

ORIGINAL ARTICLE

What Do I Bring to the Team? Self-Capacities Mediate the Association Between Childhood Interpersonal Trauma and Parenting Alliance in Couples

Camille Andrée Rassart¹  | Alison Paradis¹  | Martine Hébert²  | Natacha Godbout² 

¹Department of Psychology, Université du Québec à Montréal, Montreal, Québec, Canada | ²Department of Sexology, Université du Québec à Montréal, Montreal, Québec, Canada

Correspondence: Camille Andrée Rassart (rassart.camille-andree@courrier.uqam.ca)

Received: 16 October 2024 | **Revised:** 18 December 2025 | **Accepted:** 21 January 2026

Keywords: actor-partner interdependence model | childhood interpersonal trauma | coparenting | parenting alliance | self-capacities

ABSTRACT

Parents exposed to childhood interpersonal trauma are at risk of reporting difficulties following the birth of a child. Although parenting alliance is crucial for both parental and infant well-being, it is often overlooked for trauma survivors in the postpartum period. More research is needed, focusing on both co-parents and using a dyadic and longitudinal approach to understand the underlying mechanisms. Self-capacities offer insights into trauma's effects at different life stages and might play a role in survivors' parenting alliance. Using a dyadic and longitudinal design, this study examined the possible mediating role of self-capacities in the association between cumulative childhood interpersonal trauma (CCIT) and parenting alliance. A randomly selected sample of 923 couples who recently had a child, completed questionnaires on CCIT, self-capacities disturbances (i.e., affect dysregulation, identity disturbance and interpersonal conflicts), and parenting alliance at two time-points (T1, T2). Path analyses revealed that, when controlling for parenting alliance at T1, CCIT was associated with lower parenting alliance at T2 for both mothers and fathers, through interpersonal conflicts and affect dysregulation at T1. Precisely, a higher disposition to interpersonal conflicts mediated the link between one parent's CCIT and their own parenting alliance, while higher affect dysregulation mediated the link between one parent's CCIT and their co-parent's parenting alliance. Findings suggest that CCIT survivors may struggle with parenting alliance through affect dysregulation and interpersonal conflicts during early postpartum, highlighting self-capacities as both prevention and intervention targets to foster parenting alliance.

1 | Introduction

The first year following the birth of a child is a time of significant transition for most parents. This period is characterized by additional pressures on the couple's resources (Keizer and Schenk 2012), and by cognitive, emotional, and behavioral challenges (Ahmed et al. 2019). Recent studies on postpartum mental health show that parents with a history of childhood trauma tend to report more difficulties than non-survivors (Godbout

et al. 2023; Rassart et al. 2023). Parenting alliance is a unique component of the couple relationship that is linked to increased parental and infant well-being (Kang et al. 2020). Despite being central to families' postpartum lives, the quality of parenting alliance in childhood trauma survivors is understudied, and there is limited data on how childhood interpersonal trauma may be related to parenting alliance. In this regard, self-capacities could have important implications for parenting alliance as they are intrinsically linked to resilience following trauma (Briere 1996).

1.1 | Childhood Interpersonal Trauma

Childhood interpersonal trauma refers to negative experiences that occur during childhood or adolescence within a relational context, including sexual abuse, physical and psychological violence, physical and psychological neglect, exposure to interparental violence (Godbout et al. 2023) and peer bullying (Espelage et al. 2016). In Canada, one in three children reports having been a victim of physical (26%) or sexual (8%) violence, or having witnessed physical violence by a parent or guardian (10%) before the age of 15 (Afifi et al. 2014). Epidemiological and self-report studies have shown that survivors tend to experience multiple different forms of childhood interpersonal trauma across their childhood and adolescence (Dugal et al. 2018; Finkelhor et al. 2009). More recently, a study of over 25,000 Canadian adults found that 35% of survivors report more than one form of adverse childhood experiences, including interpersonal trauma (Joshi et al. 2021), while studies conducted with heterosexual couples from the general population report an average of 2.5 to 3 types of childhood interpersonal trauma (Dugal et al. 2018; Godbout et al. 2020). Such accumulation, referred to as Cumulative Childhood Interpersonal Trauma (CCIT), is related to more severe symptoms (e.g., depression, posttraumatic stress) in survivors, even when accounting for the severity of each individual trauma (e.g., sexual or physical abuse; Finkelhor et al. 2007; McKay et al. 2021). These symptoms tend to be long-lasting and intensified during stressful events where vulnerability is increased, notably when having a new child (Siverns and Morgan 2019). Studies have shown that survivors tend to report more challenges during the postpartum period (for a review on mothers from diverse ethnic backgrounds, see Christie et al. 2018), including higher parenting stress (Hugill et al. 2017) and higher postpartum depression (Choi et al. 2017; Godbout et al. 2023). Current research has mainly focused on intrapersonal outcomes for parents, but since childhood trauma often involves relational aspects (e.g., attachment figures, known perpetrators), relational outcomes should also be examined. Furthermore, a growing number of studies suggest that CCIT has significant repercussions not only for survivors but also crossover effects for their intimate partners (e.g., Dugal et al. 2020; Vaillancourt-Morel et al. 2019). It is therefore important to examine the impact of CCIT on dynamics between parents, specifically how each parent perceives their coparenting relationship.

1.2 | Parenting Alliance

Parenting alliance refers to the level of respect, support, and communication between coparents towards their respective parental roles and involvement (Abidin and Konold 1999; McHale and Lindahl 2011). It represents the degree to which coparents form a good team when caring for their child. During the first months postpartum, the perception of a greater parenting alliance is associated with lower parenting stress (Kang et al. 2020), reduced risk of maternal postpartum depression (Pilkington et al. 2016), and better infant outcomes, such as improved executive functioning and fewer behavior problems (Altenburger and Schoppe-Sullivan 2021; Choi and Becher 2019). These key findings highlight the importance of studying parenting alliance and its correlates. Yet, studies on which factors are linked to lower

parenting alliance remain sparse, making it difficult to identify which parents are vulnerable to low parenting alliance. This limited data may stem from the difficulty of assessing parenting alliance from only one parent's perspective, and the challenge of recruiting fathers or couples. Grounded in family systems theory (Minuchin and Fishman 1975; Olson et al. 1979), parenting alliance highlights the interdependent nature of parenting where interinfluences between coparents in their functioning are expected. Authors clearly distinguished parenting alliance from other individual parenting outcomes (e.g., sense of competence), framing parenting alliance as an interpersonal process and a dynamic system rather than a collection of isolated individual outcomes (Feinberg 2003; McHale and Lindahl 2011). The dynamic and interpersonal nature of parenting alliance further highlights the need to adopt a dyadic perspective to study parenting alliance, ensuring that both parents' experiences are considered.

1.3 | Childhood Interpersonal Trauma and Parenting Alliance

As a fundamentally interpersonal component of the parenting experience (Feinberg et al. 2016), parenting alliance could be specifically affected by childhood interpersonal trauma. Indeed, these early interpersonal experiences tend to negatively color intimate relationships in adulthood, including those with the life partner with whom one coparents a child. Many studies have highlighted the negative repercussions of childhood interpersonal trauma on relationships in adulthood (e.g., marital satisfaction; Godbout et al. 2009, communication; Banford Witting and Busby 2019). Trauma-related repercussions could include a lower parenting alliance, a relationship dynamic central to the daily life of couples with children. Indeed, a cross-sectional study with 84 White mothers of school-aged children revealed that intrafamilial childhood sexual abuse was negatively linked to parenting alliance (Cole et al. 1992). More recently, a study showed that CCIT was associated to lower parenting alliance in heterosexual couples welcoming a newborn, through a lower disposition to mindfulness (Rassart et al. 2023). These studies highlight the importance of further exploring the link between childhood interpersonal trauma and parenting alliance, as well as identifying the key risk factors driving this relationship. Examining further the association between CCIT and parenting alliance is of the utmost importance since parenting alliance is intrinsically linked to parenting practices (Choi and Becher 2019), and trauma survivors may find themselves in an intergenerational cycle where their own experience of maltreatment is being transmitted to their child (Greene et al. 2020). The identification of such mechanisms could indeed guide prevention and intervention aimed at fostering parenting alliance and survivors' long-term resilience as parents.

1.4 | The Role of Self-Capacities Disturbances

Self-capacities represent the main areas of functioning potentially altered in the aftermath of childhood interpersonal trauma and are crucial for managing that same trauma (Bigras and Godbout 2020; Briere 1996). Self-capacities encompass three key areas: (a) maintaining personal identity and self-awareness

(identity cohesion); (b) regulating strong negative emotions without resorting to tension-reduction activities (affect regulation); and (c) sustaining meaningful relationships without undue conflict or fears of abandonment (relatedness). These three self-capacities echo the “disorders in self-organization” criteria of the complex post-traumatic stress disorder diagnosis depicted in the International Classification of Diseases (ICD-11). The development of self-capacities appears to be especially altered by childhood interpersonal trauma due to its early and often cumulative nature (Bigras et al. 2017; Dugal et al. 2018). In return, survivors with affect dysregulation, identity, and relatedness disturbances could struggle to experience a strong parenting alliance. Studies indicate that self-capacities help explain the association between CCIT and couple functioning in predominantly white and heterosexual couples, with different self-capacities being linked to specific relational outcomes (e.g., sexual satisfaction, intimate partner violence; Bigras et al. 2016; Dugal et al. 2021). While these outcomes differ from parenting alliance, they involve couple dynamics, such as communication, problem-solving, and support, that can impact childrearing and coparenting. Yet, no study has examined all three self-capacities in relation with CCIT and parenting alliance.

Links have, however, been documented between variables reflecting self-capacities and parenting alliance. In their study with heterosexual couples, Kolak and Volling (2007) found that when parents managed to express more positive emotions and less negative emotions, they also reported a greater parenting alliance with more cooperation and fewer conflicts. Sheftall et al. (2010) linked attachment avoidance to lower parenting alliance among predominantly White adolescent mothers, suggesting relatedness issues. Although identity cohesion has been less studied, Fagan (2021) found that among fathers from diverse ethnic backgrounds, a stronger parental identity was associated with better parental involvement and coparenting, characterized by supportive interactions and less maternal gatekeeping. Fathers with higher parental identity reported lower maternal gatekeeping, indicating better collaboration with a co-parent who was more supportive and encouraging of their involvement with the child. A recent study also documented mindfulness as a mediator in the association between CCIT and parenting alliance (Rassart et al. 2023). Mindfulness disposition, characterized by non-reactivity, is generally incompatible with affect dysregulation (Roche et al. 2019), which could indicate the underlying role of self-capacities at play. Further examining childhood interpersonal trauma and self-capacities in relation to parenting alliance. Exploring the possible impact of CCIT on parenting alliance using mediating variables that reflect the complexity of trauma sequelae could help fill in an important gap in the current literature on trauma and parenting. Doing so within a dyadic study where the interinfluences between parents are accounted could in turn provide information on how to help survivors get the most from parental programs where parenting alliance is so often key.

1.5 | The Current Study

The aim of this study was to examine the mediating role of self-capacities (i.e., affect regulation, identity cohesion, and relatedness) in the association between CCIT and parenting alliance

among couples. Within a longitudinal design, this study aimed to examine the mediating role of self-capacities disturbances (T1) in the relationship between CCIT (measured at T1) and parenting alliance (T2). Since parenthood generally involves two parents in a relationship and considering the various dyadic processes that may occur between one parent's CCIT and their coparent's functioning, this study adopted a dyadic approach (Kenny et al. 2006) to effectively capture this interplay. It was hypothesized that one parent's higher level of CCIT would be associated with their own and their coparent's lower parenting alliance. This study then aimed to examine every possible mediation path within the parental dyad. For example, within the same parent's variables, one parent's higher level of CCIT was expected to be associated with their own self-capacities disturbances at T1, which, in return, would be associated with their own lower parenting alliance at T2. At the dyadic level, one parent's level of CCIT would be positively associated with their own self-capacities disturbances at T1, which would then be negatively associated with their partner's later parenting alliance at T2. We also expected to observe the hypothesized indirect effects when controlling for the parenting alliance at T1, thus increasing the reliability of the observed mediation effects. Finally, this study also aimed to examine possible gender differences in the associations between CCIT, self-capacities disturbances, and parenting alliance. Given that past studies have shown differences as well as similarities between mothers and fathers during early postpartum (e.g., Leavitt et al. 2017), the role of gender in these associations remains exploratory.

2 | Method

2.1 | Participants and Procedure

Participants were recruited as part of a larger longitudinal research project on links between childhood interpersonal trauma and parental functioning. After ethical process and authorization by the Commission d'accès à l'information (i.e., organization responsible for implementing the Access Act and the Privacy Act, and for protecting citizens' personal information), contact details (i.e., names, phone numbers, and email addresses) from parents across the province of Quebec were randomly selected through a partnership with the Quebec Parental Insurance Plan (QPIP; parental leave income replacement plan for parents of a newborn). The research team reached out to both parents by email and phone to confirm their eligibility and offer them to be part of the study. Couples who had separated by the time they were contacted were deemed ineligible and thus not invited to participate in the study. Data were collected at two timepoints; during the first 6 months postpartum (T1) and 6 months following the first participation (T2). For both T1 and T2, parents were invited to individually complete an online questionnaire hosted on the Qualtrics platform, using a personalized code. Each participation required approximately 40 min, and each parent was compensated with a 20\$ gift card. The study was approved by the research ethics committee of the University of Quebec in Montreal. The inclusion criteria were (a) being parents of an infant less than 8 months of age at T1, (b) being 18 years of age or older (legal age in the province of Quebec), (c) being in a couple relationship with the co-parent, (d) being fluent in written and spoken French or English, and (e) one of the parents had carried

the child. At T1, the completion rate among parents that were contacted by the research team was 56%. Among the parents contacted who did not participate, 26% declined for personal reasons (e.g., lack of time) while 18% accepted but failed to complete within the required timeframe.

At the time of the study, 923 couples ($n=1846$ parents) had completed T1 and were eligible to complete T2 6 months later. A total of 142 couples from the baseline T1 sample did not complete T2, consisting in an attrition rate of 15.4% (for more details on attrition at T2, see Table S1). Further analyses were conducted to examine potential differences between parents who completed both T1 and T2 ($n=781$) and those who did not complete the second wave ($n=142$). Mothers who completed both waves tended to have slightly higher levels of education ($M=3.52$) than those who did not continue in the study ($M=3.33$), $t(818)=2.03$, $p=0.04$. Mothers who did not complete the second wave tended to have more children ($M=2.01$) than those who continued ($M=1.74$), $t(813)=-2.72$, $p=0.01$. As for fathers, those who completed both waves tended to report a higher score of CCIT ($M=2.83$) than those who only completed T1 ($M=2.06$), $t(921)=4.014$, $p<0.001$. However, fathers who dropped out of the study showed slightly higher average scores of affect dysregulation (14.5 vs. 13.5; $t[918]=-2.02$, $p=0.04$) and had more children (2.06 vs. 1.74; $t[816]=-3.49$, $p<0.001$) than those who continued. There were no other significant differences in demographic characteristics (i.e., age, relationship length, income) and scores (i.e., CCIT, self-capacities, parenting alliance) between parents who remained in the study and those who did not. All analyses reported in the current study were conducted with the full sample of 923 couples (923 mothers and 923 fathers). On average, mothers in the final sample were 30.34 years of age ($SD=5$; range=19–50 years) while fathers were 32.41 years of age ($SD=5.96$; range=20–57 years). Most parents were born in Canada (84.1%) and spoke French as their primary language (85.3%). As for ethnicity, 83.1% of participants identified as White, 4.3% as Black, 2.8% as Middle Eastern, 2.3% as Latino, 1.6% as Mixed, 1.2% as East Asian, 1.1% as South Asian, 0.7% as Indigenous, and 1.1% as belonging to other ethnicities. Additionally, 0.4% of participants did not specify their ethnicity, while 1.4% preferred not to answer. In mothers, 40.1% reported a gross annual salary below \$ 40,000 CAN, more than a third (36%) had completed a technical level of education, and 32.4% had completed a university undergraduate degree. In fathers, 16.8% reported a gross annual salary below \$ 40,000 CAN or more, 39.8% had completed a professional level of education, and 24.1% had a university undergraduate degree. These characteristics are similar to available data on average income and education levels in Canada (Statistics Canada 2021, 2022a) and is close to the reported data on cultural diversity in the province of Quebec (Statistics Canada 2022b). Regarding marital status, 71.8% ($n=663$) of parental couples were in common-law relationships (i.e., living together but not married) and 28.3% ($n=260$) were married. The average relationship duration was 7.1 years and ranged from 11 months to 22 years ($SD=4.11$). All participants were parents of an infant and reported an average of 1.8 children ($SD=1.02$). More precisely, 48.8% of parents had welcomed their first child, 33% had welcomed their second child, 14.4% had welcomed their third, and 3.8% had welcomed their fourth child or more. The age of the infant varied from 1 week to 6 months ($M=2.52$ months; $SD=1.5$) at T1, and from 6 months

to 16 months ($M=8.7$ months; $SD=2.38$) at T2. At T1, 27.4% of parents in the sample participated during the first wave of the COVID-19 pandemic, while 13.4% participated during the same period at T2. This first wave period was targeted according to the measures established in the province of Quebec and its declared state of emergency (i.e., starting on March 14th, 2020, and ending on August 23rd, 2020).

2.2 | Measures

2.2.1 | Childhood Interpersonal Trauma

Cumulative childhood interpersonal trauma (CCIT) was assessed at T1 using the Childhood Cumulative Trauma Questionnaire (CCTQ; Godbout et al. 2017). In light of studies showing that CCIT is the strongest predictor of symptomatology in survivors (Finkelhor et al. 2007; McKay et al. 2021), the current study used a measure encompassing a wide range of different types of traumas and allowing to assess its accumulation. The CCTQ assesses eight different forms of childhood interpersonal trauma: physical abuse, psychological abuse, physical neglect, psychological neglect, sexual abuse, peer bullying, and exposure to interparental psychological and physical violence, using 24 items. Childhood sexual abuse was assessed based on Canada's Criminal Code and considered if it had occurred at least once before the age of 18 (i.e., age of majority in the province of the study). As for other forms of interpersonal traumas, participants were asked to report how often they experienced them during a typical year, via a 7-point Likert scale ranging from 0 (*never*) to 6 (*every day*) and each form was considered if it had occurred at least once, during a typical year before the age of 18. Each form of childhood trauma was then first dichotomized as experienced (1), or not (0) and summed to form an index of CCIT, ranging from 0—no childhood trauma to 8—eight different childhood traumas. The resulting continuous score has been used in many previous studies when operationalizing CCIT (e.g., Godbout et al. 2020; Dugal et al. 2018). The CCTQ has shown satisfactory psychometric qualities in previous studies (e.g., Bigras et al. 2017) as well as in the current sample, with Cronbach's alpha indicating satisfactory internal consistency (mothers; $\alpha=0.90$, fathers; $\alpha=0.89$), corresponding to previous alphas from studies using the CCTQ.

2.2.2 | Self-Capacities

Self-capacities were assessed at T1 using scales from the Inventory of Altered Self-Capacities (IASC; Briere and Runtz 2002; translated and validated in French by Bigras and Godbout 2020). The IASC is a standardized instrument validated within the general population which has been developed specifically for adults who have experienced interpersonal trauma (Briere and Runtz 2002). The scales of affect dysregulation, identity impairment, and interpersonal conflicts measured the self-capacities of affect regulation, identity cohesion, and relatedness respectively. Each of the scales consists of 9 items rated on a 5-point Likert scale ranging from 1 (*never*) to 5 (*very often*). The total score for each subscale ranges from 9 to 45; a higher score indicates a higher level of alteration of self-capacities. Cronbach's alphas in the current study indicated high internal consistency

of all three scales: affect dysregulation (mothers; $\alpha=0.88$, fathers; $\alpha=0.91$), identity impairment (mothers; $\alpha=0.85$, fathers; $\alpha=0.87$) and interpersonal conflicts (mothers; $\alpha=0.85$, fathers; $\alpha=0.86$), similarly to the alphas observed in validation studies (Bigras and Godbout 2020).

2.2.3 | Parenting Alliance

Parenting alliance was assessed at T1 and T2 using the Parenting Alliance Measure (PAM; Abidin and Konold 1999). The PAM is a self-reported 20-item questionnaire measuring perceived respect between parents (3 items) and perceived communication and teamwork within the parental couple (17 items). Participants were asked to answer on a 5-point Likert scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*) and according to their experience with the same child for which they answered measures during the last assessment. Ranging from 20 to 100, the total score is obtained through a sum of the items, with a higher score indicating a higher parenting alliance. In the current study, the total score showed excellent internal consistency at T1 (mothers; $\alpha=0.94$, fathers; $\alpha=0.93$) and T2 (mothers; $\alpha=0.94$, fathers; $\alpha=0.94$), similarly to past studies with parents of infants (e.g., Kang et al. 2020).

2.3 | Data Analysis

Descriptive and correlational analyses were performed using the Statistical Package for Social Sciences software (SPSS 26; IBM Corp., 2016). The hypothesized model was tested using the software Mplus 8.4 (Muth en and Muth en 2015). This software allowed us to conduct analyses robust to non-normality through the use of Maximum Likelihood Estimation with Robust Standard Errors (MLR) and to handle missing data for the parenting alliance and self-capacities disturbances measures at T1 using the Full Information Maximum Likelihood (FIML) procedure.

Considering that the current sample is made up of parental couples, we wished to examine potential dyadic links between CCIT, self-capacities, and parenting alliance. Therefore, structural equation modeling was guided by an extension of the Actor-Partner Interdependence Model (APIM) incorporating potential effects of mediating variables from both parents simultaneously (APIMeM; Ledermann et al. 2011). Within the APIMeM model, the exogenous (i.e., CCIT level) and the endogenous parent (i.e., parenting alliance) variables of each were simultaneously linked according to the actor effect (i.e., relationship between a parent's CCIT levels and their own parenting alliance) and to the partner effect (i.e., relationship between a parent's CCIT level and the parenting alliance of their coparent). As suggested by the MacArthur approach (Kraemer et al. 2008), we used a longitudinal design with two time points to examine autoregressive effects between an outcome variable at T1 and the same outcome variable at T2. Parenting alliance scores at T1 were included in the model and lagged onto the parenting alliance scores at T2 in the form of autoregressive links. This allowed the examination of the hypothesized mediation effects between CCIT and parenting alliance while controlling for the parenting alliance at T1. In this longitudinal design, CCIT is deemed to be a fixed

marker as it happens in childhood and is constant across the study's measurement waves.

Parameter estimates were constrained to determine whether a more parsimonious model would provide a better fit to the data; that is, if estimates could be constrained to be equal across fathers and mothers and be considered equivalent (Ledermann et al. 2011). All actor links, partner links, autoregressive links, and covariances were progressively constrained to be equal between mothers and fathers. Further model comparison examined if actor and partner effects could be constrained to be equal. For example, we examined if the effect of mothers' CCIT on mothers' parenting alliance was statistically equivalent to the effect of fathers' CCIT on mothers' parenting alliance. Produced constrained models were compared to the baseline APIMeM model and were compared with each other using the rescaled -2 log likelihood difference test (Satorra and Bentler 2010; Sadikaj et al. 2020). A non-significant chi-squared test value ($\alpha=0.05$) was used to assess the significance of the model fit decrease. Throughout the analyses, every path and covariance was retained in the model, whether significant or not. A combination of a non-statistically significant chi-square value, a ratio value of chi-square to degrees of freedom (χ^2/df) less than three, comparative fit index (CFI) and Tucker-Lewis index (TLI) values of 0.90 or higher, and a root mean square error of approximation (RMSEA) value below 0.06 were used to determine whether the parsimonious APIMeM model was well-adjusted to the data (Kline 2011).

The bootstrap resampling method was used in the final model to test whether the indirect effects of self-capacities were significant (Hayes 2017). This technique allows estimating indirect effects by testing them in 10,000 randomly selected subsamples. If the bootstrap confidence interval obtained does not contain zero, the indirect effect is considered to be significant (MacKinnon and Fairchild 2009). Control variables were progressively tested in the final constrained APIMeM model and were as follows: maternal and paternal age, maternal and paternal income, maternal and paternal level of education, maternal and paternal number of children, as well as assessment during the COVID-19 pandemic at either T1 or T2.

3 | Results

3.1 | Descriptive Statistics

Results of paired comparison tests indicated that CCIT scores were statistically different between mothers and fathers ($t[914]=2.57$, $p=0.01$), with mothers reporting a higher score. Rates of CCIT among parents were as follows: 11.3% of mothers and 17% of fathers reported no trauma, 17.7% of mothers and 19.4% of fathers reported one type of trauma, 22.4% of mothers and 20.3% of fathers reported two forms of trauma, 16.6% of mothers and 15.6% of fathers reported three forms of trauma, and 32.1% of mothers and 27.7% of fathers reported four or more forms of trauma. There were also significant differences between mothers and fathers regarding their scores on the IASC scales (self-capacities disturbances); mothers reported more identity disturbance than fathers ($t[920]=2.9$, $p=0.004$), more interpersonal conflicts than fathers ($t[921]=2.88$, $p=0.004$), and

more affect dysregulation than fathers ($t[920] = 5.58, p < 0.001$). Parenting alliance scores differed significantly between mothers and fathers both at T1 ($t[921] = -2.54, p = 0.01$) and at T2 ($t[780] = -2.37, p = 0.02$), with fathers reporting higher parenting alliance at both time-points. Results indicated a significant decrease in parenting alliance means between T1 and T2 for both mothers ($t[780] = 2.76, p = 0.006$) and fathers ($t[780] = 2.70, p = 0.007$). In mothers, the correlation between the control variables (i.e., sociodemographic characteristics) and the main study variables ranged from 0.01 to 0.13, while in fathers, it ranged from 0.01 to 0.10. Table 1 presents the means and standard deviations for all measures as well as the correlations observed among CCIT scores, IASC scales scores, and parenting alliance scores.

3.2 | APIMeM Model of the Link Between CCIT and Parenting Alliance Mediated by Self-Capacities

The first set of path analyses was performed to examine direct links between CCIT and parenting alliance, revealing significant actor links for mothers ($\beta = -0.16, p < 0.001$) and fathers ($\beta = -0.21, p < 0.001$). As for partner links, mothers' higher CCIT was associated with fathers' lower parenting alliance ($\beta = -0.15, p < 0.001$) while more CCIT in fathers was associated with mothers' lower parenting alliance ($\beta = -0.17, p < 0.001$). In total, actor and partner direct links explained 5.8% and 8.2% of parenting alliance in mothers and in fathers respectively.

To examine the mediating role of self-capacities in the associations between CCIT and parenting alliance, we included identity disturbance, interpersonal conflicts, and affect dysregulation scores. Covariances between self-capacities were significant, and standardized estimates ranged between 0.64 and 0.68. Then, parenting alliance scores at T1 were added to the fully saturated-baseline APIMeM model. All paths and covariances could be constrained to be equal across gender without significant fit decrease when compared to the saturated-baseline model, indicating gender invariance. The same comparison process with nested models allowed us to observe that the association between one's parent CCIT and their own parenting alliance did not statistically differ from the association between one's parent CCIT and their co-parent's parenting alliance, $\chi^2_{(59)} = 0.47, p = 0.49$ (for all comparisons, see Table S2). Non-significant associations were progressively removed, leading to the final constrained model. In the final model (see Figure 1), pooled standardized estimates are reported since all links were found to be statistically equivalent between mothers and fathers. This model was found to adequately fit the data, CFI = 0.999, TLI = 0.999, RMSEA = 0.08 [0.000, 0.026], $\chi^2_{(32)} = 36.052, p = 0.3691, \chi^2/df = 1.13$, and explained 44.3% ($p < 0.001$) and 43.7% ($p < 0.001$) of the variance in mothers' parenting alliance and fathers' parenting alliance, respectively.

In the final model (Figure 1), three significant mediation effects were found for each co-parent (i.e., the mother and the father within a same couple). Bootstrap confidence intervals showed that one parent's level of interpersonal conflicts significantly mediated the link between their own CCIT level and their own parenting alliance ($\beta = -0.031, p < 0.001, 95\% \text{ CI } [-0.047, -0.015]$). One parent's level of interpersonal conflicts also mediated the

link between their co-parent's CCIT and their own parenting alliance ($\beta = -0.008, p = 0.004, 95\% \text{ CI } [-0.014, -0.003]$). In addition, one parent's level of affect dysregulation mediated the association between their own CCIT and their co-parents' parenting alliance ($\beta = -0.020, p = 0.003, 95\% \text{ CI } [-0.033, -0.007]$).

Covariates were added one at a time in the final model to assess its robustness to socio-demographic and confounding variables. Specifically, parents' age, level of education, personal annual income, age of infant, number of children, as well as participation during the COVID-19 pandemic at T1 were regressed on self-capacities scores. Then, parents' age, level of education, personal annual income, age of infant, number of children, and participation during the COVID-19 pandemic at T2 were regressed on parenting alliance scores at T2. In mothers, none of the tested covariates were significantly related to either self-capacities or parenting alliance scores. In fathers, parental age at T1 was negatively associated with identity impairment ($\beta = -0.01, p = 0.01$) and affect dysregulation scores ($\beta = -0.01, p = 0.02$), indicating more disturbances for these self-capacities in fathers of younger age. The same links with similar magnitude were observed in the model when including significant covariates, with minor variations in standardized estimates (ranging 0.001–0.004), indicating that the model remained stable while controlling for covariates.

4 | Discussion

This study aimed to examine the association between cumulative childhood interpersonal trauma (CCIT) and the perceived parenting alliance in couples with an infant and assess whether this association was mediated by self-capacities disturbances. Using a longitudinal design, findings show that when controlling for parenting alliance at T1, the association between CCIT and later parenting alliance at T2 was mediated by postpartum levels of interpersonal conflicts and affect dysregulation (measured at T1). Dyadic links were also observed between one parent's CCIT and their co-parent's parenting alliance, again, partially explained by self-capacities disturbances.

4.1 | Cumulative Childhood Interpersonal Trauma and Parenting Alliance

The terms parent and co-parent are used in the following text to represent both mothers and fathers, as no significant gender differences were found in the associations. As expected in our first hypothesis, one parent's level of CCIT was associated with their reported parenting alliance. Therefore, a higher number of different forms of endured childhood interpersonal traumas is linked to the perception of a lower quality of the parenting alliance at 8 months postpartum (i.e., average infant age in this sample at T2). These results are in line with studies that documented the links between childhood interpersonal trauma and parenting alliance (Cole et al. 1992; Rassart et al. 2023). Additionally, parents reported experiencing, on average, nearly three distinct forms of childhood interpersonal trauma. This finding aligns with previous research conducted with adult populations and CCIT (e.g., Godbout et al. 2020) and underscores that such early traumatic experiences affect not only intrapersonal components

TABLE 1 | Correlation matrix between CCIT, self-capacities disturbances and parenting alliance among mothers and fathers ($n = 1846$ parents).

Variables	M (SD)	1	2	3	4	5	6	7	8	9	10	11	12
1. Mothers' CCIT	2.96 (2)												
2. Mothers' AD	15 (5.58)	0.30***											
3. Mothers' II	13.96 (5.17)	0.28***	0.69***										
4. Mothers' IC	15.64 (4.57)	0.32***	0.67***	0.56***									
5. Mothers' PA ^{T1}	89.11 (9.73)	-0.17***	-0.28***	-0.26***	-0.29***								
6. Mothers' PA ^{T2}	88.34 (10.58)	-0.18***	-0.24***	-0.25***	-0.28***	0.67***							
7. Fathers' CCIT	2.71 (2.09)	0.16***	0.18***	0.14***	0.16***	-0.14***	-0.19***						
8. Fathers' AD	13.66 (5.76)	0.08*	0.18***	0.23***	0.20***	-0.21***	-0.24***	0.29***					
9. Fathers' II	13.34 (5.22)	0.10**	0.20***	0.23***	0.23***	-0.13***	-0.17***	0.31***	0.71***				
10. Fathers' IC	15.10 (4.75)	0.11***	0.19***	0.20***	0.26***	-0.21***	-0.23***	0.35***	0.69***	0.59***			
11. Fathers' PA ^{T1}	90.02 (9.19)	-0.14***	-0.24***	-0.17***	-0.23***	0.35***	0.30***	-0.23***	-0.29***	-0.32***	-0.24***		
12. Fathers' PA ^{T2}	89.29 (9.91)	-0.19***	-0.24***	-0.22***	-0.24***	0.30***	0.40***	-0.24***	-0.31***	-0.35***	-0.30***	0.61***	

Abbreviations: AD, affect dysregulation; CCIT, cumulative childhood interpersonal trauma; IC, interpersonal conflicts; II, identity impairment; PA^{T1}, parenting alliance at T1; PA^{T2}, parenting alliance at T2.

* $p \leq 0.05$.

** $p \leq 0.01$.

*** $p \leq 0.001$.

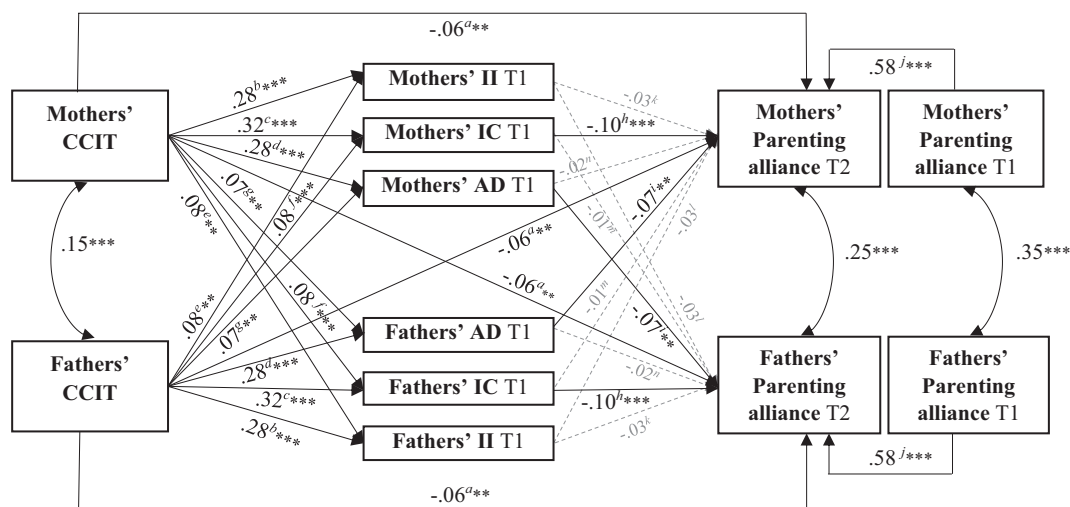


FIGURE 1 | Constrained APIMeM Model of the mediating role of self-capacities disturbances in the association between CCIT and parenting alliance ($n=923$ couples). AD = affect dysregulation; CCIT = cumulative childhood interpersonal trauma; IC = interpersonal conflicts; II = identity impairment. Pooled standardized estimates are reported for links that were found to be statistically equivalent. Identical subscripts (*a, b, c, d, e, f, g, h, i, j, k, l, m, n*) represent links that have been constrained to be equal. Significant links are in bold. Covariances between variables were kept in the final model but not included in this figure to preserve visual clarity. * $p \leq 0.05$; ** $p \leq 0.01$; *** $p \leq 0.001$.

of parenting, as previously documented (e.g., postpartum depression, attitudes towards parenting; Christie et al. 2018) but also interpersonal ones. Results showed that one parent's higher CCIT is associated with their co-parent's perception of a lower parenting alliance (partner effect), but they also went further, showing that this association is equivalent to the one between one parent's own CCIT and their own lower perception of parenting alliance (actor effect). This supports the idea that childhood interpersonal trauma tends to affect both partners in intimate relationships (e.g., Dugal et al. 2020). The proximity co-parents often experience during early postpartum may add to the entanglement of CCIT sequelae between them and partially explain why one parent's childhood experiences similarly affect both parents' perception of the parenting alliance.

4.2 | The Mediating Role of Self-Capacities Disturbances

Three mediation effects involving self-capacities disturbances were found for both parent and co-parent within the dyad. These findings are further supported by the fact that all significant effects held while controlling for parenting alliance at a previous time-point. Indeed, the longitudinal design involving two time-points allowed for better directionality assessment. In the same parent, we first hypothesized that the level of CCIT would be linked to more self-capacities disturbances at T1 which, in return, would be linked to lower perceived parenting alliance at T2. This mediation effect was found for interpersonal conflicts (i.e., self-capacity of relatedness); the more a parent had endured CCIT, the more they reported interpersonal conflicts and instability in their relationships (friends, colleagues, family, etc.) and in return, reported a lower parenting alliance. These parents may find that conflicts with others interfere with their developing coparenting relationship at home, especially as they face numerous postpartum strains (e.g., reduced sleep; Keizer and Schenk 2012). This could explain the mediating role of

interpersonal conflicts in the link between CCIT and lower parenting alliance. Beyond relationships with others, parents could have also directly referred to conflicts with their co-parent, accounting in part for the association between CCIT and parenting alliance. CCIT survivors reporting more conflictual relationships may also be deprived of important sources of support during postpartum. Less perceived social support can leave parents unsatisfied about their romantic relationship (e.g., Jim enez-Pic on et al. 2021), and the same phenomenon could translate into the perceived co-parental alliance during postpartum. Finally, an increased tendency for conflicts could reflect underlying interpersonal dysfunctions (e.g., hostile attribution bias, difficulties with communication and interpersonal problem-solving) related to childhood interpersonal trauma (Janovsky et al. 2020; Zhu et al. 2020). Such dysfunctions could be exacerbated during stressful transitions and would necessarily have an impact on the quality of parenting alliance, and the parent's perception of it.

Second, we had postulated that one parent's level of CCIT would be linked to their own self-capacities disturbances, which would be linked to their partner's lower reported parenting alliance 6 months later. Results showed this hypothesized mediation effect for affect dysregulation. In other words, the more a parent had endured CCIT, the harder they found it to regulate their emotions, and the lower their partner's perception of the parenting alliance was. These results suggest that, during early postpartum, parents who experienced CCIT could struggle when attempting to cope with negative emotions, and therefore resort more to tension-reduction strategies (Briere 1996; Dugal et al. 2018). This echoes Rassart et al. (2023) findings that CCIT survivors tend to report less dispositional mindfulness, which in return is negatively associated with both parents' perceptions of their coparenting. Difficulties with staying in the present moment could reflect what the current study is indicating; a disruption of core emotional regulation capacities in CCIT survivors as they deal with their coparent during the postpartum period.

In return, these parents could be perceived as less supportive or less reliable from their partner's perspective. Qualitative studies with first-time parents revealed that successful coparenting relies on being present with one's co-parent, even amidst challenges, and not making them feel left to their own devices (Sheedy et al. 2019). Having the partner well-regulated throughout postpartum challenges (e.g., sleepless nights), could increase their capacity to form a strong parental team. Although post-traumatic symptomatology was not assessed, CCIT survivors in this study could be at risk for such symptoms (Bigras et al. 2017), and the dysregulated states they encompass (e.g., hyperarousal, flashbacks; Ludmer et al. 2018). Such dysregulation could alter the quality of communication about childrearing, reduce responsiveness to the child and partner, and lead to a lower perceived parenting alliance by the co-parent. Interestingly, one parent's affect dysregulation was linked to their partner's parenting alliance, but not to their own perception of parenting alliance. At the time of the study, parents were adjusting to new experiences with their newborns, some parenting for the first time. In this context of novelty, some parents may not have yet developed the coping mechanisms needed to handle a co-parent's changing moods. As a result, the partner's dysregulation could be even more impactful than personal self-regulation abilities. These results are consistent with a previous study showing that partner effects may be more significant than actor effects when couples experience together new experiences (Paradis et al. 2017). Our findings also point to the necessity of examining parenting alliance within a dyadic design, with access to the inter-influence between parents, since partner effects may contribute more than actor effects.

Lastly, we found that one parent's CCIT was linked to their partner's tendency for interpersonal conflicts which, in turn, was linked to their partner's reported lower parenting alliance 6 months later. Specifically, a parent with greater exposure to CCIT was more likely to have a partner who struggles with interpersonal relationships and who reports a lower parenting alliance. Given that CCIT survivors themselves were more likely to experience interpersonal conflicts, it is possible that this entanglement between the trauma of one parent and the self-capacities disturbances of their co-parent is in fact due to a certain resemblance between partners from a same couple in the sample. Past studies have shown that romantic partners often share similar experiences of childhood interpersonal trauma (Andersson et al. 2021). Therefore, CCIT survivors may be more likely to be paired with partners who have similar trauma exposure and corresponding self-capacities. Previous studies identifying such entanglement also suggest that certain underlying mechanisms (e.g., negative urgency) may foster the crossover of one parent's trauma sequelae to their partner's (Dugal et al. 2020), thus highlighting the need to use a dyadic approach.

Although identity impairment was associated with both CCIT and parenting alliance in bivariate correlations, it was not related to parenting alliance in the final integrative model. Affect regulation and relatedness thus appeared to be more intrinsically connected to the perception of parenting alliance. During daily interactions, co-parents probably need affect regulation and low conflicts in priority to work as a team, discuss their coparenting, and manage their postpartum challenges. Identity may be a less proximal and less tangible process for survivors to

experience, grasp, and then relate to their ongoing perception of their coparenting experience. It is also possible that the presence of affect dysregulation, interpersonal conflicts, and parenting alliance at T1, competing for variance in the same model, may have prevented weaker links with identity impairment from being significant.

4.3 | Clinical Implications

The study has significant implications for the parenting alliance of CCIT-exposed parents in their child's first year. The first year postpartum is often a period during which parents spend more time together with their child, and during which the foundations of their co-parenting relationship are formed or challenged. It may be possible to take advantage of this time to prepare CCIT-exposed parents and prevent parenting alliance difficulties. Our results suggest that fostering affect regulation and relatedness could be beneficial to promote parenting alliance. For example, it could be helpful to use cognitive processing strategies tailored to trauma experience and its impact (Resick et al. 2024), to promote distress tolerance skills, and to use mindfulness strategies aimed at observing and accepting emotions (Linehan 2014). Addressing postpartum tensions with the entourage could also benefit CCIT survivors, who often face more conflicts and report a lower parenting alliance. This might be achieved through communication strategies used in couple-focused parenting programs (e.g., Couple CARE for Parents; Heyman et al. 2019). In fact, since pre and postpartum programs often focus on parenting alliance (e.g., Feinberg et al. 2016; Philipp et al. 2020), it seems relevant for these programs to adopt a trauma-informed approach. This could translate into recognizing signs of traumatic sequelae and actively prevent re-traumatisation (Huang et al. 2014), but also into a focus on self-capacities disturbances. Finally, the identified dyadic effects in this study suggest that prevention and intervention efforts should target both co-parents and account for their interdependence in co-parenting.

4.4 | Limitations and Future Directions

The results of the current study need to be examined with consideration for their inherent limitations. Its correlational design does not allow to infer any causation between variables. At least, controlling for parental alliance at a previous time-point helps us assess the contribution of self-capacities disturbances to our outcome (i.e., parenting alliance T2) independently of the contribution of parental alliance at T1, eliminating a major confounding factor in these associations. Although participants at T1 were selected randomly, it is possible that those who took part in the study were parents who functioned better or had more availability in their postpartum schedule to do so. For example, parents who did not complete the second wave of the study tended to have more children. This potential selection bias should be considered when generalizing the study's findings to broader populations of parents. Yet, the participation of higher-functioning couples may have allowed for a more conservative test of our proposed model. Therefore, the links identified between CCIT, self-capacities and parenting alliance in this study may be especially strong, as they were detected among well-functioning parents who might exhibit high adaptation and even resilience. It is

important to note that the use of self-reported measures to measure the parenting alliance is a limitation, as it depends on the parent's perception rather than direct observation of coparenting. However, studying parents' perceptions remains relevant, and the use of dyadic data ensures the study is not limited to the perspective of a single parent. Finally, as the current sample was limited to different-gender and predominantly White couples, the results cannot be generalized to parents from more diverse ethnic backgrounds or to same-gender couples. Future work needs to include more diverse parents and couples in order to examine how potential differences in CCIT, self-capacities disturbances, and parenting alliance may come into play.

Despite these limits, this study offers insights based on two measurement waves during the first postpartum year, when crucial elements for the adjustment of survivors and their families come into play. It provides much needed insight on childhood interpersonal trauma and parenting alliance and offers cues on targets to focus on in existing interventions for CCIT-exposed parents who are welcoming a new child in their lives.

Funding

This work was supported by the Social Sciences and Humanities Research Council Insight Grant (grant no. 435-2017-1015) and a Research Scholar Grant from the Fonds de recherche du Qu ebec—Sant e (grant no. 251615) to Natacha Godbout and by doctoral fellowships to Camille Andr ee Rassart from the Social Sciences and Humanities Research Council (grant no 752-2021-2505) and the Fonds de recherche du Qu ebec—Soci et e et Culture (grant no. 301816).

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

Research data are not shared.

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Supporting Information

Additional supporting information can be found online in the Supporting Information section. **Appendix S1:** famp70124-sup-0001-AppendixS1.docx.