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Multilevel factors associated with the intergenerational continuity of child sexual abuse

Abstract

Background: Despite burgeoning interest in the phenomenon of intergenerational continuity, literature concerning risk and protective factors in the context of child sexual abuse (CSA) is still underdeveloped. **Objective:** Since the identification of such risk and protective factors is essential in order to break these negative cycles, the present study aimed to identify specific multilevel factors associated with the continuity of CSA in a large sample of mother-child dyads using secondary analysis of data. **Participants and setting:** Mother-child dyads ($n = 1,250$) were divided into four groups: 1) CSA Continuity (mother and child are victims); 2) CSA Discontinuity (only mothers are victims); 3) No Abuse Continuity (mother and child are not victims); and 4) No Abuse Discontinuity (only children are victims). **Methods:** Mothers completed a series of self-report measures assessing maternal characteristics (e.g., history of intimate partner victimization, psychological functioning), parenting and familial characteristics (e.g., cohesion, conflicts, empowerment), and demographic variables (e.g., early maternity, income, education). **Results:** The four groups were compared using analyses of variance and chi-square analyses. Overall, mothers in the CSA Continuity group showed an increased number of risk factors compared to the mothers in the other three groups; however, mothers in the No Abuse Discontinuity group also presented with high levels of risk factors. **Conclusions:** Findings suggest that practitioners should be attentive to the needs of the mothers of young CSA victims they are serving, since mothers involved in the cycle of intergenerational continuity appear to be particularly vulnerable and distressed.

Keywords: Child sexual abuse, Intergenerational cycles, Risk factors, Protective factors

Multilevel factors associated with the intergenerational continuity of child sexual abuse

Child sexual abuse (CSA) is a pervasive problem in society. Although definitions of CSA, and hence prevalence rates, have varied extensively in the literature (Haugaard, 2000; Pereda, Guilera, Forns, & Gómez-Benito, 2009), CSA generally refers to sexual abuse that was perpetrated against a child before the age of 18 (Pereda et al., 2009; Hillis, Anda, Felitti, & Marchbanks, 2001). In a meta-analysis consisting of over 300 international studies, self-reported prevalence rates of CSA were approximately 20% for women and 8% for men (Stoltenborgh, van Ijzendoorn Euser, & Bakermans-Kranenburg, 2011). This is particularly concerning given that CSA has been associated with a myriad of negative consequences, not only for the victim, but also for future generations of children given its tendency to show intergenerational continuity (Marcenko, Kemp & Larson, 2000; Roberts, O'Connor, Dunn, Golding & The ALSPAC Study Team, 2004; Trickett, Noll, & Putnam, 2011). As such, the present study aimed to identify factors associated with the intergenerational continuity of CSA.

Intergenerational Continuity of Child Sexual Abuse

Children born to sexually abused mothers are at an increased risk of experiencing various forms of abuse themselves and are more likely be removed from their homes compared to children of mothers with no CSA history (Marcenko et al., 2000; Trickett et al., 2011). Concomitantly, a maternal history of CSA has consistently been identified as a risk factor for CSA occurring in the next generation (e.g., McCloskey & Bailey, 2000; Testa, Hoffman, & Livingston, 2011). However, mothers who have been sexually abused are rarely the perpetrators of the abuse that occurs in the subsequent generation. Rather, evidence suggests that the removal of children from their care is largely attributable to substance abuse issues (Marcenko et al., 2000; Trickett et. al., 2011) and the tendency to unintentionally recreate environmental conditions that are conducive to abuse (Trickett et al., 2011). While it is essential to keep in mind that the

perpetrator is always the one responsible for CSA, understanding other factors that might confer a greater risk for the victimization of children is of the utmost importance. Indeed, such investigations can help identify potential targets for prevention efforts and inform the development of more effective interventions that are tailored to the needs of CSA victims and their families.

In an effort to elucidate the mechanisms by which intergenerational continuity occurs, Baril and Tourigny (2015) proposed an explanatory model grounded in theories of complex trauma and the existing literature concerning the etiology and consequences of CSA. According to this model, the victim's reaction to CSA will be influenced by abuse-related characteristics (e.g., severity, frequency, age of onset) as well as the co-occurrence of other forms of victimization in childhood. Subsequently, the long-term sequelae of CSA – including the mothers' neurobiological response to trauma, psychological factors (e.g., psychopathology and coping), as well as relational difficulties – increase the risk of CSA in children through a variety of complex trajectories. More specifically, it is thought that the negative consequences associated with CSA can be exacerbated or re-activated over time, particularly in the context of perinatal difficulties (see Leeners, Richter-Appelt, Imthurn, & Rath, 2006 for review), which in turn, can interfere with mothers' parental role. Taken together, the difficulties that mothers experience as a consequence of their CSA history may jeopardize parenting or contribute to the development of child characteristics that are sought out by abusers (e.g., social isolation, behaviour problems), thereby increasing the child's vulnerability to sexual victimization. The next sections will review the most salient factors that have been linked with the intergenerational continuity of CSA.

Maternal Characteristics

Childhood trauma. Evidence suggests that approximately 50% of mothers whose children have been sexually abused have also been victims of CSA themselves (Cyr, McDuff, &

Hébert, 2013; Pereda et al., 2009). In addition to CSA, the co-occurrence of other forms of maltreatment is common and tends to be associated with worse outcomes (Bouchard, Tourigny, Hébert, & Cyr, 2008; Edwards, Holden, Felitti, & Anda, 2003). For example, exposure to intimate partner violence (IPV) in childhood has been positively correlated with the severity of CSA (Fergusson, McLeod, & Horwood, 2013) and sexually abused mothers were significantly more likely to have been exposed to IPV in childhood (Daignault, Hébert, Cyr, Pelletier, & McDuff, 2018) compared to those who had not experienced CSA. Childhood exposure to IPV has been associated with an increased risk of future family violence experiences (Heyman & Slep, 2002), but more research is needed to examine its potential role in the continuity of CSA specifically.

Psychological functioning. The relationship between CSA and psychological difficulties is well-established, with numerous studies documenting the link between CSA and various forms of psychopathology in adulthood such as posttraumatic stress disorder (Chen et al., 2010), depression (Rohde et al., 2008), anxiety disorders (Maniglio, 2013), substance use (Marcenko et al., 2000), and dissociation (Hall & Powell, 2000). Moreover, posttraumatic stress symptoms (Baril & Tourigny, 2016; Leifer, Kilbane, & Kalick, 2004) and maternal substance use (Leifer et al., 2004; McCloskey & Bailey, 2000) have been shown to increase the risk of CSA continuity. In turn, psychological distress might be exacerbated in the context of intergenerational continuity, wherein the mother's history of CSA and the disclosure of CSA on the part of her child both present themselves as stressors. Extant literature shows that parents who learn of their child's victimization, no matter if they are victims themselves, are susceptible to elevated levels of stress, psychiatric symptoms, and challenges related to parenting (Banyard, Rozelle, & Englund, 2001; Cyr et al., 2013). However, these difficulties appear to be more pronounced amongst sexually abused mothers (Hiebert-Murphy, 1998; Trickett et al., 2011).

Although there are links between CSA and the development of psychopathology, research has constantly identified a subgroup of victims reporting no symptomatology in adulthood (Finkelhor, 1990; Collishaw et al., 2007) that can thus be described as resilient. The strategies survivors used to cope with the abuse are thought to have a stronger influence on symptomatology than the abuse experience itself and could therefore have a protective effect against intergenerational cycles of CSA (Merrill, Thomsen, Sinclair, Gold, & Milner, 2001; Runtz & Schallow, 1997). Female CSA survivors who displayed higher levels of resilience were found more likely to engage in adaptive methods of coping to deal with stress (Banyard & Williams, 2007). However, CSA victims may be more likely to engage in avoidant coping when compared to their non-abused counterparts (e.g., Bal, Van Oost, De Bourdeaudhuij, & Crombez, 2003). Avoidant coping strategies have consistently been associated with negative outcomes in CSA survivors including psychological distress (Hébert, Daigneault, Collin-Vézina, & Cyr, 2007), depressive symptoms (Wright, Crawford, & Sebastian, 2007), and posttraumatic stress (Johnson, Sheahan, & Chard, 2004). Findings pertaining to approach coping strategies (e.g., social support seeking and problem-solving) are less stable (Walsh, Fortier, & DiLillo, 2010) in that some studies have failed to find relationships between these coping strategies and adjustment indices (Wright et al., 2007), while other studies suggest that reliance on approach coping is associated with more positive adaptation (McDonagh et al., 2005).

Relational difficulties and intimate partner violence victimization. In addition to these psychological problems, survivors of CSA also experience relational difficulties in adulthood that might contribute to the intergenerational continuity of abuse. Compared to those who have not experienced CSA, women who have been victimized display more insecure attachment patterns (Kwako, Noll, Putnam, & Trickett, 2010), lower levels of satisfaction in their intimate relationships (Friesen, Woodward, Horwood, & Fergusson, 2010) and higher levels of

interpersonal conflicts (Kernhof, Kaufhold, & Grabhorn, 2008). CSA survivors are also at an increased risk of being victims of IPV in adulthood (Trickett et al., 2011; Widom, Czaja, & Dutton, 2014), which in turn, has been associated with higher levels of psychological distress (Hébert et al., 2007) and an increased risk of CSA being perpetrated against one's own children (Baril & Tourigny, 2016). Further, the experience of additional traumas in adulthood has been negatively associated with resilience (Banyard & Williams, 2007) and positively associated with depression and dissociative symptoms, which increase the risk for further revictimization (Banyard, Williams, & Siegal, 2003). As such, women who experience IPV in addition to CSA may be faced with additional stressors that make it difficult to break the cycle of CSA.

Parenting and Familial Functioning

The relational difficulties that CSA survivors experience also extend to the realm of parenting. For example, maternal CSA has been associated with difficulties in the parental role including higher levels of parenting stress (Hugill, Berry, & Fletcher, 2017) and lower levels of parental self-efficacy (Fitzgerald, Shipman, Jackson, McMahon, & Hanley, 2005). Evidence suggests that perceptions of control and self-efficacy may be particularly important to women's well-being, especially in the context of parenting a sexually abused child. More specifically, lower levels of parental empowerment were found to predict clinical levels of distress amongst mothers of sexually abused children (Hébert et al., 2007). Consequently, parental sense of empowerment may be particularly important in the context of intergenerational continuity. Concomitant with higher levels of parenting stress and lower perceived competence, women who have experienced CSA also exhibit lower levels of supportive parenting (Trickett et al., 2011) and deficiencies in parental monitoring (Testa et al., 2011), which pose a risk for CSA in the next generation. In contrast, more positive parenting practices (Serbin & Karp, 2004), as well as higher levels of family cohesion and lower levels of conflict (McClure Chavez, Agars, Peacock,

& Matosian, 2007) are associated with resilience.

Demographic Risk Factors

In addition to the personal and familial risk factors outlined above, CSA is predictive of demographic risk factors that have been found to be associated with an increased likelihood of intergenerational continuity. For example, CSA has been associated with more non-traditional family structures (i.e., single mother or blended families; Roberts et. al., 2004), which increase the risk of sexual victimization in children (Black, Heyman, & Slep, 2001). CSA has also been linked to increased rates of teen motherhood and high school drop-out (Trickett et. al., 2011), which in turn, are associated with lower income, job instability, and lower occupational status (Serbin & Karp, 2004). Accordingly, younger maternal age and living in poverty have both been identified as significant predictors of CSA (MacMillan, Tanaka, Duku, Vaillancourt, & Boyle, 2013) and evidence suggests that lower levels of educational attainment are a risk factor for CSA in one's children (Assink et al., 2019). Conversely, having more formal education seems to be a buffering factor that protects against CSA (Serbin & Karp, 2014).

Rationale for the Current Study

Despite burgeoning interest in the phenomenon of intergenerational continuity of maltreatment the literature on CSA is still vastly underdeveloped (Baril & Tourigny, 2015) in that relatively few studies have identified factors that operate in the context of intergenerational continuity (e.g., Baril & Tourigny, 2016; Leifer et. al., 2004; McCloskey & Bailey, 2000; Testa et al., 2011; Trickett et. al., 2011).

In one of the more comprehensive studies to date, a cross-sectional study, Leifer and colleagues (2004) divided participants into four groups based on CSA status (i.e., abused or not abused) and whether there was continuity or discontinuity of the abuse. They found that mothers in the abuse continuity group (i.e., both themselves and their children had been sexually abused)

displayed higher levels of trauma-related symptomatology, substance abuse problems, and relationship difficulties relative to the other three groups. In contrast, mothers who showed abuse discontinuity (i.e., those who experienced CSA, but whose children did not) appeared to function just as well as mothers who had not been sexually abused (Leifer et al., 2004). Mothers who broke the cycle of CSA also reported experiencing less disruption in their childhood attachment relationships and more secure attachment styles in adulthood (Leifer et al., 2004), while mothers in the abuse continuity group reported the highest levels of disturbance in this domain. However, more research is needed to identify characteristics that distinguish between mother-child dyads who present with CSA continuity versus discontinuity. This kind of research is crucial, as it will help better identify children who may be at risk for CSA and inform the development of more effective interventions aimed at disrupting the cycle of intergenerational continuity.

In line with Baril and Tourigny's model (2015) and the empirical findings presented above, the present study examined how a) maternal characteristics (exposure to IPV in childhood, psychological functioning, and intimate partner violence victimization), b) parenting and familial characteristics (parental empowerment, support, and family cohesion and conflict) and c) demographic characteristics (early maternity, educational attainment, income, and family structure) differentiated between: 1) sexually abused mothers whose children were also sexually abused (CSA Both); 2) sexually abused mothers whose children were not sexually abused (CSA Mother); 3) mothers with no sexual abuse history whose children were sexually abused (CSA Child); and 4) mothers with no sexual abuse history whose children were not abused (CSA Neither). It was hypothesized that mothers in the CSA Both group would present with more difficulties and less protective factors across all three domains relative to mothers in the other three groups. This study fills important gaps in the literature and addresses some of the limitations identified by Thornberry et al. (2012) as it involves: 1) a very large sample of

participants, increasing its representativeness; 2) a clear definition of CSA; 3) the inclusion of comparison groups recruited concomitantly with the CSA groups, with an assessment of the CSA status within these groups; and 4) mostly validated measures/questions.

Methods

Participants

This study involved a secondary analysis of data regarding 1,250 mother–child dyads that were recruited over an 18-year period (1999–2017) in urban and suburban areas, from different projects on the developmental outcomes associated with CSA. The recruitment of sexually abused children between the ages of 3 to 14 years old ($M = 7.37$, $SD = 2.66$) took place in five specialized intervention sites offering services to sexually abused children and their families. Comparison groups of non-abused children were also recruited in public schools and daycare centres in Montreal, Quebec, Canada. Overall, 78.4% of child participants were girls and 21.6% were boys. Sex distribution was comparable for abused and non-abused children (girls = 79.1% vs 75.5% respectively; boys = 20.9% vs 24.5%) Similar to the procedure adopted by Leifer and colleagues (2004), the dyads originally separated into two groups based on the victimization status of the child were separated into four subgroups based on the sexual victimization status of the mother and the child: CSA Both ($n = 492$), CSA Mother ($n = 61$), CSA Child ($n = 505$), and CSA Neither ($n = 192$).

Procedures

Sexually abused children (in the CSA Both and CSA Child groups) were recruited during the intake interview at the intervention center. To be included, the specialized team at the centre had to confirm that CSA was highly likely to have occurred (i.e., non-contact CSA such as exhibitionism, clothed or unclothed touching, penetration, or attempted penetration). Parents were also required to speak French or English and to have no major disability that would prevent

them from understanding the questionnaires. Families completed the questionnaires at their center after parents gave informed written consent. Families with non-sexually abused children (CSA Mother and CSA Neither groups) were met at home. To ascertain that children in these two groups were not CSA victims, the recruitment ad clearly specified this requirement. Additionally, parents were asked a specific question about their child's victimization status in the questionnaires. Parents completed questionnaires alone (French or English), except if they needed assistance (e.g., for reading difficulties). Families in the groups with sexually abused children were clearly informed that their participation in the study was voluntary and that refusing to participate would not affect service provision. Ethics Committees of the CHU Sainte-Justine and the Université du Québec à Montréal approved all research procedures.

Measures

Maternal characteristics.

Childhood trauma. Childhood sexual abuse was assessed using one question answered by the mothers. Two additional retrospective questions using a dichotomous (*yes/no*) format were used to assess whether mothers had witnessed minor (e.g., pushing, throwing something) or severe (e.g., kicking, punching) forms of physical intimate partner violence in childhood.

Psychological functioning. A short, 6-item version of The Dissociative Experiences Scale II (DES-II; Carlson & Putnam, 1993) was used to assess the frequency of mothers' current dissociative experiences on a continuum ranging from 0 to 100. Five of the items were derived from the Absorption and Imaginative Involvement subscale while the sixth item was derived from the Amnestic Dissociation subscale. These items were selected based on findings showing they were able to differentiate victims of sexual abuse from non-victims (Giesbrecht, Merckelbach, & Geraerts, 2007). The 6-item version was shown to have adequate internal consistency ($\alpha = .80$). A subsample of 859 mothers had available dissociation scores.

The Psychiatric Symptom Index (PSI; Prévile, Boyer, Potvin, Perrault, & Légaré, 1992) is a 14-item self-report measure that assesses symptoms of irritability, depression, anxiety, and cognitive difficulties in the last week. Respondents were asked to rate the intensity of symptoms they experienced over the last week on a 4-point Likert-type scale ranging from (0 = *never* to 3 = *very often*). A total score for mothers' psychological distress, ranging from 0 to 100, was calculated based on the responses the 14 items. Internal consistency for the total score was $\alpha = .92$.

The Modified PTSD Symptom Scale – Self Report (MPSS-SR; Falsetti, Resnick, Resick, & Kilpatrick, 1993) is a 17-item self-report measure that assesses both the frequency and severity of current PTSD symptoms. The 17 items represent symptoms contained in the DSM-IV Posttraumatic Stress Disorder diagnosis (American Psychiatric Association, 1994). The MPSS-SR has been validated in samples reporting a wide range of traumatic events and the total score (derived from the frequency and severity subscales) has demonstrated good internal consistency (Falsetti et al., 1993). Mothers of sexually abused children (CSA Both and CSA Child) were asked to refer to the child's disclosure while answering items. The mothers from the CSA Mother group were asked to answer while thinking about their own histories of CSA, while mothers in the CSA Neither group were asked to think about the most stressful event they had ever experienced. The internal consistency for the total score was $\alpha = .96$. PTSD scores were available for a subsample of 810 mothers.

Brief versions of the Ways of Coping Questionnaire (WCQ; Bouchard, Sabourin, Lussier, Wright & Richer, 1995; Folkman & Lazarus, 1988) were used to measure mothers' coping. Mothers in the CSA Continuity and No Abuse Discontinuity groups were asked to indicate how they dealt with the disclosure of CSA by their child, while mothers in the CSA Discontinuity and No Abuse Continuity groups were asked to indicate how they dealt with a difficult event that

happened to their child. The present study used three subscales: 1) Distancing/Avoidance; 2) Seeking Social Support; and 3) Planful Problem Solving. Answers were recorded on a 4-point Likert-type scale ranging from 0 (*does not apply or not used*) to 3 (*used a great deal*). The three subscales had acceptable internal consistencies ($\alpha = .60$ for Distancing/Avoidance; $.75$ for Seeking Social Support; $.71$ for Planful Problem Solving).

Mothers' intimate partner violence victimization. Four items from the Conflict Tactics Scale (CTS-2; Straus, Hamby, Boney-McCoy, & Sugarman, 1996) were used to assess whether mothers had experienced acts of minor psychological aggression, severe psychological aggression, minor physical assault, and severe physical assault. Responses were recorded using a dichotomous (*yes/no*) format for lifetime victimization.

Parenting and familial characteristics.

Parental empowerment and support. The Family subscale of the Family Empowerment Scale (FES; Koren, DeChillo, & Friesen, 1992) was used to assess mothers' current sense of empowerment regarding their child. This subscale consists of five items that tap into mothers' self-perceptions surrounding their ability to support their child's growth and development, or handle problems that arise with their child. In addition, four items were developed based on the FES format to assess the support that the mother provides to her child following difficult situations (e.g., Hébert & Parent, 1999). Each item was rated on a 5-point Likert-type scale ranging from 1 (*not true at all*) to 5 (*very true*). The FES has been shown to have robust psychometric properties (Singh et al., 1995) and in the present study, the parental empowerment and support scales had acceptable internal consistencies ($\alpha = .78$ and $.75$ respectively).

Family cohesion and conflict. Two dimensions of the Family Relationship Index (18 items) derived from the Family Environment Scale – Real Form (FES – Form R; Moos & Moos, 1994) were used to assess the current social climate of families: 1) Family Cohesion; and 2)

Family Conflict. Mothers were asked to answer to each item based on whether they felt the statement provided was an accurate representation of their family. Responses were recorded using a dichotomous (*true/false*) format. Internal consistencies for the Family Cohesion and Family Conflict scales were $\alpha = .71$ and $.53$ respectively.

Demographic characteristics. Mothers reported on various demographic characteristics including the age they were when they gave birth to their participating child, annual family income, family structure (e.g., two-parent or single-parent family), and their level of education.

Results

The four groups of dyads were compared using analyses of variance and chi-square analyses depending on the scale of the dependent variable (continuous or dichotomous). Adjusted residuals were examined to see if there were more or less dyads than expected in each category; a value of ± 1.96 or higher was used as the cut-off. Results related to maternal characteristics are presented first, followed by those concerning parenting and familial characteristics, then demographic characteristics.

Maternal Characteristics

The means and percentages, as well as specific group differences for maternal variables are presented in Table 1.

Maternal childhood trauma. Significant differences between mothers in the four groups were identified with witnessing both minor and severe physical intimate partner violence in childhood: $\chi^2(3) = 46.88, p < .001$ and $\chi^2(3) = 33.02, p < .001$. Table 1 identifies specific group differences. Inspection of adjusted residuals reveals that there were more mothers than expected that had been exposed to minor and severe physical IPV in childhood in the CSA Both group and the reverse was true for the CSA Child and CSA Neither groups.

Maternal psychological functioning. The four groups of mothers also differed in their

scores on dissociation: $F(3, 858) = 20.59, p < .001$. Mothers with histories of CSA (CSA Both and CSA Mother) reported higher levels of dissociation than mothers without such histories. Mothers also differed in terms of their scores of psychological distress: $F(3, 1246) = 31.32, p < .001$. When examining the dichotomous clinical score of psychological distress, significant group differences were also found: $\chi^2(3) = 79.66, p < .001$. There were more mothers than expected that had clinical levels of distress in the CSA Both group, and less mothers than expected in the CSA Neither group. The highest scores for psychological distress were found in mothers from the CSA Both Group, followed by the mothers in the CSA Child and CSA Mother groups. In terms of posttraumatic stress symptoms, mothers also differed $F(3, 809) = 38.30, p < .001$. Mothers in the CSA Both group reported more post-traumatic stress symptoms than any other group of mothers, followed by mothers in the CSA Child group. The mothers of non-abused children had the lowest scores. When using a dichotomous clinical score of posttraumatic stress, significant group differences were also found: $\chi^2(3) = 79.66, p < .001$. There were more mothers than expected that had clinical levels of posttraumatic stress in the CSA Both group, and the reverse was true for the CSA Neither group.

Regarding their coping strategies, mothers in the four groups did not differ in their tendency to seek social support: $F(3, 1137) = 1.84, p = .14$. However, they differed in their use of problem-solving and avoidance coping: $F(3, 1137) = 9.47, p < .001$ and $F(3, 1137) = 14.97, p < .001$. Mothers in the CSA Both Group reported significantly more problem-solving than any other group of mothers. Mothers of sexually abused children (CSA Both and CSA Child) reported using more avoidant coping than mothers of non-abused children (CSA Neither and CSA Mother).

Mothers' intimate partner violence victimization. When they were compared on their

experiences of IPV victimization, mothers differed for both psychological and physical violence: $\chi^2(3) = 11.34, p = .01$ and $\chi^2(3) = 85.53, p < .001$. There were more mothers than expected that experienced psychological IPV in the CSA Both group, and less mothers than expected in the CSA Neither group. There were more mothers than expected who reported experiencing physical IPV in the CSA Both group, and less in the CSA Neither and CSA Mother groups.

Summary of maternal characteristics. To summarize, mothers in the CSA Both group, when compared to mothers in the CSA Mother group (only difference is the victimization status of the children), reported more problem-solving and avoidant coping, had higher levels of psychological distress, endorsed more posttraumatic stress symptoms, and were more likely to have been physically abused by a romantic partner. When compared to the mothers in the CSA Child group, mothers in the CSA Both group (only difference is the victimization status of the mother) were more likely to report having witnessed severe and minor physical violence in childhood, reported more problem-solving, dissociation, and psychological distress, had higher levels of posttraumatic stress symptoms, and were more likely to report having been physically and psychologically abused by a romantic partner. Mothers in the CSA Child group, when compared to mothers in the CSA Neither group (only difference is the victimization status of the children), reported more avoidant coping, more psychological distress and post-traumatic stress symptoms, and more physical abuse by a romantic partner.

Parental and Familial Characteristics

The means and percentages, as well as specific group differences for parental and familial variables are presented in Table 3. Overall, the ANOVA indicated that the scores on empowerment ($F(3, 1118) = 4.81, p = .002$) and parental support ($F(3, 1044) = 19.71, p < .001$) differed across groups, but post-hoc analyses revealed non-significant differences between mothers in the four groups. Family cohesion appeared to differ across groups of mothers ($F(3,$

1228) = 11.87, $p < .001$), with mothers in the CSA Neither group having the highest scores and mothers with histories of CSA (CSA Both and CSA Mother groups) having the lowest scores. Family conflicts also differed ($F(3, 1226) = 6.98, p < .001$) in that mothers with histories of CSA reported higher levels of family conflict, while mothers without such histories reported lower levels of conflict.

Summary of parental and familial characteristics. To summarize, the CSA Child group had higher levels of family cohesion and less family conflicts than the CSA Both group. When the CSA Child group was compared to the CSA Neither group, the former reported lower levels of family cohesion.

Demographic Characteristics

The means and percentages as well as specific group differences for demographic variables are presented in Table 3. When groups were compared based on the age of the mother when the child was born, significant differences appeared: $\chi^2(3) = 46.50, p < .001$. There were more mothers than expected from the CSA Both group that had a child at or before the age of 21, and less mothers than expected in the CSA Neither group. Groups also differed regarding their annual family income: $\chi^2(3) = 131.76, p < .001$. There were more families than expected from the CSA Both group that had an annual income under \$40,000. There were also more families than expected from the CSA Neither and CSA Mother groups that had incomes of \$40,000 or more. The proportions of single-parent families, intact families, and blended families also differed: $\chi^2(3) = 68.92, p < .001$, $\chi^2(3) = 209.98, p < .001$, and $\chi^2(3) = 28.24, p < .001$. There were more single-parent families and less intact families than expected in the CSA Both and CSA Child groups. Conversely, there were less single-parent families and more intact families than expected in the two other groups. For blended families, there were more than expected in the CSA Both group and less than expected in the CSA Neither and CSA Mother groups. Mothers'

education also varied across groups: $\chi^2(3) = 111.73, p < .001$. There were more mothers than expected with high school or lower education in the CSA Both group. There were more mothers than expected for the CSA Neither group with college levels of education or higher.

Summary of demographic characteristics. To summarize, when families in the CSA Both group were compared to the CSA Mother group, those in the former group were more likely to have an annual family income of less than \$40,000. They were also more likely to be a single-parent family and less likely to be an intact family. The CSA Child group had higher rates of incomes over \$40,000 than the CSA Both Group, but higher rates of low income (< \$40, 000 yearly) when compared to the CSA Neither group. The CSA Child group was also more likely to be a single-parent family or a blended family and less likely to be an intact family when compared to the CSA Neither group. With respect to education, mothers in the CSA Both group were less likely to have post-secondary education when compared to mothers in the CSA Child group. When compared to mothers in the CSA Neither Group, mothers in the CSA Child group were also less likely to have a post-secondary level of education. Finally, the percentages of early maternity were the highest in the groups that included sexually abused children.

Discussion

The aim of this study was to expand on the findings from Leifer et al. (2004) and identify multilevel risk and protective factors associated with the intergenerational continuity of CSA in a considerable sample of mother–child dyads ($n = 1,250$). In line with Baril and Tourigny’s model (2015), dyads manifesting CSA continuity and discontinuity were compared on several factors including maternal psychological functioning and IPV histories, parenting and familial characteristics, and demographic characteristics. Our hypothesis was partially supported, as mothers in the CSA Both group showed an increased number of risk factors compared to the mothers in the other three groups, however, mothers in the CSA Child group also presented with

high levels of risk factors. We want to reiterate that the perpetrator is always the one responsible for CSA and that the goal of documenting demographic, maternal, and familial risk factors in the present study was to provide further information about the needs of mothers and families who are affected by CSA. It is our hope that such information can inform practitioners about important targets for intervention and increase our ability to prevent the recurrence of CSA in the next generation. Specific group comparisons are discussed further, followed by the limitations and implications of the present study.

CSA Both vs. CSA Mother

Results indicate that when compared to mothers that broke the cycle of CSA, mothers where continuity was observed were more likely to have low levels of income and to be the head of a single-parent family. This is consistent with studies showing that these are risk factors associated with CSA (Assink et al., 2019). Thus, it appears that better financial conditions and intact families may be protective against the intergenerational continuity of CSA.

The higher levels of income and rates of intact families among the CSA Mother group could be partly due to their better mental health (Sareen, Afifi, McMillan, & Asmundson, 2011). Accordingly, these mothers reported less depressive, anxiety, and post-traumatic stress symptoms than those in the CSA Both group. However, because of the cross-sectional nature of this study, we cannot ascertain whether the mental health symptoms reported by mothers in the CSA Both group appeared or increased only after the disclosure of CSA by their child (Banyard et al., 2001; Cyr et al., 2013; Hiebert-Murphy, 1998; Trickett et al., 2011). It is worth noting that our results pertaining to the post-traumatic stress symptoms of CSA Both group are consistent with those of Leifer et al. (2004), as well as the findings related to their IPV victimization in adulthood. Specifically, mothers in the CSA Continuity group experienced higher levels of post-traumatic

stress symptoms and had more experiences of victimization in adulthood relative to the other three groups.

The increased risk of having experienced physical violence at the hand of an intimate partner amongst the CSA Both group could also be a factor contributing to their mental health difficulties and their higher rates of separation from their child's father (Beydoun, Williams, Beydoun, Eid, & Zonderman, 2017; Campbell, 2002). Additionally, according to Baril and Tourigny (2015; 2016), IPV could be associated with an increased risk of having a partner that commits CSA. Interestingly, mothers in the CSA Both and CSA Mother groups did not report different levels of family cohesion and conflict. While this might appear in contradiction to the finding that CSA Both mothers experienced more IPV, it is important to keep in mind that IPV victimization in our study was a lifetime measure, while family cohesion and conflict concerned the current family situation. Current levels of cohesion and conflict might be conflated with the family structure, with single mothers reporting lower levels of conflicts than mothers with a partner. Accordingly, more mothers in the CSA Both group than in the CSA Mother group were single.

Finally, another difference between mothers in the CSA Both and CSA Mother groups relates to their coping strategies. Mothers in the CSA Both group reported more avoidant and problem-solving coping than mothers in the CSA Mother group. While avoidant coping has consistently been associated with worse outcomes in CSA victims (e.g. Hébert et al., 2007), findings regarding problem-solving have been inconsistent, sometimes being associated with positive outcomes and sometimes not (e.g. Wright et al., 2007, McDonagh et al., 2005). Mothers in both groups where the child was sexually abused reported using more problem-solving and avoidant coping in general, indicating that this might be due to the fact that these mothers are currently facing a difficult situation that compels them to engage in these forms of coping,

whereas this might not be the case for mothers in the two other groups. Mothers from the CSA Both and CSA Mother groups reported equal levels of empowerment and support in their role as parent.

CSA Both vs. CSA Child

Comparing mothers in the CSA Both group to those in the CSA Child group can offer greater insight into how mothers of sexually abused children differ depending on their own history of CSA. Our results show that mothers who experienced dual traumas (i.e., being sexually abused themselves and learning that their child has been sexually abused) were presenting with higher levels of mental health difficulties, specifically dissociation, depressive symptoms, irritability, post-traumatic stress symptoms, and general psychological distress. This is consistent with Leifer et al. (2004) and with previous findings showing that even though a disclosure of CSA from ones' child is distressing for most parents, it represents a heightened burden of risk for mothers who have experienced this form of abuse themselves (Cyr et al., 2013, Hiebert-Murphy, 1998). This could be explained, at least in part, by the re-experiencing symptoms that could be triggered by such a disclosure. Interestingly though, mothers in the CSA Both group reported using more problem-solving coping than mothers in the CSA Child group, which has actually been associated with better outcomes in CSA victims (McDonagh et al., 2005). It is possible that their prior experience of being sexually abused provided these mothers with better knowledge of what should be done in this situation or made them more eager to do something tangible to address the problem, whereas mothers without such prior history might have felt less equipped to cope with this novel situation.

Another finding regarding mothers in the CSA Both vs. CSA Child group is their higher rates of other forms of victimization. Indeed, mothers in these groups reported higher rates of childhood exposure to IPV as well as higher rates of psychological and physical abuse at the hand of an

intimate partner in adulthood. This is not surprising given the abundant literature documenting polyvictimization (e.g., Turner, Finkelhor, & Ormrod, 2010) and revictimization in CSA victims (Trickett et al., 2011, Widom et al., 2014). Also, in line with this literature, when compared to mothers in the CSA Both group, mothers in the CSA Mother group reported similar rates of childhood exposure to IPV and psychological IPV victimization in adulthood.

The sociodemographic variables that discriminated between mothers in the CSA Both and CSA Child groups were their level of education and family income. Mothers in the former group reported lower levels of education and income. This is consistent with research showing that socioeconomic disadvantage and low education are risk factors for CSA (Assink et al., 2019). However, mothers in the CSA Child group reported more family cohesion and lower levels of conflicts than mothers in the CSA Both group. This could be related to the higher levels of mental health issues and IPV victimization in the former group (Whisman, 2013).

CSA Mother vs. CSA Neither

Mothers in the CSA Mother group and those in the CSA Neither group (only difference is the victimization status of the mother) were similar in most aspects, except for exposure to severe physical violence in childhood, levels of education, some mental health variables (dissociation and psychological distress), and family cohesion. These results are in line with those of Leifer and colleagues (2004) showing that mothers who break the intergenerational cycle of CSA appear to have had the opportunity to process and resolve their trauma better than the mothers for whom continuity is observed. However, their higher levels of dissociation and psychological distress might indicate that they still experience lingering effects of their childhood victimization.

CSA Neither vs. CSA Child

Finally, mothers in the CSA Neither and CSA Child groups were different in many aspects, especially in terms of sociodemographic variables and mental health. Mothers from the CSA

Child group were more disadvantaged and were more likely to have had their child at 21 years old or younger. In this respect, they bore more resemblance to the mothers from the CSA Both group, which is consistent with findings produced by Leifer and colleagues (2004). Mothers in the CSA Child group also reported higher levels of avoidant coping and symptoms of depression, anxiety, and post-traumatic stress relative to mothers in the CSA Neither group. They were also more likely to have experienced physical abuse at the hands of an intimate partner and reported lower family cohesion. The higher rates of mental health symptoms reported by mothers in the CSA Child group could be related to the recent disclosure of CSA by their child and/or have been present even before the abuse, however the cross-sectional nature of our data precluded us from examining this. That being said, most of the differences that were observed between these groups represent well-known risk factors for CSA (Assink et al., 2019).

Limitations and Implications

While this study provides important information on multilevel factors that are associated with the intergenerational continuity of CSA, some limitations should be acknowledged, including the fact that this study relies on secondary analysis of data, which led to unequal age distributions in groups of abused and non-abused children. Furthermore, we only had data on two generations, rather than three, with the latter being more typical of intergenerational studies. As previously mentioned, this study relied on a cross-sectional design, and measures were taken after children's disclosure of CSA when applicable. Unfortunately, this prohibits us from drawing conclusions regarding the directionality of the effects and from being able to account for mothers' functioning prior to their child's disclosure in the CSA Both and CSA Child groups. In addition, the CSA victimization status of the mothers was only assessed using one question and the prompts to certain questionnaires differed depending on the victimization status of the children or the mothers, thereby limiting our ability to compare these scores across different

groups. Due to the nature of the data collection, the CSA Mother group had fewer participants than the other groups. Additionally, we cannot exclude the possibility that the group membership of certain dyads may have been subject to change given that the children were not yet 18 years old and the fact that mothers reported on the victimization status of their child in the CSA Mother and CSA Neither groups, even though CSA has low rates of disclosure. Finally, although the inclusion of a comparison group was a strength, it also led to comparisons between clinical and non-clinical populations, which can pose limitations with regard to the interpretation of these findings.

Despite these limitations, this study has important strengths, including an impressive sample size and the comprehensive nature of the assessment. Future studies should build on the current findings by examining fathers and other factors from Baril and Tourigny's model (2015) that were not included here, such as the support received by abused parents in childhood and perinatal experiences. Indeed, it is well documented that general and specific parental support received following disclosure of CSA can have major impacts on trajectories of resilience in victims (e.g., Domhardt, Münzer, Fegert, & Goldbeck, 2015). Furthermore, a growing body of research shows that perinatal experiences, such as psychopathology, could act as a major risk factor for the intergenerational continuity of child abuse (Dixon et al., 2004, Plant et al., 2013). Future studies could also use more detailed measures of the different constructs examined in this study (e.g. parenting practices, mothers' romantic relational functioning, mothers' psychopathology) and include a comprehensive assessment of childhood maltreatment. Prospective longitudinal studies should also be implemented in order elucidate causal mechanisms implicated in intergenerational cycles of CSA.

There are several practical implications for intervention that can be derived from this study and

applied in the context of child welfare agencies. Firstly, maternal histories of CSA should be routinely assessed when children present for CSA intervention or assessment. Practitioners who are providing care to young CSA victims should also pay close attention to their mothers' mental status and provide referrals as necessary, since mothers in the CSA Both group appeared particularly vulnerable and distressed. Trauma-informed interventions should be provided to these mothers in the context of the intervention for their abused child to ensure that they are able to function as supports, since research has consistently shown that maternal support following CSA is strongly associated with resilience in victims (Domhardt et al., 2015). Also, with avoidant coping being higher in both groups of mothers with sexually abused children, interventions aiming at reducing their reliance on such coping may be beneficial as they would enable mothers to process and heal from their traumas, which in turn, could make them better supports for their children. The present study also showed that IPV victimization in adulthood appears to be an important risk factor for CSA, highlighting the importance of resources and interventions addressing this issue for affected families. As such, it could be relevant to assess for the presence of CSA in interventions with families who are reported to child welfare services for exposure to intimate partner violence.

On the positive side, a general finding of this study is that achieving higher levels of education and income may serve as a protective factor against CSA. Policies that are geared toward making sure that all families, and especially mothers with a history of CSA, have access to resources that will enable them to achieve their professional aspirations appears essential. Consequently, practitioners who are treating young CSA victims might also play a role in referring mothers to resources (e.g., subsidized childcare services, free second-language classes, food banks, supportive housing) that could help mitigate some of the barriers that women may face when trying to advance their education or pursue a new career path. To conclude, all CSA victims

should be provided with affordable, accessible, and high-quality therapeutic services to ensure that they have the opportunity to process and resolve their sexual trauma, and any other interpersonal and complex traumas that they may have been exposed to throughout their development. Maximizing the chances for every victim to overcome their trauma could substantially reduce the risk of sexual abuse for the future generations of children.

References

- American Psychiatric Association (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.
- Assink, M., van der Put, C. E., Meeuwse, M. W., de Jong, N. M., Oort, F. J., Stams, G. J. J., & Hoeve, M. (2019). Risk factors for child sexual abuse victimization: A meta-analytic review. *Psychological Bulletin*. doi:10.1037%2Fbul0000188
- Bal, S., Van Oost, P., De Bourdeaudhuij, I., & Crombez, G. (2003). Avoidant coping as a mediator between self-reported sexual abuse and stress-related symptoms in adolescents. *Child Abuse & Neglect*, 27(8), 883-897. doi:10.1016/S0145-2134(03)00137-6
- Banyard, V. L., Rozelle, D., & Englund, D. W. (2001). Parenting the traumatized child: Attending to the needs of nonoffending caregivers of traumatized children. *Psychotherapy: Theory, Research, Practice, Training*, 38(1), 74-87. doi:10.1037/0033-3204.38.1.74
- Banyard, V. L., & Williams, L. M. (2007). Women's voices on recovery: A multi-method study of the complexity of recovery from child sexual abuse. *Child Abuse & Neglect*, 31(3), 275-290. doi:10.1016/j.chiabu.2006.02.016
- Banyard, V. L., Williams, L. M., & Siegel, J. A. (2003). The impact of complex trauma and depression on parenting: An exploration of mediating risk and protective factors. *Child Maltreatment*, 8(4), 334-349. doi:10.1177/1077559503257106
- Baril, K., & Tourigny, M. (2015). Le cycle intergénérationnel de la victimisation sexuelle dans l'enfance: modèle explicatif basé sur la théorie du trauma. *Carnet de Notes sur les Maltraitances Infantiles*, (1), 28-63.
- Baril, K., & Tourigny, M. (2016). Facteurs maternels associés au cycle intergénérationnel de la victimisation sexuelle dans l'enfance parmi des femmes de la population générale. *Canadian Journal of Behavioural Science*, 48(4), 266-277. doi:10.1037/cbs0000052

- Beydoun, H. A., Williams, M., Beydoun, M. A., Eid, S. M., & Zonderman, A. B. (2017). Relationship of physical intimate partner violence with mental health diagnoses in the nationwide emergency department sample. *Journal of Women's Health, 26*(2), 141-151. doi:10.1089/jwh.2016.5840
- Black, D. A., Heyman, R. E., & Slep, A. M. S. (2001). Risk factors for child sexual abuse. *Aggression and Violent Behavior, 6*(2-3), 203-229. doi:10.1016/S1359-1789(00)00023-9
- Bouchard, G., Sabourin, S., Lussier, Y., Richer, C., & Wright, J. (1995). Nature des stratégies d'adaptation au sein des relations conjugales: présentation d'une version abrégée du Ways of Coping Questionnaire. *Canadian Journal of Behavioural Science, 27*(3), 371-377. doi:10.1037/0008-400X.27.3.371
- Bouchard, E. M., Tourigny, M., Joly, J., Hébert, M., & Cyr, M. (2008). Les conséquences à long terme de la violence sexuelle, physique et psychologique vécue pendant l'enfance. *Revue d'Épidémiologie et de Santé Publique, 56*(5), 333-344. doi:10.1016/j.respe.2008.06.260
- Campbell, J. C. (2002). Health consequences of intimate partner violence. *The Lancet, 359*(9314), 1331-1336. doi:10.1016/S0140-6736(02)08336-8
- Carlson, E. B., & Putnam, F. W. (1993). An update on the dissociative experiences scale. *Dissociation: Progress in the Dissociative Disorders, 6*(1), 16-27.
- Chen, L. P., Murad, M. H., Paras, M. L., Colbenson, K. M., Sattler, A. L., Goranson, E. N., ... & Zirakzadeh, A. (2010). Sexual abuse and lifetime diagnosis of psychiatric disorders: systematic review and meta-analysis. *Mayo Clinic Proceedings, 85*(7), 618-629. doi:10.4065/mcp.2009.0583
- Collishaw, S., Pickles, A., Messer, J., Rutter, M., Shearer, C., & Maughan, B. (2007). Resilience to adult psychopathology following childhood maltreatment: Evidence from a community sample. *Child Abuse & Neglect, 31*(3), 211-229. doi:10.1016/j.chiabu.2007.02.004

- Cyr, M., McDuff, P., & Hébert, M. (2013). Support and profiles of nonoffending mothers of sexually abused children. *Journal of Child Sexual Abuse, 22*(2), 209-230.
doi:10.1080/10538712.2013.737444
- Daignault, I. V., Hébert, M., Cyr, M., Pelletier, M., & McDuff, P. (2018). Correlates and predictors of mothers' adaptation and trauma symptoms following the unveiling of the sexual abuse of their child. *Journal of Interpersonal Violence, 00*(0), 1-25.
doi:10.1177/0886260518808849
- Dixon, L., Hamilton-Giachritsis, C., & Browne, K.D. (2004). Risk factors and behavioural measures of parents abused as children: A mediational analysis of the intergenerational continuity of child maltreatment. *Journal of Child Psychology and Psychiatry,*
doi:10.1111/j.1469-7610.2004.00340.x.
- Domhardt, M., Münzer, A., Fegert, J. M., & Goldbeck, L. (2015). Resilience in survivors of child sexual abuse: A systematic review of the literature. *Trauma, Violence, & Abuse, 16*(4), 476-493. doi:10.1177/1524838014557288
- Edwards, V. J., Holden, G. W., Felitti, V. J., & Anda, R. F. (2003). Relationship between multiple forms of childhood maltreatment and adult mental health in community respondents: Results from the adverse childhood experiences study. *American Journal of Psychiatry, 160*(8), 1453-1460. doi:10.1176/appi.ajp.160.8.1453
- Falsetti, S. A., Resnick, H. S., Resick, P. A., & Kilpatrick, D. G. (1993). The modified PTSD symptom scale: a brief self-report measure of posttraumatic stress disorder. *The Behavior Therapist, 16*, 161-162.
- Fergusson, D. M., McLeod, G. F., & Horwood, L. J. (2013). Childhood sexual abuse and adult developmental outcomes: Findings from a 30-year longitudinal study in New Zealand. *Child Abuse & Neglect, 37*(9), 664-674. doi:10.1016/j.chiabu.2013.03.013

- Finkelhor, D. (1990). Early and long-term effects of child sexual abuse: An update. *Professional Psychology: Research and Practice*, *21*(5), 325-330. doi:10.1037/0735-7028.21.5.325
- Fitzgerald, M. M., Shipman, K. L., Jackson, J. L., McMahon, R. J., & Hanley, H. M. (2005). Perceptions of parenting versus parent-child interactions among incest survivors. *Child Abuse & Neglect*, *29*(6), 661-681. doi:10.1016/j.chiabu.2004.10.012
- Folkman, S., & Lazarus, R. S. (1988). Coping as a mediator of emotion. *Journal of Personality and Social Psychology*, *54*(3), 466-475. doi:10.1037/0022-3514.54.3.466
- Friesen, M. D., Woodward, L. J., Horwood, L. J., & Fergusson, D. M. (2010). Childhood exposure to sexual abuse and partnership outcomes at age 30. *Psychological Medicine*, *40*(4), 679-688. doi:10.1017/S0033291709990389
- Giesbrecht, T., Merckelbach, H., & Geraerts, E. (2007). The dissociative experiences taxon is related to fantasy proneness. *The Journal of Nervous and Mental Disease*, *195*(9), 769-772. doi:10.1097/NMD.0b013e318142ce55
- Hall, J. M., & Powell, J. (2000). Dissociative experiences described by women survivors of childhood abuse. *Journal of Interpersonal Violence*, *15*(2), 184-204. doi:10.1177/088626000015002005
- Haugaard, J. J. (2000). The challenge of defining child sexual abuse. *American Psychologist*, *55*(9), 1036-1039. doi:10.1037/0003-066X.55.9.1036
- Hébert, M., Daigneault, I., Collin-Vézina, D., & Cyr, M. (2007). Factors linked to distress in mothers of children disclosing sexual abuse. *The Journal of Nervous and Mental Disease*, *195*(10), 805-811. doi:10.1097/NMD.0b013e3181568149
- Hébert, M., & Parent, N. (1999). *Feelings and actions of parents*. Unpublished document. Sainte-Foy, QC: Department of Measurement and Evaluation, Laval University.
- Heyman, R. E., & Slep, A. M. S. (2002). Do child abuse and interparental violence lead to

adulthood family violence?. *Journal of Marriage and Family*, 64(4), 864-870.

doi:10.1111/j.1741-3737.2002.00864.x

Hiebert-Murphy, D. (1998). Emotional distress among mothers whose children have been sexually abused: The role of a history of child sexual abuse, social support, and coping. *Child Abuse & Neglect*, 22(5), 423-435. doi: 10.1016/S0145-2134(98)00006-4

Hillis, S. D., Anda, R. F., Felitti, V. J., & Marchbanks, P. A. (2001). Adverse childhood experiences and sexual risk behaviors in women: a retrospective cohort study. *Family Planning Perspectives*, 206-211. doi:10.2307/2673783

Hugill, M., Berry, K., & Fletcher, I. (2017). The association between historical childhood sexual abuse and later parenting stress: a systematic review. *Archives of Women's Mental Health*, 20(2), 257-271. doi:10.1007/s00737-016-0708-3

Johnson, D. M., Sheahan, T. C., & Chard, K. M. (2004). Personality disorders, coping strategies, and posttraumatic stress disorder in women with histories of childhood sexual abuse. *Journal of Child Sexual Abuse*, 12(2), 19-39. doi:10.1300/J070v12n02_02

Kernhof, K., Kaufhold, J., & Grabhorn, R. (2008). Object relations and interpersonal problems in sexually abused female patients: An empirical study with the SCORS and the IIP. *Journal of Personality Assessment*, 90(1), 44-51. doi:10.1080/00223890701693728

Koren, P. E., DeChillo, N., & Friesen, B. J. (1992). Measuring empowerment in families whose children have emotional disabilities: a brief questionnaire. *Rehabilitation Psychology*, 37(4), 305-321.

Kwako, L. E., Noll, J. G., Putnam, F. W., & Trickett, P. K. (2010). Childhood sexual abuse and attachment: An intergenerational perspective. *Clinical Child Psychology and Psychiatry*, 15(3), 407-422. doi:10.1177/1359104510367590

Leeners, B., Richter-Appelt, H., Imthurn, B., & Rath, W. (2006). Influence of childhood sexual

abuse on pregnancy, delivery, and the early postpartum period in adult women. *Journal of Psychosomatic Research*, 61(2), 139-151. doi:10.1016/j.jpsychores.2005.11.006

Leifer, M., Kilbane, T., & Kalick, S. (2004). Vulnerability or resilience to intergenerational sexual abuse: The role of maternal factors. *Child Maltreatment*, 9(1), 78-91.
doi:10.1177/1077559503261181

MacMillan, H. L., Tanaka, M., Duku, E., Vaillancourt, T., & Boyle, M. H. (2013). Child physical and sexual abuse in a community sample of young adults: Results from the Ontario Child Health Study. *Child Abuse & Neglect*, 37(1), 14-21. doi:10.1016/j.chiabu.2012.06.005

Maniglio, R. (2013). Child sexual abuse in the etiology of anxiety disorders: A systematic review of reviews. *Trauma, Violence, & Abuse*, 14(2), 96-112. doi:10.1177/1524838012470032

Marcenko, M. O., Kemp, S. P., & Larson, N. C. (2000). Childhood experiences of abuse, later substance use, and parenting outcomes among low-income mothers. *American Journal of Orthopsychiatry*, 70(3), 316-326. doi:10.1037/h0087853

McCloskey, L. A., & Bailey, J. A. (2000). The intergenerational transmission of risk for child sexual abuse. *Journal of Interpersonal Violence*, 15(10), 1019-1035.
doi:10.1177/088626000015010001

McClure, F. H., Chavez, D. V., Agars, M. D., Peacock, M. J., & Matosian, A. (2008). Resilience in sexually abused women: Risk and protective factors. *Journal of Family Violence*, 23(2), 81-88. doi:10.1007/s10896-007-9129-4

McDonagh, A., Friedman, M., McHugo, G., Ford, J., Sengupta, A., Mueser, K., ... & Descamps, M. (2005). Randomized trial of cognitive-behavioral therapy for chronic posttraumatic stress disorder in adult female survivors of childhood sexual abuse. *Journal of Consulting and Clinical Psychology*, 73(3), 515-524. doi:10.1037/0022-006X.73.3.515

Merrill, L. L., Thomsen, C. J., Sinclair, B. B., Gold, S. R., & Milner, J. S. (2001). Predicting the

impact of child sexual abuse on women: The role of abuse severity, parental support, and coping strategies. *Journal of Consulting and Clinical Psychology*, 69(6), 992.

doi:10.1037/0022-006X.69.6.992

Moos, R. H., & Moos, B. S. (1994). *Family environment scale manual*. Consulting Psychologists Press.

Pereda, N., Guilera, G., Forns, M., & Gómez-Benito, J. (2009). The prevalence of child sexual abuse in community and student samples: A meta-analysis. *Clinical Psychology Review*, 29(4), 328-338. doi:10.1016/j.cpr.2009.02.007

Plant, D. T., Barker, E. D., Waters, C. S., Pawlby, S., & Pariante, C. M. (2013). Intergenerational transmission of maltreatment and psychopathology: the role of antenatal depression. *Psychological Medicine*, 43(3), 519-528. doi:10.1017/S0033291712001298

Préville, M., Boyer, R., Potvin, L., Perrault, C., & Légaré, G. (1992). La détresse psychologique: Détermination de la fiabilité et de la validité de la mesure utilisée dans l'enquête santé Québec. Québec, Canada: Ministère de la Santé et des Services Sociaux du Québec.

Rohde, P., Ichikawa, L., Simon, G. E., Ludman, E. J., Linde, J. A., Jeffery, R. W., & Operskalski, B. H. (2008). Associations of child sexual and physical abuse with obesity and depression in middle-aged women. *Child Abuse & Neglect*, 32(9), 878-887.

doi:10.1016/j.chiabu.2007.11.004

Roberts, R., O'Connor, T., Dunn, J., Golding, J., & ALSPAC Study Team. (2004). The effects of child sexual abuse in later family life; mental health, parenting and adjustment of offspring. *Child Abuse & Neglect*, 28(5), 525-545. doi:10.1016/j.chiabu.2003.07.006

Runtz, M. G., & Schallow, J. R. (1997). Social support and coping strategies as mediators of adult adjustment following childhood maltreatment. *Child Abuse & Neglect*, 21(2), 211-226. doi:10.1016/S0145-2134(96)00147-0

- Sareen, J., Afifi, T. O., McMillan, K. A., & Asmundson, G. J. (2011). Relationship between household income and mental disorders: findings from a population-based longitudinal study. *Archives of General Psychiatry*, *68*(4), 419-427. doi:10.1001/archgenpsychiatry.2011.15
- Serbin, L. A., & Karp, J. (2004). The intergenerational transfer of psychosocial risk: Mediators of vulnerability and resilience. *Annual Review of Psychology*, *55*, 333-363. doi:10.1146/annurev.psych.54.101601.145228
- Singh, N. N., Curtis, W. J., Ellis, C. R., Nicholson, M. W., Villani, T. M., & Wechsler, H. A. (1995). Psychometric analysis of the family empowerment scale. *Journal of Emotional and Behavioral Disorders*, *3*(2), 85-91. doi:10.1177/106342669500300203
- Stoltenborgh, M., Van Ijzendoorn, M. H., Euser, E. M., & Bakermans-Kranenburg, M. J. (2011). A global perspective on child sexual abuse: meta-analysis of prevalence around the world. *Child maltreatment*, *16*(2), 79-101. doi:10.1177/1077559511403920
- Straus, M. A., & Hamby, S. L. Boney-McCoy, & Sugarman, DB (1996). The revised conflict tactics scales (CTS2). *Journal of Family Issues*, *17*, 283-316.
- Testa, M., Hoffman, J. H., & Livingston, J. A. (2011). Intergenerational transmission of sexual victimization vulnerability as mediated via parenting. *Child Abuse & Neglect*, *35*(5), 363-371. doi:10.1016/j.chiabu.2011.01.010
- Trickett, P. K., Noll, J. G., & Putnam, F. W. (2011). The impact of sexual abuse on female development: Lessons from a multigenerational, longitudinal research study. *Development and Psychopathology*, *23*(2), 453-476. doi:10.1017/S0954579411000174
- Turner, H. A., Finkelhor, D., & Ormrod, R. (2010). Poly-victimization in a national sample of children and youth. *American Journal of Preventive Medicine*, *38*(3), 323-330. doi:10.1016/j.amepre. 2009.11.012.
- Whisman, M. A. (2013). Relationship discord and the prevalence, incidence, and treatment of

psychopathology. *Journal of Social and Personal Relationships*, 30(2), 163-170.

doi:10.1177/0265407512455269

Widom, C. S., Czaja, S., & Dutton, M. A. (2014). Child abuse and neglect and intimate partner violence victimization and perpetration: A prospective investigation. *Child Abuse & Neglect*, 38(4), 650-663. doi:10.1016/j.chiabu.2013.11.004

Wright, M. O. D., Crawford, E., & Sebastian, K. (2007). Positive resolution of childhood sexual abuse experiences: The role of coping, benefit-finding and meaning-making. *Journal of Family Violence*, 22(7), 597-608. doi:10.1007/s10896-007-9111-1

Walsh, K., Fortier, M. A., & DiLillo, D. (2010). Adult coping with childhood sexual abuse: A theoretical and empirical review. *Aggression and violent behavior*, 15(1), 1-13.

doi:10.1016/j.avb.2009.06.009

Tables

Table 1.
Group Differences in Maternal Characteristics

Variable	CSA Continuity <i>M/%</i>	No Abuse Discontinuity <i>M/%</i>	No Abuse Continuity <i>M/%</i>	CSA Discontinuity <i>M/%</i>
Exposure to IPV in Childhood				
Minor physical violence (<i>n</i> = 1,023)	43.4% ^{+, a}	23.2% ^{-, b}	23.6% ^{-, b, c}	44.4% ^{a, c}
Severe physical violence (<i>n</i> = 1,022)	26.8% ^{+, a}	14.2% ^{-, b, c}	10.1% ^{-, c}	30.6% ^{a, b}
Psychological Functioning				
Coping – Social Support (<i>n</i> = 1,138)	8.22	7.93	8.11	7.36
Coping – Problem-Solving (<i>n</i> = 1,138)	8.78 ^a	8.16 ^b	7.77 ^b	7.39 ^b
Coping – Avoidance (<i>n</i> = 1,140)	4.93 ^a	4.51 ^{a, c}	3.18 ^b	3.46 ^{b, c}
Dissociation (<i>n</i> = 859)	21.11 ^a	13.58 ^b	11.55 ^b	24.30 ^a
Psychological Distress (<i>n</i> = 1,247)	39.38 ^a	34.10 ^b	21.83 ^c	31.93 ^b
Clinical Psychological Distress (<i>n</i> = 1,247)	65.8% ^{+, a}	53.9% ^b	28.1% ^{-, c}	50.8% ^{a, b}
Posttraumatic Stress (<i>n</i> = 810)	35.81 ^a	30.58 ^b	9.92 ^c	14.06 ^c
Clinical Posttraumatic Stress (<i>n</i> = 810)	28.7% ^{+, a}	22.4% ^a	2.8% ^{-, b}	2.9% ^{-, b}
IPV Victimization				
Psychological Abuse (<i>n</i> = 1,242)	86.5% ^{+, a}	79.2% ^{-, b}	79.7% ^{a, b}	76.7% ^{a, b}
Physical Abuse (<i>n</i> = 1,242)	51.6% ^{+, a}	41.6% ^b	15.6% ^{-, c}	21.7% ^{-, c}

Note. CSA Continuity: *n* = 492; No Abuse Discontinuity: *n* = 505; No Abuse Continuity: *n* = 192; CSA Discontinuity: *n* = 61. Scores with the same subscript are not significantly different from each other but are significantly different from those with different subscripts ($p < .05$). +/- flag observed values significantly different than expected as determined by an adjusted residual greater than 1.96.

Table 2
Group Differences in Parenting and Familial Characteristics

Variable	CSA Continuity	No Abuse Discontinuity	No Abuse Continuity	CSA Discontinuity
	<i>M</i>	<i>M</i>	<i>M</i>	<i>M</i>
Empowerment (<i>n</i> = 1,119)	21.72 ^a	21.95 ^a	21.96 ^a	20.32 ^a
Parental support (<i>n</i> = 1,045)	18.85 ^a	19.09 ^a	18.42 ^a	17.79 ^a
Family Cohesion (<i>n</i> = 1,229)	55.51 ^a	58.33 ^b	61.70 ^c	55.82 ^{a, b}
Family Conflicts (<i>n</i> = 1,227)	50.42 ^a	48.28 ^b	47.98 ^b	52.05 ^{a, b}

Note. CSA Continuity: *n* = 492; No Abuse Discontinuity: *n* = 505; No Abuse Continuity: *n* = 192; CSA Discontinuity: *n* = 61. Scores with the same subscript are not significantly different from each other but are significantly different from those with different subscripts ($p < .05$).

Table 3
Group Differences in Demographic Characteristics

Variable	CSA Continuity %	No Abuse Discontinuity %	No Abuse Continuity %	CSA Discontinuity %
Early Maternity (n = 1,250)				
Child born when mother was \leq 21 years old	24.8% ^{+, a}	21.2% ^a	3.1% ^{-, b}	9.8% ^{a, b}
Education (n = 1,239)				
High School or lower	57.3% ^{+, a}	44.9% ^b	12.5% ^{-, c}	45.9% ^{a, b}
CEGEP* or higher	42.7% ^{-, a}	55.1% ^b	87.5% ^{+, c}	64.1% ^{a, b}
Annual Family Income (n = 1,015)				
\leq \$39,999 CAN	71.3% ^{+, a}	61.0% ^b	19.2% ^{-, c}	32.4% ^{-, c}
\geq \$40,000 CAN	28.7% ^{-, a}	39.0% ^b	80.8% ^{+, c}	67.6% ^{+, c}
Family Structure (n = 1,239)				
Single-parent family	52.4% ^{+, a}	51.0% ^{+, a}	20.8% ^{-, b}	29.5% ^{-, b}
Intact Family	19.9% ^{-, a}	23.2% ^{-, a}	70.3% ^{+, b}	59.0% ^{+, b}
Blended family	25.4% ^{+, a}	24.2% ^a	8.9% ^{-, b}	11.5% ^{-, a, b}

Note. CSA Continuity: n = 492; No Abuse Discontinuity: n = 505; No Abuse Continuity: n = 192; CSA Discontinuity: n = 61. Scores with the same subscript are not significantly different from each other but are significantly different from those with different subscripts ($p < .05$). +/- flag observed values significantly different than expected as determined by an adjusted residual greater than 1.96. *In the Province of Quebec, CEGEP level of education reflects 13-to-14 years of education.