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The intersection of intimate partner violence and childhood sexual abuse in mother-child dyads

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ABSTRACT

Background: Child sexual abuse (CSA) and intimate partner violence (IPV) have been associated with negative consequences for adult victims and their children including a risk of revictimization and intergenerational continuity.

Objectives: The aim of this study was to document correlates of intergenerational cumulative trauma profiles in mother-child dyads.

Participants and setting: A sample of 997 sexually abused children (mean age = 7.61 years; 79.1% girls) and their mothers was recruited.

Methods: Latent Class Analysis (LCA) was used to identify classes of cumulative trauma among dyads. Classes were compared on validated measures of psychological functioning for both members of the dyads.

Results: Four distinct classes emerged: *CSA Only* (43.3%), *Intergenerational CSA with Psychological IPV* (14.2%), *Physical and Psychological IPV with Low Child Exposure* (24.0%) and *Intergenerational Polyvictimization* (18.5%). Comparisons generally revealed lower distress in *CSA Only* dyads, and higher levels of psychological difficulties in the two most victimized groups. However, the dose-response pattern was not as clear as expected, as the two most victimized groups did not differ in terms of psychological functioning.

Conclusions: This study shows that higher levels of intergenerational cumulative trauma are associated with increased psychological symptoms in mothers and more dissociation in their sexually abused children. Interventions should be adapted to the specific needs of families to prevent lasting intergenerational difficulties in trauma-exposed individuals.

1. Introduction

Intimate partner violence (IPV) is defined by the Centers for Disease Control and Prevention as “physical violence, sexual violence, stalking, or psychological aggression (including coercive acts) by a current or former intimate partner, whether or not the partner is a spouse” (Miller & McCaw, 2019; p. 850). In the United States, results from the National Intimate Partner and Sexual Violence Survey show that the lifetime prevalence of IPV and severe IPV is 37.3% and 23.2% for women, and 30.9% and 13.9% for men respectively (Miller & McCaw, 2019). As for child sexual abuse (CSA), it is defined by the World Health Organization (WHO) as “The involvement of

a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violate the laws or social taboos of society” (WHO, 1999; p. 75). It affects approximately 18.0% of women and 7.6% of men worldwide (Stoltenborgh, van IJzendoorn, Euser, & Bakermans-Kranenburg, 2011). IPV has been associated with a plethora of negative consequences for victims, including fatal and non-fatal injuries, chronic health conditions, harmful substance use, obstetrical and gynecologic complications (e.g., induced abortion, prematurity, low birth weight), psychological difficulties (e.g., depression, anxiety, post traumatic stress), and suicidal behaviors (Miller & McCaw, 2019; WHO, 2013). Similarly, CSA is associated with short- and long-term negative consequences for mental (e.g., depression, posttraumatic stress, dissociation), physical (e.g., obesity, cardiopulmonary symptoms), and sexual health (e.g., gynecological symptoms, sexually transmitted diseases), as well as impairment in interpersonal relationships (Abajobir, Kisely, Maravilla, Williams, & Najman, 2017; Daigneault, Vézina-Gagnon, Bourgeois, Esposito, & Hébert, 2017; Fergusson, McLeod, & Horwood, 2013). It has been consistently associated with a high risk of sexual revictimization or revictimization through IPV later in adolescence and adulthood (Hébert, Moreau, Blais, Lavoie, & Guerrier, 2017; Walker, Freud, Ellis, Fraine, & Wilson, 2019). These empirical findings are in line with the Complex Trauma Model, postulating that complex trauma – resulting from exposure to severe, repetitive, and prolonged stressors often involving attachment figures – has deleterious short- and long-term consequences on several aspects of individual's functioning, including affect dysregulation, dissociation, somatic dysregulation, impaired self-development, and disorganized attachment (Ford & Courtois, 2009). In line with this model and previous empirical findings, this study aimed to explore profiles of intergenerational intersection between IPV and CSA in mother-child dyads and their associated consequences on maternal and child psychological functioning.

1.1. Intergenerational consequences of IPV and CSA

Intergenerational impacts of IPV, such as mental health difficulties, physical health conditions, and an increased risk of being a victim or perpetrator of IPV in adolescence and adulthood, are documented in children exposed to IPV (Bair-Merritt, Zuckerman, Augustyn, & Cronholm, 2013; Miller & McCaw, 2019). These associations could be partly accounted for by the impacts of IPV on parenting. Indeed, a recent meta-analysis showed a negative correlation between IPV and positive parenting (e.g., parenting skills, connectedness) and a positive correlation between IPV and physical aggression and neglect (Chiesa et al., 2018). Further, intergenerational continuity of CSA, whereas children of abused parents are also sexually victimized, has been documented, showing the increased risk for children of sexually abused parents of being sexually abused themselves (Baril & Tourigny, 2015). Thus, children of sexually abused individuals are at heightened risk of both being exposed to IPV and sexually victimized in childhood (Bidarra, Lessard, & Dumont, 2016; Widom, Czaja, & Dutton, 2014). Pathways leading from CSA, to IPV victimization, and next generation's victimization are hypothesized to involve several mechanisms including disrupted parent-child attachment, parenting difficulties (e.g., harsh or permissive parenting), and psychopathology (Alexander, 2015; Langevin, Hébert, & Cabecinha-Alati, 2020).

1.2. Consequences associated with cumulative relational violence

It is well established that cumulative trauma is associated with increased mental health difficulties and symptom complexity compared to single forms of abuse or single events (e.g., Briere, Kaltman, & Green, 2008; Cloitre et al., 2009). In a sample of older adults (60 years), Ogle, Rubin, and Siegler (2013) found a dose-response relation between cumulative trauma and posttraumatic stress disorder (PTSD) symptoms. Further, childhood violence and adulthood physical assault were most strongly associated with PTSD. In adult survivors of CSA, a dose-response relation between cumulative child maltreatment and mental health difficulties (e.g., posttraumatic stress, anxiety, depression, eating disorders, dissociation) was identified (Steine et al., 2017). In a sample of college students, cumulative trauma was related to more symptoms of depression, dissociation, and PTSD, and high betrayal traumas (e.g., CSA) contributed to these symptoms the most (Martin, Cromer, DePrince, & Freyd, 2013).

In addition to these impacts on adult mental health, cumulative trauma is known to have deleterious consequences on parenting (Cabecinha-Alati, Langevin, & Montreuil, 2020). For example, Banyard, Williams, and Siegel (2003) found that higher rates of trauma exposure in mothers were associated with lower parenting satisfaction, child neglect, physical punishment, and reports to Child Protection Services (CPS). Another study reported that cumulative maternal trauma predicted child abuse potential, punitiveness, and aggression (Cohen, Hien, & Batchelder, 2008). Cumulative childhood maltreatment was also found to be associated with suboptimal emotion socialization practices in parents, that were in turn associated with the use of maladaptive emotion regulation strategies in school-aged children (Cabecinha-Alati, Langevin, Kern, & Montreuil, 2020). Therefore, cumulative experiences of interpersonal trauma do not only impact the victims but are likely to have negative consequences on their children.

Cumulative trauma is also associated with maladaptive outcomes in youth. Accumulated risks in childhood (child maltreatment, inter-parental violence, family disruption, low socioeconomic status, and high parental stress) was found to predict increased behavior problems in adolescence (Appleyard, Egeland, Dulmen, & Alan Sroufe, 2004). Another study showed that cumulative violence exposure was associated with symptoms of depression and anxiety, somatic complaints, delinquent behaviors, and academic failure (Margolin, Vickerman, Oliver, & Gordis, 2010). Yet, studies involving children are sparse. One such study documented the increased symptom complexity (e.g., depression, posttraumatic stress, anger) of school-aged children exposed to cumulative trauma including child maltreatment subtypes and witnessing IPV (Hodges et al., 2013). In a sample of sexually abused school-aged children, cumulative trauma (CSA physical abuse, psychological abuse, neglect, or exposure to IPV) predicted impaired emotion regulation and increased dissociation, which were in turn sequentially associated with internalizing and externalizing symptoms a year later (Hébert, Langevin, & Oussaid, 2018). Previous studies tend to indicate that emotion dysregulation and high dissociation in maltreated children are due to

insecure attachment relationships and altered neurobiology (Carvalho et al., 2016; Hébert, Langevin, & Charest, 2020).

Using Latent Class Analysis (LCA), Lanier, Maguire-Jack, Lombardi, Frey, and Rose (2018) documented the distinct impacts of various configurations of adverse childhood experiences (ACEs) on children's health. Children reporting zero or one ACE had better health outcomes than children reporting three or more ACEs, one or two ACEs, or a combination of parental mental illness and family poverty. Further, children exposed to IPV, but not mental illness, did not have poorer health outcomes than children with zero or one ACE. LCA is a person-centered approach that has the advantage, in the context of cumulative trauma studies, of allowing for naturally occurring subgroups of individuals to be formed based on their similar cumulative trauma experiences (Lanza & Cooper, 2016; von Eye, 2010). The main interest stems from the subsequent ability to compare these subgroups on various predictors or outcomes to determine the risk factors involved, and how different profiles of cumulative trauma types impact individuals' functioning (Ballard et al., 2015). Few studies used such an approach to document the consequences of cumulative trauma in children, and none, to our knowledge, has done so to document outcomes of intergenerational victimization profiles in mother-child dyads.

1.3. The present study

Despite findings showing intergenerational impacts of IPV and CSA, to date, most studies have examined the consequences of cumulative exposure on only one generation, and intergenerational configurations of traumatic events among mother-child dyads, as opposed to configurations in mothers or children alone, have not been documented in relation to their impacts on maternal and child's functioning. The current study will address these issues by deriving profiles of intergenerational cumulative trauma with dyads of sexually abused children and their mother. Further, the few studies involving samples of minors excluded preschool-aged children, even though the preschool years are an extremely sensitive developmental period where exposure to relational trauma can be especially detrimental (e.g. Cicchetti & Banny, 2014). To fill the identified gaps in past empirical reports and contribute to an enhanced knowledge of intergenerational configurations of cumulative trauma and their impacts, this study aimed to: 1) identify profiles of intergenerational victimization (childhood exposure to IPV, IPV victimization, CSA) in sexually abused preschool and school-aged children and their mother using LCA; and 2) document the outcomes associated with these profiles in terms of maternal and child psychological functioning (maternal psychological distress, PTSD symptoms, and dissociation; child dissociation and emotion dysregulation). We hypothesize that in our sample of sexually abused children and their mothers, various profiles of intergenerational victimization will be identified. While the exact configurations cannot be predicted, we expect one profile to involve highly poly-victimized dyads and one profile to involve dyads where few other traumatic events, apart from the sexual abuse of the child, are present. As past findings related to cumulative trauma in individuals, we expect that mental health difficulties in mothers and children will rise in a dose-response manner as the number of intergenerational victimization experiences increases.

Table 1
Sociodemographic and CSA characteristics of participants

Characteristic	M/n	SD/%
Child age	7.61	2.61
Child sex		
Boys	208	20.9%
Girls	789	79.1%
Mothers' age (<i>n</i> = 990)	34.14	6.34
Mothers' education (<i>n</i> = 986)		
High-school or less	503	51.0%
College or more	483	49.0%
Family structure (<i>n</i> = 996)		
Single-parent	515	51.7%
Intact, blended or other	481	48.3%
Annual family income (<i>n</i> = 832)		
<\$20,000 CAN	329	39.5%
\$20,000 or more	503	60.4%
Early maternity (yes)	229	23.0%
CSA severity (<i>n</i> = 958)		
Clothed touching or non-contact	64	6.7%
Unclothed touching	290	30.3%
Penetration or attempted penetration	604	63.0%
CSA frequency (<i>n</i> = 911)		
Single episode	276	30.3%
Few episodes	331	36.3%
Chronic	304	33.4%
Relationship with the perpetrator (<i>n</i> = 984)		
Intrafamilial	724	73.6%
Extrafamilial	260	26.4%

Note. CAN = Canadian; CSA = child sexual abuse.

2. Method

2.1. Participants

This study is a secondary analysis of data of a clinical sample of 997 sexually abused children aged 3 to 14 years old and their mothers. The recruitment of participants took place at five specialized intervention centres from Quebec, Canada, offering services to sexually abused children and their families. [Table 1](#) presents the sociodemographic characteristics of the families and the characteristics of the sexual abuse experienced by the children.

2.2. Procedures

The recruitment of mothers and their children took place during the initial visit to the intervention centre prior to service provision. After obtaining informed written consent from the mothers about their participation in the study, they completed the questionnaires on site. Families were aware that their participation in the study was voluntary and that not agreeing to participate would have no consequences on service provision. Inclusion criteria were: 1) corroboration of CSA by CPS; or expert judgement – following in-depth assessment of children and their families by a multidisciplinary team in a hospital clinic specialized in CSA – deemed that the child was a victim of sexual abuse; 2) speaking French or English; and 3) not presenting with a major disability which would prevent them from consenting to this study and/or understanding the questionnaires. Teachers and early childhood educators were sent the questionnaire via regular mail along with a consent form. One reminder was sent after a month. The study was approved by the CHU Sainte-Justine and Université du Québec à Montréal's Ethics Committees.

2.3. Measures

2.3.1. Sociodemographic characteristics

A sociodemographic questionnaire was used to obtain background information from the mothers (e.g., income, family structure, education). CSA characteristics for children were coded from children's clinical files from the intervention centres. A risk index, ranging from 0 to 4, was created using these four variables each assigned a value of one if participants reported: a) an annual income of less than \$20,000 CAN; b) elementary or high-school level of maternal education; c) single-parent family; and d) early motherhood (21 years old or less). A modified version of the History of Victimization Form ([Wolfe, Gentile, & Bourdeau, 1987](#)) was used to code information on the severity of the abuse experienced (involving penetration or attempted penetration), the duration, and the relationship with the perpetrator (intra-familial vs. extra-familial) from the clinical files of the children.

2.3.2. Maternal histories and psychological functioning

Mothers reported on their own histories of childhood sexual victimization using one question: "In your childhood, have you ever been sexually abused?" Two additional retrospective questions using a dichotomous (*yes/no*) format were used to evaluate whether mothers had witnessed minor (e.g., pushing, throwing of an object) or severe (e.g., kicking, punching) forms of physical IPV in their childhood.

Mothers reported on whether they had experienced psychological and physical IPV using four items of the Conflict Tactics Scale (CTS-2; [Straus, Hamby, Boney-McCoy, & Sugarman, 1996](#)). Scores were dichotomized (*yes/no*) for lifetime victimization. Due to the high prevalence of minor psychological IPV (e.g., yelling, swearing, insulting), only the presence of severe psychological IPV was used (i.e., destroying belongings, harshly criticizing appearance, or threatening to hit). If the mother answered *yes* for either item, an additional question was used to assess whether their child had witnessed these acts.

The 14-item Psychiatric Symptom Index (PSI; [Préville, Boyer, Potvin, Perrault, & Légaré, 1992](#)) was used to assess the mothers' symptoms of irritability, depression, anxiety, and cognitive difficulties in the last week. Participants were asked to rate the intensity of symptoms they experienced on a 4-point Likert-type scale ranging from (0 = never to 3 = very often). A total score of mothers' psychological distress ranging from 0 to 100 was calculated. Internal consistency for the total score was α 0.92.

A 6-item version of the Dissociation Experiences Scale II (DES-II; [Carlson & Putnam, 1993](#)) was used to evaluate the frequency of mothers' dissociative experiences on a continuum ranging from 0 to 100. One item was derived from the Amnesic Dissociation subscale whereas the five other items came from the Absorption and Imaginative Involvement subscales. These items were selected based on findings which showed that they were able to differentiate victims of sexual abuse from non-victims ([Giesbrecht, Merckelbach, & Geraerts, 2007](#)). The 6-item version has demonstrated moderate internal consistency (α 0.78). Dissociation scores were available from a subsample of 673 mothers (67.5% of total sample).

The 17-item Modified PTSD Symptom Scale–Self Report (MPSS-SR; [Falsetti, Resnick, Resick, & Kilpatrick, 1993](#)) is a validated measure that assesses both the frequency and severity of current PTSD symptoms. It represents symptoms contained in the DSM-IV PTSD diagnosis and has been validated in samples reporting a wide range of traumatic events. Mothers were asked to answer the items by referring to their child's disclosure of CSA. The total score demonstrated internal consistency (α 0.95). PTSD scores were available for a subsample of 667 mothers (66.9%).

2.3.3. Child psychological functioning

Parents completed the Child Dissociation Checklist to assess their children's dissociation symptoms (CDC; [Putnam, Helmers, & Trickett, 1993](#)). The CDC comprises 20 items rated on a 3-point Likert-type scale (0 = not true to 2 = very true) evaluating a wide range

of dissociative behaviors from typical (e.g. child daydreams) to pathological reactions (e.g. child has two personalities). A total score is summed ranging from 0 to 40 with a clinical cut-off score of >12 (Putnam et al., 1993). In the current sample, the total score demonstrated high internal consistency (α 0.82).

Child emotion dysregulation was assessed by teachers or early childhood educators reports on children's behavior problems using the Teacher Report Form from the Child Behavior Checklist (TRF; Achenbach & Rescorla, 2000, 2001). The frequency of behaviors in the last two-months was measured using a Likert-type scale (0 not true, 1 somewhat or sometimes true, 2 very true or often true). As per previous studies, scores from the Anxiety/Depression, Aggression, and Attention subscales of the TRF, known as the CBCL-Dysregulation Profile (Deutz et al., 2018; Hébert et al., 2020) were used to assess deficits in emotional regulation. A linear score was obtained by adding the T-scores of the three subscales. Internal consistency of the dysregulation score was acceptable (α = 0.95).

2.4. Data analyses

Descriptive statistics and correlations between study variables were conducted using SPSS 20. LCA were run in Mplus version 8.3 with the implementation of the Full-Information Maximum Likelihood (FIML) estimation for the treatment of missing data. In order to include both covariates and distal outcomes in the LCA, the three-step method was implemented manually using Wang and Wang (2020) guidelines. Adopting a conservative approach, we assumed that the variance of the distal outcomes varied across latent classes and used the DU3STEP auxiliary command. In order to determine the optimal number of classes, several indices were examined as recommended by (Wang & Wang, 2020): Akaike's information criterion (AIC), Bayesian information criterion (BIC), and sample-size adjusted Bayesian information criterion (ABIC). Additionally, the Lo-Mendell-Rubin likelihood ratio (LMR LR) test, adjusted Lo-Mendell-Rubin likelihood ratio test (ALMR LR), and bootstrap likelihood ratio test (BLRT) were used. Finally, the size of the groups (sufficiently large), the conceptual/clinical value of adding a class, entropy (closest to 1.0), and posterior probabilities (closest to 1.0) were also considered. The variables used to create the classes were: mothers' childhood exposure to physical IPV and CSA history, maternal lifetime physical and severe psychological IPV victimization, and child exposure to physical or severe psychological IPV. The Risk Index was included as a covariate for class membership and for the outcomes. The outcomes included were maternal psychological distress, posttraumatic stress symptoms, and dissociation, and child dissociation and emotion dysregulation. Chi-square analyses were performed a posteriori in SPSS to see if the CSA characteristics for children differed across classes.

3. Results

3.1. Preliminary analyses

Descriptive statistics for the full sample are presented in Table 2. Results show that about half of participating mothers reported a history of CSA (49.3%), and lifetime physical (46.6%) or severe psychological IPV (50.2%), while a third reported witnessing physical IPV (34.6%) in their childhood. Of the 490 mothers who reported a history of CSA, 56.3% were revictimised through severe psychological IPV in adulthood (vs. 44.1% of non-sexually abused mothers) and 59.6% through physical IPV (vs. 41.6%). Further, a total of 22.9% of mothers reported that their child witnessed at least one episode of physical IPV and 25.8% at least one episode of severe psychological IPV. Families had a mean of 1.5 sociodemographic risk factors. Means and standard deviations for dependent variables revealed great variability in scores among participants. Significant correlations were found between maternal dissociation, child dissociation, and emotion dysregulation and the risk index ($r = 0.110-0.137$). Significant positive correlations ranging from $r = 0.357$ to 0.589 were present between maternal outcomes. Child outcomes were also positively correlated ($r = 0.126$), and child dissociation ($r = 0.231-0.269$), but not emotion dysregulation ($r = -0.074-0.058$), was significantly correlated with the maternal outcomes.

Table 2
Descriptive statistics for the full sample.

Variable	N	% (n)
<i>Used for class creation</i>		
Witness of physical IPV in childhood (mother)	997	34.6 (290)
Child sexual abuse (mother)	997	49.3 (492)
Lifetime severe psychological IPV (mother)	990	50.2 (497)
Lifetime physical IPV (mother)	990	46.6 (462)
Witness of severe psychological IPV (child)	985	25.8 (254)
Witness of physical IPV (child)	989	22.9 (226)
<i>Auxiliary variable</i>		
Risk index	996	<i>M (SD)</i> 1.58 (1.15)
<i>Distal outcomes</i>		
Psychological distress (mother)	994	36.70 (22.80)
Post traumatic stress symptoms (mother)	667	33.15 (25.01)
Dissociation (mother)	673	17.32 (16.41)
Dissociation (child)	977	7.39 (5.79)
Emotion dysregulation (child)	559	179.18 (20.61)

Note. IPV = intimate partner violence.

3.2. Latent class analyses

3.2.1. Optimal number of classes

To determine the optimal number of classes, an increasing number of classes, up to five, was modeled and various indices were examined. The AIC diminished from one to five classes, but the BIC and ABIC decreased from one to four then increased when adding a fifth class. The LMR LR, ALMR LR, and BLRT tests were significant for up to five classes, but significance reduced with ALMR LR and

BLRT once five classes were reached (from $p < 0.0001$ between one and four classes to 0.01 when adding the fifth class). The entropy with four classes was high (0.913), and larger than with five classes (0.897). Posterior probabilities for most likely latent class membership was high with the four classes model, ranging from 0.829 to 0.995. The number of participants per class with the four classes model was satisfactory: ranging from 138 to 432; the five-class model included an extremely small class with less than 3% of participants ($n = 24$). Based on all these indices and the fact that adding a fifth class did not increase conceptual/clinical value, the four classes model was retained.

After determining that the four-class model was optimal, the three-step method was finalized. At Step 1, response probabilities of each class for predictor variables are determined (see Table 3). At Step 3 (Step 2 is done automatically with Mplus), class comparison on dependant variables is done and the effect of the covariate (Risk Index) is estimated. At that last step, entropy decreased to 0.876. Final class count and proportions, as well as final posterior probabilities for most likely latent class membership at Step 3 are presented in Table 3.

3.2.2. Class description

Class 1, involving 43.3% of the total sample, is comprised of dyads, which relative to the other classes, reported very few victimization experiences apart from the sexual abuse of the child. Indeed, the levels of maternal childhood exposure to physical IPV is 28.6%, which is lower than that of the complete sample (34.6%), and the same is true for maternal CSA (41.2% vs. 49.3% in the total sample). Practically none of the mothers in this group were victims of IPV and no children witnessed IPV. Therefore, this group was labeled CSA Only.

Class 2 (14.2% of the sample) includes mothers that all reported severe psychological IPV victimization to which an important proportion of children were exposed (38.5%). A slightly higher proportion of mothers in this group was sexually abused in childhood as compared to the total sample (56.0% vs. 49.3%). However relative to other classes, mothers in this class reported in a smaller proportion physical IPV, witnessing IPV in childhood, and that the child witnessed occurrences of physical IPV. Thus, this group was labeled Intergenerational CSA with Psychological IPV.

Class 3, including 24.0% of the sample, comprises mothers that all reported physical IPV victimization, with somewhat low proportion of children being exposed to these situations (21.5% vs. 22.9% in the total sample). Mothers also reported severe psychological IPV in a high proportion (67.5%), but no exposure of the child to these events. Compared to the total sample, mothers in this group had average probabilities of CSA and exposure to physical IPV. Accordingly, this group was labeled Physical and Psychological IPV with Low Child Exposure.

Class 4 (18.5% of the sample) comprises highly victimized dyads. Relative to other classes, mothers in this class also reported the highest rates of exposure to physical IPV as a child (49.1%), and a history of CSA (60%). All mothers reported experiencing physical and severe psychological IPV, to which virtually all children were exposed (100% exposed to psychological IPV and 95.5% exposed to physical IPV). This class was labeled Intergenerational Polyvictimization.

The child's gender was not associated to class membership: $\chi^2(3, N = 997) = 0.854, p = .837$; neither was the age of the mothers: $F(3, 986) = 0.803, p = .493$.

However, an ANOVA revealed a significant difference between classes regarding the age of the child: $F(3, 993) = 2.919, p = .033$. A post-hoc analysis revealed that children in the Intergenerational CSA with Psychological IPV group ($M = 8.17, SD = 2.63$) were slightly older than children in the CSA Only group ($M = 7.44, SD = 2.56$). No other significant difference emerged.

3.2.3. Class comparisons

To further delineate the classes, a series of comparisons were considered regarding a) the characteristics of the CSA experienced by

Table 3

Class count, posterior classification probabilities, and response probabilities for the four-class model at Step 3.

	Class 1	Class 2	Class 3	Class 4
<i>n</i> (%)	432 (43.3)	141 (14.2)	239 (24.0)	184 (18.5)
Posterior classification probabilities	0.996	0.760	0.988	0.954
Maternal history of victimization				
Witness of physical IPV in childhood	28.6	27.6	37.7	49.1
Child sexual abuse	41.2	56.0	51.1	59.9
Lifetime severe psychological IPV	0.0	100	67.5	100
Lifetime physical IPV	0.3	39.3	100	100
Child's exposure to IPV				
Witness of severe psychological IPV	0.0	38.5	0.0	100
Witness of physical IPV	0.0	0.0	21.5	95.5

Note. IPV = intimate partner violence.

the child, b) the sociodemographic risk index, c) maternal symptoms, and d) child symptoms.

3.2.3.1. CSA characteristics

Three variables were considered: chronicity of the CSA, type of CSA (intra vs extra-familial), and severity of the CSA. Chi-square analyses revealed a significant difference in the chronicity of the CSA across groups: $\chi^2(6, N = 911) = 12.841, p = 0.046$. Adjusted residuals indicated that children in the CSA Only group were more likely to report having experienced CSA involving a single episode and less likely to report chronic CSA. On the other hand, children in the Intergenerational CSA with Psychological IPV group were overrepresented in the chronic CSA category. Significant differences also emerged regarding the type of CSA: $\chi^2(3, N = 984) = 15.388, p = 0.002$. Children in the CSA Only group were more likely to be victims of extra-familial CSA, while children in the Intergenerational CSA with Psychological IPV group suffered in a greater proportion than expected intra-familial CSA. No difference appeared regarding the severity of the CSA.

3.2.3.2. Risk Index.

The Risk Index was significantly higher in members of the Intergenerational Polyvictimization group when compared to the CSA Only group (OR = 0.621, $p < 0.001$) and to the Physical and Psychological IPV with Low Child Exposure group (OR = 0.802, $p = 0.007$), but not to the Intergenerational CSA with Psychological IPV group (OR = 0.846, $p = 0.069$). Members of the CSA Only group also had lower Risk Index than the other two groups (Intergenerational CSA with Psychological IPV: OR = 1.363, $p = 0.004$; Physical and Psychological IPV with Low Child Exposure: OR = 1.292, $p = 0.009$). Finally, no difference emerged for the Risk Index between members of the Intergenerational CSA with Psychological IPV and the Physical and Psychological IPV with Low Child Exposure groups (OR = 0.948, $p = 0.644$). **Maternal psychological functioning.** Table 4 presents the scores of mothers in each class. Mothers in the CSA Only group had lower scores of psychological distress than mothers in the Physical and Psychological IPV with Low Child Exposure group. They had lower scores of PTSD symptoms and dissociation than mothers in both the Physical and Psychological IPV with Low Child Exposure and the Intergenerational Polyvictimization groups. No difference emerged between mothers in the CSA Only and Intergenerational CSA with Psychological IPV groups. Mothers in the Intergenerational CSA with Psychological IPV had lower scores of dissociation than mothers in Physical and Psychological IPV with Low Child Exposure and the Intergenerational Polyvictimization groups, but despite somewhat lower scores of psychological distress and PTSD symptoms, did not significantly differ from mothers in those two groups on these variables. Finally, mothers on the Physical and Psychological IPV with Low Child Exposure and the Intergenerational Polyvictimization groups had similar scores of psychological distress, PTSD symptoms, and dissociation.

Child psychological functioning. Table 4 also presents the scores of children in each class. Children in the CSA Only and the Intergenerational CSA with Psychological IPV had lower scores of dissociation than children in the two other classes, but were not significantly different from one another. Children in the Physical and Psychological IPV with Low Child Exposure and the Intergenerational Polyvictimization groups had similar scores. In terms of emotion dysregulation, children in the CSA Only group had significantly lower scores than children in the Intergenerational CSA with Psychological IPV, but their scores did not differ from those of children in the two other classes. No significant difference emerged between children in the Intergenerational CSA with Psychological IPV, Physical and Psychological IPV with Low Child Exposure, and Intergenerational Polyvictimization groups.

4. Discussion

Intergenerational patterns of CSA or IPV, usually examined separately in multigeneration studies, have been documented in the literature. There is an urgent need to better understand how patterns of intergenerational cumulative trauma present among families, and how they might impact mothers' and children's functioning. Thus, this study aimed to identify profiles of mother-child dyads based on intergenerational experiences of IPV, childhood exposure to IPV, and CSA in a sample of sexually abused children. As expected, profiles reflecting different degrees and configurations of cumulative interpersonal trauma experiences were identified, which attests to the heterogeneity of families seeking services following a child's disclosure of CSA. As hypothesized, one class involved dyads affected mainly by the sexual abuse of the child, with fewer other traumas as compared to the full sample and the other classes. One class included a high percentage of sexually abused mothers that experienced high levels of severe psychological IPV to which children

Table 4
Associations among latent class membership and dependant variables

Variable	Class 1 — CSA only	Class 2 — intergenerational CSA with psychological IPV	Class 3 — physical and psychological IPV with low child exposure	Class 4 — intergenerational polyvictimization
Psychological distress (mother)	31.83 ^a	36.81 ^{a,b}	41.76 ^b	39.30 ^{a,b}
PTSD symptoms (mother)	26.27 ^a	33.47 ^{a,b}	41.17 ^b	36.56 ^b
Dissociation (mother)	13.22 ^a	10.56 ^a	21.33 ^b	22.04 ^b
Dissociation (child)	5.71 ^a	5.52 ^a	8.17 ^b	9.26 ^b
Emotion dysregulation (child)	172.71 ^a	181.93 ^b	176.17 ^{a,b}	175.16 ^{a,b}

Note. Different superscripts indicate significant group differences. PTSD = posttraumatic stress disorder.

were exposed. The third class involved highly victimized mothers in terms of physical and psychological IPV, but a somewhat small percentage of children who were exposed to this victimization. Finally, in line with our hypothesis, the fourth class included highly victimized dyads on all accounts. Overall, our sample had higher rates of IPV and CSA than those found in populational studies, with approximately 50% of the mothers reporting a history of CSA and IPV (Miller & McCaw, 2019; Stoltenborgh et al., 2011). Three of the four classes showed such patterns of high victimization as compared to rates found in the general population.

The second and central aim of this study, in line with the Complex Posttraumatic Stress model and previous empirical studies on cumulative trauma, was to examine the correlates of these various profiles of intergenerational victimization in terms of maternal and child psychological functioning. As expected, mothers in the CSA Only group reported the lowest levels of psychological distress, PTSD symptoms, and dissociation. However, the dose-response relation between increasing numbers of interpersonal traumas and maternal psychological functioning was not as clear as expected based on previous findings (e.g., Martin et al., 2013; Ogle et al., 2013; Steine et al., 2017). Indeed, maternal dissociation was similar in dyads from the CSA Only and Intergenerational CSA with Psychological IPV groups and lower in these groups than in the two other, more victimized groups. This finding could be reflective of the importance of physical IPV in the etiology and maintenance of dissociation symptoms as all mothers in the Physical and Psychological IPV with Low Child Exposure and Intergenerational Polyvictimization groups reported physical IPV and similar levels of dissociation. Mothers in these two groups also reported high exposure to physical IPV in childhood. It is worth mentioning that dissociation is suspected to play a role in increasing the risk of revictimization in survivors of child maltreatment and IPV as it results in minimizing or ignoring social cues indicative of danger, therefore leading to a reduced capacity to recognize and respond adaptively in such situations (e.g., Zamir, Szepeswol, Englund, & Simpson, 2018). The absence of a clear dose-response relation could also reflect the presence of a ceiling effect whereas after a certain point, increasing victimization experiences no longer result in a parallel significant increase in symptomatology. Indeed, mothers in the two groups with higher intergenerational victimization experiences all reported high levels of physical and severe psychological IPV, CSA, and childhood exposure to IPV, in addition to caring for a sexually abused child.

These explanations could also apply to the results pertaining to maternal PTSD symptoms and psychological distress. Here again, the expected dose-response effect was not found as mothers in all groups except CSA Only had scores that did not statistically differ. Risks of developing PTSD are higher in individuals who experienced harm to their physical integrity during the traumatic event (Sayed, Iacoviello, & Charney, 2015). There is also an interaction between dissociation and PTSD symptoms, as peri-traumatic dissociation is a known risk factor for PTSD (Sayed et al., 2015). This could explain the higher scores of PTSD symptoms in both groups reporting physical IPV and higher levels of dissociation. Regarding psychological distress, the reason why mothers in the Physical and Psychological IPV with Low Child Exposure group differed from the mothers in the CSA Only group, but mothers in the Intergenerational Polyvictimization did not is unclear. It is worth noting that mothers in the former and latter groups only had a 2-point difference in their mean scores of psychological distress, while mothers in the CSA Only group had much lower scores. The clinical cut-offs for the IDP range from 21.43 to 33.33 depending on the age, placing mothers in the Physical and Psychological IPV with Low Child Exposure and Intergenerational Polyvictimization groups way above the cut-off. The smaller sample size for the Intergenerational Polyvictimization group could have resulted in lower statistical power to detect significant differences. Another potential explanation for the high psychological difficulties of mothers in the Physical and Psychological IPV with Low Child Exposure group could be that they are putting much effort in preventing exposure of their child to the IPV they are subjected to, and are thereby left with fewer internal resources to cope with their own distress making them as symptomatic as more victimized mothers (Intergenerational Polyvictimization). However, we do not want to assume that mothers in the other groups did not try to protect their children; it is important to emphasize that in many situations, a victim of IPV does not have any control over who is exposed or not to their victimization and that the burden of responsibility for children's exposure to IPV falls entirely on the perpetrators. Finally, there might be other forms of trauma experiences or a number of mediators and moderators that were not accounted for in the present study (e.g., other child maltreatment types, maternal emotion regulation, trauma processing level, mother-child attachment, socioeconomic and contextual factors) (Cabecinha-Alati, Langevin, & Montreuil, 2020; Langevin et al., 2020; Marshall, Langevin, & Cabecinha-Alati, 2021).

To summarize, five potential explanations are provided for the unclear dose-response pattern observed: 1) every mother in the two most victimized groups reported physical IPV, and a high proportion was also exposed to physical IPV in childhood, which could explain their high levels of psychological difficulties; 2) the presence of a ceiling effect, given the highly victimized nature of our sample; 3) the lack of power for the smallest group (Intergenerational Polyvictimization); 4) the efforts of mothers in the Intergenerational CSA with Psychological IPV group to protect their child from exposure to violence and resulting distress; and 5) potential traumatic experiences or mediators and moderators unaccounted for.

Findings from group comparisons for child dissociation mirror those found with the mothers, as children in the CSA Only and Intergenerational CSA with Psychological IPV have similar scores that are lower than those of children in the two other groups. These findings, that might also reflect a ceiling effect, are somewhat inconsistent with previous studies reflecting a clearer dose-response pattern with single generation youth samples (e.g., Hébert et al., 2018; Hodges et al., 2013). Again here, physical IPV experienced by mothers could provide an explanation for that finding. While children in the Physical and Psychological IPV with Low Child Exposure were not exposed to psychological IPV, 21.5% of them were exposed to physical IPV according to their mothers, and all of their mothers reported physical IPV. Mothers could have underestimated their child exposure to physical IPV events (Zimmerman & Pogarsky, 2011), and exposure to IPV, even prenatally, is known to have significant impacts on children in terms of dissociation (Yalch, Black, Martin, & Levendosky, 2016). This finding highlights the relevance of studying intergenerational patterns of cumulative trauma as the mothers' experiences of physical IPV, regardless of maternal reports of child exposure, appear relevant in understanding children's dissociation. Vicarious learning processes could also be at play, with children of highly dissociative mothers using the same coping strategy when faced with difficult emotions or situations (Hulette, Kaehler, & Freyd, 2011).

Surprisingly, children in the Intergenerational CSA with Psychological IPV were assessed by their teachers/educators as presenting

the highest levels of emotion dysregulation, while we would have expected children in the Intergenerational Polyvictimization group to do so. However, results from a posteriori group comparison showed that children in this group experienced more chronic CSA and were abused in a greater proportion by an intra-familial perpetrator, two factors associated with increased levels of difficulties following CSA (Ventus, Antfolk, & Salo, 2017). It is also possible that teachers are more likely to observe externalizing difficulties in class settings and are less akin to perceive more internalized symptoms in children. Given the associations between dissociation and emotion dysregulation (Hébert et al., 2020), it is surprising that children in this group were not reported by their mothers as presenting higher levels of dissociation than children in the other groups. Inter-rater discrepancies might be responsible for this finding (De Los Reyes, 2011). Also, children in the Intergenerational CSA with Psychological IPV did not experience more severe acts during the CSA (e.g., penetration, use of coercive violence, multiple perpetrators), which could explain their lower dissociation scores (Johnson, Pike, & Chard, 2001).

4.1. Limitations of the study

This study was the first, to our knowledge, to use LCA to derive classes of intergenerational victimization in dyads of sexually abused children and their mothers, and to compare maternal and child psychological functioning among these subgroups using a large sample of close to 1000 families affected by CSA. While this study has important strengths, some limitations need to be acknowledged. First, the cross-sectional nature of the design precludes from concluding about causality. Second, since this study was a secondary analysis of data collected over the course of different projects, scores of PTSD and dissociation were not available for the full sample and PTSD symptoms were reported as related to children's disclosure of CSA, not in relation to mothers' traumatic histories. Also, it was not possible to include other types of traumatic experiences such as childhood physical and psychological abuse or neglect in mothers and children. The multi-informant perspective is a strength, but it resulted in missing data for emotion dysregulation scores given they were derived from teacher reports. However, FIML procedure was implemented to minimize the biases that could have resulted from these missing data. Another limitation is the use of single, unstandardized questions to assess maternal histories of CSA and childhood exposure to physical IPV, even though this does not seem to have resulted in underreporting of those traumatic experiences based on prevalence rates in our full sample, which is comparable to that reported in other studies of mothers of CSA children (Daignault, Cyr, & Hébert, 2017). The sole reliance on questionnaires – self-reported in the case of the mothers – to assess the outcomes and traumatic experiences is not ideal, as observational or structured interview measures would have strengthened the study design. Lastly, given that sexually abused boys have been found to display more dissociation symptoms and emotional dysregulation as compared to sexually abused girls (Bernier, Hébert, & Collin-Vézina, 2013; Langevin, Cossette, & Hébert, 2016; Séguin-Lemire, Hébert, Cossette, & Langevin, 2017), it is possible that a larger number of boys in our sample could have resulted in different findings regarding children's outcomes. Consequently, future studies investigating these issues should use prospective, longitudinal, and intergenerational designs and could involve more boys and a third generation of participants to assess intergenerational continuity over several generations. Involving fathers would also be important as histories of past trauma and psychological distress have also been found to be higher in fathers of sexually abused children (Cyr et al., 2016). Further, using various methods of assessment including standardized questionnaires, official CPS records, and behavioral observations is warranted. Documenting other types of traumatic experiences and the mechanisms underlying the association between intergenerational cumulative victimization experiences and later psychological functioning is another avenue worthy of investigation (e.g., attachment, neurobiological aspects), as would be exploring these associations while contrasting results with a comparison group of non-sexually abused children.

4.2. Practical implications

Despite the limitations, this study has practical implications that should be mentioned. However, given that this is the first study to document the impacts of intergenerational patterns of cumulative trauma on mothers' and children's functioning and that the sample only includes sexually abused children, future studies should attempt to replicate our findings with varied samples and including other types of traumatic experiences. Service providers working with sexually abused children and their families should routinely assess the victimization history of both the parents and the child as these factors delineate associated outcomes. They should assess possible concurrent IPV and consider the distress and needs of the mothers. This could help mothers better support their children throughout their recovery from CSA (van Toledo & Seymour, 2013), especially those with cumulative exposure to trauma in the Intergenerational CSA with Psychological IPV, Physical and Psychological IPV with Low Child Exposure, and Intergenerational Polyvictimization groups. Our findings also highlight the importance of CSA characteristics for children's symptomatology above and beyond the effect of cumulative trauma, especially chronicity of the abuse and the relationship with the perpetrator. Further, particular attention should be paid to dissociative symptoms in both the mother and the child, as they are known for the impairment they cause to several aspects of functioning (e.g., relational, academic, psychological), their pervasive nature (Silberg, 2014) as well as their role in revictimization trajectories (Zamir et al., 2018).

Given the findings showing that mothers and children in the CSA Only group have fewer psychological difficulties, after in-depth assessment of the family's situation including factors unaccounted for in this study, a targeted treatment for CSA such as Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) with the child might be indicated, or a psychoeducational intervention to prevent revictimization (Deblinger, Behl, & Glickman, 2012). TF-CBT has been found effective not only with sexually abused children and youth, but also with children and youth exposed to IPV, traumatic loss, and multiple traumatic experiences (Mannarino, Cohen, & Deblinger, 2014) and children displaying complex symptomatology akin to the Complex PTSD domains of impairment (Hébert & Amédée, 2020; Sachser, Keller, & Goldbeck, 2016). Therefore, this approach might even be relevant for children from all groups. In the

CSA Only group, unforeseen difficulties might arise later in development (Lalor & McElvaney, 2010). Milestones in terms of sexual development (for instance the emergence of first romantic relationships) and the occurrence of other adverse life events (e.g., divorce) could be sensitive periods in which previously asymptomatic sexually abused children may start showing some difficulties (e.g., Teicher, Samson, Polcari, & Andersen, 2009), so planning for periodic reassessments may be warranted. To conclude, offering services tailored to the diverse needs of sexually abused children and their family is essential, as not every family shows the same patterns of symptoms following such trauma. Tailored services will foster resilience in sexually abused children and their family, preventing enduring difficulties and their unfortunate intergenerational spill-over effects.

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