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Parenting practices across generations: a mixed methods study of vulnerable mothers' parenting practices and understandings – to complement THRIVE

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Abstract

Background: The idea of intergenerational transmission of parenting practices is well-established. However, there is no consensus as to how or why this happens. Complementing THRIVE, a randomised controlled trial of two parenting interventions for women with additional health and social care needs, this research sets out to gain an understanding of whether parenting practices are transmitted across generations among this 'vulnerable' population, and if so, how. Informed by theories of attachment and social reproduction, this thesis seeks to gain the perspective of these mothers, and understand how childhood experiences, and the ways in which they were parented, impact upon the practices they adopt with their own children. By understanding these women's lived experiences, and how they respond to them, this mixed methods PhD provides new insights on this topic, and gives a voice to those at whom parenting interventions are targeted.

Methods: Baseline quantitative data from the THRIVE population ($N = 463$) were analysed, using binary logistic regression, to examine factors associated with parental self-efficacy. Twenty-one women, recruited through THRIVE, participated in in-depth interviews. Interviews focused on their upbringing - in particular their recollections of the parenting practices of their mother and father - and the environment in which these practices were experienced. Participants recorded the parenting style of their parents using the Parental Bonding Instrument.

Findings: Drug use, deprivation, anxiety and having a child removed from the family home are associated with parental self-efficacy among THRIVE participants. Reflections upon childhood experiences are acute for these women during the perinatal period, and often inform conceptualisations of 'good' and 'bad' parenting. These perceptions shape decisions around how they parent their own children. Those who recall 'optimal' parenting are likely to attempt to model their approaches on their parents, but mental health issues and other contextual factors may mean they are not always able to do so. Recalled experiences of 'neglectful' or 'affectionless' parenting may lead to a rejection of the approaches of their parents, but some mothers find themselves repeating these harsh practices. Some mothers may find it difficult to recognise or effectively respond to challenging, externalising behaviours in their children.

Conclusions: Parenting practices can be seen to be passed from one generation to the next, in both conscious and unconscious ways. Underlying vulnerabilities, compounded by life histories that include adversity, trauma and deprivation, may make it difficult for mothers to consistently parent in warm and supportive ways and break unwanted cycles. Parenting interventions targeted at these mothers should: incorporate ways of alleviating the added difficulties associated with these contextual factors; seek to improve maternal self-efficacy; and take account of the subjective nature of parenting and internalised norms and beliefs.

List of Abbreviations:

AAI – Adult Attachment Interview

ACEs – Adverse Childhood Experiences

CaU – Care as Usual

CPO – Child Protection Order

CTQ – Childhood Trauma Questionnaire

ETPB – Enhanced Triple P for Baby

HADS – Hospital Anxiety and Depression Scores

MB – Mellow Bumps

MRC/CSO – Medical Research Council/Chief Scientist Office

PBI – Parental Bonding Instrument

SES – Socioeconomic Status

SIMD – Scottish Index of Multiple Deprivation

SPHSU – Social and Public Health Sciences Unit

THRIVE – Trial of Healthy Relationships in the Very Early years

Table of Contents

List of Tables and Figures

Tables

Figures

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As with any PhD, this thesis represents the culmination of several years' efforts, and it presented a myriad of challenges along the way. As such, it required from me unprecedented commitment and perseverance, and this would not have been possible without the unwavering support, guidance and encouragement of those around me.

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THRIVE was itself an enormous project, and to be part of such a trial was extremely valuable and rewarding. Being part of a bigger team, contributing to research with potential real-life impacts, sharing stories and being there for one another during the highs and lows certainly made this PhD a richer experience. My thanks to Cat and Shona especially, who were always there when I needed them, even in the face of my persistent naïve questions.

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I am lucky to have made such wonderful friends among my fellow students throughout this journey. I cannot imagine how I would have coped without the chocolate, coffee, chat, gossip, yoga sessions, runs, nights out, and overly long lunches. To Marissa, Kathryn, Rebecca, Karl, Rachel, Michal, Catherine, Ian and Lauren – thank you. The laughs and the commiserations, the thought-provoking conversations, the encouragement and support all made an incredible experience even better. Enormous thanks too to Lido, who came into my life at just the right moment and provided the insights, the inspiration, and the motivation to finish this thing.

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Finally, I am extraordinarily grateful to the women who took part in THRIVE, and especially those who agreed to sit with me and share their stories. At points these stories were difficult, and tears were shed; at other times they were funny and punctuated with laughter – often there was not much space in between. These women have inspired me and moved me more than they will probably know, and I think of our conversations frequently. Attempting to do justice to what they shared with me has been an enormous challenge, and one which I hope I have managed in the following pages.

Author's Declaration

I declare that, except where explicit reference is made to the contribution of others, that this dissertation is the result of my own work and has not been submitted for any other degree at the University of Glasgow or any other institution.

Simon Barrett

1 Introduction

1.1 Overview

The idea of intergenerational transmission of parenting - that is to say that parenting styles or specific parenting practices observed in one generation are often observed in the next - is well-established, both in popular culture and increasingly in academic literature. There is an increasing body of evidence which supports the view that the way parents raise their children is influenced to a significant degree by the childrearing they themselves experienced during their own childhood (Conger *et al.*, 2012).

There is also growing evidence that parenting practices are associated with a variety of outcomes in children in terms of their adjustment, development and wellbeing (Amato and Fowler, 2002). As such those who have been parented in potentially harsh or negative ways for example, may be in need of much greater levels of support when it comes to parenting their own children. Difficulties or challenges faced in parenting, especially when parenting in the context of additional health and social care needs, may then have impacts across generations. This PhD project specifically seeks to understand, from the perspective of mothers with additional health and social care needs, how they feel their childhood experiences, and the ways in which they were parented, impact upon the parenting practices they adopt with their own children. It also seeks to uncover the factors which affect their parental self-efficacy. This project complements the Trial of Healthy Relationships in the Very Early years (THRIVE), a three-armed randomised control trial, funded by the National Institute for Health Research. THRIVE evaluated two parenting interventions in addition to routine antenatal care for women with additional health and social care needs (Henderson *et al.*, 2019b).

1.2 Rationale

Despite recent improvements, the United Kingdom still scores badly on many UNICEF child and adolescent wellbeing measures (Hudson and Kühner, 2016) highlighting a need for improvement in children's health and wellbeing in the UK. Evidence from neurological studies suggests that the early years of

development from conception to age six set the base for competence and coping skills throughout the life course, with potential impacts upon future learning abilities, behaviour, and health (Chugani *et al.*, 2001). Furthermore, evidence is growing that depression, stress and anxiety in pregnant women can permanently affect the baby's response to stress and disrupt the mother's ability to be sensitive to her baby, adversely affecting the mother-infant interaction. In turn, poor mother-child interaction and maternal mental health are highly prevalent among mothers identified as vulnerable in pregnancy (Macrae *et al.*, 2015; Stein *et al.*, 2014). Both poor mother-child interaction and poor maternal mental health strongly predict child maltreatment and a disadvantaged trajectory for children in terms of their future social, emotional, cognitive development and health (Mäntymaa *et al.*, 2003; Mäntymaa *et al.*, 2004; Paulson *et al.*, 2009).

Research indicates that women who have suffered disturbances in the mother-child dyad are at risk of having difficulties when it comes to raising their own children (Benoit and Parker, 1994; Walters, 1990), and these difficulties can be exacerbated by a range of other factors including a lack of resources, generational discrimination, and exploitation (Polansky *et al.*, 2006). Traumatic experiences are also related to difficulties in parenting, whether suffered in childhood or adulthood (Banyard *et al.*, 2003; Radford and Hester, 2006; Renner and Shook Slack, 2006). There is a greater likelihood that women identified as vulnerable due to a lack of resources will also have been traumatised by sexual abuse and violence (Weinfield *et al.*, 2000). When women's lives are characterised by abuse and violence, this severely compromises their ability to parent in line with societal expectations (Carolan *et al.*, 2010; Newman *et al.*, 2007). Furthermore these parents are at greater risk of continuing these patterns of neglect and abuse not only with their own children but with subsequent generations also (Wark *et al.*, 2003).

Existing guidance relating to health during pregnancy has identified populations of women considered to be 'vulnerable', due to social and psychological difficulties that pose a potential 'risk' to the foetus, infant and child (National Institute for Health and Care Excellence, 2010). These populations include women with mental health problems, those who are socially deprived, those with substance misuse problems, women experiencing domestic violence, as well

as those who were sexually abused as children, and women with a history of involvement with child protection services (National Institute for Health and Care Excellence, 2010). These women therefore have multiple and complex needs, and healthcare guidance identifies three underlying 'risk' factors purported to be common to these populations: social inequality; maternal stress; and reduced capacity for developing a healthy attachment relationship (National Institute for Health and Care Excellence, 2010). Because of the specific inclusion criteria for THRIVE (see Section 3.5.2), the women involved in this study therefore represent some of those at greatest risk of the factors described above. It is the presence of these increased risks that means the women included in this study are therefore framed as 'vulnerable'.

The term vulnerable is used throughout this thesis, but with an awareness of its potential problematic nature and the surrounding debates - in that it potentially risks labelling people with a term with which they do not themselves identify for example. Labelling of groups of people as vulnerable also fails to acknowledge an individual's resilience or resistance in the face of these adversities or risk, and potentially denies their personal agency.

Where I do use the term, and employ concepts of vulnerability, I therefore follow the definition of Virokannas *et al.* (2018) who suggest attention should be turned not to the 'vulnerable' individual, but towards vulnerable life situations, social processes, societies and institutions, which generate and reproduce vulnerabilities. I use the term vulnerable in this wider sense then, alongside a commitment to acknowledging and facilitating the ability of these women to articulate and make meaning of their own experiences (Virokannas *et al.*, 2018). This is discussed in more detail, as well as the ethical implications of research with such populations, in Section 3.5.1.

In light of all of the above, there is a need to develop interventions which seek to improve maternal mental health and mother-child interaction, and ultimately improve outcomes for both mother and baby and disrupt any negative intergenerational cycles. This PhD complements the THRIVE process evaluation of two such parenting interventions, by examining how experiences from childhood shape the parenting practices of women with additional health and social care needs.

1.2.1 THRIVE Overview

Women who are vulnerable in pregnancy, due to, for example, mental health difficulties, domestic abuse, an addiction, having been in care, have been shown to be more anxious, depressed and produce higher levels of stress-related hormones than those who are not exposed to these factors (Obel *et al.*, 2005). Increasing evidence indicates that depression, stress and anxiety in pregnant women can create adverse modifications to the foetus in utero that can permanently negatively influence the baby's response to stress (Hunter *et al.*, 2011; Radtke *et al.*, 2011). These mental health issues may also disrupt the mother's ability to be sensitive to her baby (Pearson *et al.*, 2010). These factors have the likely potential to adversely affect mother-baby interactions; poor mother-baby interaction and maternal mental health strongly predict child maltreatment (Brown *et al.*, 1998; Morton and Browne, 1998). Therefore, the rationale is that *postnatal* interventions may not be able to sufficiently overcome some of the damage already sustained by infants due to their parents' maladaptive coping in adverse circumstances, and *antenatal* interventions, such as those evaluated by THRIVE, may prove more effective and provide better outcomes (Henderson *et al.*, 2019b).

The overarching aim of THRIVE was to rigorously evaluate the impact of two parenting interventions aimed at women with additional health and social care needs, in addition to their routine antenatal care, or care as usual (CaU). THRIVE consisted of both an outcome evaluation (Henderson *et al.*, 2019b) and a process evaluation (O'Brien *et al.*, 2019). The former assessed whether women who received either Enhanced Triple P for Baby (ETPB) or Mellow Bumps (MB), in addition to CaU, experienced improved mental health and wellbeing and developed positive, interactive and attuned mother-child relationships. The trial, contingent on further funding, also aims to undertake routine data linkage to enable assessment of whether children whose mother received ETPB or MB showed reduced incidence of child maltreatment, and improved language development and socio-emotional wellbeing.

1.2.2 The Interventions

1.2.2.1 Enhanced Triple P for Baby

Triple P (Positive Parenting Program) is an evidence-based family support system, which draws on social learning, cognitive behavioural and developmental theory in order to prevent and treat social and behavioural problems in children, up to twelve years of age. It aims to equip parents with the skills and confidence they need by providing simple and practical strategies which help them build strong, healthy relationships, confidently manage their children's behaviour and prevent problems developing. The theory of change underpinning Triple P is outlined in Figure 1.1.

Triple P is suite of interventions of increasing intensity, more than half of which focus on developing positive relationships, attitudes and conduct. There is a flexible choice of delivery methods for each level, delivered in groups or to individuals by trained practitioners, with evidence of its effectiveness across cultures, socio-economic groups and family structures (Triple P - Positive Parenting Program, 2020).

While Triple P is designed to be universal, the 'enhanced' level, Enhanced Triple P for Baby (ETPB), is intended to address additional maternal vulnerability when identified. It offers four antenatal group sessions and four post-natal telephone consultations, with a further four sessions offered to address any additional maternal vulnerability in this group. ETPB sessions take from 30 minutes (telephone) to 2 hours (group) and the intervention is around 14 hours in total. ETPB's emphasis is on families and includes fathers. It incorporates social learning principles and has skills-based content around expectations of, and coping with, the new challenges of parenthood while maintaining a happy family.
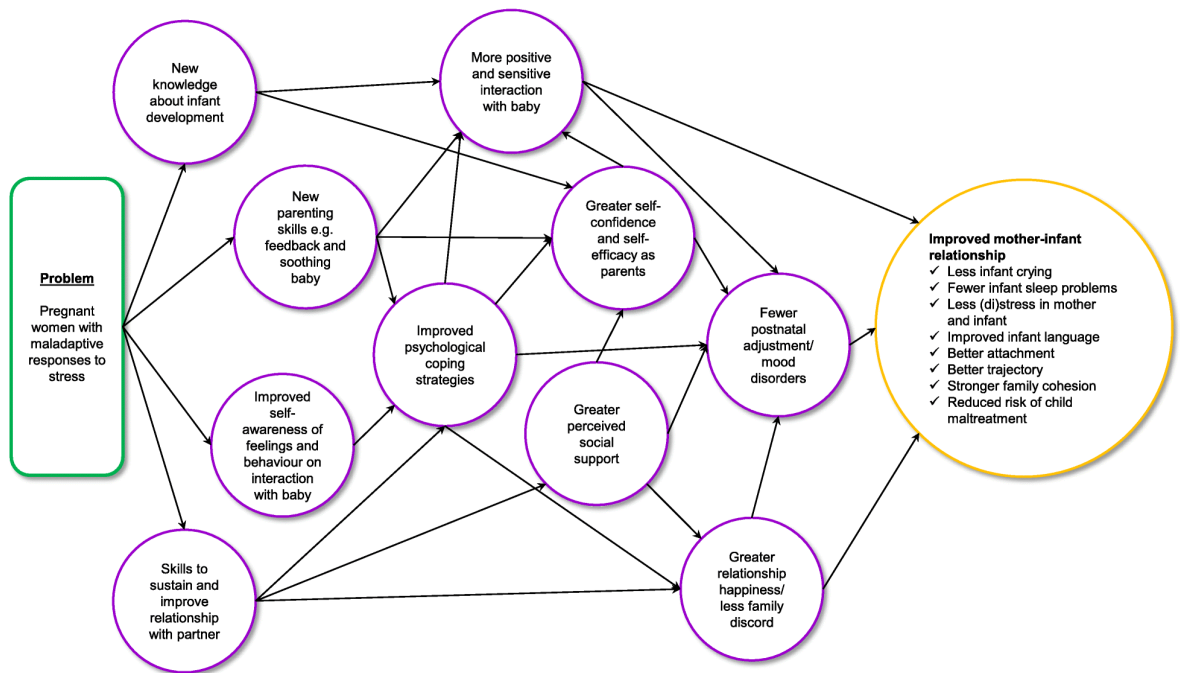
Figure 1.1: Triple P Theory of Change
(O'Brien *et al.*, 2019)

1.2.2.2 Mellow Bumps

Mellow Bumps, a Scottish parenting programme, is part of the Mellow Parenting suite of parenting interventions, and is underpinned by attachment theory, as well as drawing on social learning and cognitive behavioural therapy. It focuses on improving parent-child relationships and targets mothers who are vulnerable in pregnancy. The aim is to decrease stress levels of mums-to-be in pregnancy, improve their mental health by reducing anxiety and depression, and increase well-being, self-esteem and self-confidence. The theory of change for Mellow Bumps can be seen in Figure 1.2.

It involves seven antenatal group sessions (2 hours each) and focuses on mothers, although fathers are invited to one session. The content focuses on nurturing mothers' self-care, providing them with guided reflection, encouraging nurturing of and engagement with the foetus or baby. Each week there are activities for the mums-to-be to support emotional containment and stress reduction, and activities to raise awareness of the social capabilities of babies and the value of early intervention. Mellow Bumps is designed to be offered at about twenty to

thirty weeks gestation to capture the period when the pregnancy is most secure (Mellow Parenting, 2013).
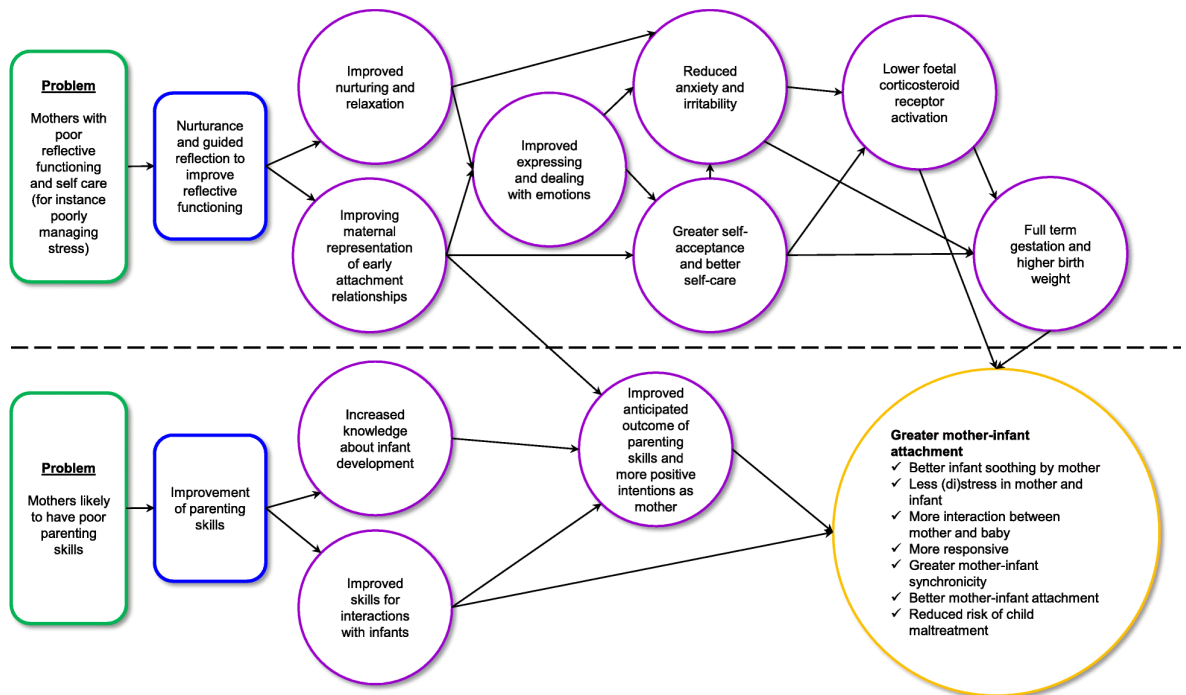
Figure 1.2: Mellow Bumps Theory of Change
(O'Brien *et al.*, 2019)

1.3 Thesis Structure

Drawing upon baseline quantitative data from THRIVE, as well as interviewing a sub-sample of the mothers recruited to the trial, this mixed methods PhD complements THRIVE by seeking to understand, from the perspective of mothers with additional health and social care needs, how they feel their childhood experiences, and the ways in which they were parented, impact upon the parenting practices they adopt with their own children. This thesis outlines the research to date on the topic of intergenerational transmission of parenting practices, highlighting where gaps exist, and ways in which this topic can be better understood. It will also contribute to the continued development of parenting interventions such as those evaluated by THRIVE. This mixed methods PhD provides a quantitative exploration of the factors associated with parental self-efficacy, and, by listening to, analysing and reflecting these women's lived experiences and how they respond to them, a much-needed qualitative

perspective on this topic. It thereby also provides a voice for those women at whom such parenting interventions are targeted.

This thesis begins with a review of the literature on the intergenerational transmission of parenting (Chapter Two). This chapter focuses on several areas: Firstly, the association between parenting practices and social and developmental outcomes for children, and in turn the intergenerational transmission of parenting practices; it examines the evidence base for these and outlines the theories which attempt to explain them. It also provides a critical discussion regarding the discourses which are often used to frame parenting as a public health issue.

The literature review also examines how Adverse Childhood Experiences (ACEs) are thought to have lifelong implications into adulthood. It focuses on the ways in which experiences of being parented, and experiences of adversity, are thought to impact upon later parental abilities and which may therefore have consequences across several generations. It concludes with a review of both the Parental Bonding Instrument and the Adult Attachment Interview, two tools used in this research, with particular regard to the intergenerational transmission of parenting, and developmental outcomes for children and parents.

Chapter Three outlines the mixed methods used in this study, describing the underpinning theoretical approach, decisions around recruitment, the research design, and the generation, collection and the analysis of both qualitative and quantitative data.

Chapter Four reports the quantitative findings of this study and outlines the adversities and complexities that characterise the backgrounds and current situations of the women recruited to THRIVE. It then goes on to assess the representativeness of those who make up the sample for the qualitative interviews for this project. Finally, this chapter utilises binary logistic regression analysis to investigate how ACEs and other factors impact upon the reported parental self-efficacy of these mothers.

Chapters Five and Six report the qualitative findings. The first of these chapters explores the lived experiences of these women: their recollections of their

parents' practices and the environment in which these practices were experienced. Further, it gives a qualitative account of some of the extreme adversities faced by these participants during their childhood. The second qualitative chapter draws upon these narrative accounts and examines how these women respond to their backgrounds and experiences when it comes to their conceptualisations of parenting, the practices they adopt, and the decisions they make as they navigate the challenges of raising their own children.

Chapter Seven brings together the findings from these previous chapters and situates them within the existing literature. Reflexivity is also discussed in this chapter, considering my own role in the design of the research project, and the generation, collection and analysis of the data, especially in light of the vulnerable nature of the population of interest. This chapter then ends with final conclusions, an assessment of the strengths and limitations of this study, and recommendations for future research, policy and practice.

2 Literature Review

2.1 Evidence Base and Theories of Intergenerational Transmission

Reviewing the evidence on how parenting in one generation might influence parenting in the next enables us to situate this study in relation to previously published work on this topic. It allowed me to draw upon and build upon theories of how parenting practices are associated with outcomes in children, and how this in turn can lead to the intergenerational transmission of parenting practices. This review identified the gaps in the literature that this study can help to fill, explored the potential research tools which may aid this enquiry, and informed the eventual research design of this study in terms of how data was generated, collected, analysed and interpreted.

2.2 Rationale for this Review

This review aimed to outline, explore and critically assess the existing published literature regarding the association between parenting practices and children's social and developmental outcomes. It also examined the existing literature surrounding the intergenerational transmission of parenting – where practices and attitudes towards parenting observed in one generation are passed to the next.

As this present study seeks to examine how a group of mothers feel that their upbringing influences their subsequent parenting practices, it is necessary to begin with a review of existing evidence of how parenting in one generation is thought to influence parenting practices in the next. This review examines the evidence as to whether such transmission occurs, and if so to what degree, as well as uncovering potential mechanisms and discussing the factors which may moderate or mediate this transmission of parenting between generations. It is by understanding these issues that policymakers and practitioners will be better able to interrupt these processes with the aim of improving outcomes for both parents and children.

Parenting practices, such as support, monitoring, protection and discipline, have long been associated with children's adjustment, development and wellbeing, and parenting behaviours and the quality of the parent-child relationship have frequently been associated with both positive and negative outcomes for children (Amato and Fowler, 2002). The evidence that parenting has long-term implications for children's developmental adaptation (Collins *et al.*, 2000; Fraley *et al.*, 2013; O'Connor, 2002; Repetti *et al.*, 2002; Sroufe *et al.*, 2010) has also provided much of the motivation to study why adults parent the way they do (Raby *et al.*, 2015). However, despite over fifty years of research into the topic, the case for the quality of a parent-child relationship as a causal influence on children's psychological, social, and cognitive outcomes remains controversial.

More specifically, the question of if and how parents' own experiences as children later influence their own parenting practices and attitudes towards their children has long been of interest to developmental psychologists (Belsky, 1984). The topic of intergenerational transmission of parenting spans several different theoretical perspectives – such as attachment theory, social learning and social reproduction theories for example – and is of interest to a range of researchers including sociologists, social psychologists, and geneticists. It is particularly relevant to those seeking to understand and therefore remediate or prevent problematic parenting, as well as those who hope to promote and facilitate child rearing practices which support the healthy growth and development of infants (Belsky *et al.*, 2009).

The concept of intergenerational transmission of parenting is concerned with identifying the origins of parenting behaviours and attitudes in an earlier generation, and further seeking to understand the mechanisms by which these behaviours and attitudes are transferred from one generation to the next. Kovan *et al.* (2009) suggest that the hypothesis of intergenerational transmission is an intuitive one that has gained widespread support not only among researchers but also with the wider public, and one which has caught the attention of politicians, policy makers and mass media. Indeed, there is widespread agreement derived from a growing body of empirical evidence that such transmission exists (Madden *et al.*, 2015), leading some to suggest that the

concept of intergenerational transmission is so well-accepted as to be 'virtually axiomatic' (Hops *et al.*, 2003, p.161).

However, there is by no means any agreement upon the degree to which parenting behaviours are transmitted to the next generation, or indeed the processes by which this may happen (Belsky *et al.*, 2009). Much of the research to date has sought to address the question of whether continuity of specific parenting practices across generations is the result of psychological influences, a consequence of genetics, due to broader social mechanisms, or a complex mixture of these factors.

In light of this, the following sections outline the evidence base for the association between parenting practices and children's social and developmental outcomes, and how these practices may or may not be transmitted across generations.

2.2.1 Literature Search Strategy

Several databases were used to search for and retrieve published literature surrounding the intergenerational transmission of parenting, with pertinent studies selected for inclusion in this review, using the criteria outlined below. This search strategy was developed under the guidance of a trained and experienced Information Scientist based at the Medical Research Council/Chief Scientist Office, Social and Public Health Sciences Unit. Given that the topic spans several disciplines, a range of databases were searched. MedLineR, CINAHL, ASSIA and SocIndex were all searched using the following terms: "parenting", "child rearing", "child parent relation", "mother child relation", "parent-infant relations", "parental behaviour", and "child outcomes", "child development", "intergenerational", "transgenerational", "transmission" and "transfer". This search was restricted to academic journals, in the English language, with no date range specified. A total of 2729 papers were returned. Abstracts were reviewed, with duplicated papers removed, and those which covered solely grandparenting (189) excluded, along with those concerning disease transmission. The remaining 281 papers form the basis of this literature review.

2.3 Defining Parenting Practices

According to Maccoby (2000), parenting is best seen as a set of deliberate and discrete actions which together have the specified goal of socialising children in order that the child may develop behaviours deemed appropriate within the society or community in which he or she is raised. Maccoby (2000), while recognising that there are certain familial risk factors for the development of behaviours in children, suggests that wider societal influences play a vital role, and further, these important social conditions affect how parenting practices are adopted and enacted. She also points out that these parenting behaviours may act as mediators between societal risk factors - such as poverty, lack of education - and children's adjustment and development. In this way, while parenting is undoubtedly largely a family-based practice, it must also be viewed in a much wider societal context.

In order to distinguish between parenting practices and parenting styles, throughout this thesis I draw upon Darling and Steinberg (1993). They suggest a parenting style is best defined as a constellation of attitudes toward the child that create the wider emotional environment in which parents express their behaviours. Parenting practices are understood as those specific goal-directed behaviours through which parental duties are performed, and include different forms of discipline, support and monitoring for example, which operate in this wider context. Parenting styles are conceptualised therefore as the context that moderates the influence of specific parenting practices on the child (Darling and Steinberg, 1993). High levels of support and monitoring, and the avoidance of harsh punishment, have consistently been suggested as the optimal combination of parental practices (Baumrind, 1968, 1978; Darling and Steinberg, 1993; Maccoby and Martin, 1983; Rollins and Thomas, 1979).

It has been suggested that as a contrast to the top-down, unidirectional trait-like process implied by 'parenting', the term 'parent-child relationship… connotes a more mutual, dynamic, interactive process that describes the processes of mechanisms of influence' (O'Connor and Scott, 2007, p.2). While research would suggest that mothers and fathers each approach and fulfil their parental roles in a variety of different ways (Cabrera *et al.*, 2000) there is no strong indication that optimal parent-child relationships take a different form

depending upon the sex of the parent, and it is suggested that the processes linking this relationship with a child's developmental outcome remain broadly the same irrespective of whether one is discussing mothers or fathers (O'Connor and Scott, 2007).

2.4 Theoretical Perspectives of the Intergenerational Transmission of Parenting

The proposition that parenting practices can have impacts across generations is one that spans various theoretical perspectives, including attachment (Bowlby, 1969), social-learning theory as promoted by Bandura (1977) and Patterson (1998), and social reproduction (Bourdieu, 1984). An outline of each of these is provided in the following sections, as well as a discussion of potential biological and genetic explanations for continuity in parenting practices.

2.4.1 Attachment Theory

Attachment theory is an ethologically based concept, developed by Bowlby (1969, 1973, 1980, 1985), in which he describes a control system defined by behaviours in the infant, such as crying and remaining close to caregivers for example, which have a set goal of keeping the child comforted and protected. Based on the quality of care received at this developmental stage the child builds expectations or models of the world, of people, of relationships and of the self. These internal representations are the result of complicated autobiographical memory processes and, in turn, this view of the world is carried into adult life, where these memories continue to organise perceptions and, importantly, influence and guide behaviours in new situations. The quality of the care received at this early stage, especially in terms of the sensitivity and responsiveness of the caregiver, leads to an attachment style which can be either secure, insecure or disorganised. It is in this way that early parenting practices can be seen to be responsible for shaping the psychology of young infants: this view of the world is carried into adult relationships, with potential impacts upon attachment and the practices adopted with their own children.

Secure attachment histories have significant associations with a wide range of improved outcomes for children, in terms of their emotional, social and

behavioural adjustment, educational achievement and peer-rated social status (Sroufe, 2005). Conversely, both insecure and disorganised attachment are associated with a variety of problems in children and in later life (van der Voort *et al.*, 2014) including externalising disorders, or outwardly aggressive behaviours (Fearon *et al.*, 2010), dissociation (Lyons-Ruth *et al.*, 2005), post-traumatic stress disorder (MacDonald *et al.*, 2008) and personality disorder (Steele and Siever, 2010).

Attachment style has been seen to be strongly linked with a variety of developmental outcomes in children, where early experiences shape the subsequent development of attachment styles and cognitive function, and may also influence important expectations and relationships throughout the life course. Importantly though, as Bowlby (1988) himself indicates, they do not do so in a deterministic manner.

Studies by Ainsworth *et al.* (1978) expanded the understanding of attachment theory by demonstrating not only that mother-child pairs differed in the quality of their attachment relationship, but also that these differences can be measured and classified. Further they shifted the attention to the mother, demonstrating that the classification of the relationship could be predicted by maternal behaviours. Similarly, Fraiberg *et al.* (1974) suggest parents are influenced by unresolved conflicts – often unconscious anxious moments and experiences during their own childhood – which condemn the parent to repeat these experiences with their own child.

An outline of two tools which are used to measure and classify attachment is provided in Section 2.11, along with a review of how these are used to assess intergenerational patterns of attachment styles, and the link between these attachment styles and outcomes for children and parents.

2.4.2 Social Learning Theory

Social learning theory provides one of the most influential models of parent-child relationships and is built in large part on the work of Patterson (1969) and Bandura (1977). This theory suggests that a child's real-life exposures and experiences will, either directly or indirectly, shape his or her behaviours. A set

of sequential links are thought to explain how early parent-child relationship experiences can predict adult parenting outcomes. Social learning theory places emphasis on the crucial learning opportunities provided by the interactions with others, in particular parents and caregivers. The parent-child relationship then can be seen to be the primary source of this experiential learning.

Conditioning and reinforcement occurs in these moment-to-moment exchanges with behaviours in the children being either rewarded or punished accordingly (O'Connor and Scott, 2007). It is through this engagement with their parents and through their experiences of how others react to them that children develop strategies to manage their own emotions, resolve disputes and engage with other people around them. The hypothesis is that experiences in the early parent-child relationship are linked to the quality of peer relationships developed throughout childhood. These childhood peer relationships then set the basis for competence in adult, romantic relationships.

This model integrates earlier evidence, supported by subsequent empirical evidence, and suggests that social skills developed by children during early parent-child relationships enable more competent peer group interactions as the child grows and develops (Fraley *et al.*, 2013). These prior experiences are important in building and maintaining healthy romantic partnerships, especially during young adulthood (Allen *et al.*, 2014; Roisman *et al.*, 2004; Simpson *et al.*, 2007). Evidence also suggests that current social ecology, and particularly the quality of these romantic relationships, is a significant influence upon the quality of parenting an adult is able to provide (Belsky and Jaffee, 2006; Krishnakumar and Buehler, 2000).

2.4.3 Bourdieu and Social Reproduction

Bourdieu (1986) describes capital as accumulated labour, in either a materialised form or an incorporated or embodied form; this capital is then used by agents in order to appropriate social energy. It is the structure and distribution of these varying types of capital at any given time which both represent and govern the functioning of the social world. Aside from the more established economic capital, Bourdieu suggests that capital can take two other fundamental forms: cultural capital and social capital.

Cultural capital relates to values and knowledge and can exist in an embodied state, in the form of enduring dispositions of the mind and body. Bourdieu's theory of social reproduction posits that cultural capital consists of cultural codes and practices, transmissible through family socialisation, from parents to their children.

Social capital is described as those resources, actual or potential, that are derived from relationships of mutual recognition and acquaintance, in other words from membership of a group or from social connections (Bourdieu, 1986). This form of capital can also be defined as including the values that people hold, and is seen both as a result of, and resulting in, socially negotiated ties and relationships (Edwards *et al*., 2003a).

According to Bourdieu (1984) the habitus is a socially constituted system of structures which shape both how we think and the choices that we make - cognitive and motivating structures. Located within the body, the habitus reproduces social structures by providing individuals with a particular world view which is shaped by their social location. This world view predisposes individuals to relate to familiar and new situations in this class-dependent way, and is based upon and reconciled to their position within society; this for Bourdieu is a fundamental principle of how we as individuals construct and evaluate the social world and how social class is maintained and reproduced (Bourdieu, 1984). This set of dispositions and particular practices can be carried out without consciousness or reflection and may lead to regularities in patterns of transmission across family generations (Bourdieu, 1990).

Employing the theories of Bourdieu for this research can be seen as appropriate given his ontological and methodological position. Bourdieu suggests the meanings that actors attribute their relationships and the motivations behind them are significant, and that examining the content of these relationships is important (Gillies and Edwards, 2006). Additionally, the categories he employs, such as capital, are not fixed but instead are seen as heuristic, changeable and temporary constructions, and concepts that, if they are to be of any utility, need to be continually informed by contemporary empirical research (Fine, 2001; Reay, 2000).

The work of Bourdieu has been formative in shaping the debate on social capital and families (Gillies and Edwards, 2006), with Bourdieu seeing families as motors of social capital, with enduring family practices responsible for perpetuating inequity across generations. As such, previous work has employed frameworks derived from Bourdieu's work or relied exclusively on frameworks informed by him (Gillies, 2005; Gillies and Edwards, 2006; Skeggs, 1997; Skeggs, 2004). This approach allows a focus on how societal arrangements are encountered and engaged with by people in their daily lives, and the impacts they have upon parenting practices – enabling the researcher to examine those day-to-day relationships 'through which a mother encounters, experiences, mediates, and interprets the social structures which shape her parenting practices' (Fram, 2003, p.28).

The transmission of practices and values can be implicit as well as explicit (Brannen *et al.*, 2011). What passes between generations, or is passed on, is embedded in routine practices and relationships and as a result it may not always be immediately recognised as such. Framing this PhD research this way, we are therefore able to uncover what may otherwise remain unseen and provide participants with an opportunity to consciously reflect upon something which is often taken for granted.

2.4.4 Genetic and Environmental Interaction

An alternative explanation for similarities in the behaviours and practices across generations is that they are the result of genes shared between parents and their children. Uncertainty around the evidence, and suggestions that continuity in behaviour between parents and their children may result as much from genetic and social mechanisms as from any psychological influence, led to caution by Rutter (1998) against drawing definitive conclusions in light of the limited understanding of the precise mechanisms responsible for any continuity, and calls for further research in this area.

It is proposed that the genes inherited from parents, in interaction with environmental factors, are a significant driver of both biological and psychological processes. Indeed, studies have demonstrated how specific parenting practices interact with genetic variations which affect the emotional

and behavioural development of children, leading to conduct problems and antisocial behaviours for example (Caspi *et al.*, 2002; Sheese *et al.*, 2007). While some studies have found a moderate genetic influence on some aspects of parenting as reported by participants (Spinath and O'Connor, 2003), there is less evidence of a genetic influence when observations are made of parenting behaviours (Fearon *et al.*, 2006; Neiderhiser *et al.*, 2004). The Gene X Environment theory posits that individual children will vary in their susceptibility to environmental factors, especially the quality of parenting practices (Belsky, 1997, 2005), leading some to suggest that there may be a widespread over- and underestimation of cross-generation continuity by all studies into the intergenerational transmission of parenting (Conger *et al.*, 2009). These differences in developmental plasticity (Pluess and Belsky, 2009) may lead to overestimations of continuities for those who are less susceptible to environmental influences, and underestimating them for those who are more susceptible.

While the evidence is not clear in this area, Conger *et al.* (2009) concluded that genes do not deterministically result in certain behaviours or parenting styles. Rather, they suggested, the complex process of genetic and environmental interaction involves mutually influential genes and experiences which shape human development and the intergenerational transmission of parenting practices. Similarly, Serbin and Karp (2003) cited a growing amount of empirical research and concluded that this strongly suggested that intergenerational similarities in adopted parenting styles are produced by a combination of genetic and environmental influences.

While genes transmitted from one generation to the next may shape the predispositions and responses of individuals towards their social and physical environments, it is also the case that contextual factors may exert an influence on the intergenerational transmission of parenting. Where subsequent generations each raise their children in roughly the same physical and social circumstances it may be argued that these contextual factors shape parenting practices and attitudes, and the previous generation exerts no direct psychological influence on parenting in the next (Quinton and Rutter, 1984). This

again suggests there is a need for studies to examine these contextual factors and their impact upon how parenting is transmitted across generations.

2.5 van Ijzendoorn Review

Amid growing interest in the topic, a specially commissioned review by van Ijzendoorn (1992) examined the evidence for intergenerational transmission of parenting, in particular within non-clinical populations. This formative review aimed to establish the evidence to-date and explore ways of advancing knowledge in this area, and defined intergenerational transmission of parenting as:

'the process through which purposively or unintendedly an earlier generation psychologically influences parenting attitudes and behaviour of the next generation' (van Ijzendoorn, 1992, p.76).

In this way, intergenerational transmission of parenting forms part of the socialisation process, and specifically the 'socialisation of the socialiser' whereby those from the first generation – grandparents – socialise their children who then go on in turn to do the same with their own (Feldman and Goldsmith, 1986). For van Ijzendoorn, the process of intergenerational transmission implies the involvement of three generations – grandparents, parents, and children. However, while acknowledging that grandparents may have a direct influence on the socialisation of their grandchildren, this process is by necessity defined as 'grand-parenting' as there is usually – at least in Western societies - no direct involvement in childrearing by grandparents as a primary caregiver (van Ijzendoorn, 1992). In other words, the model of intergenerational transmission he outlines is only concerned with how one generation psychologically influences the subsequent one, how the grandparents of the first generation socialise the second, and how these parents in turn socialise the third generation of children. By framing intergenerational transmission in this way, van Ijzendoorn (1992) seeks to focus on the psychological influences parents may exert upon their offspring, and at the same time differentiate this from any genetic or contextual factors which may account for continuity of parenting in subsequent generations.

This tightly framed definition of intergenerational transmission is further restricted to the investigation of continuities (or discontinuities) between parenting behaviours and attitudes in different generations as displayed at roughly the same social or chronological age. In this way, the model proposed by van Ijzendoorn (1992) is able to minimise the potential effects of contextual factors and the impact of varying stages of childhood development which necessarily influence parenting attitudes and behaviours (Conger *et al.*, 2009). It also, he argues, allows us to distinguish between actual intergenerational transmission, as distinct from childrearing by grandparents and grand-parenting in general, and also support given to parents by grandparents (van Ijzendoorn, 1992).

Concluding his review, van Ijzendoorn (1992) pointed to early promise in that studies showed that the intergenerational transmission of parenting may exist, even when using such a clearly defined model which differentiated this from those contextual and genetic factors which may explain intergenerational similarities. However, according to van Ijzendoorn (1992) none had yet addressed the issue in what he saw as a methodologically adequate way. Most promising, he suggested, were those studies that used the Adult Attachment Interview and observational measures of parenting (van Ijzendoorn, 1992). Where early studies relied upon retrospective accounts from a single source, the review called for prospective and longitudinal research designs to be brought to the investigation. In his concluding remarks there is also a call for future research which is able to take into account the various contextual factors involved in shaping parenting practices and child development. Finally, he called for studies to incorporate detailed descriptions of individual cases in order to further examine the causal mechanisms which may lay behind the parental influence upon the parenting practices adopted with one's own children. Consequently, van Ijzendoorn's (1992) review and his subsequent recommendations have served as a benchmark for those studies which followed, as well as marking a definite shift to using more prospective research designs along with longitudinal data in order to investigate the intergenerational continuity or discontinuity of parenting practices. There is therefore a clear need for studies such as this PhD which take into account these contextual factors and examine individual cases.

2.6 Responses to van Ijzendoorn's Review

Two decades after van Ijzendoorn's (1992) summary of the evidence of the intergenerational transmission of parenting, a review of the intervening years concluded that the latest studies had begun to provide the prospective longitudinal data which was previously largely absent from the literature. Several specially commissioned studies were able to utilise prospective data of community cohorts, using two generations and with high rates of retention. Collectively, these studies were able to show parenting in one generation did predict parenting in the next. Parenting practices were measured in two subsequent generations at different time points, using both observed and reported measures, and demonstrated correlation ranging between 0.20 - 0.45 (Conger *et al.*, 2009). Although this association between parenting practices in two generations was correlated only to a modest to moderate degree, these are similar to the findings from earlier work, and importantly the continuity does not vary greatly depending upon the type of population studied (Conger *et al.*, 2009). Overall the authors concluded that the displayed continuity appeared robust across different populations and geographical locations, as well as the types of measures of parenting used and the years between assessments. Given that some individual characteristics and related consistencies in social context were controlled for during the analysis, the authors suggest that intergenerational transmission of parenting exists outside of these factors, and while the findings add to the evidence for this, there is still work needed to enable a better understanding of the factors which mediate, and especially, moderate this continuity (Conger *et al.*, 2009).

2.7 Parenting Styles

2.7.1 Parenting Styles and Outcomes in Children

The style of parenting adopted by adults, and the specific practices associated with each of these styles, have a long association with both positive and negative outcomes in terms of children's development. Informed by naturalistic studies, Baumrind's (1968, 1978, 1991) descriptions of important dimensions of parenting have become the dominant model of effective parenting (O'Connor and Scott, 2007). Utilising warmth, an absence of conflict, and the adoption of

control strategies as the basis, Baumrind (1968, 1971, 1978) constructed four parenting typologies: authoritative, authoritarian, permissive, and neglectful/disengaged. While authoritative parents are characterised by high warmth and positive or assertive control, authoritarian parents are conversely typified by low warmth, high conflict and coercive or punitive control measures. Permissive parents generally display high warmth coupled with low control, whereas neglectful and disengaged parents exhibit low levels of both control and warmth.

Each of these styles of parenting has been repeatedly associated with child outcomes. Children and adolescents of authoritative parents have been consistently demonstrated to be more pro-social, more academically and socially competent, and less symptomatic than their peers whose parents display other styles; authoritative styles of parenting have been linked with higher educational outcomes in children, increased self-esteem and self-adequacy, higher rates of life satisfaction and lower rates of depression, and fewer observed deviant behaviours (Baumrind, 1991; McClun and Merrell, 1998; Milevsky *et al.*, 2007). Conversely children of authoritarian parents have typically been shown to display the most disturbed adjustment and development (O'Connor and Scott, 2007). Authoritarian parenting styles of mothers have also been linked with the observation of social phobia, depression, low academic performance, low self-esteem, aggressive behaviour and eating disorders among children (Baumrind, 1991; Herz and Gullone, 1999; McClun and Merrell, 1998; Russell *et al.*, 2003; Tata, 2001).

Several deleterious effects have been associated with permissive parenting styles, including behavioural problems, difficulties in taking personal responsibility for actions and poorer emotional adjustment and academic performance (Baumrind, 1991; Campana *et al.*, 2008). While permissive parenting can lead to negative outcomes in children, the same can also be said of parental overprotection: this style of parenting has been consistently associated in the literature with poor adjustment outcomes such as shyness and fearfulness, panic disorders and externalising problems, as well as other physiological issues (Koszycki *et al.*, 2013; Young *et al.*, 2013). This association

has been demonstrated in both community samples (Kiel and Maack, 2012; Nishikawa *et al.*, 2010) and at-risk groups (Gere *et al.*, 2012).

As well as the many ways in which parents - and in particular the parent-child relationship - can have an effect upon the developmental outcomes of their children, it is also the case that a variety of health, psychological and social characteristics can combine to impact the early care that parents are able to provide for their children (Serbin *et al.*, 2014). In addition to the well-established negative gradient between a family's socioeconomic status (SES) and health outcomes (Murphy *et al.*, 2014), SES is also firmly linked not only to a child's health outcomes but also to health care use (Braveman *et al.*, 2011; Dow and Rehkopf, 2010). This may mean that women with lower SES, who already face challenges in terms of their own health, find it even more difficult to provide necessary care for their children or access health care services. Depression, anxiety, and general behavioural problems in parents have also been linked to both a decreased use in preventative health care for their children as well as an increase in the use of emergency care (Minkovitz *et al.*, 2005; Serbin *et al.*, 1996).

There is a significant body of evidence which documents that exposure to ACEs, including abuse, neglect, and household dysfunction, places children and adolescents at greater risk of suicide (Dube *et al.*, 2001), an increased risk of illicit drug use, HIV and sexual risk behaviour (Dube *et al.*, 2003; Leibling, 1986; Meade *et al.*, 2009), alcohol abuse (Dube *et al.*, 2002) and heavy smoking (Herrenkohl, 2011). This association between parent-child relationship quality and childhood experiences and the adoption of such high-risk health behaviours is thought to be mediated through a modelling of behaviour observed in parents or others within the social circle (Steinglass, 1981), or by the creation of a psychological environment within which children may become more prone to substance use (Steinberg, 1987). Section 2.10 gives more detail on ACEs and how these potentially impact upon health and reverberate across generations.

Where children are exposed to physical violence and abuse there is an increased likelihood that they themselves will engage in antisocial behaviours, delinquency and other criminal acts (Herrenkohl, 2011). These children are also more likely to be diagnosed with mental health problems as well as a greater risk of

developing physical health problems earlier in life (Herrenkohl, 2011; Middlebrook and Audage, 2008). Injury rates among children have also been related to parenting practices, including the use of behavioural control (Morrongiello, 2005; Schwebel and Brezausek, 2010).

Although the link between the quality of the parent-child relationship and aggression and delinquency in children has been demonstrated in large-scale epidemiological investigations, intense clinical investigations, and mixed method naturalistic studies, it is important to note caution in terms of how such externalising behaviours in children are defined and measured (O'Connor and Scott, 2007). Largely defined as rule-breaking behaviour, aggressive and oppositional behaviour, and attention problems (Beyers *et al.*, 2003; Gershoff, 2002; Leve *et al.*, 2005; Stanger *et al.*, 2004), externalising problems can encompass a variety of behaviours. While some studies use observation, others rely on self-report, teacher or parent comments, or police and criminal records; further there is no agreed upon definition of what constitutes externalising behaviour. It may be evident that several different dimensions of the parent-child relationship are independently related to externalising behaviours in children (Fletcher *et al.*, 2004; Kerr and Stattin, 2000), however, such behaviours cannot be linked to a single component of this relationship (O'Connor and Scott, 2007).

2.7.2 Parenting Styles and Intergenerational Transmission

By looking further at two distinct styles of parenting, and those for which there is the most abundant evidence - harsh parenting and positive parenting - the evidence for intergenerational continuity in both styles can be reviewed. It also provides an assessment of how the published literature helps us to understand the mechanisms which may lay behind the mediation and moderation of any continuity in such styles of parenting.

2.7.2.1 Harsh Parenting

Much of the early work regarding the intergenerational transmission of parenting had a focus on harsh parenting, characterised by practices such as harsh discipline and child maltreatment for example; indeed these studies provide

what is perhaps the earliest evidence of parenting practices being transmitted across subsequent generations. Scientists studying neglectful and abusive parents have long contended that those who maltreat their children were often subject to such mistreatment themselves, a view also shared by clinicians treating these parents (Spinetta and Rigler, 1972). Early work by Belsky (1978) and Cicchetti and Rizley (1981) also provided evidence that mistreatment as a child often leads to neglectful or abusive practices with one's own children. However, more recent work suggests that although there is an acknowledged increased risk (Madigan *et al.*, 2019; Widom *et al.*, 2015), the true extent to which maltreatment occurs across generations is difficult to quantify due to reporting issues and a lack of rigorous prospective studies (Warmingham *et al.*, 2020).

Abusive or neglectful parenting practices, along with parental monitoring and harsh discipline have though consistently been linked to externalising behaviours in children – defined as rule-breaking behaviour, aggressive and oppositional behaviour, and attention problems (Beyers *et al.*, 2003; Gershoff, 2002; Leve *et al.*, 2005; Stanger *et al.*, 2004). In turn these externalising behaviours are often associated with a wide range of negative consequences in terms of the child's development; there is further evidence that these externalising behaviours themselves, when observed in one generation, are often associated with similar behaviours in the next.

Using the Social Development Model, which identifies socialisation processes that lead to both pro- and antisocial behaviours across the lifespan, Bailey *et al.* (2009) found some degree of intergenerational continuity in both externalising behaviour and in parenting practices. Integrating social learning theory (Bandura, 1977), the Social Development Model suggests that where children display anti-social behaviours these are often continued into adulthood, and these adults associate with others who exhibit similar externalising behaviours; as such, antisocial norms and beliefs become internalised. Assortative mating – whereby individuals choose partners displaying similar traits, in this case antisocial behaviours for example – is also considered an important part of the process of intergenerational transmission of risk for externalising behaviours (Capaldi *et al.*, 2003b). Consequently, as parents, those with antisocial

behaviours may place fewer constraints on their children and may often resort to harsh or coercive disciplinary practices. Subsequently their children may internalise these norms, beliefs and practices, and in turn form social bonds with their parents and also with others who share similar antisocial behaviours. Recent studies have also found associations between exposure to psychological violence as a child, and later intimate partner violence and difficulties in raising children (Neppl *et al.*, 2019). It is in these ways that a cycle of externalising behaviours and the resulting harsh parenting practices may be perpetuated across generations.

Findings from a small body of prospective, multigenerational studies into harsh parenting has led several authors to establish intergenerational continuity in such practices, and further, they identify aspects of social learning as key mechanisms for this transmission (Capaldi *et al.*, 2003b; Thornberry *et al.*, 2003). However, Bailey *et al.* (2009) concluded that the degree of continuity reflected in their study was small, and as such there was also a good deal of unexplained discontinuity. Their results suggest that although parenting is related to child anti-social behaviour, intergenerational continuity in parenting practices did not account for this child externalising behaviour. Rather, they suggest, the association between these externalising behaviours in subsequent generations was explained not by parenting practices themselves, but instead by parental substance use. Along with family violence and sociodemographic risk, parental substance use has associations with externalising behaviours in children and all have been demonstrated to display continuity across generations (Langhinrichsen-Rohling, 2005; Musick and Mare, 2006; Smith and Farrington, 2004; Stanger *et al.*, 2004; Thornberry *et al.*, 2003). Thus, where a parent is affected by substance use, they may not be able to provide adequate care, and these factors may provide plausible alternative mechanisms for any observed continuity across generations, as distinct from specific parenting practices such as parental monitoring or harsh discipline.

While Bailey *et al.* (2009) concluded that continuity in parenting practices did not explain the intergenerational continuity in externalising behaviour, others have suggested child externalising behaviours and parenting practices may be mutually influential mechanisms (Fite *et al.*, 2006; Stoolmiller *et al.*, 1997).

When investigating harsh parenting Neppl *et al.* (2009) found not only intergenerational continuity in these practices but also stability in problem behaviours in children. Thus, rather than being competing explanations, the authors suggest these mechanisms act together and have an additive influence on the childrearing practices adopted.

Further research indicates that when it comes to harsh parenting, intergenerational continuity in such practices between grandparents and parents was only observed when the grandchild demonstrated high negative reactivity, a process which is thought to elicit or condition hostile parenting practices (Scaramella and Conger, 2003). Studies have highlighted that harsh parenting and punishment may be elicited by problem behaviours in the child, with children scoring high in externalising behaviours seeming to intensify poor parental responses in terms of monitoring, support and discipline (Fite *et al.*, 2006; Huh *et al.*, 2006). While the behaviour of children is seen by some to be a significant driver behind the parenting practices adopted by parents, others suggest the behaviours and attitudes of these parents is not simply a result of current child effects, but rather is explained in part by continuity of such practices across generations (Neppl *et al.*, 2009).

2.7.2.2 Child Maltreatment and Partners

While the experience of being mistreated as a child is seen as a key risk factor for a parent mistreating their own children (Egeland *et al.*, 2002; Kotch *et al.*, 1999) a parent's history of maltreatment has also be seen to elevate the risk of their child being maltreated by their partner or other caregivers (Dixon *et al.*, 2005a; Egeland *et al.*, 2002; Pears and Capaldi, 2001).

In an attempt to understand the factors which may mediate this cycle of maltreatment, Berlin *et al.* (2011) suggest that this is best viewed as multiply determined, and identify two main processes: social isolation and social information processing. Pointing to considerable evidence that maltreatment experiences as a child can lead to problematic adult relationships, the authors suggest this may often result in higher levels of social isolation and lower levels of social support, meaning added difficulties when it comes to parenting and therefore a greater risk of adopting harsh parenting practices. This can be

directly contrasted with the idea that safe, stable and nurturing romantic relationships may moderate the intergenerational transmission of harsh parenting (Schofield *et al.*, 2013).

Secondly, evidence suggests that children who suffer physical maltreatment or harsh punishment are likely to develop biased patterns of processing social information (Gibb *et al.*, 2009; Pollak and Tolley-Schell, 2003) which often leads to attributing hostile intent to the actions of others and reliance upon aggressive, retaliatory responses – in other words, externalising behaviours. Thus, harsh parenting and maltreatment can both predict offspring victimisation, and this association is mediated by a mother's social isolation and aggressive response biases. Thus, these mothers are at increased risk of continuing these practices with their own children (Berlin *et al.*, 2011). Similarly, a mothers' mental health may also provide an important mediating mechanism: if childhood maltreatment is linked to later mental health problems, then these same issues may be the ones which lead to victimisation of her child (Dixon *et al.*, 2005a; Dixon *et al.*, 2005b).

Despite the idea of maltreatment in one generation predicting maltreatment in the next being widely acknowledged and well-established, several authors have raised methodological concerns about work undertaken in this area. This concern is based upon the considerable variation between the methods used for assessing both the history of parental maltreatment and current child victimisation, a situation that often leads to disagreements about the validity of their association (Berlin *et al.*, 2011).

2.7.2.3 Moderating Factors

In contrast to those studies that examined the potential mediating mechanisms of harsh parenting, more recent work has been undertaken which seeks to understand the factors which may in fact interrupt the intergenerational transmission of such practices. A meta-analysis of five peer reviewed studies into the intergenerational continuity of child maltreatment sought to establish whether safe, stable and nurturing relationships may act as a moderator to the transmission of such maltreatment. All of the studies included used prospective, longitudinal methodologies, and all found that child maltreatment in one

generation is positively related to maltreatment in the next. Schofield *et al.* (2013) suggest that while the effect sizes may be moderate, they are comparable with the zero-order correlation results from previous studies. Jaffee *et al.* (2013), however, identified several factors present in those families where maltreatment of the mother did not result in maltreatment of the child: these proximal protective factors included a supportive and trusting relationship with intimate partners; low levels of partner violence; and high levels of maternal warmth. Similarly, Conger *et al.* (2013) concluded that a nurturing romantic relationship, characterised by warmth, support, and communication, was able to moderate this association between harsh parenting observed in one generation and similar behaviours in the next.

Using slightly different proxies for a safe, stable and nurturing relationship, Thornberry *et al.* (2013) identified that parental satisfaction, parental attachment to the child, and intimate relationship satisfaction, may have direct protective effects in interrupting the continuity of maltreatment. These findings echo earlier conclusions by Quinton and Rutter (1984) and Quinton *et al.* (1984) that a good relationship with a partner was an important factor in explaining why some girls who were raised in institutional settings due to their experiences in dysfunctional families were better able to parent effectively than others, and especially when compared to their own parents. While safe, stable and nurturing relationships can be seen to provide a protective factor when it comes to intergenerational cycles of maltreatment, it is likely that there are other as yet unknown potential protective factors that qualitative methods may prove useful in uncovering (Litrownik, 2013).

2.7.2.4 Positive Parenting

Where the early research into maltreatment and harsh parenting as outlined above is more well-established and widespread, there is much less research with a focus on sensitive and responsive parenting and how this can predict such behaviours in subsequent generations (Serbin and Karp, 2004). First and foremost, it is important to conceptualise positive parenting as much more than merely the absence of harsh, abusive, or neglectful parenting (Belsky *et al.*, 2005; Chen and Kaplan, 2001). Throughout the literature, the central elements of various dimensions of parenting form the basis for how such positive and

supportive parenting is defined. As with much research into this area, this is built upon Baumrind's (1971) conceptualisations of warmth, acceptance, engagement and responsiveness.

The literature surrounding positive aspects of parenting, albeit less extensive than investigations centred on harsh parenting, also suggests that patterns of parenting can at least in part be predicted by those practices adopted by their own parents (Belsky *et al.*, 2009; Kerr *et al.*, 2009). Intergenerational continuity in positive parenting has been demonstrated across a variety of studies (Belsky *et al.*, 2009; Madden *et al.*, 2015; Schofield *et al.*, 2014; Shaffer *et al.*, 2009) and interest has grown in how these (dis)continuities may be mediated or moderated.

As with studies into harsh parenting, by building upon previous evidence it is possible for researchers to reach hypotheses regarding how such parenting practices may predict behaviours in subsequent generations. Sharing parallels with ideas of social learning, evidence indicates that where parents demonstrate higher levels of affection, intimacy and acceptance, as well as expressing interest and becoming involved with the activities of their children and providing enthusiasm and encouragement, there is a direct association with the social interaction skills of these children (Barber *et al.*, 1999). In this way, the observed associations between parenting in two generations can be seen as indirect, in so much that it is a function of the social and academic competencies that are promoted by parenting practices that are involved and supportive (Conger *et al.*, 2009).

Neppl *et al.* (2009) also suggest that as well as academic success being linked with competence-promoting parenting, socially and academically competent behaviours in the child may have positive effects upon the parents and impact upon the practices employed, thus having an additive effect. In other words, they suggest well-adjusted and well-behaved children are easier to parent, and require less control and discipline, thus creating a virtuous circle. Other measures of social competence, such as peer acceptance, popularity, and the quality of close friendships, have all been shown to mediate the intergenerational associations of parenting quality even after controlling for various factors such as personality, gender, ethnic and socioeconomic status and

IQ (Kerr *et al.*, 2009). Higher levels of affection in grandmothers has also been shown to have an association with more positive parenting by their sons (Madden *et al.*, 2015).

Evidence also indicates that using age-appropriate and consistent discipline provides a buffer against a variety of stressful and negative life events, and parental warmth may facilitate the development of self-regulation by the child and help to protect from the development of externalising behaviours (Kerr *et al.*, 2009). This can be seen in direct contrast to the evidence described earlier which indicates harsh parenting may result in such externalising behaviours.

If little research has been carried out into the mediating effects of positive parenting, even less has assessed possible moderating mechanisms. Schofield *et al.* (2014) used prospective assessments of observed behaviours, in one of the first studies of this kind, and proposed parental efficacy and active coping skills as two potential moderators of intergenerational continuity based upon their findings. Where parents displayed high levels of these attributes, that is to say they had a strong belief that parents are able to shape the development of their child and also active coping skills which enabled them to inhibit negative emotional responses at times of stress, these same parents displayed positive parenting even when their own mothers did not. Conversely, they also suggest their evidence can be interpreted that where there is a history of positive parenting then this fosters resilience when these mothers do not have high levels of these attributes. In other words, having a positive role model displaying supportive parenting may enable those mothers who lack active coping skills and a strong belief in parental efficacy to still provide such parenting to their own children.

When assessing parenting, there are other potential moderating factors which need to be taken into consideration. Conger *et al.* (2009) hypothesise that a delay in the age at which the first child is born may have an impact upon the parenting practices adopted by the mother. The longer the time between her experiences of being parented and becoming a parent herself, the longer she will have to learn more and refine her experience from her own upbringing. Similarly, the life stage at which parenting is assessed will also have an impact upon any observed continuity. Finally, they also suggest that general or social

changes may serve to moderate parenting practices: changes in accepted practices and societal views on the appropriateness of certain practices will undoubtedly influence any intergenerational continuity. In this vein, in an attempt to account for the discontinuity observed in their study, Bailey et al. (2009), suggest that the Social Development Model predicts that the socialisation experiences of those parents in the first generation is likely to be somewhat different for that of the second generation of parents.

2.8 Parenting as a Public Health Issue and the Medicalisation of Motherhood

This section of the literature review explores the various ways in which parenting has been conceptualised and discussed, and how the application of a scientific and medical discourse around parenting has developed in recent years.

Neuroscientific evidence has grown in prevalence in recent years. Such research suggests that the early years of development - from conception to age six - set the base for competence and coping skills throughout the life course, with potential impacts upon future learning abilities, behaviour, and health (Chugani *et al.*, 2001). Furthermore, evidence is growing that depression, stress and anxiety in pregnant women can permanently affect the baby's response to stress and disrupt the mother's ability to be sensitive to her baby, thus adversely affecting the mother-infant interaction. In turn, poor mother-child interaction and maternal mental health are highly prevalent among mothers identified as vulnerable in pregnancy (Macrae *et al.*, 2015; Stein *et al.*, 2014) and both strongly predict child maltreatment and a disadvantaged trajectory for children in terms of their future social, emotional, cognitive development and health (Mäntymaa *et al.*, 2003; Mäntymaa *et al.*, 2004; Paulson *et al.*, 2009).

There have been calls for caution however when it comes to the use of neuroscience, in particular that during public communication this evidence can often be reconstituted. When neuroscientific evidence has cultural preconceptions projected onto it, and becomes socially represented, it can have tangible societal consequences and have important implications for thinking in terms of determinism, personal responsibility, and self-control (O'Connor *et al.*, 2012).

As with the move towards neuroscientific evidence, similarly many scholars have argued that there has been a general intensification and scrutiny of parenting within society, and also that motherhood has been the subject of expanding medicalisation. As such, they argue, motherhood is increasingly an experience which is dictated and regulated by external authorities (Apple, 2006; Kanieski, 2010; Malacrida, 2002; Rafalovich, 2001).

This medicalisation stems from the rise in surveillance medicine, which moves away from a distinction between health and illness and becomes instead the identification of risk factors that are probabilistically associated with the development of illness or conditions. Importantly, when these risk factors are found to be present, individuals are impelled to reduce these risks through lifestyle or behavioural changes in order to reduce the likelihood of disease, and as such this creates obligations for parents and caregivers (Kanieski, 2010). Further, there is social pressure which morally compels women to work to reduce any perceived risks, especially during pregnancy (Lupton, 1999; Weir, 2006).

Kanieski (2010) draws direct links between the rise of surveillance medicine and the discourse on attachment and argues that this has significantly shifted the social regulation of mothers. This situation began, she argues, with Levy (1942) who like Bowlby linked maternal deprivation (poverty, unemployment, divorce), to failures in the family and failures of her own childhood family - both of which could potentially lead to a mother's inability to provide the required warm attention to her child. In this way Bowlby conceptualised maternal deprivation as a disorder and constructed mothers in terms of victims of their social environments. As a result, mothers of infants who failed to thrive were deemed in need of treatment, and 'inadequate' mothering was seen to be the result of a self-perpetuating cycle of maladaptive parenting. This had the effect of not only medicalising motherhood as a problem, but also framing it as one which is independent of socioeconomic status. Moreover, because attachment disorders represented a risk, decisions of mothers were scrutinised in greater detail and a greater emphasis was placed on individual, and especially maternal, responsibility for the wellbeing of their children. Further the medicalisation of

attachment disorders constructed any failings by mothers as problems often beyond their control.

In light of an association between the actions of parents and potential outcomes for their children, parenting has increasingly come to be seen as a public health issue (O'Connor and Scott, 2007). Inevitably, this has led to discussions around what constitutes 'good parenting' and acute concerns about the effects of 'poor parenting' (Dermott and Pomati, 2015). In some cases this has resulted in a transformation of the discourse into one of overt criticism of those perceived to be poor at parenting (Gillies, 2008). Hays' (1996) description of the expectations placed on mothers as 'intensive' is seen by many as a significant point of departure in both academic and non-academic debate regarding parenting culture in contemporary society. This debate around parenting culture and practices stems from a new neoliberal discourse which placed greater expectations upon individuals to fulfil their multitude of obligations of parenting; as such, mothering has been described as 'emotionally absorbing, labour-intensive, and financially expensive' (Hays, 1996, p.8).

When it comes to discussing 'good' parenting practices the most educationally advantaged parents are often looked to as the benchmark, while in contrast there are often, mostly political, claims that poor people - those from lower SES backgrounds - are poor at parenting (Dermott and Pomati, 2015). Despite dominant ideas of good parenting being derived largely from a middle-class perspective (Klett-Davies, 2010), Dermott and Pomati (2015) find that this narrative is misplaced, and that this most privileged group is the exception. The reality is, they conclude, that perceived positive parenting practices such as reading, playing games and eating meals together are not absent among deprived families or those on lower incomes.

The work of Lareau (2002) from the United States does indicate though that there may class differences in parental practices. She found that middle-class parents tended to engage in what she termed 'concerted cultivation' by extensive reasoning and organising leisure activities with their children. Working class and poor parents meanwhile tended to leave leisure activities to their children, and also use directives rather than reasoning. Crucially, she argues, 'differences in a cultural logic of childrearing gave parents and their children

differential resources to draw on in their interactions with professionals and other adults outside the home' (Lareau, 2002, p.747).

Amato and Fowler (2002) suggest that the evidence is mixed as to whether optimal parenting exists across a variety of family contexts. While some studies suggest optimal parenting practices vary across different family types, others hold that regardless of societal context the fundamental dimensions of effective parenting are applicable. This serves to illustrate the complexity and nuances of this type of research (Demo and Cox, 2000; McLoyd *et al.*, 2000), and has led to calls for additional studies into this area (Darling and Steinberg, 1993; Deater-Deckard *et al.*, 1996; Demo and Cox, 2000; Jackson *et al.*, 1998; McNeal, 1999; Pilgrim *et al.*, 1999).

Notwithstanding, it is true to say access to desirable resources that come with affluence add value to children's potential, their development, and ultimately their outcomes, while parents with fewer material and social resources often struggle to ensure the basic safety and minimum needs for their children (Fram, 2003). It is through the managing of these resources – skills, experiences, knowledge, material goods, and community resources, by which day-to-day parenting practices are enacted.

According to Furedi (2001) a barrage of advice from self-confessed parenting experts frequently represents parents as the cause of any problems faced by their children. This serves, he argues, as a prelude to scaring them with the likely terrible consequences of their bad parenting upon the future wellbeing of their children. Yet, at the same time, this same advice often labels parents as incompetent. This undermining of parental confidence while over inflating parental responsibility - you are as a parent potentially ineffective when it comes to raising your children, and at the same time what you do can carry great consequences - is a paradox which results in paranoid parents (Furedi, 2001). Bristow (2014) calls this the 'double bind' of parenting, where 'parents are criticised both for absorbing the imperatives of intensive parenting' and also criticised for rejecting them (p.200).

This intensive culture surrounding parenting is said to result in a situation where parents wrap their children in cotton wool and thereby stifle them and prevent

them from taking often necessary risks, further stunting their development (Gill, 2007; Guldberg, 2009; Lindon, 1999; Skenazy, 2009). This underdevelopment leads to a need for parents of older children to be constantly hovering over them, being too closely involved and protective, and ultimately leaving the children unable to achieve on their own; such traits typify those who have come to be known as 'helicopter parents'. Building upon the work of Furedi (2001, 2002), and in an attempt to counter this view of parental determinism, Lee *et al.* (2014) often draw upon the subject of breastfeeding babies, or rather deciding not to, in order to illustrate their point that such a seemingly simple everyday act is often extrapolated as demonstrative of bigger societal issues, and is seen as both directly harming children and wider society.

2.9 Summary

2.9.1 Parenting and Outcomes in Children

While it may be true to say that early research overstated the conclusions about the impacts of parenting behaviour on outcomes in children, relying as they did on correlational findings and proposing singular, deterministic views of parental influence, it is also not the case that parenting effects are insubstantial as many critics suggest (Collins *et al.*, 2000). The contemporary critique runs that the effects of parental behaviours upon child outcomes - when detected - are weak, often correlational rather than causal, and that a child's behaviour and personality will often drive parenting practices and impact upon the parent-child relationship as much as parenting behaviours influence children. Maccoby (2000) also suggests that a major criticism comes from those who feel that parental influence is over-emphasised at the expense of potential genetic predispositions and the influence of peers.

Notwithstanding the controversy which surrounds the subject, the emerging empirical evidence from a variety of disciplines would suggest that a link does exist between parenting practices and outcomes for children, but such links are neither simple and nor are they direct (O'Connor and Scott, 2007). The evidence base reveals the topic to be a complex one that defies simple explanations (Collins *et al.*, 2000). As Maccoby (2000) suggests, the simple reliance upon any correlation between parent and child behaviours and genetics as an explanation

is a mistake, since this ignores the reciprocal influences of both children and parents, and seriously underestimates the effects of parenting. Strong genetic factors, she argues, do not necessarily mean that environmental factors such as parenting are weak. Such genetic effects cannot be ignored, but the challenge for researchers remains understanding the inextricable link between both nature and nurture, and how these two factors function together to impact upon a child's development.

The evidence from meta-analyses and conceptual literature reviews indicates a consistent association between the quality of parent-child relationships and child developmental outcomes, ranging from externalising behaviours, depression, anxiety, internalising problems, attachment issues, cognitive and educational outcomes, social competence and general health and development. However, as O'Connor and Scott (2007) point out, the magnitude of this association is far from clear and depends to a great extent on the definitions used, how these are operationalised, the methodological approaches, and the samples in question. While research continues to show increasing evidence that parent-child relationships impact upon a child's development, challenges in interpreting this evidence remain. What is clear is that this association is at least in part genetically mediated, it is bi-directional in that children may influence the behaviours and practices of their parents as much as the other way around, and further that this association is also confounded with other influences in a much broader social context.

2.9.2 Intergenerational Transmission of Parenting

While it may be increasingly accepted that parenting experienced in one generation is, at least to some degree, repeated in the next, it is not the case that this transmission is inevitable or complete, and it must be stated that there is nothing close to a one-to-one correspondence between parenting in adjacent generations (Belsky *et al.*, 2009). It is also the case that no data has been able to provide conclusive evidence of causal mechanisms, and despite consistent and extensive evidence of these associations, doubt remains as to whether this can be directly interpreted as causal inference (Schofield *et al.*, 2014). Research suggests a variety of factors combine to produce differing outcomes and life trajectories among individuals, and despite the observed similarities and

continuities within families, there is often considerable variability between the behaviour of individuals within families. This also remains true within disadvantaged groups and those who are seen as most at risk of continuing behavioural, cognitive, and health problems with their own children (Serbin and Karp, 2003). Such factors as individual characteristics, learning experiences, educational achievement, environmental contexts, and developmental processes are used to explain these differentiated outcomes.

What is true though is that the evidence remains robust and consistent across a variety of populations and measures of parenting (Conger *et al.*, 2009), and although zero-order correlations may indicate continuity is often modest, as Rutter (1998) points out, discontinuities are more likely to be evident than any continuities. These limitations notwithstanding, the idea that parenting behaviours are directly modelled, and thus transferred from one generation to another, has then gained much support in psychology literature (Capaldi *et al.*, 2003b; Chen and Kaplan, 2001; Conger *et al.*, 2003; Conger *et al.*, 2012; Thornberry *et al.*, 2003). These same studies suggest that an adult's style of parenting incorporates not only modelled behaviours derived from childhood experiences, but also their own behavioural style, something which was formed and was already apparent during childhood. Thus, it can be seen that the process by which parenting practices are developed is one which is both cumulative and interactive.

Conger *et al.* (2012) suggest that intergenerational continuities in parenting practices are explained by mechanisms or processes specific to the type of parenting being considered. Harsh parenting, as characterised by practices which include abuse, neglect, or physical discipline for example, has been demonstrated to lead to antisocial behaviour in adolescence (Capaldi *et al.*, 2003a; Capaldi *et al.*, 2003b; Conger *et al.*, 2012). Furthermore these antisocial behaviours are directly related to these adolescents displaying harsh parenting practices during early adulthood with their own children (Neppl *et al.*, 2009), further demonstrating learned or modelled behaviour. On the other hand, academic attainment has been seen to mediate positive parenting across generations (Neppl *et al.*, 2009), while other studies have suggested that continuity in positive parenting – demonstrating interest, concern and providing

clear communication – can be explained by the personal and social competencies promoted by these practices (Conger *et al.*, 2009).

This review has provided an assessment of the existing literature and outlined the robust and consistent evidence base for intergenerational transmission of parenting. This evidence comes from a variety of studies, increasingly relying upon methodologically rigorous and replicable research designs, utilising longitudinal, prospective data from a wide range of population groups and geographical locations, and includes both normative and high-risk samples. While the evidence suggests that the degree of continuity of parenting practices may often be moderate, the consistency and volume of this evidence appears to be overwhelming, leaving the field to no longer question if such a transmission occurs but how. Although much work has been done in this area, greater understanding of the precise mechanisms by which practices may or may not persist across generations is needed. A well-designed and rigorous approach, especially one which incorporates a qualitative perspective, is well placed to fill these gaps in our understanding of the process by which a mother's upbringing influences her subsequent parenting practices.

The following section of this literature review explores the Adverse Childhood Experiences (ACEs) inventory and examines the evidence base regarding how adversity in childhood may potentially have lifelong implications.

2.10 Adverse Childhood Experiences

2.10.1 Overview

As this study seeks to understand how experiences in childhood impact upon parenting practices, this section explores the evidence base regarding how adversity in childhood may potentially have lifelong implications. It does so by exploring the Adverse Childhood Experiences (ACEs) inventory, which has been used to demonstrate how adverse conditions in childhood have implications throughout the life-course, and as such may also impact upon one's ability to meet the demands of parenting.

ACEs include being a victim of abuse and/or neglect, and growing up in households characterised by mental ill-health, substance abuse, domestic violence, parental separation and parental imprisonment (Felitti *et al.*, 1998). Contemporary research continues to add to an already well-established, robust evidence-base, which demonstrates that ACEs increase the risk of mental and physical illnesses, and a variety of negative health outcomes across the life-course (Afifi *et al.*, 2008; Draper *et al.*, 2008; Dube *et al.*, 2001; Dube *et al.*, 2003; Felitti and Anda, 2010; Hughes *et al.*, 2017; Kessler *et al.*, 2010; Molnar *et al.*, 2001).

Given the recruitment criteria of THRIVE (see Section 3.5.2), it was anticipated that many of the women in the population of interest would have backgrounds characterised by adverse experiences. This section examines the potential mechanisms by which it is believed adversity in childhood impacts upon health across the life-course. It then goes on to explore how parenting forms a part of a 'person-environment interaction' and how this in turn can potentially lead to the intergenerational transmission of ACEs. Finally, it discusses the role parenting may play in providing resilience in order to protect against or recover from adversity.

2.10.2 ACEs Inventory

It is only in the past two decades that researchers have begun to systematically assess the relationship between exposure to emotional, physical, or sexual abuse and household dysfunction during childhood and health risk behaviours and diseases in adulthood. Since Felitti *et al.* (1998) reported a strong, graded relationship between the breadth of exposure to such abuse or household dysfunction during childhood and multiple risk factors for several leading causes of deaths among adults, an increasing international literature points to an association between these adverse childhood experiences and deleterious impacts upon health across the life-course (Bellis *et al.*, 2014b; Flaherty *et al.*, 2013; Ramiro *et al.*, 2010).

Incorporating both maltreatment and household dysfunction (or in some literature, household adversity), ACEs have been defined as:

'intra-familial events or conditions causing chronic stress responses in the child's immediate environment' including 'notions of maltreatment and deviations from societal norms' (Kelly-Irving *et al.*, 2013a, p.722).

Maltreatment refers to physical, emotional or sexual abuse, as well as neglect. Household adversity encompasses domestic violence, substance misuse by adults within the home, mental illness among adults in the home (either diagnosed or undiagnosed), involvement with the criminal justice system, separation from one or both parents (either by divorce or by death), and children living in care facilities (Felitti *et al.*, 1998).

In their seminal ACEs study, Felitti *et al.* (1998) entered the number of childhood exposures in these categories as a single ordinal variable into a logistic regression model for each condition or risk factor, adjusting for the effects of age, sex, race and educational attainment. Findings from this initial ACEs study indicated that as the number of childhood exposures increased, so did the prevalence and risk of obesity, physical inactivity, and depressed mood. Those experiencing four categories of exposure to ACEs were twelve times more likely to attempt suicide than those who reported no adverse childhood events. Similarly, the prevalence of substance abuse and risky sexual behaviour also increased as the number of childhood exposures to adversity increased: those with four or more adverse experiences during childhood were seven times more likely to develop alcohol problems and ten times more likely to inject illicit drugs when compared to those with no exposure to adverse events (Felitti *et al.*, 1998).

In the intervening years since the development of the ACE inventory, an increasing literature has demonstrated similar strong, step-wise, dose-response relationships between exposure to adversity and mental and physical health implications across the life-course (Bellis *et al.*, 2014a; Flaherty *et al.*, 2013; Ramiro *et al.*, 2010).

The ACE scale has been found to predict a range of physical conditions, including: heart disease (Dong *et al.*, 2004b); liver disease (Dong *et al.*, 2003); as well as relationships between risks of stroke (Draper *et al.*, 2008); cancer, hypertension, diabetes and asthma (Hughes *et al.*, 2017). ACEs have also been

connected with the development of potentially health harming behaviours such as smoking, early initiation of sexual activity, increased number of sexual partners, and early pregnancy (Centers for Disease Control and Prevention, 2017), and also with subsequent unintended pregnancies (Dietz *et al.*, 1999). There is also a reported association between exposure to multiple adverse experiences in childhood and subsequently becoming a victim or perpetrator of violence, include violence towards intimate partners (Whitfield *et al.*, 2003). What is consistent in all of these studies is that reported risk is cumulative, with those experiencing higher numbers of ACEs having the poorest health.

2.10.3 Prevalence of ACEs

Approximately half of all of adults in England and Wales have experienced more than one ACE; 8% of people report 4+ ACEs in England and 14% in Wales (Bellis *et al.*, 2015; Bellis *et al.*, 2014b). In Scotland, the prevalence of ACEs is high with 65% of children experiencing one or more ACEs by the age of 8 years; 10% of children have experienced 3 or more ACEs by age eight (Marryat and Frank, 2019). The widespread prevalence of adverse experiences in childhood raises an interesting debate around ACEs being 'deviations from societal norms' (Kelly-Irving *et al.*, 2013a; Kelly-Irving *et al.*, 2013b) and suggest rather that ACES are in fact a societal 'norm'.

Adverse experiences in childhood are not equally distributed across society. On average, those children living in low-income households experience a greater number of ACEs than those from high-income areas: 53% of children in the highest income households are ACE-free by age eight, compared to 8% in the lowest income households (Marryat and Frank, 2019). It is also generally agreed that due to the sensitivity of the subject, and measurement issues, prevalence statistics are largely underestimated; for example, the GUS figures used by Marryat and Frank (2019) do not include measures of material neglect or sexual abuse (Blair *et al.*, 2017), which may mean the true number is much higher.

2.10.4 Potential Mechanisms

The previously discussed studies have collectively led to a conceptual model which seeks to describe how a history of childhood adversity and exposure to

adverse events results in impairment, as well as the adoption of risk behaviours that may promote morbidity, disability, societal problems and premature mortality (Cronholm *et al.*, 2015). There are three main pathways via which ACEs are believed to impact upon health: The first is by the adoption of health-harming behaviours such as smoking and other substance use or misuse, behaviours leading to obesity, engaging in sexual risk behaviour, violence, or criminality. Secondly, exposures to adverse events impact upon the social determinants of health such as education, employment and income, each of which has been demonstrated to contribute to health outcomes. Finally, it is believed that a pathway exists whereby ACEs impact upon genetic, epigenetic, and neurological functioning (Allen and Donkin, 2015). These pathways are outlined in Figure 2.1.
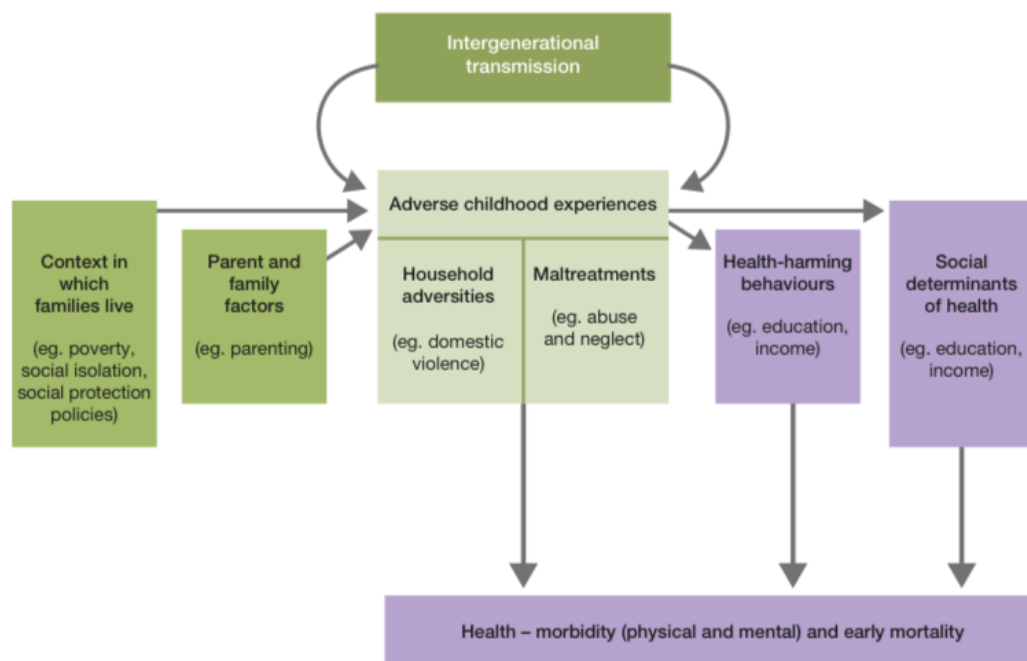
Figure 2.1: Conceptual Framework of ACEs and Intergenerational Transmission (Allen and Donkin, 2015)

Much work has been undertaken to understand these potential mechanisms by which exposure to adversity during childhood may lead to such health harming behaviours and risk of physical disease conditions. Recent studies indicate that early brain development can be altered by ACEs, including that of the pre-frontal cortex which impacts upon impulse control and pleasure and reward responses (Sheridan and McLaughlin, 2014; Teicher and Samson, 2016). These changes, along with others within the brain, may reduce the tolerance to stress, and in turn lead to a greater propensity for violence and other anti-social behaviours, as well as difficulties in feeling close to other people (Duke *et al.*, 2010; Hughes *et al.*, 2016). Stressors during childhood may also induce neurological changes which can adversely impact upon learning abilities, memory, and educational performance (Pechtel and Pizzagalli, 2011). Further potentially explanatory mechanisms include altered cortisol and other immunological and hormonal system changes which can result in chronic tissue inflammation and an increased allostatic load, both of which contribute to earlier onset of diabetes, cancer, heart disease and premature mortality (Brown *et al.*, 2009; Danese and McEwen, 2012; Huang *et al.*, 2015; Kelly-Irving *et al.*, 2013b; Su *et al.*, 2015).

Evidence suggests that long-term activation of the body's stress responses alters its function in such a way that when an individual who has been exposed to ACEs feels stressed the usual dampening of stress hormones that occurs when threats are alleviated does not happen. This results in chronically elevated stress hormones and is referred to in the literature as a 'toxic stress response'. Chronic and toxic stress places additional wear and tear upon physiological systems, and contributes to increased risk of mortality and morbidity (Epel *et al.*, 2004; McEwen, 1998; McEwen and Wingfield, 2003; Peavy *et al.*, 2009).

In this way, ACEs can be seen to be inter-related and cumulative, where this cumulative risk both has a greater impact on overall health and at the same time the experience of one risk factor can also contribute to further risk factors (Felitti *et al.*, 1998). This presents greater challenges then for protective resources to mitigate these combined risks, as well as making it more difficult for individuals to recover from adversity in the face of multiple risks (Larkin *et al.*, 2014).

Despite this evidence, there are those who suggest that this 'biologisation' of social experiences, where complex social experiences are converted into biological and chemical effects, excludes the ability of the human mind to translate seemingly similar experiences in a variety of different ways. Thus, according to Edwards *et al.* (2017), utilising ACEs to predict outcomes potentially risks turning the individual into an object who is subjected to these experiences, rather than a human being who interprets them. It is therefore important for qualitative work to be undertaken which aims to understand these interpretations and the social contexts in which they occur.

2.10.5 Parenting, ACEs, Resilience, and Self-efficacy

In essence, parents with multiple ACEs are at greater risk of poor outcomes such as disrupted relationships and social networks, mental health problems, substance misuse and limited educational attainment (Shonkoff *et al.*, 2012). When these problems combine with economic disadvantage and deprivation, it can be difficult for these parents to provide a supportive and nurturing environment, which can then lead to intergenerational cycles of stress and ACEs (Bridgett *et al.*, 2015). However, ACEs are far from deterministic of such outcomes, and despite the presence of ACEs and socioeconomic disadvantage, many families demonstrate resilience (Masten and Monn, 2015). Understanding the role of the parent-child relationship in this resilience against early adversity – as well as how this relationship can also contribute to adversity - is key if we are to break this intergenerational cycle (Woods-Jaeger *et al.*, 2018).

Recognising that an individual's development and behaviours across the lifespan are only properly viewed when studied within their relevant cultural and systemic contexts, Larkin (2008) advocates a biopsychosocial perspective to understand and resolve adversity. Such a perspective allows us to simultaneously perceive both the individual and the collective within these relevant contexts (Larkin *et al.*, 2014). Drawing upon Lazarus and Folkman's (1984) stress and coping framework, Larkin *et al.* (2014) examine the interface between adverse events as potential stressors and developmental processes. In a person-environment interaction, stress arises when an individual's subjective assessment of the demands of an event diverge from that individual's subjective assessment of their own internal and external resources available to meet those

demands. Thus, how a threat is cognitively assessed as well as how any available resources are perceived, impacts upon the ability of the individual to cope with this stress. The ability of an individual to transform toxic stress into more tolerable stress and therefore reduce its harmful physiological and psychological impacts reflects their resilience (Bellis *et al.*, 2017), and this response to adverse experiences is influenced greatly by family context (Banyard *et al.*, 2001; Masten *et al.*, 1999).

In this way, the notion of adversity is a subjective one, and the response to this stress may depend upon the individual and their circumstances, and how they view both themselves and the stressor. Those with a greater resilience for example may react in a different way to those with diminished resilience. It is in this way that cumulative adversity can be seen to impact upon one's ability to be resilient to these stressors.

What is clear is that there is an interplay between the individual and the environment, which can often work in both directions. As Larkin *et al.* (2014) point out, environmental contexts – such as parenting - are able to support childhood development by providing the necessary resources or conversely negatively impact upon development through a lack of resources or where there is risk, poverty or oppression. In a similar way, those facing adversity may seek environmental resources in an attempt to cope, and as such substance abuse and other health risk behaviours may be best seen as attempted personal solutions to difficulties when other more appropriate resources are not available.

Most relevant to this research is the idea that systemic risks such as poverty and oppression may be both compounded or moderated by interpersonal relationships; the quality of these relationships serves as an example of a mechanism via which ACEs could lead to health risk outcomes or conversely could indeed provide a protective factor against these (Larkin *et al.*, 2014). Utilising a biopsychosocial perspective, it is therefore apparent that 'intervention with one family generation enhances the protective resources for the next generation, which might prevent intergenerational ACE transmission' (Larkin *et al.*, 2014, p.7).

There is some evidence that parental psychopathology, child maltreatment and being a looked after child in residential care are the strongest predictors of depressive disorders, anxiety disorders, suicide attempts, drug use, engagement in risky sexual behaviour and the contraction of sexually transmitted infections (Chartier *et al.*, 2010; Geoffroy *et al.*, 2014; Hughes *et al.*, 2017; Ports *et al.*, 2016; Sethi *et al.*, 2013). As previously mentioned however, given that clustering of risk factors for negative health outcomes is common (Madigan *et al.*, 2017), it is not surprising that research which assesses associations between discrete categories of maternal adversity and negative outcomes for her children have had mixed results (Appleyard *et al.*, 2011; Bifulco *et al.*, 2002; Brodsky *et al.*, 2008; Evans *et al.*, 2013; Madigan *et al.*, 2015). However, evidence indicates that it is the accumulation of multiple risks that prove detrimental to individual health and development, rather than the type or severity of any one specific risk (Dong *et al.*, 2004a).

A mother's adverse childhood experiences have been associated with children's physical and emotional health via two intermediary mechanisms: cumulative biomedical and psychosocial risk. Madigan *et al.* (2017), found that where a mother was exposed to four or more ACEs during her own childhood, there was a 2-fold increase in biomedical risks to her child's physical health during the first two years of his or her life. This linear association was also true for psychosocial risks: the presence of four or more adverse experiences for mothers led to a 5-fold increase in psychosocial risks factors for her child, such as being a single parent, teenage pregnancy, low maternal education, marital conflict and maternal depression. Thus Madigan *et al.* (2017) were able to an demonstrate an intergenerational link between maternal ACEs and infant emotional health problems, identifying these psychosocial risk factors as key mechanisms of transmission, leading to disadvantage across generations. This echoes previous work which suggested that it is through sexual and violent behaviours that a potential mechanism exists for the intergenerational transmission of ACEs and the related health consequences of these exposures (Bellis *et al.*, 2013). As discussed previously, it is these psychosocial stressors which may impact upon a mother's emotional availability to be there for her children and to be attuned to their needs, which in turn impacts upon the child's capacity to understand and

regulate their own emotions, as well as potentially denying the child an appropriate model for managing distress (Madigan *et al.*, 2015).

It is arguable then that those who have been exposed to a variety of ACEs, due to their cumulative impacts upon their health and their resilience, represent some of the most vulnerable members of society, and it has been demonstrated that the presence of ACEs are significantly associated with feelings of lower self-efficacy (Allen and Donkin, 2015; Dregan *et al.*, 2011). However, it is worth pointing out that exposure to ACEs is in no way deterministic of poor health outcomes. Although those children whose parents have experienced ACEs are more likely to themselves experience such adversity (Allen and Donkin, 2015), which undoubtedly contributes to social inequalities by placing increased burdens upon those from disadvantaged backgrounds, protective factors exist which can break this intergenerational cycle. Aside from a higher socioeconomic status and sufficient economic resources (Mensah and Kiernan, 2010), the presence of a continued trusted adult has been shown to mitigate the negative impacts of ACEs.

2.10.5.1 ACEs and Resilience

It is by promoting knowledge, skills, and an appropriate environment that resilience in children is developed, in such a way that they may be prepared for the challenges they may face in life and are supported through experiences of adversity. Guidance indicates that a range of parenting factors are important in nurturing resilience:

- Warmth, responsiveness and stimulation;
- Adequate and consistent role models and harmony between parents;
- Spending time with children;
- Consistent guidance and provision of structure and rules.

Together, it is argued, these provide the secure attachment, good self-esteem, and appropriate sense of self-efficacy which are necessary for resilience (Hill *et al.*, 2007).

This is reflected in recent research by Bellis *et al.* (2017), for example, who, in line with other studies, found that the prevalence of poor mental wellbeing increased with deprivation, as well as with increased exposure to ACEs; however, among those who reported four or more ACEs, this prevalence was almost halved across all deprivation quintiles where the respondent had a continuous trusted adult throughout their childhood. This indicates then that such continuous trusted adult support during childhood may be a key factor in promoting resilience and avoiding the negative health impacts usually associated with adversity. In a similar way, Balistreri and Alvira-Hammond (2016) found that low levels of parental stress, coupled with frequent, positive parent-child interaction, provide protective factors against an increased number of adverse experiences in adolescence.

In this way parenting which fosters positive and supportive relationships can be seen to help develop resilience and, alongside interventions which build self-control and adaptive skills in order to avoid health harming behaviours, can in turn help to prevent the occurrence of ACEs and their intergenerational transmission.

2.10.5.2 ACEs and Parental Self-efficacy

The impact that adversity in childhood can have upon mental and physical health in later life is now well-established (Edwards *et al.*, 2003b). However, as previously discussed, to date, the ACEs framework has largely been employed to examine the relationship between these adverse experiences and later health outcomes at a population level (see, for example, Bellis *et al.*, 2014b; Felitti *et al.*, 1998; Flaherty *et al.*, 2013; Ramiro *et al.*, 2010). While interest in this area has grown at an exponential rate (Kelly-Irving and Delpierre, 2019), there is currently much less research which looks at how ACEs impact parenting in terms of parental decision-making and abilities.

Parents who have previously experienced adversities during their childhood may find it difficult to effectively parent in line with societal expectations or engage in positive parenting behaviours (Bailey *et al.*, 2012). As well as being linked to over responding in stressful situations and poorer decision-making (Anda *et al.*, 2006), ACEs are shown to be related to maternal depression, which in turn has

been linked to less sensitive and responsive parenting and parent-child interactions (Murray *et al.*, 1996). Given that this association is more robust for women with low socioeconomic status (Lovejoy *et al.*, 2000) it is perhaps even more salient for the population of this study.

Self-efficacy is defined as a person's 'beliefs about their capabilities to produce designated levels of performance that exercise influence over events that affect their lives' (Bandura, 1997, p.2). These beliefs about their capabilities to produce effects determine how people feel, think, motivate themselves and behave, and according to Bandura (1994), one of the main ways of creating and strengthening beliefs of self-efficacy is through the vicarious experiences provided by social models. The perceived similarity between oneself and the model is strongly influential and seeing others like you succeed or fail can be influential in your own feelings of self-efficacy. In this way, the modelled successes or failures of parents can be seen to have an influence on the feelings of self-efficacy of their children, with parents providing social standards against which to judge one's own parenting capabilities for example.

Parents may also influence the feelings of self-efficacy in their children by either providing competent models, who Bandura suggests 'transmit knowledge and teach effective skills and strategies for managing demands' (Bandura, 1994, p.73) or alternatively by persuading their own children that 'they possess the capabilities to master given activities' (Bandura, 1994, p.73). This means they are more likely to mobilise greater efforts and sustain these efforts when difficulties arise, rather than harbouring self-doubts or dwelling on personal deficiencies in the face of challenges.

Parental self-efficacy – a belief in an ability to manage the varied tasks and situations of parenthood (Gross and Rocissano, 1988) – has been demonstrated to directly impact the quality of care parents provide to their children. Higher levels of maternal self-efficacy are associated with an increased quality of mother-toddler interactions, maternal sensitivity and warmth (Teti and Gelfand, 1991) and maternal responsiveness (Stifter and Bono, 1998). Conversely, lower levels of self-efficacy are associated with parental use of coercive discipline (Bugental and Cortez, 1988). Enhanced Triple P for Baby - one of the interventions evaluated by THRIVE - aims to increase the self-efficacy of parents

and their confidence to manage the day-to-day tasks of parenthood, as well as their self-regulation skills, drawing upon evidence that parent training based on social learning models can be effective in improving behavioural and emotional outcomes in children (Sanders, 1999).

Sanders and Woolley (2005) found that measures of self-efficacy significantly predicted both parental over reactivity or harsh discipline, as well as parental laxness – permissive and inconsistent approaches to discipline - after controlling for other parent, child and risk factors. Both over reactivity (Koszycki *et al.*, 2013; Young *et al.*, 2013) and permissive approaches to parenting (Baumrind, 1991; Campana *et al.*, 2008) have been shown to have impacts on children's social and emotional wellbeing outcomes.

The findings of Treat *et al.* (2019) suggest that mothers' self-reported ACE scores were related to their parenting efficacy, as well as depressive symptoms, and their perceptions of their child's social and emotional problems. They found that mothers with a history of ACEs were less confident in their parenting abilities and this low self-efficacy has a negative effect on their children's social and emotional development. Further, they found that social support and parenting self-efficacy were highly correlated with one another, suggesting that mothers with higher levels of social support have more confidence in their parenting abilities.

2.10.6 Critiques and Limitations of ACEs Model

This absence of measures of specific types of adversity in many studies is not uncommon. In fact, it is the case that across research literature, policy frameworks and local interventions, there are differences in the way that ACEs are defined, operationalised, and classified. This leads to difficulties in making comparisons across different contexts (Allen and Donkin, 2015). It is also the case that in spite of the predictive ability of the ACEs inventory, some researchers argue neither the scale itself nor the component items were the result of any systematic process (Finkelhor *et al.*, 2015). This has therefore led to a more recent examination of ways in which these measures might be expanded and improved. Finkelhor *et al.* (2015), for example, suggest that the original ACEs scale misses other common childhood adversities, such as bullying

and victimisation by one's peers, isolation and peer rejection, deprivation and poverty, and exposure to violence within the community. These are, according to the authors, related to negative long-term developmental effects. Further, when these researchers included measures of community violence, peer victimisation, and peer rejection to the ACE scale, these added significantly to the prediction of mental health symptoms in their population. Similarly, including low socioeconomic status added significantly to the prediction of physical health problems.

Likewise, Cronholm *et al.* (2015) expanded ACEs to include experiencing racism, bullying, witnessing violence, and living in an unsafe community to a study which focused on a much more socioeconomically and racially diverse urban population than that which made up the white, middle-class dominated original ACEs study. They found that 14% of their participants faced adversities that would have gone unrecognised by the established ACE scale. This supported their call to extend these conventional ACE measures in order to more accurately measure the level of adversity in various sociodemographic groups.

Another potential issue with these conventional ACE measures is the transferability of constructs such as marriage and divorce to different populations and cultures, which raises questions about the potential impacts of these factors on long term health and development. While at one time divorce may have bestowed a particular stigma and deprivation, it is argued that this is much less of a factor as divorce becomes more widespread (Amato and Keith, 1991). Cronholm *et al.* (2015) also indicated that the constructs of divorce and separation did not accurately reflect the complexities of intimate relationships within their diverse, urban sample. Similarly, Dubowitz *et al.* (2004) suggest that neglect is a subjective concept, and is often therefore a challenging construct in assessments.

Irrespective of the measures used, there are further limitations to studies which use ACE scores. Given their use of retrospective self-response data, they may be subject to recall bias, and respondents may have over and under-reported past experiences of adversity (Wade *et al.*, 2016). Since the events in question may have occurred some considerable time ago, they may also be vulnerable to memory (Finkelhor *et al.*, 2015). Secondly, due to the cross-sectional design of

these studies, they are only able to demonstrate associations between the ACE and health outcome variables and therefore it is not possible to draw conclusions regarding causality (Allen and Donkin, 2015; Wade *et al.*, 2016). In light of the sensitivity of the data being collected, it is also possible that those experiencing adversities choose not to respond or are indeed unable to be reached or to respond, therefore leading to a potential underestimation of actual ACEs in any given sample (Cronholm *et al.*, 2015). The measurement of ACEs from large scale surveys often relies upon the use of proxy measures that may lead to an over- or under-representation of adversity and its effects upon health and wellbeing.

Some academics also take the view that the notion of ACEs represents yet another attempt to offer simplistic diagnoses of, and solutions to, complex social issues (Edwards *et al.*, 2017). Indeed, they argue that the variations in social contexts of previous ACE studies, as well as questionable statistical practices which leave evaluations underpowered, means that it is often difficult to replicate findings. Further, the broad remit of problematic outcomes associated with ACEs makes it very difficult to exclude confounding factors (Edwards *et al.*, 2017).

Similarly, the lack of a sociological perspective on ACEs is also seen as problematic to some, where key aspects are missing from the picture. In research into suicide and self-harm (Chandler, 2019) highlights that her participants often draw upon their early experiences and adversity when discussing their current behaviours, and that the ACEs model misses the vital component of the *interpretation* of the meaning made of these - the emotional, social, and cultural meanings of these events, and how they are narrated, experienced or understood.

2.10.6.1 ACEs from a Feminist Perspective

Arguing from a feminist perspective Callaghan (2019) suggests that the ACEs inventory is not a positive model, in that it offers no sense of how to intervene or disrupt these cycles of adversity and poor outcomes. Moreover, she suggests, like those described above, that it is an asocial model, whereby the cycle is entirely located in the interpersonal relationships – the abuse, neglect, and

violence at the hands of others - and takes no account of the social structures and complex factors within which these operate.

Callaghan (2019) also argues that the ACEs inventory, while putting adversity front and centre and offering much needed explicit links between adversity and poor outcomes, often medicalises adversity and makes it a biological process, and something embodied within individuals. It also blurs adversity and trauma. By confounding the two, adversity – the bad thing that happens – becomes synonymous with trauma – the way in which we respond to this adversity, and as such the ACEs inventory leaves no room for the concept of resilience or understanding how people interpret, make sense of and respond to adversity in agentic ways.

As well as lacking any social elements, it is also argued that the model is one which contributes to blaming individuals, and women in particular, for their problems (Mowat and Macleod, 2019). Callaghan (2019) points to the bluntness of the tool, in that it both neutralises gender issues and lacks intersectionality. She argues that stigmatising separation and divorce as bad for children adds to a woman-blaming culture where being a single parent family is framed as an adversity in and of itself and may put pressure on women to remain in abusive relationships. By pointing to single parent families as a source of adversity, which are predominantly women raising children by themselves, it leaves no room for understanding the complex dynamics at play, where often economic restraint and coercive control by absent fathers are the contributing factors to any difficulties these women may face in parenting their children. Thus, absent fathers, potentially withholding financial support, are repositioned as a failure of and a problem for mothers.

Similarly, domestic abuse is arguably gender neutralised in the ACEs model. It says nothing of power dynamics and coercive control and reduces gender-based violence to the physical incident of abuse and misses the complexity of family life. It places the emphasis on the impact upon the victim and her child, and it is seemingly widely accepted in literature that the child will be unaffected in the face of such violence, so long as the mother is not depressed, anxious, or using substances. In other words, if the child is having difficulty, it is the fault of the mother, not the perpetrator (Callaghan, 2015). In this way, the simplicity of the

ACEs model misses the complex implications that domestic violence has upon families, and in particular the relationships between mothers and their children (Katz, 2019).

Finally, Callaghan (2019) calls for any public health model to be grounded in the experiences of the people to whom it is directed; in this case children and women who are mothers – and neither have been particularly consulted in the policy agenda or in the ACEs movement. This PhD project can help to address that shortcoming by providing mothers with an opportunity to share their experiences of adversity, and how these have been shaped by other contextual factors, how they have responded to them, and ultimately how they have influenced their conceptualisations of and approaches to parenting.

2.10.7 Summary

There is a clearly demonstrated connection between exposure to adversities such as abuse and neglect during childhood, as well as the presence of mental ill health and violence within the family home, and negative outcomes in adulthood in terms of physical and mental ill health (Bellis *et al.*, 2014b; Felitti *et al.*, 1998; Flaherty *et al.*, 2013; Ramiro *et al.*, 2010). Further studies have also expanded concepts of adversity to include deprivation and neighbourhood factors, and associations between these factors and health outcomes remain (Cronholm *et al.*, 2015; Finkelhor *et al.*, 2015). These adversities have been demonstrated to have impacts across generations by increasing the biomedical and psychosocial risks to mothers and their children, which in turn places those whose parents have experienced adverse events at greater risk of experiencing similar adversities themselves. As such ACEs contribute greatly to continued social inequalities.

As Kelly-Irving and Delpierre (2019) argue, the focus of ACEs research should be upon conditions that may be adverse for child well-being, and how these conditions arise. As such, the targeted level for intervention must be the structural social context in which children are exposed to ACEs and their socioeconomic disadvantage. Taking an individualistic approach whereby the responsibility lies with the individual for both the causes of ACEs and their solutions, may lead to incrimination of parents. Rather, the evidence on ACEs

needs to be used to reveal the social conditions in which parents and children live and how they cope with these challenges. These issues can only be understood and addressed when seeing them as a whole, and acknowledging that the risks to health and wellbeing of adversity increase their impacts upon this population because of their syndemic interactions (Singer, 2009) with other illnesses and diseases alongside unequal and unjust social conditions.

Outside of socioeconomic status and access to economic resources, positive parenting does though offer a key mechanism via which the impacts of childhood adversity upon life course behaviours and health can be substantially mitigated (Afifi and MacMillan, 2011; Marriott *et al.*, 2014). It is within the early parent-child relationship that the foundations for resilience may be built, and it is this resilience which can reduce the impact of ACEs and prevent these from impacting upon the health of mothers and their children. The quality of these interpersonal relationships provides an example of a mechanism via which ACEs could lead to health risk outcomes or conversely could indeed provide a protective factor against these same adversities (Larkin *et al.*, 2014). It is by understanding how these factors interact through differing childhood histories, and their consequent impact upon health and the adoption of parenting practices, that research such as this may address ways of breaking any intergenerational cycles of adversity.

The final section of this literature review outlines the development and utilisation of two particular tools which seek to measure parental attachment, and which are drawn upon in the methods of this research project. It assesses the validity of these tools, with particular regard to the intergenerational transmission of parenting and attachment, and developmental outcomes for children and parents, especially among those identified as having additional health and social care needs.

2.11 Measuring Attachment – the Parental Bonding Instrument and the Adult Attachment Interview

2.11.1 Overview of Section

As previously discussed, the role of early experience and parenting is, according to Bowlby's theory of attachment (1969, 1973, 1980, 1985), of crucial importance to child development and mental health; and further, attachment has been demonstrated as influential upon a variety of biopsychosocial phenomena, including social functioning, psychological wellbeing, responses to stress, and a range of health behaviours and morbidity (Ravitz *et al.*, 2010). In addition, several research findings suggest that parental bonding and different types of attachment play a crucial role in personality development (Avagianou and Zafiropoulou, 2008), including the development of parenting practices. Attachment has then become an important focus for research, and a multitude of instruments have been established in an attempt to measure and classify attachment. It is argued that by employing established measurements of attachment, researchers can gain a unique perspective on this topic, since constructs of attachment are both theoretically and empirically distinct from other social and personality constructs (Ravitz *et al.*, 2010).

This section outlines the development and utilisation of two particular tools which seek to measure attachment, and which are drawn upon in the methods of this research project: the Adult Attachment Interview (AAI) (Main and Goldwyn, 1991), and the Parental Bonding Instrument (PBI) (Parker *et al.*, 1979) – a copy of which can be seen in Appendix 4 – Parental Bonding Instrument. This review evaluates each of the tools in terms of their theoretical development and subsequent application, with particular regard to the intergenerational transmission of parenting and developmental outcomes for children and parents, especially among parents identified as having additional health and social care needs.

In order to review the existing literature which both describes and utilises these instruments, databases at MedLineR, CINAHL, ASSIA, Scopus, and SocIndex were all searched, first using the search term 'Parental Bonding Instrument', and then repeated using the term 'Adult Attachment Interview'. This returned totals of

752 papers for the former, and 1497 papers for the latter. Once imported to a reference management tool, duplicates were removed, as were those not written in the English language; following a screening of abstracts to ensure relevance to this study, a total of 307 studies described their use or review of the PBI, and 398 their use or review of the AAI.

2.11.2 Parental Bonding Instrument

Based on the premise that a parent influences his or her child's attachment security, Parker (1983) suggests that this is principally a result of two key variables from the parent: care and protection. The PBI was developed on this basis by Parker *et al.* (1979) as a measure to retrospectively assess how an individual subjectively perceives the parenting provided to them by both their mother and father separately. The PBI survey is self-completed, with a separate form for both mothers and fathers (see Appendix 4 – Parental Bonding Instrument). Two variables are measured by this instrument, termed 'care' and 'protection' (sometimes referred to as 'control' or 'overprotection'). There are 25 questions - 12 measuring 'care' and 13 measuring 'protection'. These measure fundamental parental styles as perceived by the child, and the measure is retrospective, meaning that adults complete the measure for how they remember their parents during the first 16 years of childhood.

Each answer on the PBI is scored on a four-point scale (between 0 and 3), giving a total score for the 12 'care' items, and a total score for the 13 'protection' items. Using differing cut-off scores for mothers and fathers, each parent is then assigned to either high or low care and either high or low protection. As well as generating scores for each scale, each of the participants' parents can be effectively assigned to one of four quadrants according to their style of parenting:

- High care and high protection – described as "affectionate constraint"
- High care and low protection – described as "optimal parenting"
- High protection and low care – described as "affectionless control"
- Low protection and low care – described as "neglectful parenting"

(Parker *et al.*, 1979)

This instrument requires no specialist training to score (Manassis *et al.*, 1999), and can be both completed and scored in only a few minutes; high test re-test reliability and concurrent and predictive validity of the test has been established; it has also been demonstrated to be independent to the effects of current mood (Parker, 1990). Further, it has been demonstrated, through consistency in PBI scores over extended periods of time (over 20 years in some cases), that attitudinal change due to life experience does not impact upon how an individual recollects the parenting environment experienced (Wilhelm *et al.*, 2005). Thus the PBI is among the most consistently adopted measures of parenting style (Enns *et al.*, 2002), and the PBI scores are not substantially influenced by the gender or depression history of the individual, and nor do they shift with fluctuation in states of mind such as episodes of depression or neuroticism (Wilhelm *et al.*, 2005).

It is important to note that the PBI measures perception of parenting rather than actual parenting, and with that come potential recall bias issues; however, Wilhelm *et al.* (2005) indicate that it is often this perception of parenting behaviour which carries the greatest risk for subsequent psychopathology and affective disorders. Indeed, the discriminant validity of the PBI has been consistently demonstrated in both clinical and non-clinical populations (Manassis *et al.*, 1999).

Low scores on the care dimension of the PBI, coupled with high scores on the (over)protection scale, are widely considered to be risk factors for depression (Wilhelm *et al.*, 2005). Because of this, and because the validity of the tool has been demonstrated in both clinical and non-clinical populations, much of the work which utilises the PBI has a focus on developmental and mental health disorders, substance abuse, and wider social adjustment problems. It is this work which will be discussed here, with particular regard to those studies which have relevance to the previously outlined risk factors which may lead to additional health and social care needs for the women recruited to this study, and their inclusion in THRIVE.

The PBI has been used extensively across several decades in order to investigate the relationship between perceived parenting styles and problem drinking. Gomez (1984) employed the PBI alongside the Eysenck Personality Inventory to

attempt to understand how faulty attachment may lead to eating disorders and problematic drinking. Similarly, Schweitzer and Lawton (1989) examined the perceptions of parenting among drug abusers, and the links between styles of parenting and subsequent emotional problems which may lead to substance abuse problems. Conversely, Luk *et al.* (2015) examined autonomy granting and warmth, as measured with the PBI, as protective factors against such emotional problems and potential substance abuse. The PBI has also been employed to research connections between anorexia and bulimia and perceived parenting (Horesh *et al.*, 2015; Sordelli *et al.*, 1996; Sullivan *et al.*, 1996), as well as general affective symptoms in adulthood (Rodgers, 1996).

In addition to being utilised in several studies to understand cultural differences in perceptions of parenting (Luthar and Quinlan, 1993; Shams and Williams, 1995), the PBI has been used to examine relationships between parenting and perfectionism and self-esteem (Rice *et al.*, 1996), as well as how other psychosocial factors may be associated with teenage pregnancy (Keddie, 1992). Bower (1995) also employed the PBI to examine factors which affect mother-daughter intimacy in young adult women, particularly around the time of these women's first pregnancy.

The PBI has also been used to control for parental attitudes when examining psychological wellbeing in adolescents subjected to physical punishment (Canetti *et al.*, 1997), bereaved adolescents (Bachar *et al.*, 1997), and delinquency and general mental health and wellbeing in adolescents (Bachar *et al.*, 1997). Biggam and Power (1998) measured parenting style with the PBI to investigate the relationship between parenting styles and levels of depression, anxiety, and wellbeing among incarcerated young offenders in a Scottish prison. Several studies have also assessed conduct and oppositional disorders in adolescence as related to parenting style, as measured by the PBI (Freeze *et al.*, 2014; Pedersen, 1994; Plapp and Rey, 1990).

The work of Fergusson *et al.* (1996) measured social, family and related factors via the PBI in order to examine any associations between these and an increased risk of child sexual abuse, while Brown (1998) measured parenting styles using the instrument to examine outcomes associated with such sexual abuse. Others have measured parent-child attachment in attempts to explore how Bowlby's

attachment theory may explain the pathway between sexual abuse in childhood and the development of psychological problems in adulthood (Kutil, 1998).

The association between panic and anxiety disorders and recollections of parenting have also been examined utilising the PBI (Bennet and Stirling, 1998; Wiborg and Dahl, 1997), with Heider *et al.* (2008) identifying adverse parenting as a risk factor for such disorders. Similarly, the extent of dissociative experiences and the prevalence of dissociative disorders among psychiatric patients, and their relationship to perceived parenting, has been explored by with the PBI (Modestin *et al.*, 1996; Modestin *et al.*, 2002; Modestin *et al.*, 2004). Helgeland and Torgersen (1997) reported how negative maternal behaviours, as assessed by the PBI, played a role in the development of severe mental health disorders.

Among others, Avagianou and Zafiropoulou (2008) and Weissman *et al.* (2014) have administered the PBI alongside other clinical measurement tools to investigate and assess the links between parental rearing and depression. Handa *et al.* (2009) demonstrated that female patients with low levels of maternal care and low levels of education have a higher likelihood of showing symptoms of prolonged depression in a primary episode, and further that women who reported 'affectionless control' from their fathers faced a higher risk of prolonged depression when compared to those women who reported 'optimal' paternal parenting. Similarly, using the PBI along with data from the Avon Longitudinal Study of Parents and Children, Mahedy *et al.* (2014) concluded that sensitive caregiving is important in regard to the future risk of depression in the offspring of depressed mothers.

Finally, and perhaps most pertinent to this study of intergenerational transmission of parenting practices, Miller *et al.* (1997) were able to demonstrate, via the PBI, that the intergenerational transmission of parental bonding style was independent of both depression and temperament in either the mother or daughter, as well as being independent of socioeconomic status. Madden *et al.* (2015) were also able to provide evidence for the intergenerational transmission of parenting in a UK context by using observation methods in tandem with the PBI. Murphy *et al.* (2010) concluded that the PBI provided a robust measure of an important environmental risk factor for

depressive disorders, which also showed long-term stability over a 20-year period.

2.11.3 Adult Attachment Interview

The AAI is a semi-structured, hour-long interview, comprising 20 questions with additional follow-up probes, which enquires about attachment relationships with caregivers, both during childhood and within current relationships, as well as potentially traumatic experiences suffered during childhood, such as abuse or the loss of loved ones (George *et al.*, 1984, 1985, 1996). Verbatim interview transcripts are then coded, with participants classified into one of three principal attachment groups: *secure-autonomous* (valuing of attachment relationships and experiences, while apparently objective regarding any particular relationship experience); *dismissing* (dismissive of, devaluing, or cut-off from attachment relationships and experiences); or *preoccupied* (preoccupied with or by early attachments or attachment-related experiences) (Main and Goldwyn, 1998). The AAI requires specialist training to code and interpret responses and derive from these an individual's own attachment style. The stability and discriminant and predictive validity of the AAI, in both clinical and non-clinical populations, have been demonstrated by meta-analyses and rigorous psychometric testing (Bakermans-Kranenburg and van Ijzendoorn, 1993; Roisman *et al.*, 2007; van Ijzendoorn and Bakermans-Kranenburg, 2008).

The AAI format has been widely used to provide parents with an opportunity to begin to draw on childhood memories and reflect on their own experiences, and how these relate to their own parenting styles (Polansky *et al.*, 2006). It is not the goal of the AAI however to uncover the precise nature of these childhood experiences, but rather to assess how these experiences are currently represented by the participant. Accordingly, it is the linguistic properties of the participant's narrative which are used for classification purposes - the content then becomes less central, with the emphasis placed on how the story is told rather than the story itself (Main *et al.*, 2002).

These attachment classifications represent the participant's state of mind with respect to attachment, and it is these which have been found to have important correlations to individual functioning. State of mind as assessed by the AAI has

been linked to individual behaviours, not just in relationships with their children (van Ijzendoorn, 1995), but also with romantic partners (Holland and Roisman, 2010; Roisman *et al.*, 2001). Furthermore, it has been consistently demonstrated that a parent's attachment representation is predictive of a variety of psychological outcomes for their children. Most notably, AAI classifications have been seen to predict the quality of attachment in the infant as assessed by the Strange Situation experiment (Ainsworth *et al.*, 1978; Shah *et al.*, 2010), an association which is still evident when the AAI is administered before the birth of the child (Fonagy *et al.*, 1991). Studies have also suggested that the attachment state of mind of parents is prospectively linked to internalising and externalising behaviours in their children, as well as wider social adjustment problems (Cowan *et al.*, 1996; Kouvo and Silven, 2010) and emotional development and understanding (Steele *et al.*, 2002).

Although largely employed to assess how the attachment style of a caregiver impacts upon a child's own attachment behaviours, the AAI has also been widely used to assess the intergenerational transmission of attachment. Benoit and Parker (1994) were able to demonstrate parent-to-child transmission of attachment style across three generations as measured by the AAI, while Hautamaki *et al.* (2010) used the AAI with grandmother-mother-child triads, and found continuity of attachment in almost half of these cases, albeit with a small sample.

Several studies have also attempted to take the narrative elements of the AAI and build upon this for further research. This includes administering the AAI and examining participants' frequency of word usage (Cassidy *et al.*, 2012), exploring the use of narrative in resilience to adverse events (Hauser *et al.*, 2006), and understanding how language is used in emotion regulation processes related to attachment (Borelli *et al.*, 2013).

2.11.4 Combining both Instruments

In a study to determine whether or not the PBI was able to provide information about parent-child attachment comparable to that obtained by the AAI, Manassis *et al.* (1999) found a significant association between AAI attachment classifications and maternal PBI scores. While there was no association for paternal PBI scores, Manassis *et al.* (1999) suggest that this reflects the predominance of the mother-child relationship when it comes to shaping and determining attitudes towards attachment.

Administering both the PBI and AAI with the same set of parents, in an attempt to test aspects of each tool's validity, van Ijzendoorn *et al.* (1991) concluded that both instruments were related. Aside from the reliability and validity of individual attachment instruments, Ravitz *et al.* (2010) suggest when choosing an appropriate tool it is necessary for researchers to take into account the attachment relationship which forms the focus of the research, as well as the attachment constructs relevant to the research question. These considerations are in addition to the time required for training, administering and scoring of participants' responses.

Both the AAI and the PBI then can be seen to be robust, widely used and rigorously validated measures of attachment, and while they may measure slightly different categories or dimensions of attachment, there is some degree of convergence between the two tools. Further, it can also be seen that both of these instruments have been employed to better understand the mechanisms by which parenting may be influential upon the developmental outcomes in both childhood and adulthood, and how styles of parenting may be passed through subsequent generations. It is for these reasons that these tools were adopted in this research project, to better understand the women's attachments and relationships with their parents, and how these potentially impact upon the ways in which they parent their own children.

How these tools were used to address the research questions of this current study are outlined in the next chapter, which identifies the specific research questions of this project, and describes in detail all of the methods used in order to answer these questions.

3 Methods

3.1 Overview of Chapter

This chapter describes and discusses the research methods utilised in this study. It begins by explaining the aims and scope of this PhD, followed by a discussion of the epistemological and methodological considerations that informed the decisions regarding the design of this research. This is followed by a discussion of issues of reflexivity and of potential power imbalances, especially in the context of working with vulnerable populations. Finally, this chapter concludes with a description of the specific research design and data collection methods, as well as detailing the data management and analysis processes.

3.2 Aims and Scope of the Study

3.2.1 Identifying the Population of Interest

This study is nested in THRIVE: a study funded by the National Institute for Health Research, examining healthy relationship initiatives for the very early years. It complements the process evaluation component of THRIVE, focusing on the childhood context of parenting behaviour, seeking to answer the central question: How does a parent's childhood, and events from their lives, shape the way they parent their own child?

This mixed methods PhD makes use of the baseline parental questionnaire data collected for the THRIVE outcome evaluation, which focused on the respondent's own childhood. These measures included demographic characteristics of the population, as well as ACEs and other measures of childhood trauma, mental health issues, and levels of social support. This data is complemented by primary in-depth qualitative interview data from a sub-sample of the THRIVE mothers. These interviews focused on their upbringing and how they think this, along with other events from their lives, has shaped their parenting practices.

3.2.2 Aims of the Study

The overarching objective of this PhD project is to gain an understanding of how parenting practices are transmitted across generations. It seeks to understand,

from the perspective of mothers with additional health and social care needs, how their childhood experiences and the ways in which they were parented impact upon the parenting practices they adopt with their own children. It also seeks to uncover the factors associated with parental self-efficacy.

Ultimately this project aims to contribute to better health and wellbeing for both mothers and their children by providing an understanding of intergenerational cycles of parenting practices, both positive and negative. By contributing to the paucity of data on this topic, this PhD can inform future interventions - such as those being evaluated by THRIVE – with a view to disrupting any negative cycles and supporting mothers to parent in more positive ways.

There are four main research questions:

1. What are the factors which impact upon parental self-efficacy among women recruited to THRIVE? (Results outlined in Chapter 4).

2. What are the lived experiences of these women – what do these women recollect regarding the practices adopted by their parents, and how do they reflect upon their experiences and the environment in which they were raised? (Results outlined in Chapter 5).

3. How do these women respond to these experiences when it comes to their conceptualisations of parenting, and what impact does this have upon their decisions regarding their parenting practices with their own children? What can this tell us about the ways in which parenting practices are repeated across generations? (Results outlined in Chapter 6).

4. How can these findings inform parenting interventions like those evaluated by THRIVE? (Discussed in Section 7.2.4).

3.3 Epistemological and Methodological Rationales

3.3.1 Using Mixed Methods

Numerous definitions of mixed methods research abound, and all differ in scope and detail, but essentially all come down to an integration of both quantitative and qualitative methods in a single research project. By combining both methods into a research design, it is hoped that a better understanding can be achieved than either a quantitative or qualitative approach could provide by itself (Guest *et al.*, 2012). Creswell and Plano Clark (2010) suggest that mixed methods approaches can provide more comprehensive evidence, answer certain research questions that a single-method approach cannot, and also that they can enhance a study and help to generalise exploratory findings.

The approach I have taken is best described as an explanatory sequential one, where a quantitative analysis is used to help interpret results from, and provide context to, qualitative findings (Guest *et al.*, 2012). A multilevel approach is taken to combining both the quantitative and qualitative data, where different data types are collected at different levels of analysis, but together create the context surrounding a behaviour or event (Bernard and Ryan, 2010).

3.3.2 Using Quantitative Methods

THRIVE practitioners collected data from mothers during baseline and follow-up visits. These data provide, among other things, demographic information about these women, and ask about the presence of ACEs in their own childhood, as well as their current views on parenting. In the case of this research project, it was felt that utilising part of this quantitative dataset would serve several purposes. First, it would provide background context on the demographics of both the wider THRIVE population and the sample of women with whom I conducted interviews. This allowed me to present descriptive statistics of both the population and my sample, to examine how representative or otherwise this sample is, and provide an indication as to how generalisable any findings may be.

Second, the use of the quantitative data around ACEs and demographic variables is best suited to answering the first of my research questions: what are the

factors which impact upon parental self-efficacy among women recruited to THRIVE? Quantitative analysis allows for correlations to be examined between the presence and prevalence of ACEs, other adverse life events and health and lifestyle factors, and these mothers' views on parenting and their own self-efficacy in this area.

The Parental Bonding Instrument (PBI), outlined in further detail in Section 2.11, enabled me to categorise each of the participants according to their perception of the parenting style of their own mother and father, as recalled from childhood. This was useful for contextual, background information when analysing and discussing the interview data, as well as providing a discrete attribute which could be used throughout the analysis.

3.3.3 Using Qualitative Methods

Qualitative methods were also selected for this research as this type of approach aims to examine the construction of meaning and understand the details of people's lives and their frames of reference (Gibson and Brown, 2009). Qualitative methods in general - and qualitative interviews in particular - are closely related to the approaches of interpretative sociology; the purpose of qualitative interviews is largely to derive interpretations (Warren, 2002). Interviews are a useful method for enquiring openly about self-interpretations (Hopf, 2004), and interviewees in this context are seen as meaning makers (Holstein and Gubrium, 1995). Moreover, it is interpretivist in that it works from the premise that individuals and groups interpret the social world and their place within it, and that gaining narratives can tell us about the person and the social world they inhabit (Lawler, 2002).

Qualitative methods are useful for exploring in-depth accounts and the meaning people ascribe to experiences and events. They were chosen therefore as they are best placed to answer two of my research questions which seek to examine the lived experiences of these women (Chapter 5), and how they feel these experiences shape their current parenting, as well as exploring the contexts in which parenting practices in one generation may impact those in another (Chapter 6).

When it comes to sensitive research with vulnerable participants, qualitative methods are especially appropriate (Daly, 1992). Qualitative methods, suited due to their fluid and flexible approach, allow researchers to gain an understanding of the meanings, interpretations and subjective experiences of vulnerable groups in a variety of contexts and around a multitude of complex and sensitive subjects (Lee, 1993; Liamputtong and Ezzy, 2005; Miller, 1997; Renzetti, 1997). Similarly, qualitative methods give researchers 'a window on family processes' (Daly, 1992, p.4) through which patterns of interaction can be observed, as well as the ongoing negotiation of family roles and relationships. In this way such methods allow researchers access to the private meanings of and within families as well as providing an insight into the diversity of family structures and experiences. As Silverman (2013) points out, qualitative research is at its most powerful in exploring things which are seemingly every day and are thus often taken for granted.

Literature relating to vulnerable women and pregnancy is largely dominated by a theoretical and professional discourse centred on 'risk', with little research which incorporates the actual experiences of pregnancy and motherhood of vulnerable women themselves (Birtwell *et al.*, 2015). The stories included in this current study therefore aim to elucidate these personal narratives, which may then inform theory and practice.

By combining both quantitative and qualitative methods in this project, I am able to use a wealth of data to examine a complex issue. While qualitative approaches are best suited to revealing in-depth accounts and the meaning people ascribe to experiences and events, quantitative methods can be employed to answer different, but supporting, questions. Quantitative methods can shed light on contextual factors which impact upon the THRIVE population, and in turn the qualitative data gives deeper insights into these issues. Therefore, it is felt that by utilising both methods, a triangulation of data is possible, ultimately allowing for a richer, deeper understanding.

3.4 Advisory Committee

To help inform the research design of this project, an advisory committee was convened in the early stages. Meeting in June 2017, after the literature review but before data collection, the committee consisted:

- Both academic supervisors – Dr Katie Buston and Dr Marion Henderson
- Professor Danny Wight - Senior Researcher in MRC/CSO Social and Public Health Sciences Unit, with experience in parenting studies and interventions
- Professor Helen Minnis - from the University of Glasgow, with expertise in attachment and parenting interventions
- Lynsey Parker - Social Worker from Glasgow City Council with experience in working with vulnerable families
- Biba Devine - Policy Officer from Stepping Stones for Families, a Glasgow-based charity, who work alongside children, young people and families to give them support, opportunities and a voice in tackling the effects of poverty and disadvantage in their lives.

The purpose of this advisory committee was primarily to inform and refine my research questions. I was able to seek guidance on my proposed methodological approaches, and advice on any practical issues which may arise, especially with regarding recruitment and sensitive research with vulnerable populations. I also used this opportunity for suggestions on areas of the literature I may have missed or overlooked, or how other areas of literature may help to inform or shape my research. I also presented my work-to-date and welcomed questions, comments and critiques. This committee also proved useful in establishing ongoing points of contact throughout the study.

I also presented my work several times to the THRIVE trial steering committee, who were able to give their insights into the project as it evolved. This steering committee featured Public and Patient Involvement representatives, and through this channel the design of this study therefore benefitted from being able to include the perspective of a wide range of informants.

3.5 Ethics

Thought must be given to ethical considerations of any research project at the design stage, as well as featuring throughout the research process itself. This is true of both qualitative and quantitative approaches which involve working with people, and ethical considerations should be taken into account in the data collection phase, as well as in the analysis and writing up stages. It is through these processes - both informal ones that help build trust and rapport, and more formal ones which provide ethical guidance and protection for researchers and participants alike – that research can be seen as a relationship and collaboration.

Application for ethical approval took the form of an amendment to the existing THRIVE ethical approval and involved the submission of a detailed research proposal for this project. Subsequently approval was granted by the West of Scotland Research Ethics Committee (Reference: 13/WS/0163). I also required an Honorary Contract in order to gain access to those THRIVE participants who are NHS patients.

3.5.1 Research with Vulnerable Populations and Participants

Given the nature of this research, and the population from which participants are drawn, it is salient to examine the potential implications when conducting sensitive research with vulnerable groups. Research which involves vulnerable participants and sensitive issues carries certain implications in terms of the processes followed throughout the project and also its eventual outcomes. This section discusses the relevant issues when it comes to conducting such research, both in terms of the potential impact on participants and on the research project itself, as well as the potential impact of the researcher's positionality and chosen approach.

Conducting research with so-called vulnerable groups brings with it particular ethical, practical, and methodological concerns. First and foremost, defining what is meant by 'vulnerable', and indeed who makes this determination of who is vulnerable, raises immediate issues: this is problematic in the first instance since the term vulnerable is itself one which is socially constructed (Moore and Miller, 1999). It is therefore necessary to take into account the contexts within

which research participants may be categorised as vulnerable, as well as exploring the potential consequences of such a label, both to the participant themselves and the wider population of interest. Being mindful of the importance of contextual factors within which the definition is made, Flaskerud and Winslow (1998) suggest that the term vulnerable applies to those social groups who share an 'increased relative risk or susceptibility to adverse health outcomes' . As such, certain groups may be seen as vulnerable only in the context of comparisons to other groups, especially so when they are likely to suffer relatively worse health. It is important when discussing vulnerability to these increased risks to focus not on the vulnerable individual, but on the life situations, social processes, society and institutions which generate and reproduce these vulnerabilities (Virokannas *et al.*, 2018). These factors are reflected in healthcare guidelines which highlight those at greatest risk are: those with mental health problems, those who are socially deprived, those with substance misuse problems, women experiencing domestic violence, those who were sexually abused as children, and women with a history of involvement with child protection services (National Institute for Health and Care Excellence, 2010). This is also echoed in the criteria by which women were recruited to THRIVE.

3.5.2 The THRIVE Population

THRIVE predominantly recruited women who have been identified by a health or social care professional as having additional health and social care needs in pregnancy, using NHS Greater Glasgow and Clyde's Special Needs in Pregnancy guidelines as inclusion criteria (Glasgow Child Protection Committee, 2008). Such criteria include:

- Substance and/or alcohol misuse within the last 12 months;
- Woman and/or her partner in the criminal justice system;
- HIV positive diagnosis;
- Child protection issues/concerns for this baby or any previous children whether or not currently with parents;
- Domestic violence issues;

- Significant mental health issues such as: previous history of bipolar disorder, schizophrenia or other psychotic illness, or previous admission to hospital for treatment of mental illness;
- Immediate family member with history of bipolar disorder;
- Current mental health problem, for example depression, anxiety disorder, psychotic symptoms, or current thoughts of suicide or self-harm;
- Complex homeless issues: unaccompanied homeless minors seeking asylum/refugee, Illegal immigrants, and asylum seekers or refugees with additional above factors;
- Complex young mums or anyone under 16 years of age.

The women recruited to THRIVE this way were therefore deemed as vulnerable during their pregnancy by a trained healthcare professional, by virtue of meeting one or more of the above criteria.

Some researchers suggest all pregnant women and new mothers can be described as vulnerable, as at times of change to their lives and bodies, these women may be more likely to be susceptible to coercive or undue influence (Stone, 2003). Those who have experienced rape and domestic violence also require extra sensitivity and consideration during research (Liamputtong, 2007). Further, it is evident that any potential research participants drawn from THRIVE may face what are known as multi-faceted vulnerabilities (Radley *et al.*, 2005); women who are single mothers, from ethnic minority backgrounds and living in poverty are often rendered especially vulnerable by the combination of these social statuses (Liamputtong, 2007). A state of vulnerability is then not only a subjective one, but also one which is context dependent and most importantly one in which each of us can find ourselves at different times and in different situations.

3.5.2.1 Vulnerability within the Context of THRIVE

The issues faced when researching vulnerable groups raised here are also exacerbated by the fact that these groups of people are also the most 'hard-to-reach' for many researchers and practitioners. Longstanding evidence suggests early intervention is needed when it comes to the mental health of children and young people (Mental Health Foundation, 1999), and further that such

interventions show effectiveness in terms of improving emotional, behavioural and educational outcomes within families where such issues exist (Barlow *et al.*, 2005). However, there is often low uptake when these services are offered to the very families who need them most and who will derive the greatest benefit from them (Fonagy, 1996).

There is evidence which indicates that those women who exclude themselves from such support interventions typically tend to be younger, less well-educated, and already less likely to attend appointments with general practitioners, midwives and health visitors; these women may also have poorer outcomes when it comes to their own health and wellbeing, as well as that of their children (Murray *et al.*, 2003). This emphasises the point that those who most typically form the target for such interventions are the ones most likely to be omitted.

Reasons behind women declining to be involved with intervention programmes and research projects were explored by Barlow *et al.* (2005). Reflecting the fact that many of the women who were the intended target of such interventions were young mothers with low levels of maturity – precisely the vulnerable groups such programmes seek to reach – Barlow *et al.* (2005) found that these same women were deterred from participation due to an inability, or on occasions a lack of willingness, to relate to older adults. Conversely, some women simply did not feel that they needed to be involved as they themselves did not view their situation as unusual or warranting intervention, and nor did they feel they themselves were in need of any support. As such it can be seen that people's perceptions of their own needs, and indeed of their level of vulnerability, may not accord with the opinions of the healthcare professionals responsible for referring them to the intervention programme.

As well as the perceived lack of need for the services on offer, some women cited a lack of understanding about why they were invited to take part, while others expressed confusion about what they were told or sometimes an inability to remember being invited to participate at all. Coupled with this general confusion were also misperceptions about the service offered and what it would actually entail in practical terms. It is not surprising that many women declined to be involved if they saw the research as a burden to their already busy lives

and were pre-occupied with their own children, pregnancies, or their current mental health problems for example. Rather than seeing such services as a potential source of much-needed support, the immediate benefits - if they were apparent at all to the participants - were simply outweighed by more practical day-to-day concerns (Barlow *et al.*, 2005). Since reaching those most in need of help and support, and giving a voice to those often marginalised, often carries with it a great number of challenges, it is vital that researchers take these factors into account and attempt to mitigate them as much as possible at the early stages of any research project which works with vulnerable populations.

These issues have particular salience, since the women recruited to participate in this research project are entirely drawn from those who have accepted an invitation to be part of THRIVE and have also maintained some involvement over a significant period of time. As such those recruited here may not represent the most vulnerable, or be those who are determined as being 'hard-to-reach' in light of their precarious social and/or economic situation for example (Shaghaghi *et al.*, 2011).

3.5.3 Sensitive Research

Aside from researching a vulnerable population, the nature of this research – addressing potentially traumatic and upsetting events from the participants' past and examining intimate relationships - means that it can be considered as sensitive. The issue of sensitive research is, Liamputtong (2007) suggests, closely related with vulnerable and marginalised people. Research which requires

'disclosure of behaviours and attitudes which would normally be kept private and personal, and which might result in offence or lead to social censure or disapproval' can be deemed as sensitive (Wellings *et al.*, 2000, p.256).

Similarly, research which may cause discomfort to respondents in terms of expressing their opinions or experiences should be considered as sensitive, as should any research which involves the private sphere of individuals (Robertson, 2000). Where there are potential consequences or implications directly for the research participants, then the study should be deemed as sensitive (Sieber and Stanley, 1988). Where subjects such as abuse, death, violence, miscarriage, and

abortion are discussed, then the research is undoubtedly sensitive (Dickson-Swift *et al.*, 2007; Draucker, 1999; Liamputtong, 2007).

Given the potential difficulties of research involving vulnerable groups, it is important to pay consideration to procedural sensibilities in order to carry out this research effectively and sensitively. Vulnerable or hard-to-reach groups provide challenges when it comes to access and recruitment, and although gatekeepers are often used to facilitate this, these gatekeepers may themselves also assist in keeping out researchers and protecting participants (Dickson-Swift, 2005). To mitigate these issues, Moore and Miller (1999) suggest an approach which carefully outlines the potential risks and benefits to participants, describes who will carry out the study and how the participants will be involved, and ensures data privacy and confidentiality while demonstrating ethical approval from a reputable institution.

Building trust and rapport, and having respect for research participants, is also vital when carrying out research of this nature, especially since people are being asked to discuss intimate aspects of their lives (Dickson-Swift, 2005). This situation is exacerbated by the fact that many vulnerable groups are often suspicious of researchers (Miller and Tewksbury, 2001). For Hotham *et al.* (2016) valid findings will only occur if any scepticism about assurances of confidentiality is addressed. Taking one's time and exercising patience, and avoiding a data-raid (Wadsworth, 2011) or a hit-and-run approach (Booth and Booth, 1994) where a researcher arrives, collects data, and then disappears again, are some of the measures that can be employed in an attempt to overcome these difficulties.

Research should, where possible, make a positive difference to the lives of those it touches, and give something back; this can take the form of providing feedback and results to participants, as well as enabling them an opportunity to read their interview transcript prior to the analysis and publication of their voices (Reinharz and Davidman, 1992). It is also important to understand the potential impacts that being involved in the research project may have upon these women (Reinharz and Chase, 2002); in light of this it is good practice to be able to provide participants with information regarding referrals to support and counselling services, as was the case in this research, and participants had

frequent contact with THRIVE researchers. It is also essential that consideration is given to finding a venue for interviews to be carried out that is not only appropriate for confidentiality and privacy concerns, but one where the woman feels safe and comfortable (Liamputtong, 2007). As well as trust, the absence of judgmental and prejudicial attitudes is essential throughout (Mccullough *et al.*, 2013).

3.5.4 Feminist Methods as a Counter to Issues of Vulnerability

Given previously outlined concerns about the potential vulnerable nature of the participants, and my own position as a non-parent and male researcher talking with these women about sensitive topics, I was keen to ensure I did everything possible to minimise any distance and potential power imbalances. I was also very aware that this research was centred upon giving a voice to my participants, which is often missing from this type of research, and I was keen to make sure I was able to represent them well. It was for these reasons that I was drawn to feminist approaches.

Burgess-Proctor (2015) makes the case that, somewhat paradoxically, ethical review boards which are designed to protect vulnerable participants from potential harm of research, often leave the hierarchical differential between researcher and participant unchallenged by their traditional, positivist approach. This position unhelpfully and unrealistically frames researchers as objective, dispassionate scientists who are somehow able to reveal a truth about participants via their knowledge and expertise. As an alternative, Burgess-Proctor (2015) advocates feminist interview strategies that are 'designed to help empower rather than simply protect participants'. Indeed, she argues that feminist research methods have developed as a direct result of a growing rejection of the idea of protecting participants from research for their own good, and dissatisfaction with the prevailing attitude of individualistic and paternalistic positivism (Gorelick, 1991; Hvlaka *et al.*, 2007; Oakley, 1981). Therefore, although this research may be sensitive, and the participants may be vulnerable, that does not mean it should simply be avoided.

Relevant for this study, feminist research should, at its very core, seek to highlight the lived experiences of women and girls (Alldred and Gillies, 2012;

Olesen, 2011). Further, it should seek to not only be aware of the hierarchical disparity in power between participant and researcher, but make efforts to equalise this wherever possible (Nazneen *et al.*, 2014). Embracing an ethic of care (Edwards and Mauthner, 2012), where opportunities are created for more collaborative relationships, and practicing reciprocity (Hesse-Biber, 2014) are some of the ways in which this power differential may be acknowledged and minimised.

Feminist commentators take issue with the concept of expertise in interviews, and especially the traditional associations with white, able-bodied, western men who claim expertise in this area and, as such, they argue, objectify and dehumanise the people involved in the research. Further, since the knowledge of those researched is often omitted or overlooked, any recommendations from this research are therefore neither relevant nor objective (Stone and Priestley, 1996). Rather, feminist researchers propose a reflexive review of not only how the researcher affects the research and the study participants, but also how the researcher learns from these participants (Flavin, 2001).

While acknowledging that engagement with vulnerable populations via a feminist approach often leaves researchers caught between competing demands – conducting research or providing a voice, championing social justice or providing emotional support for participants for example – Burgess-Proctor (2015) argues that a feminist approach avoids and diminishes risks to these vulnerable participants. Rather than avoiding research with vulnerable populations, feminist methodologies allow researchers to embrace such research, giving a voice to marginalised people and ultimately aiming to improve the lives of women and girls. Finally, feminist-informed interview strategies can be seen to both empower women and at the same time also elicit quality data; by conducting interviews with a feminist insight, participants are free to choose what to reveal about themselves, and what to omit (Campbell *et al.*, 2010). Ultimately, despite potential sensitivities surrounding the subjects, and potential vulnerabilities of the people involved, I feel a sense of commitment to both acknowledging and facilitating the ability of these women to articulate and make meaning of their own experiences. The ways in which I attempted to do this are detailed in the following sections.

3.6 Qualitative Interview Rationale

Feminist scholars are among the most prominent advocates of narrative style interviews (Miller, 2000); here the interplay between interviewer and interviewee is emphasised, and a narrative approach is centred upon the development of the participant's viewpoint during the telling of his/her family story. It is generally agreed that there are three main features of narratives, encapsulated in the definition that narratives are 'discourses with a clear sequential order that connect events in a meaningful way for a definite audience' (Hinchman and Hinchman, 1997).

Lawler (2002) argues that any research which aims for more than a mere snapshot of the social world needs to somehow take account of the relationship between the past and the present, and that attention to narrative provides a way of conceptualising links. Additionally, Mishler (1986) suggests that a narrative approach overcomes some of the limitations of many forms of traditional interviewing techniques where a pre-determined set of questions suppresses stories by limiting answers to short and sometimes meaningless statements, and when narratives do occur within this style of interviewing, they are often interrupted. Further, these narratives may be seen as problematic during subsequent analysis, and rigidly structured research interviews may also fragment individual experiences and lose vital context – something I was keen to avoid.

A common starting point for much qualitative research is to code data, and the implied fragmentation of such a strategy may often result in researchers overlooking the form of their data (Coffey and Atkinson, 1996). For narrative researchers this form, or *Gestalt*, is vital to be able to interpret data in context, and the whole should be kept in mind when analysing and interpreting data, as for many researchers, the whole is more than simply the sum of its parts (Hollway and Jefferson, 2000). According to Reissman (2002) participants naturally resist the efforts of researchers to fragment these lived experiences into thematic categories and to therefore control their meaning, and narrative interviews provide a space for more relational forms of interviewing in which a sequence of events are organised into a whole so that the significance of each event may be understood in relation to that whole (Elliott, 2005).

Too often, it is argued, the traditional approach to interviewing - prolific within social sciences for several decades - centred as it is upon semi-structured questions, is largely based upon the pre-determined assumptions built in to the researcher's questions (Priest, 2001). An approach which is inherently loaded with a researcher's preconceived assumptions, and which sees diversity and differences as problems and therefore disregards them and rather seeks to aggregate people in search of what is common to each of them, runs the risk of simply learning what is true of no one in particular (Josselson, 1995). As Jones (2003, p.61) puts it, 'what interviewees have to say about their lives and self-concepts are much more illuminating than any specific research assumptions or questions could be'.

Furthermore, much social science research is predicated on a number of methodological and theoretical assumptions which can be problematic, especially when it comes to survey questions. One such assumption is that if the same words are used and communicated in the same manner, then they will have the same meaning to everyone in the sample, and upon this assumption data are often used to quantify, compare and generalise about a variety of research topics (Hollway and Jefferson, 2000).

A narrative approach on the other hand allows respondents to tell their story, as they see it, in their own reality, in their own language and with their own meaning frames, and while it may or may not be factually correct (Miller, 2003), the interviewee and interviewer collaborate to produce the story that the interviewee wishes to be told. The use of narrative approaches to enquiry means that rather than a knowledge-privileged investigator, the researcher is able to adopt a position, at least in the early stages of the research, of a reflective and passive participant as the story is being told (Priest, 2001).

It is true to say that the respondent's story may change depending upon to whom it is being told and the context in which it is related (Greenhalgh *et al.*, 2005; Miller and Glassner, 1997), and it also requires acknowledgement that another researcher of a different age or gender for example, and in a different context, may well both elicit and interpret data from the same respondent in an entirely different way. In this case the context in which the narrative is derived includes the position of both the researcher and respondent, in terms of both

social structure and time, and also the social context of the interview and even the location in which the interview takes place. While some would argue that that during an interview you should discover very little about the interviewer, a viewpoint espoused especially by proponents of neo-positivist and realist approaches, for narrativists the interaction between the two parties is the main focus, rather than being seen as contamination. For Miller (2000) the idea of hygienic research devoid of emotional involvement is an oversimplification, and rather, he argues, all research, however framed, is an interaction between the researcher and the researched. Instead of attempting to leave behind personhood and subjectivity which is ultimately impossible, it must be made full use of and capitalised upon.

It is perhaps important to point out that rather than being a study of an isolated individual, a focus on individual biographies can bring an awareness of the individual in society (Plummer, 1983). In this way, using individual biographies, social science researchers can develop an understanding of social groups and cultures and the structural relationships between them (Elliott, 2005). It is through this interplay and interaction that as social science researchers we are able to gain insights into the only available social reality – the one occurring at that particular time. The increased use of narrative methods in interviewing builds upon the kind of analysis articulated by Mills (1959), who suggested that by listening to the personal troubles that people tell us, we can learn a great deal about social processes. Narrative research tools are apt for tracing these interconnections between the personal and the social (Chamberlayne and King, 2000), and parenting, as previously outlined in this thesis, can be seen to be very much at the confluence of the personal and the social.

Narrative interviews are founded on the four main principles outlined below: using open-ended questions; eliciting stories; avoiding 'why' questions; and following up using the participant's ordering and phrasing (Hollway and Jefferson, 2000).

By using closed questions, we are unlikely to elicit much in the way of narrative and we also run the risk of suppressing the meaning-frame of our respondents by making links which they may themselves not. For example, Hollway and Jefferson (2000) asked respondents to 'tell me about your experiences of fear'

when looking at fear of crime research; asking the more closed 'what crime do you most fear?' both reveals what sort of fear interests the researcher and suppresses the meaning of fear to the respondent, which may or may not be connected to crime. Thus, the respondent's meaning-frame is used to explore fear, and how it relates to his or her life.

By eliciting stories, people's accounts are linked to events that have actually happened. The choice of story, as well as the detail and manner of its telling, the morals and conclusions, and the points of emphasis, all represent choices by the teller, and are often themselves revealing. Hollway and Jefferson (2000) argue that such questions of 'why' elicit intellectualisations rather than narratives, and further that such questions run the risk of cliché-ridden discourse which become all things to all people and as a result are devoid of meaning.

Following up using the ordering and phrasing of the participant is achieved by attentive listening and note taking during the initial narration. The words and phrases used by the participant are retained here in order to ensure that their meaning-frames are preserved, and follow-up questions in the second part of the interview should be framed in an open manner which elicits further narratives. The skill here relies upon being able to assist the narrator in saying more but without offering interpretations or judgements and without imposing the interviewer's own relevancies (Hollway and Jefferson, 2000). An important point to note here is that this does not imply a belief that the researcher is somehow objective and has no effect on the production of these accounts, but rather that they simply do not impose a structure on the narrative. These principles underlined my approach to interviews.

3.6.1 Summary

Rather than being interested in questions of facts, a narrative approach is concerned with the unique and changing perspective of the participant 'as it is mediated by context' (Miller, 2000, p.12), and the researcher and participant collaborate to construct a narrative with which the participant is ultimately satisfied. In this way the power disparity is equalised, and a voice can be given to the participant, directly addressing some of the issues which arise given the perceived vulnerability of women recruited to this study. Further, a narrative

approach may facilitate empathy by providing participants with an opportunity to externalise feelings and emphasise for themselves which feelings and events from their lives are the most important and empowers them to identify the most salient themes (Elliott, 2005).

Participants are also able to use their own vocabulary and their own conceptual framework in order to articulate their lived experiences, and narrative approaches to interviews provide good evidence about the meanings which participants attach to these experiences. Relevant to this current area of research, narrative approaches also have an appreciation of the temporal nature of these lived experiences – how these experiences have changed over time and how past events have shaped the interviewee's current thoughts and actions – as well as an interest in the 'self' and representations of the 'self' (Elliott, 2005). In this way narrative methods may be used to examine how respondents viewed themselves as a child, how they were parented, how they view themselves as a mother, and importantly how these may or may not be connected. Further, narrative approaches, while located in the present moment, allow respondents to continuously reconstruct both remembrances of the past and anticipations for the future (again, being parented and being a parent) through the lens of the present (Kohli, 1981). Importantly, plot within a narrative relates events to one another by linking prior choices or happenings with a subsequent event (Polkinghorne, 1995), directly relevant to research into how previous experiences and events may shape current parenting practices.

By advocating narrative approaches to interviews, feminist scholars have been able to move away from dominating models of interviewing. We are able to move towards more relational approaches (Reissman, 2002), and in the process give up the communicative power of the researcher and instead understand the ways in which participants organise and ascribe meaning to events within their own lives (Reinharz and Chase, 2002). In this way the narrative approach to interviewing does not assume objectivity, but rather it privileges subjectivity, as well as the positionality of the interviewer and interviewee who together collaborate to tell the story, without fragmenting the narrative, and situating the story within its relevant context. Feminist approaches have been demonstrated to be appropriate for dealing with vulnerable participants and

sensitive research topics. It is in this way that research can be conducted in such a manner that acknowledges the vulnerability of the population in question and at the same time seeks to embrace suitable approaches which not only aim to protect participants from potential harm, but at the same time attempt to empower these women and give a voice to their lived experiences.

Narrative methods for data collection, coupled with a systematic approach to thematic analysis, provide not only a rigorous and sound basis for this investigation, but further they provide appropriate methods given the potential vulnerability of the mothers involved. These methods are then best placed to facilitate an investigation in to how these women feel their upbringing – their lived experiences - relate to their parenting practices at this time, in the context of their current 'vulnerable' state, and moreover to tell that story in the way which they wish it to be told.

In light of this, a narrative approach to interviewing was chosen for the collection of the qualitative data for this study. Following the review of tools to measure attachment (Section 2.11), the topic guide (Appendix 5 – Topic Guide) was developed using the narrative element of the AAI as a basis. The PBI was also used during interviews. The following sections outline in more detail the steps involved in the collection and analysis of the data.

3.7 Data Generation and Analysis

This PhD utilised baseline data from all THRIVE participants, as well as qualitative interview data from a sample of these women. This section outlines how women were initially recruited to THRIVE and their baseline information collected by THRIVE researchers. It then outlines the steps involved in identifying and recruiting potential interview participants from the THRIVE population, as well as the process of collecting this qualitative data.

3.7.1 Recruitment

3.7.1.1 THRIVE Recruitment

Pregnant women meeting the study eligibility criteria were recruited to THRIVE when they were between 8–30 weeks' gestation (Figure 3.1). THRIVE received

973 referrals, with the majority (684, 70.3%) from health- and social-care practitioners or voluntary/community organisations within the catchment areas of NHS Greater Glasgow and Clyde (GGC) and NHS Ayrshire and Arran (A&A) Health Boards. Other referrals came from research nurses (273, 28.1%); and 16 (1.6%) were self-referrals.

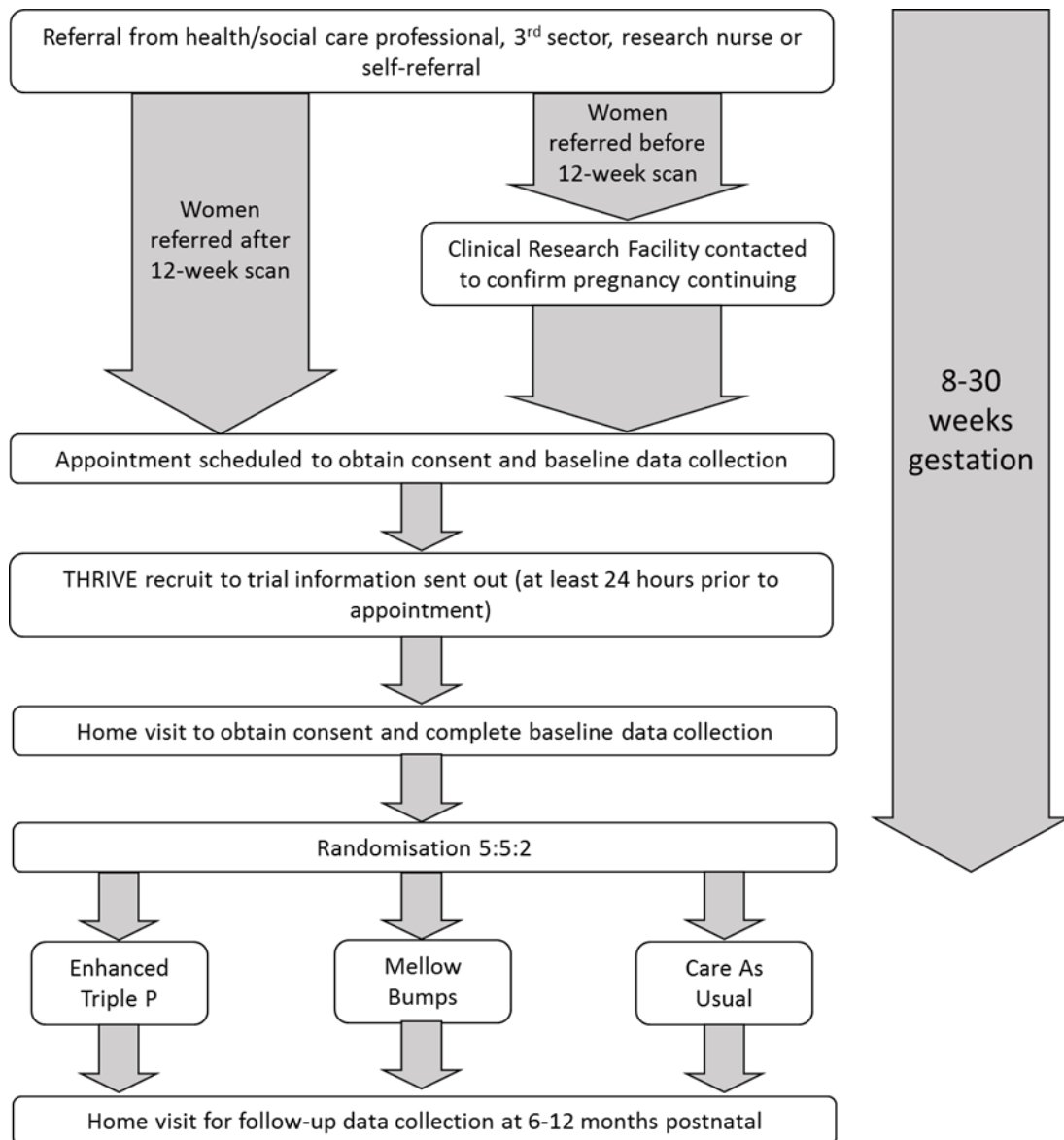Figure 3.1: THRIVE Recruitment Flowchart

Following referral, a member of the THRIVE research team confirmed whether the pregnancy was continuing through the NHS GGC Clinical Research Facility or by contacting a midwifery system administrator in NHS Ayrshire & Arran. Once confirmed, a member of the THRIVE research team contacted potential participants to arrange an appointment either in the participant's home or

another suitable location, during which the participant would have the opportunity to ask questions about the research and, should they agree, be consented to the trial and complete the baseline assessments. A copy of the THRIVE recruitment to trial information booklet was sent out to all participants ahead of this appointment, allowing at least 24 hours to read through the information prior to being asked to consent to the trial. During the consent process it was clearly indicated to potential participants that they did not have to participate in the research process, and that they had the right to withdraw from the study at any point without providing justification. Recruitment to THRIVE was slower than anticipated. This was largely due to slow recruitment at the start of the study caused by contractual issues and when the research team had limited resources, as well as changes within maternity service contexts affecting recruitment strategies. For more information regarding recruitment and issues encountered, see MacLachan *et al.* (No date).

Women were excluded from participation in THRIVE if they:

- were more than 30 weeks pregnant at referral (or reached this point before they could be randomised);
- lacked capacity to consent to participation in research;
- had insufficient spoken English to participate in research or engage in groups;
- had acute mental ill health (e.g. active psychosis, as this may affect their capacity to engage in group sessions);
- were homeless to the point of being non-contactable;
- were participants in other trials of antenatal interventions;
- miscarried after recruitment or during the delivery of the interventions;
- or, if a decision had already been made that their child would be removed at birth.

3.7.2 Quantitative Data Collection

Of the 973 referrals, 485 consented into THRIVE, and these participants were visited by a THRIVE researcher or research nurse, usually at their home, where they completed baseline assessments. This took the form of a 93-item

questionnaire, filled in either by the participant or by the research nurse. To compensate for their time, participants were given £15 shopping vouchers for completion of the baseline questionnaire. Following completion of the baseline assessment, participants were randomised to ETPB, MB or CAU, and those randomised to an intervention arm were invited to attend group sessions.

The baseline data was securely transferred to the Robertson Centre for Biostatistics Clinical Trials Unit for data entry and cleaning. For more details on recruitment and handling of THRIVE data, and THRIVE more generally, see Henderson *et al.* (2019b) and O'Brien *et al.* (2019).

3.7.3 Analysis of Quantitative Data

The baseline THRIVE data was analysed quantitatively, with three distinct purposes: using this quantitative data provided contextual information regarding the population of interest, as well as an indication of how my interview sample represents this population. Finally, these data were analysed in order to understand how ACEs and other factors affected the parental self-efficacy of the THRIVE mothers. This section outlines the steps carried out in this analysis.

3.7.3.1 Quantitative Analysis of Population Statistics

Baseline data were analysed using IBM Statistical Package for the Social Sciences (SPSS) software (v.24), and descriptive statistics and frequencies were generated for all participants regarding key demographic information. A variety of variables were selected, including age, socioeconomic circumstances, and measures of both historic and current adversity. The results of this analysis are outlined in Section 4.2.

3.7.3.2 Quantitative Analysis of Sample Representativeness

Key demographic and relevant variables of the interview sample were compared to the wider THRIVE population. Where the variables in question were not normally distributed, to avoid violating best practice when dealing with nonparametric data, each of the variables were dichotomised and cross tabulated, and differences between the groups assessed using a chi-square test or Fisher's Exact Test (2/1-sided). For those variables that were normally

distributed, a test of the differences in sample means was conducted, using Levene's Test for equality, which assesses homogeneity of any variances. This allowed for an exploration of the characteristics of those who contributed the qualitative data, as well as conclusions to be drawn as to how representative the interview sample is of THRIVE participants in general. The results of this analysis can be seen in Table 4.2 and are discussed in Section 4.3.

3.7.3.3 Quantitative Analysis of Parental Self-efficacy

From the THRIVE baseline questionnaire, seven questions relating to the participants' perception of their ability to cope with a variety of parenting tasks in the months following the birth of their child were taken together as a composite measure of parental self-efficacy. These questions asked about managing relationships between the new baby and siblings (where applicable), their baby suffering from wind or colic and other health problems, managing sleeping patterns and feeding, being able to afford all the necessary clothes and equipment, and managing other responsibilities within the home.

Participants scored these questions on a five-point scale of very well (1), quite well (2), not well (3), not well at all (4) does not apply (5). Using SPSS Statistics (v.24) for analysis of the data, participants were given a mean score across the seven questions. Where the question regarding managing relationships with the baby and siblings was not applicable, with first-time mothers or those women whose children were not living in the home for example, they were given a mean score based on their six responses. Where one other question was missing data, the mean was imputed; where more than one other question was missing data, this participant was coded as missing and therefore excluded from the final analysis.

Using binary logistic regression, each of the independent variables, beginning with ACE scores and measures of recent adverse life events, were regressed onto the self-efficacy outcome variable in turn, to test the association and its significance. Dummy coding of variables was used to create binary categories where necessary, ensuring that each of the independent variables was categorical. These variables were selected based upon theoretical associations with self-efficacy, or upon similar studies from existing literature (Colditz *et al.*,

2015; Sanders, 1999; Sanders and Woolley, 2005). Only those variables which showed a significant association at the 95% level ($p = 0.05$) were included in the final multivariate regression model.

Together, the quantitative analysis of THRIVE baseline data provides a deeper understanding of the population of interest. It allows us to understand more about the contextual demographics and characteristics of the THRIVE population, and the adversities and complexities that characterise their backgrounds and current situations, as well as a better understanding of the representativeness of the interview sample. Finally, this analysis gives insight into the factors which affect the parental self-efficacy of these women. The results of this analysis are presented in Chapter 4.

3.7.4 Qualitative Data Generation

The following sections outline the recruitment and selection of the interview sample, how I sought informed, ongoing consent, and the steps involved in the generation of the qualitative data.

3.7.4.1 Qualitative Interview Participant Selection

Following discussions with supervisors and THRIVE researchers, a recruitment strategy for interview participants was agreed. This PhD project recruited 22 women for qualitative interviews, drawn from those already consented into THRIVE who had also previously indicated they would be willing to be contacted to take part in further research. Women whose child had reached around 1-year-old as a minimum, or who we could identify already had other older children, were purposively selected. This decision was taken in order to exclusively capture experiences of women who have had time to develop and reflect upon their parenting practices. In addition to the general THRIVE exclusion criteria above, I also chose not to approach women to take part in interviews who had no current contact with their children.

3.7.4.2 Invitation to Interview

Recruitment for pilot studies began in August 2017. Five such interviews were carried out between August 2017 and January 2018. After being provided with

contact details of all those who met the above criteria, the women were contacted by telephone. My initial approach was to begin at the top of this list of 192 potential participants and contact them in this order. As they were arranged by participant number, this meant that those recruited to THRIVE earlier were first on the list. In reality this meant that these women had been recruited some time ago and were either seemingly disengaged or struggled to recall their initial involvement with THRIVE. It was also the case that many of the telephone numbers were disconnected or no longer in use. I then began to contact those towards the bottom of the list, with the rationale that these women had more recently been contacted by and engaged with the THRIVE team and were therefore more likely to be willing to agree to an interview.

Five pilot interviews were carried out between August 2017 and January 2018. These were audio-recorded, and I made the decision to transcribe these interviews myself, verbatim, in order to immerse myself deeper in the data. I also wanted to be able to learn from them in terms of how I phrased questions and how well I was able to give participants space and time to speak, as well as learning to avoid imposing my meaning and trying to use the same phrasing as my participants. I was also able to see if the interview schedule was eliciting the kind of data I had anticipated, as well as making note of areas which perhaps needed rephrasing or following up in future interviews.

After the pilot interviews, it was apparent that questions regarding loss of loved ones, for example, became irrelevant, as this was not a key focus of my inquiry and if any significant loss had occurred it appeared in the women's narrative more naturally. It was also apparent that the interview schedule did not pick up information regarding specific examples of parenting practices, and so questions were added to ensure this was covered in future interviews. The main stage of data collection continued until August 2018, and an iterative approach to interviews was undertaken where learnings and interpretations from initial interviews were used to inform those that came later.

Interviews were arranged at a time and location to suit the participant, with at least forty-eight hours between me inviting them and providing them with information (Appendix 1 – Participant Information Sheet), so as to allow them to change their mind. Care was taken to recruit women who were not currently

participating in qualitative interviews with other THRIVE researchers in an attempt to avoid overburdening these women.

It was not unusual for potential participants to change their mind on the day and pull out of interviews, often with late notice or none at all. It was also the case that some suddenly stopped replying to messages or were not around or chose not to answer when I arrived. On one occasion I was greeted at the door by a partner of the intended participant, who told me she was no longer living at the address and he did not know where she was. On another occasion, a potential participant's sister answered the door and told me she was in hospital for an emergency operation. In these instances, I made sure to contact the participant and check they were ok, and to tell them they could contact me to get involved again at any point should they wish to do so, but of course there was no problem if they did not.

Around one in ten of the people I attempted to contact were available or willing to be interviewed. Where interviews were arranged, around one in four did not happen due to cancellations or sudden withdrawal as described. This perhaps gives an indication of the unpredictable and complex lives of some of the THRIVE participants and is indicative of the challenges faced when recruiting participants from vulnerable groups. It required me to be patient and flexible, and also meant that recruitment for interviews took longer than anticipated.

3.7.4.3 Carrying out Interviews

The topic guide for interviews was loosely based upon the AAI, and guided where possible by the four principles outlined in Section 3.6 (using open questions, eliciting stories, avoiding 'why', and using the same order and phrasing as the participant). It was also refined following pilot interviews, and on an iterative basis throughout the data period of data generation.

The AAI has a narrative arc which begins with past experiences, explores current views and allows participants to explore how these may be connected, and then projects to an imagined future. As discussed previously, I was drawn to using the AAI as the format has been widely used to provide parents with an opportunity to begin to draw on childhood memories and reflect on their own experiences,

and how these relate to their own parenting styles (Polansky *et al.*, 2006). In reality though, given that the main focus of the AAI is on the formal features of the narrative and linguistic coherence, and not necessarily the content (van Ijzendoorn and Bakermans-Kranenburg, 2019), the AAI by itself did not always enable a deep discussion about experiences of adversity or trauma, or other contextual factors, and these were explored more by my follow-up questions. As I carried out more interviews, I realised I was relying less on the AAI, which had previously provided me with a scaffold by which to approach interviews, and later interviews were more free-flowing as my experience from previous interviews increased my own confidence and knowledge. This flexible use elicited much more contextual data than would have been possible relying solely on the AAI.

Following interview techniques employed by narrative interpretive methods, each interview began with a single, narrative-inducing question: tell me about yourself, perhaps beginning with your early life, your earliest memories. This minimalist, passive approach is designed to elicit an extensive, uninterrupted narration (Wengraf, 2001). The main theoretical principle here is one of *Gestalt,* that is to say discovering a whole which is more than merely the sum of its parts: uncovering, in an uninterrupted way, the experiences and events which inform a person's life. This must be elicited intact and not destroyed by a researcher following his/her own concerns (Rosenthal, 1990), and is maintained by a method of non-interruption.

The interviewer's role at this stage is limited to being supportive and offering encouragement (Miller, 2003). Silences are maintained without interruption or interjection from the interviewer; where a participant asks for help, encouraging and open words are used which reflect the opening statement but give no further information. After I had invited them to give me their opening narrative, the topic guide was used to follow up as a way to ensure all relevant areas were covered and important ideas raised by the participant were explored further. It was important that the themes from the topic guide were adapted to ensure that they were introduced in the same order and used the same words as the participant, as well as ensuring that each question was phrased in an open way so as to elicit further expansion upon the narrative.

In practice however, this was not always easy to achieve. This approach remained the ambition at the outset of each interview, and I felt these principles were important in allowing these women to frame their stories and minimise any inherent power imbalances, but in reality many of the women I spoke with had real difficulties in knowing where to start with their opening narrative. As discussed throughout the qualitative findings (Chapters 5 and 6) self-reflection came more easily to some than others, and often nerves or a lack of confidence meant this initial question was daunting and put them immediately on the spot. In these cases, it was necessary to start with more specific questions about where they lived as a child, with whom and so on, and then build slowly from there.

Notably, where one participant did give a rather extensive opening narrative, speaking for several minutes without any input from me, she described a very happy background with many positive highlights. However, at the conclusion of the ninety-minute interview she had told of many experiences which at the very least called this narrative into question, and in some cases potentially contradicted it. The strategy for eliciting these initial intact narratives, and therefore preserving the *Gestalt*, was, however, something I felt was worth exploring and preserving wherever possible.

Once participants had been given an opportunity to add anything at the conclusion of the interview, I asked them to fill out the Parental Bonding Instrument, and then the interview was brought to an end. Participants were given £15 shopping vouchers as a thank you.

It was initially envisaged that a follow-up session may be necessary, during which, following the example of Jones (2003), it would have been possible to directly respond to the story of the participant, basing inquiries on reflections and my early interpretations. In this way themes may be drawn together and presented as questions which then can be used to encourage participants to relate to and respond to these possible connections. Further, this approach allows participants to be involved in the shaping of the narrative and the early stages of analysis. In reality however, when this was offered to participants there was very little interest in seeing transcripts from the interviews or engaging in any further discussion or analysis. Only two participants expressed

any interest at all in seeing transcripts, but neither of them gave any response after receiving them. While all of my participants indicated that they were happy to take part in an interview and remain engaged with THRIVE, they saw this as the extent of their involvement with me.

One participant contacted me the day after our interview and asked that her data and the audio recording of the interview be deleted. She was apologetic and said she would explain her reasons if necessary. I told her that no explanation was required and immediately deleted all of the data I had captured during our interview. I also informed the THRIVE project manager, who contacted her in order to clarify whether she was happy to remain in THRIVE or wished to be withdrawn from the wider trial also.

Post-interview debriefing notes were used to record my initial feelings and responses. These notes were also useful when listening to the recording of the interview and while producing the transcript, as well as aiding my memory about the context of the interview situation when it came to analysis and interpretation of the data.

3.7.5 Analysis of Qualitative Data

Despite a growing interest in narrative evidence across the social sciences, there is no standard approach or list of procedures which could be seen to be generally recognised as being representative of the narrative method of analysis (Elliott, 2005). Instead of a single narrative method, there are a multitude of ways by which researchers can engage with and analyse the narrative properties of the data they generate. That being said however, (Mishler, 1995) classifies the different types of approaches to narrative analysis in an attempt to aid understanding; his framework is based upon the three different functions of language: meaning, structure, and interactional context.

It is the first of these, meaning, which is of interest here: in this type of analysis the emphasis is placed upon meanings, where researchers are primarily interested in actual events and experiences as recounted in the narrative. In other words, content takes primacy. This narrative content serves to describe past events in a chronological order, and perhaps more importantly provides an

evaluative function – making clear the meaning participants attach to their experiences and events in their lives (Labov and Waletzky, 1967). In this way, the focus of my analysis was the content and meaning of the women's narratives, not necessarily the structure of how this narrative was constructed. I felt this analysis was better suited to addressing my research questions.

Interpretive analysis requires us as researchers to understand how our participants make sense of experiences and events in their lives, something which in turn requires detailed, dense and contextualised description (Elliott, 2005). This analysis requires imaginative interpretation and reconstruction by the researcher, and is a subjective exercise not easily represented by a single method. Given the breadth and depth of the interview data, in order to begin to make sense of it, I opted for organising the narratives of these women – the meanings they attach to their experiences and events in their lives, and the things that influence their parenting practices – into broad themes.

In practical terms this is achieved by examining the accumulated data and looking for similarities and common themes across the interviews, in what Braun and Clarke (2012) term thematic analysis. This involves 'identifying, analysing and reporting patterns or themes within data' (Braun and Clarke, 2006, p.78). Ritchie *et al.* (2003) suggest that qualitative data analysis should be seen as a process, whereby we move from close to the data in the early stages, to further away in later stages as broad themes are sought and higher-level interpretations generated (Section 3.7.5.3 Thematic Analysis, gives more detail on the steps undertaken during the analysis).

While acknowledging that by its very nature interpretive data analysis is a subjective process, Hollway and Jefferson (2000) suggest that such a process is robust in that it may be applied to different data by different researchers who can then form their own opinions on the utility of this approach. Further, they suggest that if others share the researcher's own subjective interpretations and analyses and 'recognise' the sense made from the data, then this speaks to its reliability. The important point to note is that interpretations of this data are never final (Jones, 2003), and that any reader may offer their own subjective interpretation of this narrative (Hollway and Jefferson, 2000). Also, while

analysis is based on descriptions presented by interviewees, the findings presented are the interpretations of the researcher.

3.7.5.1 Pilot Interviews

Recruitment for pilot studies began in August 2017. Five such interviews were carried out between August 2017 and January 2018. The transcripts from these interviews were uploaded to Nvivo 12. After coding this data according to my initial research questions, I arranged the data into a framework (see Figure 3.2 for an example). This allowed me to see how the data for each participant mapped on to each of the research questions and identified any potential gaps in the interview schedule.

Figure 3.2: Data Mapping of Pilot Interviews

3.7.5.2 Transcription and Data Management

All interviews were audio-recorded, and these recordings transcribed; the first five interviews were transcribed by myself, to allow me to immerse myself in the data and to refine and improve the topic guide where appropriate. The remainder were transcribed by a professional transcription service adhering to MRC/SPHSU guidelines on confidentiality. All local dialects and colloquialisms

were included in the transcripts in order to avoid changing or misrepresenting participants' meanings. On receiving each transcript, I checked each of them to ensure accuracy and where the transcriber had not been able to make out particular sections of the interview (due to accent, background noise, or lack of clarity) I transcribed these parts myself where possible. At this point all transcripts were also anonymised and pseudonyms assigned to participants and their parents, partners and children. Incidental details such as place names were also changed to preserve anonymity. A data management plan was enacted, which covered secure and confidential storage of data in accordance with University and MRC guidelines.

3.7.5.3 Thematic Analysis

Following the approach of Spencer *et al*. (2003), I conducted data analysis in two stages: the first, in their terminology, is where we 'create order' of the large data by categorising it into themes. The second stage involves 'making sense' of the data by a close reading of each theme and the drawing out of interpretations (Spencer *et al*., 2003).

In practice, this involved reading and re-reading of transcripts to familiarise myself further with the data and making notes of recurrent themes within and across participants' transcripts. Alongside this, I re-familiarised myself with the field notes I made after each interview, which contained descriptions of the women's circumstances and other non-verbal details and interactions; this provided contextual data and helped to guide my initial assessments of the key themes.

To handle such a breadth of data, and to ensure a systematic approach to the analysis, each transcript was uploaded to Nvivo 12. A high-level approach was adopted at this stage, which involved coding each transcript into what Braun and Clarke (2019) call broad themes or domain summaries. These initial broad themes/domain summaries were: 1) Sources of Advice or Support around Parenting, 2) Influence (or not) of Partner, 3) Reflecting Upon How She Felt as a Child, 4) Giving the Child(ren) Something They Themselves Feel They Missed, 5) Children Driving Practices, 6) Modelling of Behaviours, 7) Approaches to Discipline, 8) Experienced Parents, 9) Current Contextual Factors.

Braun and Clarke (2019) distinguish between domain summaries, which are organised around a shared topic, and actual themes, which for them are 'patterns of *shared meaning* underpinned or united by a core concept'. An example of this evolution from domain summary to theme was 6) Modelling of Behaviours. This shared topic was evident across the data and captured the diversity of how these women modelled behaviours of their parents in various ways. This domain summary was then organised into themes of Positive Modelling of Behaviours, Oppositional Modelling of Behaviours, and Mixed Modelling of Behaviours.

I was able to map out the data from each participant that corresponded with each theme, as shown in Figure 3.3. This allowed me to easily identify gaps in the data, as well as looking at how well the data was spread across my sample, and where there were similarities and differences in participants' responses, as well as highlighting deviant cases.

Figure 3.3: Example of Data Mapping Exercise

As further themes emerged from each transcript, new codes were created accordingly. Coding early interviews immediately, alongside data generation, meant emerging themes could inform later interviews.

Figure 3.4 gives an example of the coding framework being used in Nvivo. This stage of the analysis corresponds to the 'creating order' described by (Spencer *et al.*, 2003), where broad themes are established and then refined (by combining two themes for example, or by breaking down a large theme into several smaller ones).

Figure 3.4: Example of the Coding Framework Being Used in Nvivo

In line with the approach of Spencer *et al.* (2003), I then read all the accumulated data organised under one theme (for example Oppositional Modelling of Behaviours) and began the process of, in their terminology, 'detecting elements'. This process provided a descriptive account of what the women had said relating to each theme. Once these descriptive accounts had been produced, explanatory accounts were sought by looking for connections between themes. By way of example, I examined how the theme of Oppositional Modelling related to the themes of Giving Their Children Something They Missed or Approaches to Discipline. In this way, qualitative analysis allows one to build toward theory by examining the generated themes and concepts, and seeing how they link together to create a broader explanation (Rubin and Rubin, 2011). At this stage of analysis, I looked for explanatory links between themes and then returned to the original data to confirm these ideas, or to add depth.

As such, a coding framework (Appendix 6 – Coding Framework) was developed and refined, in an iterative process whereby themes are generated, meaning is assigned to these themes, and the data which portrays this meaning is coded to each theme. This allowed me to firstly generate descriptions, and then establish patterns and typologies. Following this it was then possible to begin developing explanations from the data, and its applications to wider theories and policies. By following such an analytic hierarchy, one moves from initial data management - sorting and synthesising the data, through to more interpretive analysis, making sense of the data by producing descriptive and then explanatory accounts.

The chapter which follows presents the quantitative findings of this study, and the findings from the qualitative analysis described here are presented in Chapters 5 and 6.

4 Quantitative Findings

4.1 Overview of Chapter

This chapter presents the findings from the analysis of quantitative data from the THRIVE baseline questionnaire, and provides the findings which answer the first of my research questions: what are the factors which impact upon parental self-efficacy among women recruited to THRIVE?

The baseline data were captured after women were consented to the trial but before randomisation into either of the intervention arms or Care as Usual (CaU). The analysis presented outlines the adversities and complexities that characterise the backgrounds and current situations of the women involved in THRIVE, before going on to assess the representativeness of those who make up the sample for the qualitative interviews for this current study. Finally, this chapter uses regression analysis to investigate how ACEs and other factors impact upon the reported parental self-efficacy of these mothers.

4.2 Underlying 'Vulnerabilities' of the THRIVE Population

Given the recruitment criteria previously described, the women who took part in THRIVE represent some of the most disadvantaged and deprived members of society, and as such have a high level of vulnerability and a wide range of adverse experiences, in both childhood and adulthood. Almost two-thirds of the THRIVE women are from the most deprived areas of Scotland, based upon Scottish Index of Multiple Deprivation[1] (SIMD) ranking: 62.2% (N = 300) live in areas ranked in the most deprived quintile, and a further 15.4% (N = 74) live in areas ranked in the second most deprived quintile.

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[1]The Scottish Index of Multiple Deprivation (SIMD) assesses area-level concentrations of deprivation, through looking at proportions of people in a postcode area meeting certain criteria defined as markers of deprivation. The criteria encompass indicators such as: living in social housing, trouble with the law in the last 12 months, in receipt of benefits (JSA, ESA, Housing Benefit), school leavers aged 16-19 not in education, employment or training, working age with no qualifications, and hospital stays related to drug or alcohol misuse (Scottish Government, 2019).

Based upon responses using the Childhood Trauma Questionnaire (CTQ), a validated self-report inventory for screening histories of abuse and neglect (Bernstein and Fink, 1998) two-thirds of the women report being maltreated in some way as a child (63.7%, N = 307). Approximately one in five report some sort of sexual abuse during childhood (19.5%, N = 94). Around a third (37.1%, N = 179) report experiencing some kind of emotional abuse during their childhood, and 19.7% (N = 95) report physical abuse.

Just under half of the women (44.2%, N = 213) feel they were emotionally neglected at points during their childhood, and one in three (33.6%, N = 162) feel they were subjected to some sort of physical neglect. The CTQ scores severity across five domains of abuse and neglect, giving a score between 0 – 125; the mean severity score for these women was 41 (SD = 17.2).

Table 4.1 shows the frequency of ACEs among the THRIVE population.

Table 4.1: Frequency of ACEs in THRIVE population

		Frequency	Percent
ACEs	0	82	17
	1	124	25.7
	2	75	15.6
	3	60	12.4
	4	61	12.7
	5	38	7.9
	6	34	7.1
	7	8	1.7
	Total	482	100

When compared to Scotland-wide figures, where one in ten children experience 3+ ACEs (Marryat and Frank, 2019), Table 4.1 indicates that more than four in ten of the THRIVE women report 3+ ACEs.

Thirty-nine percent of the THRIVE women (N = 188) have experienced homelessness at some point; and 25.5% (N = 123) reported experiencing homelessness during their current conception or pregnancy. Just over half the sample (N = 243) report a history of drug use, either recreationally or misuse. More than 4 in 10 (N = 201) have experienced domestic, physical or sexual violence in the past.

The mean age of THRIVE participants was 26 years, ranging from 16 – 43 years of age; 17.4% (*N* = 84) of the THRIVE mothers were aged under 19 years at the time of recruitment.

Over a third (35.5%, *N* = 171) report social work involvement or child protection concerns of some sort, and 18.3% of the women (*N* = 88) had a Child Protection Order (CPO) in place for one or more of their children at the time of the baseline questionnaire. Around a third (30.7%, *N* = 148) were a 'Looked after Child', meaning they were in the care of the state or someone other than their parents at some point during their childhood. Published statistics show 2% of west of Scotland's mainstream school population were care experienced, and a recent paper found levels of 15% in Alternative Education Settings (Henderson *et al.*, 2019a). Therefore, the figure of 30.7% in the THRIVE sample suggests extremely high levels compared to the general population in Scotland.

More than two-thirds of the mothers report a history of mental health issues (70%, *N* = 337), and 7.5% (*N* = 36) have some sort of learning or attentional difficulties. The Hospital Anxiety and Depression Scores (HADS) scale was used to assess the prevalence of both these conditions. A score of 8-10 is described as mild, 11-14 as moderate, and 15-21 as severe. The median score for anxiety among the THRIVE population was 8. There were 257 women (53%) with scores of 8 or over. Similarly, the median score for depression was 5, and 260 (54%) were categorised as high, and 221 (46%) as low.

4.3 Representativeness of the Interview Sample

A total of 482 women were recruited to THRIVE; of these 22 were recruited to interview, and one subsequently withdrew. This section provides statistical analysis of how well the interview sample of 21 represents the wider THRIVE population.

Where the variables in question were not normally distributed, to avoid violating best practice when dealing with nonparametric data, each of the variables were dichotomised and cross tabulated, and differences between the groups assessed using a chi-square test/Fisher's Exact Test (2/1-sided). For those variables that were normally distributed, a test of the differences in sample means was conducted, using Levene's Test for equality, which assesses homogeneity of any variances.

The mean age of THRIVE participants was 26, at the time of consent, ranging from 16 to 43 years of age. Interview participants ranged from 17 to 38, with a mean age of 28. Ninety-five per cent of the THRIVE population $N = 456$ identify as white (all of my sample ($N = 21$) identify as white).

Half of the women in THRIVE have a higher educational qualification, while 14% have no qualifications at all. In the interview sample, 62% ($N = 13$) have a higher educational qualification, and none reported no qualifications.

Around one in three (32.4%) of the THRIVE population were in work at baseline (57.1% of the interview sample). One in four of the THRIVE population has never worked, compared to one in ten of the interview sample. The implication therefore is that those sampled for interview are slightly older, and slightly more educated than the overall THRIVE population, and more of them are in work. Table 4.2 outlines the characteristics of both the THRIVE population and those recruited to the qualitative interviews, and highlights any statistically significant differences between these two groups.

Table 4.2: Comparative Demographics of THRIVE Population and Interview Sample

	THRIVE Population *N* = 463	Interview Sample *N* = 21	Fishers Exact (2/1 – sided)	Pearson Chi Square p-value
Age Range (years)	16 – 43	17 – 38		
Mean Age (years)	26	28	0.643 Sig. Levene's Test (p-value)	0.391 Sig. (2-tailed) (p-value)
Young Mum (aged <19 years)	17.8%	9.5%	0.554/0.259	0.329
Ethnicity	(%)	(%)		
Ethnicity – White	94.4	100	-	0.535
SIMD	(%)	(%)		
Quintile 1 (Most deprived)	62.6	57.1	0.649/0.386	0.613
Education and Employment	(%)	(%)		
Higher education qualification	42.7	61.9	-	0.221
No educational qualifications	15.8	0.0	0.055/0.035	0.054
Left school before legal leaving age	28.0	19.0	0.461/0.266	0.370
In work (at time of consent)	31.6	57.1	**0.029/0.016**	**0.015***
Never worked	26.1	9.5	0.122/0.065	0.880
Number of children	(%)	(%)		
First time mothers	55.5	57.1	1.000/0.532	0.548
Availability of Social Support	(%)	(%)		
Partner	70.1	76.2	0.633/0.371	0.549
Parent(s)/in-laws	66.8	76.2	0.479/0.261	0.371
Other family member	51.8	38.1	0.267/0.156	0.218
Friend	39.7	42.9	0.822/0.470	0.772
Adverse events	(%)	(%)		
Experienced homelessness	39.5	28.6	0.368/0.222	0.316
Looked after child	31.7	9.5	0.030	**0.031***
Experienced sexual abuse	21.0	5.3	0.142/0.073	0.095
Experienced emotional abuse	40.0	10.0	0.008/**0.004***	**0.007***
Experienced physical abuse	20.0	14.3	-	0.407
Experienced emotional neglect	46.6	28.6	0.120/0.079	0.105
Experienced physical neglect	35.6	28.6	0.642/0.342	0.509
Experienced domestic, physical or sexual violence	42.7	19.0	**0.040*/0.024***	**0.031***
Experienced 2 or more ACEs	58.4	33.3	**0.040/0.021***	**0.023***
Experienced 4 or more ACEs	30.2	9.5	**0.049/0.029***	**0.042***
Mean number of ACEs	2.42	1.48	0.015 Sig. Levene's Test (p-value)	**0.009*** Sig. (2-tailed) (p-value)
Mental Health	(%)	(%)		
HADS Anxiety Score – High	54.2	33.3	0.074/**0.049***	0.060
HADS Depression Score - High	55.0	33.3	0.072/**0.042***	0.051
History of mental health problems	69.4	81.0	0.335/0.190	0.260
Adult Wellbeing Scale (Outwardly Expressed Irritability) Mean score	3.7	3.0	0.201 Sig. Levene's Test (p-value)	0.239 Sig. (2-tailed) (p-value)
	(%)	(%)		
History of drug use: recreational and misuse	49.7	66.7	0.180/0.096	0.128
Reports child protection concerns or social work involvement	36.0	23.8	0.352/0.183	0.253
Child Protection Order in place	18.9	4.8	0.146/0.077	0.121
Parental Self-efficacy (Mean score)	1.70	1.68	0.980 Sig. Levene's Test (p-value)	0.888 Sig. (2-tailed) (p-value)
High Parental Self-efficacy (%)	44.1	38.1	0.658/0.380	0.590
			*p < 0.05; **p < 0.01; ***p< 0.001	

Those women who make up the interview sample account for 4.4% of the THRIVE population. Those interviewed have a slightly higher mean age (not statistically different), and a similar age range to the THRIVE population. Those interviewed are all of white ethnic origin, compared to 95% of THRIVE women. They are predominantly living in the most deprived areas of Scotland by SIMD quintile (57.1%) but are more likely than the wider THRIVE cohort to be in work, and less likely to have never worked. They all have at least some educational qualifications, and a larger proportion of them have higher educational qualifications. The interview sample report higher levels of both social support and greater trust in health professionals.

The interviewed sample report fewer adversities experienced during childhood; fewer of them were in kinship care or the care of local authorities as a child, and fewer reported episodes of homelessness, both in the past and during their pregnancy. They also report significantly fewer ACEs, with a mean score of 1.48 ACEs for the interview sample compared to 2.42 for the THRIVE population. Where around 30% of the THRIVE population report 4 or more ACEs, the number in the interview sample is one in ten. Those interviewed are less likely to report experiences of emotional abuse or a history of domestic, sexual or physical violence than those in the wider population, and they are also less likely to report high levels of anxiety and depression. Each of these differences between the groups is statistically significant.

Despite this, the interviewed women are less likely on the whole to describe their childhood as very/quite happy for each of the age periods. When asked whether 'good parenting' can be taught, those in the interview sample were more likely to agree; they also demonstrated greater levels of trust in health care professionals when it came to parenting support and advice, with less fear of interference; those in the sample were more likely to seek such support and feel comfortable knowing who to ask for this support and advice. There was no statistically significant difference in mean scores for parental self-efficacy between the two groups.

In summary, when compared to the wider THRIVE population from which they are drawn, those who comprised the sample for qualitative interviews for this PhD study are more likely to be educated to a higher level, more likely to be in

work, less likely to have experienced adversities and report lower levels of mental health issues such as anxiety and depression. They are likely to have greater social support, be more trusting of professionals and be more likely to be able to identify those able to provide support and to ask for such support. They generally have fewer concerns about parenting, and higher expectations of their own self-efficacy and ability to cope with the demands of parenting.

However, it is perhaps not surprising that those women from the THRIVE cohort with greater levels of trust in professionals, greater support, with fewer adverse experiences and with lower levels of anxiety and depression are more likely to consent to an in-depth qualitative interview about their backgrounds and their views on parenting. It should also be noted that although the interviewed sample may in some respects under-represent the wider levels of deprivation and adversities experienced within the wider THRIVE population, these women themselves are still among some of the most 'vulnerable' members of society.

4.4 Factors Affecting Parental Self-efficacy

4.4.1 Hypothesis

In light of the literature discussed in Section 2.10.5, the hypothesis that underpinned this analysis is that there would be an association between the ACE scores of the THRIVE mothers and their reported self-efficacy, as highlighted in previous studies (Allen and Donkin, 2015; Dregan *et al.*, 2011; Treat *et al.*, 2019). Recent adverse life events, socioeconomic circumstances, and perceived social support were also hypothesised to have an effect on reported parental self-efficacy. The null hypothesis was of no association.

4.4.2 Results

Given the positive skewedness value of the self-efficacy outcome variable (3.24; skew statistic = 0.366, SD = 0.113), a binary logistic regression was chosen, appropriate for non-parametrically distributed data (Field, 2013). In light of this, it is more appropriate to use the median score rather than the mean, and subsequently create a binary outcome of low and high self-efficacy. Accordingly, participants were categorised using this median score, with anyone scoring 2 or below coded as 'high self-efficacy' (N = 263) and those with a median score of

2.01 or above 'low self-efficacy' (*N* = 208). After excluding participants for whom some independent variable data was missing, 463 of the 482 women were included in the final analysis.

The seven individual variables that comprised the self-efficacy score were included in a factor analysis; the basic assumption of this analysis is that for a collection of observed variables there are a set of underlying variables called factors (smaller than the observed variables), that can explain the interrelationships among those variables. The aim of factor analysis is to be able to reduce the number of variables in order to explain and interpret the results. Table 4.3 displays the results of this confirmatory factor analysis and indicates that each of the observed variables can be effectively combined to a single factor, and together form a suitable construct.

Table 4.3: Confirmatory Factor Analysis of Parental Self-efficacy Questions

	Component
	1
Expectation of parenting skills: managing relationship between baby and brothers/sisters	0.64
Expectation of parenting skills: coping with baby suffering from wind or colic	0.816
Expectation of parenting skills: coping with baby's sleeping pattern	0.824
Expectation of parenting skills: getting baby to feed	0.794
Expectation of parenting skills: coping with baby having health problems	0.712
Expectation of parenting skills: being able to afford all the baby clothes and equipment needed for baby	0.572
Expectation of parenting skills: managing the house and other domestic responsibilities	0.799

Table 4.3 indicates that each of the variables is contributing to the factor, which suggests it is not necessary to extract or rotate any of the variables, and we can therefore be confident that these individual variables have similar patterns of responses. The validity of the scale was also analysed, and a Cronbach's alpha score of 0.857 suggests these items are closely related with a high scale reliability, and is above the threshold deemed to be acceptable in social sciences (Field, 2013).

The results of this analysis indicate no significant association between self-efficacy and ACEs (p = 0.57). Nor was there any significant association between self-efficacy and any measures of Adverse Life Events occurring in the past year. These included: homelessness, serious illness to the participant or their immediate family, relationship breakdowns, bereavement, financial and unemployment issues, and contact with the criminal justice system. There were also no significant correlations between any measures of education, nor any measures of social support. Given this lack of association, other variables were selected from the baseline data, and tested for their individual association with parental self-efficacy.

The variables that were individually associated with parental self-efficacy were then included in a logistic regression. Age at consent, number of children, and deprivation as measured by SIMD are represented as a scale in the original dataset. SIMD ranking is based on SIMD16 data (Scottish Government, 2019), as a measure of multiple deprivation and ranked by quintile, with 1 being the most deprived and 5 the least. For internal consistency within the regression model this was coded as a binary measure for analysis purposes, with two groups created, representing those living in the most deprived quintile (N = 287) and all others (N = 176).

A binary measure of age was also created, taking the median age of 25 as the cut off (under 25, N = 217, 25, or over N = 246). This is also the definition of a young mum according to the Family Nurse Partnership (Olds, 2006). Being a young mother aged 19 or under was also significantly associated at the univariate level. Given that the model therefore included two measures of age, a test of correlation between these variables was run to avoid the effects of collinearity: Pearson/Spearman's both indicate a low correlation of 0.485. The decision was taken to use just the latter measure of age.

Being a looked after child, experiencing past violence, experiencing past mental health problems, having a CPO or social work involvement, and a history of drug use were each categorised as a binary yes or no. Emotional abuse scores were reported using the Childhood Trauma Questionnaire scale, and then categorised into a binary variable as 'none to minimal' or 'low to moderate or above'.

HADS measures respective scores for anxiety and depression, with values between 1 and 21. A score of 8-10 is described as mild, 11-14 as moderate, and 15-21 as severe. The median for each of these variables in the dataset was used to create binary high and low categories: those scoring above the median of 8 for anxiety were categorised as high (N = 257) and those below this median as low (N = 225). Similarly, those scoring above the median of 5 for depression were categorised as high (N = 260) and those below as low (N = 221).

The variables were grouped for inputting into a model, based upon a theoretical model building whereby variables were identified as being structural factors such as age and SIMD; childhood factors and early life events; proximal life events or circumstances which serve as additional risk factors for low parental self-efficacy; and finally current or previous mental health issues. Table 4.4 shows the block wise steps in which the variables were entered and regressed on to parental self-efficacy.

Table 4.4: Blocks of Variables used in Multivariate Regression

Step	Variable(s) Entered
1 – Structural Factors	Young teenage mum aged under 19
	Living in most deprived quintile (SIMD16)
2 – Childhood Factors	Looked after child
	No experience of domestic, physical or sexual violence in the past
3 – Proximal Factors	No history of drug use, recreational and misuse
	Child Protection Order
	Reports either child protection concerns or social work involvement
	Experienced mum with 2 or more children (2 -5)
4 – Mental Health	Low HADS Depression
	Low HADS Anxiety
	No history of mental health problems

The results of this multivariate, binary logistic regression are presented in Table 4.5.

Table 4.5: Multivariate Regression of Parental Self-efficacy

		Title			
Step	Variable(s) Entered	Model 1 (95% C.I.)	Model 2 (95% C.I.)	Model 3 (95% C.I.)	Model 4 (95% C.I.)
1 (*N* = 463)	Young/teenage mum <age 19 (yes *N* = 81; no *N* = 382)	*2.023*** (1.237 – 3.308)*	*2.063*** (1.248 – 3.410)*	*2.392**** (1.409 – 4.060)*	1.745 (0.978 – 3.112)
	Living in Most Deprived SIMD Quintile (1) (yes *N* = 287; no *N* = 176)	*2.177**** (1.467 – 3.230)*	*2.070**** (1.389 – 3.084)*	*1.916*** (1.269 – 2.894)*	*2.024**** (1.320 – 3.104)*
2 *N* = 463)	Looked after child status (yes *N* = 142; no *N* = 321)		1.319 (0.868 – 2.004)	1.195 (0.762 - 1.874)	1.243 (0.779 - 1.984)
	No reported experience of domestic, physical or sexual violence in the past (yes *N* = 192; no *N* = 271)		1.398 (0.942 – 2.077)	1.095 (0.713 - 1.683)	1.222 (0.778 - 1.919)
3 (*N* = 463)	No reported history of drug use, recreational and misuse (no *N* = 231; yes *N* = 233)			*1.653*** (1.108 - 2.466)*	*1.543** (1.109 - 2.338)*
	Child Protection Order (yes *N* =84; no *N* = 379)			*2.800*** (1.412 - 5.551)*	*2.900*** (1.426 – 5.898)*
	Reports child protection concerns or social work involvement (yes *N* = 162; no *N* = 301)			1.225 (0.712 – 2.109)	1.170 (0.666 – 2.056)
	Experienced mum with 2 or more children (2 -5) (0-1 *N* = 365; 2-5 *N* =98)			1.266 (0.736 – 2.178)	1.333 (0.753 - 2.358)
4 (*N* = 463)	Low HADS Depression (low *N* = 212; high *N* = 251)				1.431 (0.912 - 2.244)
	Low HADS Anxiety (low *N* = 215; high *N* = 248)				*2.150**** (1.349 - 3.426)*
	No reported history of mental health problems (no *N* = 139; yes *N* = 324)				1.514 (0.930 - 2.462)
	-2 Log likelihood Nagelkerke R Square	617.055 0.064	611.349 0.080	578.893 0.152	548.830 0.224
	*p < 0.05; **p < 0.01; ***p< 0.001				Chi-square: 8.560; df: 8; Sig: 0.381

In the initial model, age and SIMD remain significant when included in a multivariable model with an outcome variable of parental self-efficacy. These two factors together explain 6% of the variance; when childhood factors are added to the model, both age and SIMD remain significant, but none of the childhood factors retain their significance. Adding these childhood factors explains 1% of the variance.

A further 9% of the variance is explained by the proximal variables, where having a CPO and no reported history of drug (mis)use remain significant. Mental health measures account for a further 7% of the variance in parental self-efficacy, with the model explaining a total of 23% of the variance. Table 4.5 also demonstrates that as blocks are added to the model, the deviance reduces, indicating that the model is improving and has an increasing goodness of fit to the data.

In the final multivariate regression model, living in the most deprived SIMD quintile, no reported history of drug (mis)use, having a CPO, and low HADS anxiety scores remain significant indicators of high levels of parental self-efficacy.

Those mothers with no history of drug (mis)use are around 1.5 times more likely to report high self-efficacy than those with such a history. Similarly, those with low anxiety are around twice as likely to report high self-efficacy. Having a CPO increases the odds ratio of reporting high self-efficacy almost threefold. Those women living in the most deprived quintile as measured by SIMD are around twice as likely to report high parental self-efficacy. The predictors of parental high levels of parental self-efficacy are presented in Figure 4.1, along with effect sizes and 95% confidence intervals.
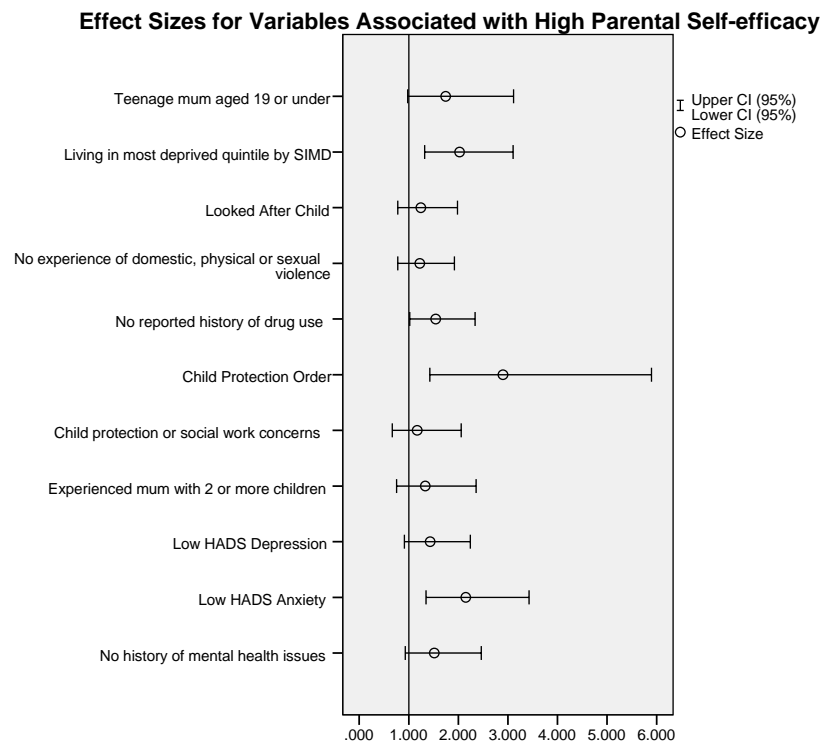
Figure 4.1: Effect Sizes for Variables Associated with High Parental Self-efficacy

The analysis described above was also run using both measures of age previously described – aged 25 or below, and including the variable of being a young mother aged 19 or under as an additional risk factor, to assess whether any significantly different results would be found. The final results of this analysis remained comparable to those in Table 4.5, and can be seen in Appendix 3 – Revised Multivariate Regression.

4.4.3 Chapter Summary

This quantitative chapter outlines the breadth and depth of the adversities faced by these women, both in childhood and adulthood, and highlights that the women in THRIVE represent some of the most deprived and vulnerable members of society, and those in greatest need of support when it comes to parenting. It also indicates that although the women who make up the interview sample for the qualitative analysis may not be the most vulnerable within the THRIVE population, they nonetheless can be seen to be at the lower end of a population that itself represents the most multiply disadvantaged women in the community.

The findings presented answer the first research question: what are the factors which impact upon parental self-efficacy among women recruited to THRIVE? The multivariate regression model assessed the factors which predict high levels of parental self-efficacy, controlling for sociodemographic variables such as age and multiple deprivation, historical adversities such as being a looked after child and experiencing physical, emotional, and sexual abuse, as well as more proximal factors and current mental health issues. The model demonstrates that higher levels of deprivation, lower levels of drug use, and lower levels of anxiety are all related to higher levels of parental-self-efficacy. Having a CPO in place is also related to higher reported levels of parental self-efficacy, with these mothers almost 3 times more likely to report high levels of self-efficacy when it comes to parenting tasks than those women who do not have a CPO in place. It is worth noting the correlation between SIMD and CPOs (Spearman 0.135, p = 0.003), which may have implications for these results. Of the 88 women who have a CPO, more than three quarters (N = 67) are living in the most deprived quintile. Therefore, some of the variance in SIMD variable may also be due to the large effect size of the CPO variable upon parental self-efficacy.

The implications of these findings are taken together with the findings from the qualitative data outlined in the next two chapters, and discussed further in Chapter 7.

5 Experiences of Being Parented - 'I'm surprised I made it through'

5.1 Overview of chapter

This chapter introduces the reader to the women's narrative accounts of their childhood experiences, their backgrounds and their early relationships with their parents. By exploring how these women recall being raised, it gives insights into their perceptions of the practices their parents adopted, and importantly the context and environment in which these practices operated. Ultimately, this chapter seeks to address the second research question posed in Section 3.2.2: what are the lived experiences of these women – what do these women recollect regarding how they were parented and the practices adopted by their parents?

It will provide detail regarding how these women experienced and reflect upon the styles of parenting as defined by the PBI – 'optimal', 'neglectful', 'affectionate constraint' and 'affectionless control'. It will examine the aspects and characteristics common to each of the styles, as well as how these experiences are potentially linked to other ACEs.

This chapter further highlights the vulnerable nature of the research participants, outlining their lived experience of violence, sexual abuse, deprivation, and emotional and physical abuse and neglect. It examines how these women feel their experiences have impacted upon them, and how they have responded to them. Throughout, this chapter will draw upon the literature discussed in Chapter 2 which suggests that those women who experienced such adversity are at greater risk of continuing potentially harmful practices with their own children and may be in need of greater support to parent in more positive ways. By providing a greater understanding of these women's own upbringing, it sets the scene for the chapter to follow which discusses how they respond to these experiences as they face the challenges of raising their own children.

This chapter opens with an exploration of the characteristics of those women who make up the interview sample and describes their backgrounds and the context of the environment in which they were parented. It looks at how

interparental conflict, violence and parental use of alcohol and other drugs shaped family life and the practices their parents adopted. It also describes how the women talked about the use of specific practices of their parents, with a focus on physical means of discipline and control. It also describes experiences of abuse, neglect and other adversities, and how these are linked to the parenting styles of their parents.

5.2 Characteristics of the Interview Sample

Of the 21 participants interviewed, all were living in Glasgow at the time; the majority were raised in or around Glasgow. Others moved to Glasgow from around Scotland, and two were raised in England. The women ranged from 19 to 40 years of age; the youngest of their children was 14-weeks old, and the eldest was 12 years. Nine of the participants have one child, eleven have two children, and one has three children. For twelve of the women, the THRIVE baby was their first child. All but one of the women in the sample have full time care of their children; in this case the children are living with their paternal grandmother, and their mother sees them twice per week.

Table 5.1 displays an overview of the key characteristics of each of the participants, including maternal and paternal PBI scores, the SIMD quintile in which they live, the arm of THRIVE to which they were allocated, their referral reasons and reported depression and anxiety levels. Table 5.2 displays the participants grouped by their parenting style they recall from their mother.

There are high levels of current deprivation among those interviewed, with just over half of the women (*N = 1*2) living in the most deprived quintile according to SIMD; a further five lived in areas categorised in the second quintile of multiple deprivation (Table 5.1). Nineteen of the women have mental health difficulties listed as one of their referral reasons into THRIVE; seven of the women were categorised as having high levels of anxiety according to the HADS anxiety scale – six of these women also reported high rates depression on the HADS depression scale.

Table 5.1: Participant Demographics

	Age	SIMD Quintile	Number of Children	Referral Reason(s)	Arm of Trial	Mother PBI	Father PBI	Number of ACEs	HADS Anxiety	HADS Depression	Self-efficacy
Amanda	23	1	2	Supports partner with mental health difficulties; traumatic birth experience with first child	MB	Affectionless Control	-	0	Low	Low	Low
Amy	20	1	2	Mental health difficulties; homelessness	ETPB	Optimal	-	1	Low	Low	High
Andrea	34	1	3	Mental health difficulties (history of depression); history of molar pregnancy; genetic carrier for undisclosed hereditary condition	MB	Affectionless Control	Optimal	1	High	High	Low
Angela	33	1	2	Mental health difficulties; history of sexual abuse; partner prescribed methadone for addiction recovery; social work involvement	ETPB	Affectionate Constraint	-	2	Low	Low	High
Caroline	29	1	1	Mental health difficulties (post-natal depression)	MB	Optimal	Optimal	1	Low	Low	Low
Catriona	22	1	1	Looked After Child status - social work involvement as a teenager due to violence within the home; diagnosed with Asperger's; depression and anxiety during and after pregnancy; young mother	MB	Affectionless Control	Optimal	3	Low	Low	Low
Ellie	28	1	1	Learning disability	MB	Neglectful	Optimal	1	Low	Low	High
Emma	23	2	1	Mental health difficulties (dissociative disorder); social work involvement	MB	Affectionless Control	Affectionate Constraint	1	Low	Low	High
Gemma	25	2	2	Extra support required	MB	Optimal	Optimal	0	Low	Low	High
Hannah	33	5	1	Mental health difficulties; panic attacks and anxiety during pregnancy	ETPB	Neglectful	Optimal	1	Low	Low	Low

Name	Age			Description	Code						
Jodie	38	1	2	Mental health difficulties; substance misuse (excess alcohol intake before pregnancy)	CaU	Neglectful	-	2	High	High	Low
Julia	20	5	1	Young mother; mental health difficulties (Previous eating disorder and self-harm)	ETPB	Optimal	Optimal	0	High	High	Low
Kerrie	39	3	2	Mental health difficulties (depression and anxiety)	MB	Affectionless Control	Affectionate Constraint	0	High	High	Low
Leanne	33	2	2	Mental health difficulties	MB	Affectionless Control	Affectionate Constraint	0	Low	Low	Low
Lorraine	27	1	1	Mental health difficulties	MB	Optimal	Affectionless Control	1	Low	Low	Low
Melanie	36	2	1	Mental health difficulties (anxiety); family history of mental health difficulties; IVF pregnancy	ETPB	Neglectful	Neglectful	5	High	Low	High
Nicola	27	1	2	Mental health difficulties (depression and anxiety); substance misuse	CaU	-	-	1	High	High	Low
Pamela	40	3	2	Mental health difficulties (depression and post-natal depression - has perinatal mental health team involvement)	MB	Affectionless Control	Neglectful	1	High	High	High
Sinead	40	2	1	Mental health difficulties (anxiety); IVF pregnancy (conceived after 6 years)	MB	Affectionless Control	Affectionless Control	2	Low	Low	Low
Siobhan	28	1	1	Mental health difficulties; family history of mental health difficulties	ETPB	Neglectful	Neglectful	3	Low	High	Low
Suzanne	27	1	2	Looked After Child status; death of her mother during teenage years. Mental health difficulties	ETPB	Neglectful	Optimal	5	Low	Low	High

Table 5.2: Participants' arranged by Maternal PBI Scores

	Mother PBI	Father PBI	Referral Reason(s)	Number of ACEs
Amy	Optimal	-	Mental health difficulties; homelessness	1
Caroline	Optimal	Optimal	Mental health difficulties (post-natal depression)	1
Gemma	Optimal	Optimal	Extra support required	0
Julia	Optimal	Optimal	Young mother; mental health difficulties (Previous eating disorder and self-harm)	0
Lorraine	Optimal	Affectionless Control	Mental health difficulties	1
Ellie	Neglectful	Optimal	Learning Disability	1
Hannah	Neglectful	Optimal	Mental health difficulties; panic attacks and anxiety during pregnancy	1
Jodie	Neglectful	-	Mental health difficulties; substance misuse (excess alcohol intake before pregnancy)	2
Melanie	Neglectful	Neglectful	Mental health difficulties (anxiety); family history of mental health difficulties; IVF pregnancy	5
Siobhan	Neglectful	Neglectful	Mental health difficulties; family history of mental health difficulties	3
Suzanne	Neglectful	Optimal	Looked After Child status; death of her mother during teenage years. Mental health difficulties	5
Amanda	Affectionless Control	-	Supports partner with mental health difficulties; traumatic birth experience with first child	0
Andrea	Affectionless Control	Optimal	Mental health difficulties (history of depression); history of molar pregnancy; genetic carrier for undisclosed hereditary condition	1
Catriona	Affectionless Control	Optimal	Looked After Child status - social work involvement as a teenager due to violence within the home; diagnosed with Asperger's; depression and anxiety during and after pregnancy; young mother	3
Emma	Affectionless Control	Affectionate Constraint	Mental health difficulties (dissociative disorder); social work involvement	1
Kerrie	Affectionless Control	Affectionate Constraint	Mental health difficulties (depression and anxiety)	0
Leanne	Affectionless Control	Affectionate Constraint	Mental health difficulties	0
Pamela	Affectionless Control	Neglectful	Mental health difficulties (depression and post-natal depression - has perinatal mental health team involvement)	1
Sinead	Affectionless Control	Affectionless Control	Mental health difficulties (anxiety); IVF pregnancy (conceived after 6 years)	2
Angela	Affectionate Constraint	-	Mental health difficulties; history of sexual abuse; partner prescribed methadone for addiction recovery; social work involvement	2
Nicola	-	-	Mental health difficulties (depression and anxiety); substance misuse	1

5.3 Family Background

All of the women interviewed were raised by their biological mother during the early years of their childhoods, and the majority of them stayed within the family home with their mother as their primary caregiver until at least their late teens. Suzanne lived with her maternal grandmother from her early teens onwards, after the death of her mother. Nicola and Amy, who left the family home at aged fifteen and sixteen respectively, subsequently spent a period of time in homeless shelters. Both Nicola and Amy describe being forced to leave the family home after the breakdown of the relationship with their mother at around sixteen years of age. Both also describe how they met their partners while they were homeless, and subsequently became pregnant with their first child.

5.3.1 Family Breakdown and Interparental Conflict

With the exception of Suzanne, for reasons described above, the primary caregiver for all of the women throughout their childhood was their biological mother. Around half of the women were raised in a home without their father biological father present - ten of them either did not know their biological father (N = 4), or their father left the family home while they were young children, between 2 years of age and sixteen (N = 6). Four of these women were then raised by a stepfather or a partner of their mother.

The breakdown of their childhood family was talked about by around half of the women during interviews. As well as not having any relationship with their father, or experiencing a change in this relationship due to his absence from the family home, often the breakdown of the family also changed the relationship with the remaining parent and altered the environment in which they were raised, often due to emotional stress and financial pressures for example.

The breakdown of families during childhood was frequently associated with other co-existing issues within the family, such as drug use and violence. This was also often perceived by the women as leading to further issues around wider deprivation and social disadvantage that impacted them long term, such as lower educational attainment and leaving school at an early age.

Recalling a happy childhood up until the point that her father left, Jodie comments.

> *Well ma dad left when I was 9, he was nowhere to be seen; ma mum she had 3 jobs trying to keep-, because there was 4 of us so she was trying to keep us afloat basically, she was out workin' and hardly ever there, so we didnae really have much guidance if you like in that way … I think it was just the pressure, like she was never there, and I was having to do things for the boys and just got a bit…well I felt a bit agitated, my mum was like 'well I can't do anything I'm oot working tryin' tae put food on the table'.*

<div align="right">

Jodie, 38, 2 children, CaU
PBI score: Mother = Neglectful. Father = n/a. ACES: 2
Low self-efficacy

</div>

As well as a changing relationship with her mother, Jodie also had to take on extra responsibility within the home and care for her siblings. Jodie felt she suddenly lacked the guidance and support she had previously experienced, and felt her schoolwork suffered as a result of these factors; this was, she said, a primary reason for her leaving school at an early age.

Although parental separation during childhood is in itself often conceptualised as an adverse experience, and it is often present alongside other adversities within the family, some women suggest that the absence of their father could in some ways be protective. His leaving the home, while financially burdensome, often removed a source of conflict, violence and/or drug use, as well as being something which led to a better or closer relationship between them and their mothers.

Where family breakdown did occur, it was often associated with co-existing adverse conditions such as interpersonal violence and substance misuse.

Well ma mum was a single parent, I mean she brung 4 kids up on her own … I've not been in contact wi' [father] 'cos he used to batter ma mum when I was younger so, no been in touch.

Amanda, 23, 2 children, MB
PBI score: Mother = Affectionless Control. Father = n/a. ACEs: 0
Low self-efficacy

I was six, and then my mum and dad split up for certain reasons. But a lot o' that was due to my mum, she was an alcoholic.

Suzanne, 27, 2 children, ETPB
PBI score: Mother = Neglectful. Father = Optimal. ACES: 5
High self-efficacy

My biological father was… I never met him, and he never met me. Mum got married and then [they] broke up because [he] was a drug addict.

Siobhan, 29, 1 child, ETPB
PBI score: Mother = Neglectful. Father = Neglectful. ACES: 3
Low self-efficacy

There were recollections too of interparental conflict when parents remained together, which was recalled as being unsettling during childhood and beyond.

I wouldn't say it was settled no because my parents argued quite a lot erm… I don't know why but I always remember them arguing as a child and up until now they still have arguments you know and its- it's probably- definitely has affected me as a, erm, a grown up in life.

Pamela, 40, 2 children, MB
PBI score: Mother = Affectionless Control. Father = Neglectful. ACES: 1
High self-efficacy

5.3.2 'She is like ma best friend' – Experiences of 'Optimal' Parenting

In contrast to the above examples of family breakdown, interpersonal violence and potentially strained relationships, those who reported 'optimal' parenting

experiences with their mother, Caroline, Gemma, Julia, Lorraine and Amy, all feel they maintained positive relationships throughout their childhood.

> *Ma mum was always there for us, ma mum done everythin' from what I can remember.*

<div align="right">

Lorraine, 27, 1 child, MB
PBI score: Mother = Optimal. Father = Affectionless Control. ACES: 1
Low self-efficacy

</div>

> *We have always had that kind of relationship, if I have got kind of a problem or something, I will go speak to her … because it has always been just like me and ma mum it is easy enough to do that.*

<div align="right">

Amy, 19, 2 children, ETPB
PBI score: Mother = Optimal. Father = n/a. ACES: 1
High self-efficacy

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For two others, there were recollections of good relationships with both of their parents, but especially their mother, and a very positive environment in which to grow up. Julia, for example, describes a very happy childhood, with 'no bad memories' and says that she has always gotten on well with both her mum and dad. She says she is particularly close to her mum and could always talk to her about 'absolutely anything'. She herself feels that this is 'unusual' when compared to other people she knows.

> *I think me and mum have got quite an unusual relationship because a lot of my friends look at me and go, 'How can you talk to your mum about that?' Or, 'How can… how is your mum okay with like that?' Or, like just find it strange that me and my mum are really close, like, I don't think many people… like, they'll maybe say they're dead close to their mum, but I don't think many people are that close to their mum.*

<div align="right">

Julia, 20, 1 child, ETPB
PBI score: Mother = Optimal. Father = Optimal. ACEs: 0
High self-Efficacy

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[We were always] really close, erm I could tell her anything; she is like ma best friend now... I think it has affected me positively... I feel like I have got good attachments and stuff like that.

Gemma, 25, 2 children, MB
PBI score: Mother = Optimal. Father = Optimal. ACEs: 0
High self-efficacy

All five of those reporting the maternal parenting they experienced as 'optimal' reflect positively on their relationship with their mother. Three of them also recall 'optimal' parenting from their father. They all suggest that this positive and warm parenting has continued as they have grown, and also that these experiences have affected them positively and carried with them into adulthood.

Each of these women also report either zero or just one ACE. This may suggest that having a positive relationship with their mother may be a protective factor for them, in that it provides a buffer from other ACEs; at the very least it suggests a positive maternal relationship is indicative of a childhood which is characterised by fewer or no adverse experiences.

5.3.3 'I'm surprised I actually made it through' – Experiences of 'Neglectful' Parenting

The above accounts can be contrasted with those who reported experiencing more harsh and negative aspects of parenting, and in turn discuss difficult and challenging relationships with their parents. Six participants categorised their experience of their mother as 'neglectful'- Ellie, Hannah, Jodie, Melanie, Siobhan and Suzanne. However, this was manifested in different ways; typically though, these accounts did include experiences of wider adversity. For some, they included recollections of harsh practices happening alongside their parents' use of alcohol or other drugs.

5.3.4 Parental use of Alcohol and Other Drugs

Melanie, Suzanne and Lorraine spoke of the disruption that their parents' alcohol use had had upon their daily lives as children, as well as the different ways in which it defined their relationships. For Melanie, her mother's alcohol use had

been a defining characteristic of their relationship for as long as she can remember.

> *Mum was an alcoholic, dad was physically and mentally abusive and stuff like that, so not the best kinda upbringing. Surprised I actually made it through my upbringing... we don't have a mother/daughter relationship. I don't know if we ever did have that... Like my mum's never told me that she loves me or anything like that, we don't... we don't have that.*

> Melanie, 36, 1 child, ETPB
> PBI score: Mother = Neglectful. Father = Neglectful. ACES: 5
> High self-efficacy

Melanie also discussed a feeling of resentment towards her mother as a result of the issues her drinking caused, especially the isolation from friends and family. For Melanie, her mother's inability to look after her and her brothers was also a source of resentment, and she feels that her mother often failed to protect them from their father's mental and physical abuse. There were several instances where her mother took Melanie and her siblings out of the family home as a result of this violence, but she would always return a few days later, which left Melanie resentful, as well as confused by her mother repeatedly putting herself and her children in danger. Melanie said she often wondered as a child why she was in this situation and remembers not wanting to be there; she said she would think what it would be like if the social workers just took her away and wondered how her life may have been different.

Like others, Melanie feels the conditions in which she was raised by her parents, and the adversity and challenges she faced, impacted upon her education and meant she had to leave school at an early age. This, she feels, has had long term implications for her into adulthood in terms of the choices she has been able to make and the jobs she can do to earn money for her new family.

> *We never really kinda starved or anything. It's just sometimes she'd drink all the money, and then there wouldnae be much to eat or something like that, or... But that was the thing, where my dad always had money, but it was the mental thing that he would go 'oh, your mum's drank all the money, so yous aren't eating today' and stuff like*

that. I had to become more independent. I left school quite early as well. Just 'cause I wasnae getting proper provided for… so I kinda like looked after myself.

<div align="right">

Melanie, 36, 1 child, ETPB
PBI score: Mother = Neglectful. Father = Neglectful. ACES: 5
High self-efficacy

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Similarly, Suzanne talks about her mother's drinking being a consistent feature throughout her childhood, and how she could not rely upon her mother. This in turn made life unpredictable.

There was long, long, long periods of time where she was just drinking a lot, heavily… you would go home and you wouldnae be able to get back into the hoose… Like, you would be able to look through the living room window and you would see her lying on the floor. But you just couldnae wake her. Like, no matter how many times you banged and banged, like, so… 'cause I learnt fae quite a young age that in my house, a certain way the window was left open, you would be able to put your hand in and you would be able to shimmy it, so that's primarily how I used to get in the house… I wasnae sure if when I chapped the door if my mum was gonnae be able to answer it or I was gonnae have tae dae that, or I was gonnae have tae go to my friends down the road or I was going to have tae go to my grans, like, very unpredictable that way. I wouldnae know if she would ever turn up for parents evening or there would be dinner or any food type thing, so it was like that.

<div align="right">

Suzanne, 27, 2 children, ETPB
PBI score: Mother = Neglectful. Father = Optimal. ACES: 5
High self-efficacy

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Suzanne talked of unpredictability and inconsistency in her relationship with her mum, with no real displays of affection and occasional violent 'lashing out'. However, Suzanne also talked about how this situation led her to be more self-reliant and independent as a child, in both practical and emotional ways, cooking her own food and dealing with problems by herself for example. Her parents separated when she was around six years of age, and her dad left home with her brother, leaving her and her sister with their mum. During this time

there was no structure or discipline in the home, with Suzanne doing the majority of the caring for her younger sister and the two of them deciding on a day-to-day basis whether to go into school or not. When, during her teens, her mother died suddenly, Suzanne was in kinship care for prolonged periods. She only regained contact with her father some time later, and would occasionally see him in the neighbourhood when he drove past.

In contrast to alcohol use being a consistent feature of childhood for Melanie and Suzanne, Lorraine talks about how her relationship with her father changed abruptly because of his drinking. Despite being previously 'very close' and 'very happy', when Lorraine was a teenager her younger brother died suddenly, which had a profound effect upon the family. It was around this time that Lorraine says her father began to drink more heavily and frequently, which ultimately changed their relationship. She recalls one incident where he lost his temper with her due to an incident at school.

> *I can always remember being my dad's little princess and doing everything wi' my dad, going… actually going wi' him in his truck when he was out driving and things like that, going wi' him to work and then the drinking started getting heavier, almost every night, just his whole attitude in life started to change. And then, when I got to my teens, that's when it started getting volatile…*
>
> *…he dragged me in the house and basically put me up against the wardrobe by my throat and punched me and dropped me and left me on the floor and just walked out the house. [He] was quite abusive to me in ma teenage years, mentally and physically, just because of his drinking more or less, so that kind of stopped me seeing ma dad.*

<div align="right">

Lorraine, 27, 1 child, MB
PBI score: Mother = Optimal. Father = Affectionless Control. ACES: 1
Low self-efficacy

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In similar ways, Siobhan discusses how life changed dramatically for her and her family around the time her father began using drugs, and how the impact of her father's drug use eventually took its toll.

> *I never had a dad until I was 5. My mum met a guy, he was amazing. He took me on full-time, he became my dad... and then my mum and dad broke up... because he was a drug addict. Something my mum had been kind of hiding, brushing under the carpet, dealing with as much, like, best she could... It explained a lot as in to why our circumstances were the way they were.*

> *Maybe kinda 12, 13, that was when my home life kinda started to fall apart. Obviously, I didn't know why, but my mum ... she was quite ill. The stress and things really affected her ... now we know why, like, looking back it's because of all the stress with my dad. And so we lived in a nice house - on the outside, we had everything, we should have had the perfect life. My mum [...] she has a high, like, paying job. My dad, he had a good job. So, on the outside, we should have had, we should have been like the perfect family but on the inside, we had no money, like, my mum was never oot of bed, my dad was permanently off sick because he was taking drugs obviously. We were permanently borrowing money, we never had, like... there was never any food in the house. The house was just a riot because no one was up to cleaning it.*

> Siobhan, 29, 1 child, ETPB
> PBI score: Mother = Neglectful. Father = Neglectful. ACES: 3
> Low self-efficacy

She goes on to say how this disruption to family life, at such a crucial point, also meant it was difficult for her to focus at school and do well in exams.

For Melanie, Lorraine, Suzanne, and Siobhan their relationships with their parents was either shaped by a continued presence of alcohol or other drugs, or life changed dramatically when one parent began to use these substances. This had a profound effect upon day-to-day life for all of these families, often leading to unpredictability and uncertainty, difficult or 'non-existent' relationships, as well as episodes of violence within the home. In each of these

cases, the use of alcohol or other drugs impacted upon the day-to-day parenting that each of the participants experienced, and they feel the dynamics within the family were shaped by this substance use. In each of these cases, all of the participants talk about their parent's substance misuse as at least a contributing factor in the breakdown of their families.

The accounts of these women demonstrate how violence within the home often co-exists alongside parental conflict and substance misuse. As well as the direct experience of such adverse conditions and the physical trauma that is often associated with parental substance misuse, these factors can combine to create or exacerbate deprivation and disadvantage for the families concerned. Where these families are impacted by parental substance misuse, it is also often characterised by a lack of warm, nurturing and supportive parenting during childhood, or in some cases these women experiencing neglectful or abusive practices by their parents. Parental use of alcohol and other drugs are also frequently associated with breakup of these families.

In turn, when these families are affected by parental substance misuse, conflict, and ultimately separation, this places a financial strain on the family which further contributes to the deprivation and disadvantage they often already face. Moreover, this combination of emotional distress and disruption, coupled with a financial burden, often means that as young children, these women feel their educational attainment was negatively affected. In some cases, it also meant they had to leave school early in order to financially support themselves or their families. Each of these women feel that this has shaped their adult lives and continues to impact them in a variety of ways.

Siobhan, Melanie and Suzanne represent the more extreme end of the sample in terms of adversity, reporting the highest number of ACEs within the sample (three, five and five respectively). This suggests that ACEs tend to be cumulative and co-exist alongside one another: in these women's accounts, parental use of alcohol and other drugs are seen to be directly associated with their experiences of violence, neglect, and/or abuse for example.

In contrast to those accounts which described positive and warm relationships with their mother (Gemma, Julia, Amy and Lorraine, Section 5.3.2), Siobhan,

Melanie and Suzanne describe more difficult, fractious or neglectful relationships. They have the highest number of ACEs and categorise their mother as 'neglectful' on the PBI scale. Thus, where there is a reported 'neglectful' relationship with their mother, this is correlated with a higher number of adversities. This suggests that either some of these adversities result from this 'neglectful' parenting, and/or that this perceived neglectful parenting exposes them to further adverse experiences.

All of these four women articulate how violence, conflict, and parental use of alcohol and other drugs impacts upon their relationship with their parents. These women talk about how the environment in which they were raised was, or became, one characterised by emotional and physical neglect by their parents, and one which often featured disruption, conflict and violence. It is the combination of these things, alongside a lack of modelled warm, positive parenting, which places these women at greater risk of poor outcomes themselves. They are more likely to have poorer social and emotional development and mental health, and potentially it is these women that are in need of greater support when it comes to raising their own children.

5.3.5 Other Experiences of 'Neglectful' Parenting

For Hannah, her experiences of a 'neglectful' mother consisted not of alcohol and other drug use, but of a sometimes difficult and cold relationship, coupled with a mother who was sometimes 'fiery and quick tempered'. This is couched in terms which at the same time highlight other, more positive parenting practices.

> *It's really difficult 'cause in some ways she was a very good mother. For example, she used to always, me and my sisters, she's always really cared about our education, and we should do really well at school, and that's the most important thing, and we should always be independent, and she's raised us to be quite strong in that way. But, in other ways, she's not… she's not the archetypal care — she's not a very caring kind of person, which sounds awful. But, she's not very cuddly.*

Hannah, 33, 1 child, ETPB
PBI score: Mother = Neglectful. Father = Optimal. ACES: 1
Low self-efficacy

As well as the academic pressure she felt, Hannah also talked about 'turbulent' times, and, occasionally being screamed at or hit with a slipper. Like Hannah, Ellie also recalled similar instances with her own mother.

> *Oh my god, she was a hitter, like spank the wean* [child] *because that's what you do.*

<div align="right">
Ellie, 29, 1 child, MB
PBI score: Mother = Neglectful. Father = Optimal. ACES: 1
High self-efficacy
</div>

As well as a lack of care and affection, experiences of 'neglectful' parenting, for all of these women, consisted of exposure to and a lack of protection from interpersonal violence. Other experiences of physical discipline and violence within the home, and how these women responded to them, are outlined in the following section.

5.4 Physical Discipline, Violence and Abuse within the Home

Consistent with their reflections of 'optimal' parenting, both Julia and Gemma, who earlier spoke about a closeness and good relationships with their parents, did not recall any episodes of violence or physical discipline or punishment within their family.

> *When I was younger, she would never, I don't ever remember my mum shouting at me, or she would never like hit me or anything like that.*

<div align="right">

Julia, 20, 1 child, ETPB
PBI score: Mother = Optimal. Father = Optimal. ACEs: 0
High self-Efficacy

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> *They were just really good, they, I don't remember ever being shouted at or anything like that or- they were just really nice, caring people ma mum and dad, really erm accepting of anything as well, really understanding… I don't remember any shouting, maybe raised voices but not like shouting and screaming like you hear some people.*

<div align="right">

Gemma, 25, 2 children, MB
PBI score: Mother = Optimal. Father = Optimal. ACEs: 0
High self-efficacy

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However, others did speak of regular violence towards them or other members of their family. Aside from those women who talked about violence within the home in the context of parental use of alcohol and other drugs, a further three described witnessing violence towards their mother. Amanda and Amy each say that their mother's partner did not physically discipline or use any violence towards them as children but did describe feeling upset and frightened when their mother's partner was violent and abusive towards their mother. Catriona describes similar feelings and also says that one of her mother's partner would also hit her during his violent episodes. Catriona and Amy both talked about frequent episodes of violence in the home, where their mother would be beaten, things broken in the house. On occasion police and social work involvement became necessary.

5.4.1 Experiences of Discipline

Although the scope of the interviews allowed for discussion of a broad range of parenting practices and behaviours in general terms, participants often focused on the specific practices of their parents, frequently talking about their parents' use of physical means of discipline. While the majority may not be as extreme as the cases outlined above, physical disciplinary techniques were a common theme of the participants' childhoods: thirteen women recall being hit by their parents when they were younger. Of these, nine were physically disciplined by their mother; Kerrie and Lorraine were hit by both their mother and father; and Melanie and Catriona were hit by their father (or her mother's partner). Nicola, Amanda and Jodie recall threats of violence being used by their mother, but say they were never hit as children.

5.4.1.1 Reflections upon Experiences of Physical Discipline

What is apparent is the use of minimising language in the women's accounts, playing down physical discipline where it did occur. In the majority of cases there is an internalisation, rationalisation, or normalising of physical discipline. Participants internalised the blame for this, suggesting that somehow the actions of their parents were the result of their own poor behaviour as children, or they downplayed the physical aspect as not really too bad or serious. There is also a wider acceptance that physically disciplining or punishing a child for a perceived transgression, or the use of physical means to control children more generally, was an accepted practice in previous generations, even if it may not be widely acceptable today.

Both Lorraine and Hannah talk about experiencing physical punishment or discipline from their mother, but frame this in terms of it being quite normal, and both are eager to point out that despite being hit by their mothers, and occasionally fighting with them, they would not describe their mothers as violent people.

> *I didn't feel like I was particularly scarred by it at the time, but she like smacked me and stuff. When I was younger, and I remember her getting quite angry and like chasing me up the stairs and she was going to smack*

me or something, and but, I don't know, that's just—I guess that's just the way it was at the time. And we had, she was, I think—I do think she's… I wouldn't call her a violent person, but she's, 'cause she's got that quick temper, she did still, when I was about fifteen or sixteen, she would still like try and hit me, sometimes if we were having a fight. Which sounds—I don't know, it sounds terrible when you tell a story like that, but in— in reality, it wasn't, it just seemed normal.

<div align="right">

Hannah, 33, 1 child, ETPB
PBI score: Mother = Neglectful. Father = Optimal. ACES: 1
Low self-efficacy

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Getting into trouble usually consisted of my mum screaming at us, getting a slipper across the arse, and then getting sent to our beds. Aye, just very occasional. Very occasional. Whenever she lost her temper like properly, but other than that, no, she wasn't, my mum's not a very violent person, but my dad on the other hand was.

<div align="right">

Lorraine, 27, 1 child, MB
PBI score: Mother = Optimal. Father = Affectionless Control. ACES: 1
Low self-efficacy

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Kerrie, Sinead and Andrea also used similarly minimising language when talking about being hit by their parents, describing it as just a 'wee smack', or just getting smacked 'a couple of times', but only ever as an 'extreme measure'.

We would be smacked; smacking was the thing those days wasn't it? I mean nothing, not hitting really hard or anything but that was how they disciplined us.

<div align="right">

Kerrie, 40, 2 children, MB
PBI score: Mother = Affectionless Control. Father = Affectionate Constraint. ACEs: 0
Low self-efficacy

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But yeah, in terms of discipline and stuff, I remember, like, sometimes getting a wee smack on the bum or something like that. But, you know, just normal kinda, yeah.

<div align="right">

Sinead, 40, 1 child, MB
PBI score: Mother = Affectionless Control. Father = Affectionless Control. ACES: 2
Low self-efficacy

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When I needed it, I got it. It was very rare. It was very rare for her tae skelp any of us.

Andrea, 35, 3 children, MB
PBI score: Mother = Affectionless Control. Father = Optimal. ACES: 1
Low self-efficacy

In similar ways Leanne describes episodes of violence, but also emphasises the rarity of such events, and again makes the distinction that her mother was not ordinarily a violent person, and these acts of violence were, she feels, in response to the behaviours of her and her sister.

There has been points where I was smacked. I found that, I still find that quite difficult to say that, but… There was… even once at 16, I had my mum slap… I can remember she slapped me across the head. So there was… I'm saying there was a degree of violence, it was really rare, really, really rare. But there was, there was obviously points where my… my mother just, it was a snap, and she couldn't… like she just was like, when… we'd just really just overstepped a mark.

Leanne, 33, 2 children, MB
PBI score: Mother = Affectionless Control. Father = Affectionate Constraint. ACEs: 0
Low-self-efficacy

Likewise, Emma does the same, describing her mother grabbing her by the throat and screaming at her as only happening when she had done 'serious' things.

Ah erm… when my mum got angry, erm, it's like she used to like grab me and [brother] by the throats and up against walls and like screaming in our faces. But that… that only happened like for like serious things. My dad always kinda like sort of skelped us on the bum.

Emma, 23, 1 child, MB
PBI score: Mother = Affectionless Control. Father = Affectionate Constraint. ACES: 1
High self-efficacy

Melanie also makes a very clear distinction between the approaches of her mother and father in this regard. She points out that her mum would occasionally use physical discipline, but again this was not a frequent occurrence

and again only as a result of a serious transgression. For Melanie this was quite a 'normal' approach, as opposed to the more regular and serious beatings she would experience from her father.

> *It wasnae on a weekly basis. Maybe like once, twice a month or something like that. But he would hit you quite sore. My mum wasnae really kinda… like she'd give you a kinda skelp and stuff like that, but no' really… and it would be 'cause you were actually doing something you really shouldnae be doing and stuff like that. I would say that's more a kinda like a normal kinda, like kinda smack and something like that, it wasnae like the way my dad kinda hit us.*

<div align="right">

Melanie, 36, 1 child, ETPB
PBI score: Mother = Neglectful. Father = Neglectful. ACES: 5
High self-efficacy

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By way of contrast, several participants explained that physical discipline was the sole domain of their mother, with their fathers being able to instil discipline or gain control simply by raising their voices or changing their tone. In some cases these different approaches to parenting were also a source of tension between their parents.

> *My father never disciplined us, ever, it was always my mum. It was my mum that would hit us whenever we were hit, which wasn't often, but I remember her one time hitting me in the face or the ear and I ran away, that's the only time I remember being hit and getting frightened kind of thing, my father never lifted his hand to us never, but he never disciplined either and when they did, when they were going to discipline or shout at us then they would start arguing.*

<div align="right">

Pamela, 40, 2 children, MB
PBI score: Mother = Affectionless Control. Father = Neglectful. ACES: 1
High self-efficacy

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> *He would never lift his hands to me or anything like that, but he just had to raise his voice and I'd be scared, and I would do it, 'cause if he raised his voice then you know it's serious, you know that you've crossed a line and it's time to do what they're telling you… I remember fighting with*

my mum, I remember my mum chasing me around the garden and things like that. I was a nightmare for my mum and I still am quite… I challenge everything. That's in my nature, that's my personality, so, for my mum, that's what I would do. So, yeah, I remember my mum, like, physically like hitting me and, yeah.

Siobhan, 29, 1 child, ETPB
PBI score: Mother = Neglectful. Father = Neglectful. ACES: 3
Low self-efficacy

5.4.1.2 'I guess that's just the way it was at the time' – Situating Experiences of Discipline in a Historic and Social Context

As well as rationalising and finding justification for the coercive parenting practices of their parents, especially the use of physical discipline and acts of violence that these women experienced as children, participants also discussed how parenting was just very different in previous generations. Several participants acknowledged that parenting, and general attitudes towards children, were different when they were younger. Moreover, these women do not appear to single out their parents or hold them responsible for their parenting practices or behaviours, but in fact seem to feel that the use of physical discipline for example was, historically, just a common, accepted element of parenting.

Here Sinead talks about a looking back with a sense of anger and frustration that when she was a child, children at the time were not seen as the priorities of adults, as they are today. She does not lay any blame for this with her parents directly, but views this as more indicative of the different attitudes toward parenting in her mother's generation.

I think times were different then, it was the 80's, so, like, I don't think the way, kids are sort of more put on a pedestal these days, aren't they? You know, kids are your number one when you're a parent. And I don't know if it was like that back then necessarily. I mean, I remember, my cousins even, just being sort of kicked out in the summer holidays to make their own entertainment, and that wasn't really necessarily exclusive to us. So, as much as I sort of think back angrily, oh, you know, we were never their first…priority. You know, there were things that

they prioritised over making sure that we had a nice easy time of it.
That's probably indicative of the time, rather than- I would say, 'cause
definitely, I think over the years parenting has sort of changed in that
sense.

Sinead, 40, 1 child, MB
PBI score: Mother = Affectionless Control. Father = Affectionless Control. ACES: 2
Low self-efficacy

This would suggest that although she feels she did not always have an easy time or a pleasant experience because of her parents' attitudes towards her and her siblings, at the same time she feels that it was perhaps something that was not, directly at least, the fault of her parents, but more a problem of wider societal attitudes.

Similarly, Leanne talks about her regret that in previous generations things were not always easy for parents, and how this led to her mum often being angry and lacking the help or support she might have needed to raise her children. Again, she does not blame her mother for this rage, but seeks to understand and mitigate it by placing it in a wider societal context.

I'd kinda saw my mum having rage when probably my mum could o' done
wi' talking wi' somebody. But then, that's maybe… as we're moving on in
society, we're seeing that, in actual fact, if we're angry about
something, what are we angry about? Let's talk about it, rather than
bottling it up as lots of people would've done.

Leanne, 33, 2 children, MB
PBI score: Mother = Affectionless Control. Father = Affectionate Constraint. ACEs: 0
Low-self-efficacy

Others also used similarly exculpatory phrases to contextualise the actions of their parents and situated the physical discipline they received as being just the way things were at the time, with an acknowledgement that smacking a child was a widely acceptable practice. They distance themselves from this experience by suggesting it was rare, only done when needed or deserved, and notwithstanding this harsh and coercive approach to parenting, that their mothers were generally not violent people. Moreover, it was indicative of a

different time and therefore their parents were only acting in a way commensurate with wider practices of the day, and that these things are no longer as widely acceptable as they once were.

Notably different from these accounts however, Andrea suggests that this approach from her mother was not at all problematic, and in fact makes no attempts to excuse or rationalise her mother's use of such techniques. For her, the physical discipline and punishment she received was not only normal and acceptable, but according to herself this did her 'no harm'. Such coercive and physical approaches were necessary from her mother to keep things in line with her and her two sisters, and the shift towards such practices becoming less socially acceptable is wrong and lamentable. Andrea's reflections upon this and how her experiences and circumstances shape her approaches to parenting now are presented as one of the case studies in the following chapter (Section 6.4.1).

For around two-thirds of the women interviewed, their backgrounds were characterised by repeated and continued episodes of violence within the home, with examples of sustained use of physical means of discipline and punishment towards them as children. In the majority of cases where this did occur, these participants report their maternal experiences on the PBI as 'neglectful' or 'affectionless control'. However, Amy and Lorraine rate their experiences of their mother as 'optimal' and yet describe examples of their mother using physical discipline. This would suggest that for these women, the use of such parenting techniques may be acceptable within a wider warm and supportive parenting environment, and therefore 'optimal' parenting does not necessarily preclude practices of physical discipline and control.

There are a variety of ways in which these women reflect upon their experiences of the coercive practices of their parents, and specifically being physically disciplined and punished as children. Where such physical approaches to parenting were practiced, with the notable exception of Andrea, the women reflected upon this in such a way as to separate in their minds the *actions* of their parent from the *parent* in question. This is done by justifying the physical or coercive practices of their mother by balancing it with other instances of warmth and support, or to rationalise it because of its rarity.

It is also achieved by suggesting that such practices were only employed when they, as children, deserved or required such punishment because of the seriousness of their transgression or their own actions. Such acts were only necessary, according to these women, because of their own behaviours as children, and they are not seen as indicative of violence or their mother being violent in any way. They reflect upon such practices as being a necessary and inevitable consequence of childhood misbehaviours, and they are placed in a wider social context which meant that such practices were more widely accepted, and at the same time it was more difficult for their mothers to seek the help and support they may have needed. These findings lend support to those of Conger *et al.* (2009) who suggest that general or social changes may serve to moderate parenting practices. These changes in accepted practices and societal views on the appropriateness of certain parenting practices will undoubtedly have some influence any intergenerational continuity or discontinuity.

5.4.2 Sexual Abuse

As with those who appear to have internalised blame for experiences of violence, so too Angela internalised responsibility for her childhood trauma. Angela experienced sustained physical and sexual abuse from her older brother, which continued between the ages of four and fourteen, during which time she was unable to tell anyone else in her family and was often left alone with her abusive brother.

> *If I was to go and tell anybody, they would never believe me - that was my big brother… I'd always grown up thinking it was just normal abuse; as I started to speak to people and go he done this and that and… and then [suddenly] I'm like well that was no' normal abuse because looking back I was like a guinea pig and, well I have got to live with this for the rest of my life.*

<div align="right">

Angela, 33, 2 children, ETPB
PBI score: Mother = Affectionate Constraint. Father = n/a. ACES: 2
High self-efficacy

</div>

This experience of abuse has had severe and long-term impacts upon Angela, having implications for her mental health, and affecting all aspects of her life and her relationships with others. Angela feels not only that she was unable to tell her mother of her abuse, but that her experience of abuse resulted in increased difficulties with her mother and others in the family. Angela described how she knew she was loved by her mother, but that there would never be any physical or verbal affection to confirm this. She became a naughty child she says, and her experiences also drove her to adopt unhealthy behaviours such as drinking to excess as a teenager.

> *It's not justification, but no wonder I just went and got totally wrecked every weekend because that was my escape because my brother was still coming to visit. He was in my face and all I can hear was how wonderful his life was, I had about enough of him being on this pedestal because at that time he had essentially wrecked my life and there was nothing else he could- he done such a horrendous, heinous thing but he was still this wonderful guy, you know, he went to college and uni and was great at this and great at that and I was just this waste of space that decided to leave school.*

Angela, 33, 2 children, ETPB
PBI score: Mother = Affectionate Constraint. Father = n/a. ACES: 2
High self-efficacy

Like others discussed before, Angela described how these factors combined to make school difficult for her, meaning she left education at an early age. It was in this context, frequently left to her own devices while her mother was out at work, that Angela, as a teenager, began drinking to excess. It was around this time that she began a relationship with someone whom the family did not approve, creating further disharmony and pressure. Unaware that she was pregnant, Angela continued to drink heavily throughout her pregnancy, and her son was diagnosed with foetal alcohol syndrome soon after birth.

Angela's case illustrates further the adversities and sometimes extreme traumas experienced by these women, and the complex lasting vulnerabilities they continue to face as adults as a result of them. They are often associated with persistent and continued mental health issues, and in Angela's case can be seen

to have cumulative and syndemic effects (Singer, 2009), where the experience of one factor means these women are more likely to suffer other adversities: Angela's early trauma led her to health harming behaviours, and these combine to impact upon her current mental health, her relationship with her partner and her children, as well as impacting upon the health and cognitive and social development of her son. This provides a clear example of how adversity and trauma can have consequences across generations.

5.5 Chapter Summary

This chapter provides the answers to the second research question: what are the lived experiences of these women – what do these women recollect regarding how they were parented, and the practices adopted by their parents?

This chapter described how the women reflected upon a range of lived experiences from childhood, from very positive parental relationships and environments, through to much more challenging issues and a variety of adverse and in some cases traumatic experiences. This chapter also outlined the practices they recall from their parents, and the context and environment in which these practices were experienced. The particular focus on physical discipline in these findings reflects the fact that this was predominant theme which emerged from the women's accounts; given scope to interpret and discuss parenting practices in any way they wished, it was the presence, or indeed lack of, physical discipline which these women often chose to focus upon.

Those interviewed include a range of ages, spanning from 19 to 40, and include women from across the spectrum of deprivation and disadvantage. The findings indicate a prevalence of mental health conditions, such as high levels anxiety and depression, and include histories of homelessness, sexual and physical abuse and neglect as a child, experiences of violence and parental substance misuse, and family breakdown. These factors underscore the vulnerability of these women, and as such, we are able to gain insights into the upbringing of some of the most vulnerable members of our society, something which is often notably absent from studies such into this topic.

This chapter has outlined the adverse experiences these women faced as children, and the presence of the factors which have been previously shown to lead to poorer health and developmental outcomes, as well as factors which may mean these women are at risk of repeating negative patterns with their own children (Capaldi *et al.*, 2003b; Neppl *et al.*, 2009). Where family life is described as being impacted by parental use of alcohol and other drugs, this is often accompanied by accounts of conflict, disruption, neglect, violence and abuse, suggesting that adverse experiences can be cumulative.

When they report 'optimal' parenting, this includes warm, supportive and responsive relationships, but in contrast to previously published literature (Belsky *et al.*, 2005; Chen and Kaplan, 2001), it may also include aspects of physical discipline. Overall, 'optimal' parenting is associated with fewer ACEs, and lends weight to the evidence of Balistreri and Alvira-Hammond (2016) and Bellis *et al.* (2017), that a positive maternal relationship is a protective factor against the potential impacts of adverse experiences (Hill *et al.*, 2007; Woods-Jaeger *et al.*, 2018).

Where these women recall harsh parenting, they also often indicate a lack of warm, positive experiences during childhood. Therefore, not only are these women potentially at risk of being harmed by the parenting they experienced, as well as by the other adversities they faced as children, they also appear to lack any of the protective elements that a warm, affectionate relationship with their mother may bring.

Compounding this, they may well also lack any positive parental behaviours on which to model and base their own approaches when it comes to making decisions and coping with their own children. Being raised in households where coercive parenting techniques and physical aspects of punishment and discipline were a feature of their upbringing may indicate that there is an increased likelihood of these women repeating such negative practices and patterns with their own children (Capaldi *et al.*, 2003b; Thornberry *et al.*, 2003).

Where interpersonal conflict, violence and substance use occurred during childhood, this was often followed by family breakdown which served to place further financial burdens on already deprived and disadvantaged families. This

increased financial pressure also led, on some occasions, to negative impacts upon the educational attainment of these women, which may well contribute to the perpetuation of intergenerational deprivation and disadvantage, as well as continued social inequalities.

Taken together, these experiences paint a picture of women who have often experienced adversities and traumatic events during childhood, and in some cases have had difficult relationships with their parents. It is the presence of these factors in their upbringings which may mean they have difficulties in implementing positive parenting practices, and therefore are in need extra support when it comes to raising their own children (Benoit and Parker, 1994; Walters, 1990). The next chapter explores the women's reflections upon the way they were parented, as well as their responses to these experiences, and how they feel these have shaped their current parenting. It builds upon the data outlined in this chapter and explores how, in light of these experiences, practices are either rejected or repeated across generations as these women navigate the task of raising their own children.

6 Reflecting and Responding - 'I kinda learned how I don't want to parent'

6.1 Overview of Chapter

As outlined in the previous chapter, many of the women in this study have experienced challenging backgrounds and faced significant adversities during childhood. They reflect on the relationship with their parents in a variety of ways, with some describing very close and loving 'optimal' relationships, and others experiencing more difficult, distant and strained ones, characterised by 'neglect' or lack of affection. This chapter draws upon the women's narratives, examining the ways in which they feel their backgrounds, and their relationships with their parents, past and present, have influenced their conceptualisations of motherhood and their approaches to parenting.

This chapter provides answers to the third research question, and explores the women's reflections upon the way they were parented, their responses to this, and how they feel these things have shaped their current parenting. In doing so it builds upon the findings outlined in the previous chapter and examines how cycles of parenting practices are either rejected or repeated through generations.

Often, as well as reflections upon their upbringing, changes to these women's relationships with their mothers around the time of pregnancy and new motherhood form an important context for shaping their approaches to parenting. Existing literature describes a prevailing notion that pregnancy and the transition towards motherhood are periods in which daughters more closely bond and identify with their own mothers (Fischer, 1991), or at least they begin to measure themselves against their own mothers (Pines, 1972; von Mohr *et al.*, 2017). The findings here are compared and contrasted with this.

Further analysis is informed by the work of Bourdieu (1984, 1986) who posits that cultural capital – values and knowledge, and cultural codes and practices - are transmissible through family socialisation, from parents to children; and that social capital – those resources derived from relationships and social connections – are the result of, and result in, socially negotiated ties. Dispositions and

particular practices can, Bourdieu argues, be carried out with or without consciousness or reflection, and lead to social reproduction with similar patterns observed across family generations (Bourdieu, 1990). It is these reflections and repeating of patterns, both conscious and unconscious that are outlined here.

This chapter goes on to explore how participants discuss instinctive and initial responses being difficult to overcome, despite examples of behaviour on which to model positive parenting practices. It also examines the factors which appear to affect these instinctive responses, as well as how these relate to issues of parental self-efficacy presented in Chapter 4.

Finally, this chapter concludes with case studies which give more detail of three of the participants and their narrative accounts, highlighting several of the key aspects of how practices and experiences during childhood can be seen to reverberate across generations.

6.2 Responses to Experienced Parenting Styles

As all of the women were raised by their biological mother, and not all had a father/father-figure present throughout their childhood, the women who comprise the interview sample were grouped for analysis according to how they categorised their experience of their mother's parenting on the PBI. This is also in line with previously published studies which suggest that a woman's bond with her mother is often the key driver in terms of later outcomes and predicting the transmission of parenting practices (Capaldi *et al.*, 2003a). The sample was divided among those who report experiences of maternal 'optimal' parenting (5); 'neglectful' parenting (6); and 'affectionless control' (8) (see Table 5.2). One participant reported 'affectionate constraint' and her responses are discussed along with the latter group; likewise, with Nicola, who was unable to fill out the PBI. Nicola's narrative is outlined in more detail in Section 6.4.3.

For each of the reported parenting styles experienced, the women's responses provide examples of what they perceive as 'optimal', 'neglectful' or 'affectionless' parenting, as well as a discussion of specific recollections of practices of their mother (and sometimes father). More importantly, it examines the ways in which these women reflect upon these experiences, and how they use these to frame conceptualisations of motherhood and decisions around how they approach raising their own children. Their responses to the style of parenting they experienced are explored, highlighting where there is continuity or discontinuity across generations, and examining the factors which appear to shape this transmission.

6.2.1 'I was very lucky' - Reflections on 'Optimal Parenting'

Table 6.1 shows the five women who reported maternal 'optimal' parenting, along with their referral reason and the number of reported ACEs. Three of the women also reported 'optimal' parenting from their father. As discussed in the previous chapter, Section 5.3.2, there is an apparent correlation between 'optimal' maternal scores and a low number of ACEs.

Table 6.1: Participants with 'Optimal' Maternal PBI Scores

	Mother PBI	Father PBI	Referral Reason(s)	Number of ACEs
Amy	Optimal	-	Mental health difficulties; homelessness	1
Caroline	Optimal	Optimal	Mental health difficulties (post-natal depression)	1
Gemma	Optimal	Optimal	Extra support required	0
Julia	Optimal	Optimal	Young mother; mental health difficulties (Previous eating disorder and self-harm)	0
Lorraine	Optimal	Affectionless Control	Mental health difficulties	1

Caroline, Gemma and Julia reflect on a very happy and positive experience with both their mother and father. Amy did not know her father and did not consistently have a father figure around during her childhood. As described previously, while Lorraine's relationship with her mother remained positive throughout her upbringing, her relationship with her father changed dramatically. 'Optimal' parenting is experienced by these women as being

supportive, kind, caring, and largely absent of any physical discipline or aggression.

> *My childhood? It was really good, it was a really good childhood – I was very lucky; they were just really good, they, I don't remember ever being shouted at or anything like that or… they were… just really nice, caring people ma mum and dad, really erm accepting of anything as well, really understanding; I think it has affected me positively erm… because I kinda take what they, how they brought me up, with ma kids as well; I feel like I have got good attachments and stuff like that.*
>
> *I'm quite a balanced person wi' ma emotions and stuff; I know people that haven't had a really good childhood and their mum's had addictions or they have been abusive and the way they are- they find it quite difficult to keep healthy relationships and I would hate to do that tae ma children so I just try to be as calm around them and…and erm…just because I don't feel I'm like that, I feel I am, I can build healthy relationships and erm so I just try, hope that they'd be like that.*

<div align="right">

Gemma, 25, 2 children, MB
PBI score: Mother = Optimal. Father = Optimal. ACEs: 0
High self-efficacy

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In line with theories of social reproduction, there are examples where specific practices associated with parents are consciously repeated across generations. Caroline typifies this kind of positive modelling, where parents are held as examples, and specific practices that are markers of a 'good' parent are identified. There is then a conscious implementation of these very same practices with their own children.

> *I had a kinda normal, if you want to say that, kinda upbringing. Like my mum and dad, been married for thirty-five years, they're still the 'gether noo kinda thing, so. We had quite a nice upbringing… it was kinda normal, so to speak. Aye, we never really had any kinda, nae big family dramas or anything like that, it was plain sailing… We're really close. We're probably closer now, now that I'm an adult. But we've always been close, but, do you know when you're a teenager and you're butting*

heads wi' your mum over silly things. But see like the older I've got, the kinda closer we've got.

But I says to [partner], 'that's the way I was brought up and that's the way [son will] be brought up tae', like, you can have your fun times and your happy memories an' that, but you've got to teach them to be decent human beings. Know what I mean, that's what your job is. That's the role o' a parent, isn't it? It's probably been through the standards an' that that ma mam set up when I was growing up kinda thing. And I've kinda went wi' the rules that they kinda set, do you know what I mean? My rules were always the same: you take something out, you put it away. It's your room, you tidy it, you make your bed in the morning. Them kinda things, like. So ma rules for parenting are kind brought off o' what ma mum and dad have raised me wi' kinda thing.

<div align="right">

Caroline, 29, 1 child, MB
PBI score: Mother: Optimal. Father: Optimal. ACES: 1
Low self-efficacy

</div>

Caroline's is an example of this conscious repetition of practices, whereby after reflecting upon their own happy childhood, these women think about how they felt as children and respond in ways designed to provide the same for their own children. For these women, their mother provides a clear template for 'good' mothering and the practices they associate with their mother are adopted, apparently in unquestioned and uncritical ways. Julia expands upon this further, talking about wanting to recreate with her daughter the relationship she herself experienced.

And, I always think that I'd want [child] to feel like that wi' me. Like, I want [child] to have the relationship with me that I do with my mum and dad. Like, definitely… I always said, I'd want to bring her up the way my mum and dad brought me up basically. So, I'm— as long as I'm doing my best, then that's all I can do really. But I'd try my best to make it like my mam and dad did for me.

<div align="right">

Julia, 20, 1 child, ETPB
PBI score: Mother = Optimal. Father = Optimal. ACEs: 0
High self-Efficacy

</div>

Julia discusses how her mental health issues sometimes cause her to feel stress and anger. Her approach – of walking away and not letting her daughter see that anger – is influenced by the fact she never saw her own parents angry.

> *I know some people that get angry and they shout, and they could do whatever, but for me, I'd say I get more upset, like I would never get angry and shout at her ever, like I've never done it, and I never would. I'd get angry and walk away, or I'd get angry and cry. Like, I wouldn't… I couldn't shout at her or deal with it like some, the way some people do, like I don't agree with that, 'cause that's actually making things worse for her as well, like shouting and bawling. And I always think, I don't know if part of the reason that I only have happy memories from my childhood is because my mum and dad never done that to me, so actually, if I done that to her would she remember that.*

<div align="right">

Julia, 20, 1 child, ETPB
PBI score: Mother = Optimal. Father = Optimal. ACEs: 0
High self-Efficacy

</div>

Reflecting upon a generally very happy childhood, with no reported ACEs and reporting 'optimal' parenting from both parents, Caroline, Julia and Gemma attempt to create the same environment that they experienced as a child, in the hope that their children can grow up to be as balanced and happy as they feel they are.

Lorraine said initially she was not reflecting upon her own childhood to inform any parenting approach; for her, the connection between her own experiences and the decisions she made with her daughter was made later.

> *I didn't really reflect. No. it was just kinda, 'Oh my God, I'm going to have a baby'. It was just… it was just pure excitement. That's all it was.*

<div align="right">

Lorraine, 27, 1 child, MB
PBI score: Mother = Optimal. Father = Affectionless Control. ACES: 1
Low self-efficacy

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When she did later consciously reflect, it was framed as both a way of avoiding a repeat of her own experiences at the hands of her father, while holding up her

mother as the desired example. Therefore, there is some evidence that the 'optimal' parent may serve as an example, and their behaviour modelled, while aiming to avoid the negative experiences of the other parent.

> *I don't know, like I try not to lose my temper too much wi' her, because I don't want her thinking that I don't like her, I don't love her, or anything like that. I don't want her thinking that I'm going to hurt her at every turn. It's just… I don't know, I've just never been so in love with a little person than I have wi' her. She's brilliant.*

> *'cause obviously, I don't want tae… ever be violent wi' her, like the way my dad was. I don't ever want her to feel like that and I always said when I had kids, she wouldn't, like they would never, ever feel the way I did when I was around my dad, and they would always feel how I felt when I was wi' my mum, just loved, protected, wanted.*

> Lorraine, 27, 1 child, MB
> PBI score: Mother = Optimal. Father = Affectionless Control. ACES: 1
> Low self-efficacy

Lorraine aspires to recreate the positive experiences she associates with her mother, while rejecting the harsh, violent practices she remembers from her father, hoping that her own daughter has a better experience as a result.

For Gemma and Julia, despite a lack of anger or aggression from either parent when they were younger, both suggest that their attempts to emulate the warm and kind environment they enjoyed is not always easy. For both of them, their parents provide an example to which they aspire but sometimes struggle to repeat. In similar ways, Lorraine aspires to her mother's model of parenting and rejects the violence and aggression of her father; she does though indicate that her mental health issues and stress can cause her to also instinctively react in ways she does not like.

Lorraine, in particular, frames her sometimes harsh responses in the context of issues she faces as a result of high levels of anxiety. There is also a suggestion from Lorraine, which echoes the findings regarding how some of the women felt being physically punished or disciplined, as explored in Section 5.4.1.1. There

the women spoke of only being hit when they deserved it, and of the actions of their parents being driven to hitting them by them as children. Here Lorraine suggests her responses are influenced, in part, by her child's moods and behaviours, as well as by her own anxiety. The difference between a good day and a bad day for Lorraine is often dependent upon the mood of her child.

> *Simon: And, are there some days that are better than others?*

> *Lorraine: Yeah, definitely. Some days she can just get dressed like that, other days it literally is a struggle.*

> *Simon: Mm hmm. And, what makes the difference between a better day and a worse day, do you think?*

> *Lorraine: I really don't know, just her mood, I guess. If she's having a good day, we tend to both have a good day. But, if she's having a bad day, then we both have a bad day. But you, sometimes you can tell in the morning, if she wakes up and she's quite happily singing in her cot, you usually think, 'Right, okay, today's gonna be a good day,' but then within half an hour, she's cranky.*

<div align="right">

Lorraine, 27, 1 child, MB
PBI score: Mother = Optimal. Father = Affectionless Control. ACES: 1
Low self-efficacy

</div>

Despite these 'optimal' examples from her mother by which she measures 'good' parenting, and a stated desire to reject the harsh practices associated with her father, Lorraine is not always able to respond in the ways she wants. For her, this is linked to both her mental health and her daughter's moods and behaviours. Lorraine gives no indication that she is attuned to her daughter's needs or what may be driving her moods; nor does she give any suggestion that she feels able to intervene or moderate these moods. Instead she seems resigned to a bad day if her daughter is unsettled or upset. This subject is explored in more detail with other participants in Section 6.3.

Reflecting also on 'optimal' experiences with her mother, Amy described how her mum was always there for her and supportive, but how the breakdown of her

relationship with her mother when she was 16 years old had led to her being homeless and living in temporary accommodation. She then had no contact with her mother for several months. It was during this period that Amy became pregnant, and it was the news of this which prompted Amy to reconnect with her mother.

> *Once I fell pregnant me and ma mum kind of got back on track, and now… she will come and take [eldest child] and that… yeah because she fell pregnant wi' me at 15 so she kinda like, she knows so; I was 17 right enough but… she really is supportive aye, as soon as I ask her, she will get the bus over.*

<div align="right">

Amy, 19, 2 children, ETPB
PBI score: Mother = Optimal. Father = n/a. ACES: 1
High self-efficacy

</div>

Impending motherhood enabled a reconciliation between Amy and her mother, and a shared understanding of the difficulties involved in raising a child when very young brought them closer.

Unlike the other women who report 'optimal' maternal scores, Amy did mention occasional physical discipline. This consisted of a smacked bottom when she was 'really bad', usually after a couple of warnings. This is precisely the same approach that Amy now takes with her own daughter.

> *On a bad day I might slightly raise my voice a bit, like and not mean it, but - I might shout a wee bit. On good days I will just sit down and speak to her so it's, it just depends… I just try and speak to her and stuff because she is still a bit young [but] like maybe, like if she is really, really bad, you know just a wee [smack], so she knows you can't do that; after giving her a couple of warnings obviously.*

<div align="right">

Amy, 19, 2 children, ETPB
PBI score: Mother = Optimal. Father = n/a. ACES: 1
High self-efficacy

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For each of these women, the perinatal period was a time of increased reflection when they began to consciously think about how they will raise their

children, and the practices they hoped to adopt. This is framed by how they themselves felt when they were children, and their ideas of how to be a 'good' parent are shaped by the recalled examples of their own parents.

The notion of 'optimal' parenting incorporates warmth and support, and for most, but not all, the absence of harsh or physical discipline. Amy and Gemma characterise their mothers as providing 'optimal' parenting, despite the presence of physical discipline, and, occasionally, violence and aggression. This would suggest that an 'optimal' view of parenting is a subjective one, and dependent upon contextual factors. Therefore, parenting that includes the use of physical forms of discipline may still be regarded as 'optimal' if it also incorporates warmth and supportive parenting.

What is true of all of those who describe experiences of 'optimal' parenting, is a clear desire to repeat the practices and recreate the same environments for their own children. However, for three of them, Gemma, Julia and Lorraine, recreating this warm and responsive environment can be hampered by initial responses of anger or aggression which are linked with stress and mental health concerns. As such, despite their clear examples of positive parenting and attempts to actually model the actions of their mothers, they are not always able to parent in the ways they would like.

When one parent provides positive examples and the other does not, there is a rejection of the latter's approach and a focus on recreating the practices of the parent they view positively. When experiences of parenting are viewed positively, there is an apparent conscious, unquestioned adoption of similar practices and no stated desire to look further for examples, advice, or support when it comes to parenting their own children. When physical discipline is incorporated into a wider, warm and supportive environment, it may be viewed as a practice which is part of being a 'good' parent and similarly modelled into current parenting practices.

6.2.2 'She doesn't represent comfort for me' - Reflections on 'Neglectful Parenting'

Six of the participants reported 'neglectful' parenting experiences of their mother (Table 6.2). This includes the three women in the sample who report the highest number of ACEs. This indicates that these adversities are associated with direct experience of 'neglectful' maternal practices, and also that an exposure to wider ACEs is frequently correlated with this lack of maternal care or protection.

Two of these six women also reported 'neglectful' experiences with their fathers; three recalled their fathers as providing 'optimal' experiences. The ways in which this group of women reflect upon these experiences is considered in this section, as well as an examination of how these reflections translate into ideas and decisions around parenting, and the practices these women adopt with their own children.

Table 6.2: Participants with 'Neglectful' Maternal PBI Scores

	Mother PBI	Father PBI		Number of ACEs
Ellie	Neglectful	Optimal	Learning Disability	1
Hannah	Neglectful	Optimal	Mental health difficulties; panic attacks and anxiety during pregnancy	1
Jodie	Neglectful	-	Mental health difficulties; substance misuse (excess alcohol intake before pregnancy)	2
Melanie	Neglectful	Neglectful	Mental health difficulties (anxiety); family history of mental health difficulties; IVF pregnancy	5
Siobhan	Neglectful	Neglectful	Mental health difficulties; family history of mental health difficulties	3
Suzanne	Neglectful	Optimal	Looked After Child status; death of her mother during teenage years. Mental health difficulties	5

For Ellie, her recollections of her 'neglectful' mother are characterised by stubbornness, conflict and confrontation. Frequently clashes between the two of them would become physical.

> *Oh my god, she was a hitter, like spank the wean because that's what you do, I still have arguments wi' her about that to this day man… oh a smacked arse usually, oops, but it ended up that I'd lose the rag and try and hit her back and then she would be like: 'don't hit', and I'd be like but you hit me so, I'm gonna hit you back and that was how it, it usually escalated until there was slammed doors and screaming.*

> Ellie, 29, 1 child, MB
> PBI score: Mother = Neglectful. Father = Optimal. ACES: 1
> High self-efficacy

Ellie suggests, like others, that becoming a mother herself was a time of increased reflection upon her own childhood, and that this has led to a greater understanding between her and her parents. Nonetheless, despite this improvement in their relationship, Ellie frames her approaches to parenting as in opposition to those she herself experienced.

> *So there's been a lot of like self-reflection and like understanding going on between me and ma mum and dad as well, especially since like I've had a kid, I'm like right, I get it - 'cos before that I was like oh why you doin' this… aye but it is just strange how quickly you, well, get it, it is like 'oh right, I see'. I am realising wee bits of myself now that are dead similar to my mum and I am like oh my god… some ways I try and be different and then other ways it is just that ingrained, it is done before I have kinda realised.*

> *[But] especially wi' the hittin', I'm not hittin' mine, I'm not shoutin' at them, I'm no doin' this and that. Ma dad and ma mum cannae get their heads round it; but they're coming up for 70 noo so I think they are just set in like that's the way it has always been done and I'm being presented wi' a completely different way of parenting now, and they are just so befuddled wi' it all; but definitely wi' her I'd rather explain what's upset me first and try and get [her] to understand what it is*

that's went wrong before I just start shoutin'. Because it is dead confusing, I was sittin' thinking what had I done, I hadnae realised what I had done was wrong and then I was just like getting a skelp [getting hit] *fae it.*

Ellie, 29, 1 child, MB
PBI score: Mother = Neglectful. Father = Optimal. ACES: 1
High self-efficacy

Becoming a mother led Ellie to reflect upon her upbringing and as a result she now feels she understands the things that drove her parents' actions in a way that she was not previously able, but at the same time she hopes to parent in different ways to her mother. Like Gemma, Julia and Lorraine previously, Ellie talks of an occasional instinctive angry or aggressive response to her child, a response which is 'ingrained'. While for Gemma, Julia and Loraine this initial response is framed as being in spite of their 'optimal' experiences, Ellie frames this as an unwanted repetition of her mother's actions. Ellie's case also further demonstrates that the perinatal period is often a time when reflections are more acute, as well as often being a time when these women's relationships with their parents undergo significant changes.

For Jodie, her framework for motherhood and approaches to parenting are not only in opposition to the experiences she has from childhood, where Jodie was expected to help around the house while her mother was at work, but also in contrast with how her mother tells her she should be parenting her children.

I wouldnae want [eldest child] to be lookin' after her wee sister while I was oot working for instance, erm...I don't think a child should have that amount of pressure on them, a child should be a child in ma view and ma mum just thinks I baby them, ha, I molly coddle them, I've got them wrapped in cotton wool; but they are only kids, she is only one and a bit and she is only 7 so let them be kids, aye I'll get her tae make her bed but I'm no getting' her hoovering or doing dishes or things like that at this age.

Jodie, 38, 2 children, CaU
PBI score = Mother: Neglectful. Father = n/a. ACES: 2
Low self-efficacy

Similarly, when characterised by high levels of adversity, and lacking any parental warmth and affection, as in Melanie's case, parenting can be framed in opposition to one's own experiences, and also in such a way as to provide a second opportunity at a 'family life' that was previously absent. Again, this was something Melanie felt acutely when faced with becoming a mother herself.

> *But obviously, once I had her [daughter], I started looking back and thinking; it was more about like… well, I think that just, the instant love that you have for them when they're born. And I think, I can't imagine my mum and dad being that way. Like, I don't have any baby pictures o' myself' and stuff. There's no keepsakes or anything, there's no kinda memories from any of us as a child and stuff like that.*
>
> *I think, 'cause I have my own child and it's kinda a way of kinda putting the wrongs right, kinda thing, like… I suppose it's like having your kinda family life that you never had, like back in the day… for me, it's like giving her what I never had, and just no' doing the same mistakes that they did as well.*

> Melanie, 36, 1 child, ETPB
> PBI score: Mother = Neglectful. Father = Neglectful. ACES: 5
> High self-efficacy

Melanie articulates resentment that the instant love and affection she felt for her own daughter was never evident to her from her own parents. Having a child of her own could be seen as serving to highlight the issues in this relationship, rather than bringing her and her parents closer. In Melanie's case, this reflection reinforced her desire to distance herself from the practices of her parents and her response was to adopt a very different approach with her daughter.

Although on the surface Hannah's childhood circumstances were markedly different to most, being raised in a professional, highly educated and affluent family, with no reported violence or physical discipline, and her parents' divorce her only reported ACE, she has also taken direct steps to avoid repeating behaviours she experienced with her mother. This was a motivating factor in referring herself to THRIVE and being keen to engage with the ETPB programme.

Yeah, and I think there was a fear for me that I would display some of the same behaviours. Like being impatient, shouting, you know, I really didn't want to be like that. So, that's why I wanted to do that course [ETPB]… I'd say fundamentally, it [her upbringing] does affect my parenting decisions because I do think about what I'm doing a lot, and I probably think about my parental relationships a lot still, even now, — even though I don't live near my parents, I probably daily, I think, I'll think back to something and think about it.

<div align="right">

Hannah, 33, 1 child, ETPB
PBI score: Mother = Neglectful. Father = Optimal. ACES: 1
Low self-efficacy

</div>

For Hannah, her decisions around how she approaches parenting are also in response to her reflections upon her own situation and her relationship with her mother. Perhaps more than most, Hannah demonstrates a deep level of reflection and critical analysis, which has led to an explicit desire to break these cycles with her daughter.

I'm lacking a… I… my mother isn't the person that I'd go to if I didn't feel well, or you know, I was necessarily… I'd go to her for advice if I'm having a hard time, but she doesn't represent comfort for me, necessarily. But, I'd quite like to be like that [for her daughter] … I guess deep down, I knew I wasn't like that anyway, and I'm more of a, I don't know, I'm not the same personality and I haven't had the same experiences, but I just know that, you know, the way, when you grow up, your childhood can affect you in a lot of ways, and I just didn't want to… I didn't want that to affect my child as well. So, it's like breaking that kind of cycle, I guess.

I think [her mother being critical] made me very questioning of myself and not very accepting of myself… Yeah, I think it affected my confidence and my self-esteem a lot. I feel like I don't want to be a really intense parent.

<div align="right">

Hannah, 33, 1 child, ETPB
PBI score: Mother = Neglectful. Father = Optimal. ACES: 1
Low self-efficacy

</div>

Hannah's describes 'intense' parenting from her mother, characterised by pressure, criticism, lack of affection and resulting low self-esteem. Her fear of fear of continuing this cycle with her own daughter has led her to frame her approaches to parenting in opposition to those of her mother, and further to seek support to make sure she does not repeat these practices.

In contrast, and indicative of the differing levels of conscious awareness regarding reflection across the sample, Suzanne, like Lorraine earlier, initially said she had not reflected on her own childhood when she became pregnant.

> *Not so much, I guess. I just… I guess I didnae really think aboot it … my childhood, much at that time, I was just like straightaway focused on, 'Right, what am I gonnae do?' Like, 'How am I gonnae do this?' type thing, as opposed to thinking negatively. I was just, like… I knew how I was gonnae parent and what I wanted to do and how I wanted tae achieve it, and so that was it. Maybe, I guess, I did think aboot the past and that's how I came to them conclusions, but I remember just thinking aboot, right, this is it, this is what I want to do so…*

> Suzanne, 27, 2 children, ETPB
> PBI score: Mother = Neglectful. Father = Optimal. ACES: 5
> High self-efficacy

Here Suzanne frames her decisions around parenting as being decisive about what she does want to do rather than avoiding the negative aspects of her upbringing, namely her mother's difficulties in parenting in light of her issues with alcohol. However, at the same time, she indicates that maybe her decisions around how to parent and to achieve what she wants for her children are in response to her reflections upon her childhood. In this way, Suzanne is drawing upon her own experiences when it comes to informing her parenting decisions, but not in any conscious way.

She goes on to describe wanting to create a different environment for her children, and points to specific examples of things she hopes to avoid.

> *I want to give them stuff. Like, I try and gi' them as much cuddles as much as I can, like, do you know what I mean? I try and be there as much*

*as I can. I don't allow alcohol in the house or anywhere near them… I
didn't want anybody who was under the influence o' alcohol around the
kids… I guess just a bit more loving and a bit more caring. Bit more
stable, non-violent. No… it's a bit mair, like, you know, [daughter] knows
what she's getting up tae in the morning. She knows that she's alright to
come in and we're no' gonnae hit her or stuff like that.*

Suzanne, 27, 2 children, ETPB
PBI score: Mother = Neglectful. Father = Optimal. ACES: 5
High self-efficacy

As with Melanie, Suzanne's approach with her children is framed by giving her
children the things that she says she feels were absent during her childhood –
affection, stability, dependable parents – and making sure her children do not
experience violence or aggression or come into contact with alcohol or anyone
affected by it. In this way she also conceptualises 'good' parenting and her
approach to it in direct contrast to the things she experienced with her own
mother.

Ellie, Hannah, Jodie, Melanie, Siobhan and Suzanne all describe their
'neglectful' experiences with their mothers as lacking warmth, care and
support. For them, their own mothers were not nurturing; in the case of Melanie
and Suzanne they were largely unable to provide the affection and care needed
due to addictions to alcohol. For all of the women who experienced 'neglectful'
environments and practices with their own mother, their reflections have led
them to respond by framing their approaches to parenting in direct contrast with
their own upbringing.

There is a clear desire by all of them to provide the stability, dependability and
consistency they felt were lacking, as well as a hope to be more caring, tactile,
affectionate and loving than their own mothers. Where these women did
experience physical punishment and discipline, this is viewed alongside a wider
'neglectful' environment and all of these women outwardly reject the idea of
employing any kind of physical approaches with their children.

When these women's childhoods are characterised by maternal 'neglect' – both emotional and physical – decisions around parenting approaches and practices are framed as in opposition to those they identify with their own mother. For them, being a 'good' mother means avoiding a repeat of these perceived mistakes and failures. This can be as a result of a conscious reflection and critical assessment of their own upbringing. Positioning one's self to parent in very different ways to one's own mother is also framed as an opportunity to provide their children with things they felt were absent in their own childhoods.

There is also some evidence that indicates that, despite best intentions and a conscious effort to avoid repeating negative practices, sometimes an ingrained response is difficult to overcome. Therefore these women may actually respond to their children, on occasions, in the similar ways to their parents.

Where they lacked the warm and supporting role model in their own mother, these women sought and identified other sources to provide them with the appropriate support, advice and examples they needed in order to provide such things to their own children. For Ellie this was modelled on her father's behaviours; for Hannah she sought professional support and advice from ETPB, and also researched other opportunities. Suzanne and Melanie, and also Ellie, take their example from their partner's family, to whom they say they are very close, and it is to their respective partners and his mother that they turn when they need help. They also articulate that their partner's mother demonstrates warmth and affection, and that the relationship their partners have with their mothers provides evidence that they serve as good role models for parenting.

Siobhan provides the exception here, in that since she had her son and returned home after living overseas, her and her mother now have a 'great relationship' and her mother is her main source of support and parenting advice.

For all of the women discussed in this section, the period around becoming a mother was one of reflection upon their own upbringing. Their response to this reflection was to adopt parenting practices in opposition to their own experiences, designed to avoid mistakes and provide different experiences for their children. Hannah and Suzanne perhaps represent both ends of a scale of this level of reflection. While Hannah was determined to critically engage and

take active efforts to prevent herself repeating the negative aspects she associated with her mother, Suzanne feels she did not consciously reflect. Nonetheless identifying an absence of things in her childhood, and a model of what not to do, informed Suzanne's approaches to parenting and what she wanted for her own children.

6.2.3 'It was hard for me growing up… I think that made me want to be so, so much better' - Reflections on Parenting Characterised by 'Affectionless Control'

This section outlines the responses from the other half of the sample – the eight women who recalled 'affectionless control' from their mother, as well as Angela who recalled 'affectionate constraint' and Nicola for whom no PBI data was available (see Table 6.3). Where the father was present these women reported a range of experiences of paternal parenting style. Generally they represent the lower end of experienced adversities, with most reporting none or one ACE.

Almost all of these women - Catriona, Emma, Kerrie, Leanne, Pamela, Sinead, Angela, and Nicola - spoke of adopting parenting practices based upon wanting to avoid repeating at least some of their recalled negative aspects from childhood. However, they are generally more likely to take an ambivalent approach than those with 'neglectful' experiences and identify some positive practices they wish to repeat.

Table 6.3: Participants with 'Affectionless Control' and 'Affectionate Constraint' Maternal PBI Scores

	Mother PBI	Father PBI		Number of ACEs
Amanda	Affectionless Control	-	Supports partner with mental health difficulties; traumatic birth experience with first child	0
Andrea	Affectionless Control	Optimal	Mental health difficulties (history of depression); history of molar pregnancy; genetic carrier for undisclosed hereditary condition	1
Catriona	Affectionless Control	Optimal	Looked After Child status - social work involvement as a teenager due to violence within the home; diagnosed with Asperger's; depression and anxiety during and after pregnancy; young mother	3
Emma	Affectionless Control	Affectionate Constraint	Mental health difficulties (dissociative disorder); social work involvement	1
Kerrie	Affectionless Control	Affectionate Constraint	Mental health difficulties (depression and anxiety)	0
Leanne	Affectionless Control	Affectionate Constraint	Mental health difficulties	0
Pamela	Affectionless Control	Neglectful	Mental health difficulties (depression and post-natal depression - has perinatal mental health team involvement)	1
Sinead	Affectionless Control	Affectionless Control	Mental health difficulties (anxiety); IVF pregnancy (conceived after 6 years)	2
Angela	Affectionate Constraint	-	Mental health difficulties; history of sexual abuse; partner prescribed methadone for addiction recovery; social work involvement	2
Nicola	-	-	Mental health difficulties (depression and anxiety); substance misuse	1

6.2.3.1 Rejection of Parent's Practices

The narratives of these women are framed in similar ways to those who talked about experiencing 'neglectful' parenting, in terms of wanting to avoid some negative aspects of their own upbringing. Emma's experiences of early motherhood have been characterised by tension between her and her family, with her new son placed at the centre of existing family disputes. Emma spoke of attempts by her own parents to dictate how she should raise her new son, and how she rejected this because of her resentment over how her parents had raised her. Emma spoke of extreme, long-term difficulties in her relationship

with her parents and their attempts to control her. She attributes these difficulties, and their desire to control her, to her ongoing dissociative disorder.

The rejection of their advice and involvement, and a desire to assert independence and parent in her own ways, prompted another family argument. Since then Emma has cut all communication with her parents and refuses to let them see her son.

> *I really dislike [my father] … going towards hate, 'cause the last argument we had, he said that I'm not fit to be a mother, I'm not good for Ryan [son], Ryan can do so much better. And yeah, it's like Ryan's better off wi' his… his father. I came out of an abusive relationship with Ryan's dad, so it's like he's better off wi' me than what he is wi' him. I… don't know if I'll ever speak to them again, if when Ryan's older he wants to like see them, meet them again, then he can.*

Emma, 23, 1 child, MB
PBI score: Mother = Affectionless Control. Father = Affectionate Constraint. ACES: 1
High self-efficacy

From this we can see that Emma's already difficult relationship with her parents broke down around the time she became a mother, and her decisions around her son are very much at the centre of these disputes. In this way, Emma's experiences of pregnancy and early motherhood, as well as her decisions regarding her son, have been characterised by a negative change in her relationship with her own parents. Like in Melanie's case, this time of transition is viewed negatively, reinforcing existing difficulties, and is a time of acute awareness of pre-existing issues. Crucially, this negative view of the relationship they have with their own mother can be seen to shape their conceptualisations of parenthood, and this informs their outlook when it comes to decisions and practices with their own children. In both these cases, Melanie and Emma draw upon the 'poor' examples of their own parents, something which they are now more acutely aware of since becoming mothers. They point to this as something they are keen to avoid repeating. Both indicate that their conceptualisation of parenting is framed as being in opposition to their own experiences.

However, others in this group demonstrate more willingness to accept and repeat some of the practices they remember from their parents, and reject others, rather than the apparently more complete rejection displayed by Emma and those with 'neglectful' parental role models. Angela, who experienced continued sexual abuse as a child, and Catriona, who experienced repeated physical abuse, can be seen to be consciously reflecting upon their upbringing and how they felt as children. Both frame their approaches with their children in response to these experiences and make definite decisions to give their children better experiences by providing what their parents did not.

I think 'what did I want as a child'? I wanted to feel safe, secure and happy, so I have spoiled [son] because he was the only one there for a while.

Angela, 33, 2 children, ETPB
PBI score: Mother = Affectionate Constraint. Father = n/a. ACES: 2
High self-efficacy

It was hard for me growing up as a person, but I think that made me want to be so, so much better, and give my kid so much more, do you know what I mean?

Catriona, 22, 1 child, MB
PBI score: Mother = Affectionless Control. Father = Optimal. ACES: 3
Low self-efficacy

Despite framing her parenting as in opposition to her own mother, Catriona, like others discussed before, also recognises that she often finds herself instinctively, and unwantedly, responding in similar ways.

I can understand my mum's point of view now that I'm a parent… [but] things that like my mum done or things that my mum still does or says and it's the type of thing I do, and [partner]'s like, 'You're so like your mum it's unbelievable. Like you need to stop that'.

Catriona, 22, 1 child, MB
PBI score: Mother = Affectionless Control. Father = Optimal. ACES: 3
Low self-efficacy

Now that she is aware of these instinctive responses, Catriona feels like she should avoid repeating them, especially since she feels her mother is not a good role model for such things, describing her as she does as 'not at all maternal'.

6.2.3.2 Ambivalent Responses to Parent's Practices

Being a mother of two toddlers and having to face decisions about discipline and reprimanding her two boys has led Kerrie to reflect upon how she felt as a child, and things she disliked.

> *It has just made me think about when you hear yourself saying things and doing certain things and you think oh that's what my parents used to say, I don't believe I'm actually saying that; and lately I have been thinking about actually how I responded or felt about that as well and things I didn't like, and trying to think why I didn't like them - now that we are broaching these things it is really making us think well what did we like and what didn't we like - but you've never dealt with these kind of situations before and erm I definitely do think your upbringing affects how you naturally go to handle things initially… I think memories are coming back to me and I'm analysing what's happened before and why I feel like that … but erm yeah there's just things we didn't particularly like, or we don't like about our relationship with our parents.*

Kerrie, 40, 2 children, MB
PBI score: Mother = Affectionless Control. Father = Affectionate Constraint. ACEs: 0
Low self-efficacy

This reflection has informed Kerrie's decisions when it comes to parenting practices, with a desire to recreate the things she liked while avoiding repetition of the things she did not. Again, as with others, this is also tempered by the fact that initial reactions and instincts might be difficult to overcome.

Leanne's case demonstrates further the ambivalence and complexity in this process, in contrast to the more decisive accounts previously described. Leanne explains that while she feels her parents are not the role models that she herself looks to for parenting, there are elements of the parenting she experienced which she feels were good, and for which she is grateful.

> *I… I don't obviously like the way I'm probably gonna word this, I kinda learned how I don't want to parent. Not that my parents got it utterly wrong, there's nothing wrong with me, there is… I'm quite level-headed, I have good… I would like to think, quite good morals, good manners. I'm a pleasant person. But I don't want to be as shouty, I don't want my children not to feel that asking questions are not allowed.*

> *I've learnt it along the way, because there's been points where I have turned round to my husband and I went, 'I'm my mum. I'm my mum. This is awful'. And he's going, 'But why's that bad?' 'cause my husband knows my mum is a lovely woman, she is lovely. I'm going, and this sounds awful, but it's all the bad bits about her… I'm shouting, I'm screaming, and there's no point to this.*

Leanne, 33, 2 children, MB
PBI score: Mother = Affectionless Control. Father = Affectionate Constraint. ACEs: 0
Low-self-efficacy

The realisation that she was shouting and screaming at her two children, just as her own mother did with her, has led Leanne to reassess her responses. She now works to avoid conflict and has become more relaxed as a mother, she says, trying to shout less and walk away when she is angry. Leanne reflects here on the conflict between herself and her mother and, after recognising her own repetition of these traits, she has altered her practices in an attempt to ensure her son does not feel the same, and can have a better relationship with his parents than she did with her own.

> *Me walking away right now and just leaving him is probably far better for our relationship than me going, 'Well that's not a nice thing to say. How dare you say that to me? Go and sit on the naughty-' I don't want to be in a conflict with my son from this early stage, because I kinda see that my*

mum and I were probably at that conflict from the moment I could start really talking. So therefore, I'm kind of going let's really be aware of what you're doing here, because I want him to… come to me and his dad and go, 'I am not happy. What can… what do I do?' And actually come… whereas I was fearful going to my parents.

Leanne, 33, 2 children, MB
PBI score: Mother = Affectionless Control. Father = Affectionate Constraint. ACEs: 0
Low-self-efficacy

At the same time, she is also able to recognise positive aspects that she is keen to repeat.

Like my parents, as we were younger, would read to us, and then there was… and kinda instilling that it was good to kinda sit and read. Something that I still do before bed is read a book. Regardless of if I've read it a million times. So I kind of make a point of reading, and that this is something that I already have started with both of them.

Leanne, 33, 2 children, MB
PBI score: Mother = Affectionless Control. Father = Affectionate Constraint. ACEs: 0
Low-self-efficacy

Leanne has recognised that she was using the same responses and practices her mother used to demonstrate, and she has also made the link between these practices and the difficulties that she feels exist in the relationship between her and her mother as a result. Moreover, she has made a decision to alter her own parenting practices in a conscious attempt to make sure that her relationship with her son is not affected in the same way, and he has a better experience than she did. Simultaneously she attempts to recreate the specific practices she views positively.

Pamela's case also highlights further complexities. Pamela talks about a difficult and unhappy relationship with her parents, both past and present, and how this impacted upon her not being able to parent in the 'right way'. Pamela characterises her childhood as one lacking any warmth or affection, and this has led her to reflect on a cycle of events that she wishes to avoid with her own children.

Pamela feels her parents struggled to demonstrate love and affection with her because of the way they were raised, and for her, their failure to 'correct' that cycle is a further source of unhappiness and resentment.

> *If that were me I could only hope that they think themselves 'goodness that was the way we were brought up so that will never happen to our children' kind of thing, that's what I think for mine, so why did they not think that for us you know as children, you know, it is quite annoying that they do.*

> Pamela, 40, 2 children, MB
> PBI score: Mother = Affectionless Control. Father = Neglectful. ACEs: 1
> High self-efficacy

As such, she is conscious of making different decisions with her two children, while also demonstrating a desire to not reject all of the behaviours she recalls.

> *Well I can tell my children I love them, you know, my parents never told me they loved me – never once, so erm… [cries] …and I don't feel embarrassed to tell them. I think they almost felt embarrassed to tell you that kind of thing.*

> *I mean as much as the way I was treated as a child there was always good family values as well like cook your own food, erm, making stuff tog[ether]-, erm being polite and well mannered, speaking properly, you know all these things, we were taught all these things to do as children from my mum so, so I got a lot of things from obviously being brought up by my parents you know.*

> Pamela, 40, 2 children, MB
> PBI score: Mother = Affectionless Control. Father = Neglectful. ACEs: 1
> High self-efficacy

Pamela found the time around the birth of both her children difficult, in part because of the emotions that this stirred up regarding her own childhood.

> *I think when I had my daughter erm all your emotions were there and a lot of things come flooding back like your childhood, you know you start to, when I was pregnant I started to think I will not be doing this, and I*

will not be doing that and I will be saying this and treat them like this, and I won't ever do this, and you know these things went through my mind with the depression, it was probably just before I had my daughter… erm… before I had my daughter and quite quickly after I had her that's when I started to feel I didnae want to go out the house.

Pamela, 40, 2 children, MB
PBI score: Mother = Affectionless Control. Father = Neglectful. ACEs: 1
High self-efficacy

Pamela feels her depression and low self-esteem are linked to the way she was parented, and despite these difficulties with post-partum depression and further ongoing periods of depression, she is determined to demonstrate love and affection with her own children. However, she also concedes that this depression sometimes means that this is difficult to achieve, and it is often a barrier to her being the parent she would like to be.

[Daughter] is really quite demanding at times because of the type of personality she has you know, very outgoing and she will talk to you and have wee conversations so when she is bad or doesn't do as she is told, …speaking to her - sometimes [during depressive episodes] I can't talk to her you know, it is like do this now or stand over there or don't do that, you know, it is like quite an… aggressive thing, I don't speak to her the right way… I mean I have tried to keep calm but sometimes she is just push, push, push you know so, I am quite conscious.

Pamela, 40, 2 children, MB
PBI score: Mother = Affectionless Control. Father = Neglectful. ACES: 1
High self-efficacy

Both Leanne and Pamela recognise in themselves an instinctive repetition of their mother's behaviours, and both link their low-self-esteem and depression to the way they were treated by their parents. While Leanne talks in terms of overcoming these instinctive responses, Pamela still sometimes finds herself responding harshly to her children. Therefore, even when there is an explicit recognition of patterns that they wish to avoid, and efforts are made to address this, it is possible that these instinctive responses and other contextual factors like mental health issues, may serve to undermine these attempts and lead to precisely the behaviours they seek to avoid.

The more practical and specific practices that Pamela and Leanne feel are of value and importance are distinguished from the other general aspects which made them feel they were not always treated well, and these positive facets of parenting are the ones they seek to incorporate into their own practices. This would indicate that despite responding by adopting approaches to parenting that are different to one's own parents, there is not a total rejection of all aspects of the way they were raised. Rather, there is a rejection of the overall parenting environment, but a retention of some of the practices they view positively.

6.2.3.3 Modelling of Parent's Practices

The women discussed above appear keen to parent in very different ways while still retaining some aspects of their own parent's practices. Others who experienced 'affectionless' upbringings do, however, see their mother as their model for parenting. Alongside Andrea, Amanda is the only other participant in this group who has embraced all aspects of her own experiences, and her approaches to parenting are very much modelled on her mother and her grandmother.

> *Well ma mum was a single parent, I mean she brung four kids up on her own and she did the best she could and I've had a good childhood, and I think, well she says when I had kids, she is like remember what I done wi' you, you dae it wi' them and it is just what I've taught the noo is what ma mum's taught me so … but everything I know today is due down tae ma mum, she's taught me how to deal wi' them and how to change them, walk away if they are annoying me or screamin'.*

I think it is just the way I was raised and obviously how ma mum raised me and how ma gran and granddad looked after me, I think it has just been o'er the years I realised what ma mum and ma granny did, and I was like well they done it fine then maybe I'll follow their footsteps and maybe my weans will come out fine, yeah.

Amanda, 23, 2 children, MB
PBI score = Mother: Affectionless Control. Father = n/a. ACEs: 0
Low self-efficacy

In the extract above, Amanda attributes everything she knows about raising children to her mother and grandmother, including very practical issues like changing of nappies and dealing with tantrums. She talks about how she sees no reason to do anything differently, since she turned out 'fine'. Therefore by continuing the parenting practices of her own mother and grandmother, and modelling their behaviours, she feels her own children will turn out fine too. She goes on to discuss how she feels a lot of her mother's 'controlling' practices were driven by a desire to keep her from trouble with alcohol and other drugs, and how this has also shaped her own views on parenting her two daughters.

I will try ma best for them no to go near them, no to touch stuff like that. I never touched stuff like that so why should they, but obviously it depends how I raise them compared to what mum raised me, or if I try ma hardest try to stop them fae doin' it but if I dae I just have to wait and see.

Amanda, 23, 2 children, MB
PBI score = Mother: Affectionless Control. Father = n/a. ACEs: 0
Low self-efficacy

Amanda also spoke of a greater understanding and improved relationship with her mother when her own children came along.

[The relationship] wasnae very good to start wi'… and me and mum were at each other like a bear wi' a sore head, and then I think ever since ma granny died, we came closer and ever since I've had ma two daughters we've came [even] closer…

I realise noo what ma mum's going through and what she's been through 'cos I've had weans of ma own, and that's what ma mum said, she says you'll soon realise and you won't understand what love is, what mother daughter love is until you have weans of your own, and obviously I had weans of ma own and I don't think I've ever said a bad word against ma mum again.

Amanda, 23, 2 children, MB
PBI score: Mother = Affectionless Control. Father = n/a. ACEs: 0
Low self-efficacy

For Amanda, the arrival of her children led to a greater understanding and signalled a positive change in the relationship with her mother. Where she had previously described a challenging relationship, becoming a mother herself brought about a distinct change and made her and her mother much closer.

Crucially, Amanda's case highlights the evident complexity, whereby a previously difficult and challenging relationship with a mother characterised by 'affectionless control' forms the basis of her own parenting practices. Amanda's view is that despite her descriptions of deprivation and difficulties during childhood, and a sometimes-turbulent relationship with her mother, she nonetheless had a 'good childhood' and 'turned out fine'. Her ideas around parenting are modelled directly from her own mother, and these ideas are formed in the context of a changed and much-improved relationship with her mother when she herself became a parent.

Where those who recall 'optimal' experiences largely respond by attempting to recreate these exact things with their own children, and those with 'neglectful' experiences reject all aspects of this parenting, those with mothers categorised by 'affectionless control' can be seen to respond differently. These women may reject the kind of parenting environment they experienced when it comes to approaches with their own children, but they are able to identify specific practices that have value and are worth repeating. Where there is a total acceptance of their mother as a model for their own parenting (Amanda) or a total rejection (Emma), this is influenced by mental health concerns and crucially the nature of the current relationship they have with their mother and may not necessarily be linked to a reflection upon childhood experiences.

6.3 'You don't know, you just might end up with a naughty child' – Parental Self-efficacy and Responses to Children

This section explores in more detail how some of these women describe their parenting practices and their responses to their children. This builds upon the suggestion that, as discussed throughout this chapter, instinctive and initial responses may be difficult to overcome, and explores similar responses to Lorraine's in Section 6.2.1, where she talks of her parenting in terms which may be described as more reactive than responsive. It also brings the voices of these women to the quantitative findings around parental self-efficacy outlined in Chapter 4, Section 4.4.2.

There is a widespread acceptance from all of the women, irrespective of how they were parented themselves, that parenting is a difficult and complex task, and one that is sometimes influenced by their children and their personalities. Even where conscious reflection upon their own upbringing takes place, and deliberate decisions are made regarding how they intend to parent their own children in light of this, most of the women describe parenting as something that cannot really be understood until you are actually a parent. This sentiment is captured by Sinead.

Everyone's a perfect parent aren't they? Until they have a child.

Sinead, 40, 1 child, MB
PBI score: Mother = Affectionless Control. Father = Affectionless Control. ACES: 2
Low self-efficacy

For Andrea, Kerrie, Julia, Hannah, Sinead, Siobhan, Suzanne, Ellie, Leanne and Angela, irrespective of whether they feel they want to model their approach on their own mother or entirely reject that, there is a discourse around responding to their children and their needs and feeling confident in learning from the child. Often this is also about learning from things they did with their first child, while recognising that the same techniques may not always be successful at different times or with other children. In these ways they adapt and respond in ways that is sometimes framed as 'trial and error' (Angela), 'winging it' (Suzanne) or 'learning as you go' (Leanne).

As Hannah describes, thinking about the impending birth of her second child, there is an acceptance that you may have to just wait and see.

> *I think you just have to react to what they are and who they are and how they behave… I couldn't have understood that before I had children. Again like, as I say, you're trying to read up on everything, but really… you can get advice and blah, blah, blah, but you just have to kind of respond to them. This baby might need completely different things from me, it might be a really clingy baby, you know… I don't know what he's going to be like, so… I mean, I know we won't always be perfect and stuff, but I'd like to think if we can, yeah, be reflexive about it, I guess.*

> Hannah, 33, 1 child, ETPB
> PBI score: Mother = Neglectful. Father = Optimal. ACES: 1
> Low self-efficacy

Recalling aspects of her sometimes harsh and controlling mother, Sinead discusses how, despite vowing to be 'better' than her own mother, her attempts to avoid repeating these things with her son have perhaps led to her overcompensate and make mistakes.

> *But you know I've got to remember he's his own wee person as well, so, you know, he's not an extension of me or [partner], he's him. And you've gotta give him a little bit of free reign to kind of be himself, while sort of guiding him… he's been going through a wee bit of sleep regression at the moment, and [partner] thinks I'm a complete mug, because I won't let him cry it out. And you have to, but I can't hear him in distress, I just can't. So, that's probably a mistake. They say you can't spoil a baby, but you can spoil a toddler, and perhaps I'm spoiling him. Yeah I'm a total softy, yeah, uh-huh, yeah. He's the boss, definitely. No, I try not to indulge him too much, honestly, it's just, it's, how do I describe myself? Probably, not as confident in my own abilities as I should be. Honestly, like any mum, I'd do anything to keep him happy and safe, but, I don't know, I just kind of, I doubt myself a lot.*

> Sinead, 40, 1 child, MB
> PBI score: Mother = Affectionless Control. Father = Affectionless Control. ACES: 2
> Low self-efficacy

Sinead's example highlights how a responsive approach, coupled with a low sense of self-efficacy, can lead to parenting that she herself seems to characterise as permissive, to use the terminology of Baumrind (1968).

Sinead feels she is being a permissive parent and making mistakes, but it is nonetheless important to her that she is responsive to her son and his needs, in contrast to her own experiences, and it is this overriding factor which drives her parenting approach. Sinead is typical of those (Julia, Hannah, Sinead, Siobhan, Suzanne, Ellie, Leanne and Angela) who talked of the importance of reacting to their children in these warm and responsive, although sometimes arguably permissive, ways. Each of these women drew upon their own experiences with their parents, either as a model they aspire to recreate, or an example of what to avoid.

While these women represent those who describe attempts to create a warm and responsive environment, Amy, Andrea, Emma, Pamela and Lorraine talk of finding this difficult and demonstrate much lower levels of confidence in their own parenting. In these cases, the result is not always warm, responsive or perhaps permissive parenting. Rather, these mothers' descriptions, alongside field notes taken immediately post-interview, suggest that they are more reactive to their children's moods and behaviours. Coupled with anxiety, depression and other mental health concerns, this can sometimes lead to more harsh and aggressive responses.

In similar ways to those described by Pamela and Lorraine (above), Emma and Andrea also talk of occasions where they respond in a harsh manner to their children. Emma, from whom we heard earlier in this chapter, lives with dissociative disorder and took the decision to cut all ties with her parents soon after her son was born.

> *Simon: And so that sounds like quite a stressful… do you feel like you're coping? Because it sounds like you've got a lot to do on your own, and you're…*
>
> *Emma: It can… it can be stressful, because I am doing it all on my own. But it's one of those ones where it's like, when there's days where he's*

just so moody, I'm ready to rip my hair out. And then the next day is just, he's happy, just running about, jumping about, he's happy. And it's just, it's like those days just help calm me and things, but-

Simon: Okay. And what do you think is the difference between a good day and a bad day? So you said he's sometimes moody, what do you think… what do you think causes that?

Emma: Doesn't get his own way. Like that… he's throwing a hissy fit the now because he's… I've just took those metal bit- things off him. Which he took out of the blinds and then decided he was gonnae snap it in half. So I was like… that I took off him. Take something off of him that he's not meant tae have, and he'll throw the biggest hissy fit. It's like you saw there, he cried and put his face into the floor. Surprised he never started screaming. 'Cos that's what he usually does.

Emma, 23, 1 child, MB
PBI score: Mother = Affectionless Control. Father = Affectionate Constraint. ACES: 1
High self-efficacy

Emma resigns herself to a bad day if her son is in a mood. She suggested several times that she had 'ended up with a naughty child'. She appeared unable or unwilling to recognise or regulate his emotional responses; nor did she suggest that she sought to understand the causes of his externalising behaviours. Instead she feels her only available response is firm, sometimes harsh parenting, or isolating him in his locked room until his behaviour changes.

As well as the sense that her children can dictate the shape of the day for her, like Emma, Pamela and Lorraine, Andrea also talks of sometimes responding in harsh or aggressive ways to this 'naughtiness' or 'moodiness'.

> *Some days it can be a cake walk, it really can be… it is all peace and quiet; on other days it is Armageddon: the kids get up in a foul mood, they start bickering, [son's] grumpy because he's had a rough night… sometimes it does seem like I don't know what I'm doin' … I suppose I do have to admit I do have a habit of givin' them a quick swat.*

Andrea, 35, 3 children, MB
PBI score: Mother = Affectionless Control. Father = Optimal. ACES: 1
Low self-efficacy

Here Andrea's example highlights again this sense of children's moods or behaviours driving parenting practices, which alongside an acknowledgement of not feeling confident in knowing what else to do can lead to instinctive reactions and harsh, aggressive parenting. None of these five women appear to demonstrate the willingness, ability, or capacity to question what may be impacting upon the moods of their children, and demonstrate no attempts to understand the causes of any externalising behaviours. They frame these externalising behaviours in terms of the child being naughty or having a bad attitude, and give no indication that they feel able to intervene and regulate this mood or behaviour, aside from responding with verbal aggression (Lorraine, Pamela), physical discipline (Andrea), or 'leaving them to it' (Emma, Amy).

Having a sense that their children exercise a great deal of control and can dictate how a day goes, as well as feeling uncertain as to if or how they can do anything about the moods or behaviours of their children is evident for these five women. They recall different childhood experiences and draw upon different models of parenting, and while Lorraine and Andrea report low parental self-efficacy, Amy, Emma and Pamela report higher confidence in their abilities. Therefore, the concept of being unable to regulate their child's mood or question the causes of any externalising behaviours is perhaps influenced by other complex factors and is not easily attributable to either these women's experienced parenting style or their reported parental self-efficacy. It may also

be something not accurately reflected in the measure of self-efficacy used in this study.

Of these five women, Andrea, Lorraine and Emma are also among those who earlier discussed their own experiences of physical discipline in terms of being something they 'deserved' or caused to happen (Section 5.4.1.1). It may be worthy of further exploration to examine if the concepts of internalising one's own experiences of violence and physical discipline are seen in similar ways by these women (that is, as their child being responsible when they themselves respond in similarly harsh or physical ways).

What is evident is that where there is an expression of low confidence and uncertainty around parenting, this can go in two very different directions: it can be seen to lead to either permissive parenting responses or harsh, angry reactions. More work needs to be done to understand the contextual factors that affect this, and how it may be moderated.

The following case studies give more detail of three of the participants and their narrative accounts, highlighting several of the key aspects of how practices and experiences during childhood, as well as many of the issues described above, can be seen to have impacts across generations.

6.4 Case Studies

6.4.1 Andrea: 'Nowadays, you can't even chastise your kids'

Andrea, 35, 3 children, MB
PBI score: Mother = Affectionless Control. Father = Optimal.
ACES: 1
Low self-efficacy.

In contrast to those who suggest that changing attitudes towards parenting over generations is welcome, in particular towards physical means of discipline and control, Andrea suggests that this has been a backwards step. She feels that this 'politically correct' attitude toward parenting is somehow holding her back from employing physical discipline with her own children, and this is a source of frustration and regret for her. Her view is that the perceived inability to use such coercive techniques has limited her options when it comes to dealing with and disciplining her children. Moreover she feels that being unable to 'chastise your kids' in a physical way has had a detrimental effect on her children - on their development and their behaviour - and on wider society. Andrea explicitly expresses regrets about this, as well as a desire to directly repeat the physical approach to discipline and control that her mum adopted with her.

It is worth noting more here about the context of Andrea's situation: Andrea, 35, and her three children were living with her mother following the breakdown of Andrea's relationship with the father of her children. The five of them now share the family home in which Andrea was raised, in one of Scotland's most socially deprived areas. Andrea spoke about intimate partner violence as a contributing factor to the ending of her relationship, and ultimately her decision to remove her children from that situation and to return living with her mother. Andrea reports low self-efficacy, high levels of depression and anxiety, and via the PBI categorised mother's parenting style as one of 'affectionless control' during her early years.

It was in the family home that I interviewed Andrea, and I was greeted at the door by her mother. Initially uncertain how best to proceed, I continued to make small talk and engage in conversation with Andrea, with the expectation that her mother would soon excuse herself. When it became apparent that she was in fact staying, and went into the next room to make us all tea, I mentioned to

Andrea that a lot of my questions would be about her upbringing and her relationship with her mum, and checked if she was definitely happy to proceed. She assured me it was fine, and we began the interview. At points her mother returned into the room, interjecting in response to what her daughter was saying, and occasionally speaking over her. This lack of regard for the interview situation was difficult to deal with at points, with her mother appearing to just carry on with her daily routine around us. I spoke with her mother when it became obvious she would be staying, and received confirmation it was acceptable to continue recording, and that her comments would also be captured – her nonchalant attitude to the process was typified by her returning to the lounge with a sandwich and sitting on the recording device I had placed on the sofa.

Because of both the closeness of their relationship, and the fact that they all now share a home, Andrea was in a position to be directly influenced by her mother when it comes to parenting decisions. In fact, her mother said that while Andrea and her children are living under her roof, they will all abide by her rules. Andrea's mother spoke to me about how she was hit as a child, and it never did her any harm, and she saw no reason why she should not do the same with her children, and why they should not do the same with their own.

Despite saying several times that changes in attitudes mean you are no longer allowed to smack your children, Andrea later said that she does, on occasion, use physical forms of discipline with her children. Again, she explicitly agreed with her mother's opinion that it does no harm, and, in their view, it is an appropriate part of parenting, even if this is not something shared by wider society.

> *Andrea: just tap 'em that's what I do*
> *Mother: 3 strikes and you're oot – it did alright for yous*
> *Andrea: yes, mum it did*
> *Mother: you might not have liked it at the time*
> *Andrea: I don't disagree wi' that, I'm sayin' you can't do it now with kids*
> *Mother: there's a difference between abuse and a child that won't learn because it can get away wi' it*

Andrea: yes, I know mum!

Mother: there's a line to be drawn

Andrea: yes, I know mum! But you still can't draw that line any more. Parenting has changed since you were a child, since I was a child

Mother: yeah it has changed but the thing- at the end of the day there is still a line to be drawn and if you've not got anything to take away fae them or stop them, then a quick sharp slap on the hand or the backside is better fae them.

Despite being subjected to violent and coercive parenting techniques from her own mother, and describing the violence that she experienced within her intimate relationship as traumatic, Andrea sees the use of physical discipline as an appropriate parenting technique. She views these as necessary in order to control and discipline her own children, and as a way to keep them safe from harm.

Yes because back then, when we grew up there was moral standards-boundaries our parents set fae us, and if you stepped over, yes you got a smack, not a doin', but a smack, you got tae- basically chastisement and these days you can't even chastise your child without there being issues. You used to be able to tap them on the hand and say no, now you can't even tap them on the hand even if you are trying to protect them from danger, it is to the point- somewhat ridiculous. I understand kids get abused and get beaten and that, and it is wrong, but you can't even give them sort of common sense of fear into your kids… because you can't put common sense fear into them because if you do you will be wrong and you'll be nasty to them… they need to be protected, but to protect them you have to sometimes be cruel to be kind.

It annoys me the fact that kids back in my day, 3 strikes and you are out, that was it, your consequence was done. Nowadays as I said you can't even chastise your kids, you- they even expect you to get down on your knees, look them right in the eye, and say 'this is wrong, you cannot do this'. You can't say the word 'bad', you can't say 'naughty', this is all about child development and all that, or how- or psychologists say you

can damage your kid, give them a negative image of themselves, but they can even get away with murder anyway, there's no consequences tae it and then the kid does something really wrong.

During the interview all three of Andrea's children were present at various points. Each of them was threatened with being hit in order to control their behaviour by both Andrea and her mother. In one instance the two-year-old boy was told he would be 'out the window' if he continued with his apparently naughty behaviour. Following a later altercation between the two older girls upstairs, Andrea's mother got up from the sofa and shouted various threats of them being hit if they didn't behave. When more noises came from upstairs a few minutes later, she then went up and shouting and banging could be heard. Andrea's daughter appeared a few seconds later, in tears, looking for support and comfort. Andrea's response was to give a wry smile and tell her daughter: *'well, you know what she is like and you have tae learn'.*

Despite the challenges that arose due to the presence of Andrea's mother, it did allow for observations to be made and data to be captured that might otherwise have been missed. In the observations above, I have drawn on both the interview transcript and my field notes recorded immediately after the interview ended. I was uncertain as to whether I would be able to use any of these data, however, and whether it would be useful given the particular circumstances of the interview. Following discussions with my supervisors and the THRIVE team, it was decided that these data were both valuable and interesting, and I sought retrospective written consent from Andrea's mother, making sure she understood what I was doing and how the interview and field note data would be used. She said she was more than happy to get involved, and that people need to learn that giving children a smack is appropriate and necessary. As I left, she lamented her other daughter's refusal to smack her own child, who as a result has ended up with a 'brat' who has tantrums; her advice to her daughter on how to control these tantrums if she did not want to use physical discipline was to throw a bucket of water on the child. Apparently the shock of this would stop the tantrums.

Among those women that did experience physical means of control and discipline during their childhood, there is a divergence of opinion on whether this is something which should be employed with their own children. Some believe that it is no longer acceptable, while others suggest it is inevitable, but certainly not something that should be done in public. Andrea is alone is suggesting explicitly that she feels this inhibits her ability to parent in the way she would like. Andrea appears to model her behaviours on those she herself experienced. She adopts and defends the techniques that her own mother employed, and also currently strongly espouses and practices with her grandchildren. Andrea also appears to feel that without such techniques she is unable to provide the control, structure and discipline her children need. Importantly, although she is aware of potential alternative approaches, Andrea is sceptical of them, and employs harsh, physical approaches with her children in spite of the perceived societal pressures.

There is also a cognitive dissonance where Andrea describes fleeing a traumatic and violent relationship in order to protect herself and her children, to take them to another environment where the use of physical means of punishment and discipline are routine. Her decision to return to her mother's home was potentially her only realistic option due to practical and financial constraints; nonetheless, Andrea conceptualises interpersonal violence towards herself and her children from a partner as harmful and damaging, and yet simultaneously argues that physical aspects of parenting are not only harmless, but indeed a necessary aspect of parenting. This modelled behaviour of harsh discipline is seemingly an appropriate, if not socially accepted practice, because it 'never did her any harm' - something on which both her mother and her agree.

This also highlights Andrea's potential lack of personal agency, where Andrea may not find it easy to take any other approach even if she wanted to do so. Andrea is in a situation where she is repeating things she experienced, parenting her children under the direct influence and almost supervision of her dominant mother. Andrea's example highlights a deviant case, but gives insights into how potentially harmful parenting approaches might be modelled, rationalised, and justified, and demonstrates the context in which these parenting practices are sometimes played out through generations.

6.4.2 Gemma: 'My childhood? It was really good; it was a really good childhood – I was very lucky'

Gemma, 25, 2 children, MB
PBI score: Mother = Optimal. Father = Optimal.
ACEs: 0
High self-efficacy.

Gemma is 25 with two children. She was pregnant with her first child aged seventeen. She is raising her children alone and has no contact with either of the fathers of her children, one of whom was in prison at the time of our interview. During her opening narrative, Gemma reflects upon a very happy and stable upbringing, and frames this as a 'lucky' experience. She feels lucky to have had supportive and caring parents, especially when compared to people she knows who experienced violence as a child or who had parents who were abusive or addicted to alcohol or other drugs.

> *They were just really good, they, I don't remember ever being shouted at or anything like that or…they were just really nice, caring people, ma mum and dad, really erm accepting of anything as well, really understanding.*

Gemma goes further, and has reflected upon why her mum in particular may have been so caring and understanding.

> *I think my mum might have had quite a hard time wi' her dad as a child and she was quite badly bullied as well so she is really non-violent, she is completely against violence. So is my dad as well, but more my mum because she was badly bullied as a child and quite violently bullied from other people in school up until she was in high school and I think her dad was a bit of a name- he would call her names a lot, call her stupid and I think she believed that she was really stupid; I think she seen the damage that that done tae her and erm… decided that she didnae want tae do that to her children, so she would never call us names or raise a hand tae us or anything.*

Gemma appears to be very conscious of potential intergenerational cycles and the impact that parents may have upon their children; it is in this context that

she discusses how she has been affected by her experiences with her parents, and also how she hopes to shape her own children too, using her parents as positive role models.

> *I think it has affected me positively erm… because I kinda take what they, how they brought me up with ma kids as well erm… so I'm quite, I'm not overly confident but I can speak when I need to, I feel like I have got good attachments and stuff like that.*

She goes on to say how she tries to take this same calm, understanding, and non-shouting approach with her children, but due to the stress she feels at having to cope with parenting by herself, she feels this isn't always possible.

> *I try not to shout. I'm not going to say I've never shouted at ma son because I have but I try not to, I try to keep ma cool as much as I can but… erm, and I do the takin' stuff away. I don't really send him to his room because someone told me that sending them to their room can make their room seem like a bad place to be, so I have, usually there's a wee chair there and I send him to sit there on the wee naughty chair erm but I do sho-, I have lost ma temper and shouted, I do feel bad for it but erm… when he's playin' up and doing whatever he's doin and she's screaming and the house is a mess and it just seems to pile up and I boil over sometimes.*

Gemma talks about a feeling of guilt when she does shout at her children, and how this weighs heavily upon her. Because of her sense that she was lucky to have the experiences and parents she had, and how this has had positive outcomes for her, it would appear Gemma puts pressure on herself to emulate this with her children for fear of otherwise causing damage to her son and daughter.

> *I think when I do shout or when I do somethin' I'm like… erm… when I shout I think I dwell on the stuff that I done wrong a lot I think oh, like sometimes I lie on ma bed and think of that time I shouted at him… I feel guilty for it. I get really worried aboot damaging them erm because I just want them to be happy and I went through a lot as a teenager as well and*

I wouldn't want them to go through stuff that happened wi' me because it was crazy and I just want, I don't know, you just want what's best for them really.

Gemma's guilt and fear is compounded by her strong desire to help her children avoid repeating what she sees as her own mistakes during her teenage years. In contrast to her opening narrative, Gemma later disclosed how, in spite of her parents' understanding and caring approach, she went through a very difficult period between the ages of thirteen and sixteen.

I was just, urgh, I got in wi', I decided I didnae like school- I was bullied through first year and I can remember the group of girls cornering me in the playground and I was really scared and I phoned ma mum, ha, and I was like they are all gonna batter me and I decided I didn't wanna feel scared like that again and instead of being bullied I decided to be a bully so I started drinking and taking drugs. This was when I was about 13 and I would run out the house at 12 O'clock [at night], get brought back by the police and arr- I was arrested a lot, I was, urgh, fightin' wi' people in the street, drinkin' in the street it was crazy- it was- urgh … well I actually hit ma mum a couple of times which I can never get it- it was horrible, it was drink, and she didnae even hit me back, she wouldnae hit me back and erm, I'd call her names, I destroyed the house, just ripped pictures off the wall, threw all the furniture aboot, so I don't even know why I would do it, it is like a different person looking back now, it is like them three years I just changed intae this different person.

Gemma's approaches to parenting can be seen to be rooted in her acute awareness of intergenerational cycles; she recognises that her mother in particular was affected by abuse and violence, and as a result parented in very different ways. The 'optimal' parenting she experienced, and the positive role model provided by her mother is seen by Gemma as influential in shaping her own outcomes and identity, and her previous outbursts of violence and aggression, along with her misuse of alcohol and other drugs, are framed as being in spite of this caring and understanding upbringing. That period of her life is a source of shame and guilt, compounded by her feelings of inadequacy at not always being able to be as calm and patient as her own parents and live up to

this ideal. This is something that Gemma also fears may damage her children and lead them to repeat her mistakes. For Gemma, this model of 'optimal' parenting against which she measures her own is not always easy to achieve, and it appears to be a huge pressure in her already stressful life.

6.4.3 Nicola: 'I found out I was pregnant in the morning, and in the afternoon social work came out'

Nicola, 27, 2 children, CaU
PBI score: Mother = N/A Father = N/A.
ACES: 1
Low Self-efficacy.

Nicola is 27 with 2 children. She recalled a positive relationship with her mother as a child, where her mother was supportive and caring. Her mother's approach was described as one of *'authority, but she was always there and understanding'*. Nicola spoke throughout the interview of trying to emulate these aspects of parenting with her own children, although not always consciously. Often she would only recognise this when looking back on things.

Despite a good relationship with her mother then and now, and no apparent adverse or traumatic experiences during her early years, Nicola reported high levels of depression and anxiety, and low levels of parental self-efficacy. Nicola was homeless for a while during her late teens and early twenties after her mother moved away and her father made her leave the house when he remarried. It was during this period that she became pregnant with her first child. She later moved into a house with her partner and their new baby.

Nicola was living in one of Scotland's most socially deprived neighbourhoods, and described how after some time she was generally unable to cope with the demands of working, a new baby and the house. This was exacerbated, she said, by a lack of support from her partner, and her own physical and mental health problems. When her child was two years old, social workers expressed concerns regarding welfare. Nicola suggested the main concern was about the condition of the house.

Nicola: I think having a partner sitting playing games all the time and not being involved in the raising of the child happening right under the same roof was a big depression point

Simon: so you were depressed at this point?

Nicola: I was suffering depression, anxiety, erm and other health issues

Simon: and what sort of impact did that have?

Nicola: I stopped going out, my mood became extremely low, I would take care of the wee one and then... everything else can just go, I don't care, I don't care enough to deal with this; you know as long as the wee one was fed, clean, I was happy

Simon: and you felt you were still able to do those things; it wasn't having an impact on that? You were able to still look after the wee one?

Nicola: yeah, but unfortunately the house conditions didn't meet the [standards], ha-ha ... they first came out, the house was a mess, we got 24 hours to clean up which we did, and within 4 weeks later they came back out again and the house had deteriorated and they decided to move the wee one... erm and we got [her] back after a couple of days. Yet again another 4 weeks passed, and the house deteriorates again, I was with a partner who wasn't helping me out with the house, I was doing night shifts, day shifts, and trying to keep on top of the house which was just soul destroying.

It was at this point that her daughter was removed from the home and placed in kinship care with her paternal grandmother. This happened on the same day that she discovered that she was pregnant with her second child.

I found out I was pregnant in the morning, and in the afternoon social work came out - the house was deteriorated - and removed the wee one from the home.

During this pregnancy Nicola was in contact with her daughter three times per week via pre-arranged visits at the social worker's office. In her third trimester she was told that her second child would also be placed with grandmother when she was born.

At the time of our interview, Nicola's children were five and two years old, and were still living with their grandmother. Nicola, now separated from her partner, visited them at their home two days each week. There, under the supervision of their grandmother, she would play with them, bathe and cook for them, and put them to bed. She said she was working on proving she could keep up this routine so that eventually she might get full custody of them.

Nicola had recently had conversations with social workers about moving towards looking after her children overnight in her own home.

> Nicola: well I am redecorating here; once in here is suitable I can start seeing them out here, then we can work to overnights and things like that, we are working towards me getting full custody yeah
>
> Simon: so that's the ambition obviously, and do you feel that's achievable and you will be able to…
>
> Nicola: oh yeah; yeah well it is starting to decorate in here, feel better about my home… and then I will be able to start taking care of it better ha-ha.

This extract encapsulates the wider sense from Nicola that, three years after her first child was removed from the home, the barrier to them returning still remains the condition of the house. This indicates that potentially Nicola does not understand or is not prepared to acknowledge to herself - or discuss with me - that it may be because of other reasons. It is certainly notable that despite the removal of her children (for her at least) being linked directly to the condition of the house, Nicola has not felt able, for whatever reason, to make the required changes in the intervening three years. She talked about eventually wanting to tidy up and decorate, and get beds for the girls when they came.

In this way she could also be said to be lacking personal agency in terms of feeling able to achieve these things, or to get support from appropriate places to achieve this. This is something she herself felt had been problematic for her in the past.

> *Nicola: I think I could have done a lot better*
>
> *Simon: ok, tell me how…*
>
> *Nicola: well if I was more upbeat and things like that I would be able to do more things for the wee one, like taking her out to the park or play group and things like that, get her socialising at least … erm seeking help a lot earlier for me to be able to maintain a healthy home for the girls*
>
> *Simon: and you just feel that's something you weren't able to do before, to seek that help?*
>
> *Nicola: to have the confidence to… yeah it was through support of social work, they took me to get some help … [I thought] I didn't need it or didn't want to bother the health services for something trivial, or, you know.*

Despite recognising that she perhaps needed to do more in the past and required greater support, and maintaining frequent visits, having her daughters returned to the home remained a distant prospect. Nicola described how she lacked confidence and had low self-efficacy when it came to doing things with her children, and deferred to others for how she should approach things.

> *Well while I'm doing this for the girls I am trying to prove at the same time I can maintain your routine and follow through [grandmother's] rules of the house.*

Nicola discussed how she would look to her own experiences growing up, and attempt to emulate the positive aspects she recalled from her mother's approach; Nicola also described how she currently relies upon her mother for support and advice when it comes to looking after herself and her children. Her

mother lives several hours away, but is nonetheless her primary source of guidance when it comes to parenting approaches and doing things to move towards the return of her children.

> *Yeah when I start to feel I am losing my way I can call her up, I'm like 'I cannot figure out what I am meant to be doing today' and she is 'ok, get pen and paper, write this down' ha-ha, erm 'this is your goals for this week, go for it!'… It is something we discuss, usually I will be like this, this, this all needs done next week, and then I get to next week my brain's went 'oh what am I meant to be doing?', you know.*

Nicola's case demonstrates how, in spite of recognising the positive relationship with her mother both presently and historically, and the role model she provides for her parenting, she nonetheless faces severe challenges in terms of her own parenting. Depression, anxiety and feelings of low self-efficacy are, for her, interlinked, and combine to impact upon her capacity to parent her two children in the ways she would like or feels she should. Because of these things, Nicola felt unable to cope with the demands of a new baby, a new home and a job, alongside an unsupportive partner.

Despite describing the presence of a stable and positive maternal relationship during her childhood, characterised by routine and authoritative control from her mother, Nicola defers to the routine and rules of others when it comes to her own parenting practices. She needs constant help and guidance with these things and remembering what she needs to do, a situation exacerbated by her mental health. She feels unable to achieve the very things that she herself identifies as barriers to the return of her children.

This case, while extreme, highlights a picture apparent in the wider sample: although these women may have positive relationships with their mother, and they point to specific practices they aim to emulate with their own children and speak of hoping to model their parents' approaches, the context in which they are trying to parent often makes this difficult. Where these women experienced 'optimal' parenting and describe positive aspects of their upbringing and use their mother's as role models, living up to these is not always achievable. Social disadvantage and deprivation, alongside mental health issues and a reduced

capacity to cope with and understand things, and often a reduced support network, mean that these women are not always able to parent in the ways that they may want, even when they have a clear, positive model of parenting that they aspire to emulate.

Each of these cases highlights how emulating aspects of parenting practices - supportive, caring practices as well as harsher practices like physical discipline – can be best understood in a much wider context. Historic and ongoing social deprivation, financial instability, instability around relationships and housing, as well as mental health issues and the current relationship these women have with their mothers, all contribute to a complex environment in which these women navigate the challenges of raising their own children.

6.5 Chapter Summary

This chapter drew upon the women's narratives and explored how reflecting on their experiences with their mother impacts upon their own parenting approaches and practices. Those women who recall 'optimal' experiences with their mothers talk of warm, supportive and affectionate environments, and aspire to recreate these environments, as well as repeating specific practices with their own children. This remains the case even where this 'optimal' parenting includes difficult periods, aggression, and physical disciplinary techniques. These women do not appear to seek examples, advice or support regarding parenting from elsewhere, and take an uncritical view of their parents' approaches, which in turn form the basis for their own parenting. Despite this 'optimal' model of parenting, some of these women discuss difficulties in replicating this, and find themselves responding to their children in ways their parents would not.

Where these women recount 'neglectful' mothers, the response is invariably to attempt to ensure that they do not parent in the same ways, and this is framed as avoiding past mistakes or providing for their children the environment they lacked. Partners, their families, and other family members are looked to for support and advice, and provide examples of 'good' parenting on which these women tend to draw. For these women, their conceptualisation of what constitutes 'good' motherhood is in contrast to that of their own mother.

Despite the response invariably being to position themselves as different to their mothers, some also suggest that ingrained and instinctive responses can be difficult to overcome, meaning they often repeat some of the practices they disliked about their own upbringing.

While some who characterise their upbringing as 'affectionless control' seek to entirely reject the approaches and practices they associate with their parents, others identify strongly with their mothers in particular and see them as the model for their own parenting. The current relationship they have with their mother and the changes to this relationship around the time of pregnancy appear to be a key factor associated with this decision. Others who draw upon the examples set by 'affectionless control' mothers appear more ready to accept and consciously repeat specific practices, while rejecting the ones they see as problematic.

While for most of the women the perinatal period was a time of increased reflection upon motherhood, and their own experiences with their mothers were drawn upon to inform these, it did not always lead to improved relationships or stronger identification with their mothers. These findings are in contrast to much of the published literature which indicates this is a time mostly of improved bonds and closer identification with one's own parents (Birtwell *et al.*, 2015; Fischer, 1991).

Levels of reflection also varied across the women interviewed; while some were consciously reflecting upon their own experiences and responding to this by making decisions on how they intended to parent, others described this as a less conscious process, where the practices they associate with their own parents are repeated in instinctive responses. Findings here lend further weight to the theory of social reproduction (Bourdieu, 1986), in that practices can be seen to be repeated across generations as a result of these conscious reflections, or it may also be an unconscious replication, driven by cultural and social norms and patterned behaviours.

Finally, the discourses these women use around their parenting practices tend to suggest that some find it easier than others to always be responsive and warm to their children. This includes some with 'optimal' parental examples as well as

those with 'affectionless' or 'neglectful' recollections. Those who talk of reacting in aggressive or angry ways point to stress, a lack of support, low self-esteem, depression, and anxiety as contributing factors, and these are often linked by these women to childhood issues. For some, the mood or behaviour of their child appears to a key driver of their parenting practices; they see their practices as a reaction to their children's actions, rather than the child responding to their practices. For these women, mental health issues may often be a factor. As well as potentially leading to permissive parenting, feelings of low parental self-efficacy and uncertainty regarding what to do or how to cope can also be seen to lead to harsh or aggressive reactions, and a repeat of such practices across generations.

The case studies highlight how emulating and repeating aspects of parenting - both supportive, caring parenting and harsher parenting practices - happen in a much wider context. Historic and ongoing social deprivation, financial precarity, instability around relationships and housing, as well as mental health issues and the current relationship these women have with their mothers, all contribute to a complex environment in which these women navigate the challenges of raising their own children.

These findings addressed the third research question, and explored the women's reflections upon the way they were parented, their responses to this, and how they feel these things have shaped their current parenting. These findings also examined the variety ways in which parenting may be transmitted across generations. The implications of these findings, as well as those outlined in the preceding chapters, and how together they address the overarching research questions and previously identified gaps in the literature, are discussed further in the chapter that follows.

7 Discussion

7.1 Overview of Chapter

This chapter provides an overview of the key findings presented in Chapters 4, 5 and 6, situating these findings within the existing literature. It goes on to discuss the relevance of these findings to parenting interventions like those evaluated by THRIVE. It also includes a reflexive section regarding my responses to the processes of data generation and analysis in light of these findings. Finally, this chapter discusses the strengths and limitations of this study, and highlights areas for future research.

7.2 Overview of Key Findings

The overarching aim of this study was to understand more about how parenting practices are transmitted across generations. It specifically sought to understand, from the perspective of mothers with additional health and social care needs, how their recollections of their childhood experiences and the ways in which they were parented impact upon the parenting practices they adopt with their own children. It also sought to understand the factors which impact upon parental self-efficacy.

The following sections summarise the answers to the research questions posed in Section 3.2.2, and discuss how experiences of parenting practices, and childhood adversity, can have impacts across generations and shape current approaches to parenting.

7.2.1 What are the factors which impact upon parental self-efficacy among women recruited to THRIVE?

This section discusses the findings which answer the first research question, and provides an assessment of the factors which impact upon parental self-efficacy among women recruited to THRIVE.

7.2.1.1 ACEs and Parental Self-efficacy

The findings of this study indicate that there is no direct association between the number of adverse experiences faced by these women, either in childhood or adulthood, and their reported parental self-efficacy. These findings can be contrasted with other recent studies which found an association between ACE scores and parental self-efficacy (Treat *et al.*, 2019). The lack of direct association for ACEs found in this current study remains true of any measures of childhood trauma, or adverse life events in the previous year. These findings indicate that although the ACE score has a powerful relationship to the risk of many public health problems as outlined in Section 2.10, it may not be an effective tool for screening individuals or projecting risk factors associated with them. Indeed, the authors of the original ACE study now advise this caution, and acknowledge that an individual's ACE score does not fully assess the frequency, intensity, or chronicity of exposure to an ACE or account for differences in the timing of exposure (Anda *et al.*, 2020).

7.2.1.2 Anxiety and Parental Self-efficacy

The regression analysis demonstrates that previous or current adversity is not directly associated with parental self-efficacy. However, anxiety does play a key role in these reported levels of parental-self-efficacy: those women with low levels of anxiety are twice as likely to report high levels of parental self-efficacy than those with high anxiety. It is feasible that higher levels of anxiety are a result of these multiple experiences of adversity, as well as the wider deprivation that these women face. A regression analysis of the available data indicates that the presence of emotional support, age, levels of depression, and recent adverse life events are all significant factors in anxiety levels among THRIVE mothers. It was felt that this further analysis may go beyond the scope of this study and restrictions around time and content did not allow for its inclusion here. Further work should be done in this area to examine the historical and proximal factors associated with anxiety.

It is perhaps unsurprising that anxiety occurs as significant contributor to self-efficacy, and it can be hypothesised that a bi-directional relationship exists between these variables. Feelings of anxiety are inevitably going to lead to less

confidence in one's ability to cope with demanding and pressured tasks with a new-born child. Conversely, a feeling of not being able to cope with parenting tasks with an impending child may well lead to a rise in levels of general anxiety. In this way these two factors may well feed into one another, and there is no way to be certain as to how one may be influencing the other.

7.2.1.3 Drug Use and Parental Self-efficacy

Those mothers who report no drug use are around one and a half times more likely to report high parental self-efficacy. Thus drug use can be seen to be associated with lower self-efficacy. There is potentially a similar complex and multi-directional relationship between anxiety and reported drug use. It is feasible that as anxiety levels increase, these women may turn to recreational drugs as a way of self-medicating and in an attempt to alleviate these feelings of anxiety, as well as using drugs as a way to cope with the impact of previous or current adversities. It is also possible that the relationship works in the opposite direction, in that recreational drug use, and indeed misuse, may well lead to increased levels of anxiety among these women, and in turn reduced levels of confidence in one's ability to cope with the demands of parenting or imminent motherhood (Latuskie *et al.*, 2019).

7.2.1.4 Child Protection Orders (CPO) and Parental Self-efficacy

Those mothers who have a CPO in place, and have therefore had at least one child removed from their care, are almost three times more likely to report high parental self-efficacy when compared to those who have not. The association between having a CPO in place and reporting of higher levels of parental self-efficacy is a complex and multi-faceted one. It is possible that those women who have had a previous child or children removed from their care, and placed under the protection of the state or in kinship care, may find it difficult to acknowledge that their own feelings of being unable to cope with parenting are in any way related to the removal of their child. In this sense it may be a protective factor, a cognitive dissonance (Festinger, 1962) whereby they are unable to acknowledge the role that they may have played in the eventual decision to remove their child or children from their care.

In similar ways, it is feasible that these women are unaware that their actions or capabilities as a parent have contributed to the decisions by social workers to issue a CPO, seeking to place responsibility with the social workers or others rather than themselves, and being in a sense of denial; this denial may well also be coupled with optimism that with their impending child things will be different. It is also certainly possible the CPO is in place due to other factors or people within the home that are outside of the mother's control, and are in no way reflective of her ability to cope, or her capacity to parent her children.

Given that the measures of self-efficacy are entirely self-reported, these women – who have had one or more children removed from their care and face the very real prospect of their unborn child being removed from them also – are unlikely to answer questions about their ability to cope with impending parenting tasks in any way that could be viewed negatively, or potentially used against them. It is possible that responses to this question, filled out in the presence of a researcher who may well also be a healthcare worker, leads to an over-inflation of confidence in an attempt to avoid being judged by others, especially on a topic so sensitive as a woman's capabilities as a mother, which are often tied so deeply to identities of womanhood.

Faced with questions about their ability to cope with things once this child is born, it is likely that these women may be fearful of negative responses to this question being used as justification to remove this child from their care, and a fear that this information may be seen by those making that decision. It is also possible that these women over-inflate their feelings of self-efficacy with parenting tasks as a way to demonstrate to the researcher, and in turns to healthcare professionals and social workers, that they are now more confident and capable. This could serve a dual purpose of demonstrating that they are now not only more confident and able to look after their soon to be born child, but they are able to look after their other children in the hope or expectation that this will lead to them being returned to their care, or at least be counted in their favour in future decisions.

Finally, the fact that those women with a CPO are more likely to report high levels of self-efficacy may be due to the subjectivity of the concepts at hand. When asked about capacity and ability to manage and cope with hypothetical

tasks, it may be that these women have no observed or reliable marker for effective parenting on which to model their own practices or approaches. If the model of parenting on which they draw is a poor or harsh one for example, they may feel that if they are doing slightly better than this, then they are, by comparison, doing well. It is also the case that the majority of the women who have had a child removed from their care were also Looked after Children themselves who had been in the care of the state or other family members during their childhood; they therefore may lack any reliable or consistent model on which to base effective or capable parenting approaches.

These findings are not entirely consistent with Bandura's (1994) theories of self-efficacy, in which he posits that one of the main ways of creating and strengthening beliefs of self-efficacy is through the vicarious experiences provided by social models. Seeing others like you succeed or fail can be influential in your own feelings of self-efficacy, especially one's parents. In this way, the modelled successes or failures of parents can be seen to have an influence on the feelings of self-efficacy of their children, with parents providing social standards against which to judge one's own parenting capabilities, for example.

Bandura (1994) also suggests parents may influence the feelings of self-efficacy in their children by either providing competent models who 'transmit knowledge and teach effective skills and strategies for managing demands' (Bandura, 1994, p.73) or alternatively by persuading their own children that 'they possess the capabilities to master given activities' (Bandura, 1994, p.73), meaning they are more likely to mobilise greater efforts and sustain these efforts when difficulties arise, rather than harbouring self-doubts or dwelling on personal deficiencies. The findings here however suggest that those women who report having 'optimal' and competent models on whom they model their parenting, do not all report high levels of self-efficacy. Despite these positive models, and these women articulating a desire to emulate their parents' effective strategies, some of them report low self-efficacy and are not always able to parent in the way they wish. More research should be undertaken to understand the factors that may lead to low parental self-efficacy even in the presence of positive parental models.

7.2.1.5 Self-efficacy and Responses to Children

When taken together with the qualitative responses outlined in the previous chapter, the findings of this study suggest that confidence in one's parenting impacts upon how these women respond to their children, and the parenting practices they employ. When the women talk of being uncertain of what to do, or lacking in confidence, this is usually associated with harsh, angry or aggressive responses, or sometimes more permissive approaches to parenting. The findings support those of Sanders and Woolley (2005), who found that self-efficacy significantly predicted both parental over reactivity or harsh discipline, as well as permissive and inconsistent approaches to discipline.

Those women who did talk of uncertainty in what to do, and therefore sometimes reacting to their children in instinctive ways, also generally spoke of mental health concerns, such as depression and anxiety, being a contributing factor. These mothers also, arguably, find it difficult to be attuned to and recognise the social and emotional problems in their child, seeing their moods and behaviours instead as naughty behaviour. These findings lend weight to other research that indicates that a mother's parenting efficacy is linked with her depressive symptoms, and also impacts upon her perceptions of her child's social and emotional cues (Treat *et al.*, 2019). Further, these findings echo previously published evidence that the presence of psychosocial stressors may impact upon a mother's emotional availability to be there for her children and to be attuned to their needs (Madigan *et al.*, 2015). This has potential implications across generations by having a negative impact upon the child's capacity to understand and regulate their own emotions, as well as potentially denying the child an appropriate model for managing distress (Madigan *et al.*, 2015).

There is no clear evidence from these findings as to whether harsh parenting and punishment is elicited by problem behaviours in the child, which intensify poor parental responses (Fite *et al.*, 2006; Huh *et al.*, 2006), or if this explained by the continuity of such harsh practices across generations (Neppl *et al.*, 2009). It remains likely to be, based upon these findings, a complex combination of both (Maccoby, 2000).

This section highlights that drug use, levels of anxiety, deprivation, and having a child removed from the family home are factors which impact upon parental self-efficacy among women recruited to THRIVE. Lower levels of self-efficacy may also be associated with permissive or harsh parenting practices.

7.2.2 What are the lived experiences of these women?

This section explores the findings related to the second research question: what are the lived experiences of these women, what do these women recollect regarding the practices adopted by their parents, and how do they reflect upon their experiences and the environment in which they were raised?

7.2.2.1 Multiple Disadvantage and Vulnerabilities

As outlined in Chapters 4, 5 and 6, the findings indicate that the women recruited to THRIVE face multiple disadvantages in their own lives as they raise their own children. They are predominantly living in some of the most deprived areas of Scotland, and have histories of sexual and physical abuse, emotional and physical neglect, have been the victims of and witnesses to violence, and have lost parents through death and separation. In some cases they were removed from their family home and placed in the care of the state or other family members.

7.2.2.2 Positive Recollections of Childhood and Protection against Adversity

In spite of this background of deprivation, trauma, adversity and conflict, for a minority of women, there were reflections upon a very happy childhood. For these women, they recalled 'optimal' parenting from their mothers, and this was usually mirrored in their paternal experiences. Descriptions of such experiences echoed that in the literature of warm, supportive, nurturing and engaged parenting (Baumrind, 1971); however, for two participants, their model of 'optimal' maternal parenting also included the use of physical disciplinary techniques. This would indicate such parenting practices may be seen as appropriate or reflected upon within a wider parenting environment, and are seen as acceptable if they are incorporated along with other more supportive, warm practices. Physical discipline and control techniques then are not always absent from reflections of 'optimal' parenting.

Findings also suggest that having a positive relationship with their mother as children may be a protective factor for adversity for these women. All of those who reported 'optimal' maternal experiences reported just one or no ACEs. Each of these women talk of childhoods characterised by warmth, responsiveness and stimulation; consistent role models and harmony between parents; spending time with their parents; and consistent guidance and the provision of structure and rules within the home. This indicates, in support of existing literature (Balistreri and Alvira-Hammond, 2016; Hill *et al.*, 2007), that a positive, consistent maternal model provides a buffer from other ACEs and therefore promotes greater resilience in the face of adverse experiences for these women.

7.2.2.3 Negative Recollections of Childhood and Cumulative Adversities

In contrast, the parenting practices other women experienced often took place in the context of family breakdown and parental separation. When this breakdown of families did occur, it was frequently associated with the use of alcohol and other drugs. The presence of these factors also contributed to additional emotional and financial stress within their childhood family, and for some of the women, they feel that this is linked to their poorer educational attainment levels. ACEs have previously been linked to lower educational attainment (Allen and Donkin, 2015) and this in turn has been linked to increased difficulties in parenting and poorer outcomes in their children (Madigan *et al.*, 2017). Therefore these findings add to existing evidence of previously identified potential pathways via which events and experiences in one generation can impact subsequent generations (Shonkoff *et al.*, 2012).

As well as contributing to inter-parental conflict and the breakdown of families, the findings indicate that where these families are impacted by parental substance misuse, it is also often characterised by a lack of warm, nurturing and supportive parenting during childhood. In some cases these women talk of being neglected at points by their parents, and having to take care of themselves and their siblings. As well as potential neglect or lack of care, parental substance misuse was also associated with acts of violence.

The findings from this study highlight the compounding effect of early adverse experiences: not only were these women often exposed to parental substance

misuse and interparental conflict or family breakdown, for example, this was also frequently coupled with a lack of maternal care and protection. Where there is a perceived 'neglectful' relationship with their mother during childhood, this is correlated with a higher number of adversities. This suggests that either some of these adversities reflect this experience of 'neglectful' parenting, and/or that this perceived neglectful parenting exposes them to further adverse experiences.

Their parents could therefore be viewed as contributing to some of these adverse experiences, while also being unable to provide the care and support to help their children deal with other, indirect adversities. In this way these women are doubly at risk, and further, they may well also lack any positive parental behaviours on which to model their own approaches when it comes to making decisions and coping with their own children. These findings reinforce the view that adverse experiences, and responses to them, are heavily influenced by family context (Banyard *et al.*, 2001; Masten *et al.*, 1999).

Often when reflecting upon their parent's use of physical discipline, such practices are framed as being a necessary and inevitable consequence of childhood misbehaviours. The findings indicate that there is pattern among these women in that they separate the *actions* of their parents, usually their mothers, from the *person* they know. For around a third of the women interviewed, there was a discourse that framed the use of physical discipline and acts of physical violence from their mother as only rare events. Further, they only occurred when it was warranted, usually because they as children had deserved it. Each of them also pointed out that, despite descriptions of harsh and violent acts, their mother was not a violent person. This presents a risk that physical parenting practices, and potentially violent acts by parents, are internalised and normalised. This distancing and mitigating language was used by women who categorised their maternal parenting experience across the PBI spectrum, and was employed by those who currently have good relationships with their mothers as well as those who do not. It is also apparent from these findings that the violent acts of a parent for example, are viewed in different ways than the violence of an intimate partner. Being raised in households where coercive parenting techniques and physical aspects of punishment and discipline were a

feature of their upbringing may lead to an increased likelihood of these women repeating such negative practices and patterns with their own children (Capaldi *et al.*, 2003b; Thornberry *et al.*, 2003).

However, for some, the use of coercive and physical disciplinary techniques are also viewed in a wider social context which reflects the fact that such practices were more widely accepted in previous generations than they are today. At the same time, it is often accompanied by a sense that it was more difficult for their mothers at that time to seek the help and support they may have needed to parent in more warm, caring and supportive ways. These findings lend support to those of Conger *et al.* (2009) who suggest that general or social changes may serve to moderate parenting practices. For the majority of these mothers, changes in widely accepted practices and societal views on their appropriateness has influenced any intergenerational continuity, and makes it far less likely that they will adopt such parenting practices.

The findings suggest there are high levels of mental health issues in this population, including anxiety, depression, and dissociative disorder, and many of the women have had one or more child removed from their care. By and large, these factors co-exist in these women's lives and when these mothers face multiple issues in combination with one another, they are at greater risk of poor outcomes (Shonkoff *et al.*, 2012), and they may find it increasingly difficult to recover or cope (Larkin *et al.*, 2014). As such, through this study, we are able to gain insights into the upbringing of some of the most vulnerable members of our society, something which is often notably absent from studies on this topic.

This project sought to understand, from the perspective of these mothers with additional health and social care needs, how they feel their childhood experiences, and the ways in which they were parented, impact upon the parenting practices they adopt with their own children. Ultimately, those women who have previously experienced adversities during their childhood may be the ones most likely to find it difficult to effectively parent in line with societal expectations or engage in positive parenting behaviours (Bailey *et al.*, 2012). When these adversities are coupled with social and economic disadvantage, as evident in the findings here, these mothers may struggle to provide caring, nurturing and supportive parenting (Bridgett *et al.*, 2015).

There is, therefore, a greatly elevated risk that these women's experiences of adversity during childhood, including the ways in which they were parented, may affect their abilities to parent their own children. This may be especially true if there is a tendency to find mitigating circumstances for their parents' use of physical discipline and acts of violence. In this way, harsh parenting and other experiences of adversity in childhood, which have been shown to have an intergenerational impact, may have potentially contributed to cycles of deprivation, disadvantage and harsh parenting practices for these women. In light of this, the following section discusses these women's perspectives on motherhood, and their responses to their experiences when it comes to making decisions with their own children.

7.2.3 How do these women respond to their experiences?

The findings discussed here relate to the third research question: how do these women respond to their experiences when it comes to their conceptualisations of parenting, and what impact does this have upon their decisions regarding their parenting practices with their own children? What can this tell us about the ways in which parenting practices are repeated across generations?

The findings of this study further indicate that the perinatal period is often a time of reflection upon one's own past experiences, and can also signal a change of family relationships. For some this reflection is more conscious than for others, and while some mothers may find it easier to reflect and respond, others may not have the willingness or the capacity to do so. As with the theories of social reproduction (Bourdieu, 1984, 1986) this study highlights that where practices are continued across generations, it may be the result of these conscious reflections, or it may also be an unconscious replication, driven by cultural and social norms and patterned behaviours. When it does occur consciously, by its very nature this reflection is subjective and deeply personal, and can be seen to shape ideas of the self, of motherhood, and moreover how these women approach raising their own children and the practices they adopt. The ways in which these women describe their parenting practices in response to their own experiences of being parented are discussed in the following sections.

7.2.3.1 Reflection and Change around the Perinatal Period

The majority of the women talk of the perinatal period being one of increased reflection. Like other studies (Birtwell *et al.*, 2015; Fischer, 1991), for some of the women here this proved to be a time of improved bonds and heralded a better, more understanding relationship. However, this was not always the case. Where a difficult relationship had previously existed, impending motherhood sometimes elicited negative reflections and resulted in determination to parent in better ways than their own mother had parented them. What is evident though, is that when these women were faced with having to make decisions about raising their own children, this often led to a reflection upon their own childhood, and to them measuring themselves against their own mothers (Pines, 1972; von Mohr *et al.*, 2017). These findings are consistent with ideas of social reproduction (Bourdieu, 1986), where practices can sometimes be seen to be repeated across generations as a result of conscious reflections, while acknowledging that they may also be due to an unconscious replication, driven by cultural and social norms and patterned behaviours.

These findings also suggest that reflection around the perinatal period signals a key transition for these women, where their internal representations of how they were treated as children shape decisions around how they parent their own children. Participants often reflected deeply on how they felt as children when faced with decisions on how they were going to parent; while some spoke of feelings of resentment and anger towards their parents now they had become parents themselves, others talked about a deeper understanding between them and their parents. This is thought to be one of the key mechanisms of the intergenerational transmission of attachment. Parents with an angry, preoccupied perspective on the way they were treated by their parents may respond in ways that increase the chance that their child will develop an insecure-resistant attachment; similarly parents who dismiss the impact or memory of negative attachment experiences may unwillingly stimulate an insecure-avoidant attachment in their child (van Ijzendoorn and Bakermans-Kranenburg, 2019). Therefore, the findings discussed here may provide some social and emotional context to help understand how the attachment histories of these women, which are shaped in childhood and translate into adult attachment styles, may influence their caregiving responses. These caregiving

responses will then potentially impact on the attachment responses of their own children, and therefore contribute to intergenerational cycles of attachment.

7.2.3.2 Intergenerational Transmission of Positive Parenting

Where these women recall positive, warm and supportive parenting from their mother, this is frequently, but not always, mirrored in their recollections of their father's parenting style. A common feature when both parents are categorised as providing 'optimal' parenting is consistency and stability during childhood, with clear boundaries and rules. In these ways this fits with Baumrind's (1968, 1971, 1978) typology of authoritative parenting; these women's reflections incorporate a sense that they feel they have benefitted from this type of parenting experience, and that they have grown into well-adjusted and healthy adults as a result. However, the evidence indicates that for some, 'optimal' parenting may still include the presence of physical discipline and aggression from a parent. The use of such techniques may therefore be internalised as acceptable when they occur in a wider warm and supportive environment; there is no evidence, however, that physical parenting practices are adopted by these women. Where there was experience of harsh paternal parenting, a comparison was drawn and her 'optimal' mother was identified as her model for parenting.

These women indicate that they are willing to incorporate all aspects of these maternal models of 'optimal' parenting, and at least do not point to any aspects they regret or wish to avoid. They look to only their own parents when it comes to making these decisions, all citing their mothers as 'good' parents, and they are the only apparent examples on which they draw to inform their own approaches. For each of these women, their mothers remain their main source of support and advice when it comes to parenting decisions.

These women then all draw on their own experiences of 'optimal' maternal examples to frame what it means to be a good mother. As a result, these women feel that they have a model on which to base their own parenting practices, and moreover it is, for them, one which has proven effective. These women highlight the pro-social aspects that their upbringing has provided them with, and as a result they feel able to build good relationships with others, including their own

children. These findings support social learning theory posited by Patterson (1969) and Bandura (1977), whereby a child's real-life exposures and experiences, either directly or indirectly, shape her behaviours. The crucial learning opportunities provided by the interactions with others, in particular parents, allow the development of strategies to manage their own emotions, resolve disputes and engage with other people around them (O'Connor and Scott, 2007).

These pro-social skills are evident in some of the women's accounts, and established literature would suggest that these women may generally find it easier to parent their own children in warm and positive ways (Conger *et al.*, 2009). However, even where their experiences are characterised by 'optimal' approaches from both parents, with one or no ACEs and no recollection of harsh approaches or physical discipline, some still talk of difficulties in coping with their children, and of occasionally responding in aggressive or angry ways. This suggests that even where there is a clear model of 'good' parenting to which they aspire and on which they base their practices, some mothers will find it difficult to consistently parent in these warm and positive ways. These women talk of the personal benefits of their upbringing and their desire to provide their children with the same, but suggest mental health issues and stress are key reasons why they are not always able to parent in the ways they hope.

These findings further indicate, in line with findings from other studies, that although there is intergenerational continuity in positive parenting, perpetuated through the pro-social benefits and the foundations of good interpersonal attachments (Belsky *et al.*, 2009; Madden *et al.*, 2015; Schofield *et al.*, 2014; Shaffer *et al.*, 2009), there is also evident discontinuity. The findings contribute to our understanding that even where positive parenting is observed in one generation, a variety of health, psychological and social characteristics can combine to impact the care that parents in the next generation are able to provide for their children (Serbin *et al.*, 2014).

Evidence from this study provides much needed qualitative insight into some of the factors which may account for this intergenerational continuity and discontinuity of parenting practices. While experiences of positive parenting may foster resilience and provide good social skills, it is, by itself, not always an

indicator that these women will be able to provide the same for their own children, and they therefore may need extra support to do so.

7.2.3.3 Intergenerational Transmission of Negative Parenting

For the six women who reported 'neglectful' maternal experiences, this was characterised by a lack of warmth and support, often an emotionally and/or physically absent mother, and in some cases, substance misuse, violence, physical abuse and neglect. All of these women suggest their decisions around the parenting approaches they adopt and the practices they use are in opposition to those they identify with their own mother. For them, being a 'good' mother means avoiding a repeat of these mistakes and failures, and providing the warmth, affection, care and stability that they feel they lacked in their own childhood. There were instances where 'neglectful' mothers were paired with similar fathers, but also examples where this was countered by more nurturing fathers. Hence there is no support for the idea of 'assortative mating' or continuity due to such parental traits being a culturally or socially accepted norm (Capaldi *et al.*, 2003b).

The perspectives of these women indicate a rejection of the practices they associate with their mothers, especially in terms of physical discipline. For them this is in response to their own memories of how it felt, and their determination to make sure their own children do not experience these same things. A similar approach is taken in attempts to avoid repeating other adverse experiences associated with parental use of alcohol and other drugs. These women's parenting practices can be seen as a result of decisions on what to avoid, alongside attempts to provide the positive aspects they feel were missing from their upbringing.

These women have no past positive maternal examples on which to draw, and in all but one case they also lack the type of relationship with their mother where she may represent a current source of support or advice. However, they feel they are better able to parent in warm and supportive ways due to the support they have around them. They talk of their relationships with their partners, and often their partner's extended family as key areas of support and advice, as well as a model of the type of parenting they aspire to emulate and replicate. Thus,

there is evidence that nurturing romantic relationships may play a role in interrupting the association between harsh parenting observed in one generation and similar behaviours in the next (Conger *et al.*, 2013; Jeon and Neppl, 2019) and those mothers who have potentially insecure attachment styles can provide positive parenting when adequately supported by social networks or through interventions (van Ijzendoorn and Bakermans-Kranenburg, 2019).

The findings here can be contrasted with those of Berlin *et al.* (2011) who found that experience of maltreatment as a child can lead to problematic adult relationships, and lead to higher levels of social isolation and lower levels of social support, meaning added difficulties when it comes to parenting and therefore a greater risk of adopting poor parenting practices.

7.2.3.4 Intergenerational Transmission of 'Affectionless' Parenting

Approaching half of the women interviewed reported the parenting styles of their mothers as characterised by 'affectionless control'. For them, while there is a rejection of the practices they viewed negatively, there is often a direct repetition of the more favourable and desirable practices they associate with their parents. Overall, these women may reject the kind of parenting environment they experienced when it comes to approaches with their own children, but they are able to identify specific practices from their upbringing that have value and are worth repeating.

There are also instances where these women talk about 'turning out fine' in spite of describing having been parented in harsh or affectionless ways. Where this occurs, there is a clear sense from these women that because they feel such practices, which often included physical approaches to discipline, did them 'no harm' then they see no reason why they should not adopt similar practices with their own children. What is common among these women who appear to consciously replicate some of these harsh aspects of parenting is not only the use of minimising language and separation in their minds between physical discipline and violence, but also the closeness of the current relationship they have with their mother. These findings therefore further align with ideas of social reproduction (Bourdieu, 1986) where capital consists of cultural codes and practices, transmissible through family socialisation, from parents to their

children, derived from socially negotiated ties and relationships (Edwards *et al.*, 2003a).

It also provides evidence of antisocial norms and beliefs becoming internalised, where parents often resort to harsh or coercive disciplinary practices, and subsequently their children internalise these norms, beliefs and practices, and in turn form social bonds with their parents. It is in this way that a cycle of externalising behaviours, and resulting harsh parenting practices, may be perpetuated across generations (Capaldi *et al.*, 2003b).

Evidence from this study suggests some of the women identify various health issues that have an impact upon them which they feel are a legacy of their upbringing. Therefore they feel they did not turn out fine, and moreover, these women frequently associate the issues they currently face with the way they were treated by their mothers. Such authoritarian and affectionless parenting styles of mothers have previously been linked with the factors these women discuss: depression, low academic performance, low self-esteem, and aggressive behaviour (Baumrind, 1991; Herz and Gullone, 1999; McClun and Merrell, 1998; Russell *et al.*, 2003; Tata, 2001). For these women, their lived experiences and the ways in which they were treated by their mothers is also indirectly associated with their instinctive, and sometimes aggressive or angry, responses to their own children. They talk of not always being able to parent in the ways they would like, due to low self-esteem, anxiety and depression, for example, and not being able to provide things for their children due to their lack of prospects and educational attainment, resulting from difficulties in school. They also discuss feelings of being unable to cope, and responding in angry ways to their children when stressed with balancing parenting responsibilities and the often competing demands of daily life.

The perspectives of these women - that their experience of negative or harsh parenting practices leads to long term issues that impact upon their ability to consistently parent their own children in positive ways - provide qualitative data that highlight important contextual intermediate factors, and expand upon previous findings that maltreatment in one generation may negatively impact upon parenting in the next (Dixon *et al.*, 2005a; Dixon *et al.*, 2005b).

7.2.4 How can these findings inform parenting interventions like those evaluated by THRIVE?

This section draws upon the findings presented, and relates them to the final research question: how can these findings inform parenting interventions like those evaluated by THRIVE?

Practitioners and policy makers should consider the impact of low parental self-efficacy upon parenting practices. The findings here demonstrate that low self-efficacy can be associated with permissive or harsh parenting responses, which in turn may impact on the development of their child. Given that reduced self-efficacy is associated with anxiety, and anxiety may be driven by previous adversity and drug use, among other things, improving parental self-efficacy will only be effective if underlying issues are understood in their full context, and addressed where possible. Gaining a deeper understanding of the subjective nature of self-efficacy, and how this may be linked to the absence of positive models of parenting, is key if we are to improve the coping skills of vulnerable mothers. The findings here also strengthen the case for further research into the mechanisms by which parenting interventions may improve self-efficacy (Wittkowski *et al.*, 2016).

By improving self-efficacy and coping skills, mothers have been demonstrated to be able to parent in positive ways even if their own mothers did not (Schofield *et al.*, 2014). Improving self-efficacy may increase mothers' confidence that they are able to shape the development of their child (Schofield *et al.*, 2014) rather than reacting with the negative emotional responses exhibited by some mothers in this study.

Interventions that seek to interrupt cycles parenting should consider the utility of the PBI in recording and understanding mothers' experiences of being parented, and how these experiences may shape her current perceptions of parenting. Those interventions which seek to reduce harsh parenting practices should take account of the subjectivity surrounding such practices. They should understand the belief of some mothers that practices such as physical discipline are not only harmless but a necessary part of parenting, a belief that persists alongside knowledge or awareness of alternative strategies. Appropriate ways

should be sought to understand and challenge their apparent willingness to continue these practices, and its roots in their own experiences and parental relationships. If we are to support these women to be able to consistently parent in different ways, then the impacts of important contextual factors, and how they are linked to the ways in which these mothers were raised, need to be understood and addressed where possible.

The findings from this study add further to existing evidence that the perinatal period is an apposite time for parenting interventions (Birtwell *et al.*, 2015), and especially those that aim to induce change via a reflective component (Buston *et al.*, 2019). Given the vulnerable nature of mothers like those included here, the history of adversity they have often faced, and the complex mental health concerns they face, caution should be taken to enable them to reflect on their childhoods in a structured and supported way. The findings discussed here also indicate that the capacity for reflection may be greater in some than in others, but that a reflective component can be a useful way of framing and considering approaches to parenting. More research should be undertaken to find ways to support this type of reflection in those women who may find this difficult.

Evidence that relationships with partners, and often partner's extended family provide key areas of support and advice, as well as a model of the type of parenting these women sometimes aspire to emulate and replicate may also be utilised by practitioners. Interventions which seek to interrupt potentially negative cycles of parenting may be able to build on and utilise existing social connections of at-risk mothers to provide much needed support, and provide positive models of parenting that are more likely to be accepted by these women (Sanders *et al.*, 2019).

Overall, these findings indicate that the lived experiences of these women, the parenting practices they experienced as children, and adversities they may have faced, have a crucial role in the adoption of parenting practices. Therefore, effective parenting interventions that seek to support these women should find ways to take account of these complex factors. By having a greater understanding of the subjective and internalised norms and beliefs that shape approaches to parenting, as well an increased awareness of the social and emotional context in which parenting decisions are made, practitioners and

those that develop interventions such as ETPB and MB can modify them to better support these women. Both interventions should utilise the findings here to better understand the different ways these women reflect upon and respond to their experiences of being parented, and identify and adapt key aspects of the interventions and theory of change models accordingly. For example, since MB contains elements which are designed to aid reflective functioning and improve the abilities of mothers to be more attuned to the needs of their child, understanding how these factors may be connected is crucial. Similarly, ETPB should draw upon the findings that levels of parental self-efficacy may be perceived and reported in subjective ways, as well as leading to different parental approaches. The findings here can help illuminate some of these processes, and give insight as to how both an apparent lack of attunement and low self-efficacy are translated into potentially harsh parenting practices, and therefore this study highlights further key processes amenable to intervention.

Crucially, these findings indicate that policies, services, and interventions which aim to support parents and interrupt negative cycles, need to see parenting in its much wider context. Interventions and services should be delivered flexibly if they are to address the issues facing these families, and they should aim to strengthen parents' social support. Effective support for these parents also needs to take account of and respond to their economic, social and cultural context. There should be recognition that the way to improve children's experiences is by supporting parents, who may have faced adversities themselves, by taking a holistic, community, asset-based approach. Importantly, policies and programmes should look to capture lived experiences, and seek to co-design interventions with those at who they are aimed, in order to better address the issues these mothers face.

7.3 Reflexivity

This section draws upon the discussion from Section 3.6 regarding the interview position I took, and provides reflexive responses to the processes of data generation and analysis in light of the findings outlined above.

It is important to be aware of the potential impacts of myself, as a male researcher, studying arguably vulnerable women. Reinharz and Chase (2002)

suggest this situation gives rise to particular issues concerning the social location and subjectivities of both interviewers and interviewees, and that the researcher must take into account how these may affect the research relationship. This can take the form of topics women may not feel comfortable talking about to men (Padfield and Procter, 1996), concerns for safety and a potentially sexualised research encounter (Trevino, 1992) and access to both space and participants which may be regulated by gender (Crosset, 1992).

Such reflexivity regarding the positionality of the researcher and the impact this has upon the research process and outcomes is one of the main themes in discussions of feminist research. Feminist scholars carry a long-standing belief that interviews should be carried out in as non-hierarchical way as possible, and wherever possible both parties should benefit from the process (Campbell, 1995; DeVault, 1999; Oakley, 1981; Smith, 1987; Wolf, 1996). This can be achieved through consultation and negotiation (Warr and Pyett, 1999) and making interviews more conversational (Hirst, 2004). In essence, if research is to be carried out in an effective and sensitive manner it needs to be mindful of issues regarding access, it needs to build rapport and trust, be sensitive to and respectful of the needs of participants, and provide some element of reciprocity.

When it came to these issues around reciprocity, this - for me - threw up a considerable amount of questions and issues with which I had to grapple. I was initially thinking along the lines of how much, if anything, to reveal about my own background during interviews. Having spent the two years prior to data collection regularly attending THRIVE meetings (the first year as a masters student and the second year while conducting the literature review in the first year of my PhD) I was only too aware of the challenges involved when it came to recruitment and engagement. My initial concern, shared by my supervisors, was that it may prove difficult to effectively engage with these women and that it may be difficult for them to share their experiences with me. It is certainly perceivable that my position as a male researcher, often older than most of my participants, with a different background and accent, and situated within an academic, university context, confers many preconceptions and makes me very different to the people with whom I am attempting to research. However, while

it may be the case that many women who declined the invitation to take part after speaking to me on the telephone did so perhaps because I was male or because I was English, for example, those who did participate gave no indication that they found it problematic speaking with me about personal issues and sensitive topics.

It is also arguable that being neither a woman nor a parent meant I could present myself as somebody with no personal experience or preconceptions of either; therefore I represented a blank canvas for these women. It could also be argued that I did not take for granted what was seemingly everyday to these mothers (Silverman, 2013). Although, when researching parenting and childhood experiences, it is inevitable that I will bring my own knowledge and experiences with me, and it is a subject where one can rarely ever be an 'outsider' (Finlay and Gough, 2008; Griffith, 1998). On the few occasions when I did share details of my own upbringing, usually when recognising personal similarities with things they were telling me, and as a way to encourage them to continue with their thoughts, my impression was that this created a safer environment in which they felt I would understand, and also identify with them without judgement.

These small disclosures, and also the immersion in the wealth of data generated by capturing these women's narratives, inevitably led me to think about my own mother. Like most people, I often reflect on the way I was raised, and I also think about how I might raise my own children if I were to have any. But only recently, in the midst of this research, have I really begun to think deeply about the way my mother raised me - and importantly why she behaved the way she often did. While I am in no doubt that I was loved, my childhood was inevitably shaped by my parents' separation, which followed many years of violence and aggression in the home. Following this, sometimes my mother seemed utterly unable to cope, and the emotional and financial stress we faced as a family seemed unbearable at times. While we undoubtedly had happy times too, the issues caused by the deprivation we faced were never far away, and often my mother's practices in light of this stress included physical and verbal aggression towards me and others. Like many of the women I discuss here, I too wonder why it was not possible to have consistently the kind and loving mother that I occasionally saw. Rather than blame her though, I have reflected a lot on how

she had been raised, what she had been through, and how difficult life was for her at times. I think this is the only option I have given that she is no longer here to ask, or indeed, to defend herself. Identifying as closely as I did with many of the accounts raised in this research may have meant I became too close to the data, and that may have coloured my interpretations. However, it is undoubtedly true that my own upbringing and experiences with my mother are partly what drew me to this topic in the first instance.

Alongside this PhD, I also volunteered as a listener with the Samaritans, who offer support to people in times of emotional distress. There were two main reasons I chose to do this: first, it was driven by a desire to use the skills I already possessed to help other people, but it was also motivated by a desire to gain experience in listening empathetically to difficult stories, and therefore be a better researcher. The intensive training I received not only taught me to be a better listener, but also to be able to react sensitively and pick up on key words and phrases, and at the same time seek clarification what these meant to the person I was talking to, rather than assuming or imposing my own meanings. It also made me appreciate the power of silence, and how space and time to think often give the other person a rare opportunity to clarify their own thoughts. Previously I may have felt pressure to fill these silences with my own thoughts or the next question in the hopes of avoiding any awkwardness, but often it was after a period of silence that my participants made connections between ideas they were not previously aware of, or they said something particularly revealing or salient.

This volunteer work also taught me the importance of being able to listen to the trauma of others without internalising this trauma as my own. Debriefing to my supervisors and to others within the THRIVE research team, as well as being able to talk about the potential impacts upon my own health, meant that I felt able to deal with some of the complex and upsetting stories of these women's lives in a way that showed sensitivity to them while not giving too much of myself.

Overall I feel that the experience and skills I have gained from this volunteer work have been very useful, but I was also aware of one or two instances where during an interview I may have responded in a 'Samaritans' way rather than as a researcher. This occasional blurring crept in and it may have meant I encouraged

my participant to talk more about things that were concerning them (if they wanted to), but these things may not have been entirely relevant to the core issues of the interview. I do not see this as problematic however, since often this not only built rapport and showed empathy, but also provided greater context about these women's backgrounds or their current situations. I also felt this allowed me to discuss these things with more confidence, and further feel comfortable engaging with these issues of trauma and areas of concern when departing from the core concepts of the Adult Attachment Interview.

7.4 Strengths and Limitations

This study has a number of strengths. First and foremost, it sheds light on an under-researched area. Although the literature around the intergenerational transmission of parenting practices is extensive, very little work has been done with vulnerable populations like those recruited to THRIVE. Even less work has been done which brings to the fore the voices of those at whom parenting interventions are aimed. This study helps to address that gap, bringing a much-needed qualitative perspective. It provides these women with an opportunity to articulate how the ways in which they were parented, and the things they experienced as children, have shaped their thoughts and decisions around how they approach the sometimes-difficult task of raising their own children. This study also sheds light on the various social and emotional contextual factors that influence how parenting practices may or may not be repeated across generations, something also previously absent from much of the literature on this topic.

As well as this qualitative perspective, this study was also able to utilise mixed methods to answer different research questions and to bring a deeper, richer, and more contextual understanding. By analysing baseline THRIVE data and utilising the PBI, a more rounded and comprehensive picture can be painted of the factors which impact these women's lives and the decisions they make around parenting. This use of several sources of data enables a triangulation of the findings, whereby together they reinforce one another and together build a stronger foundation on which to base conclusions.

The PBI provided a validated and reliable indication of the participants' experience of the parenting style they were exposed to when they were children. This allowed them firstly to be categorised, and the wealth of data analysed accordingly. The PBI is an easy to use and easy to score tool that can be readily reproduced and replicated in future studies. Despite the retrospective nature of the instrument, and the inherent issues therein regarding recall bias, the PBI scores resonated well with the qualitative interview data, meaning I was usually able to predict PBI scores post-interview. This lends weight to the validity of the PBI and its ability to capture a holistic recollection of how one was parented. Using the AAI to provide a narrative arc during interviews, but in a flexible way which allowed open follow-up questions, also enabled deeper discussions of lived experiences.

One of the inherent limitations regarding gathering accounts retrospectively, through interviews, is however, recall bias. It is entirely possible that when asked to think back many years and recall stories of their parents and their relationship with them, that this would be influenced by their current state of mind, their current mental health, and their current relationship with their parents. It is possible, for instance, that these recent factors shape their recollections and focused their minds on particularly happy events and experiences if they were in a good place at the time of interview, or conversely if they were in a depressed state they may be more likely to recall negative past experiences. Either way, it is true to say that any personal recollection is by its very nature an entirely subjective one, and interviews like those conducted here can only give a snapshot of such a complex issue. However, since the PBI has been demonstrated to be independent of current mood, depression, and other mental health issues, this serves to further reinforce the validity of the qualitative data gathered during interviews.

In similar ways to those described above, it is feasible that when asked to recall previous events and experiences, that only the most dramatic or vivid memories are accessed, whether positive or negative. By recalling either of these extremes, it may be that the day-to-day mundane aspects of the overall ways in which they were parented are forgotten. Nonetheless, this study gives insight into the perspective of these women, and how they think the ways in which they

were raised have shaped their approaches with their own children. Given the range of recollections included here, there is no indication that these women were idealising their childhoods or their parents, and I felt that the interviews reflected an honest, open engagement with the topic, and often sensitive and deeply personal information was shared.

As discussed in Chapter 3, any findings from qualitative research are by their nature shaped by the characteristics of the researcher. The findings presented are based on my interpretations of the participants' own narratives and their representations of their experiences. The representations they chose to present will have been influenced, among other things, by their perception of me as a researcher. Many of these women may be used to telling their story to social workers or other agencies, and healthcare professionals, and it is possible that they viewed me in the same way. Despite assurances of confidentiality, it may be that some of these women felt information from the interview may have been shared with these agencies, and therefore have an impact upon decisions regarding the care of their children, for example. Although every effort was made to ensure the women were comfortable and at ease during interviews, and that power imbalances were minimised, it is still possible that their judgement of me as an 'outsider' (Finlay and Gough, 2008; Griffith, 1998) may have influenced the account they chose to present to me on the day. Therefore, in interpreting the findings it is important to remember that they are based on my interpretations of the accounts that the women chose to present to me.

As well as recall issues, it is also the case that this study relies upon the women's own accounts of their parenting practices and their responses to their children. Although some of the respondents did talk of displaying anger, aggression, frustration and physical approaches towards their children, it is possible that others were less able or willing to share such details. The inclusion of an objective measure of these women's actual parenting practices may serve to strengthen further the findings of studies similar to this one.

Another potential limitation is the homogeneity of those interviewed, with regard to ethnicity. Although diverse in terms of age, background, and representing a range of characteristics that may make them vulnerable, the vast majority of the women recruited to THRIVE were white, and those interviewed

were exclusively white and from the UK. This study lacks therefore any perspective of women raised outwith the UK, and does not include any perspectives on intersectional disadvantage that may influence this transmission of parenting, or any perspectives on ethnically different parenting traditions or cultures. This ethnic homogeneity of those interviewed is, however, representative of the THRIVE population, as well as statistics which indicate around 90% of the population of Greater Glasgow is white (Walsh *et al.*, 2019).

Another major strength of this study is having access to THRIVE baseline data, which at the point I was accessing it had already been collected, collated, cleaned and coded. Few PhD projects would have this data readily available, nor the support and expertise available within the THRIVE team to recode the numerous variables and help to inform and guide the analysis. This quantitative data again helps to triangulate the findings and brings contextual information to the qualitative findings. It gives an indication of how representative the interview sample is, highlights the breadth and depth of the adversities and particular vulnerabilities of the population of interest, and allows for a more in-depth analysis of the factors which shape the parenting practices of these women.

However, the decision to use this THRIVE data also carries with it some limitations, especially in regard to the analysis being potentially limited by the use of this 'secondary' data, where questions were formulated and asked by other researchers. Although extensive baseline data was gathered, it meant working with what was already established and available in order to analyse the factors that are associated with parental self-efficacy. The ability to include different measures or variables, for example a more robust or validated measure of self-efficacy, may have yielded different results.

Also, the reliance on others to process the data carries limitations and implications. Due to slower than anticipated recruitment to THRIVE, post-intervention follow-up data were not available for analysis during this study. Having access to this post-intervention data may have further strengthened these findings and brought greater insights and understanding. As such, this study relies upon a cross sectional analysis, and therefore lacks any longitudinal perspective. Further it relies upon self-reporting of issues around parenting

practices, self-efficacy, drug use, involvement in the criminal justice system, adverse life events, and mental health issues, all of which may be prone to underreporting, recall bias and memory issues.

Overall, this mixed methods study provides robust and replicable evidence of how parenting practices are repeated or interrupted across generations, and the contextual factors which impact this transmission. It outlines the factors associated with parental self-efficacy among a vulnerable group of mothers, and also provides them with a voice, giving much-needed qualitative insights that help inform future parenting interventions that are targeted at women like them.

7.4.1 Future Research

Future research should be undertaken in light of the findings of this study, and the limitations previously outlined. Further research should include an examination into the mechanisms by which parenting interventions may improve self-efficacy (Wittkowski *et al.*, 2016), as well as understanding how self-efficacy may be best defined and measured. Future research should also look to expand upon the qualitative findings of this study, and in particular continue to examine how subjective experiences of parents influence attachment and bonding (Condon, 2012; Scopesi *et al.*, 2004), and ultimately the practices these women adopt with their own children.

Future studies should consider exploring these perspectives among other vulnerable groups, as well as more diverse populations than those represented here. Finally, future research projects could utilise longitudinal data, such as that collected at follow-up by THRIVE, in order to understand how perceptions around parenting practices and parental self-efficacy, such as those outlined in this study, may shift over time with different life circumstances.

7.5 Conclusion

The overarching objective of this PhD project was to gain an understanding of how parenting practices are transmitted across generations. It sought to understand, from the perspective of mothers with additional health and social

care needs, how their childhood experiences and the ways in which they were parented impact upon the parenting practices they adopt with their own children. It also sought to uncover the factors associated with parental self-efficacy.

Its position as part of a wider trial evaluating two parenting interventions for vulnerable mothers offered a unique opportunity to study approaches to parenting in the context of complex backgrounds and often experience of multiple adversities. The findings have demonstrated that the presence of these adverse experiences in childhood, and the women's responses to them, sometimes make it difficult for these women to raise their own children in warm, responsive and caring ways.

Reflections upon one's own childhood and the relationships with parents are acute around the perinatal period. As well as this being a time of change in these relationships, reflections upon past experiences can be seen to shape conceptualisations of motherhood. Moreover, it is by responding to these reflections, consciously or unconsciously, that these women can be seen to frame their decisions and approaches with their own children.

These reflections may, depending upon the type of parenting they associate with their own mother, lead to attempts, or at least aspirations, to emulate the practices they recall, or to reject these practices and the approaches of their parents entirely. Others may take a more ambivalent approach. Some mothers aspire to emulate their mother's parenting practices but find it difficult to do so, while some who reject the practices of their parents and aim to parent in very different ways may find themselves reacting intuitively and instinctively, and as a result responding in the ways they hoped to avoid repeating. Perceptions of parenting practices may be subjective and deeply rooted in personal experience, and behaviours that are arguably antisocial or harmful may be internalised and normalised, which therefore presents particular challenges to interrupting cycles of such practices.

Where there is a perceived lack of a suitable model of parenting from their own mothers, this is often sought elsewhere, and frequently a partner's family are held to be the aspirational model of good parenting. However, all of these

responses are impacted by a variety of contextual factors, including these women's current relationships with their mother, their mental health, other proximal factors, and their children's moods or behaviour.

The findings highlight how emulating and repeating aspects of parenting - both supportive, caring parenting and potentially more harsh aspects such as physical discipline - happen in a much wider context. Historic and ongoing social deprivation, financial precarity, instability around relationships and housing, as well as mental health issues and the current relationship these women have with their mothers, all contribute to a complex environment in which these women navigate the challenges of raising their own children.

Taken together, the findings of this study add to our understanding of parenting, and how actions and practices in one generation may impact upon subsequent generations. This research gives valuable insights into the multitude of factors that impact upon parenting practices, in an especially vulnerable population. It sheds some light on the interactions between complex processes involving parents, children, communities, and cultural contexts identified in Bronfenbrenner's (1994) ecological developmental framework. It highlights further how the multitude of factors which influence how people raise their children operate in complex interactions with one another.

By bringing light to these areas it is hoped that this study can contribute to developing a deeper and more nuanced understanding of parenting, and how the childhood experiences of some of the most vulnerable members of our society influence their approaches as they navigate the task of raising their own children. Through this increased understanding, and by giving a voice to these women, it is hoped this research can contribute to the ongoing development of appropriate support to help these disadvantaged mothers become the kinds of parents they aspire to be. By including the perspectives of those at whom interventions are targeted, we will be better able to support these women to break negative cycles of adversity and experiences of harsh parenting, and in turn provide better outcomes for them and their children.

Appendix 1 - Participant Information Sheet

PARTICIPANT INFORMATION SHEET

Title of Project

How people's own upbringing influences their subsequent parenting practices.

Name of Researcher

Simon Barrett

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Telephone: 0141 353 7645

Invitation

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish.

Please ask if there is anything that is not clear or if you would like more information.

Take time to decide whether or not you wish to take part.

What is the purpose of the study?

I am trying to establish if and how your own upbringing, and events from your own life, have shaped your relationships with your own children and how you approach raising them. I also want to talk about how you feel this may have an impact upon your own health and the health of your children, and how any negative impacts may be addressed.

Why have I been chosen?

You have been invited because you are already involved with the THRIVE Trial, and I would like to add to this research and hear your views on this particular topic. It will help me with my research, but it will also enable you to make your own voice heard and explore what I think is a very interesting subject.

Do I have to take part?

No, not at all; I am trying to get lots of people's ideas and opinions on this important topic, and it would be great to talk to you, but there is no pressure for you to take part if for any reason you don't want to. If you do agree to take part and then later change your mind that's ok too. You can withdraw at any time and you don't have to give me reason if you want to stop.

What will happen to me if I take part?

You will be invited to take part in an interview with myself, at a time and location that suits you. This will take around an hour or two, and if it is ok with you the interview will be recorded.

Will my taking part in this study be kept confidential?

Absolutely; anything we discuss will remain private and confidential, and the recordings will only be heard by me and possibly a trained transcriber. There will be no information left in which will be able to identify you personally and an alternative name will be used instead of your real one.

Please note that these assurances on confidentiality will be strictly adhered to unless evidence of wrongdoing or potential harm to others is mentioned. In such cases I may be obliged to contact relevant statutory bodies/agencies.

What will happen to the results of the research study?

I will write up the findings of my research and submit my work to the University of Glasgow as part of my studies. The work may be used in journals or articles or conferences in the future, and you are more than welcome to see my final work if you'd like.

Who is organising and funding the research?

The research is part of my studies at the University of Glasgow, and I am funded by the Medical Research Council, Social and Public Health Sciences Unit, 200 Renfield Street, Glasgow, G2 3QB.

Who has reviewed the study?

The study has been reviewed and monitored by my two supervisors at the University of Glasgow, Dr Katie Buston (Katie.buston@glasgow.ac.uk) and Dr Marion Henderson (Marion.henderson@glasgow.ac.uk). You can also contact them by telephone on 0141 353 7500 if you want to raise any concerns. The study has also been reviewed and approved by the NHS Greater Glasgow and Clyde Research Ethics Committee.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. If they are unable to help you or you wish to make a complaint about the study, please contact the Institute of Health and Wellbeing, University of Glasgow, Research Support Manager by phone on 0141 353 7500 or by email at survadmin@sphsu.mrc.ac.uk.

In the unlikely event that something does go wrong and you are harmed during the research you may have grounds for a legal action for compensation against the University of Glasgow, but you may have to pay your legal costs. The normal National Health Service (NHS) complaints mechanisms will still be available to you. You can contact 0141 201 4500 for Greater Glasgow and Clyde NHS Complaints Team and 01292 513 620 for Ayrshire and Arran NHS Complaints Team.

Appendix 2 - Consent Form

Parenting Practices and the Influence of Upbringing

Title of Project: How people's own upbringing influences their subsequent parenting practices.

Name of Researcher: Simon Barrett

Please initial the box if you agree

I confirm that I have read and understood the Participant Information Sheet (V2.1 03/08/17) for the above study and have had the opportunity to ask questions.	
I understand that my participation is voluntary and that I am free to withdraw at any time, or stop the interview, without giving any reason.	
Audio Recording	
I consent to interviews being audio-recorded.	
I acknowledge that participants will be not be referred to by name or any other identifying information, and that anonymised data and findings may be archived and later shared with other researchers.	
I agree to take part in this research study.	
I would like to see and discuss the transcript and early analysis of today's interview.	
I would like to see the final report from this study.	

Participant Name		Signature		Date	
Researcher Name	Simon Barrett	Signature		Date	

Appendix 3 – Revised Multivariate Regression

		Title			
Step	Variable(s) Entered	Model 1 (95% C.I.)	Model 2 (95% C.I.)	Model 3 (95% C.I.)	Model 4 (95% C.I.)
1	Aged <25 (vs. >25 (young mum FNP definition) and median age) (yes N = 217; no N = 246)	*1.639*** (1.127 – 2.385)*	*1.640* (1.112 – 2.420)*	1.524 (0.940 – 2.471)	1.395 (0.846 – 2.301)
(N = 463)	Living in Most Deprived SIMD Quintile (1) (yes N = 287; no N = 176)	*2.063*** (1.392 – 3.058)*	*1.966*** (1.321 – 2.926)*	*1.847** (1.219 – 2.798)*	*1.965** (1.278 – 3.022)*
2	Looked after child status (yes N = 142; no N = 321)		1.272 (0.833 – 1.942)	1.112 (0.703 – 1.758)	1.177 (0.733 – 1.892)
(N = 463)	No reported experience of domestic, physical or sexual violence in the past (yes N = 192; no N = 271)		1.396 (0.939 – 2.076)	1.126 (0.731 – 1.736)	1.249 (0.794 – 1.965)
3	Young/teenage mum <age 19 (yes N = 81; no N = 382)			1.925 (1.076 – 3.445)	1.485 (0.794 – 2.776)
(N = 463)	No reported history of drug use, recreational and misuse (yes N = 233; no N = 230)			*1.571* (1.048 – 2.355)*	1.482 (0.973 – 2.256)
	Child Protection Order (yes N = 84; no N = 379)			*2.890** (1.453 – 5.748)*	*2.965** (1.455 – 6.043)*
	Reports child protection concerns or social work involvement (yes N = 162; no N = 301)			1.182 (0.686 – 2.039)	1.141 (0.649 – 2.006)
	Experienced mum with 2 or more children (2 -5) (0-1 N = 365; 2-5 N = 98)			1.430 (0.815 – 2.511)	1.465 (0.813 – 2.640)
4	Low HADS Depression (low N = 212; high N = 251)				1.428 (0.910 – 2.242)
(N = 463)	Low HADS Anxiety (low N = 215; high N = 248)				*2.126** (1.331 - 3.394)*
	No reported history of mental health problems (no N = 139; yes N = 324)				1.482 (0.909 – 2.416)
	-2 Log likelihood Nagelkerke R Square	618.334 0.061	613.200 0.075	576.054 0.160	547.126 0.228
	*p < 0.05; **p < 0.01; ***p< 0.001				Chi-square: 9.248; df: 8; Sig: 0.322

Appendix 4 - Parental Bonding Instrument

Mother

This questionnaire asks about your memories of your mother during your first 16 years. For each question, please tick the box that is most like your mother's attitude or behaviour.

Please tick only **one box per question**.

		Very like	Moderately like	Moderately unlike	Very unlike
1	She spoke to me in a warm and friendly voice.	1	2	3	4
2	She did not help me as much as I needed.	1	2	3	4
3	She let me do those things I liked doing	1	2	3	4
4	She seemed emotionally cold to me.	1	2	3	4
5	She seemed to understand my problems and worries.	1	2	3	4

		Very like	Moderately like	Moderately unlike	Very unlike
6	She was affectionate to me.	1	2	3	4
7	She liked me to make my own decisions.	1	2	3	4
8	She did not want me to grow up.	1	2	3	4
9	She tried to control everything I did.	1	2	3	4
10	She invaded my privacy.	1	2	3	4

		Very like	Moderately like	Moderately unlike	Very unlike
11	She enjoyed talking things over with me.	1	2	3	4
12	She frequently smiled at me.	1	2	3	4
13	She tended to baby me.	1	2	3	4
14	She did not seem to understand what I needed or wanted.	1	2	3	4
15	She let me decide things for myself	1	2	3	4

		Very like	Moderately like	Moderately unlike	Very unlike
16	She made me feel I wasn't wanted.	1	2	3	4
17	She could make me feel better when I was upset.	1	2	3	4
18	She did not talk with me very much.	1	2	3	4
19	She tried to make me feel dependent on her.	1	2	3	4
20	She felt I could not look after myself unless she was there.	1	2	3	4

		Very like	Moderately like	Moderately unlike	Very unlike
21	She gave me as much freedom as I wanted.	1	2	3	4
22	She let me go out as often as I wanted.	1	2	3	4
23	She was overprotective of me.	1	2	3	4
24	She did not praise me.	1	2	3	4
25	She let me dress in any way I pleased.	1	2	3	4

Appendix 5 - Topic Guide

1   Could you start by helping me get an idea of your early family situation, and where you lived and so on? If you could tell me where you were born, where you lived, who you lived with, whether you moved around much, what your family did at various times for a living.

2   I'd like you to try to describe your relationship with your parents as a young child – if you could start from as far back as you can remember?

3   Now I'd like to ask you to choose five words that describe your relationship with your mother, starting from as far back as you can remember in early childhood – as early as you can go, but say, age 5 to 12 is fine. I know this may take a bit of time, so go ahead and think for a minute; then I'd like to ask you why you chose them. I'll write each one down as you give them to me.

4   Now I'd like to ask you to choose five words that describe your childhood relationship with your father, again starting from as far back as you can remember in early childhood – as early as you can go, but again say, age 5 to 12 is fine. I know this may take a bit of time, so go ahead and think again for a minute...then I'd like to ask you why you chose them. I'll write each one down as you give them to me.

5   Now I wonder if you could tell me, did you feel closer to one parent rather than the other?

6   When you were upset as a child, what would you do?

7   Did you ever feel rejected as a young child? Of course, looking back on it now, you may realize it wasn't really rejection, but what I'm trying to ask about here is whether you remember ever having felt rejected in childhood?
   a   How old were you when you first felt this way, and what did you do?
   b   Have you ever spoken to your parents about these things – do you think he/she realized he/she was rejecting you?

8   Can you tell me about the first time you remember being separated from your parents?

9   Did you ever feel threatened in any way as a child – maybe for discipline, or even jokingly?

   a   Did anything like this ever happen to you, or in your family?

   b   How old were you at the time?

   c   Did it happen frequently?

   d   Do you feel this experience affects you now as an adult?

   e   Does it influence your approach to your own child?

   f   Did you have any such experiences involving people outside your family?

10   In general, how do you think your overall experiences with your parents have affected your adult personality? Is there anything about your early experiences that you think might have held your development back, or had a negative effect on the way you turned out?

11   Were there any other adults with whom you were close, like parents, as a child?

12   Now I'd like to ask you a few more questions about your relationship with your parents. Were there many changes in your relationship with your parents (or remaining parent) after childhood? We'll get to the present in a moment, but right now I mean changes occurring roughly between your childhood and your adulthood?

13   So, turning to the present, can you tell me about your situation now? How many children you have, their ages, your living/working arrangements.

14   Now I'd like to ask you, what is your relationship with your parents (or remaining parent) like for you now as an adult? Here I am asking about your current relationship.

15   I'd like to move now to a different sort of question – it's not about your relationship with your parents, instead it's about an aspect of your current relationship with your child/children. How do you respond now, in terms of feelings, when you separate from your child/children?

16   If you had three wishes for your child twenty years from now, what would they be? I'm thinking partly of the kind of future you would like to see for your child. I'll give you a minute or two to think about this one.

17   Is there any particular thing which you feel you learned above all from your own childhood experiences? I'm thinking here of something you feel you might have gained from the kind of childhood you had.

18   How would you describe yourself as a mother, and how would you describe your approach to parenting? Your approach to monitoring, support, discipline etc.

   -What do you feel gets in the way of you being the sort of parent you want to be?

-Parenting can be challenging and change day-to-day. What do you think makes a good day or a bad day?

19 Do you feel that the way you were raised by your parents has affected how you approach parenting?

If so, in what ways? Can you give me some examples?

20 We've been focusing a lot on the past in this interview, but I'd like to end by looking quite a way into the future. We've just talked about what you think you may have learned from your own childhood experiences, but what would you hope your own child might have learned from his/her experiences of being parented by you?

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Appendix 6 – Coding Framework

Name	Description
Advice or Support	Other sources of advice or support which lead to decisions around adopting certain parenting practices
• Direct from Mother	Where the participant's mother is a source of support and advice currently, and has some sort of influence on the parenting practices they adopt
• Friends or Relatives	Where the mother sees/discusses good examples or good outcomes with her friends' or relatives' children and adopts those approaches or practices with her own
• Groups	Where parenting practices are directly influenced by advice or instruction from parenting groups
• Healthcare Workers	Where parenting practices are directly influenced by advice or instruction from midwives, support group workers, other mothers, social workers
• Internet	Where parenting practices are directly influenced by advice or instruction from online forums or apps
• Other Influences Upon Parenting	
Approaches to discipline	How these women talk about the discipline they remember, and also their approaches to disciplining their own children
Children Driving Practices	The dynamic interaction between parenting practices and the individual child – participants talk about things working with one child and not with another, and how practices change according to the child's behaviour, (and also the child's age), and also not knowing 'what sort of child you are going to get'
Contextual Factors	And how parenting practices are shaped by the mother's current circumstances
• Barriers to parenting	Issues or circumstances that impact upon their parenting approaches, or prevent them from parenting how they hoped or expected to parent
• Mental Health Issues	The impact these have on parenting practices and approaches to parenting
• Past Experiences, Traumas, violence, abuse	The impact these have on parenting practices and approaches to parenting
• Physical Health Conditions	The impact these have on parenting practices and approaches to parenting

Experienced Parents	Where there are older children or stepchildren in the home, participants talk about doing things differently with their younger children, and having learned from their 'mistakes'
Giving Their Child(ren) Something They Themselves Feel They Missed	Where participants discuss a sense of regret that they missed out on something as a child, and base parenting decisions upon a desire to provide this for their own children. Similarly, where they feel that experiences from childhood were very valuable, they discuss making sure they repeat those things with their children
Impacts Upon Personality	Where participants discuss the impact of their parents' attitudes and behaviours upon their own personality, and how this in turn shapes their own current approaches to parenting
Influence (or not) of Partner	Where parenting practices are influenced by the presence or the absence of a partner/father; these may be moderated because of a partner and (his) experiences, directly influenced because (he) has control, or parenting practices may be adapted or influenced taking into account the partner's absence
Ingrained Instincts	Participants talk about how they may initially react to issues they encounter with their children, but then reflect that they recognise this as repeating patterns of their parents and then seek to address this and attempt to make different decisions next time
Modelling of Behaviours	Where the participant expresses an explicit desire to continue the practices their own parents adopted, or conversely where they state the opposite – that they wish to do something differently from what they themselves experienced
• Positive Modelling	Where the participant expresses an explicit desire to continue the practices their own parents adopted
• Oppositional Modelling	Where the participant indicates that they wish to do something differently from what they themselves experienced
• Mixed modelling	Where the participant expresses an explicit desire to continue some of the practices their own parents adopted, but a rejection of other practices
Reflecting Upon How She Felt as a Child	A recognition and reflection upon how the attitudes and behaviours of their parents left them feeling as a child, and an expressed desire to make sure that their children do not experience those same feelings
Role Model for Children	Where parenting practices are framed as behaving in a way that sets an example for your children in terms of current behavioural expectations, and also teaching them skills that will enable them to develop later on and achieve in life

Temporal Aspects of Parenting	A reflection that the way their parents approached parenting was indicative of the time, and that parenting has changed, hence they do things differently; also the idea that you could do things back then you cannot do now, and also how society was different and 'safer'
Trial and Error and Seeing What Works	Participants talk about not really having a plan or an expectation of how they will parent, nor any defined approach to parenting, and acknowledge that it is largely learning from mistakes and adapting all the time

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