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Trauma transmission among parent survivors of cumulative childhood interpersonal trauma: The protective role of partner support

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ABSTRACT

Background: The intergenerational transmission of cumulative childhood interpersonal trauma (CCIT) is well established. While the protective role of relational factors, including partner support, is well recognized, few studies examined this question using dyadic designs, representing an important gap in the literature.
Objective: This study tested whether provided and received partner support (i.e., the support one provides to their partner and the support one receives from their partner) moderated the association between parents' CCIT and their own and their partner's child abuse potential (CAP).
Participants and setting: Participants were 607 heterosexual couples ($N = 1214$ parents) of toddlers recruited from a community-based longitudinal study in Canada.
Methods: Parents completed validated self-report measures of CCIT, partner support, and CAP. Analyses were conducted using the Actor-Partner Interdependence Model (APIM), accounting for non-independence of dyadic data and controlling for stressful life events.
Results: Parents' CCIT was positively associated with their own CAP ($\beta = 0.178$, $p < .001$). Received partner support was negatively associated with CAP ($\beta = -0.288$, $p < .001$) and moderated the CCIT-CAP link both within ($\beta = -0.094$, $p = .008$) and across partners ($\beta = -0.075$, $p = .026$). The association between CCIT and CAP became nonsignificant at high levels of received support. The final model explained 30% of CAP variance and fit the data well.
Conclusions: Supportive couple dynamics mitigate the intergenerational transmission of trauma. Enhancing perceived partner support represents a promising avenue for preventing child maltreatment among trauma-exposed parents.

1. Introduction

Childhood interpersonal trauma, defined as traumatic experiences that occur before the age of 18 within a relational context, affects a significant proportion of the population. Epidemiological studies indicate that nearly 60% of individuals report having

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experienced at least one interpersonal trauma in childhood (Finkelhor et al., 2009; Morriss et al., 2024). Eight forms of victimization are commonly subsumed under childhood interpersonal trauma: psychological, physical and sexual abuse, psychological and physical neglect, exposure to psychological and physical interparental violence, and peer bullying (Bigras et al., 2017). Each of these forms of victimization has been independently linked to enduring physical and mental-health sequelae (Bigras et al., 2021; Carpenter & Stacks, 2009; D'Arcy-Bewick et al., 2022; Hooven et al., 2012; Takizawa et al., 2014). However, research increasingly highlights the importance of considering their co-occurrence. Studies have shown that facing cumulative childhood interpersonal trauma (CCIT), which refers to an accumulation of different forms of interpersonal traumas (Briere & Scott, 2015; Finkelhor et al., 2009; Godbout et al., 2017a), exerts more deleterious effects than any single trauma, even after accounting for the severity of individual incidents (Briere et al., 2016). CCIT is prevalent, with 30–50% of adults in North American community samples reporting an average of 2.5 to 3 concurrent trauma forms when all eight categories are assessed (Bigras et al., 2017; Briere et al., 2015; Godbout et al., 2023). Meta-analytic and longitudinal evidence links CCIT to a spectrum of adverse outcomes (Afifi et al., 2016; Fink & Galea, 2015; Jaffee, 2017; Vaillancourt-Morel et al., 2024; Zamir, 2022) that can be reactivated or exacerbated by significant stress (McLaughlin et al., 2010). Such adverse effects are particularly relevant in the context of parenting, when the challenges of caring for young children may reactivate vulnerabilities (Rassart et al., 2022). Early childhood represents a critical period, during which children begin to assert autonomy while still requiring substantial parental guidance, which can significantly increase parental stress and the risk of coercive or abusive practices (Cicchetti & Carlson, 1989). Adverse parenting behaviors at this stage may exert profound and lasting effects on multiple developmental dimensions (Shonkoff et al., 2012).

While the mechanisms underlying adverse parenting are not fully understood and difficult to measure, there is substantial evidence identifying specific risk factors that contribute to some parents' heightened propensity for child maltreatment. This risk, commonly referred to as child abuse potential (CAP), reflects parental characteristics and tendencies that are associated with a heightened likelihood of engaging in abusive behaviors (Milner & Wimberley, 1980). In the present investigation, we focus on the association between CCIT and CAP during the toddler years, and on the importance of identifying moderating factors that may buffer these risks and help prevent cycles of trauma transmission.

1.1. Childhood cumulative interpersonal trauma and child abuse potential

CCIT is linked to greater CAP (i.e., the risk of perpetrating child abuse; Langevin et al., 2022; Rodriguez & Henderson, 2010) and to the intergenerational transmission of trauma (i.e., the continuity of maltreatment in the next generation). A systematic review of 97 studies found that parents who were victimized in childhood are more likely to engage in abusive parenting behaviors, especially when they have endured CCIT (Greene et al., 2020). Madigan et al.'s (2019) meta-analysis of 80 studies reported a moderate positive association between a parent's interpersonal trauma history and interpersonal trauma in the next generation, confirming earlier cohort findings (Sidebotham et al., 2001).

Early formulations cast this phenomenon as a victim-to-perpetrator progression, in which abused children learn to resolve conflict through violence and later enact those scripts with their own children (Curtis, 1963; Widom, 1989). While this perspective remains informative, contemporary research points to a broader set of mechanisms underlying trauma transmission. Exposure to CCIT has been associated with alterations in neurobiological development, including heightened stress reactivity, impaired emotion regulation, and increased sensitivity to threat (McLaughlin et al., 2019). These adaptations are thought to reflect survival strategies in the context of chronic or inescapable adversity, where heightened vigilance and rapid defensive responses may increase short-term safety. However, when carried into the parenting context, these same adaptations may manifest as irritability, emotional dysregulation, or harsh responses to child behavior, thereby increasing CAP. A complementary victim-to-victim perspective shows that parental trauma can endanger children even when the traumatized parent is not the perpetrator. Children of survivors remain at disproportionate risk for maltreatment by partners or other caregivers (Dixon et al., 2005; Pears & Capaldi, 2001), implying that parental trauma may compromise protective vigilance, couple functioning, or broader family ecology (Kim et al., 2007; Madigan et al., 2019). These dual pathways underscore the importance of examining trauma transmission within both members of the parenting couple, rather than focusing exclusively on one caregiver.

Empirical work increasingly points to social support as a critical buffer that can disrupt trauma transmission. Low perceived support has been shown to predict higher CAP in mothers (Ono & Honda, 2017). Recently, a systematic review identified parental social support as the single most robust protective factor across ecological levels against CAP in Western, Educated, Industrialized, Rich, and Democratic (WEIRD) contexts (except in cases of child sexual abuse; Younas & Gutman, 2022). In many cultural settings, extended family members or community networks may represent primary sources of support for parents. Within WEIRD contexts, the romantic partner is often the primary, day-to-day source of such support. As such, a dyadic focus on partner support offers a promising avenue for breaking trauma transmission. Given the global prevalence of child maltreatment as a major public health concern (Madigan et al., 2019), there is an urgent need to identify modifiable protective factors that may help disrupt the cycle of trauma transmission.

1.2. Partner support

In WEIRD contexts, romantic partners often become the primary attachment figure, especially as extended family and community networks have shifted to a less prominent role (Kiecolt-Glaser & Wilson, 2017). Relationship research demonstrates that supportive couple relationships buffer physiological and psychological stress responses, whereas distressed unions amplify health risks (Kiecolt-Glaser & Newton, 2001). For trauma survivors, a high-quality relationship may offer a safe space in which dysfunctional internal

working models can be revised, fostering positive self and other representations (Godbout et al., 2017b). Qualitative and quantitative studies report that positive support attenuates the impact of parental trauma on negative parenting and child outcomes (Austin et al., 2020). Such findings lend empirical weight to the aim of examining the protective role of partner support in the link between CCIT and CAP among parents.

Partner support is defined as the actions and behaviors engaged in by both partners to help one another (Brassard et al., 2011). It is typically conceptualized in four dimensions: emotional (expressions of empathy and love), instrumental (tangible help), informational (guidance and advice), and validation (reassurance that one's feelings are appropriate; Wills & Shinar, 2000). Bakhos et al.'s (2024) findings showed that higher partner support is related to lower levels of parental stress, a well-known predictor of CAP (Austin et al., 2020). This study is among the rare ones that explicitly differentiate received support (i.e., the perception of support received from one's partner) from provided support (i.e., the perception of support one provides to their partner). These two dimensions each make unique contributions to physical and mental well-being (Berli et al., 2021; Selcuk & Ong, 2013). A growing body of cross-sectional and longitudinal research suggests that supportive couple processes can disrupt the pathway from parental CCIT to trauma transmission. CCIT victims, however, tend to evaluate both received (Fitzgerald & Gallus, 2020) and provided support (Fitzgerald et al., 2020) lower than non-exposed peers, underscoring a potential relational deficit that research must address. While a history of maltreatment is a significant risk factor for future perpetration, evidence suggests that healthy relationships with intimate partners can mitigate this risk. Langevin et al.'s recent scoping review (2025) concluded based on the 80 studies summarized that safe, supportive and stable relationships are a strong protective factor against the intergenerational continuity of child maltreatment. In a three-generation cohort study, parents with maltreatment histories who reported high partner warmth and positive communication were significantly less likely to engage in abusive parenting (Conger et al., 2013). Thornberry et al. (2013) demonstrated in a longitudinal study that such relationships in early adulthood may reduce the likelihood of victims becoming perpetrators, and Schofield et al. (2013) found through meta-analysis that these relationships also moderate the intergenerational transmission of child maltreatment. Even with substantial evidence pointing to the benefits of supportive intimate relationships, questions remain regarding how such support is experienced within couples. Research on gender differences in partner support has produced mixed results concerning perceptions of support within couples (Ko & Lewis, 2011). Examining gender differences is particularly relevant because partners may not only provide but also perceive support differently depending on their gender, which can influence relational dynamics and well-being of the couple. Therefore, investigation of both members of couples is needed to capture the reciprocal nature of support processes.

Despite advances on the question, current knowledge is still constrained by the tendency of most studies on trauma transmission to focus exclusively on one caregiver, most often mothers. This approach obscures potential cross-partner influences and overlooks the fact that maltreatment can be perpetrated by either parent. Accordingly, researchers recommend measuring partner support with dyadic models to capture the reciprocal nature of support transactions (Liang et al., 2001). Also, reviews highlight that studies on trauma transmission tend to rely on clinical, non-representative samples, weakening generalizability (Langevin et al., 2025; Madigan et al., 2019; Thornberry et al., 2012). Furthermore, researchers typically document observed abuse rather than abuse potential, limiting our capacity to detect risk early and intervene prophylactically. This reliance on post hoc identification limits our capacity to develop preventive interventions that could mitigate harm before maltreatment is perpetrated.

2. Objectives and hypothesis

The present study uses an Actor-Partner Interdependence Model (APIM) to investigate, from a dyadic perspective, whether partner support —specifically, the support one provides to their partner and the support one receives from their partner—moderates the association between CCIT and CAP in parental couples of toddlers. We hypothesized that (1) lower CCIT and (2) higher partner support (provided and received) would be associated with lower CAP in both parents (actor effects). Also, we anticipated that (3) one parent's CCIT would be associated with the other parent's CAP (partner effects), in line with the victim-to-victim perspective of trauma transmission. Furthermore, we expected that partner support (provided and received) would moderate these relationships. Specifically, we expected that greater support (both provided and received) would attenuate the positive links between CCIT and CAP at both actor (4) and partner (5) levels.

3. Method

3.1. Participants and procedure

The present study is part of a larger longitudinal project on parental couples' relational and mental health. Parental couples were randomly recruited through a partnership with the Quebec Parental Insurance Plan, under authorization from the Commission d'Accès à l'Information. This recruitment strategy allowed access to a broad and diverse population of parents across the province, enhancing the representativeness of the sample. The selected contact details were securely transmitted to the research team, and trained research assistants contacted parents via telephone to present the study, verify eligibility criteria, and invite them to participate. Eligibility was confirmed for both partners, and only couples in an ongoing relationship at the time of contact were included. Eligibility criteria were: (a) being $\geq$18 years old; (b) parenting a child $<$6 months of age; (c) being in a couple relationship with the child's other parent; (d) being able to read and write in French or English; (e) joint participation by both partners at first measurement; and (f) one parent had to have carried the child. Questionnaires were sent by e-mail. Consenting parents completed individually a 45-min online questionnaire via the Qualtrics platform and received CAD $20 compensation. The project was approved by the University of Quebec in Montreal Research Ethics Committee. The initial wave of recruitment took place between January 2019 and January 2021, during which 2584

parents were invited to participate in the study, resulting in a participation rate of 55%. For the present study, we analyzed data from families who completed both Wave 1 (child age ≈ six months) and Wave 5 by February 2025 (child age ≈ 3.5 years). CCIT and stable sociodemographic characteristics were measured during the first time point, while CAP, partner support and fluctuating sociodemographic variables were assessed at the fifth time point. After retaining only dyads in which both members completed all required measures at both time points, the final sample consisted of 607 couples (1214 participants). All of them were in a heterosexual relationship. Mothers' mean age was 33.64 years ($SD = 4.84$, range 22–48) and fathers' mean age was 35.61 years ($SD = 5.74$, range 20–61). The average duration of the relationship was 10.45 years ($SD = 4.01$). Parents had 1 to 7 children ($M = 2.16$; $SD = 0.91$). Other sociodemographic statistics are presented in Table 1.

Table 1
Sociodemographic statistics ($n = 1214$).

	Mothers		Fathers		Total sample	
	n	%	*n*	%	*n*	%
Place of birth						
Canada	522	86.0	506	84.1	1030	84.8
Western Europe	24	4.0	24	4.0	49	4.0
Africa	10	1.6	17	2.8	28	2.3
Eastern Europe	10	1.6	8	1.3	18	1.5
South America	11	1.8	13	2.2	25	2.1
Asia	9	1.5	5	0.8	14	1.2
Other	15	2.5	23	3.8	38	3.1
Rather not say or missing	6	1	6	1.0	12	1.0
Language						
French	504	83.0	497	82.5	1004	82.6
English	28	4.6	36	6.0	64	5.3
Spanish	6	1.0	7	1.2	13	1.1
Other	40	6.6	27	4.5	68	5.6
French bilingual	19	3.1	26	4.3	46	3.8
English bilingual	1	0.2	0	0	1	0.1
Rather not say or missing	9	1.5	9	1.5	18	1.5
Ethnicity						
White (European descent)	506	83.4	482	80.1	991	81.7
Black (African descent)	21	3.5	25	4.2	46	3.8
Middle Eastern	10	1.6	17	2.8	27	2.2
Latino	15	2.5	11	1.8	26	2.1
Asian	16	2.6	8	1.3	24	1.9
Indigenous	4	0.7	4.	0.7	8	0.7
Mixed	6	1.0	13	2.2	19	1.6
Other	10	1.7	7	1.1	17	1.4
Rather not say or missing	19	3.0	35	5.8	54	4.6
Relationship status						
Common law	259	42.7	251	41.7	510	42.0
Married	133	21.9	133	22.1	266	21.9
Other	3	0.5	4	0.7	7	0.6
Rather not say or missing	212	34.9	214	35.5	426	35.5
Occupation						
Student	16	2.6	8	1.3	24	2.0
Full- or part-time worker	463	76.2	578	96.0	1041	85.7
Stay at home parent	28	4.6	4	0.7	32	2.6
Unemployed	7	1.2	5	0.8	12	1.0
Other	19	3.2	4	0.7	23	1.9
Rather not say or missing	74	12.2	3	0.5	77	6.8
Education						
Primary school	10	1.6	20	3.3	30	2.5
High school	61	10.1	98	16.3	159	13.1
College/professional	218	35.9	253	42.0	471	38.8
University	316	52.1	229	38.1	545	44.9
Rather not say or missing	2	0.3	2	0.3	5	0.7
Individual annual income						
CAD$19,999 or less	56	9.2	10	1.7	66	5.4
CAD$20,000–CAD$39,999	97	16.0	41	6.8	138	11.5
CAD$40,000–CAD$59,999	171	28.2	116	19.3	287	23.6
CAD$60,000–CAD$79,999	137	22.6	127	21.1	264	21.7
CAD$80,000 and over	138	22.7	294	48.8	432	35.6
Rather not say or missing	8	1.3	14	2.3	22	2.2

3.2. Measures

3.2.1. Cumulative childhood trauma

CCIT was assessed using the French version of the Cumulative Childhood Interpersonal Trauma Questionnaire (CCTQ; Godbout et al., 2017a). The 24 items cover eight trauma forms: psychological, physical and sexual abuse, psychological and physical neglect, exposure to psychological and physical interparental violence, and peer bullying. Childhood sexual abuse was operationalized in accordance with the Canadian Criminal Code and was considered present if participants reported at least one occurrence of unwanted sexual acts before the age of 18, or before the age of 16 with an individual at least five years older or in a position of authority. This variable was coded dichotomously (0 = absence, 1 = presence). The seven other forms of interpersonal trauma were assessed using a 7-point Likert scale ranging from 0 ("never") to 6 ("every day or almost every day"), reflecting the frequency of each experience during a typical year before the age of 18. Consistent with prior research (e.g., Bakhos et al., 2024; Rassart et al., 2022), each trauma type was dichotomized to indicate presence (1) or absence (0) of exposure. A cumulative index of CCIT was then computed by summing the eight dichotomous indicators, yielding a score ranging from 0 to 8, with higher scores reflecting greater diversity of trauma exposure. Importantly, the CCTQ is used to assess the breadth of trauma exposure (i.e., the number of distinct trauma types experienced), rather than their duration, severity, or precise developmental timing. The use of a "typical year" reference frame for most trauma items is intended to capture recurring or representative exposure patterns rather than isolated events, thereby reducing the influence of atypical or one-time occurrences. This cumulative approach aligns with a large body of research on polyvictimization, which shows that exposure to multiple forms of interpersonal trauma is a stronger and more consistent predictor of adverse outcomes than frequency or chronicity of any single type (Briere et al., 2016; Finkelhor et al., 2009). Retrospective reports of childhood adversity are known to be subject to recall bias and variability in temporal specificity, and global assessments of typical experiences may therefore provide a more reliable index of developmental exposure than attempts to reconstruct exact timing or frequency of events (Baldwin et al., 2019). The CCTQ has demonstrated strong psychometric properties in prior studies (Bigras et al., 2017) and in the present sample ($\alpha = 0.90$ for mothers and $\alpha = 0.89$ for fathers).

3.2.2. Child abuse potential

CAP was assessed using the Brief Child Abuse Potential Inventory (BCAPI; Ondersma et al., 2005), a validated short form of the original Child Abuse Potential Inventory designed to identify parents at risk for engaging in abusive behaviors. The BCAPI includes 34 items assessing abuse risk, to which participants respond in a forced-choice format (agree/disagree). Items capture a range of cognitive, emotional, and contextual risk factors associated with child maltreatment, such as impulsivity, distress, rigidity in parenting beliefs, family conflict, and negative affect (e.g., "I sometimes act without thinking," "Children should never disobey," "My family fights a lot"). The BCAPI does not directly assess abusive behaviors but rather focuses on established risk correlates of child maltreatment. Although initially developed to assess risk for physical abuse, it has been shown to predict future reports to child protection services for both physical abuse and neglect (Ondersma et al., 2005), and to be associated with broader forms of maltreatment (Milner, 1994), including emotional abuse and neglect (Lee & Sung, 2022). To calculate total CAP scores, risk-indicative answers were assigned a value of 1 and non-risk answers were assigned a value of 0. These values were then summed up to create a continuous total score, where higher scores indicate greater risk for child abuse. Reliability was strong ($\alpha = 0.85$ for mothers, 0.83 for fathers), comparable with previous research in diverse populations ($\alpha = 0.85$–0.91; Ondersma et al., 2005; Walker & Davies, 2012). Construct validity is supported by established correlations with parenting stress, mental health symptoms, social isolation, and abuse history (Milner, 1986).

3.2.3. Partner support

Partner support was assessed using the Romantic Support Questionnaire (RSQ; Brassard et al., 2011), an 8-item measure evaluating perceived support within romantic relationships. The RSQ distinguishes provided and received partner support. Items assess four dimensions of support, including emotional, instrumental, informational, and validation. Example items include: "My partner supports me in my attempts to achieve my goals," "My partner encourages me when I need it," "I give useful advice to my partner when he/she needs it," "I understand my partner's way of thinking and feeling about things". Participants rated each item on a Likert scale ranging from 1 ("never") to 5 ("always"), and mean scores were computed separately for provided and received support, with higher scores indicating greater perceived support. Reliability was excellent (received: α mothers = 0.91, α fathers = 0.90; provided: α mothers = 0.87, α fathers = 0.86), consistent with original reports ($\alpha = 0.82$–0.86; Brassard et al., 2011).

3.3. Data analytical strategy

Descriptive analyses were conducted using the Statistical Package for the Social Sciences (SPSS, Version 29) to examine the prevalence of each form of trauma and the means and distributions of the studied variables. Bivariate correlational analyses were then performed to examine associations between studied variables, looking distinctively at mothers and fathers. Two-tailed paired-sample *t*-tests were conducted to examine potential differences between mothers and fathers.

The hypothesized model was then tested on Mplus 6.0 (Muthen & Muthen, 2015) using path analyses based on the APIM. This analytic methodology allows the non-independence of data to be considered while measuring actor effects (i.e., the effect of an individual's independent variable on their own dependent variable) and partner effects (i.e., the effect of an individual's independent variable on their partner's dependent variable). All performed path analyses used maximum likelihood estimation (MLR) with standard errors and chi-square statistics that are robust to non-normality and account for missing data. An omnibus test of distinguishability

(Kenny et al., 2006) was conducted to test whether parents' data differed by gender (i.e., mother vs. father). In this test, an unconstrained model was compared to a model where all means, variances, and covariances were constrained to be equal across parents. A significant chi-square index ($p < .05$) indicates that the dyads are distinguishable (i.e., results differ between mothers and fathers).

Before identifying the final model, actor and partner effects were progressively constrained to be equal across mothers and fathers. This step allowed us to identify which associations diverged according to gender, while enhancing model parsimony and statistical efficiency. Pooled estimates were reported when no gender difference was found. Models were compared using the 2-log likelihood difference test (Satorra & Bentler, 2010). Nonsignificant paths were then removed in the final model to increase statistical power and parsimony. To account for potential confounding variables, sociodemographic and situational variables were tested as covariates in the integrative model (i.e., stressful events, post-traumatic stress disorder symptoms, maternal and paternal age, maternal and paternal income). Stressful events reported by each parent and operated as a continuous variable was included as a covariate in the model. Model fit was examined using the Comparative Fit Index (CFI), the Tucker-Lewis Index (TLI), the Root-Mean-Square Error of Approximation (RMSEA), the Standardized Root Mean Square Residual (SRMR), and the chi-square index. A nonsignificant chi-square, CFI, and TLI values greater than 0.90, and RMSEA and SRMR lower than 0.08 reflect an acceptable model fit (Hu & Bentler, 1999; Kline, 2015).

4. Results

4.1. Descriptive statistics

Prevalences of trauma forms and CCIT scores are presented in Table 2. Mothers presented significantly more CCIT than fathers ($t(591) = 2.023$, $p = .044$). Based on clinical cut-off scores, 14.1% of mothers had moderate to high CAP ($M = 4.04$; $SD = 4.69$), while 11.5% of fathers fell in this range ($M = 3.50$; $SD = 4.36$). This difference is significative according to two-tailed paired-sample *t*-tests ($t(585) = 2.123$, $p = .034$). The mean score for received support among mothers was 4.09 ($SD = 0.76$), while their mean score for provided support was 4.25 ($SD = 0.60$). For fathers, the mean score for received support was 4.10 ($SD = 0.77$), and was 4.21 ($SD = 0.61$) for provided support. No significant difference was found between these means, suggesting symmetric support dynamics within couples. Means, *SD*s, and correlations for each variable are presented in Table 3. Results of the omnibus test of distinguishability revealed that parents were distinguishable based on their gender (χ^2 [20] = 4.39; $p = .024$). Differences resided in their mean scores of CCIT and CAP, while mean scores of partner support, covariances and variances of CCIT, CAP and partner support were not significantly different between mothers and fathers.

4.2. Main results

We estimated the hypothesized model to test the moderating role of partner support (provided and received) in the association between CCIT and CAP. Actor and partner paths were progressively constrained to be equal between mothers and fathers. All main and moderation effects could be constrained without compromising model fit, indicating that the strengths of the associations were similar across parents. Pooled estimates for both main and moderation effects are therefore reported in Fig. 1.

Results showed that one's CCIT was positively associated with their own CAP ($\beta = 0.178$, $p = .000$), meaning that individuals who had experienced a greater number of different forms of trauma tended to report higher levels of CAP. However, this association was modest in size, suggesting that trauma history alone does not strongly determine parenting risk. Received support was negatively related to one's own CAP in a stronger way ($\beta = -0.288$, $p = .000$), highlighting that individuals who felt more supported by their partner reported substantially lower levels of CAP. Interestingly, providing support to one's partner was associated with slightly higher

Table 2
Prevalence of cumulative childhood interpersonal trauma and forms of interpersonal trauma ($n = 1214$).

	Mothers		Fathers		Total sample	
	n	%	*n*	%	*n*	%
Cumulative Childhood Interpersonal Trauma						
None	65	10.7	86	14.3	151	12.4
One form	102	16.8	107	17.8	209	17.5
Two forms	138	22.7	129	21.4	267	22.0
Three forms	97	16.0	87	14.5	184	15.2
Four forms and more	197	32.5	180	29.8	377	31.2
Rather not say or missing	8	1.3	13	2.2	21	1.7
Forms of Interpersonal Trauma						
Physical violence	254	42.4	260	44.1	514	43.3
Psychological violence	212	35.5	163	27.7	375	31.5
Physical neglect	71	11.9	100	17.0	171	14.4
Psychological neglect	447	74.6	408	69.3	855	72.0
Interparental physical violence	46	7.7	38	6.5	84	7.1
Interparental psychological violence	251	41.9	208	35.3	459	38.6
Bullying by peers	277	46.3	288	49.0	565	47.6
Sexual abuse	118	19.7	48	8.2	166	14.0

Table 3
Descriptive statistics and Pearson correlations of studied variables ($n = 1214$).

	1	2	3	4	5	6	7	8	9	10
1. CCIT M	–									
2. CCIT F	0.14**	–								
3. Trauma Transmission M	0.32**	0.12**	–							
4. Trauma Transmission F	0.08*	0.27**	0.27**	–						
5. Received Support M	−0.19**	−0.09*	0.39**	−0.16**	–					
6. Received Support F	−0.20**	−0.25**	−0.25**	−0.43**	0.37**	–				
7. Provided Support M	−0.17**	−0.14**	−0.37**	−0.14**	0.78**	0.35**	–			
8. Provided Support F	−0.16**	−0.18**	−0.18**	−0.34**	0.42**	0.73**	0.37**	–		
9. Stressful Event M	0.21**	0.07	0.39**	0.21**	−0.27**	−0.16**	−0.27**	−0.12**	–	
10. Stressful Event F	0.13**	0.19**	0.27**	0.37**	−0.12**	−0.26**	−0.12**	−0.21**	0.48**	–
Min	0.00	0.00	0.00	0.00	1.00	1.50	1.00	2.00	1.00	1.00
Max	8.00	8.00	24.00	22.00	5.00	5.00	5.00	5.00	2.25	2.00
M	2.80	2.57	4.04	3.51	4.09	4.10	4.25	4.21	1.20	1.18
SD	1.93	1.90	4.69	4.36	0.76	0.77	0.60	0.61	0.19	0.16
Skewness	0.53	0.58	1.53	1.96	−0.94	−0.68	−0.89	−0.44	1.72	1.56
Kurtosis	−0.391	−0.28	1.91	3.95	1.05	−0.16	1.47	−0.27	4.28	3.81

Notes. CCIT = Cumulative Childhood Interpersonal Trauma; M = Mothers; F = Fathers.
* $p < .05$.
** $p < .01$.

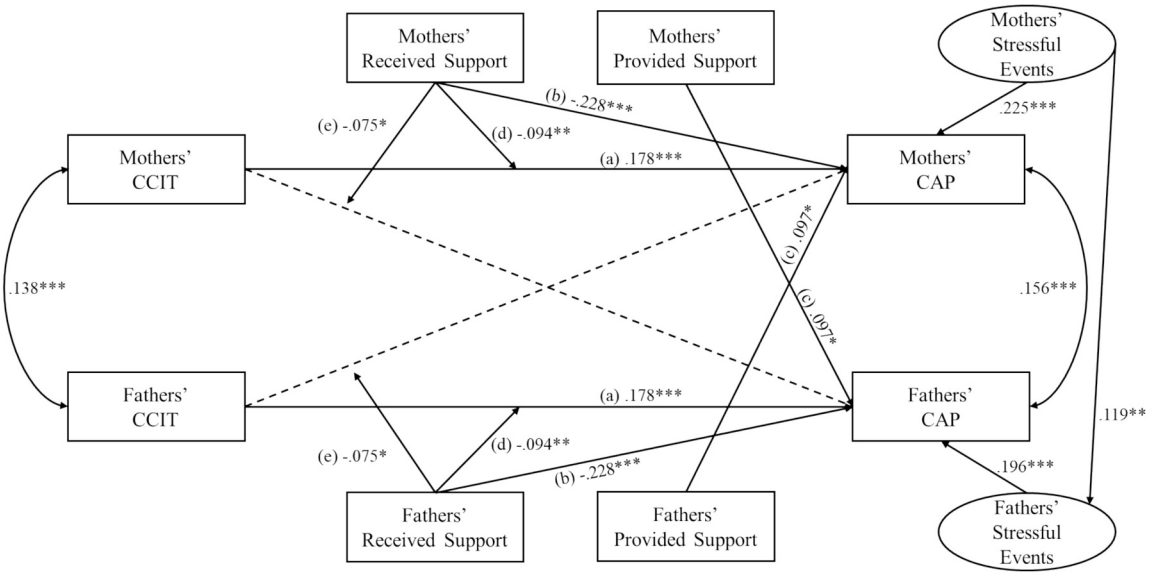

Fig. 1. Constrained APIM of the association between CCIT and CAP with moderating effects of received support.
Notes. CCIT = Cumulative Childhood Interpersonal Trauma; CAP = Child Abuse Potential; * = $p < .05$. ** = $p < .01$. *** = $p < .001$; dash line = non-significant links at mean levels of received support.

levels of CAP in the partner (β = 0.097, $p = .041$). A significant covariance was observed between mothers' and fathers' CCIT scores ($r = 0.138$, $p < .001$), indicating a small but reliable association in partners' childhood trauma histories. The presence of stressful events, which was included as a covariate, could not be constrained between parents, meaning the associations between parents were not equivalent. Mothers' stressful events were related to their higher CAP (β = 0.225, $p = .000$), and to fathers' higher CAP (β = 0.119, $p = .007$). Fathers' stressful events were only related to their own higher CAP (β = 0.196, $p = .000$).

All possible moderation effects were tested for both provided and received support, for a total of eight interaction terms. Two significant moderation effects emerged. First, one's received support moderated their association between CCIT and CAP (β = −0.094, $p = .008$). More specifically, simple slope analyses (see Fig. 2) revealed that individuals' CCIT was associated with their own higher CAP at low (−1 *SD*) and medium (0 *SD*) levels of received support, but this association was not significant at high (+1 *SD*) levels of received support. Second, one's received support also moderated the association between their CCIT and their partner's lower CAP (β = −0.075, $p = .026$). Precisely, individuals' CCIT was not significantly associated with their partner's CAP at medium and high levels of received support but was negatively related to their CAP at low levels (see Fig. 3). Results indicated adequate model fit ($\chi^2[9] = 5.057$, $p = .83$; CFI = 1.00; TLI = 1.00; RMSEA = 0.00, 90% CI [0.000, 0.027]; SRMR = 0.008). The model explained 32.2% of the variance in mother's CAP and 29.1% of the variance in father's CAP.

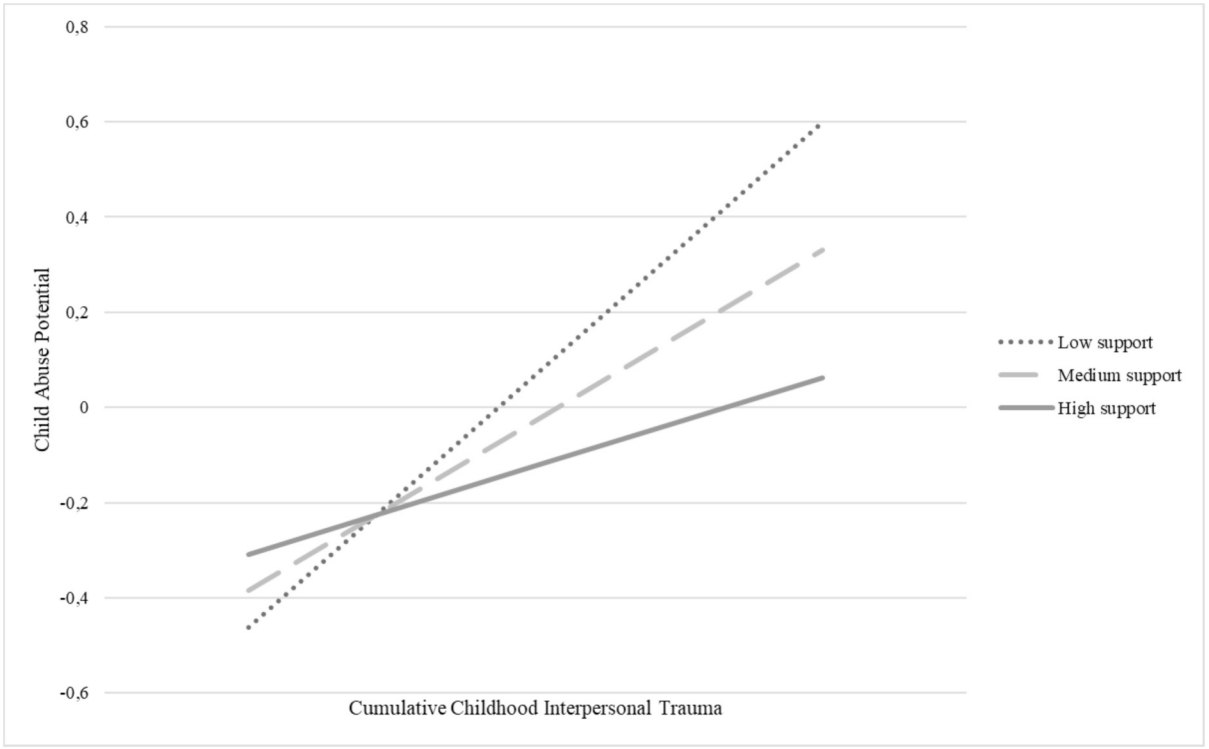

Fig. 2. Moderation effect of received support on the association between CCIT and CAP.

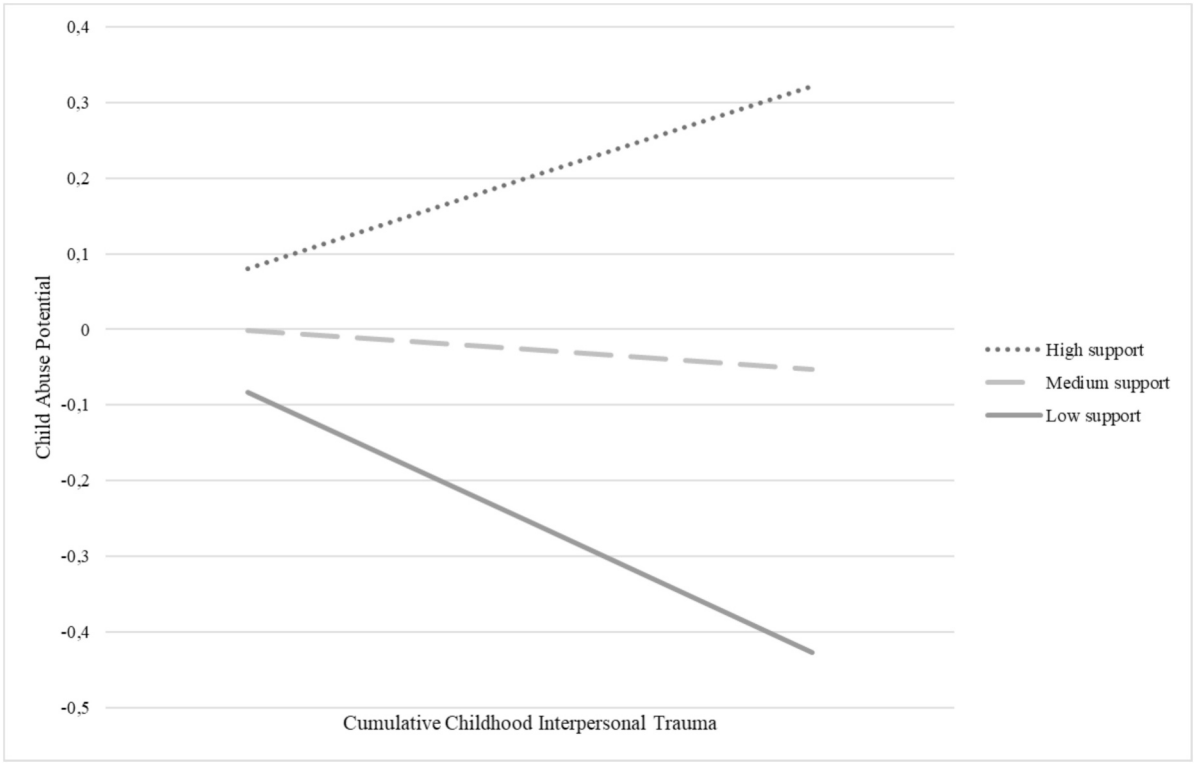

Fig. 3. Moderation effect of received support on the cross-partner association between CCIT and CAP.

5. Discussion

Using a dyadic framework, this study aimed to examine whether partner support, provided and received, moderates the association between CCIT and CAP among parenting couples of toddlers. The results contribute to a growing body of research examining the relationship between CCIT and CAP, while addressing limitations in previous work, such as the use of non-dyadic models of trauma transmission. Results support the idea that partner support is an important protective factor, potentially buffering the effects of prior childhood victimization on trauma transmission.

A contribution of the present study concerns the examination of similarities and differences between mothers and fathers. Although mothers reported slightly higher CCIT and CAP, the structural associations between variables were equivalent across parents. This suggests that the mechanisms linking trauma history, partner support, and abuse potential operate similarly for mothers and fathers, despite differences in average levels. Moreover, mothers' and fathers' CCIT scores were significantly and positively associated, suggesting that partners' trauma histories tend to co-occur, although the magnitude of this association was small.

5.1. Main associations

Mothers and fathers who experienced more forms of childhood trauma tended to show higher levels of CAP; however, this association was relatively modest, indicating that trauma history alone does not determine parenting outcomes. This result is consistent with our first hypothesis and with prior findings. Greene et al.'s systematic review (2020) provided evidence of a dose-response effect, where cumulative experiences of childhood victimization substantially heighten the subsequent risk of abusive parenting. Across ethnically and socio-economically diverse samples, mothers with overlapping histories of abuse, neglect, and exposure to interparental violence were found to be more likely to employ harsh or punitive discipline with their own children (Cohen et al., 2008; Kim, 2009). Whereas numerous studies have documented this relationship among mothers, empirical evidence for fathers has remained sparse. By including both members of the couple, the present study provides novel evidence that the association between CCIT and CAP is also present for fathers and is of comparable magnitude to that observed for mothers. These findings contrast with prior studies (e.g., Niu et al., 2018) which have found that the transmission of trauma may follow gender-specific pathways. Specifically, previous studies reported that the relationship between childhood victimization and later child maltreatment was weaker for fathers (Langevin et al., 2025). This discrepancy may be explained by the fact that previous studies focused on perpetrated abuse rather than abuse potential or the changing dynamics in co-parenting, where fathers are more involved than ever in childrearing (Statistics Canada, 2017).

In contrast to the significant actor effects, we found no partner effect linking one parent's CCIT to the co-parent's CAP, failing to support our second hypothesis. However, given the lack of consensus in literature on this question, these null findings suggest that a parent's trauma history is not associated with having a partner with higher CAP. Such a result does not provide direct evidence for the victim-to-victim perspective of trauma transmission, which posits that victimized individuals go on to have children of their own who are also at heightened risk of experiencing maltreatment, even though they may not themselves be the perpetrators (Madigan et al., 2019). It is important to note, however, that other pathways for victim-to-victim cycles exist, involving perpetrators in the broader environment rather than the child's parents.

Our analyses also revealed a partner effect where more provided support from one parent was associated with higher CAP in their coparent. While the model tested this as a pathway from provided support to the partner's CAP, the observed pattern could also reflect a reverse process, consistent with a compensatory lens, where one parent might invest more time and emotional resources in parenting if they perceive their coparent as having limited capacities (Goldberg & Easterbrooks, 1984). Further longitudinal research is needed to clarify these associations and this potential explanation. For received support, results showed that higher support received from a parent was associated with their lower CAP, in line with our third hypothesis. This result is aligned with earlier research indicating that having a supportive partner mitigates the risk for harsh and abusive parenting practices (Conger et al., 2013; Thornberry et al., 2013). Because parenting is usually undertaken with a co-parent who serves as the primary day-to-day source of assistance, feeling supported may lessen parenting strain and, in turn, lower CAP.

It is also important to interpret these findings in light of the COVID-19 pandemic context in which data were collected. This period was marked by increased stressors, which have been shown to elevate parental stress and, in turn, increase CAP (Brown et al., 2020). At the same time, evidence suggests that parental support may play a critical protective role in this context, being associated with lower levels of stress and reduced CAP (Brown et al., 2020). In a context where social isolation and reduced access to external resources were common, close relational support may have represented a key buffer against heightened parenting difficulties. As such, the protective role of partner support observed in the present study may be particularly salient in the context of the pandemic, where support from a romantic partner may have been one of the most consistently available resources.

5.2. Moderating associations

The findings supported our postulate that received support moderates the relationship between CCIT and CAP. More precisely, among parents reporting high levels of received support, the association between CCIT and CAP was non-significant, highlighting the protective function of partner support. In line with our fourth hypothesis, this finding may explain why only a subset of individuals exposed to CCIT are more vulnerable to trauma transmission. From a stress-buffering perspective, emotionally responsive partners tend to provide empathy, warmth, and non-judgmental listening. These behaviors could attenuate trauma-related arousal and negative affect, thereby interrupting potential escalade from dysregulated stress to harsh parenting (Cohen & Wills, 1985; Repetti & Wood, 1997). Partner support can also enhance parenting self-efficacy. Informational and validating behaviors may strengthen parents'

confidence in their ability to manage the challenges of parenthood, which is related to gentler discipline and lower CAP (Barlevy & Shrivastava, 2023; Jones & Prinz, 2005). Conversely, when partner support is low, the self-efficacy pathway could be undermined, which could explain why CCIT was more strongly associated with CAP in our results. A lack of feedback or validation could deprive the parent of the self-awareness necessary to foster gentler discipline (Yildirim et al., 2024). Moreover, high support typically co-occurs with a strong co-parenting alliance in which responsibilities are shared (Campbell, 2023). This load-sharing may also reduce time pressure and mental fatigue, both of which are proximal triggers of CAP (Younas & Gutman, 2022).

Our results may also be interpreted through the lens of relationship quality. Receiving regular support from a partner may reflect not only acts of assistance but also a generally healthier and more satisfying intimate relationship. A high-quality partnership offers a supportive foundation that fosters a warm family climate and enables parents to feel more satisfied and psychologically resourced (Durtschi et al., 2017; Rusu et al., 2025). In turn, relationship quality has been consistently linked to more effective and less coercive parenting practices (Bonds & Gondoli, 2007). Conversely, low levels of partner support are often accompanied by greater psychological distress and marital conflict, both of which are known to directly spill over into parenting (Bakhos et al., 2024; Kopystynska et al., 2023; Sears et al., 2016), in addition to erode the protective climate that might otherwise buffer the effects of trauma. The buffering effect of support we observed in this study may therefore reflect not only the direct benefits of partner support, but also the broader influence of a positive couple environment that helps parents exposed to CCIT break the intergenerational transmission of trauma.

Results of the moderation analysis also showed that one parent's higher CCIT is associated with their partner's lower CAP only when the victimized parent reports low received support. When the received support is high, this cross-partner association is non-significant. Several complementary processes may explain the effect of support on the link between a parent's CCIT and their co-parent CAP. First, as proposed earlier, compensatory caregiving may occur. This over-involvement in the parental role can result in less partner support due to reduced resources, which could explain why this association is significant when partner support is low. In the same vein, Sturge-Apple et al. latent class analyses (2014) identified families exhibiting simultaneously high levels of interparental difficulties and elevated parental warmth toward the child and low levels of problematic parenting behaviors. This finding illustrates how difficulties within the couple do not necessarily translate into compromised parenting, as one parent may adaptively increase positive engagement with the child. Secondly, perceptual bias in evaluating support may also play a role. Survivors of CCIT tend to under-perceive the assistance that is actually available to them, due to the influence of negative relational schemas they internalized in the context of childhood trauma (Gobin & Freyd, 2014). The greater the severity of experienced trauma, the more likely survivors are to perceive their partners as less supportive and less understanding (Vaillancourt-Morel et al., 2019). Consequently, couples reporting low support may, in fact, include dyads in which the partner provides substantial help. In such cases, the partner would have effective caregiving abilities, even if the support they provide their partner is not fully acknowledged.

5.3. Limitations and future studies

These findings should be appreciated in the light of this study's limitations. First, due to the study's cross-sectional design, causal relationships between variables could not be established. Future studies would benefit from using longitudinal design to confirm associations between these variables and observe the links between CCIT, partner support and CAP. Although the sociodemographic characteristics of the sample are broadly consistent with population-level data, the recruitment strategy and voluntary participation may have contributed to a sample composed of relatively high-functioning parents. Self-selection bias may therefore have influenced participation, as individuals experiencing greater stability may be more likely to engage in research, potentially limiting the representativeness of the sample. Moreover, because of the dyadic design of the study, only couples in which both partners consented to participate were included, which may have biased the sample toward more positive relationships. That said, the dyadic nature of the study also represents a key strength, enabling a more nuanced understanding of relational dynamics. Although the present study did not directly test configurations of trauma exposure within couples (e.g., one vs. both partners exposed to high levels of trauma), the results suggest that such patterns may be important for understanding variability in parenting risk. Future research would benefit from explicitly examining these dyadic profiles to better identify families at highest risk and tailor intervention efforts accordingly. Furthermore, although recruitment was not exclusive of sexual diversity, the final sample was exclusively composed of heterosexual couples, limiting the generalization of our results different family configuration. The eligibility criteria that one parent had to have carried the child might explain this. Future studies should examine if our findings can be generalized to other populations facing different challenges including clinical populations, sexual diversity or cultural diversity.

5.4. Implications for practice

The findings of this study have important implications for clinical practice, prevention programs, and public health policy aimed at breaking the cycle of trauma transmission. First, they highlight the critical role of partner support as a protective factor in families where parent(s) have experienced CCIT. Interventions targeting child maltreatment should systematically assess not only parental trauma history but also dyadic processes in the parental couple, and specifically the quality of support exchanges. Practitioners working with trauma-exposed parents should adopt a dyadic lens that includes both partners. Supportive relational dynamics offer leveraged to reduce CAP, even among parents with extensive trauma histories. Couple-based interventions, such as dyadic parenting programs, may be particularly effective for increasing perceived support and strengthening co-parenting alliances (Eira Nunes et al., 2021). Furthermore, clinical screening tools should be refined to capture both received and provided support, as these two constructs yield unique and complementary insights. Therapeutic work can benefit from exploring discrepancies between these perceptions,

particularly in trauma survivors who may underperceive the support available to them. Psychoeducation regarding trauma-related cognitive biases may also improve clients' ability to recognize and receive support more effectively, thereby enhancing the buffering effect on CAP. Additionally, integration of trauma-informed approaches into parenting programs may facilitate accessibility and engagement among trauma-exposed parents. Finally, these results have relevance for policy development. Public health campaigns and perinatal care systems should prioritize access to couple-based support services as part of comprehensive family health programs. Given the significant proportion of parents affected by CCIT, scalable and accessible interventions aimed at enhancing partner support may lead to better coping with parenting stress and long-term reductions of trauma transmission.

CRediT authorship contribution statement

Shalie-Emma Vaillancourt: Writing – review & editing, Writing – original draft, Project administration, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Alison Paradis:** Writing – review & editing, Writing – original draft, Supervision, Project administration, Methodology, Investigation, Funding acquisition, Data curation, Conceptualization. **Mathilde Carle-Trouillard:** Writing – review & editing, Writing – original draft. **Rachel Langevin:** Writing – review & editing. **Martine Hébert:** Writing – review & editing. **Natacha Godbout:** Writing – review & editing, Writing – original draft, Supervision, Project administration, Methodology, Investigation, Funding acquisition, Data curation, Conceptualization.

Ethical approval statement

This study was approved by the Université du Québec à Montréal Research Ethics Committee.

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Declaration of competing interest

None.

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Authors reviewed and edited the content as needed and take full responsibility for the integrity and accuracy of all material in their manuscript.

Data availability

Data will be made available on request.

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