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# THE ROLE OF COMPLEX POSTTRAUMATIC STRESS DISORDER AND PROTECTIVE FACTORS IN ACCEPTING-REJECTING DIMENSION OF PARENTING OF WOMEN SURVIVORS OF ABUSE

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## ABSTRACT

*The research intended to establish a connection between complex posttraumatic stress disorder (C-PTSD) and the accepting/rejecting parenting of mothers, survivors of complex trauma. The goal was also to examine how protective factors, resilience, and perceived social support moderate the effect of C-PTSD on the mother's rejecting parenting, as well as how parental traumas and their parenting predicts parenting of women survivors. The study results are based on a survey completed by 100 women at the age 19 – 64. The sample had two groups: mothers with C-PTSD and a control group without C-PSTD. The results indicate that complex trauma can predict mother's parenting rejection. C-PTSD displays correlations with all five dimensions of the negative parenting styles (lack*

Key words:
C-PTSD, trauma exposure, women, parenting, resilience

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*of affection/neglect/aggression/control/undifferentiated rejection). Resilience acted as a moderator between C-PTSD and rejecting parenting. Parental traumas and their rejecting parenting manifest in women's parenting.*

# INTRODUCTION

Literature has vastly documented the harmful effects of psychological trauma related to abuse and violence on women and children. Yet, limited attention has been paid to understand how complex risks and protective factors of trauma manifest in women's capacity to parent. Some limited research shows that when mothers experience distressing symptoms of trauma, it can jeopardize their normative tasks of motherhood (Lombardo and Motta, 2008; Smith et al., 2014; Gilbert et al., 2015). Mothers are mostly involved in fostering the children's emotional and psychological development, and they are, unfortunately, two to three times more likely to develop PTSD in comparison to men (De Vries and Olff, 2009; Ditlevsen and Elklit, 2012). Literature also confirms that women are, in general, more likely to experience complex trauma such as childhood sexual abuse, neglect, sexual or physical assault, intimate partner violence, and rape (Belknap and Holsinger, 2006; de Waal et al., 2017). Beyond self-reported psychological symptoms, complex trauma places women at risk for difficulties with the psychological regulation of stress during parenting tasks (Schechter et al., 2012, 2015; Moser et al., 2015). Therefore, if a mother suffers from complex trauma-related symptoms, her parenting will probably be affected.

Children of traumatized parents may, directly or indirectly, develop posttraumatic symptoms, similar to their parents. These terms can also be found in the literature under the name of intergenerational trauma. Many research empirically identified the psychological mechanisms that characterize intergenerational trauma transmission and found that emotional dysregulation as a result of previous traumatic experience can be transmitted through parenting on the offspring (Neppl et al., 2009; Cort et al., 2011; Finzi-Dottan and Harel, 2014; Schechter et al., 2015). For example, parents with the history of childhood physical abuse are found to have a tendency of abusing their children (Renner and Slack, 2006). Also, the victims of sexual violence are often exposed to dysfunctional family relationships that have the potential to be reflected through their parenting (McCloskey and Bailey, 2000). The authors claim that the history of childhood sexual abuse represents a significant predictor of sexual abuse in the next generation. The risk of abuse is 3.6 times higher for daughters of mothers with a history of sexual abuse. Combined with a history of childhood sexual abuse and maternal drug use, the risk of sexual abuse of daughters becomes 23.7 times higher (McCloskey and Bailey, 2000). Data from different research vary in terms how

much of trauma can be transmitted to the next generation. Instead of replicating the exact types or forms of maltreatment from their childhoods, it is possible that parents with a history of abuse may simply have a diminished capacity to cope with the everyday stresses and challenges of raising children, which created rejecting parenting behavours (Rodriguez-JenKins and Marchenko, 2014).

While many women worry that a history of trauma is determinative and fear that prior experiences leave them volunerable to the repetition of past traumas, clinical research leaves hope for healing and resilience. Results are mixed in terms of the impact of complex trauma on parenting, as other studies did not find a direct correlate beteeen complex trauma history and parenting stress (Lang et al., 2010; Bailey et al., 2012). There are some conclusions that protective factors could play an important role in parental recovery from trauma and its impact on the offspring (Folger and O'Dogherty Wright, 2013; Maguire-Jack and Negash, 2016; Jaffee et al., 2017).

## Psychological trauma and complex PTSD

Psychological trauma is an intense experience that affects emotional and physical safety of self and others (Yehuda et al., 2015). Therefore, when people face trauma, they primarily focus on survival and protection. Consequently, they can experience a mixture of various emotional reactions, such as withdrawal, confusion, shock, and anger. However, one-time trauma is rather unusual, particularly for women from highly dysfunctional families.

Complex posttraumatic stress disorder (C-PTSD) represents a set of symptoms related to a series of stressful events that occur repeatedly and cumulatively and within specific relationships and contexts (Courtois, 2004). Judith Herman, one of the pioneers in the trauma research, explained that the traumatic events go beyond any understanding, not becase they rarely happen, but because they overcome ordinary human experience (Herman, 1992). She put the highlight on the comlex trauma as a result of early developmental trauma exposure (for example, childhood abuse and maltreatment), intimate partner and domestic violence or war-torture. These adverse experiences all constitute typical forms of chronic traumatization that creates severe mental health consenquences if not resolved. Generally, C-PTSD meets all diagnostic requirements for PTSD. In addition, Complex PTSD is characterised by severe and persistent symptoms: 1) problems in affect regulation; 2) beliefs about oneself as diminished, defeated or worthless, accompanied by feelings of shame, guilt or failure related to the traumatic event; and 3) difficulties in sustaining relationships and in feeling close to others (World Health Organization, 2018). These symptoms cause

significant impairment in personal, family, social, educational, occupational or other important areas of functioning (Cloitre et. al, 2009, 2014; Hyland et al., 2017).

People with a history of childhood trauma have a very different set of problems in comparison to people who experienced trauma for the first time as adults. The same trauma does not always lead to the same symptoms; however, people with C-PTSD display similar developmental disturbances. Literature confirmed that parents with a history of childhood trauma have a higher risk of child abuse (Assink, et al., 2019; Montgomery, Just-Østergaard and Jervelund, 2019). Notably, the history of childhood sexual abuse was a significant predictor of next-generation sexual abuse (Cohen et al., 2008; Assink et al., 2019). Studies also show that mother's experience of childhood neglect led to a similar parenting pattern, and her childhood sexual abuse led to aggressive parenting (Leen-Feldner et al., 2011; Delker et al., 2014). Not rarely, families that experience many adverse situation may also be developmentally traumatizing for the offspring, which creates an environment for the complex trauma (van der Kolk Courtois, 2005; Ozturk et al., 2008; Spinazzola et al., 2014; Grünbaum et al., 2018).

## Protective factors of trauma and complex PTSD

Despite all these symptoms, people with C-PTSD are still able to maintain daily levels of functioning. As previously mentioned, mothers with a history of childhood abuse are at a higher risk of presenting adverse parenting outcomes; yet, many abused mothers stop the cycle of abuse. It is still unclear what protective factors support discontinuity in this intergenerational transmission. Research confirms that some protective factors could play an essential role in maintaining functioning levels and thus prevent negative parenting. For example, resilience, social support, socio-economic status, and age are some of the factors that can suppress trauma symptoms (Benzies and Mychasiuk, 2009; Dym Bartlet and Easterbrooks, 2015).

Resilience usually acts as an antidote against adverse experiences. It represents the human ability to maintain normative or baseline levels of functioning and is often a typical response to stressful situations (Agabi and Wilson, 2005; Bonnano and Macini, 2012). Theorists argue that there is a need for two critical conditions to be met to have resilience: exposure to a significant threat or severe adversity and achievement of positive adaptation despite major assaults on the development process (McCabe et al., 2014; Galatzer-Levy, Huang and Bonanno, 2018). Generally, people cannot be resilient unless the conditions are set to activate these responses. A longitudinal study of Werner and Smith was the first one to define dimensions of resilience: positive attention, positive self-concept, internal locus of control, nurturant

characteristics, and fewer number of siblings (Werner and Smith, 1992). Many years later, literature highlighted that there are multiple pathways to resilience, such as self-enhancement, problem-solving, spirituality, humor, sense of self, and community and family connections (Connor and Davidson, 2003; Payne, 2011; Galatzer-Levy, Huang and Bonanno, 2018). In addition to resilience, social support was also considered as another protective factor against trauma.

Social support represents an important concept concerning human physical and mental health (Smith and Christakis, 2008; Thoits, 2011; Cicchetti, 2013). In difficult times, social support is necessary for survival. Some meta-analytical studies even presented a link between social isolation and mortality risk (Holt-Lunstad et al., 2010). Empirical evidence and theories of trauma suggest the importance of social support as a moderator of the effects of trauma (Harris et al., 2014; Brown et al., 2018). Studies also concluded that the lack of social support turns out to be more strongly related to the development of PTSD in women than in men (Crevier et al., 2014; Farhood, Fares and Hamady, 2018). If the disorder does occur, the patient will recover faster through positive social bonding. Also, healing of any kind has been more proactive in a nurturing social environment. Dym Bartlet and Estherbrooks (2015) also confirmed that mother's social support can suppress the impact on child neglect by increasing maternal empathy.

## Parenting acceptance/rejection

Besides risk factors, such as anxiety and depression, the complex trauma heightens one's risk for developing shameful feelings that persist across time. Shame driven beliefs contribute to internal negative self-attributions that impact psychologal well-being and impede healing after trauma, thus continuing to transfer traumatic experiences to next generation (Menke et al., 2018). Complex trauma might also impact mother's view of what it means to be a caregiver, given that developmental trauma usually occurs while in caregiver's care. As result, women who experienced trauma may be at the greater risk of developing unhelpful attitudes and beliefs about parenting than women who were not maltreated as children and did not experience any trauma in adulthood (Wright et al., 2012). Consenquently, many studies have addressed the impact of parenting on children's mental health in these conditions (Rudolph and Zimmer-Gembeck, 2014; Putnick et al., 2015; Rohner, 2016). Despite this risk, a history of complex trauma does not doom a woman to develop maladaptive parenting attitudes and beliefs. Over the decades, many theories defined parenting on the continuum between parental affection and rejection (Maccoby, 2007; Rohner, 2016; Ali et al., 2018). An essential domain of parenting is the ability to make sense

of one's past experiences of being parented and to reconcile those experiences with current parenting beliefs and behaviours. Within this realm, Rohner (2016) concluded that some connotations appear universally to organize perceptions of parental acceptance-rejection, and these are reflected around four classes of behavior: warmth/affection (or the opposite, coldness/lack of love), hostility/aggression, indifference / neglect, and undifferentiated rejection.

In summary, many studies investigated the prevention of mental disorders and traumatic symptoms. Concerning the complex trauma, some of these findings indicate that people with higher resilience and social support have a better chance of overcoming traumatic stress and are less likely to develop C-PTSD. In this study, we used these protective factors to explore if they could moderate the relationship between C-PTSD and rejecting parenting in women trauma survivors.

## RESEARCH OBJECTIVES

The presented study was exploratory. The main goal was to examine the relationship between risk and protective factors in rejecting parenting of women who were abused. Following this goal, we set the specific objectives:

1. The first objective was to compare trauma and control group in their rejecting prenting style. Hypothesis was that the trauma group will show the increased rejecting parenting.
2. The next goal was to examine if complex posttraumatic stress disorder correlates with mother's rejecting parenting. The hypothesis was that C-PTSD will be positively correlated with all dimensions of mother's rejecting parenting.
3. The third objective was to determine if social support and resilience, as protective factors, and C-PTSD are significantly correlated. We were expecting protective factors to be negatively correlated with C-PTSD.
4. The fourth goal was to find if protective factors moderate the effect of trauma on parenting. The hypothesis was that associations between complex trauma exposure and mohter's rejecting parenting would be, at least partially, moderated by the protective factors.
5. The fifth objective was to explore unique and collective contributions of a variety of types of childhood and adult trauma on parenting. The hypothesis was that exposure to adverse childhood experiences predicts mother's rejecting parenting.
6. In order to obtain information about potential intergenerational trauma, as the sixth goal, we examined a connection between experienced trauma of the mother's parents, her perception of their parenting style, and her own

parenting. The hypothesis was that the maternal and paternal traumas, as well as parents' rejecting parenting, could predict the participant's rejecting parenting.

7. The last objective was to determine a connection between risk, protective factors, rejecting parenting style and demographic variables.

# METHOD

## Participants in the study

The participants in the research included a convenient sample of 100 mothers from urban areas. Research was conducted in Canada. Half of the women were victims of complex traumatic experiences with C-PTSD diagnosis, whereas the other half were from a control group with no reported history of complex trauma. Participants in the complex trauma group have been attending a trauma psychotherapy program at the counselling agency. Before they were sent to the treatment, the participants with the trauma history were diagnosed with C-PTSD by the provincial mental health assessment team. At the time of referral, the trauma survivors had no other concurrent psychotherapy treatment while receiving trauma therapy. The group with no complex trauma history represented the mothers whose children, at the time of the reaseach, attended elementary and secondary schools. This group of caregivers reported never receiving any psychological treatment for trauma and not being on any treatment at the time of the study. Demographic data for both groups are as presented in Table 1 and 2.

**Table 1.** Socio-demographic data of mothers in both groups

| | | Trauma | Control | Total |
|---|---|---|---|---|
| Age | 19-24 | 0 (0%) | 1 (2%) | 1 (1%) |
| | 25-34 | 9 (18%) | 7 (14%) | 16 (16%) |
| | 35-44 | 17 (34%) | 14 (28%) | 31 (31%) |
| | 45-54 | 23 (46%) | 26 (52%) | 49 (49%) |
| | 55-64 | 1 (2%) | 2 (4%) | 3 (3%) |
| Income | Under poverty line | 3 (6 %) | 2(4%) | 5 (5%) |
| | Modest | 19 (38%) | 7(14%) | 26 (26%) |
| | Average | 22 (44%) | 21(42%) | 43 (43%) |
| | Comfortable | 2(4%) | 9 (18%) | 11 (11%) |
| | High | 4(8%) | 11 (22%) | 15 (15%) |
| Education | Post-graduated (MA. PhD, MD) | 3 ( 6%) | 12 (24%) | 15 (15%) |
| | Graduated (BA) | 14 (28%) | 24 (48%) | 38 (38%) |
| | Diploma | 5 (10%) | 4 (8%) | 9 (9%) |
| | Some college, no degree | 6 (12%) | 2 (4%) | 8 (8%) |
| | High school | 21 (42%) | 8 (16%) | 29 (29%) |
| | Elementary school | 1 (2%) | 0 (0%) | 1 (1%) |
| Employment | Full-time | 24 (48%) | 30 (60%) | 54 (54%) |
| | Part-time | 9 (18%) | 13 (26%) | 22 (22%) |
| | Unemployed, looking for work | 1 (2%) | 3 (6%) | 4 (4%) |
| | Unemployed, not looking for work (retired, disabled, etc.) | 16 (32%) | 4 (8%) | 20 (20%) |
| Marital status | Divorced | 16 (32%) | 9 (18%) | 25 (25%) |
| | Married/Common-law | 21 (42%) | 34 (68%) | 55 (55%) |
| | Separated | 2 (4%) | 5 (10%) | 7 (7%) |
| | Single | 11 (22%) | 1 (2%) | 12 (12%) |
| | Widowed | 0 (0%) | 1 (2%) | 1 (1%) |
| Number of children | 1 | 17 (34%) | 14 (28%) | 31 (31%) |
| | 2 | 23 (46%) | 29 (58%) | 52 (52%) |
| | 3 | 8 (16%) | 7 (14%) | 15 (15%) |
| | 4+ | 2 (4%) | 0 (0%) | 2 (2%) |

*Legend: Control – control group, mothers with no C-PTSD; Trauma – group with mothers who experienced complex trauma and have been diagnosed with C-PTSD*

The mean age for mothers participating in the study was between 45 – 54 years (SD = 0.83). The number of children ranged from 1 to more than 4, with a mean of 1.9 (SD = 0.73). Fifty-five percent of the women were married. Forty-nine of women were born in Canada, and the remaining fifty-one percent immigrated to Canada from 29 different countries. The majority (62%) had a post-secondary degree. Seventy-six percent were employed and were currently working at the time of completing the survey (Table 1).

**Table 2.** Socio-demographic data for mother's parents and family of origin

| | | Trauma | Control | Total |
|---|---|---|---|---|
| Mother's education | Post-graduated (MA, PhD) | 0 (0%) | 1 (2%) | 1 (1%) |
| | Graduated (BA) | 3 (6%) | 12 (24%) | 15 (15%) |
| | Diploma | 9 (18%) | 7 (14%) | 16 (16%) |
| | Some college, no degree | 2 (4%) | 6 (12%) | 8 (8%) |
| | High school | 19(38%) | 22 (44%) | 41 (41%) |
| | Elementary school | 17(34%) | 2 (4%) | 19 (19%) |
| Father's education | Post-graduated (MA, PhD) | 6 (12%) | 3 (6%) | 9 (9%) |
| | Graduated (BA) | 6 (12%) | 18 (36%) | 24 (24%) |
| | Diploma | 3 (6%) | 6 (12%) | 9 (9%) |
| | Some college, no degree | 3 (6%) | 1 (2%) | 4 (4%) |
| | High school | 26 (52%) | 19 (38%) | 45 (45%) |
| | Elementary school | 6 (12%) | 3 (6%) | 9 (9%) |
| Parental relationship | Biological parents (married/common- law) | 14(28%) | 36 (72%) | 50 (50%) |
| | Father died when I was 18 | 1 (2%) | 0 (0%) | 1 (1%) |
| | Parent and stepparent | 1 (2%) | 2 (4%) | 3 (3%) |
| | Parents divorced | 16(32%) | 6(12%) | 22 (22%) |
| | Single parent household | 6 (12%) | 6 (12%) | 24 (24%) |
| Number of siblings | 0 | 8 (16%) | 9 (18%) | 17 (17%) |
| | 1 | 25 (50%) | 28 (56%) | 53 (53%) |
| | 2 | 8 (16%) | 10 (20%) | 18 (18%) |
| | 3 | 7 (14%) | 0 (0%) | 7 (7%) |
| | 4+ | 2 (4%) | 3 (6%) | 5 (5%) |

*Legend: Control – control group, mothers with no C-PTSD; Trauma – group with mothers who experienced complex trauma and have been diagnosed with C-PTSD*

In the Table 2 we presented the data about the mother's parents and family of origin. Participants' mothers from the trauma group had mostly elementary school education (34%) and a high school diploma (38%), while the mothers in the control group had a higher level of education (high school (44%) and post-secondary (52%)). Participants' fathers, on the other hand, in the trauma group had mostly high school diploma (52%) , while the fathers in the control group were more educated (high school (38%) and post-secondary (66%). The majority of mothers in the trauma group had divorced parents while growing up (32%), while the majority of mothers from the control group were raised by the biological parents who lived together (72%). There was no significant difference in the number of siblings, as mothers in both groups mostly had one sibling while growing up.

## Instruments

The questionnaire contained several questions related to variables discussed in the literature as potential resources or factors that may contribute to positive parenting. For this study, we decided to include perceived social support and a high level of resilience as protective factors.

**Demographic variables.** Participants answered the questionnaire in regards to the following socio-demographic data: age, education, income, marital status, number of children and employment. In addition to their own, participants also reported on the sociodemographic characteristics of the parental relationship, father's and mother's education and the number of siblings in the family of origin.

**Parental Rejection.** We used the *Parental Acceptance/Rejection Questionnaire* (PARQ, Rohner and Sumbleen, 2016.) to assess mothers' current perceptions of how they see their acceptance or rejection concerning their children. The scale was also used to get the information about the perceived parenting of their parents. The instrument consists of 29 items divided in five dimensions: 1) warmth and affection (or coldness and lack of affection when reverted, which was what we have been referring to further in the study, and all scores for this subscale are based on this reverted calculation) (8 items, e.g. "I feel my parent loves me and I feel needed" and "I hug and kiss my child when s(he) is good", 2) hostility and aggression (6 items, e.g. "She is purposely trying to hurt my feelings" and "I hit my child, even when s(he) doesn't deserve it"), 3) indifference and neglect (6 items, e.g. "She/he doesn't pay attention to me" and "I am too busy to answer my child's questions"), 4) undifferentiated rejection (4 items, e.g. "My mother/father doesn't love me" and "I resent my child") and 5) control (5 items, e.g. "My parent is controlling what I do" and " I insist that my child does exacly as s(he) is told"). Collectively, all five dimensions represent an overall

measure of perceptions of parental rejection, when the warmth and affection scale is reverted (Rohner, 2016). Cronbach's alpha for the full scale is 0.89 and 0.90 for the warmth scale, 0.87 for hostility scale, 0.77 for neglect scale 0.72 for undifferentiated rejection and 0.88 for parental control scale.

**Trauma.** The questionnaire contained items referring to the type of psychological trauma that participants experienced in their lifetime. This was a dichotomous variable and it was assessing if the participant responded positively on the presence of the experienced traumas, such as childhood sexual abuse, verbal and physical abuse, rape and sexual assault in adulthood, physical assault, domestic violence, childhood physical and emotional neglect, parental physical and mental health, parental alcohol and drug use, loss of a significant person, physical illness of the participant, parents, or other family member, war, torture, parental divorce and refuge. Based on the number of reported traumas, we were able to calculate the cumulative number of experienced traumas per participant.

**C-PTSD.** *Self-Report Inventory of Extreme Stress Disorders*, (SIDES-SR, Pelcovitz et al., 1997.) was used for the assessment of C-PTSD symptoms. Forty-five items assess the presence and/or severity of a diagnostic construct of extreme stress disorder. Self-questionnaire has good correlations for behavior and has shown good internal reliability as a measure of the current presence of complex posttraumatic stress disorder. SIDES consists of six main scales: affect dysregulation, negative self-concept; changes in self-esteem; interpersonal disturbances; somatization and changes in systems of meaning. Respondents evaluated their symptom intensity in the numerical range from 0 to 3. Generally speaking, confirmation of the clinical level of severity of the syndrome was obtained if the participant responded to the item with 2 or more. This assessment approach is based on SCID (Structured Clinical Interview for DSM-IV) scoring of disorders, in which an item labeled "1" is considered subclinical, "2" indicates a clinical level of impairment, while "3" is considered a serious presence of the disorder.

Even though there are many new versions developed to precisely measure C-PTSD, the SIDES instrument remains useful for two reasons: 1) clinical research into the complexity of adaptation to chronic, early, and interpersonal forms of trauma; and 2) basic and ongoing assessment of clients in psychotherapy for which the forms of expression of complex symptoms of trauma and associated functional impairment have been noted by SIDES as relevant and which are not adequately covered by other measures of existing clinical diagnostic batteries. For this reason, we decided to use this inventory, as it covers a wide range of symptoms that cannot necessarily be identified by the existing C-PTSD questionnaires. As it was previously mentioned, the participants in the trauma groups have already been diagnosed, and the instrument was used for the purpose of the research only . The internal consistency for the whole

scale was high (alpha = 0.93), and all subscales, with the exception of somatization (alpha = 0.68), presented strong internal consistency (alpha ranged from 0.74 to 0.82).

**Social support.** With the *Multidimensional Scale of Perceived Social Support* (MSPSS) (Zimet & et al., 1988), the participants were asked to indicate on a seven-point scale if they had a family member or friends who currently supported them in their life. The questionnaire consists of 12 items, evenly divided into dimensions of support from family, friends and other important people (4 items for each subscale). Scores range from 1, indicating they entirely disagree with the statement to seven, stating substantial agreement with a given comment. On each item, the respondent expresses the degrees of agreement or disagreement with the content of the item on a five-point Likert-type assessment scale. The values of the alpha coefficient range from .81 to .90 for family support, from .90 to .94 for the friends subscale and from .83 to .98, for the support of other important people in an individual's life. The total alpha coefficient is in between .84 to .92 for the scale as a whole.

**Resilience**. *Connor-Davidson Resilience Scale* (CD-RISC 25, Connor and Davidson, 2003) was used to measure resilience. The CD-RISC 25 consists of five subscales (resilience components) that are considered to encompass quality and behaviors in individuals who adapt positively despite adverse experiences: 1) personal competence and toughness (8 items; e.g. "Even when things seem hopeless, I do not give up"), 2) confidence in my own instincts and strengthening the effect of stress (7 items, e.g. "Exposure to stress makes me stronger"), 3) positive acceptance of change (5 items, e.g., "Past successes give me confidence to deal with new challenges and difficulties"), 4) control factor (3 items, e.g. "I feel like I have control over my life"), and 5) spiritual influences (2 items e.g. "When I can't find a solution to my problems, maybe fate or God can help"). Participants should indicate to what extent they agree with each statement that relates to their life experience. If the situation did not happen to them, then they should pretend it did and how they would react to it. The answers to each item are given on a five-point Likert scale (0 – not true at all to 4 – correct almost all the time). The total scale has 25 items and it ranges from 0-100, and a higher score on the scale indicates higher resilience (Davidson et al., 2005). Cronbach's alpha for the full scale is 0.89, and 0.93 for personal competence scale, 0.80 for confidence scale, 0.75 for positive acceptance and change, 0.74 for control and 0.69 for spiritual influences scale. CD-RISC is considered one of better instruments in psychometric assessment of resilience (Vindle, Bennett and Noies, 2011).

## Procedure

The study was conducted in the period from June to September 2019. Prior to conducting the research, a valid ethics certificate was obtained from the Panel on

Research Ethics Canada as well as a consent from the director of the agency involved in the study. Also, the consent was obtained from the authors of the instruments used. Participants were asked to fill out an online survey where their trauma symptoms, demographic factors, trauma history, parenting (their own and the perceived one of their parents), percieved social support and resilience were assessed. The invitation to participate in the study was offered through advertisement at the agency and nearby schools for the control group.

Participants accessed surveys via the Survey Gizmo application. They were offered a detailed explanation of the study at the beginning of the survey, where they also answered the questions related to their informed consent to participate in the study. The authors created a website where the research was explained into details. The link to this website was placed in the survey introduction. Participants were guaranteed voluntary, anonymous and confidential participation in the study, with the right to quit their participation at any time, as well as the right not to answer some questions. The average time for finalizing the questionnaire was 35 minutes. We gave participants an option to leave their e-mail ID if they wished to be included in a draw to win one of five $100 gift cards. Considering that some of the survey questions could be triggering to the participants, we wanted to make sure the participants felt safe while engaging in the study. For this reason, the follow-up option was available to them if they found any question upsetting or wished further emotional support. They could also contact the researchers directly to obtain more information about the study.

The surveys included many questions about the current parental acceptance and rejection, trauma history, present symptoms of trauma, level of resilience, acceptance/rejection of their parents, available resources, and perceived social support. Questions about parenting were presented, referring to their past behavior. Specific details about parenting, such as who the child was (if there were more children in the family), whether the behavior was ongoing, or whether they were the guardians of their child, were not included in the survey.

The participants' trauma history was obtained by asking questions about the type of abuse/violence the participants experienced, such as childhood sexual abuse, childhood physical abuse, neglect, witnessing domestic violence, sexual assault, and others.

A total of ten sociodemographic variables were included in this study: age, number of siblings, marital status, employment, income, parental relationship growing up, and parental education. Pearson's correlations in between these variables showed a low connection, and therefore we decided to include them in the research as separate variables.

## Statistical procedure

For the statistical analysis we used SPSS 23.0 software (IBM Coorporation, 2015). The data have been examined in several steps. First, we used a t-test to explore the impact of the complex posttraumatic disorder on the parenting style of the participants who have experienced trauma. The results were compared with the control group. Second, we used Pearson's correlations to calculate the connection between C-PTSD and parental rejection. Third, Pearson's correlations were also used to present the relationship between protective factors, C-PTSD and rejecting parenting. Fourth, the multiple regression equations were used to assess protective factors as potential moderators between C-TPSD and rejecting parenting. Baron and Kenny's moderation analysis was conducted to assess if protective factors moderate the relationship between C-PTSD and parenting style (Baron and Kenny, 1986). Fifth, with exploratory analysis, we identified unique and collective contributions of a variety of types of childhood and adult trauma on parenting style for the subgroup of participants who reported complex trauma exposure. Sixth, multiple regression was used to show how parental traumas and their rejecting parenting predict the mother's rejecting parenting. Lastly, we examined the correlation between socio-demographic variables and other important variables in the study.

# RESULTS

## Descriptive data for the used intruments

In the descriptive data analysis for the C-PTSD we identified a significant difference in the scores for C-PTSD for the control group ($M = 0.20$, $SD = 0.28$) and trauma group ($M = 1.07$, $SD = 0.63$); $t = -8.88$, $p<0.001$). Furthermore, we also concluded there was a significant difference in the scores for parental rejection for trauma group ($M = 66.34$, $SD = 13.59$) and control group ($M = 54.66$, $SD=7.57$); $t = -5.31$, $p < 0.001$. The perceived social support of the trauma survivors ($M = 41.68$, $SD = 19.59$) was lesser comparing to the control group ($M = 67.82$, $SD = 12.82$); $t =7.89$, $p < 0.001$. The resilience was lower in the trauma group ($M = 44.60$, $SD = 22.57$), compared to the control group ($M = 69.66$, $SD = 15.45$); $t = 6.48$, $p < 0.001$. In addition, the types of experienced traumas in both groups are presented in the Table 3.

**Table 3.** Types of experienced traumas in the trauma and control group

| Type of trauma | Trauma | | Control | | $X^2$ |
|---|---|---|---|---|---|
| | n | % | n | % | |
| Childhood verbal abuse | 27 | 54 | 4 | 8 | 24.73* |
| Childhood physical abuse | 25 | 50 | 2 | 4 | 26.84* |
| Childhood sexual absue | 31 | 62 | 1 | 2 | 41.36* |
| Neglect | 31 | 62 | 2 | 4 | 38.04* |
| Illness | 4 | 8 | 2 | 4 | .71 |
| Physical assault | 16 | 32 | 7 | 14 | 4.57 |
| Sexual assault/Rape | 26 | 52 | 3 | 6 | 25.69* |
| Domestic violence | 31 | 62 | 5 | 10 | 29.34* |
| Violence | 8 | 16 | 3 | 6 | 2.55 |
| Parental mental health | 19 | 38 | 4 | 8 | 12.71* |
| Parental health | 6 | 12 | 6 | 12 | .00 |
| Parental alcohol and drug use | 20 | 40 | 1 | 2 | 21.76* |
| War | 8 | 16 | 10 | 20 | .27 |
| Refuge | 4 | 8 | 1 | 2 | 1.90 |
| Torture | 2 | 4 | 0 | 0 | 2.04 |
| Significant loss | 18 | 36 | 17 | 34 | .04 |
| Illness (family member) | 9 | 18 | 10 | 20 | .07 |
| Parental divorce | 16 | 32 | 6 | 12 | 5.83 |

*Legend: *Groups are significantly different (p<.001); Trauma – group with complex PTSD; Control – group without complex PTSD*

A Chi-square test of independence was calculated comparing the frequency of experienced traumas in both groups of mothers. A significant interaction was found for the experienced childhood verbal abuse ($X^2$ (1) = 24.73, p < 0.001), childhood physical abuse ($X^2$ (1) = 26.84, p < 0.001), childhood sexual abuse ($X^2$ (1) = 41.36, p < 0.001), neglect ($X^2$ (1) = 38.04, p < 0.001), sexual assault/rape ($X^2$ (1) = 26.69, p < 0.001), experienced domestic violence ($X^2$ (1) = 26.34, p < 0.001), parental mental health ($X^2$ (1) = 12.71, p < 0.001), and parental alcohol and drug use ($X^2$ (1) = 21.76, p < 0.001). It is concluded that the experienced traumas, mostly the ones from the childhood, were significantly more prevalent in the trauma group.

## Analysis of difference in groups in regard to mother's rejecting parenting

In the next analysis, in order to explore the rejecting parenting in both groups of mothers, we ran an independent-samples t-test to compare the difference between the two groups. The results are as presented in Table 4.

**Table 4.** The difference in rejecting parenting style between trauma and control group (N=100)

| Dependent variable | Groups | N | Mean | SD | SD Mean |
|---|---|---|---|---|---|
| Rejecting parenting | Control | 50 | 54.66 | 7.57 | 1.07 |
| | Trauma | 50 | 66.34 | 13.59 | 1.92 |

*Legend: Control – control group, mothers with no complex trauma experience; Trauma – group with mothers who experienced complex trauma*

Analysis displays that there was a significant difference in the scores for rejecting parenting for trauma group (M = 66.34, SD = 13.59) and control group (M = 54.66, SD = 7.57); t = -5.31, p < 0.001. These results suggest that the exposure to complex trauma is correlated to the rejecting parenting.

## Analysis of correlations between complex posttraumatic disorder and rejecting parenting

The study further used Person correlations to explain the connection between C-PTSD and the parenting behaviors. It was found that C-PTSD was positively correlated with the lack of affection (r = 0.63, p < 0.001), parental hostility (r = 0.79, p < 0.001), neglect (r = 0.74, p < 0.001) and control (r = 0.56, p < 0.001), and negatively correlated with variable parental rejection (r = -0.42, p < 0.001). The results are as presented in Table 5.

**Table 5.** Rejecting parenting and complex posttraumatic stress disorder: correlations (N = 100)

| Variables | 1 | 2 | 3 | 4 | 5 | 6 |
|---|---|---|---|---|---|---|
| 1. Lack of affection | - | | | | | |
| 2. Hostility | .54*** | - | | | | |
| 3. Neglect | .77*** | .66*** | - | | | |
| 4. Rejection | -.25** | -.36*** | -.42*** | - | | |
| 5. Control | .27* | .49*** | .37*** | -.28** | - | |
| 6. C-PTSD | .63*** | .72*** | .74*** | -.42*** | .55*** | - |

*Legend: C-PTSD – complex posttraumatic stress disorder; *p < .01. **p < .005. ***p < .001*

Analysis showed a negative correlation between complex trauma symptoms and mother's rejection. Therefore, there will be a higher activation of negative parenting behaviors if there is an increased presence of complex trauma symptoms.

## Analysis of correlations between social support and resilience, as protective factors, rejecting parenting and C-PTSD

In the next step the Pearson correlations were used in order to examine the bivariate relationships between rejecting parenting and the following variables: resilience, the total number of traumas, C-PTSD, and perceived social support (Table 6).

**Table 6.** Protective factors, C-PTSD, and mother's rejecting parenting: correlations (N = 100)

| | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| C-PTSD | - | | | |
| Rejecting parenting | .82** | - | | |
| Resilience | -.87** | -.84** | - | |
| Social support | -.79** | -.68** | .85** | - |

*Legend: C-PTSD – complex posttraumatic stress disorder; *p < .01. **p < .005. ***p < .001*

It was found that negative parenting style was positively correlated with C-PTSD ($r = 0.82$, $p < 0.001$). Rejecting parenting was negatively correlated with variables resilience ($r = -0.87$, $p < 0.001$) and perceived social support ($r = -0.68$, $p < 0.001$).

These findings suggest that a mother presents less negativity in parenting when she has higher resilience and perceived social support.

## Analysis of protective factors as moderators of the effect of complex trauma on mother's rejecting parenting

We conducted multiple regression to explore if complex posttraumatic stress disorder could predict mother's rejecting parenting. We also calculated if protective factors could suppress the effect of C-PTSD on parenting. The results are as presented in Table 7.

**Table 7.** Summary of multiple regression analysis for C-PTSD and protective variables predicting mother's rejecting parenting (N = 100)

| | Model 1 | | | Model 2 | | |
|---|---|---|---|---|---|---|
| **Variable** | ***B*** | ***SE B*** | ***β*** | ***B*** | ***SE B*** | ***β*** |
| Resilience | -.45 | .03 | -.84*** | -.26 | .06 | -.49*** |
| C-PTSD | | | | 7.60 | 2.03 | .40*** |
| $R^2$ | | .70 | | | .74 | |
| *F* for change in $R^2$ | | 226.52*** | | | 135.32*** | |

*Legend: C-PTSD – complex posttraumatic stress disorder; *p < .01. **p < .005. ***p < .001*

The analysis suggested that complex posttraumatic stress disorder could predict the mother's rejecting parenting, as confirmed with the previous results showing a correlation between negative parenting behaviors and C-PTSD. When we entered protective variables, resilience and perceived social support, the analysis showed that resilience could suppress the relationship between C-PTSD and negative parenting. Perceived social support failed to explain a variance in rejecting parenting.

## Analysis to explore unique contributions of a variety of types of childhood and adult trauma on parenting

Pearson's correlation was used to identify unique and common contributions of a variety of types of childhood and adult trauma on parenting style for the subgroup of participants who reported complex trauma exposure.

**Table 8.** Summary of multiple regression analysis for type of trauma variables in predicting mother's rejecting parenting (N = 50)

| | Model 1 | | | Model 2 | | | Model 3 | | |
|---|---|---|---|---|---|---|---|---|---|
| **Variable** | ***B*** | ***SE B*** | ***β*** | ***B*** | ***SE B*** | ***β*** | ***B*** | ***SE B*** | ***β*** |
| CSA | 14.29 | 2.25 | .54*** | 11.03 | 2.34 | .42*** | 11.76 | 2.30 | .44*** |
| CPA | | | | 8.49 | 2.46 | .31** | 9.50 | 2.43 | .34*** |
| Torture | | | | | | | -14.78 | 7.20 | -.20* |
| $R^2$ | | .29 | | | .37 | | | .41 | |
| *F* for change in $R^2$ | | 40.22*** | | | 28.34*** | | | 21.92*** | |

*Legend: CSA – childhood sexual abuse; CPA –childhood physical abuse; Torture – torture (emotional of physical); *p < .01. **p < .005. ***p < .001.; inquired values for the CSA, CPA, and Torture variables were: 0-Not present and 1- present*

Analysis show that rejecting parenting style was significantly positively correlated with childhood physical abuse (r = 0.47, p < 0.001), childhood sexual abuse (r = 0.54, p < 0.001), childhood verbal abuse (r = 0.32, p < 0.005), neglect (r = 0.35, p < 0.001), and adult trauma – sexual assault or rape (r = 0.28, p < 0.005). With the help of multiple regression, we explored if these traumas could predict the rejecting parenting style. The results, as presented in Table 8, showed that childhood sexual abuse, childhood physical abuse, and torture in small percent, out of all childhood and adulthood traumas, could predict a negative parenting style. Therefore, we were led to conclude that the experience caused by such childhood traumas could predict rejecting parenting. Even though torture didn't show a significant correlation with mother's parenting, it is interesting that it showed suppression effect in the regression analysis in relation to other traumas.

## Analysis on how parental traumas, as well as their perceived rejecting parenting, could predict mother's parenting style

Another objective was to estimate to what extent could perceived parental rejection and their trauma predict mother's rejecting parenting, assuming the presence of intergenerational trauma. We also added parental cumulative traumas (calculated as the total number of traumas practicipants reported about their parents) and added them into linear regression analysis. The results are as presented in Table 9.

**Table 9.** Summary of multiple regression analysis for variables predicting mother's rejecting parenting (N = 100)

| | Model 1 | | | Model 2 | | |
|---|---|---|---|---|---|---|
| **Variable** | ***B*** | ***SE B*** | ***β*** | ***B*** | ***SE B*** | ***β*** |
| Mother's rejection | .27 | .04 | 0.61*** | .24 | .04 | .53*** |
| Father's trauma | | | | 1.80 | .90 | .18* |
| $R^2$ | | .37 | | | .40 | |
| *F* for change in $R^2$ | | 57.52*** | | | 31.67*** | |

*Legend: Mother's rejection – referring to mothers rejecting parenting behaviour towards the child; Father's trauma – cumulative number of fathers' experienced traumas, calculated as a mean of the cumulative value; *p < .01. **p < .005. ***p < .001*

The analysis shows that the mother's rejection predicts the participant's rejecting parenting, thus assuming intergenerational traumatic transfer. If a child is continuously rejected by the mother while growing up, then the modelling and internalized rejecting experiences could create rejective behaviors when they become parents. The participants' mother's cumulative traumas did not show any effect on the negative parenting style; however, the father's traumas cumulatively with the mother's rejections suggested such prediction.

## Analysis about the connection between risk, protective factors, mother's rejecting parenting and demographic variables

With regard to the last research goal to examine the correlation between socio-demographic variables, such as participant's level of education, number of children in the family, employment, marital status, income and participant's parenting style, risk and protective factors, we received significant correlations for these variables. The results are presented in Table 10.

**Table 10.** Protective factors, demographic variables, and rejecting parenting: correlations (N = 100)

| | Age | Edu | Inc | Mar-Sta | Empl | ParRel | Num-Sibl | Mom-Edu | Fath-Edu | #Child |
|---|---|---|---|---|---|---|---|---|---|---|
| Trauma | -.15 | .34** | .18 | .11 | .35** | .21* | .01 | .10 | .14 | .08 |
| C-PTSD | -.18 | .41*** | .27** | .32** | .38** | .20* | .11 | .17 | .25* | -.07 |
| Soc. Support | .10 | -.42*** | -.21* | -.26** | -.48*** | -.20 | -.08 | -.21* | -.23* | .02 |
| Resilience | .18 | -.41*** | -.26** | -.27** | -.39*** | -.19 | -.07 | -.20* | -.26* | .09 |
| PARQ | -.13 | .32** | .20 | .33** | .30** | .15 | -.00 | .22* | .23* | -.06 |

*Legend: Edu – education; MarSta – marital status; Empl – employment, ParRel – parental relationship; NumSibl – number of siblings growing up; MomEdu – mother's education; FathEdu – father's education; #Child – number of children in the family; Soc.Support – perveived social support; Trauma – number of collective experienced traumas; C-PTSD – symptoms of complex posttraumatic stress discorder; PARQ – accepting-rejecting dimension of the parenting style; *p < 0.1 **p < .005. ***p < .001*

Analyses show that mother's rejecting parenting was correlated with her education ($r = 0.32$, $p < 0.005$), marital relationship ($r = 0.33$, $p < 0.005$) and employment ($r = 0.30$, $p < 0.005$). The results suggest negative parenting to be more prevalent among women who have acquired higher education, who are single parents or those in a non-consistent intimate relationship, and who are employed. Single mothers are usually busier trying to make their ends meet, which leaves less time to connect to their children. The number of experienced traumas significantly correlated with participant's education ($r = 0.34$, $p < 0.005$), employment ($r = 0.35$, $p < 0.005$) where C-PTSD positively correlated with education ($r = 0.41$, $p < 0.001$), income ($r = 0.27$, $p < 0.005$), marital status ($r = 0.32$, $p < 0.050$) and employment ($r = 0.38$, $p < 0.005$). Results indicate that mothers with higher income, higher education, separated or divorced and employeed are most likely to develop symptoms of C-PTSD. Social support showed negative connection to education ($r = -0.42$, $p < 0.001$), marital status ($r = -0.26$, $p < 0.005$) and employment ($r = -0.48$, $p < 0.001$). Mothers who are not in a significant relationship, who are educated and employeed are perceiving not having appropriate social support. Similarly, resilience is negatively correlated with education ($r = -0.41$, $p < 0.001$), income ($r = -0.26$, $p < 0.005$), marital status ($r = -0.27$, $p < 0.005$) and employment ($r = -0.39$, $p < 0.001$), indicating that mothers who are not in a significant intimate relationship and who are employeed with higher income and education tend to be less resilient to trauma. The protective factors are simirarly correlated to these variables, suggesting that mothers who don't have an ongoing support from their partners, and who are most likely single mothers, are more vulnerable to developing the C-PTSD symptoms. Age and number of children did not appear to have connection to the risk and protective factors, as well as to the rejecting parenting.

# DISCUSSION

The current study found that traumatic experiences in both childhood and adulthood were related to problems in parenting. Experience of complex trauma, particularly childhood sexual and physical abuse, as well as the presence of C-PTSD symptoms, suggested a significant connection with mother's parenting. However, resilience as a protective factor moderated the relationship between C-PTSD and mother's rejecting parenting. These findings are consistent with a variety of earlier studies and go beyond these studies by integrating the examination of the impact of multiple types of trauma across the lifespan and C-PTSD symptoms on parenting (Delker et al., 2014). Perceived rejecting parenting of participant's mother predicts her own rejecting parenting, which may suggest a transmission of intergenerational trauma.

## Parenting and complex traumas

This research underscores the importance of attending to the history of participant's traumas on parenting, examining not just the impact of childhood trauma, but also including all of the traumas experienced throughout the person's lifetime. Childhood physical and sexual abuse are significantly correlated to the rejecting parenting at the bivariate level, which is consistent with previous research (Peterson et al., 2014; Rodriguez-JenKins and Marchenko, 2014). Childhood physical and sexual abuse also succeeded in explaining variance in rejecting parenting. Other traumas in childhood and adulthood, even though they correlated with the rejecting parenting, such as childhood verbal abuse, neglect, sexual assault, and rape in adulthood, as well as parental divorce, failed to explain the variance in the rejecting parenting. Torture, on the other hand, presented the opposite effect on mother's negative parenting. This contradicts the existing literature that presents torture as one of significant risk factors in developing PTSD and therefore mediating the effect on functional parenting (Spinazzola et al., 2014; Grünbaum et al., 2018).

Individual traumas that have the most significant effect on parenting were the ones that occurred during childhood. Child maltreatment may be a more distal factor that increases the risk of exposure to more proximal stresses on parenting. This has been supported by literature that emphasizes the importance of multiple types of trauma on negative mental health outcomes (Leen-Feldner et al., 2011; Assink, et al., 2019; Montgomery, Just-Østergaard and Jervelund, 2019). Also, childhood physical and sexual abuse are more likely to involve perpetration by caregivers in the family of origin and thus may be a better marker for disturbed family-of-origin relationships. Theories of intergenerational transmission of abuse support these findings (Spinazzola et al, 2014; Grünbaum et al., 2018).

## C-PTSD, Protective factors and parenting style

The current study fits in with previous parenting research that highlights the importance of complex posttraumatic disorder as a risk factor for problems in parenting (Spinazzola et al., 2014; Grünbaum et al., 2018). C-PTSD involves a negative self-perception, such as negative self-worth and low self-esteem. Therefore, C-PTSD can be reflected in the negative view a mother has of herself as a parent. It is also likely that multiple protective moderators play an essential role in the suppression of C-PTSD symptoms. For this reason, there is a need to learn more about the variability of these factors among survivors. Study results indicate the importance for trauma survivors to have a resilient outlook, such as positive connections to others, spirituality, sense of self, and humility. This is consistent with previous research on the positive effects of protective factors (Harris et al., 2014; McCabe et al., 2014; Dym-Bartlet and Easterbrooks, 2015, Brown et al., 2018). The results of our study go beyond merely examining the direct relationship between complex trauma history, C-PTSD, and mother's rejecting parenting. It has also confirmed the findings of the literature that suggest that it is important to work with survivors to create new connections, develop self-care skills and self-compassion. These are vital for reducing and ameliorating the negative psychological consequences of trauma exposure (Yehuda et al., 2015). These new skills also create in survivors an ability to adapt and successfully cope with trauma, as suggested in the previous research (Payne, 2011; Bonnano and Macini, 2012). Besides, the current study found the significant role resilience has on the suppression of C-PTSD symptoms, which invites mother's accepting behaviours. This confirms previous literature findings (Galatzer-Levy, Huang and Bonanno, 2018) and brings more understanding about the connection between all these factors. C-PTSD and resilience together were able to explain the variance of the rejecting parenting.

Socio-demographic variables such as participant's level of education, income, number of children in the family, employment and marital status, also presented a significant correlation with the rejecting parenting. The results suggest negative parenting to be more prevalent among women who have acquired higher education and income, who are single parents or those in a non-consistent intimate relationship, and who are employed. This can be explained by the fact that single mothers are usually busier trying to make their ends meet, which leaves less time to connect to their children. This, at the same time, makes them vulnerable to developing C-PTSD symptoms and more likely isolate themselves, thus affecting limitations to the social support. These findings remind us that the trauma histories of parents are just a small part of a much larger matrix of factors that determine rejecting parenting. Further research into how different dimensions of this ecology interact is needed.

## Limitations and implicaitons for research

There are some limitations to the current work. The presented analyses used broad categorizations of traumatic experiences because information about frequency and duration of all the traumas was not available. Additionally, we examined the presence of self-reported intergenerational trauma through the participants' knowledge of the experienced parental traumas and their parenting. Future research would benefit from collecting other measures of parental history that include attachment and family-of-origin relationships to more accurately test the impact of trauma through the intergenerational lens. Mothers may have also shown bias toward the study by giving socially desirable responses concerning their parenting and may have had an idealized picture of their parenting as well. We also didn't have complete information about the control group and the traumas they experienced. Mothers from this group expressed they were not in any treatment at the time of the research. However, when we obtained the data, some of them reported having a history of trauma. This could interfere with our conclusions about generalizability of the study.

Indeed, trauma is one of many variables affecting both parenting and C-PTSD, and the current model accounted for only a part of the variance in rejecting dimension of parenting. Future research should continue to examine a wider variety of interlocking factors that may contribute to a variance in C-PTSD and parenting. We need to continue to develop studies that look at risk and protective factors on the individual, family, community, and broader societal levels.

In terms of the participants, the current sample predominantly represents educated women from families with an average income. Lack of diversity in terms of the participants' social-economic status also limits the generalizability of these findings. Half of the women participating in the research are skilled immigrants who came to Canada in search of a secure and stable life. To pass the Canadian government immigration requirements, applicants would need to have had a higher level of education or specific professional skills to obtain immigration status. Therefore, it was no surprise that most of the sample had a higher educational level.

This study was conducted online and that also represents one of the limitations for the further generalizations. Even though quite resourceful, online questionnaires do not promote personal contact with the participants which could help to obtain detailed reports in regards to the study objectives.

# CONCLUSION

The research documented that mothers possess the capacity to adapt to adversity. Even though the impact of C-PTSD cannot be overseen, there is still clear

evidence of the effect that resilience has on the mother's ability to stop the cycle of abuse. The current study was an exploratory step in understanding how a variety of risks and protective factors may operate in the lives of parents. The study emphasizes the negative impact of childhood traumas and other factors that affect caregiving behaviors. Also, it is essential to evaluate each parent's ability to overcome the trauma impact on their parenting style.

The impact of this study is to create awareness of the importance of trauma-informed support for survivors to build capacity for a positive and accepting parenting. Trauma-informed support refers to educating service providers to create an environment where trauma survivors could explore past traumas and enhance their resilience in order to develop accepting and loving parenting behaviors. It also confirms that special attention has to go the single mothers, who are well educated and employed, as research show they might be more prone to developing C-PTSD and less resilient to complex trauma.

Additional studies should continue to focus on complex trauma exposure across the lifespan and its association with multiple mediators affecting specific parenting behaviors.

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# *ULOGA SLOŽENOG POSTRAUMATSKOG STRESNOG POREMEĆAJA I ZAŠTITNIH FAKTORA U PRIHVAĆAJUĆE-ODBIJAJUĆEM RODITELJSKOM STILU ŽENA KOJE SU PREŽIVJELE ZLOSTAVLJANJE*

## *SAŽETAK*

*Istraživanje je imalo za cilj uspostaviti vezu između složenog posttraumatskog stresnog poremećaja (C-PTSD) i roditeljskog stila žrtava složene traume. Cilj je također bio ispitati kako zaštitni faktori, rezilijentnost i percepcija socijalne potpore umanjuju učinak C-PTSD na odbijajuće roditeljstvo majke, kao i kako trauma njenih roditelja i njihovo odbacivanje utječu na roditeljstvo kod žena koje su preživjele složenu traumu. Rezultati studije temelje se na istraživanju na 100 žena u dobi od 19 do 64 godine. Uzorak je imao dvije skupine: majke s poviješću C-PTSD-a i kontrolne skupine bez registriranih poremećaja mentalnog zdravlja. Rezultati pokazuju da složena trauma negativno utječe na roditeljstvo žene. C-PTSD prikazuje korelacije sa svih pet dimenzija negativnih stilova roditeljstva (nedostatak naklonosti/ zanemarivanje/ agresija/ kontrola/ nediferencirano odbijanje). Rezilijentnost je djelovala kao moderator između C-PTSD i odbacivanja roditeljskog stila. Roditeljske traume i njihov odbijajući roditeljski stil očituju se u majčinom roditeljstvu.*

***Ključne riječi:*** *složeni PTSP; izloženost traumi; žene; roditeljski stil; rezilijentnost*