Journal of Family Violence
https://doi.org/10.1007/s10896-024-00685-0

ORIGINAL ARTICLE

'It's so Beneficial to be Able to Stop the Cycle': Perceptions of Intergenerational Transmission of Violence and Parenting Practices Among Pregnant Women and their Abusive Partners

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Accepted: 27 January 2024

Abstract

Purpose This study aimed to explore how pregnant women who experience Domestic Violence and Abuse (DVA) and men who commit DVA understand the impact of their childhood environment on their relationships with their children and co-parents, and how a DVA psychological intervention may shape their parenting.

Methods Repeated individual qualitative interviews were conducted with pregnant mothers and fathers who reported DVA and were taking part in a psychological intervention to address DVA. Interviews were carried out at the start (during pregnancy) and end of the intervention (two years post-childbirth). Reflexive Thematic Analysis was used to analyse interviews.

Results 56 interviews (26 mothers; 13 fathers) were analysed. Five themes were identified: (1) Acknowledging childhood experiences of DVA; (2) The scars of traumatic experiences; (3) Challenging the silencing of abuse; (4) The transmission of parenting styles and behaviours from one generation to another; (5) Becoming the best parent one can be. The intergenerational transmission of violence was identifiable in most narratives. Despite this, several participants described skills they acquired during the intervention (e.g., emotional regulation strategies) as assisting in interrupting violence and improving their relationships with their children.

Conclusions Participants who acknowledged having encountered childhood abuse recognised it as one of several risk factors for DVA in adulthood. They also discussed the potential for trauma-informed interventions to address the intergenerational transmission of violence and poor parenting practices.

Keywords Domestic violence and abuse · Intergenerational transmission · Parenting · Trauma · Intervention

Introduction

Domestic Violence and Abuse (DVA) consists of the use of violence, abuse, and threats by a relative, partner, or ex-partner against a person aged 16 years and older (Oliver et al., 2019). According to global estimates around 23–31% of women (15–49 years) experience physical and/or sexual partner abuse at least once in their lives (WHO, 2021). The number of women who experience DVA in England and Wales is reported to be more than twice that of men (1.7 million women and 699,000 men) (ONS, 2022). No statistically significant differences have been found in DVA prevalence rates among women from different ethnic groups (i.e., white, mixed, black or black British, Asian or Asian British) (ONS, 2022). However, violence and abuse is less likely to be disclosed to statutory services by ethnic minorities than by white British women (Femi-Ajao, 2018). Women also report experiencing DVA in pregnancy, with prevalence estimates ranging from 3 to 30% (Bacchus et al., 2004; Bowen et al., 2005; Devries et al., 2010; Mojahed et al., 2021; Salari & Nakhaee, 2008; Van Parys et al., 2014).The variability of these figures reflects that of global prevalence rates (Van Parys et al., 2014). Notably, prevalence rates appeared to be elevated in African and Latin American countries compared to those surveyed in European and Asian countries (Devries et al., 2010; Van Parys et al., 2014). However, it is worth highlighting that prevalence

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Published online: 10 February 2024

estimates within both regions and individual countries displayed considerable variability (Devries et al., 2010; Van Parys et al., 2014). Furthermore, the prevalence and this variation may be attributable to the definitions, methodology and study design employed (Román-Gálvez et al., 2021). Focusing on the UK where our study was located, Bowen et al. (2005) examined the prevalence of domestic violence among a sample of 7,591 women. The findings indicated a lower incidence of domestic violence victimisation during pregnancy compared to the postpartum period: during pregnancy (i.e., at 18 weeks of gestation) 5.1% of the sample reported experiencing any form of victimisation, 1% reported experiencing physical abuse, and 4.8% reported the experience of emotional abuse; during postpartum (i.e., at 33 months postpartum) 11% of the sample reported experiencing any form of victimisation, 2.9% reported experiencing physical abuse and, 10.8% reported the experience of emotional abuse. Considering a more recent international cohort study on DVA experienced during pregnancy in Sweden, the findings indicated that 2.5% ($n = 40/1573$) of the participants reported experiencing DVA, regardless of its type or severity (Finnbogadóttir & Dykes, 2016).

Alongside numerous negative physical health impacts, people who experience DVA are at risk of developing a range of mental health problems, such as depression, anxiety, substance use problems and suicide attempts (Bailey et al., 2019; Beck et al., 2011; Beeble et al., 2009; Mantovani et al., 2023; Oram et al., 2022; Trevillion et al., 2012; Trombetta & Rollè, 2022). Additionally, when experienced during pregnancy, DVA is associated with antenatal and postnatal depression (Howard et al., 2013) and poor obstetric outcomes, including low birth weight and preterm birth (Hill et al., 2016).

DVA can also affect offspring. Children living in a violent environment may directly or indirectly experience DVA between caregivers (Henry, 2018), with around 1 in 5 children reporting such experiences (Radford et al., 2011). Following the Domestic Abuse Act 2021, UK legislation now recognises the impact of DVA on children such that children are considered victims of domestic abuse when they see, hear, or experience the consequences of DVA. Moreover, in households with DVA, it is estimated that the risk of child abuse is 30–60% higher (Hester et al., 2007; Humphreys & Thiara, 2002). Adverse Childhood Events (ACEs), including childhood abuse and experience of domestic violence, have been shown to contribute to poor outcomes for adults, such as substance misuse problems, PTSD, depression and chronic disease (Anda et al., 2006; Chang et al., 2019; Felitti, 2009; Felitti et al., 1998).These ACEs also contribute to children's poor peer relationships, low academic achievement, risky health behaviours, substance misuse and mental health problems (Guss et al., 2020; Kalmakis & Chandler, 2015; Lange et al., 2019; Murphy et al., 2014; Thornberry et al., 2012). Furthermore, the risk of polyvictimisation – which can consist of experiencing at least two types of interpersonal abuse victimisation (e.g., caregiver victimisation, parental neglect) – in this population appears to be high (Jackson- Hollis et al., 2015; Tura et al., 2022). In this regard, the study by Jackson- Hollis et al. (2015) found that 3.57% of the British adolescents who took part in all four survey waves (with a total sample size of 364) experienced poly-victimization consistently across those four years. Taking into consideration other age ranges, Radford et al. (2013) found that in the previous year, 2.5% of children under 11 years old and 6% of young people aged 11–17 years reported experiencing one or more instances of physical, sexual, or emotional abuse, or neglect by a parent or caregiver. Additionally, during their childhood, at least once, 8.9% of children under 11 years old, 21.9% of young people aged 11–17 years, and 24.5% of young adults had encountered such experiences. Moreover, the results by Radford et al. (2013) showed that there were minimal disparities in the rates of child maltreatment reported by males and females when perpetrated by parents or caregivers. In terms of other forms of childhood victimisation, males encountered higher incidences of victimisation from peers, increased instances of non-caregiver-related physical violence, and greater exposure to community violence. Conversely, females in the two older age brackets disclosed a higher prevalence of experiences involving sexual victimisation compared to their male counterparts. Such cumulative exposures to traumatic events can be particularly harmful, with a higher number of negative events in childhood related to poorer physical and mental health well-being in adulthood (Merrick et al., 2017).

DVA experienced in childhood and/or adolescence is a major risk factor for committing violence or experiencing victimisation in adulthood (Rikić et al., 2017; Tyler et al., 2011), and this phenomenon has been termed *intergenerational transmission of violence* (Black et al., 2010; Rikić et al., 2017; Taccini et al., 2021; Tyler et al., 2011). Ehrensaft et al. (2003)'s 20-year prospective study shows that children who have direct or indirect exposure to DVA between caregivers may adopt similar dysfunctional conflict management methods in adult romantic relationships. Tyler et al. (2011) also found associations between childhood exposure to DVA and dating violence among adolescents. Moreover, a review by Lomanowska et al. (2017) shows that early adversities seem to affect parenting in adulthood. Specifically, Newcomb and Locke (2001)'s results show that child maltreatment is associated with subsequent poor parenting practices, i.e., low warmth, aggression, undifferentiated rejection, and neglect.

However, some findings do not support continuity in violence and abuse in intimate relationships across generations (Ertem et al., 2000; Langevin et al., 2021; Thornberry et al., 2012; Tracy et al., 2018). Specifically, numerous protective factors can come into play for children who experience DVA, such as high levels of maternal social support in the postpartum period (Tracy et al., 2018), maternal warmth (Jaffee et al., 2013), paternal participation (Tracy et al., 2018), high socioeconomic status (Jaffee et al., 2013), higher satisfaction with parenthood (Thornberry et al., 2013) and healthy relationship with the partner (Jaffee et al., 2013). Several protective factors can also contribute to breaking the cycle of abusive parenting, such as financial stability and social support (Crouch et al., 2001; Dixon et al., 2009) and the presence of memories of positive childhood experiences (Narayan et al., 2019; Radford et al., 2019).

Moreover, a review by Radford et al. (2019) report several studies that investigated whether people model their behaviour on that of the caregiver of their same sex; therefore, father-to-mother violence may predict a male child's use of violence and a female child's victimisation in adult intimate relationships. The results were mixed with some studies such as that by Kwong et al. (2003) finding no association between the gender pattern of DVA experienced in childhood and DVA in adult relationships. Others (e.g., Heyman & Slep, 2002) supported a gendered approach to the intergenerational transmission of violence by showing that respondents had similar experiences of violence (committing or experiencing DVA) in adulthood as their same-sex (male or female) caregivers.

Taking into account the above literature, this study aims to explore the perceived impact of abusive childhood experiences on women's and men's parenting practices, from the perspectives of those who have experienced and who have perpetrated DVA and examine how a DVA psychological intervention may draw on these perceptions to shape caregivers' parenting practices.

Methods

Consolidated criteria for reporting qualitative research (CORE-Q) guidelines have been followed (Tong et al., 2007). This research is a secondary data analysis of repeated individual qualitative interviews, with pregnant mothers and fathers who reported DVA, conducted as part of a larger mixed-methods research evaluation of the prototype phase of a UK DVA psychological parenting intervention called *For Baby's Sake* (Domoney et al., 2019; Trevillion et al., 2020).

A range of terms are commonly used to describe people who experience DVA, such as 'victim', 'survivor' or 'person with lived experience of domestic abuse'. Perot and Chevous (2018) suggest that many people may not feel comfortable with terms used in the scientific literature, such as 'victim' or 'survivor'. This is due to the fact that they may not have heard of these words before, or they do not feel they describe their experiences appropriately. Consequently, this paper adopts the term 'people who have experienced DVA' to refer to women participating in this project and who experienced violence by their partners. Moreover, for the purpose of this study, we will refer to the fathers included in the project as "men who commit DVA".

Procedure

For Baby's Sake is a whole-family psychotherapeutic intervention for pregnant mothers and fathers where there is DVA in their relationship. It was developed and delivered in the UK. According to the whole-family approach, both co-parents are included in the intervention, whether they are cohabiting or not and/or whether they are together as a couple or not. This inclusive approach stems from the understanding that separating an abusive parent from their children might not always be feasible or the preferred choice of families living with DVA (Stanley & Humphreys, 2017). Instead, an alternative perspective is emerging that promotes interventions which target all family members. These strategies align with the evolving emphasis on holding perpetrators accountable for the effects of children's exposure to DVA and acknowledge research indicating that fatherhood could serve as a substantial catalyst for behavioral transformation (Meyer, 2018; Stanley et al., 2012). Each parent has a different *For Baby's Sake* practitioner who works independently with them through one-to-one sessions. *For Baby's Sake* practitioners are co-located within local social care service settings but operate as an independent organisation; the practice of co-location helps to promote awareness of the intervention and encourage referrals from their statutory social care partners. In addition, *For Baby's Sake* practitioners proactively advertise their intervention to other local relevant organisations (e.g., statutory health services, criminal justice services and voluntary services), via attendance at team meetings. Parents meeting the eligibility criteria have the option to self-refer to the program- (N.B. *For Baby's Sake* practitioners administer social marketing materials to advertise the program to the public), or they may be referred by midwifery and health visiting services, children's social care services, GP services, police, probation, or local voluntary and community services. During this research study, children's social care services were the predominant organization to make referrals to *For Baby's Sake* and participating families reported a range of DVA experiences, including physical, sexual, psychological and coercive abuse.

The objectives of the intervention are: "(1) to bring an end to domestic abuse; (2) to overcome the impact of traumatic experiences in their own childhoods; (3) to make sustained changes in their behaviour, and (4) to create the conditions through their parenting techniques and family environment to prevent poor outcomes for infants" (Domoney et al., 2019, p. 127). Psychotherapeutic sessions are delivered face-to-face and integrate several techniques from different therapeutic theories – Cognitive Behavioural Therapy (CBT) (Beck, 2011); Gestalt Therapy (Kellogg, 2014); Transactional Analysis (Berne, 2016); Motivational Interviewing (Rollnick & Miller, 1995); Mindfulness Therapy (Whitaker et al., 2014) and Inner Child Work (Bradshaw, 1992). The latter is at the heart of the programme as it aims to help parents address ACEs and recover from trauma. The *For Baby's Sake* program is manualised and delivered in modules. Example of modules are: the 'Video Interaction Guidance (VIG)' (Kennedy et al., 2011) which is aimed at evaluating and improving parent-child communication and sensitive attuned parenting through recording videos of parent-child interactions. In this module, parents are guided by their *For Baby's Sake* practitioners (who had been trained in delivering Video Interaction Guidance) to analyse and reflect on the recordings to improve communication with their children. 'Healthy Expression of Feelings' constitutes another programme module. This module has two parts: the first explores the emotions of guilt, shame, and dissociation and is aimed at enhancing mothers and fathers' emotion regulation strategies; the second is focused on strengthening emotional identification and expression in a healthy way. The second part also aimes to improve the ability of mothers and fathers to respond sensitively to children's feelings.

The research evaluation measured the quantitative and qualitative outcomes of mothers and fathers over a two-year period, from the point that they entered the intervention program (in early-mid pregnancy) to when they finished the intervention (approximately two years post childbirth). More information on the project design and methodology, including safety considerations for participants, can be found here (Domoney et al., 2019) and in the final evaluation report (Trevillion et al., 2020).

Inclusion criteria for the intervention were: both parents intended to participate in the intervention from pregnancy; both parents were aged 17 or over; the mother experienced DVA from the father of the unborn child, with the possibility of violence and abuse becoming recurrent, prolonged or escalating; parents resided within the areas where the intervention operated (a borough in Central London or a county in southern England). Further, even if they were not together as a couple, parents must have wanted to co-parent their unborn baby. Other exclusion factors assessed on a case-by-case basis as impinging the ability to engage in the intervention, included the particular nature of a mental health diagnosis (such as acute substance misuse problems) or other needs or issues; confirmed permanent removal of the unborn child from the parent's care after delivery. The exclusion criteria for the research were the same as those for the intervention, plus participants' inability to provide informed consent at time of interview.

The program was evolving during the prototype phase and has continued to develop since the evaluation took place. Such developments have included the delivery of remote therapeutic sessions through video and audio technology, arising from experience and learning in lockdowns during the global COVID-19 pandemic. Cohort criteria now explicitly include families where the mother is being abusive towards the father and also same-sex co-parents. Exclusion criteria no longer refer to a level of mental health diagnoses, substance misuse or other complex needs that could prevent a parent from being able to engage as, in practice, the programme rarely excluded parents for these reasons. Similarly, the programme now works with parents whose baby may be removed from their care and if this does happen, the parents are offered support for a period afterwards to achieve a trauma-informed planned ending.

Interview

Mothers and fathers were interviewed separately at three separate time points during their participation in the research evaluation: (1) Baseline Interview – in the first 10 months starting the *For Baby's Sake* intervention; (2) at one-year post sign-up to the program, and (3) two-years post sign-up to the program. Regarding baseline interviews, the research evaluation team aimed to complete them antenatally and this was achieved for 14 service users. However, delays in accessing interviewees meant that most completed baseline interviews postnatally (although within 2 months of program sign-up for about half of the sample). This means that some participants were already able to reflect on program benefits at baseline. Interviews were conducted face-to-face either at the community services where families received the intervention or, if safe to do so, at participants' homes; interviews were audio recorded and transcribed verbatim. If participants did not want to be audio recorded, then researchers took written notes at the interview, and these were analysed. Trained qualitative researchers conducted the interviews (JD, KT, Lauren Carson, Danielle Megranahan) and participants were informed that the study aimed to understand the impact of the intervention on their intimate and parenting relationships. Topic guides were used to facilitate interviews, with discussion topics including help-seeking processes, perceptions, expectations and experiences of the intervention, and parents' objectives for and

thoughts about the program. These topic guides did not explicitly ask about how childhood experiences impact on current parenting but this topic emerged during exploration of the topics listed above. This may have occurred because the relationship between childhood experiences and current parenting was a major focus of the *For Baby's Sake* intervention. Topic guides are available upon request. All participants received a £20 gift token per interview.

Pilot testing was conducted to determine whether it was feasible to administer the full baseline interview schedule. This involved identifying items that participants reported as challenging, the time it took to complete the baseline evaluations, and participants' verbal feedback on the interview content and process. Consequently, some adjustments were made to the interview schedule.

The research team developed standardised operating procedures and safety protocols to prioritise the safety and well-being of all participants. This documentation included guidelines on how to safely make contact with potential participants, how to accommodate interview locations to ensure confidentiality, and how to communicate with interviewees about potential risks and ways to mitigate them (Ellsberg & Heise, 2002; WHO, 2001). Examples of these procedures include: during the recruitment phase, *For Baby's Sake* practitioners assessed potential participation risks for participants, and if determined to be safe, they proceeded to provide information about the study's objectives, procedures, informed consent process, and addressed any inquiries or concerns participants might have had regarding their involvement. Once (and if), participants had expressed their interest, they provided a secure communication mode (e.g., letter, mobile phone call) where the research team could contact them to discuss the project and plan the interviews. Prior to the baseline interview, written informed consent encompassing all aspects of the study was obtained from each participant by the researcher. Fathers and mothers were interviewed separately in safe and private settings and no information was provided on partner interviews to the other parent.

The present study focuses only on the baseline and two-year post-sign-up interviews; the theme of childhood experiences and parenting did not emerge at the one-year interview timepoint and, thus these interviews were not included in this study. Interviews were all analysed together since the focus of the present work does not entail examining differences across the two time points.

Ethics

NHS Research Ethics Committee approval was granted for the mixed-methods research evaluation on 25th January 2016 by the London-Camberwell St Giles Research Ethics Committee (Reference number: 15/LO/2006).

Qualitative Analysis

Reflexive thematic analysis was used to identify repeated patterns of meanings in interviews (Braun & Clarke, 2022). Data were analysed by one of the authors [FT]) and all data was managed in *Nvivo12Pro.* An inductive and data-driven method was used whereby the focus was not merely on the semantic content – which corresponds to the obvious meanings in interviews – but also on the latent constructs –the implicit meaning. The following six phases of reflexive thematic analysis (Braun & Clarke, 2022) were followed: (1) 'familiarization' with the data – which consisted of reading and rereading the transcripts of the interviews; (2) the initial 'coding' frame was developed; (3) initial themes were generated which comprised coding patterns of meanings across transcripts; (4) 'Developing and reviewing themes' comprised detailed readings of the data to refine the themes, including merging codes that shared similar information and refining thematic labels to accurately reflect the revised codes. Throughout all these phases, the coding frame was refined over progressive iterations, and earlier transcripts were re-coded if necessary. In the last two phases: (5) Refining, defining and naming themes, another author [KT] independently rated the appropriateness of the coding frame; the two researchers then met several times subsequently to discuss and agree on a finalised thematic coding frame; (6) Writing Up– was conducted by FT (Braun & Clarke, 2022; Yapp et al., 2019).

A reflexive approach stressed individual characteristics (e.g., age, gender) and ideological motivations (i.e., Feminism). Specifically, FT is a woman, she has done two internships in two Anti-Violence Centres for women who have experienced abuse. These experiences and her ideological motivation (i.e., Intersectional Feminism) may have informed the analysis. However, the reflexivity process was carried out throughout the entire analytic process.

Results

Participants

Demographic Information

A total of 56 interviews was conducted with 39 participants, 26 mothers and 13 fathers. Specifically, baseline interviews were completed with 38 participants between July 2016 and August 2017. Of these interviews, 24 were with co-parents (12 couples), 13 were only with mothers, and one was only

with a father. At the two-year post-sign up, 18 participants completed the interview: 8 of these interviews were with co-parents (4 couples), 8 were only with mothers, 2 were only with fathers. Of these 18 participants, only one did not complete the baseline interview. Sociodemographic information on the participants is summarised in Table 1.

Reasons for drop-out at the two-year post intervention interviews included drop out from or non-completion of the intervention and researchers unable to engage with the family.

Results of the Reflexive Thematic Analysis

Five themes were identified: (1) Acknowledging childhood experiences of DVA; (2) The scars of traumatic experiences; (3) Challenging the silencing of abuse; (4) The transmission of parenting styles and behaviours from one generation to another; (5) Becoming the best parent one can be.

Table 1 Sociodemographic characteristics of mothers (N = 26) and fathers (N = 13)

Socio-demographics	N mothers*	N fathers
Age (mean (SD))	27.71 (7.64)	29 (7.7)
N (%)		
Education level		
No formal qualifications	2 (8.0)	2 (15.4)
GCSE	2 (8.0)	4 (30.8)
A-Level/NVQ/BTEC	13 (52.0)	5 (38.5)
HND/Bachelor's degree/MSc**	8 (32.0)	2 (15.4)
Employment status***		
Full time paid work		7 (53.8)
Not working/unemployed		6 (46.2)
Ethnicity		
White British	19 (73.07)	11 (84.6)
White Other	5 (19.23)	1 (7.7)
Black Caribbean	1 (3.85)	0
Mixed white and Asian	1 (3.85)	0
Mixed other	0	1 (7.7)
Self-reported mental illness (yes)	12 (48.0)	7 (53.8)
Current smoking (yes)	8 (32.0)	10 (76.9)
Relationship status		
Single	5 (20.0)	0
Partner, not cohabiting	8 (32.0)	6 (46.1)
Married or cohabiting	9 (36.0)	7 (53.8)
Separated/divorced	3 (11.1)	0
Physical health problems (yes)	9 (36)	4 (30.8)

* N mothers = 25 for some variables due to missing data; ** Only mothers had MSc; *** Information on mothers' employment status is not reported as several baseline interviews took place in the postnatal period, when women were not working, so there is considerable missing data for this variable

Acknowledging Childhood Experiences of DVA

Many mothers and fathers described the traumatic events they experienced in their home environment in childhood, how these early experiences led them to view abusive behaviours as normal and how they impacted on their subsequent understanding of acceptable behaviours in intimate relationships:

> *'I felt that my relationship with my dad is what started off my bad relationships with every man…I'd never known what a dad should have been like. Seeing him being abusive to my mum and my step-mum was what I'd known so I just accepted that as how it should be' (ID06; Mother; Baseline).*

A few mothers also spoke about how the normalisation of violence in intimate relationships extended to their social networks and family members:

> *'If I told somebody about it they would say, 'That's nothing. From the background you come from it's just normal'…That's the way people back home are brought up, to believe that it's okay to be abused, basically' (ID08; Mother; Baseline).*

> *'My mum went through the same thing, so I think she kind of thinks it's normal as well' (ID04; Mother; Baseline).*

This father was also explicit about the normalising effects of childhood experiences of violence but there is also an indication here, in his focus on other men's behaviour, that a history of family violence can be used as a device to deny personal responsibility for abusive behaviour:

> *'It is a case of you don't realise you're being domestically abusive. If your parents were like that, your family was like that they [men who commit violence in intimate relationships] think that's normal. They think it's normal to hit your wife, they think it's normal to be controlling and control finances. For them they don't know there's a problem' (ID05; Father; Baseline).*

One father described the impact of childhood abuse in shaping their use of violence and abuse, explaining that the behaviours they used as an adult were a means of reclaiming the power they lost during past victimisation experiences:

> *'Sometimes the perpetrator has been that victim, in fact in a lot of cases that perpetrator has been the victim at some point…It's a power thing, it's no different*

whether it is a relationship or a domestic setting…. You have all your power taken away from you [when victimised] and you're determined to never, ever give anyone that opportunity so you become overpowering, controlling person and unfortunately a lot of traits come with it that you think is okay because you're protecting yourself. You think that's okay and you've got the reason for that if anyone tells you you're wrong' (ID05; Father; Baseline).

The Scars of Traumatic Experiences

Some participants reported mental health problems and drug misuse as consequences of trauma experienced in childhood. Moreover, fathers identified alcohol and drug misuse as a trigger for violent episodes:

'He [her partner who commits DVA] was carrying a lot of stuff from his parents and childhood, which was affecting his drinking' (ID28; Mother; Post-intervention).

"What led us [father and his partner] there [to the intervention] was me getting drunk, and being aggressive and abusive" (ID02; Father; Post-intervention).

A number of mothers expressed self-blame for the DVA experienced in childhood and they shared the positive implications of having self-blame targeted by the program:

'I was a child that was around domestic violence, […]. When I was younger, I used to blame myself, because I didn't really know what was going on. Since being on For Baby's Sake, it's helped me in a way of learning, just my thought- you learn about the baby's brain. It's out of their control when they're young, so it's helped me to become a stronger person' (ID11; Mother; Post-intervention).

Challenging the Silencing of Abuse

Several participants reported some of the ways in which the *For Baby's Sake* intervention helped them to address their understanding and needs related to past experiences of abuse. Both mothers and fathers reported that being listened to in a non-judgmental way was one of the first steps to overcome childhood trauma and DVA:

'I feel supported, because…they speak, like about your past, and I didn't really have a good upbringing. […] I can speak about my childhood to [women's practitioner], and she listens. It is nice that they take time to listen, even though that is their job, but it is nice to be listened to' (ID11; Mother; Baseline).

'It's just nice to have that extra person I can go to who doesn't judge and who can help, instead of putting me down and whatever. I can tell her everything' (ID27; Mother; Baseline).

'There's a very big stigma with men being able to actually go and say to somebody I've got problems with domestic violence. There's not really something that's out there where you feel you're not going to be judged. It's nice to have that stigma removed and know you can sit there and talk about the issues you know you've got, and the issues you want to address in a setting where there is no stigma attached to it (ID05; Father; Baseline).

Participants found it challenging to recount the violent episodes they had experienced and feared reliving the trauma. However, they also identified this approach as an important way of processing the trauma:

'Sometimes it can be difficult talking about…my childhood, and, but then sometimes it helps to talk about it because if you build things up inside it is not going to make you any better. Because I have been breaking the family chain. Like, the family chain is a bit messed up, but I don't want nothing bad for [baby], and I want him to have the best he can have'. (ID11; Mother; Baseline)

The Transmission of Parenting Styles and Behaviours from One Generation to another

All participants described a willingness to be mindful of the impact of their parenting practices on their children and to protect their children from the ACEs that had characterised their own childhood:

'I also didn't realise that the way I [was] brought up has an effect on the way I will bring my child up, which really shocked me. So, I've made a lot of changes on my parenting efforts, because I don't agree with the way I was brought up' (ID01; Mother; Post-intervention).

'[baby] is the most important thing in my life I'd quite strongly say. Partly from a selfish point of view because I had a really horrible childhood. I would never ever

want to inflict that on another human being. So yes, I guess what happened for us to be on this programme [For Baby's Sake] I was quite traumatised by. I never thought I can kind of step over that line. […]. And that was quite a difficult thing to live with at the time. I was totally distraught. So, having something to kind of make sure that something like that didn't happen again felt really positive' (ID02; Father; Baseline).

Most mothers and fathers described acquiring increased awareness through the intervention, including understanding of children's development and cognitions, the intergenerational transmission of violence and parenting practices, and risk of the modelling of their own parenting experiences. They reported that this knowledge helped them to take steps to break the cycle:

'Especially with my children. I've never really been a loving dad, maybe because of my past. My dad wasn't loving; he was very strict and very controlling. It's made me look back and realise how controlling I was…Doing this programme made me realise I was very controlling without realising. To me, it was normal' (ID20; Father; Post-intervention).

'I think [For Baby's Sake intervention] is able to stop that cycle from happening, where the children that are born into these families are given a chance to not experience these things, which I just think is incredible, really' (ID02; Mother; Baseline).

Some mothers reported that they had a better understanding of the physiological and psychological impacts of abuse on children and through this knowledge they were motivated to avoid exposing their own children to the same type of negative childhood trauma they experienced:

'[Having a child] made you sort of realise about what's really going on; how clever they are, and how they easily pick things up and how if they get too stressed and things like that. I never realised that it causes that sort of effect to your brain. It quite upset me a bit. Some of it [the work in the intervention]….hit me quite hard, with the way I grew up and how I react now as an adult. It sorts of made me realise that some of the things I do, is because of probably how I grew up. It made me just want to be like, 'I never want my baby to go through that.' (ID12; Mother; Baseline).

'We've done lots of activities […]: child development, how they develop, their social skills. It's very interesting and it taught me a lot, actually. There are things that I didn't actually know, especially how the brain develops in a child, and, if they see abuse or have been abused, that it actually forms differently to a normal brain' (ID05; Mother; Post-intervention).

Fathers described how the intervention helped them to change their perspectives about themselves and their behaviours, in a safe environment:

'Kind of going through this process of understanding all of it, assimilating it. Healing some of those moments to whatever nth degree that you could possibly ever heal something like that. Just bring awareness of where some of the behaviours originate from. Creating some choice in how we behave towards each other. I think that's probably invaluable' (ID02; Father; Baseline).

"Understanding how I have taken on certain things that my parents had sort of put onto me. And actually being able to then separate myself from their opinions or judgments" (ID028; Father; Post-intervention).

Linked to this, several fathers described how the psychological work in the intervention helped them to share their emotions and develop new emotion regulation strategies, to avoid using dysfunctional strategies to regulate their emotions in front of their children. In this regard, they stressed the importance of learning to regulate their anger:

'The amount of stuff that they cover, like inner child stuff around anger and triggers, sort of everything I needed support with' (ID13, Father; Baseline).

'Dealing with my childhood anger stuff was really helpful' (ID02; Father; Post-intervention).

Becoming the best Parent One Can Be

Several parents described how through the intervention they developed new parenting skills and practices that they hoped would ensure their children would not also grow up in an abusive home. Several mothers described developing better coping strategies and learning the skills of identifying and communicating their feelings and emotions to their children:

'Because now I can see there's a bit of a light at the end of the tunnel. Back in the day, I was like, 'Why did I have this baby?' And, 'Why am I pregnant?' Bringing another child into this life with this. And now I

can actually begin to cope a little bit, and there's more support out there' (ID11; Mother; Baseline).

'We do laugh a lot and we do have a lot of fun in the house, but we're not always like that, and so it's helped us both [mother and father]to be very open about, 'Oh, mummy was a bit grumpy today,' and I've said that to [child] 'Oh, I was a bit grumpy this morning, wasn't I? Oh, I'm sorry. This is why, but it's not great, and I'm going to really try hard not to be grumpy.' You know, and we've talked about that […] I've noticed that [First Daughter] can identify her emotions more, and even [Second Daughter], at a very young age. If we read a book, she'll notice when someone's sad and she'll say, 'Oh, they're sad, crying.' So, it's helped us to just be more honest and open about our emotions with the kids' (ID28; Mother; Post-intervention).

Fathers had learned through the intervention how to increase their self-awareness and their emotion regulation strategies. This alongside learning skills around positive parenting practices, characterised by affection, safety and warmth helped them in their attempts to avoid harsh and/or neglectful parenting:

'You can't be the best parent you can be if you're not looking inwards and analysing and improving the kind of person that you are. So, I think that's a consequence, the improved parenting is a consequence of looking at me and the way I am' (ID28; Father; Post-intervention).

'I became a lot less volatile. I do think a lot of that has also got to do with the fact that [name of child] is in the picture and I wanted, more than anything in the world, to be a good dad, but yes, definitely, I picked up some tools [from For Baby's Sake] to help me do that.' (ID02; Father; Post-intervention).

Both mothers and fathers reported feeling confident in their parenting abilities after seeing the bonds that they were able to develop with their children, as recorded on video. Those parent-child interactions were recorded as part of the *For Baby's Sake* intervention:

'She [practitioner] was more about kind of uplifting me as a mother. Her talking, about doing the video thing, because she's like 'You know, as a Mum, you sometimes feel you're not doing your job correctly, but seeing it on video, you'll see it's not all that bad and you can give yourself some credit'. And I think that will be quite helpful' (ID07; Mother; Baseline).

Discussion

The purpose of the present work was to explore how women who experience DVA, and men who commit DVA perceive the impact of early experiences on their relationships with their children and co-parents and how a DVA psychological intervention may shape their parenting practices. Through the analysis of 56 interviews, five themes were identified.

Intergenerational Transmission of Abuse

Participants described their experiences of ACEs as highly traumatic, to the point that these experiences could be conceptualised as a risk factor for experiencing violence and abuse in adulthood. Both mothers and fathers described how growing up in a violent environment normalised the use of violence in intimate relationships. Consequently, this analysis highlighted an *intergenerational transmission of violence* in several of the narratives of the participants. This finding aligns with other work with fathers who commit DVA (Domoney & Trevillion, 2021). In addition to that, it is important to state that for some participants, opening up about their ACEs marked a significant turning point in their journey towards healing. It allowed them to not only share their experiences but also regain control over their own narrative. This shift in dynamic from being a passive recipient of their own story to actively steering it can be profoundly empowering for people with an experience of trauma. On the other hand, it is important to recognise that for others, delving into these painful past experiences can be a difficult task, laden with emotional distress. This underscores the complex and deeply personal nature of trauma recovery. It also emphasises the critical role of practitioners in creating a safe and supportive environment. Understanding and respecting the unique needs and preferences of individuals is paramount in providing effective trauma care. This involves recognising when verbal communication may not be the most suitable or comfortable approach. In such cases, alternative forms of expression, such as writing (Frattaroli, 2006; Pennebaker & Beall, 1986), can offer a valuable outlet for processing and articulating the complex emotions associated with trauma.

If gender is addressed, it was evident that both fathers and mothers who talked about an experience of interparental violence in childhood reported the violence being committed by the father. This result appears to be in line with the literature advocating a gendered perspective on intergenerational transmission of violence (Radford et al., 2019): when children witness father-to-mother violence in their households, it can have lasting effects. For male children, it may contribute to a greater likelihood of using violence in their own intimate relationships later in life. On the other hand,

for female children, it may increase the possibility of experiencing victimisation in their adult intimate relationships. It is crucial to acknowledge that patriarchal structures and power imbalances can underlie these intergenerational patterns of violence. Fathers can be seen as figures of authority and power within the family unit who, in these power dynamics, can use controlling or aggressive behaviours. As male children observe and internalise these dynamics, they may, consciously or subconsciously, replicate them in their own relationships as adults. These learned behaviours and attitudes can manifest in their adult relationships, perpetuating the cycle of violence (McCormack & Lantry, 2022; Mihalic & Elliott, 1997). In addition, certain fathers appeared to use their childhood adverse experiences as a means of rationalising their violence. This interpretation draws on the work of Hearn (1998) and other recent studies (e.g., Kelly & Westmorland, 2016; Seymour et al., 2021), that argue when men engage in discussions about violence, they often seek to establish a sense of credibility with the interviewer, offering explanations, excuses, and justifications for their aggressive behaviour. Consequently, some individuals 'justified' their violent actions by drawing parallels with the conduct of men from their past. From this perspective, it can be argued that culture provides the backdrop for violence or constructs the standard for it. In this sense, they found 'support' or even validation from these men and the narratives and memories associated with them. For such individuals, violence perpetrated by other men can be seen as an integral part of a trajectory and culture of aggression that ultimately extends to violence against women (Hearn, 1998). It is crucial to note that this pattern does not always apply: some men in the study demonstrated an understanding of their violent behaviour and took accountability for their actions. While this was not the primary focus of this study, it is essential to acknowledge it and take account of the language used by men to describe violent behaviour, as it can represent an indicator of therapeutic change (Seymour et al., 2021).

Furthermore, mothers expressed grappling with feelings of self-blame for their negative childhood experiences. Self-blame entails attributing an event to one's own actions (Rancher et al., 2022) and is a prevalent experience among women who have endured violence. Research indicates that this feeling of culpability could serve as a coping mechanism, allowing women to rationalise and find a reason for the traumatic events they experienced (Ullman et al., 2007). Additionally, negative reactions from others, such as victim-blaming attitudes, can exacerbate or even instigate this self-blame (Taccini & Mannarini, 2023; Ullman et al., 2007). This can have a detrimental effect on women's mental well-being and impede their capacity to seek assistance, thus perpetuating a harmful cycle that exacerbates the psychological well-being of women (Beck et al., 2011; McLean & Foa, 2017). Some mothers participating in the *For Baby's Sake* program noted that the intervention had a positive impact on their feelings of self-blame. In particular, becoming informed through psychoeducation sessions about how violence affects children not only enhanced their comprehension of the environment in which they wanted to nurture their children but also shed light on some of their own behaviours and emotions that could be attributed to their ACEs. As a result, this reduced their sense of self-blame for those traumatic events. Moreover, the *For Baby's Sake* program environment contributed to reduce feelings of blame. In fact, the establishment of an inclusive and non-judgmental environment within the program played a significant role in enabling participants to openly discuss their negative experiences and their roles as individuals who have experienced violence, providing them with a space where they could feel safe and supported. The experience of an atmosphere free from judgment is particularly important for women who have endured DVA since in such a setting, they are more likely to feel comfortable sharing their experiences without the fear of being held responsible for the violence they experienced. This non-judgmental environment also aligns with best practices in trauma-informed care (Raja et al., 2015) – which is "based on the understanding that most people in contact with human services have experienced trauma, and this understanding needs to permeate service relationships and delivery" (Sweeney et al., 2016, p. 174). Consequently, it was acknowledged during the program the complex and sensitive nature of DVA and the work prioritised the emotional well-being and autonomy of women. By creating a space where women can discuss their experiences without fear of blame, the program empowers them to take control of their narratives and begin the process of healing and recovery.

In much the same way, fathers emphasised the profound impact of experiencing a non-judgmental environment. This setting allowed them to confront the violence they had inflicted upon their partners. This emphasis on the importance of such an environment underscores that delving into discussions about violent behaviour necessitates a space devoid of societal condemnation or judgment. This, in turn, can foster an environment where men who committed DVA feel more inclined to confront and process their actions, leading to a deeper understanding and potential for change. Therefore, the program achieved a careful balance of being non-judgmental while still challenging men's harmful beliefs in relation to the acceptability of using violence. This delicate equilibrium played a pivotal role in creating a supportive environment where participants felt both validated and accountable for their actions. By fostering an atmosphere of understanding and constructive

confrontation, the program aimed to facilitate a transformative process wherein individuals could grapple with the roots of their violent behaviour. This, in turn, could pave the way for a more profound and lasting shift towards non-violent approaches in their relationships. This result is in line with previous research (e.g., Knight & Modi, 2014; Morrison et al., 2019). For example, Morrison et al. (2019) conducted interviews with 76 men who committed intimate partner violence (IPV) and were participating in an intervention to reduce abuse, to gain insights into their perspectives of the facilitators who were running the program. One of the six prominent themes that emerged from their study was the experience of non-judgmental facilitators. This term denoted facilitators who exhibited an open-minded and non-condemnatory approach towards participants. Such an attitude was recognised as a crucial element in fostering a sense of safety, enabling the participants to feel comfortable expressing themselves within the sessions and receiving feedback from the facilitators.

Both mothers and fathers reflected on whether such negative experiences in childhood also represented a risk factor for the development of mental disorders or substance use problems. This is in line with the research evidence (e.g., Dube et al., 2003; He et al., 2022; Merrick et al., 2017) which shows that the higher the number of traumatic events experienced in childhood, the higher the probability of experiencing mental health problems and substance use problems in adulthood. However, it is important to note that experiencing violence and abuse in childhood does not causally imply experiencing violence and abuse in adulthood. In fact, violence and abuse in childhood are one of many risk factors for experiencing violence and abuse in adulthood. For example, other risk factors for violence and abuse perpetration include financial stress, mental conditions, including personality disorders (such as antisocial personality disorder), and alcohol and drug use problems (Capaldi et al., 2012; Schluter et al., 2008; Slep et al., 2010).

It is worth acknowledging that this sample were parents participating in an intensive therapeutic program and, as a consequence, participants' insights may not reflect the wider population affected by DVA, as the program explicitly addresses the impact of violence and abuse. Furthermore, it appeared that the language and type of non-judgmental discourse used in the program assisted participants to open up to staff, and enhanced understanding of the use of abusive behaviours and the development of insight.

Intergenerational Transmission of Parenting Practices

Mothers and fathers in this study stressed their strong commitment to breaking the cycle of violence and protecting children from directly or indirectly experiencing DVA as a key motivator for taking part in *For Baby's Sake*. They expressed the hope that their participation in the intervention would enable them to acquire healthy strategies to protect their children from adverse events.

Participants connected their own childhood parenting experiences with their current parenting practices, describing a concept of *intergenerational transmission of parenting* (Madden et al., 2015). They had developed a growing awareness of the impact of the parenting styles and behaviours they experienced as a child on shaping their current parenting styles. This awareness helped to strengthen their resolve to prevent their children from experiencing the same traumas they did in their childhood. Consequently, over the course of the *For Baby's Sake* intervention both mothers and fathers described using positive parenting techniques characterised by care, parental warmth, safety, affection, and involvement with children. Moreover, most mothers in the two-years follow-up interview described their relationship with their children as characterised by attention to children's socialisation of emotions, which can be defined as a complex multifaced process aimed at the development and/or improvement of children's understanding, expression, and regulation of feelings and emotions (Eisenberg et al., 1998).

Regarding fathers, this study identified increased attention in men to their emotion regulation and to the use of adaptive positive emotion regulation strategies in the presence of their children. Emotion regulation is characterised by '(a) awareness and understanding of emotions, (b) acceptance of emotions, (c) ability to control impulsive behaviors and behave in accordance with desired goals when experiencing negative emotions, and (d) ability to use situationally appropriate emotion regulation strategies flexibly to modulate emotional responses as desired in order to meet individual goals and situational demands' (Gratz & Roemer, 2004, pp. 43–44). Although the literature on the role of fathers in the regulation of children's emotions is scarce, the data suggests that the experience of an emotionally dysregulated father can negatively affect a child's regulation of emotions (Bariola et al., 2011). Consequently, both parents' emotion regulation is key to children's emotional socialisation (Bariola et al., 2011; Eisenberg et al., 1998; Morelen et al., 2016). In this regard, fathers stressed the relevance of acquiring new skills to identify and regulate their anger in order to break the cycle of violence and not perpetuate this with their partners and children. In addition, the fathers shared that psychoeducation on child development strengthened their motivation to break the cycle of violence because they were able to understand the consequences that the experience of violence in a family environment can have on children.

Implications for Practice

Using a trauma-informed approach with people who have experienced trauma should begin by understanding their specific needs (Anyikwa, 2016; Campbell et al., 2019; Wilson et al., 2015). The analysis enabled us to identify which aspects of the *For Baby's Sake* intervention were considered most useful by participants and what needs they wanted to address with respect to recovering from DVA and improving their parental relationships.

Specifically, participants in this study shared a need to experience a safe and non-judgemental environment where they could freely discuss their adverse experiences of being parented and where they could change their perspective about themselves and their parenting skills. In this regard, the data suggests that guilt and shame, which are strongly associated with post-traumatic stress disorder and depression (McLean & Foa, 2017; Owens et al., 2009; Taccini et al., 2022), should be particularly addressed in any psychological interventions. Fathers stressed the usefulness of acquiring new ways of regulating anger.

The intervention also addressed parenting practices and most of the participants in this study found video feedback on parent-child interactions to be helpful in improving their parenting behaviours and attunement with their children. It also helped improve their self-esteem and self-efficacy in parenting. Self-esteem and self-efficacy were also improved by psychoeducation about the development of their children, as participants felt they had a safe space where they could acquire useful information about the child's development and ask questions about parenting. Consequently, video feedback on parent-child interactions and psychoeducation on children's development were identified as useful techniques for both fathers and mothers experiencing DVA.

Limitations and Future Directions

Some limitations of this research should be identified. First, although the number of qualitative interviews collected as part of the research evaluation was large, particularly with respect to interviews with people who have used abusive behaviours, more interviews were conducted with mothers than with fathers. This may be related to the fact that fewer fathers signed up for the *For Baby's Sake* program, resulting in a smaller number of male participants. Second, dropouts ($N=20$) were present in the two years follow up interviews. Specifically, at the two-year follow up interview, a follow-up rate of 47% was achieved. Third, this study did not aim to investigate changes over time from a longitudinal perspective. However, future work will address this.

A key strength of this study was the extensive longitudinal approach adopted, involving repeated interviews with participants spanning a substantial duration (specifically, a total of 2 years). This approach not only bolsters the research's robustness but also presents an opportunity for other interventions addressing DVA to extract valuable insights. The wider applicability stems from the notion that investigating violence and parenting over time can offer a comprehensive evaluation of how parent-child relationships evolve over time. Additionally, such an extended analysis facilitates the identification of potentially enduring benefits arising from the intervention, thus contributing to a more nuanced understanding of its efficacy in the long term.

Conclusions

The present research focused on exploring how pregnant mothers who experience DVA and men who commit DVA participating in a therapeutic parenting program perceived the impact of ACEs on their parenting behaviours and styles.

The results showed that childhood traumatic events were understood by participants as a risk factor for their experience of violence and abuse in intimate relationships in adulthood. Moreover, several participants reported developing mental health and substance misuse problems as a consequence of their negative childhood experiences.

Regarding parenting styles and behaviours, most mothers reported that the intervention strengthened their positive parenting practices and their attention to children's socialisation of emotions. Most fathers reported a growing attention to the use of adaptive emotion regulation strategies in front of the children and the positive impact this had on their relationships with their children. Both mothers and fathers reported being highly motivated to break the cycle of violence and prevent their children from experiencing the same traumatic events that they did.

A key learning from *For Baby's Sake* is that interventions aimed at breaking the continuity of violence should focus on the development of emotion regulation strategies by participants, on strengthening participants' self-awareness and their positive parenting practices. Furthermore, interventions should include training, education and therapeutic empowerment in children's psycho-development to help parents better attune to the needs of their children and to understand the impacts of the family environment on children's development.

Acknowledgements We would like to thank all the families who took part in this study. KT, MH, NS and JD were funded by the Stefanou Foundation to undertake the independent evaluation study. All remaining authors did not receive any specific funding for this study. Dr Josephine Ocloo, King's College London is supported by the National Institute for Health and Care Research (NIHR) Applied Research Collaboration South London (NIHR ARC South London) at King's College Hospital NHS Foundation Trust. The views expressed are those of

the author[s] and not necessarily those of the NIHR or the Department of Health and Social Care. Dr. Harriet MacMillan is supported by the Chedoke Health Chair in Child Psychiatry. For the purposes of open access, the author has applied a Creative Commons Attribution (CC BY) licence to any Accepted Author Manuscript version arising from this submission.

Author Contributions Conceptualization of the study design and methodology was completed by MH, SB, DB, LMH, HM, PR, NS, KT. Investigation and analysis for this paper was led by FT and supported by KT and SM. FT led the drafting of the paper, with all authors reviewing and editing the manuscript.

Funding The For Baby's Sake Trust (known as The Stefanou Foundation at the time of funding).

Declarations

Conflict of interest Not applicable.

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