b>	<b>53.6</b>	5.66
Misuse of alcohol as an adult	31	50.0	31	50.0	9.81**
Cocaine use during maltreatment period	2	22.2	<b>7</b>	<b>77.8</b>	8.21**
Attempted/actual self-harm	<b>28</b>	<b>50.9</b>	27	49.1	7.53*
Participant feels isolated with no-one to turn to	23	47.9	<b>25</b>	<b>52.1</b>	9.04**
Participant has serious financial problems	18	40.9	<b>26</b>	<b>59.1</b>	15.43***

Note: \*  $p < .01$ , \*\*  $p < .005$ , \*\*\*  $p < .001$ . Figures in bold highlight higher percentage of participants

### Childhood Experiences

There was a highly significant association between maltreatment type and reports of the participants' own parents experiencing physical or sexual abuse as a child,  $\chi^2 (2) = 9.56$ ,  $p = .008$ . This association produced a fairly small effect size (.20) and women in the 'child abuse' group accounted for 64.7% of participants who reported this information.

### **Relationship History**

When exploring variables associated with current relationships, it is important to consider that not all participants were in a relationship at the time of assessment. The following section of results is therefore limited to 74 participants in the '*child abuse*' group and 39 participants in the '*child neglect*' group who reported being a relationship at the time of assessment.

A highly significant relationship was found between maltreatment type and the mothers' self-reports of their current partners not providing enough care (towards the child),  $\chi^2(3) = 15.92, p = .001$ . This produced a small effect size (.24) and women in the '*child neglect*' group accounted for 62.9% of participants who felt their current partner did not provide enough care towards their child. Similarly, there was a highly significant association between maltreatment type and the mothers' self-reports of feeling unsupported by their partners ('feels current partner is not supportive'),  $\chi^2(3) = 14.04, p = .003$ . The effect size for this finding was small (.23) and, as demonstrated in Table 7, analysis of the percentages demonstrated that women in the '*child neglect*' group accounted for 63.3% of participants who reported feeling unsupported by their partner.

With regards to conflict within the participants' current relationships, there was an association between maltreatment type and reciprocal physical violence,  $\chi^2(3) = 10.41, p = .01$ . Slightly more women in the '*child neglect*' group ( $n = 12$ ) reported experiencing violence both towards and from their current partner than women in the '*child abuse*' group ( $n = 9$ ), which produced a small effect size (.20).

### Substance Misuse

A number of relationships were found between maltreatment type and substance misuse in both adolescence and adulthood. Two significant relationships were found between maltreatment type and mothers' use of amphetamines,  $\chi^2 (2) = 11.33$ ,  $p = .003$ , and alcohol,  $\chi^2 (2) = 11.57$ ,  $p = .003$ , as an adolescent. Whilst mothers in the '*child neglect*' reported slightly higher rates of amphetamine use in adolescence (59.1%), both groups reported equal use of alcohol ( $n = 24$  per group). Analysis of Cramer's V demonstrated small effect sizes (.20) for both of these associations. A further significant relationship was found between maltreatment type and misuse of cannabis as an adolescent,  $\chi^2 (2) = 8.03$ ,  $p = .01$ , with women in the '*child abuse*' group accounting for more affirmative responses (56.3%).

Analyses were also conducted on substance misuse in adulthood and specifically during the period of maltreatment. With regards to current substance misuse, there was a highly significant association between maltreatment type and alcohol use,  $\chi^2 (1) = 9.81$ ,  $p = .002$ . Similarly to self-report of alcohol use in adolescence, an equal number of women from both groups reported alcohol misuse in adulthood ( $n = 31$ ). Although not highly significant, there was a relationship between maltreatment type and misuse of cocaine,  $\chi^2 (1) = 6.56$ ,  $p = .01$ , and misuse of heroin,  $\chi^2 (1) = 5.66$ ,  $p = .01$ . Both of these associations produces small effect sizes (.15 and .15, respectively) and both were reported more frequently by women in the '*child neglect*' group, as demonstrated in Table 7.

Further analyses demonstrated significant relationships between maltreatment type and self-reported substance misuse at the time of the index offence, i.e. during the period of child maltreatment. A highly significant associations were found between maltreatment type and misuse of cocaine,  $\chi^2 (1) = 8.21, p = .004$ , which yielded a small effect size (.17). Cocaine use during the period of maltreatment was more frequently reported by women in the '*child neglect*' group (77.8%), which demonstrated a small effect size of .12.

### **Mental health history**

With regards to self-report of mental health problems, chi-square analyses yielded only one significant relationship which was between maltreatment type and attempted/actual self-harm,  $\chi^2 (1) = 7.53, p < .006$ . Cramer's *V* indicated a small effect size (.17), with women in the '*child abuse*' group accounting for just over half of participants who reported having attempted to or actually engaged in self-harm.

### **Risk factors**

With regards to identified risk factors, a number of significant relationships were identified. Firstly, there was a highly significant association between the type of maltreatment and financial difficulties ('parent has serious financial problems'),  $\chi^2 (1) = 15.43, p < .001$ . This analysis produced a moderately small effect size (.24) and of the participants who reported having serious financial problems, 59.1% were in the '*child neglect*' group. Chi-square analyses also found a highly significant relationship between maltreatment type and feelings of isolation ('parent feels isolated with no-one to turn to'),  $\chi^2 (1) = 9.04, p = .003$ . Cramer's *V* indicated a small effect size (.18) and similar to

previous results, the slightly higher proportion of women who reported feeling isolated were from the '*child neglect*' group (52.1%).

### **Psychometric Testing**

As the assumptions of parametric testing were met, ANOVA analyses were run on participants' scores on the MCMI-III, CRI, STAXI-2 and PSI to determine differences in mean scores between mothers who abuse and mothers who neglect their children.

#### **MCMI-III scores**

A one-way between-subjects ANOVA was conducted to compare the effect of maltreatment type on MCMI-III scores. There was a highly significant effect of maltreatment type on the 'antisocial' scale,  $F(1, 276) = 12.43, p < .001$ . On average, women in the '*child neglect*' group scored higher ( $M = 58.03, SD = 21.58$ ) than women in the '*child abuse*' group ( $M = 47.73, SD = 23.65$ ). A further highly significant effect of maltreatment type was found on the 'sadistic (aggressive)' scale,  $F(1, 276) = 7.93, p = .005$ . Analyses demonstrated that women in the '*child neglect*' group scored, on average, higher on this scale ( $M = 53.28, SD = 19.32$ ) than women in the '*child abuse*' group ( $M = 45.88, SD = 21.40$ ). Although not as significant, there was an effect of maltreatment type on the 'drug dependence' scores,  $F(1, 276) = 14.71, p < .01$ . On average, women in the '*child neglect*' group scored higher on the 'drug dependence' scale ( $M = 56.98, SD = 25.94$ ) than women in the '*child abuse*' group ( $M = 44.11, SD = 26.59$ ).

### **CRI scores**

A one-way between-subjects ANOVA was conducted to compare the effect of maltreatment type on CRI scores. There was a significant effect of maltreatment type on 'problem solving' item scores,  $F(1, 276) = 6.13, p = .01$ . On average, women in the '*child neglect*' group scored higher on this item ( $M = 53.39, SD = 9.37$ ) than women in the '*child abuse*' group ( $M = 50.57, SD = 9.55$ ).

### **STAXI-2 scores**

A one-way between-subjects ANOVA was conducted to compare the effect of maltreatment type on STAXI-2 scores. No significant differences were found in the mean scores between the two groups ( $p > .01$ ).

### **PSI scores**

A one-way between subjects ANOVA was conducted to compare the effect of maltreatment type on the 113 participants who had PSI scores. There was a significant effect of maltreatment type on 'distractibility/hyperactivity' scale scores,  $F(1, 111) = 6.95, p = .01$ . On average, women in the '*child neglect*' group scored significantly higher on this scale ( $M = 58.13, SD = 29.52$ ) than women in the '*child abuse*' group ( $M = 42.66, SD = 29.70$ ). Another significant effect of maltreatment type was found on the total stress scores on the PSI,  $F(1, 111) = 6.02, p = .01$  with, again, women in the '*child neglect*' group scoring higher ( $M = 65.82, SD = 31.46$ ) than women in the '*child abuse*' group ( $M = 50.00, SD = 32.06$ ).

## **PSI scores and age**

### **Pearson's correlation**

Due to the significant results from the ANOVA analyses of PSI scores, two Pearson's correlations were conducted to assess the relationship between age and scores on the four PSI scales reported above. Table 7 shows the results of these correlations demonstrating the negative relationships between age and PSI scores. There was only borderline significant negative correlation which was found between age and scores on the scores on the 'distractibility/hyperactivity' scale,  $r(113) = -.177, p = .03$ . The results indicate that scores on this scale increase as the age of the participant decreases, i.e. the younger the mother, the higher the scores on these scales. No other significant correlations were identified.

### **Linear regression**

One linear regression was performed with age as the predictor and PSI scores for 'distractibility/hyperactivity', since this correlation was significant. It was found that age did not predict scores on the 'distractibility/hyperactivity' scale ( $\beta = -.59, p = .06$ ) and, as per the  $R^2$  value (.03), only 3% of the variance in 'distractibility/hyperactivity' scores are accounted for by age.

## Discussion

### Gender-specific patterns of maltreatment transmission

The aim of this research was to explore the incidence of intergenerational child maltreatment within a British sample of mothers assessed for child maltreatment and who reported childhood histories of abuse and neglect. The study hypothesised that women who reported having an abusive or neglectful childhood, perpetrated specifically by their mothers, will be more likely to maltreat their own child(ren) and perpetrate the same abusive or neglectful behaviours. Statistical analyses of the participants did not yield any significant associations between childhood experiences of abuse or neglect and maltreatment behaviour perpetuated in adulthood. This suggests that, within this sample, childhood experiences of a specific form of maternal maltreatment did not determine either abuse or neglect being repeated in adulthood, thus both hypotheses were rejected.

Before examining the incidence of type-to-type maltreatment transmission, it is important to consider the reported perpetrators of the participants' childhood maltreatment. Firstly, 139 (50%) of participants reported having no history of childhood maltreatment. With regards to maternal maltreatment, a high proportion of participants in both groups did not report being maltreated solely by their mother; within the '*child abuse*' group, 131 (78.1%) women and within the '*child neglect*' group, 58 (62.3%) women reported being neither physically, emotionally or sexually abused nor physically or emotionally neglected by their mothers. Whilst these figures suggest the possible presence of another perpetrator, such as the participants' fathers about whom maltreatment data was recorded (and indeed a number of participants reported being

abused and/or neglected by their mother *and* father as well as by their father alone), it also raises questions regarding the onset of maltreatment in mothers with no reported childhood experiences of maltreatment, often described as ‘initiators’.

Research specific to initiators of child maltreatment (whom have no reported history of childhood abuse or neglect) within the intergenerational field is limited; Dixon et al. (2009) compared differences in risk factors and parenting styles between parents who initiated, maintained and broke the cycle of maltreatment (with non-maltreating parents). Results indicated that initiators produced a similar risk profile to maintainers and cycle breakers, as well as increased reports of financial difficulties and single parenthood in comparison to controls, suggesting that a childhood history of maltreatment was not the only means by which risk for transmission can be produced. Other research does touch on the presence of child maltreatment in families with no reported parental childhood maltreatment but often in tandem with risk factors for the perpetration of abuse or neglect such as living with a violent partner, substance misuse, financial difficulties, social isolation and conditions specific to the child such as developmental and behavioural disabilities (Bower-Russa, Knutson & Winebarger, 2001; Ronan, Canoy & Burkner, 2009).

The role of single or joint parental maltreatment is also an important consideration. Within the study, there were a total of 91 separate reports of being maltreated by mothers alone, 116 reports of being maltreated by fathers alone and 78 reports of being maltreated by both mothers and fathers. Although the gender of the maltreating parent may not affect the process of transmission, it is important to consider the degree of

maltreatment that the participants were exposed to in childhood in terms of number of perpetrators as well as the presence of a non-maltreating parent in situations where only one parent was identified as abusive or neglectful. Indeed, non-abusive parents are often identified as a protective factor against the process of transmission (Cowen, 2001; Timmer, Urquiza, Zebell, & McGrath, 2005; Wilson et al., 2008)

Interestingly, a significant relationship was found between maltreatment type and participants' self-reports of their own parent being physically or sexually abused as a child (i.e. by a grandparent of the original sample). However, the reports of this were extremely low and, as the variable coded in the data set provided no further information on the gender of this parent, the significance of this parent being female cannot be determined or discussed within the context of the sample.

### **Type-to-type transmission of maltreatment behaviours**

Results demonstrate that maltreatment type in childhood was not significantly associated with the same behaviours being perpetrated in adulthood. This was, however, difficult to determine as although there was detailed data on specific abusive and neglectful behaviours experienced in adulthood, the participants had been grouped collectively under 'abuse' and 'neglect' with no further detail on the maltreatment perpetrated towards their own children. As a result, no comment can be made on the patterns of type-to-type transmission.

This raises important questions, particularly with regards to physical and sexual abuse, both of which have very different etiologies and outcomes with regards to parenting

behaviours. Childhood physical abuse is reported more frequently amongst males, often documented in families where intimate partner violence is present and research has established links between experiencing physical abuse in childhood with low self-esteem, depression and higher levels of aggressive behaviours towards others, including own children in adulthood. In comparison, sexual abuse is more frequently reported amongst female children and research has documented a wide range of physical and psychological consequences including poor sexual development and dysfunction, difficulties in maintaining intimate relationships as well as depression, anxiety and PTSD. With regards to parenting, sexual abuse is associated with more negative self-view and low confidence of parenting skills, increased use of physical punishment strategies and lack of control relating to parenting situations (Appel & Holden, 1998; Banyard, 1997; Briere & Elliot, 2003; Briere & Runtz, 1990; Dutton, 2000; Silvern, 1994). Only four participants reported experiencing sexual abuse in childhood, three of whom were assessed for child neglect. Although the type of maltreatment perpetrated in adulthood cannot be determined for these women, it is possible that the psychological repercussions of experiencing sexual abuse has played a role in the neglect of their own child, either directly (avoiding or limiting contact with the child) or indirectly (reliance on substance use, emotional distance, poor attachment).

In examining the results, it is also important to consider specific abusive or neglectful behaviours preceding and/or occurring concurrently with other form of child maltreatment. The degree to which a child is subjected to multiple forms of maltreatment is a complex area for research, given the tendency to focus on one particular form of abuse or neglect (Clemons, DiLillo, Martinez, DeGue & Jeffcott,

2003; Higgins & McCabe, 2001). It would be unwise to assume that children are exposed to single forms of maltreatment; indeed, there is significant recognition in the maltreatment literature of physical abuse and sexual abuse co-existing within maltreating families (Appel & Holden, 1998; Westen, Ludolph, Misle, Ruffins & Block, 1990) as well as the co-occurrence of psychological and physical abuse (Claussen & Crittenden, 1991). Table 7 demonstrates that women in the sample have been exposed to both abuse and neglect, despite the form of maltreatment they have been assessed for. Given the lack of detail provided in the dataset (collected prior to the author's analysis), it is not possible to make type-to-type comparisons of maltreatment but it is important to note that women assessed for child abuse and neglect have been exposed themselves to multiple forms of maltreatment in childhood. Briefly looking at the maltreatment experienced by the children of the participants, only four women in the '*child neglect*' group were suspected of also abusing their child. Unfortunately, no information was provided in the data set for women in the '*child abuse*' group. Similar to the experiences of their own mothers' childhood maltreatment, it is highly likely that these children may be victim to a number of abusive and neglectful behaviours.

Although there are no particular studies that examine why childhood histories of abuse may result specifically in the perpetration of neglect, or vice-versa, research on intergenerational child maltreatment bases much of its argument for its existence on the hypothesis that the experience of any form of maltreatment in childhood is responsible for a number of developmental problems, including poor or maladaptive parenting behaviours in adulthood (Bartlett & Easterbooks, 2012). There is an argument that abusive and neglectful experiences in childhood can elicit different outcomes in

parenting. Lang, Gartstein, Rodgers and Lebeck's (2010) study on the effect of maternal childhood abuse on parenting practices found that physical abuse was associated with poor mother-child interactions, increased vigilance and difficulty managing infant distress. Bailey et al. (2012) found a significant difference in observed maternal behaviour, depending on their childhood histories of maltreatment. Childhood neglect was significantly associated with mothers' hostility towards their children whereas sexual abuse in childhood was associated with self-report of parenting incompetency. There is evidence of maltreatment being perpetrated by women victimised in childhood but the results suggest this rate of transmission is very low.

### **Outcome variables of child maltreatment and their significance in parenting**

As demonstrated in previous research (Stone, unpublished Master's dissertation, 2012), specific variables were identified as significantly related to child maltreatment in adulthood. Within the current study, significant associations were found between child maltreatment and conflict in current relationships including domestic violence, substance misuse, both in adulthood and adolescence, self-harm, financial difficulties and self-reported feelings of isolation. These variables, along with many others, are continuously identified in intergenerational literature, both as consequences of childhood abuse and neglect and as risk factors in perpetuating child maltreatment in adulthood (Brown et al., 2010; Huang et al., 2011; Norman, Hawkley, Ball, Berntson, & Cacioppo, 2013; Rellini, Vujanovic, Gilbert, & Zvolensky, 2012; Shenk, Noll & Cassarly, 2010; Thornberry, Henry, Ireland, & Smith, 2010; Young-Wolff, Kendler, & Prescott, 2012).

It is interesting to note that of all the variables, a number of significant associations were found between maltreatment types and substance misuse, and some were equally reported by both groups of women. The role of drugs and alcohol within maladaptive parenting is well-documented; substance misuse in adolescence can often determine use in adulthood, particularly if its use becomes effective coping strategy in response to adverse or stressful situations, managing emotional difficulties or in a form of recreation (Palmer et al., 2009). The consequences of drug and alcohol misuse include intoxication, neglecting of personal hygiene and diet (often extending to the neglect of others' hygiene and diet in the immediate environment), disinterest in regular activities, inability to perform day-to-day tasks and inconsistent care and attention (Barnard & McKeganey, 2004). From the significant proportion of mothers in both the '*child abuse*' and '*child neglect*' groups reporting substance misuse in adulthood and during the period of child maltreatment, it appears likely that their drug use had an impact on their ability to provide appropriate care for their child. Furthermore, a higher number of women in the '*child neglect*' group also reported substance misuse as well as struggling financially, suggesting that drug dependency may be affecting their ability to provide material and physical care for the child. In terms of the process of transmission, children who are maltreated as a result of the impact substance misuse has on parenting capacity, they themselves may turn to alcohol and drugs as a way of managing or suppressing painful memories and thus increase the risk of being impaired by substance misuse when they become parents themselves (Sheridan, 1995).

### **Differences across the maltreatment types - neglect**

It is interesting to note that out of the significant associations identified, the majority of these were reported by women in the '*child neglect*' group. In looking at relationship difficulties, highly significant associations were identified between child maltreatment and self-reported feelings of being unsupported and insufficient child care provided by a current partner, and were reported more frequently by mothers in the '*child neglect*' group. Furthermore, this group reported more incidences of reciprocal physical violence in their current relationships. This suggests two possible explanations; firstly, previous research has shown that child neglect is often perpetrated within an environment where there is conflict within the adult relationships. Kantor and Little (2003) assert that child maltreatment does not exist in isolation from other forms of familial conflict and thus neglect may be a result of a parent's lowered awareness of their child's needs due to the stress of their own adult relationships (Cox, Kotch & Everson, 2003).

A possible secondary explanation is that childhood experiences of maltreatment can lead to poor and insecure attachments within adult relationships (Riggs & Kaminski, 2010) and this can become particularly strained within parenting dynamics (Carbone, 2010). Some studies have characterised women who neglect their children as unable to recognise and meet the emotional needs of their children due to established attachment deficiencies (Adshead, Paz, King, & Tagg, 2010; Davies, Rowe, & Hassall, 2011). These have frequently been identified as a result of abusive and neglectful childhood experiences; indeed, Friesen, Woodward, Horwood and Fergusson's (2012) longitudinal study on parent-child attachment in adolescence and later parenting found that adolescents who reported higher quality parent-child relationships demonstrated higher

levels of warmth and sensitivity, and effective child management in their own parenting behaviours. Women who neglect their children have also been noted as having an inability to effectively interpret their children's behaviour (Hazler & Denham, 2002) This is particularly prevalent within samples of mothers diagnosed with borderline personality disorder, as documented by Newman and Stevenson's (2008) observational study of mother-child interactions. Their results indicated that these mothers appeared resentful and even envious at times when playing with their children, articulating their frustration that 'no-one did this for me' (p. 512). The task of parenting for women with borderline personality disorders can evoke 'anxiety, distress and even rejection of the infant' (Newman & Stevenson, 2008, p.507), so acutely are the problems of attachment characterised by this type of personality disorder.

However, this deficit in interpreting behaviour can also extend to partners or other adults involved in child-care. Bögels, Lehtonen and Restifo (2010) draw attention to this issue in their argument for the benefits of 'mindful parenting', a concept whereby mindfulness techniques are practised within a parenting context to alleviate parental stress and strengthen child-rearing bonds. They suggest that borderline personality disorder is associated with more 'reactive parenting' (p.111), i.e., responding to an event after it has occurred as opposed to anticipating possible challenges and preparing for them. Bogels et al. (2010) suggest this is also evident in the adult relationships and thus instead of effective co-parenting, parents are drawn into a 'negative spiral of anger and blame during discussions of conflict' (p.113). Although we should not entirely dismiss the credibility of self-report of partners being unsupportive or not providing enough care within this study sample, it is unrealistic to suggest that all fathers or

father-figures are suitable or appropriate child-carers. However, as the concept of 'enough care' is very much subjective, it is nearly impossible to determine if a partner is lacking or not.

With regards to the other variables reported more consistently by women in the '*child neglect*' group, it is important to consider why or how their presence contributes to an environment of neglectful parenting. Their financial difficulties suggest an impact on the availability and expenditure of practical resources (Thorburn et al., 2000) and of the women who reported feeling isolated with no-one to turn to, just over half of them were women in the '*child neglect*' group. It is possible that their feelings of isolation and inability to seek help may impact on a child's neglect; the mother may feel overwhelmed by the responsibility of parenting and unable to turn to others for support and advice or she may fail to seek suitable professional help (i.e. doctors, health visitors, child care professionals) and thus disengagement from social environments may only amplify the neglectful parenting.

### **Differences across the maltreatment types - abuse**

Aside from a number of significant associations with substance and alcohol misuse across the lifespan, women in the '*child abuse*' group demonstrated a relationship with attempted and/or actual self-harm. Interestingly, this was expected to be more frequently reported by women in the '*child neglect*' group, although the available literature provides very little background on the association with parenting behaviour and childhood histories of maltreatment. We may assume that deliberate self-injury may have begun in adolescence and continued into adulthood once proven to be an effective

behaviour for the person. It is also possible that the event of motherhood may have triggered further incidences self-harm as a way of managing parental stress. In an attempt to cope with the difficulties of parenting, the mother may choose to alleviate her own stressors as opposed to focusing on her child's needs or, depending on the nature of the self-harm, these behaviours may be so engrossing or debilitating for the mother that the child becomes neglected through the mother's physical and psychological removal from the situation. However, its role within abusive parenting is less easy to hypothesise.

Research has identified links between the onset of self-injurious behaviours in response to the experience of maltreatment particularly in women who have experienced childhood sexual abuse (Gratz, 2006; Noll et al., 2003). In terms of its significance with abusive parenting behaviour, we may speculate that, subject to the specific self-injurious behaviours, self-harm may be an extension of their aggression or a coping mechanism when angry or frustrated. Alternatively, mothers who abuse may use self-harm as a way of alleviating guilt for their maladaptive parenting behaviours. However, this is purely conjecture and may be an area of future research in order to identify the role of self-harm within parenting behaviours of those with childhood histories of maltreatment.

### **Psychometric testing and its significance in parenting**

Unfortunately, analyses of STAXI-2 scores yielded no significant results for interpretation. Although not an explicit measure of parenting styles, any significant results achieved on the STAXI-2 may have been indicative of the experience of anger

and how this may impact on parenting behaviours, particularly during times of high stress or conflict.

The impact of personality disorder on parenting behaviours was explored in the previous study (Stone, unpublished Master's dissertation, 2012), as a number of significant associations were found between child maltreatment and high scores on particular personality disorder scales of the MCMI-III. The results from the analyses of this study yielded only three significant result from the MCMI-III; firstly, women in the '*child neglect*' group scored higher on the 'drug dependence' scale than women in the '*child abuse*' group. This indicates that, within this sample, women identified as neglecting their children were likely to have a history of substance misuse as well as a tendency to 'find it difficult to restrain impulses or keep them within conventional social limits, and unable to manage the personal consequences of this behaviour' (Millon, 2006, p.23). This result is concurrent with other child maltreatment literature which has long argued that a parent's ability to recognise or meet the needs of their child may be significantly impaired by substance misuse (Arria, Mericle, Meyers & Winters, 2012; Becoña et al., 2012). Not only does this suggest a physical and cognitive inability to effectively perform parenting tasks due to the influence of illicit substances but a child's physical needs may be neglected in favour of financially supporting a drug habit.

Women in the '*child neglect*' group also scored higher on the 'antisocial' and 'sadistic (aggressive)' scales. Often examined in combination with each other, these two scales provide some insight into the personality traits of women who neglect their children. An

elevated score on the 'antisocial' scale suggests an individual who although appears charming and friendly on the surface, engages in a number of provocative and exploitative behaviours predominantly for the purpose of self-gain. This is often undertaken with a lack of consideration for the consequences of their behaviour and unsympathetic regard for others. It is interesting to note that these individuals frequently display a dependency for drugs and alcohol, an association demonstrated by this sample. With regards to women in the '*child neglect*' group, these maladaptive personality traits may allow a mother to be selfish in her parenting; the needs of her child may be disregarded in favour of personal need and any engagement in active parenting may be purely for the purpose of self-gain. A mistrust of outsiders may extend to other parents or professionals involved in child care, such as doctors, health visitors, and thus the individual may deliberately avoid social contact, even to the detriment of her own child's health and development.

The 'antisocial (aggressive)' scale depicts a slightly different set of personality traits. Although similar to the 'antisocial' scale in its social intolerance and disregard for the rights of others, an individual with elevated scores on this scale may be more likely to engage in behaviours that violate or humiliate others for their own satisfaction. As a parent, they may be more authoritarian and rigid in their child-rearing and demonstrate more punitive or persecutory disciplinary methods. When considering the behaviours of child neglect, it is possible that mothers in this group used physical neglect as a way of controlling or punishing their child for misbehaving, even taking pleasure from the mental or physical state in which the child was left. Elevated scores on this scale often depict an individual who demonstrates no shame, guilt or sentimentality and therefore

emotional neglect may be the result of a distant and indifferent mother-child relationship.

Although not a specific parenting psychometric, high scores on CRI scales can indicate difficulties in managing parenting stress. This sample yielded only one significant result from CRI scores, again demonstrating a higher score from women in the '*child neglect*' group. Mothers in this group, on average, scored higher on the 'problem solving' scale which, interestingly, lies in the positive cognitive and behavioural approach to life stressors (as opposed to cognitive and behavioural avoidance). An elevated score on the 'problem solving' scale infers that the individual manages difficulty by effective planning. It is interesting to note that women in the '*child neglect*' group considered themselves more adept at these coping skills than women in the '*child abuse*' group. A possible explanation for this could be found in the context in which the psychometrics would have been completed. The CRI is included in a battery of psychometrics used in parenting assessments (at the practice where this data set was created), the results of which are included in a report assessing an individual's ability to parent safely. Pressure to perform well in the assessment and give socially desirable answers may account for why they are higher scores on these scales and indeed other psychometrics, which will be explored in further detail in the limitations of the study. However, this does not entirely explain the reason for higher scores specifically for mothers who neglect their children. It is important to consider that the MCMI-III's desirability scale monitors desirable responding and, similarly, the PSI has a defensive responding measure.

When attempting to understand the higher scores, it is possible that in failing to recognise the needs of their child, women are unable to recognise their own maladaptive parenting, therefore holding a skewed opinion on their ability to cope with parenting stressors. Aspects of neglectful behaviour may be ways in which mothers see themselves as successfully managing these stressors (Robboy & Anderson, 2011); behaviour perceived to be challenging such as crying, tantrums or whimpering may be managed by the mother by ignoring the child or removing them from the mother's environment. Although isolated incidents of this may not be considered neglectful, prolonged periods of time whereby a child's behaviour is not managed, particularly if the child is distressed, and then left unattended by the mother may be perceived as a form of child neglect. However, with no further detailed information on the participants' views of their parenting styles, it is not possible to firmly conclude why this difference between the two groups has been identified. It is possible that more detailed information on their views of their own parenting was evident within the parenting assessment reports but not coded in the database. What is interesting to note was this sample did not yield a significant association between child maltreatment and lacking insight, as the score on the 'problem solving' scale suggest that mothers within the sample are significantly lacking in insight and perceive themselves to be parenting effectively and appropriately.

One psychometric that does allow exploration of parenting behaviour is the PSI and despite scores being available for only 113 of the participants, it is still important to explore the significant results yielded from the analyses in relation to child maltreatment. Similar to scores on previous psychometric testing, maltreatment type

had a significant effect on two specific scales with women assessed for child neglect scoring higher on the ‘distractibility/hyperactivity’ and ‘total stress’ scales than women in the ‘*child abuse*’ group. The ‘distractibility/hyperactivity’ scale is within the ‘child domain’ of the PSI – the domain designed to represent the mother’s perception of parenting difficulties specifically related to the child’s characteristics. For example, within the ‘distractibility/hyperactivity’ scale, mothers in the neglect group may have closely identified with items such as ‘my child appears disorganised and is easily distracted’. The child may display behaviours associated with attention deficit disorder or be overly active, restless and not listen to instruction. Alternatively, the mother could be lacking in energy necessary to keep up with a normal child’s behaviour or they may have unreasonable expectations for a child to demonstrate mature behaviours beyond their years of development. The ‘total stress’ score is a composite of the ‘child domain’ and ‘parent domain’ scores, the latter of which focuses on the mother’s ability to function adequately in her parenting role. An elevated score on this scale is indicative of a mother who experiences significant levels of strain and anxiety being a parent, accrediting difficulty to both her child(ren) and her capacity to parent. As a result, the mother may demonstrate more neglectful parenting; she may find day-to-day responsibilities too overwhelming and thus restrict her parenting or attribute her difficulties to the child’s behaviour. In believing that her child is being deliberately provocative or challenging, her ability to emotionally connect with the child may be strained.

Further analyses demonstrated a negative correlation between younger age and scores on the ‘distractibility/hyperactivity’ scale, although age was not found to be a predictor

of high scores on this scale. This suggests that within this sample of 113 women, younger mothers interpreted their child's behaviour as more chaotic and more demanding of them as a parent. This is very much in keeping with previous child maltreatment literature on the effect of maternal age on parenting capability (Easterbrooks, Chaudhuri, Bartlett, & Copeman, 2011; Phoenix, 2013; Ruttan, Laboucane-Benson, & Munro, 2012). Age is continually identified as a risk factor for child maltreatment, often in tandem with other destabilising factors pertinent to young maternal age such as interrupted or lack of formal education, substance misuse and being a single parent.

### **Limitations of the study**

As in any study, there are a number of limitations that are important to consider in terms of their impact on the analyses and interpretation of the results. Firstly, the author had no control over the development or recording of data within the dataset. As a result, certain analyses were unable to be undertaken, such as the direct comparison of type-to-type maltreatment transmission. This was particularly evident when examining the childhood histories of physical and sexual abuse of mothers for whom their own forms of maltreatment were not detailed. As discussed in the previous section, both of these forms of abuse have very different processes of development and consequences, and the research was unable to examine this fully. By grouping the participants' maltreatment into two broad groups, it has been impossible to determine the type of abuse or neglect they have perpetrated and make more detailed comparative analyses of their profiles.

There are likely to be other unmeasured variables that may have influenced the participants' maltreatment behaviours. Although this research explores a significantly higher number of variables than the previous study (Stone, unpublished Master's dissertation, 2012), a database does not always provide more detailed information that may be pertinent in understanding child maltreatment. This is undoubtedly a limitation within quantitative research in that results are based on significant numerical results and not narrative information from which more insightful conclusions can be drawn. It is possible that qualitative exploration may yield more insight into the processes of intergenerational child maltreatment within this sample.

A further limitation of the study is that the childhood maltreatment measures were based entirely on self-report. It is important to remember that information for the participants was taken from parenting assessments, the results of which are often crucial in the decision process for custody and access to the child. Therefore, it is possible that women being assessed for child maltreatment may feel the need to lie or embellish about their parenting behaviours in order to improve their chances of regaining custody of their children. Furthermore, their account of childhood maltreatment may be somewhat skewed in order to alleviate feelings of guilt or responsibility. Indeed, Shaffer, Huston and Egeland (2008) highlight the problems in obtaining accurate information when disclosing childhood maltreatment as there is a tendency for participants to both under- and over-report incidences of childhood abuse and neglect. Individuals may be reluctant to disclose maltreatment, particularly experiences of intrafamilial sexual abuse, and thus deny any adverse childhood experiences to avoid feelings of shame or embarrassment.

An additional consideration is that participant's retrospective reports of childhood maltreatment, which may be affected by memory or cognitive distortions, and parenting behaviours may be influenced by the individual's current level of psychopathology, including presenting personality disorders. Specifically, individuals who have more severe psychological problems may be more likely to report experiences of childhood maltreatment. This in turn may increase the apparent significant relationship between childhood maltreatment, participants' psychopathology and parental behaviour.

A further limitation relating to the sample was by not using a control group. Although the research was constructed as exploratory, it may have benefitted from comparing the presence of variables and psychometric scoring of mothers with a childhood history of maltreatment who do not go on to maltreat their children. This would allow for the exploration of protective factors within the cycle of maltreatment.

### **Implications for future research and practice**

The evidence of parents without a history of abuse or neglect who perpetrate maltreatment suggests that this area needs further exploration. Whilst it may be convenient to explain parenting behaviours by formative experiences, this does not account for all women who perpetrate child maltreatment. Although some studies do exist in comparing such individuals with or without childhood experiences of victimisation, further research is certainly required to understand how these parenting behaviours develop as well as the treatment needs of women who have experienced abuse or neglect themselves.

The results of this research suggest an interesting split in the self-report of both personal histories and parenting behaviours between women who abuse and women who neglect their children. Within this sample, women assessed for child neglect have continually demonstrated differences in their risk and parenting behaviours as well as their perception of their parenting skills, suggesting that intervention and treatment services for child maltreatment cannot be a 'one-size-fits-all' approach. Therefore, it is important to recognise the treatment needs specific to the form of maltreatment. Providing parent training programmes for high-risk mothers may be effective in lowering rates of child maltreatment and active outreach programs offered to high-risk parents in families where intergenerational maltreatment has been previously identified may ultimately reduce the pressure on professional services. Mentalisation therapy may be of specific benefit to mothers who neglect their children; scores on CRI and PSI suggest an inability to mentalise and thus enables a mother's unrealistic expectations of her child's needs to be acknowledged as the main source of parental stress.

Coming from an attachment approach to parenting, Suchman, Decoste, McMahon, Rounsaville and Mayes (2011) argue that 'maternal insensitivity and unresponsiveness to child emotional cues is often a function of the caregiver's own unmet attachment needs stemming from the caregiver's own experience with early caregivers' (p.429). They suggest that these early caregiving experiences become prototypes for relationships in adulthood, including relationships with their children, and therefore 'guiding the new mother's expectations of herself and her child and strongly influencing the mother's parenting behaviour' (p.429). Particularly pertinent to the results of this

study, substance misuse significantly impairs the ability to think about the child's mind and effectively mentalise. Suchman et al.'s (2011) research highlighted the high reporting of 'enduring, impoverished perceptions of early caregivers as uncaring and intrusive and have very limited capacities for mentalising' (p.430) in women with significant substance misuse histories. These deficits in maternal attachment have shown to influence many aspects of maternal functioning in adulthood, including substance misuse, which compromises parenting ability thus increasing the risk of repeating maladaptive patterns of parenting. In their mother-toddler programme for supporting women with substance misuse problems, Suchman et al. (2011) used mentalisation techniques as a way of firstly exploring the mother's affective states and then in helping the mother understand how these affective states affect her behaviour and relationships. Once the mother was no longer preoccupied with specific crises or events and could focus on her relationship with her child, Suchman et al. (2011) reported positive developments in the mother's ability to consider the impact of such events on her child, the purpose of which is to help the mother in mentalising about her child's behaviour and their relationship. Suchman et al. (2011) highlighted that this marked a transition in the mother's ability to identify distorted aspects of her mental representations and the shift towards a more positive and flexible approach to parenting.

Bögels et al.'s (2010) mindful parenting strategies may also be a way forward in working with women identified as at risk of neglecting their children. Noted for its success in treating mental health problems, mindfulness techniques in parenting are aimed at reducing parental stress and resulting parental reactivity to stressful situations, improve interpretation of child behaviour and improve marital and co-parenting

functioning. Mindful parenting techniques have also found benefit with parental reactivity, i.e. a parent's response to difficult or challenging behaviour. This sample demonstrated a desire to respond physically when experiencing anger; in mindful parenting, parents are encouraged to attend to their breathing (through taking a 'breathing space') before 'responding to difficult behaviour that may trigger impulsive reactions' and reduce negative parental reactivity (Bögels et al., 2010, p.111). Mindful parenting programmes have been developed for a number of child-parent dyads including parents and their children going through divorce (Altmaier & Maloney, 2007), parents with children who have developmental disabilities (Singh et al., 2010) and the negative effects of prenatal stress on mother-child interactions (Vietin & Astin, 2008). These programmes demonstrated the benefits of mindful techniques such as meditation, breathing, body awareness and centering:

'The idea was that, as parents become more mindful, they become more aware of how their responses influence their interactions with their child and learn to be more intentional in their parenting to choose ways that enhance and sustain a positive emotional connection'.

(Bögels et al.'s, 2010, p. 115)

These therapeutic approaches may be of specific benefit to women who neglect their children, particularly those with substance misuse problems, as the inability to mentalise may be a significant factor in the process of intergenerational child neglect. Mindful parenting may also be a more beneficial approach in building positive relationships between parents at risk and care professionals. It is important to remember that this data

is taken from parenting assessments, a context within which mothers are subject to legal proceedings regarding their child care and consequently may feel more sensitive to scrutiny of their parenting skills (or observed lack thereof). This may be particularly pertinent for younger mothers who may feel criticised because of their age and perceived parental immaturity. It is therefore important for professionals to be sensitive to this dynamic so not to undermine or criticise these women. Further research into mindful parenting with younger mothers may be of benefit in informing this dynamic.

One of the key benefits of using mindfulness and mentalisation techniques is that they approach parenting in a non-judgemental, empathetic and emotionally congruent manner (Maguire, 2012). Young, Klosko and Weishaar (2003) argued that all individuals possess 'parenting schemas' consisting of information and experiences of being parented themselves. Consequently, dysfunctional parenting schemas were a result of emotional or negative experiences in parenting, particularly those that bear resemblance to the parent's childhood experiences of being parented. Schemas may be activated without the mother's knowledge and guide her parenting behaviour. Wahler, Rowinski and Williams' (2008) study on the childhood experiences of parents with children in social services developed a method whereby mindful techniques were used to reflect on past parenting experiences and restructure current parenting behaviours.

### **Conclusion**

Crittenden (1996) states that 'maltreatment is a family problem' (p.158) and that the occurrence of such behaviours are entrenched in the functioning of the family. The intergenerational perspective is supported by emerging evidence of the reoccurrence of

abuse and neglect in maltreating families perpetrated by mothers. This is not to say that every mistreated daughter will develop into a maltreating mother. Furthermore, there is evidence that child maltreatment can develop in families where victimisation has not been detected in the formative experiences of parents who abuse and neglect their children. Analysis of the childhood and adult histories of women assessed for child maltreatment and preliminary identification of behavioural and psychological issues present in these individuals has begun to piece together an important puzzle for understanding intergenerational child maltreatment. In looking at all the significant results of the study, we can begin to generate a tentative explanation of the potency of child neglect in particular, and its role in intergenerational child maltreatment. If there are such significant maltreatment differences for mothers who abuse and neglect their children, then this study's results have implications for the development of intervention programmes. Even when intergenerational factors can be carefully estimated, what is arguably more important in research is an understanding of the variables and processes that affect continuation and discontinuation of child maltreatment and ultimately, inform the responsibility that falls to professional services to intervene, educate and potentially eradicate as effectively as possible.

## **Chapter Four**

### **Psychometric Critique of the Millon Clinical Multiaxial Inventory – Third Edition**

#### **(MCMI-III)**

## **Abstract**

Chapter Four presents a critique of the Millon Clinical Multiaxial Inventory – Third Edition (MCMI-III; Millon, 2006). This was a psychometric tool used in the research project and is commonly used to assess the presence of personality traits and assist in the diagnosis of personality disorder. The critique provides an overview of the assessment tool and its psychometric properties, including reliability and validity. In addition, limitations of the MCMI-III are also presented. The MCMI-III is widely used in the field of forensic psychology for the assessment of personality and psychosocial difficulties. It is also used as a way of explaining interpersonal difficulties to forensic clients and can encourage collaborative understanding of their presenting problems. The MCMI-III has been normed on male and female psychiatric patients varying in a number of demographic characteristics including ethnicity, education and clinical setting. Its use with parenting assessment proceedings is discussed as well as its respective strengths and limitations. There remains significant support for the use of the MCMI-III in forensic settings, not only due to its normative sampling based on psychiatric patients but also for its development from clinical theory and reflection of diagnostic criteria, as well as its use of base rates to increase diagnostic accuracy and strong validity. However, criticism of the MCMI-III remains, including underrepresentation of ethnic minority groups in its normative sampling, few validation studies concerning interpretation into other languages and formats and its poor convergent validity with standard psychiatric assessment measures. With regards to its forensic use, criticism has been made regarding the MCMI-III's criterion validity and subsequent diagnostic qualities when assessing Axis II disorders.

## **Introduction**

The British Psychological Society (BPS) defines a psychometric as ‘an assessment procedure designed to provide objective measures of one or more psychological characteristics’ (BPS, 2012). The earliest, and most well-known, example of psychological testing was Hermann Rorschach’s ink-blot test in 1921 (Verma, 2003). Although the use and validity of the Rorschach technique generates wide debate due to its ambiguous stimuli and subjective interpretation (Bishopp, 2012), it is a classic example of using a tool in an attempt to define an individual’s thoughts and feelings. Over time, psychometric testing has evolved with ever-increasing sophisticated measures, particularly with the use of statistical methodology (Kaplan & Saccuzzo, 2009), in order to improve test administration and interpretation of results, strengthen reliability and validity and, ultimately, advise diagnosis and planning for treatment and intervention.

This review focuses on the current version of the psychometric assessment by Theodore Millon, the Millon Clinical Multiaxial Inventory – Third Edition (MCMI-III; Millon, Millon, Davis, & Grossman, 2006). Essentially the MCMI-III and its earlier editions were designed to assist the identification of specific personality patterns and clinical syndromes and particularly following the second edition of the measure, reflect the diagnostic criteria used in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R; APA, 1987). This review examines the MCMI-III in terms of its applicability to assessing personality, its testing properties, and its strengths and limitations as a psychometric tool. It will also examine its applicability to forensic

settings, in particular its purpose within child protection services as an assessment of parents subject to legal proceedings and who have childhood histories of maltreatment. It should be noted that for the purpose of this review and unless stated otherwise, the majority of manual information has been taken from the most current edition of the measure.

### **Overview of the MCMI-III**

The first version of the MCMI (MCMI-I; Millon, 1983) was originally developed from Millon's theory of psychopathology in *Modern Psychopathology* (1969). In this literature, Millon proposed that normal and abnormal personality were derived from three main axes – active-passive, pleasure-pain and self-other. In exploring coping patterns which maximise positive reinforcements and avoid punishment, Millon's model combined the active-passive axis with four main reinforcement strategies – detached, independent, dependent and ambivalent – from which Millon then identified eight basic personality patterns; avoidant, asocial, submissive, narcissistic, conforming, aggressive and negativistic. Millon also identified 'three severe variants' (Craig, 2008, p. 2) of these patterns; paranoid, schizoid and cycloid. Although Millon did not put forward a model of clinical syndromes based on his personality categorisation, he did argue that a significant proportion of psychiatric conditions 'could be best explained as extensions of personality' (Craig, 2008, p.2). Using Loevinger's (1957) three-step process whereby theory guided development and validation, Millon created the MCMI (Millon, 1983); a 175-item tool derived from clinical trials with psychiatric professionals and patients. Since the original version of the MCMI-I, this measure has undertaken a number of editions to its current form. The MCMI-II (Millon, 1987) was

developed to bring the measure in line with the diagnostic changes of the DSM-III-R (APA, 1987) including modification of scale items, changes to item weighting to strengthen scoring on items fundamentally related to the disorder, and the addition of the three validity scales. Like the progress of its predecessor, the MCMI-III was developed to closely reflect the diagnostic criteria of the DSM-IV (APA, 1994; Millon, 2006). In doing so, 45 of the 175 items were adapted as well as the addition of the depressive personality disorder and post-traumatic stress disorder scales. Pertinent to this critique, items relating to childhood abuse (as well as eating disorders) were added although not scored on any of the scales.

Described by Millon (2006) as ‘an evolving assessment tool’ (p.1), the current version of the MCMI-III is a 175-item self-report measure of three modifying indices, 14 personality scales and 10 clinical syndrome scales. The tool itself comes in the format of a response sheet and item inventory. Individuals, aged 18 years and above, are instructed to work independently through the items and rate each item’s applicability to themselves by marking ‘true/false’ responses. Although traditionally hand-scored, the MCMI-III is now frequently scored by computer, which ‘saves time and effort and ensures accuracy’ (Millon, 2006, p.120). The MCMI-III can be administered in both English and Spanish in a number of formats; paper, computer or using audio recordings for individuals with visual impairments or limited reading skills. However, Van Gerko (2012) advises caution with verbal administration as this deviates from the format in which the MCMI-III is standardised and interpersonal processes may impact on the manner in which the patient responds to items.

In terms of scoring, the personality and clinical syndrome scores were standardised using base rates as opposed to using *T* scores (Millon, 2006). This is based on the assumption that *T* scores represent a normal population distribution whereas the MCMI-III uses a normative sample of psychiatric patients. Therefore, standardisation using base rates is more suitable as they reflect the diagnoses of the individuals in the normative sample (Craig, 2008). The normative sample for this measure and development of score significance will be explored in further detail later in the critique. On the personality scale, base rate scores of 75 – 84 represent the presence of a ‘clinically significant personality trait’ (Craig, 2008, p.8) whereas a base rate score of 85 or above suggests the presence of a personality disorder. On the clinical syndrome scales, base rate scores of 75 – 84 demonstrate the presence of a clinical syndrome, whereas a score of 85 or above suggests the ‘prominence of a particular syndrome’ (Craig, 2008, p.8).

Scoring and subsequent interpretation of the MCMI-III often comes under much scrutiny due to the frequent misuse of the measure in terms of ‘rapidly assessing the presence or absence of personality disorders’ (Craig, 2008, p.45). Whilst it is designed to ‘directly reflect the diagnostic criteria’ of the DSM-IV (Craig, 2008, p.3), Sperry (2003) argues that the MCMI-III should not be relied on as a sole assessment of personality disorder. As opposed to being used as an aid in the assessment of an individual’s interpersonal style, research has shown that the MCMI-III is frequently misused as a diagnostic tool (Butcher, 2009), which can impact clinical practice as well as have serious implications for the individual being tested. Van Gerko (2012) stresses the importance of using the MCMI-III as a tool to assess personality style and traits in a

manner that is client-focused. Through collaborative working, van Gerko (2012) supports the use of the MCMI-III in exploring and formulating personality problems with clients ‘which helps explain behaviour patterns that may be problematic or dysfunctional’ (slide #23). With the impact of labelling an individual with a personality disorder being so pertinent in the current mental health climate (Newton-Howes, Weaver, & Tyrer, 2008), the MCMI-III can potentially be misused as an instrument of diagnosis by professionals unfamiliar with the assessment process.

Millon (2006) argued that the ease of administration and availability of computer scoring and interpretation allowed the MCMI-III to be used ‘on a routine basis’ (p.5) in such settings. However, he does specify the type of professional administering the MCMI-III should be limited to ‘psychologists, counsellors, psychiatrists or their administrative assistants ... and properly trained assistants in clinical settings’ (Millon, 2006, p.119). Indeed, the key to any psychometric measure is the clinical skills required to interpret the results.

### **Use of MCMI-III**

In terms of its proposed usage, Millon (2006) stated that the primary purpose of the MCMI-III is to ‘provide information to clinicians who must make assessment and treatment decisions about individuals with emotional and interpersonal difficulties’ (p. 5). A number of settings were identified in the manual as an appropriate milieu for using the MCMI-III and the volume of research in such settings is significant; general and secure hospitals (Craig, 2000; Lake, 2006; Main & Gudjonsson, 2007; Milton, 2000; Ryan et al., 2002; Vanem, Krog, & Hartmann, 2007), community and outpatient

agencies (Bruns & Disorbio, 2000; Gondolf, 1999; Simmons, Lehmann, Cobb, & Fowler, 2008), independent practices (Bow, Flens, & Gould, 2010; Grove & Vrieze, 2009; Smith, Gorske, Wiggins, & Little, 2010) and forensic settings (Gudjonsson & Young, 2011; Lenny & Dear, 2009; Loinaz, Ortiz, & Ferragut, 2012). Archer, Buffington-Vollum, Stredny and Handel's (2006) study of psychometric usage determined that psychologists spent approximately 30% of their time in forensic practice using psychometric testing and, among their sample, the MCMI-III was their third most frequently used test for personality after the MMPI-2 and PAI.

### **Using the MCMI-III in parenting assessments**

Although not extensive, there is research on using the MCMI-III with parents involved in child protection proceedings, primarily in the assessment of parenting capacity (Blood, 2008; Moran & Weinstock, 2011; Lenny & Dear, 2007). Nurse and Sperry (2012) reasoned that the MCMI-III was a core instrument in a comprehensive battery of assessment tools due to its consistency with the DSM-IV-R. The purpose for using the measure under these circumstances appears to be in understanding the context within which the maltreatment took place (Cloninger & Svrakic, 2008; Ellenbogen & Hodgins, 2004; Newman & Stevenson, 2008), as well as informing treatment and intervention for individuals subject to child protection proceedings. Indeed, Nurse and Sperry (2012) argued that the MCMI-III was 'extremely useful in formulation hypotheses about personality structure an interactive pattern of underlying immediate conflicts (p. 61) which could be useful in deconstructing parent-child relationships.

Although there has been criticism for the use of MCMI-III in child protection proceedings as the normative sample did not include 'normals' (Craig, 2012, p.). However, current norms include those from forensic settings and normative data does exist on the use of the MCMI-III in custody evaluations. Stredny, Archer and Mason (2006) suggest the measure as a potential contributor to understanding the emotional and personality functioning of individuals whose ability to parent safely is of a primary concern. Several studies have noted an association between parental personality disorders and children who internalise and externalise problematic behaviour (Bertino, Connell & Lewis, 2012). It is possible that this process may add to the course of intergenerational transmission as maladaptive behaviours internalised as children could shape and influence personality development in adulthood, and further triggered by parenthood.

Due to the prevalence of reported abuse and neglect in the childhood histories of parents accused of child maltreatment, further research has explored individual psychological profiles using the MCMI-III. Bogacki and Weiss's (2007) research reported two-thirds of their sample of parents accused of abuse and neglect demonstrated elevated scores on narcissistic, dependent, borderline and antisocial personality disorder scales. Similarly, Fontaine and Nolin's (2012) study found significant differences between parents accused of physical abuse and neglect and their control group, particularly on schizoid, paranoid, antisocial and borderline personality disorder scales. This is reflective of previous research (Stone, unpublished Master's dissertation, 2012) whereby parents assessed for both child abuse and neglect demonstrated elevated scores on histrionic personality disorder scales. Furthermore, parents assessed for child neglect

demonstrated elevated scores on schizoid, bipolar and delusional personality disorder scales. Cordess (2003) argues that despite an increased emphasis on evidence-based opinions, the use of psychometrics in parenting assessments should ‘always be regarded as adjuncts to overall clinical judgement’ (p.172)

### **MCMI-III Manual**

The accompanying manual for the MCMI-III is a comprehensive guide to administering, scoring and interpreting the measure in addition to providing background on the theoretical, professional and empirical advances since the MCMI-II (Millon, 1987) which have influenced the structural changes to the tool. The manual also provides guidance for intervention and treatment planning, as well applications for the MCMI-III tool beyond clinical practice and research into other therapeutic services such as marital counselling and interventions for substance misuse. A significant proportion of the manual documents the process in which the MCMI-III scales and indices were developed, detailing research undertaken with a development sample. It also provides literature on the ‘external validity of three generations of the MCMI test’ (Millon, 2006, p.67). Although thorough in its effort to demonstrate the current version as ‘refined and strengthened’ (Millon, 2006, p.1), the manual literature is dense and upon first glance, the volume of information can be off-putting for the reader. The correct facilitation of a psychometric may only be as informed as its user and there is no argument that the authors of the current manual have made every effort to provide enough information necessary for correct usage. However, the manual can feel overwhelming as a guide and Millon’s (2006) documentation of his current version begins to present proof for the measure’s position as ‘the mainstay in clinical assessment’ (Craig, 2005, p. ix).

### **Testing properties of the MCMI-III**

Kline (2000) stipulates that in order to determine a psychometric test as ‘good’, one should look at the following characteristics; an interval scale that has true zero point, appropriate norms, acceptable reliability and validity, and be discriminating in what it claims to measure. Reliability and validity will be discussed in further detail in the following section of the review but first the appropriate norms will be examined. In terms of an interval scale, Kline (2000) argues that on personality measures there can be no true zero point as it would be impossible to conceptualise what a score of zero on a personality disorder scale would mean. Despite this, psychometrics cannot be deemed unscientific or invalid and thus greater emphasis is placed on the norms for understanding the meaning of the measurement (Kline, 2000).

As stated earlier, Millon’s normative sample were psychiatric patients varying in demographic characteristics – gender, ethnicity, education and setting. The manual stresses the test’s applicability only to ‘individuals who evidence problematic emotional and interpersonal symptoms’ (Millon, 2006, p.6) and that administration to individuals outside of this remit would not produce valid, interpretative results. It would be fair to assume that a large proportion of individuals completed the MCMI-III are in appropriate settings for its usage but its use with individuals subject to child care proceedings has been questioned in terms of applying an instrument for which it is not intended or suitable. In support of its use within child care proceedings, one could argue that the features of a parent’s emotional and cognitive style have resulted in problems with the family’s functioning thus prompting the intervention of local authorities.

McCann et al.'s (2001) research provided normative data based on child care examinees and determined that the MCMI-III did not over-pathologise the sample, challenging the argument that the MCMI-III is inappropriate for parenting assessments as it is based on a clinical and not a 'normal' sample (Quinnell & Bow, 2001). However, McCann and Dyer (1996) noted that the normative groups include couples in marital therapy, arguing that it was suitable for such assessments.

In comparison to Kline's (1986) characteristics of an effective psychological test, Blount, Evans, Warren, Birch and Norton (2002) suggest that the classical approach to test theory is only sufficient in 'sorting and grading' patients and disregards their internal state 'providing their psychometric results are good' (p.152). In their research comparing the lay, patient and professional responses to a number of self-report personality measures, Blount et al. (2002) note several weaknesses; length of measure, simplicity of language, clarity of instructions, and completion of early questions may affect response style for later items, particularly as they are administered to individuals assumed to have personality disorders. Their research argues that an idiographic approach to psychometrics cannot be applied to the assessment of personality disorder, underlined by an acknowledgement of the processes in which an individual's completion of a measure can affect results (faking good/bad, manipulation, and non-, partial and incomplete responses). Blount et al. (2002) were particularly critical of the MCMI-III in terms of its length, stating that its length would discourage willingness to complete and could affect response motivation. They also criticised the measure's face and content validity, particularly its use of the three-item validity index (e.g. *I flew over*

*the Atlantic 30 times last year*'). Blount et al. (2002) felt these items may raise suspicion or negative responses in some users.

### **Reliability**

Wise, Streiner and Walfish (2010) argue that a 'psychological test should meet at least minimal standards for reliability' (p.246). They propose that for self-report tests, such as the MCMI-III, reliability should be measured by test-retest reliability and internal consistency. Measured by correlating an individual's scores of the same test taken on at least two separate occasions, test-retest reliability ensures the consistency of a measure over time (Kline, 2002).

Internal consistency refers to the suitability of the test items in measuring the identified psychological construct (Streiner, 2003), mainly demonstrated by Cronbach's alpha. High alphas are generally preferable; Nunnally (1967) recommended that for clinical purpose, tests should demonstrate alpha coefficients of at least .90. However, there is some argument that a very high alpha indicates a scale comprised of items that are rephrasings of each other (Streiner, 2003; Wise et al., 2010). In developing the MCMI-III scales and indices, the manual reports internal consistency results range between .66 and .90 with 20 of the scales exceeding alphas of .80 (Millon, 2006). Several authors specify that an acceptable internal consistency coefficient for a test ranges between .70 and .90 (Streiner & Norman, 2008).

In terms of test-retest reliability, Millon (2006) reports re-administering the MCMI-II to participants 5 – 14 days after initial administration and using the results to estimate test-

retest stability of the MCMI-III scales. The correlational analysis demonstrated high test-retest reliability rates between .82 and .96 with a median stability coefficient of .91 (Millon, 2006), suggesting that MCMI-III results remain stable across short periods of time. Wise et al.'s (2010) study comparing the respective reliabilities of the MCMI-III, the Minnesota Multiphasic Personality Inventory–2 (MMPI-2; Butcher et al., 2001) and Personality Assessment Inventory (PAI; Morey, 1991) found that the MCMI-III demonstrated 'consistently high coefficients' for both internal consistency and test-retest reliability (p.249), compared to the other measures. Wise et al. (2010) argued that item overlap, a clinical normative sample and explicit assessment of personality disorders contribute to the internal consistency and test-retest rates.

### **Validity**

As a basic construct, validity is confirmation that a test measures what it claims to measure. Bishopp (2012) argues that the test developer is 'responsible for ensuring that test validation research continues long after test publication and throughout the life of the test' (slide #49). According to Craig (2008), Millon's theoretical interests led him to develop the MCMI-I based on Loevinger's (1957) proposition that the design of an assessment tool should be based on theory guiding development and validation. This is an approach that Millon (2006) reports to follow with every edition of his measure, in order to ensure the test 'upholds the standards of test developers who are committed to diverse methods of construction and validation' (p.3). The first stage of Loevinger's (1957) three-step process of test development and validation is '*theory-substantive*' whereby Millon created an initial collection of face-valid items, i.e. items that conform best to the theory of personality. In the second stage, '*internal-structural*', scales are

created to fit a set of criteria defined by the theory. Craig (2008) cites Millon's (2006) model as suggesting that personality scales 'should have high internal consistency, test-retest reliability and a theoretically consistent pattern of correlations with other scales' (p.2). For this second stage, Millon administered two test forms to a range of clinical sample groups and retained items with the highest item-total score correlations. By calculating item-scale intercorrelations and item endorsement frequencies, Millon was able to eliminate any extreme frequencies and reduce the number of items. He then administered the experimental form of the MCMI-I to a range of clinical patients and had clinicians complete a diagnostic form for patients seen for assessment or therapy. Following this process, the number of items was reduced again. After eliminating three scales and adding three experimental scales, Millon repeated the validation process previously described and the final version was left with 175 items. In the final stage of this three-step process, '*external criterion validation*', Millon administered the final form of the MCMI-I to psychiatric patients as well as having them complete other self-report measures of personality and clinical syndromes. From the data of this process, Millon deemed the scales to be faithful to his theory of personality and the MCMI-I was published. Since this initial development process, subsequent versions of the MCMI and their respective scale items have undertaken a similar procedure to ensure that 'the final scales of an inventory do not consist of items that optimise one particular parameter of test construction' (Millon, 2006, p.3) but instead satisfy various prerequisites of testing and improve the generalisability of the final product.

### **Construct validity**

Despite high internal consistency and test-retest reliability, Wise et al. (2010) argue that this is not an indication of a psychometric's construct validity nor a definition of the psychological construct it purports to measure. Increasingly, psychometric testing is applied to evermore complex psychological phenomena such as personality, which raises important issues around construct validity. Even simpler constructs such as impulsivity may be multi-factorial and thus it may be improbable that a single study could establish the construct validity of a test (Bishopp, 2012). Millon (2006) has made some attempt in the current version of the measure to improve diagnostic accuracy by including the Grossman facet scales in an effort to improve the assessment capacity of the measure. These scales were introduced as an attempt to further define the clinical personality pattern scales and severe personality pathology scales by examining specific elevations on the personality scales. This was suggested to aid interpretation and 'maximise the therapeutic utility' of the tool (Millon, 2006, p.111).

### **Face validity**

This three-stage validation process has been recognised as a significant strength of the MCMI-III (Craig, 2008; Van Gerko, 2012), in that the measure has been developed from a comprehensive clinical theory:

'each of the Axis II scales is an operational measure of a syndrome derived from a theory of personality ... although the Axis I scales are not explicitly derived from theory, they are nevertheless refined in terms of its generative framework'.

(Millon, 2006, p.1-2)

The manual states the versions of the test reflect theoretical and professional progress in terms of understanding personality, particularly the second and third editions having been developed in line with the diagnostic revisions in the DSM-III/IV. This suggests that the face validity of the MCMI-III is relatively strong; it has a theoretical development basis which has reflected the change in the perspective of personality from behavioural to evolutionary principles (Millon, 2006), and its close following and reflection of the DSM suggests a measure whose items develop with the progression in theory, research, diagnosis and clinical practice (McCann, 2002; Retzlaff, Stoner & Kleinsasser, 2002). As noted earlier in the high reliability coefficients of the MCMI-III in comparison with other personality measures, it is important to explore the multifactorial nature of the tests, i.e. the way in which their respective scales were constructed. In the initial development of the MMPI, each item differentiated those in the diagnostic group from the non-diagnostic group and thus neither item content (face validity) nor correlations between items were criteria for scale development (Wise et al., 2010). Wise et al. (2010) also noted that the PAI and MCMI-III shared similarities in their theory-based development. Blount et al.'s (2002) research sample gave positive feedback regarding the face validity of the MCMI-III and that the items 'seemed relevant'. However, their study found the MCMI-III to be lacking in face validity in comparison to the Personality Diagnostic Questionnaire – Fourth Edition (PDQ-IV; Hyler & Reider, 1994) whose items were described as 'pertinent ... tapping into key aspects of personality disorder' (p.162).

### **Concurrent validity**

If a test correlates with other tests purporting to measure the same construct, it is deemed to have appropriate concurrent validity (Hsu, 2002). Although it is acknowledged that the MCMI-III is 'one of the most frequently used assessment instruments' (Craig, 2008, p.1), there are several other measures of personality, some of which have already been explored in this review. Morgan, Schoenberg, Dorr and Burke's (2002) comparison research of the MCMI-III's modifying indices and validity measures of the MMPI-2 found that the MCMI-III had a very high tolerance for over-report; the disclosure index was in the upper end and, at times, exceeded the recommendation validity scores of the MMPI-2.

In exploring specific scales on the MCMI-III, some studies have explored the concurrent validity of certain Axis I and II disorders. Blais et al. (2003) found that although both the avoidant and anxiety scales were reliable ( $r > .75$ ), there were concerns around the discriminant validity of the anxiety scale in that a scale composed of the core anxiety items had better discriminant validity. They did find both scales to be consistent with other measures of anxiety and avoidance. Although not a comparison of concurrent validity between other psychometric measures, Retzlaff et al.'s (2002) research in MCMI-II screening of offenders found concurrent validity in areas of mental health, substance abuse and violence, with regards to the measure consistently matching the opinions of professionals working with the offenders in the research sample. In particular, there were strong correlations with mental health assessments for borderline personality and post-traumatic stress disorders and major depression scales.

### **Predictive validity**

Retzlaff et al.'s (2002) research also highlighted aspects of the MCMI-III's predictive validity, notably in 'predicting future institutional behaviour' (p.329). An earlier study by Retzlaff (2000) has demonstrated predictability to exceed the threshold of .90 for all personality disorder scales. By using an odds ratio analysis, Retzlaff et al. (2002) demonstrated how a score of 75 and above on the MCMI-III among 9,500 admissions to correctional facilities could generate risk ratios for specific behaviours. Their research found a 'sevenfold increase in future medication use for those scoring high on major depression' (p. 329) as well as high risk for future substance misuse among those with elevated scores on, as might be expected, the drug dependence scale. They also found that the MCMI-III predicted who would be at greater risk of institutional violence; in contrast to popular belief of antisocial prisoners being the expected perpetrators, Retzlaff et al. (2002) concluded that prisoners with high scores on schizoid, delusional, depressive and avoidant scales were more likely to instigate violence. Interestingly, Retzlaff et al.'s (2002) sample identified only 29% of admissions had elevated scores for antisocial personality disorder scales whereas base rates for this diagnosis in correctional settings have been repeatedly identified as being between 50 – 75% (Hare, 1991).

### **Content validity**

Ryder and Wetzler (2005) state that the MCMI-III is based on a 'clearly outlined model of psychology and psychopathology' (p.250), and that Millon's method of item selection based on theory is 'strongly suggestive of good content validity' (p.250). Its development alongside the DSM-IV also demonstrates strong content validity supported

by a well-used diagnostic standard. However, there is criticism that items new to the current version of the test have been researched considerably less and that the content validity is compromised by a lack of evaluation on these items (Rogers, Salekin, & Sewell, 2000). Rogers, Salekin and Sewell (1999) also criticise the MCMI-III for the lack of adequate information on item selection despite detailed account of these procedures in the current manual. Millon (1985) argued that not every personality disorder symptom would be assessed by the MCMI-III and the test was ‘an operational measure of his biopsychosocial theory of personality pathology’ (Craig, 1997). Although there are some scales which are not exactly in accordance with DSM-IV diagnosis, the manual does outline the criteria for each personality disorder and the MCMI-III test item which assess it.

### **Criticisms of the MCMI-III**

The British Psychological Society defines psychometrics as the following:

'a psychological test ... by which inferences are made concerning a person's capacity, propensity or liability to act, react, experience, or to structure or order thought or behaviour in particular ways'.

(British Psychological Society, 2012)

The MCMI-III measure is described as ‘refined and strengthened’ (Millon, 2006, p.1) in response to developments in theory, research and professional knowledge around the concept of personality. Significant research has demonstrated a number of its strengths: development from comprehensive clinical theory (Millon, 1997), reflection of

diagnostic criteria used in the DSM-IV, its use of base rates of personality disorder and clinical syndromes thus increasing diagnostic accuracy (Craig, 2008), and its easy administration in a variety of clinical and forensic settings. However, criticism of the MCMI-III is also well-documented including its normative sample underrepresenting minority groups (Lloyd, 2010), its poor convergent validity with standard psychiatric rating scales and few validation studies verifying the accuracy of its interpretations in other languages and formats (van Gerko, 2012).

There is also criticism that there is an imbalance in its dichotomous items with a majority of items keyed towards the 'true' response, making the test susceptible to patients with an acquiescent response set (Van Gerko, 2012). In terms of responding patterns within parenting assessments, there has been criticism that despite monitoring for desirable responses, individuals in such assessments may produce invalid profiles due to elevated socially desirable responding which affects the scores on other scales and produces incorrect diagnoses. In testing this, Lenny and Dear (2007) asked respondents to 'fake good' when completing the MCMI-III and found elevated scores on the 'desirability', 'histrionic', 'narcissistic' and 'compulsive' scales. Lenny and Dear (2007) argued that elevations on these scale may be indicative of faking good as opposed to pathology. Indeed, Carr, Morretti and Cue's (2005) study on responding patterns in custody evaluations found that despite individuals assessed for parenting capacity often being of lower cognitive functioning and educational level, patterns of positive self-representation were still evident in their responding on the MCMI-III.

Criticism has also been made of the MCMI-III's use within forensic processes; McCann and Dyer (1996) strongly advocated the use of the second edition of the MCM) in both civil (child protection, custody and fitness to parent) and criminal (child abuse and neglect, domestic violence) cases, arguing that the MCMI-II (Millon, 1987) provides detailed information on 'potential clinical symptoms and personality disturbances that can impact adversely on the [parent-child] relationship' (p.118). Although recommending the use of the MCMI-III in forensic evaluation, McCann and Dyer (1996) questioned the lack of criterion-validity studies of its use in forensic settings, concerns that were shared by Rogers et al. (1999). Rogers et al.'s (1999) meta-analysis addressing the construct validity of the MCMI inventories and their relation to the *Daubert* standards suggests that the MCMI-III struggles to reach '*Daubert's* threshold for scientific validity' (p. 430).

Significant criticism comes from the methodology utilised in Millon's (1994) criterion-validity study. Retzlaff (1996) noted that, firstly, clinicians were not informed of the purpose of the study, thus allowing for patient bias when selecting their cases. Secondly, diagnoses were made with little contact with the patients and, thirdly, diagnosis was made when 'the criteria were unavailable or poorly established' (Rogers et al., 1996, p. 430). By reanalysing Millon's (1994) data and calculating the 'positive predictive power' (PPP; Retzlaff, 1996, p.431) for personality disorders, an estimate of diagnostic usefulness, Retzlaff (1996) argued that the MCMI-III's PPP values for Axis II disorders were very poor, suggesting that elevated scores lead to incorrect diagnosis.

With regard to the use of psychometric measures in court, Rogers et al. (1999) argued that forensic psychologists should vigorously review their use of testing in light of the *Daubert* standards to ensure high levels of scientific evidence. In response to the issues raised by Rogers et al. (1999), Dyer and McCann's (2000) paper criticises Rogers et al.'s (1996) significant failure to cite the most recent edition of the manual when evaluating the measure's concurrent validity and their incomplete and 'inappropriate' research (Dyer & McCann, 2000, p.492), thus, in their opinion, rendering the critique findings inapplicable.

One of Roger's et al.'s (1999) key criticisms of the MCMI inventories was the measures development based on criteria presented in the DSM; they argued that the MCMI-III cannot be used to assess DSM-IV disorders because of its development alongside the DSM-III-R. Despite Dyer and McCann's (2000) argument that both DSM versions are reflective of Millon's theoretical background (and his presence as a committee member for the personality disorders work force with both editions), this does raise questions around the MCMI-III's applicability to the diagnostic criteria of the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (5<sup>th</sup> ed.; DSM-V; APA, 2013). Studies concerning the latest edition of the DSM have begun to manifest although research specific to the MCMI-III's applicability to the DSM-V's outline for personality disorder diagnosis appears to be very limited. Taking into consideration the DSM-V's changes regarding personality disorder diagnosis and assessment, the next logical step in psychometric research would examine the MCMI-III's applicability to the most recent developments in diagnosis.

### **Gender bias within testing items**

When considering the use of psychometric testing on female participants, it is important to consider gender bias, particularly in item construction, as this could lead to the misidentification of personality difficulties. Early research into the development of parent psychopathology found that fathers were significantly underrepresented (Phares & Compas, 1992) and despite some 'modest gains' in research including fathers, personality functioning and parenthood was still dominated with studies of mothers (Phares, Fields, Kamboukos & Lopez, 2005). Still looking for Poppa., 2005). Research on the MCMI-III profiles of women has found elevated scores on substance and alcohol misuse and psychiatric problems (Siqueland, Olafsen & Moe, 2013). In terms of parenting, studies have shown that maternal sensitivity appears lower in women with substance misuse and psychiatric problems, substance misuse and depression and anxiety were higher in women who reported personality disorders and children with hyperactive and/or oppositional behavioural problems (Goldstein et al., 2007; Siqueland et al., 2013). Furthermore, in a study of female child homicide perpetrators, these women had a primary Axis II profile, demonstrated significantly elevated scores on a number of personality scales (Newman, 2006).

However, there is argument that the MCMI-III items are constructed in a manner which encourages affirmative responding from women (Kaplan, 1983; Lindsay, Sankis & Widiger, 2000). Indeed, Widiger and Chaynes (2003) argue that gender bias can occur not only in item wording but in the conceptualisation of personality disorders, the wording of diagnostic criteria and even in the use of self-report inventories. They suggested that borderline, dependent and histrionic personality disorders were more

frequently diagnosed in women due to items that may resonate specifically with women. For example, item 80 on the histrionic scale ('it's easy for me to make friends') has been identified as an item where healthy and functioning individuals who lack maladaptive personality functioning would respond to affirmatively. Furthermore, Widiger and Chaynes (2003) argued that feminine women are more likely to respond affirmatively than masculine men, which could lead to misconstruction of personality profiles. Although not accounted for within the scales, there are a number of items which refer to weight ('people say I'm a thin person but I feel that my thighs and backside are much too big'). Again, it is possible that this item would be marked as 'true' more frequently by men than women due to the social and gender construction of fixation on weight and body image. Indeed, Kaplan (1983) described histrionic and dependent personality disorders as 'caricatures of femininity' (p. 802).

Where there is criticism of gender bias which correlates with the biological sex of the respondent, socially desirable feminine behaviour and a negative correlation with dysfunction, this does raise questions around the validity of personality profiles produced by women who use the MCMI-III. It has particular implications for parenting capacity assessments of mothers accused of child maltreatment, as the MCMI-III is so frequently used within the battery of assessment tools and decisions concerning child care are often made taking such assessment results into consideration. Gender bias within item wording and misdiagnosis should highlight the importance of using the MCMI-III in tandem with other psychometric tests as well as clinical judgement in order to conduct a thorough assessment of the individual.

## Conclusion

With the increasing significance being placed on evidence-based opinions, the role of psychometric testing has become a prominent aspect in forensic proceedings. Gould and Stahl (2000) argue that the use of psychometric testing in child care proceedings should be based on its 'acceptance as scientific evidence in previous jurisdictions, published psychometric data supporting its reliability and validity, its relevance to psycholegal questions, and a basis in scientific theory' (p.404), very much in keeping with the *Daubert* standards of legal practice. There is support that psychometric testing provides objective support for the professional's opinion and helps balance bias in clinical interviews (Gould, 1998). Cordess (2003) cautions against the use of psychometric testing in isolation; he argues that although they may be auxiliary to overall clinical judgement, they are not 'transparently accurate ... since they seek to assess not on static but dynamic factors which are inherently only partially predictable' (p.172). Criticism has also been made of their use in isolation (Roseby, 1995), over-interpretation of results (Heilbrun, 1995) and using tests that are irrelevant to the legal requirements of the assessment. The MCMI-III is one of the most frequently used measures in both clinical and forensic practice, often forming part of a battery of tests administered during child protection assessments. Its popularity within forensic psychology practice indicates its benefits in its application as a diagnostic tool. However, the MCMI inventories continue to generate controversy surrounding their usage and a well-used psychometric should be robust in facing professional and academic criticism.

## **Chapter Five**

### **Discussion**

Intergenerational child maltreatment is verified by a multitude of research and literature supporting its existence in families where abusive and neglectful behaviours have become entrenched in parenting behaviours. Amongst a vast number of risk factors for the continued perpetration of child maltreatment, a history of victimisation in childhood has stood out as a key factor for the intergenerational pattern of abuse and neglect (Thornberry et al., 2012). Child maltreatment literature, reinforced by research and theory, suggests that children who have been subjected to adverse parenting experiences can develop significant psychological deficits that put them at risk for perpetrating harmful behaviours when they become parents themselves. Particular attention has been paid to the self-report of abuse and neglect in the childhood histories of parents with personality disorders, particularly those brought to the attention of child protection agencies, suggesting a key exacerbating factor in the cyclical nature of intergenerational maltreatment (Pereplechikova et al., 2012).

Gaining a solid understanding of the parent's gender as a dependent variable for child maltreatment is complex; several studies have found differences both in the maltreatment experienced by male and female children, as well as the maltreating behaviours carried out by fathers and mothers, although the research linking the two is very sparse (Fisher et al., 2009; Lansford, Dodge, Pettit, & Bates, 2010; Leifer, Kilbane, & Kalick, 2004). However, literature searches yielded few studies examining maternal intergenerational patterns of child abuse and neglect. Furthermore, available studies appeared to be published predominantly in the last few years, suggesting research in this area is still in its infancy.

On the basis of this, the aims of the thesis was to explore the transmission of intergenerational familial child maltreatment across mothers, identify and explore risk and protective factors pertinent to transmission, compare the profiles of women who abuse and women who neglect their children and, finally, explore the role of psychometric testing with the identification and assessment of personality traits within maladaptive parenting. This was undertaken with the purpose of formulating what places women with a childhood history of maltreatment at risk of engaging in abusive and neglectful behaviours, and how to treat these individuals in order to reduce the risk of continuing the cycle. A number of processes were conducted in order to achieve the aims of this thesis and they are discussed below. With regards to its use beyond academic application, the findings of this thesis may benefit and inform forensic practice, particularly with those working within child protection services, and parenting assessment and intervention proceedings.

## **Main findings relevant to the literature**

### **Chapter Two: Maternal Intergenerational Child Maltreatment: A Systematic Approach**

The systematic literature review was able to justify exploring intergenerational child maltreatment amongst women. Despite only identifying 10 studies, an association was found between childhood histories of maltreatment perpetrated by mothers and risk of engaging in abusive and neglectful behaviour as adults. Three studies in particular identified a direct link between exposure to maternal abuse in childhood and

perpetration of severe punitive behaviour in adulthood. These studies demonstrated how female parents subjected to a range of abusive and neglectful contact and non-contact parenting behaviours in childhood had presented with similar maltreating behaviours in adulthood. Although all the studies demonstrated a relationship between the experience and subsequent perpetration of child maltreatment, in almost all cases where specifically abuse had occurred, women reported experiencing abusive behaviours from their own mother in childhood. Abusive behaviours in particular were best predicted by childhood maternal psychological abuse with these mothers reporting higher parenting stress and demonstrating higher scores on punitive and authoritarian parenting scales. Exposure to childhood maltreatment was also linked to involvement with child protection agencies, substance misuse, psychiatric problems and domestic violence in adult relationships. The literature review also demonstrated the presence of other risk factors in the intergenerational cycle including post-traumatic stress disorder, parenting stress and substance misuse. It also identified a number of protective factors including social support, positive intimate and family relationships, therapeutic intervention and socioeconomic stability. A key finding from the literature review indicated that the mother's insight into her own abusive experiences was critical in breaking the cycle of maltreatment.

### **Chapter Three: The Incidence of Maternal Intergenerational Child Maltreatment in a British Sample**

The systematic literature review demonstrated the paucity of research in this area, particularly the lack of research conducted on a European sample. With a predominance

of the studies being based on a North American participant sample, it was evident that research using a British sample would add to the field's research base and may be beneficial in generalising results to implement policy and practice in the UK. The main finding in this chapter unfortunately did not contribute to the intergenerational child maltreatment theory as, in this sample, there were no significant associations between women who reported childhood histories of abuse and neglect and perpetrating the same maltreating behaviours. Furthermore, half the sample did not report a childhood history of maltreatment which raises the question of why mothers have initiated child abuse or neglect, and indicates a wider risk profile than just a childhood history of victimisation.

However, parallels could be drawn between the study and published literature regarding risk factors for child abuse and neglect. Significant associations were found between child maltreatment and perceptions that the mothers' partners are neither supportive enough towards them nor providing enough care for the child which adds to the literature which links child maltreatment with poor adult relationships (Reyome, 2010). Contrary to expectation, women in the '*child abuse*' group accounted for the higher percentage of reported attempted or actual self-injurious behaviours. Furthermore, significant associations were found between self-reported drug use both in adolescence and during the time period of maltreatment, which again supports significant literature on child maltreatment as a precursor to substance misuse (Lansford et al., 2010) and drug use as a risk factor in the perpetration of both child abuse and neglect (Manning, Best, Faulkner, & Titherington, 2009).

These findings were also supported by the 'drug dependence' scale scores on the MCMI-III, which indicated that women in the '*child neglect*' group scored higher on this scale. Analysis of the other MCMI-III scales also demonstrated higher scores on the 'antisocial' and 'sadistic (aggressive)' personality measures from women in the '*child neglect*' group, indicating a number of harmful personality traits which may be present in maladaptive parenting styles.

Further analysis of psychometric performance also produced some interesting findings, notably with mothers assessed for child neglect who consistently achieved higher scores on personality, coping responses and parenting stress scales. These results suggested that although women engaging in neglectful parenting behaviours perceive their child's behaviour as overly-demanding and unfulfilling of their own expectations, they perceive themselves as more competent and effective in problem solving compared to others in similar parenting situations. This is a particularly pertinent finding as it reflects the thinking processes of mothers who believe their parenting style to be appropriate despite evidence of child neglect, which reflects research around the stressors of parenting and the demands of a child's behaviour which can jeopardise parental sensitivity (Laukkanen, Ojansuu, Tolvanen, Alatupa, & Aunola, 2013). Furthermore, it demonstrates the potency of neglect as an intergenerational maltreatment type. In an environment where neglectful behaviour is modelled and not perceived as harmful within the family context, it has a far less likely chance of being challenged and may be more likely to be internalised by the child as appropriate parenting skills. The study also highlighted age as a specific factor with regards to scores on the parenting stress scales which demonstrated that higher scores of the participants' perception of their child's

*'distractibility/hyperactivity'* were associated with lower maternal age. This is very much in keeping with the research on parental age as a risk factor for child maltreatment and parenting competence although it differs in that the predominance of literature in this area is based on adolescent/teenage mothers whereas this sample used mothers age 18 and above, and mothers in their teenage years accounted for only 8% (n = 22) of the sample.

#### **Chapter Four: Psychometric Critique of the Millon Clinical Multiaxial Inventory – Third Edition (MCMI-III)**

The critique highlighted that the tool is derived from comprehensive clinical theory and is designed to reflect the diagnostic criteria of the DSM-IV. Its strong evidence base for validity and reliability demonstrate its effectiveness as a psychometric and, as a result, it is frequently used within forensic settings as an assessment and diagnostic tool for personality disorders. Although its use within parenting assessments has been criticised due to applicability to the assessment and over-representation of results, using personality psychometric measures such as the MCMI-III can support the formulation of maladaptive parenting behaviours, as well as inform appropriate intervention options (Gould, 1998). Previous research on the application of the MCMI-III in parenting assessments has demonstrated mixed opinion. Numerous studies have quoted the self-report inventory as staple of the battery of assessment measures used in cases concerning parenting capacity and child protection:

‘the MCMI-III is a potential contributor to understanding the emotional and personality functioning of a parent whose ability to parent is the primary concern’.

Stredny et al., 2006, p.113

Its supporters argue that its main strength allows for the exploration of the role of parent psychopathology in the parent-child dynamic and that this can inform treatment following identification of personality disorders. However, there is also strong argument for the role of gender bias and that a number of the MCMI-III's items are 'caricatures of the gender of femininity...such as item 80: 'it is very easy for me to make many friends'' (Lindsay, Sankis & Widiger, 2000, p. 219), specifically citing histrionic, borderline and dependent personality disorder items. Critics also argue that items keyed towards a specific gender may increase the risk of individuals responding affirmatively to items that may lead to misdiagnosis. This is a particularly important issue to consider in the light of assessing mothers and the role of their psychopathology within child maltreatment. Whilst a number of studies have found personality disorders to be higher in women who abuse and neglect their children, criticisms of gender bias may lead to questions surrounding the accuracy of diagnosis and significance of certain personality disorders associated with maternal child maltreatment.

It is understandable that a widely-used psychometric measure is also vulnerable to criticism; the MCMI inventories have been critiqued for their diagnostic applicability, not only on their development alongside the DSM publications, and subsequent delays when a revised MCMI inventory does not match changes within the DSM, but also for its criterion validity and suitability for accurately assessing Axis II disorders (Rogers et al., 1999). Criticism has also been found around gender bias in item development and identification of maladaptive personality function. This is particularly important when

considering its use with women in child protection proceedings and the use of psychometric findings in informing procedures of treatment and child care.

### **Summary of thesis findings**

Although there is evidence for maltreatment curing in families where parents have not experienced maltreatment in childhood, the findings from this thesis suggest that maltreatment in childhood can be seen as having implications for maladaptive parenting behaviours in adulthood, particularly regarding the development of personality and psychosocial responses and is a key risk factor in understanding why and how child abuse and neglect is perpetrated throughout generations. Figure 4 presents a formulation of risk factors for the transmission of child maltreatment based on the overall findings of the thesis.

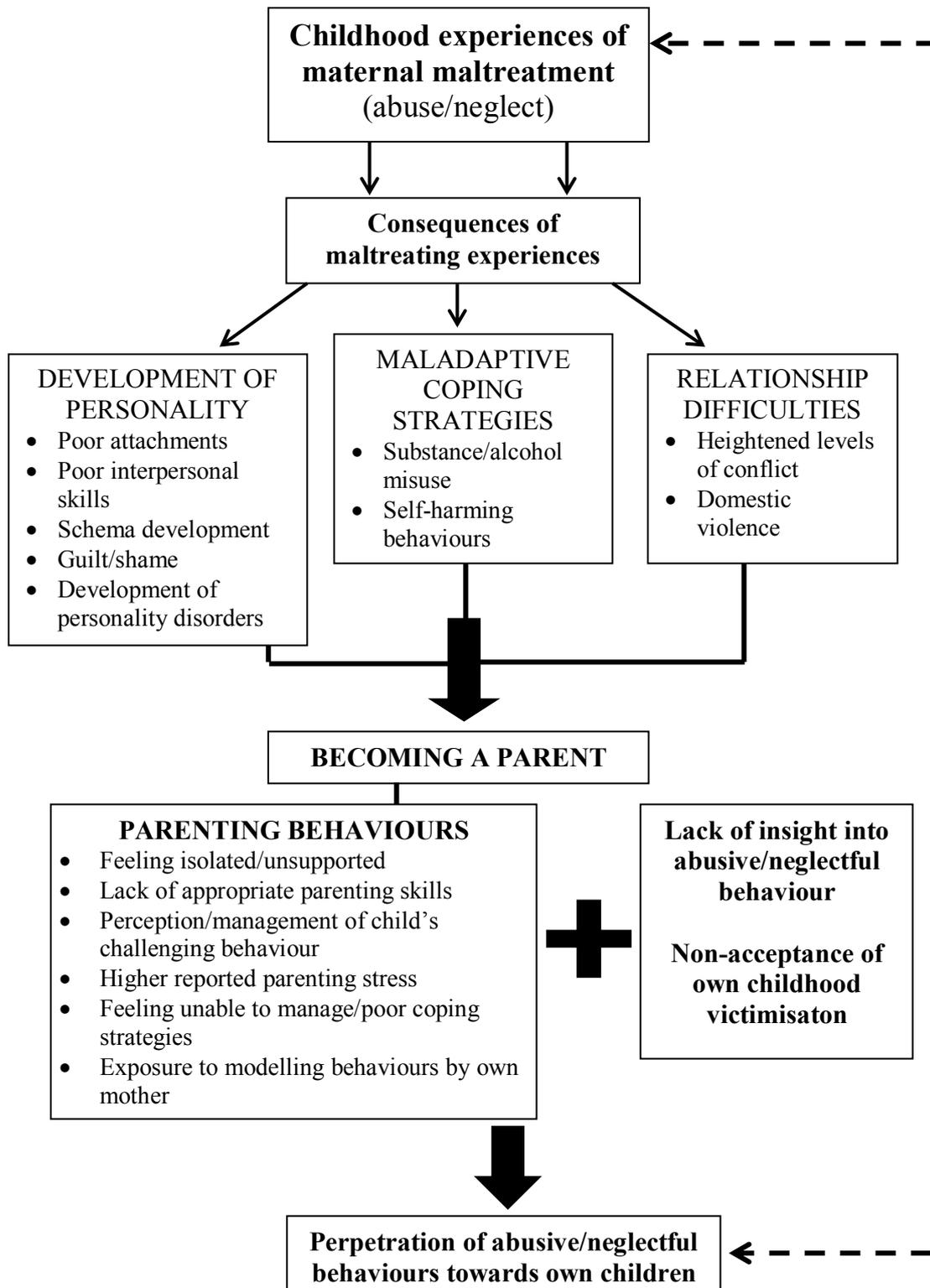


Figure 4. Hypothetical transmission model of maternal intergenerational child maltreatment based on thesis findings.

### **Strengths and limitations of the thesis**

The main strength of the thesis is that its sample of British female participants has contributed to the developing understanding around maternal childhood maltreatment, particularly when studies using European samples appear to be so lacking in current research and literature. A further strength was that the research highlighted particular findings around maternal neglect, suggesting that an umbrella approach to maltreatment intervention may not be suitable for mothers engaging in different child maltreatment behaviours and may not address their specific needs.

The main limitation of the research study was the use of retrospective data which was used to create the database and subsequently used in the research study. As this database has been steadily updated since 2001 and by a number of different psychological staff at the practice, it is possible that data may have been inaccurately recorded or coded or could have contained biases. It is important to remember that the presence of a variable was based not only on the staff's understanding of that variable being present in the assessment information but also the variable being correctly coded within the database, therefore we must allow for human error in the recording of such information. It is important to consider that the database was made available to the author after its development and thus the author had no influence on the variables that were identified and the manner in which they were recorded.

A further limitation was the use of self-reporting measures, both in psychometric testing and interview information. Although this was helpful in allowing the respondent to

report on herself and provided a very detailed account of both her childhood and parenting experience, it leaves open the possibility that she could present a biased and inaccurate picture, particularly for those keen to present themselves in a socially favourable light during parenting capacity assessments.

### **Applicability of thesis findings**

As with any study, it is important to consider how the research findings are interpreted and applied to forensic practice. Where there is a concern around the safeguarding of a child, a referral to children's services can be made to prompt investigation. This referral can come from a variety of sources, although it is often an adult in frequent contact with the child, such as a teacher, or a member of the public concerned for a child's welfare. Following an initial assessment, the local authority then decide if further investigation is required, thus prompting the involvement of social services and the police (Meadows et al., 2011). A core assessment may be undertaken to determine the extent of maltreatment as well as the most appropriate response to the child's safety and welfare.

Children who are maltreated are normally brought to the attention of legal services by local authorities through public law cases in family courts where a number of orders can be made for the provision and management of their care. This includes deciding whether a parent or guardian is suitable to continue caring for a child, whether the child should be looked after or supervised by the local authority, and emergency protection for children in immediate danger (Ministry of Justice [MoJ], 2013). The MoJ's Court Statistics Quarterly for January to March 2013 reported that 7,239 children were involved in public law applications made by local authorities. Since the publicity

surrounding the Baby P case in 2009, the number of children involved in such applications has increased from 20,000 per year to almost 26,000 with figures stabilising at around 7,500 per quarter. In the first quarter of 2013, care orders were the most common type of order applied for, followed by emergency care. With regards to orders made, care orders were again the most prominent, followed closely by supervision and residence orders.

Although subjective to each case, the usual process of the family court reaching such a decision is informed by the assessment of the parents or guardians involved in the child's care. This is normally requested by the court and often involves psychological assessment of the child's care-givers as well as, depending on the nature of the case, psychological assessment of the child themselves. As a result, forensic and clinical psychologists are frequently involved in child protection cases and are often instrumental in the court's decision, through recommendations for intervention and treatment. The nature of these assessments is often complex; central to the process is an understanding of how the maltreatment has occurred, which is often complicated by a combination of risk factors, personality and interpersonal problems, adverse experiences and mental health and emotional difficulties. Furthermore, recommendations for further action are difficult to consider when we cannot predict how they may affect the parent's behaviour or the child's development. Supported by policies and guidelines, it is evidence-based research that can best inform practice.

A number of factors must be taken into consideration when applying and interpreting the findings reported in this research study. Firstly, this study was focused on British

mothers and therefore it is important to consider the generalisability of results. Although comparisons can be made, and similarities found, between the maltreatment behaviours of fathers and mothers, this research was an extension of a previous study which found significant parenting differences between the two genders. As a result of both previous and current findings demonstrating neglectful behaviours to be more pertinent in mothers, it is important to think about how this adds to the understanding of the assessment and treatment of mothers perpetrating child neglect. It can be argued that the assessment of and response to abusive behaviours may be more straightforward; physical or sexual harm implies abuse by a serious act of commission, one that can be identified and form a focus for treatment. Maltreatment by omission – the mother's breach of her parental duty – is often harder to conceptualise. Similar to physical abuse, physical neglect may be easier to assess and form a basis for intervention. Neglect, however, may be harder to formulate, particularly when it has become entrenched in a family's functioning. It is not unusual for members of the same family, across several generations, to come to the attention of local authorities for child maltreatment time and time again.

The results from the research study suggested that mothers engaging in child maltreatment may benefit from parenting skills training, mentalisation-based therapy (MBT) and mindfulness in order to address their maladaptive parenting behaviours. However, in considering the information from literature review, research and psychometric findings, effective intervention may have to form a two-tiered model – firstly, addressing the mother's own victimisation in childhood and its repercussions, and, secondly, her parenting behaviours in adulthood, whilst supporting her in

formulating links between these two significant stages in her life. However, the administration of such an intervention may be lengthy, time-consuming and financially limited.

This leads to a second factor to consider, using research evidence to inform good practice whilst restricted by social and economic circumstances. Depending on the outcomes of child protection cases, it is common for parents accused of child maltreatment to be recommended for a number of interventions dependent on their presenting problems. Meadow et al. (2011) listed a number of primary, secondary and tertiary prevention services including parenting awareness and education, community mental health services for both parents and children, social services support, family centres, home visiting services and, in extreme cases, removal of the parent for the child's safety. In 2010, the UK government ministers backed a pilot scheme for 10 pilot programmes of multisystemic therapy (MST) to be undertaken with young offenders and adolescents engaging in antisocial behaviour. Designed to prevent young people from entering prison or the care system through intensive family support, the original pilot scheme in north London demonstrated its effectiveness in reducing re-offending figures among 108 young offenders by working with their families on 'every front .... from parenting education to increasing the young people's engagement in education or training to tackling drinking and drug taking and improving mental health' (Boseley, 2010, para. 5). Although the focus was on reducing offending, the pilot scheme found positive developments within family functioning, particularly for families with long involvement in social services. Programmes incorporating treatment such as MST may prove to be beneficial to families where intergenerational child maltreatment continues

to occur; by addressing not just the parent or child involved but the whole family, there may be more scope for breaking the cycle. However, this is dependent on a number of factors – practical issues such as the availability and financial support of such a programme as well as the parent’s willingness to engage in the intervention. As noted previously, this is often influenced by the parent’s insight into their own behaviour coupled with an understanding of their own victimisation.

### **Future research**

Although a number of studies identified in the literature review used a control group of women who did not continue the cycle of abuse, this was not included in the research design in Chapter Three. A further development of this study would be to include a third participant group of women with childhood histories of maltreatment who did not abuse or neglect their own children. This would have allowed for further exploration of the intergenerational theory and by comparing the three groups, analysis could be conducted on the differences in childhood histories, presence of risk factors and psychometric testing.

Quantitative research often has its benefits in terms of producing statistical evidence within a particular field that can be generalised across sample type. However, the results of this research suggest that further exploration of the potency of neglectful parenting may benefit from a qualitative methodology. Although not without its own disadvantages compared to quantitative methods (inability to generate any solid statistical findings or generalise to a wider group), a qualitative approach does allow for more exploratory research, particularly with regards to flexible approaches to research,

generating theory and providing in-depth analysis of attitudes and behaviour. This may be beneficial in exploring the qualitative strength of intergenerational child maltreatment in terms of how mothers have processed their abusive and neglectful experiences and perceptions of their own parenting. Although a quantitative approach has allowed researchers to generate a thorough catalogue of risk factors that are continuously identified in the intergenerational process, it is still unclear why certain protective factors may or may not mitigate the risk of perpetuating the cycle of abuse. Insight has indeed been identified as a strong protective factor in addition to the presence of a non-abusive adult, positive adult relationships and the child's resilience (Holt et al., 2008; Howe et al., 1999; Wilson & James, 2003). A qualitative approach to this may shed light on the process of intergenerational child maltreatment through the eyes of women subjected to the cycle and thus inform intervention that is directly applicable to their experiences.

The field may also benefit from studies concerning the options and efficacy of treatment or intervention specifically aimed at women with intergenerational histories of child maltreatment. Although a number of children's services and charities offer parenting support through guidebooks, programmes, workshops and online resources, this is very much at the primary level of intervention. According to the NSPCC, tertiary programmes target families in which child maltreatment has already occurred and been identified by external agencies; 'the central aim of tertiary interventions is to reduce the negative impact of maltreatment and reduce the likelihood of abuse recurring' (Meadows et al., 2011, p. 101). These interventions cover a number of different approaches including punitive, monitoring, supportive and therapeutic strategies such as

social worker support, psychological interventions (CBT and anger management), and parenting programmes (Meadows et al., 2011). However, working with parents involved in child protection proceedings can present a number of difficult issues. Child care interventions often require detailed assessment and monitoring which may result in parents feeling watched or scrutinised for incriminating evidence against them. Furthermore, as a result of the stigma associated with child protection proceedings, parents may feel hostile or reluctant to participate in the intervention process thus rendering them ineffective.

Research into prevention programmes may benefit from focusing on women-specific interventions, particularly for mothers with personality disorders. Analysis of the current parenting programmes suggests very little resources designed specifically for mothers and those in circulation are mainly aimed at preventing domestic violence, such as the NSPCC's 'Whole Woman' guide and UK charity Women's Aid. Research has shown the advantages of female-only psychoeducational programmes, citing benefits such as positive group cohesion marked by the formation of supportive relationships in a safe and non-judgemental environment, making social connections and feeling cared for and/or accepted (Strantz & Welch, 1995; Waite, 2010; Woolhouse, Cooper, & Pickard, 2013). In their work with female intravenous drug-users, Woolhouse et al. (2013, in press) found that in their women-only programme, participants could 'challenge themselves and others, ultimately enabling change' (p. 6). The majority of studies on women-only psychoeducational programmes have focused on their benefits for physical health problems but there is a possibility that the same positive group dynamics will not benefit women in parenting programmes.

## **Conclusion**

Childhood history of maternal maltreatment alone cannot predict the perpetration of maltreating behaviours in one's own parenting, although several studies have explored the phenomenon, many have found a very low rate of transmission and there is also the issue of women who initiate maltreatment despite not having a childhood history of victimisation. However, childhood abuse or neglect can be viewed as one factor that makes individuals more vulnerable to maladaptive psychological development and should be integrated in structured parenting assessment, due to its consideration of personality difficulties, emotional regulation and psychosocial functioning. These can be understood as severely rooted problems and treatment should aim to provide mothers not only with an understanding of their own experiences of victimisation but also with the insight into the impact this has on their negative parenting behaviours. For forensic practitioners assessing and working with women accused of child abuse and neglect, this all becomes relevant when exploring their childhood histories and consideration must be made when formulating the function of such maladaptive behaviours and deciding which intervention approaches may be of the most benefit in reducing the risk of maltreatment transmission.

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## **Appendix One: Search syntax for literature review**

### **PsycINFO (02/05/11)**

limit 19 to (english and human and yr="1990 -Current")

- + Search terms used:

- adolescen\*
- babies
- baby
- child abuse
- child neglect
- child\*
- emotional abuse
- female
- infant\*
- maternal
- mother\*
- mothers
- parent
- parent child relations
- physical abuse
- sexual abuse
- teen\*
- transgenerational patterns
- verbal abuse

1	ChildAbuse/ 17927	
<input type="checkbox"/>	2 exp Child Neglect/	2632
<input type="checkbox"/>	3 exp Physical Abuse/	4270
<input type="checkbox"/>	4 exp Emotional Abuse/	1581
<input type="checkbox"/>	5 exp Sexual Abuse/	18532
<input type="checkbox"/>	6 exp Verbal Abuse/	234
<input type="checkbox"/>	(child* or infant* or adolescen* or teen* or baby or babies).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures]	423807
<input type="checkbox"/>	8 3 or 4 or 5 or 6	21600
<input type="checkbox"/>	9 7 and 8	14065
<input type="checkbox"/>	10 1 or 2 or 9	22587
<input type="checkbox"/>	11 exp Transgenerational Patterns/	1748
<input type="checkbox"/>	12 10 and 11	153
<input type="checkbox"/>	(maternal or mother* or female parent).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures]	73467
<input type="checkbox"/>	14 12 and 13	64
<input type="checkbox"/>	15 limit 14 to (english language and yr="1990 -Current")	59
<input type="checkbox"/>	16 exp parent child relations/	36731
<input type="checkbox"/>	17 exp mothers/	21943
<input type="checkbox"/>	18 13 or 16 or 17	90693
<input type="checkbox"/>	19 12 and 18	80
<input type="checkbox"/>	20 limit 19 to (english and human and yr="1990 -Current")	74

**MEDLINE ® (02/05/11)**

ChildAbuse/		21799
<input type="checkbox"/>	24 exp Child Neglect/	21799
<input type="checkbox"/>	25 exp Physical Abuse/	0
<input type="checkbox"/>	26 exp Emotional Abuse/	0
<input type="checkbox"/>	27 exp Sexual Abuse/	15706
<input type="checkbox"/>	28 exp Verbal Abuse/	0
<input type="checkbox"/>	(child* or infant* or adolescen* or teen* or baby or babies).mp. [mp=protocol supplementary concept, rare disease supplementary concept, title, original title, abstract, name of substance word, subject heading word, unique identifier]	2721149
<input type="checkbox"/>	30 25 or 26 or 27 or 28	15706
<input type="checkbox"/>	31 29 and 30	10825
<input type="checkbox"/>	32 23 or 24 or 31	24562
<input type="checkbox"/>	33 exp Transgenerational Patterns/	0
<input type="checkbox"/>	34 32 and 33	0
<input type="checkbox"/>	(maternal or mother* or female parent).mp. [mp=protocol supplementary concept, rare disease supplementary concept, title, original title, abstract, name of substance word, subject heading word, unique identifier]	266518
<input type="checkbox"/>	36 34 and 35	0
<input type="checkbox"/>	37 limit 36 to (english language and yr="1990 -Current")	0
<input type="checkbox"/>	38 exp parent child relations/	39984
<input type="checkbox"/>	39 exp mothers/	20812
<input type="checkbox"/>	40 35 or 38 or 39	287287
<input type="checkbox"/>	41 34 and 40	0

42 limit 41 to (english and human and yr="1990 -Current") 0

## EMBASE (02/05/11)

expChildAbuse/

20777

24 exp Child Neglect/

25 exp Physical Abuse/ 0

26 exp Emotional Abuse/ 0

27 exp Sexual Abuse/ 21634

28 exp Verbal Abuse/ 489

(child\* or infant\* or adolescen\* or teen\* or baby or babies).mp. [mp=title, abstract, subject headings, heading word, drug trade name, original title, device manufacturer, drug manufacturer, device trade name, keyword]

29 1701828

30 25 or 26 or 27 or 28 22033

31 29 and 30 13389

32 23 or 24 or 31 25886

33 exp Transgenerational Patterns/ 0

34 32 and 33 0

(maternal or mother\* or female parent).mp. [mp=title, abstract, subject

35 headings, heading word, drug trade name, original title, device 231053  
manufacturer, drug manufacturer, device trade name, keyword]

36 34 and 35 0

37 limit 36 to (english language and yr="1990 -Current") 0

38 exp parent child relations/ 39975

39 exp mothers/ 46900

<input type="checkbox"/>	40 35 or 38 or 39	248797
<input type="checkbox"/>	41 34 and 40	0
<input type="checkbox"/>	42 limit 41 to (english and human and yr="1990 -Current")	0

### Web of Science (04/05/11)

<b>Set</b>	<b>Web of Science Search History - "C:\fakepath\WoShistory.wos"</b>
#7	#5 AND #4 AND #3
#6	Topic=(maternal* or mother* or "female parent*") OR Topic=("parent child " or "mother child " or "parent-child " or "mother-child")
#5	Topic=(maternal* or mother* or "female parent*") OR Topic=("parent child relations" or "mother child relations" or "parent-child relations" or "mother-child relations")
#4	Topic=("transgenerational patterns" or intergenerational) OR Topic=("family relations")
#3	#2 OR #1
#2	Topic=("physical* abuse*" or "emotional* abuse*" or "sexual* abuse*" or "verbal* abuse*" or "Psychological* abus*") AND Topic=(child* or infant* or adolescen* or teen* or baby or babies)
#1	Topic=("child abuse" or "child neglect" or "child maltreatment")

### ASSIA (04/05/11)

**(ab(maternal\* or mother\* or "female parent\*" or "parent child relations" or "mother child relations" or "parent-child relations" or "mother-child relations")) and (ab("transgenerational patterns" or intergenerational or "family relations")) and ((ab("physical\* abuse\*" or "emotional\* abuse\*" or "sexual\* abuse\*" or "verbal\* abuse\*" or "Psychological\* abus\*") and child\* or infant\* or adolescent\* or teen\* or baby or babies)) or (ab("child abuse" or "child neglect" or "child maltreatment")))**

## Appendix Two

### Inclusion and Exclusion Criteria for Study Selection

	Inclusion Criteria	Exclusion Criteria
Population	Mothers and their biological children	Male only studies  Studies where the perpetrator of the abuse was the biological father, step-father, maternal boyfriend/partner, sibling or extended family member
Study Design	Observational studies, cohort studies, case control studies, case series	Reviews, opinion papers, commentaries, editorials, non-English language papers, non-published papers

## Appendix Three

### Table of Excluded Studies (Examples)

Details of Study	Reasons for Exclusion
Dijkstra, S. (1995). Two mothers abused as children on raising their children: Making a plea for a differentiated approach. <i>Child Abuse Review, 4</i> , 291-297.	<ul style="list-style-type: none"> <li>• Included at PICO stage but rejected at the quality assessment stage.</li> <li>• Very small sample size, no detail on recruitment strategy, assessment methodology and results.</li> <li>• Not able to generalise results to target population.</li> </ul>
Langeland, W. & Dijkstra, S. (1995). Breaking the intergenerational transmission of child abuse: Beyond the mother-child relationship. <i>Child Abuse Review, 4</i> , 4-13.	<ul style="list-style-type: none"> <li>• Rejected at PICO stage.</li> <li>• Review of studies.</li> </ul>
Fisher, N.K. (2000). <i>Mental representations of attachment and care giving in women sexually abuse during childhood: Links to the intergenerational transmission of abuse?</i> (Unpublished doctoral dissertation). The City University of New York: New York.	<ul style="list-style-type: none"> <li>• Rejected at PICO stage.</li> <li>• Focus of study was on attachment and not perpetration of abuse.</li> </ul>
Fauble, M.A. (2009). <i>How maternal childhood maltreatment negatively impacts children's mental health outcomes among polysubstance exposed children.</i> (Unpublished doctoral dissertation) Case Western Reserve University: Ohio.	<ul style="list-style-type: none"> <li>• Rejected at PICO stage.</li> <li>• Based on children having mental health issues as a result of substance misuse amongst mothers.</li> <li>• Child's negative mental health outcomes were identified as a risk factor for abuse.</li> </ul>
Leifer, M., Kilbane, T. & Kalick, S. (2004). Vulnerability or resilience to intergenerational sexual abuse: The role of the maternal factors. <i>Child Maltreatment, 9</i> , 78-91.	<ul style="list-style-type: none"> <li>• Rejected at PICO stage.</li> <li>• Part of the participant criteria was that the perpetrator of the abuse was NOT the mother.</li> <li>• Focus of study was on maternal partner choice and how this choice affected a child's risk of exposure to abuse.</li> </ul>
Kim, K., Trickett, P.K. & Putnam, F.W. (2011). Attachment representations and anxiety: Differential relationships among mothers of sexually abused and comparison girls. <i>Journal of Interpersonal Violence, 26</i> , 498-521.	<ul style="list-style-type: none"> <li>• Rejected at PICO stage.</li> <li>• Mothers in this study had not been abused nor were the perpetrators of their child(ren)'s abuse.</li> </ul>

## Appendix Four

### Quality Assessment Forms

#### Qualitative Research

Taken from the Public Health Resource Unit, England (2006)

QUESTION	Yes	No	Partially	Unknown	COMMENTS
<b>INITIAL SCREENING</b>					
Is the study addressing the incidence of child maltreatment amongst mothers with personal histories of child maltreatment?					
Are the hypotheses/research questions clearly stated?					
<b>RESEARCH DESIGN</b>					
Is the research design an appropriate way of addressing the aims of the research?					
<b>SAMPLING</b>					
Has the researcher explained how participants were selected?					
Has the researcher explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study?					
Is there any discussion around recruitment?					
<b>DATA COLLECTION</b>					
Was the data collected in a way that addressed the research issue?					
Is the setting for data collection justified?					
Is it clear how data was collected?					
Has the researcher justified the methods of data collection?					
Has the researcher made the data collection methods explicit?					
Have the methods been modified during the study? If so, has the researcher explained how and why?					
Is the form of data collection clear (tape recordings, video material, notes)?					

<b>RELEVITY</b>					
Has the relationship between researcher and participants been adequately considered?					
Has the researcher critically examined their own role, potential bias and influence during the following:					
<ul style="list-style-type: none"> <li>• Formulation of research questions</li> </ul>					
<ul style="list-style-type: none"> <li>• Data collection including sample recruitment and choice of location</li> </ul>					
Has the researcher responded to events during the study and did they consider the implications of any changes in the research design?					
<b>ETHICAL ISSUES</b>					
Are there sufficient details of how the research was explained to participants?					
Has the researcher discussed informed consent and confidentiality?					
Has the researcher discussed how they have handled the effects of the study on participants during and after the study?					
<b>DATA ANALYSIS</b>					
Is there an in-depth description of the analysis process?					
If thematic analysis is used, is it clear how the categories/themes were derived from the data?					
Has the researcher explained how the data presented was selected from the original sample to demonstrate the analysis process?					
Is sufficient data presented to support the findings?					
Is contrary data taken into account? If so, to what extent?					
Has the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation?					
<b>FINDINGS</b>					
Are the findings explicit?					
Is there adequate discussion of the evidence both for and against the researcher's arguments?					

Has the researcher discussed the credibility of their findings?					
Are the findings discussed in relation to the original research questions/hypotheses?					
<b>VALUE OF THE RESEARCH</b>					
Has the researcher discussed the contribution the study makes to existing knowledge or understanding of intergenerational child abuse between mothers and their children?					
Has the researcher identified new areas where research is necessary?					
Has the researcher discussed whether or how the findings can be transferred to another population or considered other ways in which the research may be used?					

## Cohort Study

Taken from the Public Health Resource Unit, England (2006)

QUESTION	Yes	No	Partially	Unknown	COMMENTS
<b>INITIAL SCREENING</b>					
Did the study address a clearly focused issue (population, risk factors, outcome)?					
Did the author(s) use an appropriate method to answer their question?					
<b>SAMPLING</b>					
Was the cohort representative of a defined population?					
Was there something special about the cohort?					
Was everybody included in the sample who should have been included?					
<b>EXPOSURE</b>					
Did they use subjective or objective measurements?					
Have the measures been validated?					
Were all the subjects classified into exposure groups using the same procedure?					
<b>OUTCOMES</b>					
Did they use subjective or objective measurements?					
Have the measures been validated?					
Has a reliable system been established for detecting all the cases?					
Were the measurement methods similar in the different groups?					
If relevant, were the subjects blinded to exposure?					
<b>CONFOUNDING FACTORS</b>					
Have the authors identified all important confounding factors?					
Have they taken account of the confounding factors in the design and/or analysis?					
<b>FOLLOW UP PROCEDURES</b>					
Was the follow up of subjects complete enough?					
Was the follow up of subjects long enough?					

<b>RESULTS</b>					
Have they reported the results adequately?					
Are the design methods of this study sufficiently flawed to make the results unreliable?					
<b>APPLICATION OF RESULTS</b>					
Can the results be applied to the local population?					
Are the subjects in the study sufficiently different from your population to case concern?					
Can you quantify the local benefits and harms?					
Do the results of this study fit with other available evidence?					

## Case Control Studies

Taken from the Public Health Resource Unit, England (2006)

QUESTION	Yes	No	Partially	Unknown	COMMENTS
<b>INITIAL SCREENING</b>					
Did the study address a clearly focused issue (population, risk factors)?					
Did the study try to detect a beneficial or harmful effect?					
Did the authors use an appropriate method to answer their question?					
<b>RECRUITMENT</b>					
Are the cases defined precisely?					
Were the cases representative of a defined population?					
Was there an established and reliable system for selecting all the cases?					
Are the cases incident or prevalent?					
Is there something special about the cases?					
Were a sufficient number of cases selected?					
<b>CONTROLS</b>					
Were the controls representative of a defined population?					
Was there something special about the controls?					
Was the non-response high?					
Are the controls:					
• Matched					
• Population-based					
• Randomly selected					
Were there a sufficient number of controls selected?					
<b>EXPOSURE</b>					
Was the exposure clearly defined and accurately measured?					
Did the authors use subjective or objective measures?					
Do the measures truly reflect what they are supposed to measure?					
Were the measurement methods similar in case and controls?					
<b>CONFOUNDING FACTORS</b>					
What confounding factors have the authors accounted for?					

Have the authors taken into account of the potential confounding factors in the design and/or in their analysis?					
<b>RESULTS</b>					
Can the results be applied to the local population?					
Are the subjects covered in the study sufficiently different from your population to cause concern?					
Is your local setting likely to differ much from that of the study?					
Can you estimate the local benefits and harms?					
Do the results of this study fit with other available evidence?					

## Appendix Five

### Data Extraction Form

#### GENERAL INFORMATION

**Date of data extraction**

**Author**

**Identification of the reviewer**

**Notes**

**Re-verification of study eligibility**

**Population:** Mothers Y N ?

**Population:** Biological Children Y N ?

**Study Design** Cohort Case Control Case Series

**Continue?** Yes No

#### SPECIFIC INFORMATION

##### Population - Mothers

1. Target population (describe):
2. Inclusion Criteria:
3. Exclusion Criteria:
4. Recruitment procedures used:
5. Characteristics of participants:

Number of participants:

Age Range (include means):

Ethnicity:

Other information:

*Additional Notes:*

**Population – Children**

1. Target population (describe):
2. Inclusion Criteria:
3. Exclusion Criteria:
4. Recruitment procedures used:
5. Characteristics of participants:

Number of participants:

Age Range (include means):

Ethnicity:

Other information:

*Additional Notes:*

**Assessment**

- a) Use of structured assessment?
- b) Which assessment tool was used?
- c) Was the assessment conducted in a suitable/ confidential environment?
- d) Who facilitated the assessment?

**Results**

- 1) How was the outcome measured?
- 2) Was self-reporting utilised? If so, to what extent?
- 3) Was there a follow up? If so, how long was the follow up period?
- 4) Drop out rates?
- 5) Reason for drop outs?

6) Was study clearly reported?

7) Limitations?

*Additional Notes:*

### **Analysis**

1) Statistics techniques used?

2) Were the statistics and results reported clearly?

Overall study quality?            **Poor**            **Adequate**            **Good**            **Very Good**

Number of 'unclear' or unanswered assessment items?

*Additional Notes:*

Appendix Six

**MEMORANDUM OF UNDERSTANDING**

This Memorandum of Understanding is between **Forensic Psychology Practice Ltd** and **xxxxxx Solicitors and xxxxxx Solicitors**

The client is **xxxxxx** and the service to be provided is: Assessment and clinical interview, reading documentation, research as necessary and a comprehensive report.

An anticipated cost for the full assessment and report is **£xxxxxx ex VAT Plus travelling time and mileage.**

In normal circumstances a report will be submitted within twelve weeks of the commencement of the assessment. Any delay will be notified.

Forensic Psychology Practice adheres to the Code of Conduct and Professional Practice Guidelines of The British Psychological Society and The NHS Confidentiality Code of Practice (Caldicott). xxxxxxxx operate under the Law Society's professional rule of conduct and are responsible for the payment of fees due to expert witnesses when the service has been fulfilled.

On completion an invoice will be submitted. Payment to be made within 30 days.

**MEMORANDUM OF UNDERSTANDING  
(CONTINUED)**

**Signed** ..... **Signed** .....

**Date** ..... **Date** .....

**Forensic Psychology Practice xxxxxxx Solicitors**

**Signed** ..... **Signed** .....

**Date** ..... **Date** .....

**xxxxxxx Solicitors**                      **xxxxxxx Solicitors**

**Appendix Seven**

