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Making the Invisible Visible: Exploring the Complex Pathways Between Childhood Experiences of Maltreatment and the Perpetration of Family Harm

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Abstract

Preventing family harm and providing care for those affected is a high priority for governments and social services worldwide. Adverse consequences of family harm continue to place demands on justice, mental health and care and protection services. The costs to individuals, families and communities are beyond measure, given that rates of family harm are under-reported. Quantitative researchers have demonstrated a link between childhood maltreatment and family harm perpetration with existing psychological theories used to explain this link. However, mainstream theories were first developed many decades ago, at a time when the notion of gender was not inclusively factored into theory development. Neither were they developed with or by Indigenous peoples, calling into question the translatability of mainstream theories for stopping the intergenerational transmission of trauma and violence.

The main aim of this thesis was to explore the relationship between childhood maltreatment and the perpetration of family harm by investigating two research questions. How could psychological theories better explain the pathways between childhood experiences of maltreatment and family harm perpetration? And, to what extent do psychological theories about the cycle of family harm reflect the experiences of Māori and non-Māori men and women in Aotearoa New Zealand? To answer these questions, interviews were conducted with 16 individuals who self-identified as perpetrating family harm and had childhood histories of maltreatment. (n=8 men, n=8 women). Purposive sampling ensured an equal number of Māori (Indigenous people of Aotearoa New Zealand) and non-Māori participated in the research. Thematic analysis was utilised to examine the personal conceptualisations regarding the association between experiences of childhood maltreatment and subsequent perpetration of family harm. The core corpus of data explored the

maltreatment-family harm relationship within and between Māori and non-Māori men and women. This thesis is comprised of three studies that investigate the intergenerational transmission of trauma and violence.

The first study analysed the interviews of the seven participants removed from their families of origin as children. All described ongoing experiences of poly-victimisation in subsequent placements, whether through adoption, foster or residential settings. When examined alongside all women interviewed in this thesis, men more often reported that their childhood maltreatment was overlooked by professionals. The findings of this study highlighted a relationship between the perpetration of family harm and limited relational and emotional experiences during childhood. Intervention points across the life span were identified to stop the intergenerational transmission of trauma and violence for people removed from their family of origin as children.

The second study focused on the experiences of the eight Māori men and women interviewed. A culture of silence surrounding childhood maltreatment pervaded all interviewees' childhood experiences. However, additional issues, including cultural isolation, were evident for Māori from the adults and professionals charged with their care. Māori interviewees identified three core Indigenous concepts that facilitated healing and intergenerational wellbeing: Wairua (spiritual connection), Pou (becoming a symbol of strength and support for self and others), and Tūrangawaewae (finding a sense of belonging). A return to Indigenous knowledge and practices was integral to stopping the intergenerational transmission of trauma and violence. This highlights the importance of privileging Indigenous knowledge in existing theoretical understanding of the cycle of family harm and incorporation in prevention initiatives.

The final study explored the impact of psychological distress within the cycle of family harm. Everyone interviewed experienced severe adverse trauma reactions linked to mental health and addiction issues, self-harm and suicidality, and instances of family harm. A significant barrier to psychological and familial wellbeing was the lack of access to integrated models of care capable of responding to complex and intertwined issues in trauma informed and Indigenous informed ways. Thus, family harm, trauma and mental health and addiction services need to work together to tailor and deliver treatment according to the individual and family needs to break the cycle of family harm and ongoing adverse life course trajectories.

This research identifies significant limitations in the psychological theories that usually contribute to thinking about family harm. There has been a particular failure to develop a theory that accounts for the heterogeneous cultural and gendered experiences of the cycle of family harm. Going forward, expanding the? view of traditional psychological theories of intergenerational trauma and violence is required to account for the historical trauma of colonisation and the ongoing adverse consequences for Indigenous communities. Family harm prevention initiatives must be led by and/or developed in partnership with and by Indigenous peoples to ensure responsivity through active incorporation of traditional practices for intergenerational healing and wellbeing.

The impact of poly-victimisation in childhood had severe and ongoing adverse consequences for both men and women that outweighed any obvious gender difference. For people who have experienced childhood maltreatment, it is essential to imbue initiatives with opportunities to understand emotions in relational contexts. Children who are placed in the care of the state must be cared for and, unlike the interviewees in this thesis, free from further childhood maltreatment. A therapeutic web should be established to stop the systemic issues

identified in this thesis by providing cohesive and coherent services in a timely fashion for children and adults affected by the cycle of family harm. In conclusion, adopting practices that are informed by understandings of trauma, gender, and Indigenous knowledge are needed to replace the intergenerational transmission of trauma and violence with hope and wellbeing.

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Ultimately, this thesis is a 'big shout out' to the people who work tirelessly to stop the culture of silence surrounding the intergenerational transmission of trauma and violence. Every day in Aotearoa New Zealand people are striving to make the world better for our future ancestors by breaking adverse generational patterns. No one has worked harder to stop the cycle of harm and replace it with hope and wellbeing than the people interviewed in this research. This thesis belongs to them, their children, and their children's children.

Mā te kōrero ka mōhio, mā te mōhio ka mārama, mā te mārama ka mātau, mā te mātau ka ora te iwi

Through discussion we learn, through learning we are enlightened, through enlightenment we are empowered, through empowerment the wellbeing of the people is achieved.

Dedication

In loving memory of my mum, Jillian Anne Dempster-Rivett

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Glossary of Māori Terms

This glossary identifies Māori words used in this article. The English version reflects the researchers' interpretation, often based on how the Māori word was used by participants. The terms presented here are in alignment with Health Research Council of New Zealand terminology (HRC, 2010).

Māori	**English**
Aotearoa	New Zealand
Hapū	Kinship group
Iwi	Extended kinship group, tribe
Kaitiakitanga	Guardianship
Karakia	Prayer, incantation
Kaumātua	Māori elders
Kotahitanga	Collective unity
Manaakitanga	Cultural and social responsibility Respecting the mana (authority) of others
Mātauranga	Traditional knowledge
Mokopuna	Grandchildren
Pākehā	Non-Māori
Pou	Steadfast and reliable; becoming a symbol of strength and support for self and others*
Rangatiratanga	Leadership
Tāne	Men
Tamariki	Children
Tangata whenua	Indigenous people
Takatāpui	Individuals who Identify as Gay, Lesbian, Bisexual, Transgender, Intersex
Te ao Māori	Māori worldview
Tūrangawaewae	A place to stand; finding a sense of belonging*
Tūpuna	Ancestors
Wairua	Spirit; spiritual connection*
Wairuatanga	Spirituality
Wāhine	Women
Whakatauki	Proverb
Whakapapa	Genealogy
Whānau	Family
Whatumanawa	Emotions

* Interpretation as emerged from the interview content.

List of Abbreviations

ACES	Adverse Childhood Events
APTEs	Adverse and Potentially Adverse Traumatic Events
PTSD	Post Traumatic Stress Disorder
SLT	Social Learning Theory
TA	Thematic Analysis

List of Publications and Presentations

Manuscripts

Dempster-Rivett, K. L., Roen, K., Masters-Awatere, B., & Starkey, N. (resubmitted 2021). Understanding the complex relationship between child maltreatment in care and family harm. *Child Children and Youth Services Review*. [Manuscript resubmitted after invitation to revise and resubmit].

Dempster-Rivett, K. L., Masters-Awatere, B., Roen, K., & Starkey, N. (2022). Māori voices in healing childhood maltreatment and breaking the cycle of family harm. *New Zealand Journal of Psychology*, *51,* 36-45.

Dempster-Rivett, K. L (resubmitted 2021). Is the time for siloed models of care ending? Examining the complex outcomes associated with childhood experiences of maltreatment and the perpetration of family harm. *Journal of Family Trauma, Child Custody and Child Development*. [Manuscript resubmitted after invitation to revise and resubmit].

Conference Presentations:

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Dempster-Rivett, K. (2021). Māori voices in healing intergenerational trauma and violence. In *The International Society of Critical health Psychology.* Conference hosted virtually through Victoria University of Wellington Aotearoa New Zealand.

Dempster-Rivett, K. (2020). Exploring the mechanisms linking child maltreatment and the perpetration of family violence. In *New Zealand Psychological Society Annual Conference.* Conference held at Rotorua Aotearoa New Zealand.

Dempster-Rivett, K. (2018). Exploring the Mechanisms Linking Child Maltreatment and the Perpetration of Family Violence. In *Department of Corrections National Training Event for Psychologists*. Conference held at Rotorua, Aotearoa New Zealand.

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Dempster-Rivett, K. (2021). Dealing with trauma as a legal professional. *Presented Virtually to the Abuse in Care Royal Commission of Inquiry*. For all employees working with the Royal Commission of Inquiry.

Dempster-Rivett, K. (2021). Dealing with trauma as a legal professional. *Presented Virtually to Legalwise Continuing Competency Programme*. For Lawyers based in Australia and Aotearoa New Zealand.

Dempster-Rivett, K. (2021). Coping with trauma as a legal professional. *Presented to Meredith Connell*. For lawyers at Meredith Connell. Held in Auckland Aotearoa New Zealand.

Dempster-Rivett, K. (2021). Dealing with trauma as a legal professional. Keynote presentation for *Te Kura Kaiwhakawā | Institute of Judicial Studies*. For Judges practicing in Aotearoa New Zealand. Held in Wellington Aotearoa New Zealand.

Dempster-Rivett, K. (2020). Introduction to trauma-informed practice. *Presented Meredith Connell*. For lawyers at Meredith Connell. Held in Auckland Aotearoa New Zealand.

Dempster-Rivett, K. (2020; 2018). Strategies for supporting their grandchildren/mokopuna with significant trauma histories. For *Waikato Bay of Plenty Branch of Grandparents raising Grandchildren.* Held in Hamilton Aotearoa New Zealand.

Dempster-Rivett, K. (2020). Dealing with trauma as a legal professional. Presented Virtually for *Te Kura Kaiwhakawā | Institute of Judicial Studies*. For High Court Judges practicing in Aotearoa New Zealand.

Dempster-Rivett, K. (2018). Hope is a strategy. Keynote presentation at the *National Conference for Life Education Trust* on working with children and young people with mental health issues. Held in Auckland Aotearoa New Zealand.

Dempster-Rivett, K. (2018). Healthy Relationships. For UniQ support group for queer students at Te Whare Wānanga o Waikato Waikato University. Held in Hamilton Aotearoa New Zealand.

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Dempster-Rivett, K. (2018). Development and implementation of trauma-informed training for women's corrections facilities in Aotearoa New Zealand. *Practice: The New Zealand Corrections Journal, 6*(2), 43-46. [Appendix A]

Chapter 1: Pathways Linking Childhood Experiences of Maltreatment with Family Harm Perpetration

At its heart, the intergenerational cycle of family harm reflects the fact that some adults who experience childhood maltreatment go on to perpetuate family harm. It is a phenomenon observed across the globe that has ramifications for individuals, families, communities, and multiple governmental and non-governmental agencies (Fortson, Klevens, Merrick, Gilbert, & Alexander, 2016; Goddard & Pooley, 2018). When this research project began, the New Zealand Police investigated 121,747 reports of family harm in 2017, resulting in 60,000 family violence referrals to Oranga Tamariki Ministry for Children (New Zealand Police National Headquarters, 2018; as cited in Lambie, 2018). It is widely accepted that the rates of family harm are likely to be underreported (Reilly & Mayhew, 2007), with New Zealand estimates of up to 76% of adults who experienced victimisation in a given year (Ministry of Justice, 2015). At the extreme end, between 2009 and 2015, 92 New Zealand women died due to intimate partner violence (IPV) and sadly, 52 child deaths were caused by child abuse and neglect (Family Violence Death Review Committee, 2017). The personal costs of the cycle of family harm are unmeasurable, and the financial cost to society is phenomenal, approximately $7 billion per year in Aotearoa New Zealand (Kahui & Snively, 2014). Therefore, it is pertinent for people working in the areas of childhood maltreatment and family harm perpetration to ensure that we employ the best theoretical frameworks when it comes to identifying, preventing, and providing interventions.

Chapter 1 contains an overview of the literature reviewed at the outset of this thesis which then informed the research rationale and methodology. The rationale for using the terms family harm and childhood maltreatment are outlined and defined. Followed by a

review of research regarding the prevalence and impact of childhood experiences of maltreatment for people who perpetrate family harm and the relationship between the two. A summary of the traditional theories that describe the underlying mechanisms linking childhood maltreatment and family harm are then provided setting the scene for the contemporary critiques of these outlined in Chapter 2.

Key Definitions of Childhood Maltreatment and Family Harm

Childhood experiences of abuse are not consistently defined in research within and across disciplines. However, by and large, the types of childhood abuse tend to be grouped into categories, including emotional/psychological abuse and neglect, physical abuse and neglect, and sexual abuse (Finkelhor, Ormrold, & Turner, 2007; Hildyard & Wolfe, 2002; Ministry of Social Development, 2018; New Zealand Police, 2018). There has been an increasing focus on the investigation into various subtypes of abuse and the associated risk for developing negative long-term outcomes (Hurren, Stewart & Dennison, 2017; Horan & Widom, 2015). For example, using latent profile analysis, Pears, Kim, and Fisher (2008) found four distinct patterns of abuse in preschool children in care and protection systems: neglect and emotional maltreatment; sexual abuse and emotional maltreatment; physical abuse and emotional maltreatment; or experienced all forms of maltreatment. One of the current advances in our understanding of child abuse has been identifying a subgroup of children who have been exposed to multiple forms of abuse and are at high risk of adverse outcomes (Baglivio & Epps, 2016; Cheng & Li, 2017; Widom, 2017). Given the diversity and complexity of the forms of child abuse and neglect, the current trend in the literature is to refer to child abuse as childhood maltreatment (Davis, Masters, Casey, Kajumulo, Norris & George, 2018; Ford,

Grasso, Hawke & Chapman, 2013; Finkelhor, Ormrod & Turner, 2011; Moore, Gaskom & Indig, 2013; Widom, 2017). This thesis is interested in all forms of childhood experiences of maltreatment; therefore, the term childhood maltreatment is used to capture the following domains of abuse and neglect: emotional, sexual, and physical.

Domestic violence was the previously accepted term for the physical harm perpetrated by one household member towards another (Lambie, 2018). However, over time our understanding of the breadth of violence that occurs within family systems resulted in the increased acceptance of the term family violence. Family violence is used as a descriptor for the range of behaviours within the family context, including neglect, emotional, physical, and sexual abuse *(*Oranga Tamariki Ministry for Children site, 2015; Department of Corrections, 2015). Family violence is a term that encapsulates violence towards children, parents, siblings, and the perpetration of IPV by a partner or ex-partner (Lambie, 2018). The New Zealand Police have adopted the terminology of family harm to encapsulate the variety of harmful behaviours within familial and intimate partner relationships (New Zealand Police, 2018). Behaviours that fall within the category of family harm include family violence and child abuse and neglect, including activities that are not deemed criminal such as psychological abuse, coercion, and control. Henceforth, this thesis will adopt the term family harm to align with the New Zealand Police terminology and research literature in this area.

Prevalence of Childhood Maltreatment in Offending Populations

Around the world, quantitative research has demonstrated that a history of childhood abuse and neglect are risk factors that predict a higher likelihood of violence and contact with youth justice systems (Briggs-Gowan, Pollak, Grasso, Voss, Mian, Zobel, McCarthy, Wakschlag, &

Pine 2015; Davis et al., 2018; Doolan, Najman, Mills, Cherney, & Strathearn, 2013; Fox, Perez, Cass, Baglivio, & Epps, 2015; Van Wert, Trocme, & Faloon, 2017). For example, Finkelhor et al. (2011) reported that 67% of American youth offenders had experienced childhood maltreatment. In a meta-analysis of longitudinal studies, Braga Goncalves, Basto-Pereira and Maia (2017) found that maltreatment was associated with a higher rate of general antisocial behaviour and aggression in juveniles.

Not surprisingly, the prevalence of childhood maltreatment in adult offending populations is considerable (Farrington, Gaffney, & Tofi, 2017; Widom, 2017). Courtney and Maschi (2013) explored the prevalence of abuse in the offending population and found that up to half of the male US prisoners reported childhood physical abuse, with 10– 30% reporting unwanted sexual contact. Similar to other research in the area (Haugebrook, Zgoba, Maschi, Morgen, & Brown, 2010; Messina, Grella, Burdon, & Prendergast, 2007), the participants reported experiencing multiple forms of other types of traumas such as: witnessing violence; parental separation or abandonment, death of family members, foster care placements or parental substance abuse. Bevan (2017) reported that 68% of New Zealand women and 52% of men prisoners experienced family harm. The prevalence of childhood maltreatment reported during intake interviews by a sample of 100 high-risk violent offenders in the Special Treatment Units (the low-medium security treatment programmes) in four men's prisons in New Zealand is sobering (D. L. L. Polaschek, personal communication, January 22, 2019). Specifically, 67% reported having been physically abused, 24% sexually abused, 21% psychologically abused, 10% reported all three types and another 18% two types. Of these men, 39% spent time in a foster home, boys' home or in the state's care. In an American community-based study of 626 male offenders, Davis et al.

(2018) identified that 80% of the sample experienced what they defined as a low level of childhood maltreatment, with 12% reporting both emotional and physical maltreatment and 4% describing both emotional and sexual maltreatment. The remaining 4% fell into a poly-victimised category in which they experienced multiple occurrences and forms of maltreatment.

Exploring the rates and consequences of poly-victimisation is an emerging and fascinating area of interest regarding the maltreatment-offending link (Baglivio & Epps, 2015; Ford, Elhai, Connor, & Frueh, 2010; Ford, Grasso, Hawke, & Chapman, 2013; Kerig, 2018). There is emerging evidence that poly-victimisation increases the risk of developing delinquency and psychosocial impairment that is not wholly explained by the presence of psychiatric or behavioural disorders such as post-traumatic stress disorder (Baglivio, Wolff, Piquero, & Epps, 2015; Ford, Connor, & Hawke, 2009; Ford, Wasser, & Connor, 2011). The consequences of poly-victimisation include childhood behavioural problems such as reactive aggression, impulsivity, and disturbances in relating to others (Cloitre, Stolbach, Herman, Kolk, Pynoos, Wang, & Petkova 2009; D'andrea, Ford, Stolbach, Spinazzola, & van der Kolk, 2012; Kerig, 2018). Thus, the more varied and diverse childhood maltreatment experiences are, the greater the likelihood of ongoing negative impacts.

Pathways Between Childhood Experiences of Maltreatment and Family Harm Perpetration

To date, no single theory has been identified that explains the relationship between childhood maltreatment and maladaptive outcomes (Horan & Widom, 2015; Masten & Wright, 1998). However, the impacts can be short-term, intermittent in presentation or pervasive across the

lifespan (Felitti, Anda, Nordenberg, Williamson, Spitz, Edwards, Koss, & Marks, 1998; Gilbert, Widom, Browne, Fergussen, Webb, & Janson, 2009). Children can be abused within various settings, including school, social activities, and within neighbourhoods, but it is believed that violence within the home can have one of the most significant impacts on children's development (Margolan & Gordis, 2000).

The term family harm is relatively new. Therefore, in writing this chapter, I draw more broadly on research that focuses on elements of the types of harm encapsulated in the term family harm. For example, different studies investigate the nature of the pathways between childhood experiences of maltreatment and family harm by focusing on specific forms such as IPV, domestic violence, and childhood experiences of maltreatment is significant (Ehrensaft, Cohen, Brown, Smailes, Chen, & Johnson, 2003; Morris, Mrug, & Windle, 2015; Linder & Collins, 2005; Semiatin et al., 2017; Whitfield, Anda, Dube, & Felitti, 2003). In a meta-analysis, Wolfe, Crooks, Lee, McIntyre and Jaffe (2003) found that experiences of childhood family violence were the best predictors of adolescent male violence and aggression towards females when in intimate relationships. Some research goes as far as to suggest that traumatic experiences are central to the development of violent behaviours, including IPV (Capaldi, Knobble, Shortt, & Kim, 2012). Studies investigating the relationship between adverse childhood experiences (ACES) and youth offending indicate the strongest link for children who have experienced multiple forms of abuse especially within family settings (Baglivio & Epps, 2015; Fox, Perez, Cass, Baglivio, & Epps, 2015).

However, narrowing the focus to link specific types of childhood abuse to the perpetration of family harm has produced some conflicting outcomes (Braga et al., 2017). For

example, some studies identify childhood sexual abuse as a risk factor for IPV for men only (Abbey, Parkhill, BeShears, Clinton-Shepard, & Zawacki, 2006; Whitfield et al., 2003). In contrast, other studies have identified it for women only (Kendra, Bell, & Guimond, 2012; Luthra & Gidycz, 2006). One explanation for the difficulty of identifying pathways from a particular form of childhood abuse is that multiple forms of abuse can often happen simultaneously as with emotional and verbal abuse (Cubellis, Peterson, Hennigner, & Lee, 2018). Therefore, this thesis will not narrow the focus to one type of abuse to the perpetration of family harm but rather leave it open to include all potential forms of childhood maltreatment.

A limitation in the research regarding the link between childhood maltreatment and the perpetration of family harm is the reliance on retrospective studies (Capaldi et al., 2012). For example, Stilth et al. (2000) conducted a meta-analysis of spousal abuse studies regarding intergenerational transmission and found a weak to moderate relationship with childhood maltreatment. Whereas, in a prospective study Widom, Czaja and Dutton (2014) found that of two groups of children who experienced child abuse (n = 497) and those who did not (n=395), approximately 75% of both groups reported perpetrating violence towards intimate partners. Childhood experiences of neglect were the only experience associated with an increased risk of the most severe physical injuries to partners. Widom, Czaja and Dutton's (2014) research highlights the prevalence and negative impact of IPV in the general population but also reminds us that childhood experiences are not always a factor in IPV. Not all people who experience childhood traumatic events develop adverse traumatic reactions (Kessler et al., 2005). Personal factors such as resiliency and external protective factors can help people adjust to extreme stress during childhood (Breslau et al., 2013).

The Impact of Childhood Maltreatment

Childhood experiences of maltreatment can result in emotional (Hurren, Stewart, & Dennison, 2017), social, behavioural (Briggs-Gowan et al., 2012; Hunt, Slack, & Berger, 2017), cognitive and physical (Danese, Moffitt & Harrington, Milne, Polanczyk, Pariante, Poultone, & Caspi, 2009; McKelvey, Selig, & White-Mansell, 2017) and neurodevelopmental (Teicher, Samson, Anderson, & Ohashi, 2016; Tomoda, Sheu, Rabi, Suzuki, Navalta, Polcari, & Teicher, 2011) disruptions in typical human development. These impacts can be short-term, intermittent in the presentation or pervasive across the lifespan (Hurren, Stewart, & Dennison, 2017).

Mental health and addictions issues are well documented trajectories for people who have childhood trauma histories (Alink, Cicchetti, Kim & Rogosch, 2012; McKelvey, Selig, & White-Mansell, 2017; Davis et al., 2018; Felitti et al., 1998; Merrick, Ports, Ford, Afifi, Gershoff, & Grogan-Kaylor, A., 2017; Streeck-Fischer & van der Kolk, 2000). Understandably there is an overrepresentation of mental health and addiction problems identifiable in offending populations highlighting the need for correctional and forensic services to consider the impact of past trauma on current presenting problems (Indig, Gear, & Wilhelm, 2016; McKee & Hilton, 2017). The recent New Zealand Government (2018a) Inquiry into Mental Health and Addiction: He Ara Oranga highlighted the need for greater consideration and understanding of the impact of trauma within forensic and mental health settings.

The cognitive, social, and behavioural issues related to past or ongoing abuse can significantly impact children and young people's ability to solve problems (Gilbert et al.,

2009) and participate at school (Davis et al., 2018). Sadly, early behavioural and learning difficulties open the pathway for truancy, suspensions, and eventual school dropout (Lansford, Miller-Johnson, Berlin, Dodge, Bates, & Pettit., 2007; Perez, Jennings, & Baglivio, 2018). Youth who do not complete their education are more likely to engage with antisocial peers, have a high risk of criminal justice involvement (Lansford et al., 2007) and potentially face ongoing socio-economic hardship (Davis et al., 2018). Externalised problematic behaviours are one of the critical reasons maltreated youth come to the attention of justice systems (Van Wert et al., 2017). These studies support the proposal that there is an underlying pathway from child maltreatment to interpersonal violence.

The range of adverse impacts of childhood maltreatment illustrates the importance of understanding the underlying pathways between childhood maltreatment and family harm (Reid & Sullivan, 2012; Widom, 2017). For people working in the area of family harm prevention, it is imperative to understand the theoretical underpinnings of the maltreatment-family harm link to ensure a solid foundation upon which to build tailored family harm prevention initiatives.

Key Psychological Theories Linking Childhood Maltreatment and the Perpetration of Family Harm

The following section summarises the key psychological theories explain the relationship between childhood experiences of maltreatment and family harm perpetration. The broad conceptual frameworks outlined fall into attachment, emotion regulation, cognitive and intergenerational transmission theories.

Attachment and emotion regulation theories

Attachment problems can result from child abuse and neglect. Insecure attachment is thought to consist of three categories; preoccupied or anxious, dismissing and avoidant, and fearful, which is a mixture of anxious and avoidant (Hildyard & Wolf, 2002; Streeck-Fischer & van der Kolk, 2000). Attachment theorists argue that if there is inconsistent caregiving, an insecure attachment can develop, characterised by internal working models of oneself as unworthy of love and that other people are unavailable and untrustworthy (Berlin, Caasidy, & Appleyard, 2008). Thus, their internal working model of the world is built upon a sense of distrust of others and attributions of hostile intent even in non-threatening situations (Egland, 1993). Clinicians and programme providers often utilise Bowlby's (1969) attachment theory to help understand the pathways between childhood maltreatment and the perpetration of family harm (Crittenden & Ainsworth, 1989; Hildyard & Wolf, 2002; Streeck-Fischer & van der Kolk, 2000). This theory posits that people with a childhood history of an insecure attachment may respond aggressively and even violently with peers, teachers, romantic partners as they more readily assume social interactions are hostile and will be aggressive towards them (Alink, Cicchetti, Kim, & Rogosch, 2012; Schofield & Beek, 2005). In particular, IPV and aggression may stem from childhood fears about being abandoned, resulting in the engagement of behaviours that may, in turn, damage the relationship (Dutton, 1995). However, limitations to the application of this theory can occur when working with individuals who are not in intimate relationships and or come from cultures where dyadic relationships do not solely define attachment.

One of the key frameworks used to understand why people engage in violence towards intimate partners has been identifying different types of batterers in relation to insecure attachment styles (Gondolf, 1998; Hamberger & Hastings, 1986; Jacobson & Gottman, 1998). Holtzworth-Munroe and Stuart (1994) summarised these into three main types of men who physically and verbally abuse their wives. One subtype was the generally violent and antisocial batterer who was more likely to have witnessed parental IPV; they were more likely to be hostile, disengaged and form a dismissing attachment style. Another subtype was the family only batterer, which accounted for 50% of the community sample they studied. They proposed that this sub-group was more likely to have either a secure or preoccupied attachment style and thus was less likely to engage in severe IPV. The last subtype was the dysphoric/borderline batterers, who represented 25% of the sample who were described as being the most dysphoric, emotionally volatile, and psychologically distressed of all the types of batterers. Holtzworth-Munroe and Stuart (1994) theorised that this group's moderate to severe physical and emotional spousal violence and anger was explainable in terms of underlying preoccupied attachment patterns. Similarly, Dutton's (1995) Borderline Personality Organisation theory proposes that insecure attachment and shaming during childhood and adolescence perpetrate IPV. However, an obvious limitation of these conceptualisations is that they described potential pathways for men only and did not include women in their theory evolution.

Other psychological theories propose that attachment is a measure of emotional regulation; thus, an inability to inhibit emotions is related to insecure attachment (Cassidy & Kobak, 1988; Dutton & Browning, 1988; Cohn, Silver, Cowan, Cowan, & Pearson, 1992; Kobak & Hazen, 1991; Mikulincer, 1988; Dutton, Saunders, Starzomski, & Bartholomew,

1994). Challenges in regulating emotion have been linked to issues within intimate relationships highlighting the role of emotion dysregulation, increasing the risk of IPV during arguments and conflict (Babcock, Jacobson, & Gottman, 2000). Riggs (2010) developed a model of adult attachment that suggests an insecure attachment disrupts emotion regulation as it creates dysfunctional coping strategies that are avoidant, emotion-focused, and almost compulsive responses to stress. Riggs (2010) suggests that this chain of events from childhood abuse to social and emotional difficulties places people at risk of issues with intimate partners. Kong, Roh, Easton, Lee and Lawler (2016) employed Rigg's (2010) model about adult attachment to explore the pathways that link childhood maltreatment to IPV victimisation in adulthood. One of their key findings was that an insecure attachment style, and depressive symptoms were associated with pathways to IPV. In short, research supports the link between family violence and childhood histories of maltreatment via disruptions to attachment and emotion regulation (Chang, Kasckurkin, Mclean, & Foa, 2018; Young & Widom, 2014). However, other theories advocate the need to further understand the role of thinking and belief systems as potential pathways to family harm as outlined in the next section.

Cognitive theories

As children develop, they are forming a sense of self and experiences of childhood abuse begin to be integrated into this self-perception such as negative self-image, an underdeveloped sense of identity, and concerns about control (Martin, Cromer, DePrince, & Freyd, 2013; Young, Klosko, & Weishaar, 2003). For schema theorists, a desire to control others and situations stem from the disruptions childhood maltreatment has on internal

working models of the world, resulting in distrust of others and fear around personal safety (Crittenden, 2006; Gay, Harding, Jackson, Burns, & Baker, 2013). Thus, a negative relational schema that is hypervigilant to rejection and abandonment may be part of the reason why individuals engage in IPV (Taft & Murphy, 2007) and to feel empowered within intimate relationships (Voith, Logan-Greene, Strodtoff, & Bender, 2018).

Social information processing theories explain the link between childhood maltreatment and later aggression and violence similar to attachment theories by pointing to a bias towards interpreting society as being hostile or threatening (Widom & Wilson, 2015). The seminal research into this area demonstrated that physically abused children were less attentive to social cues but vigilant to hostile intent when interacting with others even if their interactions were harmless compared to other children (Dodge, Bates, & Pettit, 1990). These changes in social information processing are linked to an increased risk of IPV as individuals with childhood abuse histories are more likely to view partners' interactions with them as hostile and are more likely to escalate the conflict in response (Taft & Murphy, 2007). In further analysis of studies using a prospective cohort design to explore the long-term effects of child abuse, Young and Widom (2014) found that adults who were maltreated as children were less accurate in their ability to process emotion. Fite et al. (2008) linked an impaired problem-solving ability with challenges in emotion regulation and processing to explain interpersonal conflict and IPV.

Exposure to abuse can have detrimental effects on brain development resulting in developmental delays, especially during the first years of life (Teicher et al., 2016). Carrion and Wong (2012) suggest the link between traumatic experiences and diminished prefrontal

cortex activity may contribute to limited cognitive abilities and emotional reasoning. Voith et al. (2018) take this link further, suggesting that people engage in IPV due to difficulties identifying and expressing their emotions and therefore become more easily overwhelmed. The subsequent emotional, social, and intellectual delays resulting from childhood maltreatment can, in turn, increase caregivers' frustration that may result in the perpetration of more violence towards the child, creating a vicious cycle of delayed learning (Lambie, 2018).

Social learning and behavioural theories

Bandura's (1973) social learning theory (SLT) is frequently employed to explain intergenerational violence. Social learning theorists propose that children observe and then imitate the behaviour, hence imitating the violent and aggressive behaviour they have seen and learned from within their families and view this behaviour as acceptable (Neighbors, Walker, Mbilinyi, O'Rourke, Edleson, Zegree, & Roffman, 2010). SLT relates the maintenance of this behaviour to the experience that aggression appears to effectively resolve interpersonal conflicts (Simons & Wurtele, 2010). SLT has continued to develop over time to explain the transmission of violence. For example, Patterson, Reid and Dishion (1992) proposed that children's aggressive and violent behaviour with peers' results from observing coercive interactions between parents. The coercion model suggests that one of the pathways for continued aggression and violence is that the children, in turn, tend to associate with other aggressive peers providing additional social modelling and reinforcement for aggressive and violent behaviours.

Similarly, the Intergenerational Transmission of Violence theory (Kalmuss, 1984) explains the transmission of violence occurring due to children learning, amongst other things, that IPV can result in positive consequences (victim compliance) and increases the likelihood of them adopting violent behaviours in adulthood (Black et al., 2011). Attachment issues may also play a part in the intergenerational transmission of abuse. For example, Rodgriquez and Tucker (2011) found that a poor attachment history in at-risk mothers predicted their likelihood of abuse towards their children. However, other theorists propose that insecure attachment is a measure of emotional regulation concerning interpersonal relationships is better explained by an inability to inhibit emotions (Cassidy & Kobak, 1988; Fuendeling, 1998; Mikulincer, 1988) and this, in turn, is related to aggression and violence in personal relationships (Kobak & Hazen, 1991). Alternatively, other theorists try to pull the theories and frameworks together to enhance our understanding of the cycle of family harm and argue for multifactorial models that acknowledges the interaction between genetic and environmental effects (Caspi, McClay, Moffitt, & Mill, 2002).

Multifactorial models

Cognitive, behavioural, emotion regulation and attachment theories aim to explain the cycle of family harm by examining the processes that occur within the individual. In comparison, multifactorial models acknowledge that many factors can perpetuate cycles of family harm, including individual, interpersonal, situational, and socio-cultural factors (Bartholomew, Cobb & Dutton, 2015; Bell & Naugle, 2008). Ultimately, moving from seeking a single theory to account for the link to examining the influence of multiple factors such as mental health and addiction, gender, age and economic status (Draucker, Martsolf, Stephenson,

Heckman, Ferguson, Perkins, & Cook, 2012; Kessler, Molnar, Feurer, & Appelbaum, 2001; Leonard & Quigley, 1999; Malvaso et al., 2018; Riggs, Caulfield, & Street, 2000). The Ecological Framework for the Violence Prevention Alliance for the World Health Organization (World Health Organisation, 2017) holds that the different factors involved in interpersonal violence are equally important. An example they give is that violence observed in youth may result from complications during pregnancy leading to neurological damage and subsequent psychological challenges that poor parenting practices can equally influence. Multifactorial models highlight the need for multiple interventions aimed at each ecological level to reduce violent behaviours. While these models highlight the complexities of considering multiple factors to explain the realities of people's lives, they also highlight that there could be multiple explanations for why they harm family members at any one point in a person's life. The role of gender in family harm perpetration is an example of a factor that can be conceptualised in multifactorial models such as the impact of societal gender expectations and stereotypes for men and women in terms of victimhood and perpetration.

Summary

Accepted psychological theories appear to explain some but not all links between childhood maltreatment and the perpetration of family harm (Horan & Widom, 2015; Masten & Wright, 1998). A core challenge is that the pathways linking childhood maltreatment experiences to family harm can be complicated and theoretical understandings diverse. Consequently, the practical application of these theories tends to vary between individuals and agencies in the way assessment and interventions are conducted. One of the challenges for theorists has been the heterogeneity in the types of people that perpetuate family harm and the complexity and

diverse experiences of family harm (Bell & Naugle, 2008). Nevertheless, the phenomenon of family harm has been described across the globe, thus making it a universal problem (Alhabib, Nur & Jones, 2010; García-Moreno, 2013). Thus, highlighting the need for research that examines the processes behind the relationship between childhood maltreatment and family harm perpetration (Braga et al., 2017; Goddard & Pooley, 2018; Farrington et al., 2017; Kimber. Adham, Gill, McTavish, & MacMillan, 2018; Kong, Roh, Easton, Lee, & Lawler, 2016; LaMotte et al., 2018; Malvaso et al., 2018; Voith et al., 2018; Widom, 2017). A better understanding of this relationship will help guide the development of targeted individual and group interventions to address the long-term effects of child maltreatment and family harm prevention and intervention programmes.

However, when examined through a contemporary lens there are notable gaps in the key theories identified that need to be explored and challenged. For instance, are they relevant to explain the experience of the intergenerational transmission of trauma and violence for men and women of different cultures and countries (Rhodes & Langtiw, 2018). Given they were not developed by or with Indigenous peoples they do not incorporate Indigenous psychologies and neither do they acknowledge the adverse generational experiences of colonisation (Teo & Wendt, 2020). Furthermore, societal roles and expectations for men and women have evolved considerably since the development of these theories. Consequently, the next chapter delves into contemporary critiques of traditional psychological theories.

Chapter 2: Critical Reflections

An important consideration for research into family harm is the identification of the theoretical frameworks that inform the research objectives. Especially given that research based on established theories is deemed best practice when investigating the efficacy of assessment and treatment approaches. In a systematic review, Farrington, Gaffney and Ttofl (2017) highlighted the lack of explanatory risk factors (that define the underlying constructs) for violence, offending and delinquency. Kimber et al. (2018) conducted a systematic review of the association between childhood exposure to IPV and perpetration in adulthood. They only found four of the 19 studies reviewed considered theoretical frameworks including: social cognitive theory, SLT, developmental understandings of emotional and behavioural regulation in children and general and gender-specific modelling hypotheses. These two systematic reviews highlight the importance of critically examining the theories underpinning the research that informs how we help interrupt the adverse trajectories associated with intergenerational trauma and violence. Bell and Naugle (2008) highlighted the need to dismantle what we think we know about pathways towards the perpetration of violence within family contexts and rebuild theoretical understandings based on contextual frameworks.

Critical and Indigenous psychologists have been deconstructing and challenging theory from overlapping but differing viewpoints (Shuck, 2020; Teo & Wendt, 2020). For example, Critical psychologists emphasise the significance of the role of society and expectations at the centre of psychological theory and practice (Held, 2020). Indigenous

psychologists highlight the importance of considering the impact of colonisation and the traumatic historical events that have had and continue to affect Indigenous populations (Campbell & Evans-Campbell, 2011; Rhodes & Langtiw, 2018; Pihama et al., 2014; Teo, 2018; Willmon-Hague & BigFoot, 2008). One of the major critiques of existing theories is the tendency to position children as silent victims of circumstance (Scarry, 1985; Hlavka, 2019). Whereas, other researchers have demonstrated that children provide insightful reflections on experiences of abuse and family harm and actively try to make sense of what is happening for the family members perpetrating family harm (Callaghan, Alexander & Fellin, 2016; Ugazio, 2013; Dallos & Vetere, 2012, Overlien, 2013). Tipene and Green (2017) explain the trivialisation of children's experiences to society's cultural and gender norms and as such should be challenged and their experiences valued. Ultimately, families consist of all genders and ages and research needs to consider the impact and multidirectional pathways between and within genders when considering cycles of family harm. The following summarises the arguments for considering intergenerational trauma, especially with respect to Indigenous populations and gender.

Intergenerational Trauma and Violence

Family harm is one aspect of trauma and violence that can be transmitted through generations. For example, Indigenous people of America experience higher rates of personal trauma than non-Indigenous people and suffer a higher prevalence of lifetime trauma, abuse (Brave Heart, 2003). Over the last couple of decades, scholars have been highlighting the cumulative impact of traumatic events that have happened to groups of people across time around the world. The phrase historical trauma was developed to understand the traumatic

experiences of Holocaust survivors and the subsequent impact of those experiences on the following generations (Brave Heart & DeBruyn, 1998). Historical trauma places a framework and understanding of the impacts of past trauma for Indigenous peoples that goes beyond the individual, acknowledging the cumulative emotional and psychological effects across generations (Pihama, Reynolds, Smith, Reid, Smith, & Te Nana, 2014; Wirihana, 2014). The ongoing adverse psychological distress associated with colonisation has been linked to a higher prevalence of IPV, substance abuse, and out-of-home placements (Campbell & Evans-Campbell, 2011; Willmon-Hague & BigFoot, 2008). Of particular relevance to this thesis, colonisation has had a devastating impact on the social connections and passing on traditional knowledge and values of Indigenous people (Cavino, 2016; Ruwhiu, Ashby, Eruiti, Halliday, Horne, & Paikea, 2009). Drywater-Whitekiller (2014) suggests that one of the underlying mechanisms for intergenerational abuse in Indigenous populations is the disruptions to the cultural and familial structures that bind social groups together.

In addition to the adverse impacts of historical trauma mentioned above, being removed by the state and placed in non-kin placements results in an additional loss of cultural knowledge and connection. Recent reports in Canada and Aotearoa New Zealand, highlight the devastating loss of connection to cultural identity and practices for Indigenous children placed in state care (Aboriginal Children in Care Working Group, 2015; Office of the Children's Commissioner, 2015). The breadth of the impact of being in state care is sobering when one considers that in Aotearoa New Zealand, 61% of the 5,708 New children and young people in the care at the end of June 2017 were Māori (Lambie, 2018). This overrepresentation is staggering, given that the proportion of Māori in Aotearoa New Zealand identified in the 2018 census, was 16.5%. Research undertaken by Malvaso, Delfabbro and

Day (2017) reported that Aboriginal and Torres Strait Islander children experience maltreatment at 7.4 times the rate and are placed in care and protection services at nearly nine times that of non-Aboriginal and Torres Strait Islander Australian children and young people. The overrepresentation of Indigenous children in care has been linked to systemic bias stemming from colonisation (Gram, Gulliver, Ota, & Wislon (2015).

When we first began developing the research questions and scope of this thesis, several key issues were highlighted regarding children and adults' welfare in Aotearoa New Zealand. Firstly, considerable concern was raised regarding the practices of Oranga Tamariki Ministry for Children coming to a head when the uplift of a baby from the hospital just after birth was recorded and shared on social media. Concerns regarding systemic racism and lack of care and protection saw a groundswell of concern and need for an urgent review into Oranga Tamariki's practices and policies (New Zealand Government, 2018b; Office of the Children's Commissioner, 2020). Subsequently, Te Mana Whakamaru Tamariki Motuhake Independent Children's Monitor was established to monitor the policies and practices in place regarding the welfare of children in care. Of note, this group has active input and support from the office of the Ombudsman and Office of the Children's Commissioner, which gives it added legal and external powers. In addition, the New Zealand Government (2018b) ordered a Royal Commission of Inquiry into the historical abuse in care and faith-based institutions. For decades survivors of abuse when placed in the welfare settings had called for this inquiry motivated by a desire to stop this continuing to occur for current and future generations. Consequently, research conducted in Aotearoa New Zealand at the time of this thesis needed to encapsulate the impact of being placed in care especially for Māori.

A major limitation of the traditional psychological theories outlined in Chapter 1 is the lack of consideration and inclusion of human psychologies originating from diverse cultures worldwide (Held, 2020). Indigenous understandings of the psychology of humans have long been called upon to help teach and guide healing and wellbeing (Glover & Hirini, 2005; Milne, 2005; Nikora, Levy, Masters & Waitoki, 2006; Levy, 2016; Valentine, Tassell-Mataamua, & Flett, 2017). A substantial gap given that theoretical understandings inform the practice of interrupting the transmission of intergenerational trauma and violence. If Indigenous theories are not acknowledged, the associated models of wellbeing and healing are not acknowledged, contributing to the limited employment of mātauranga Māori and kaupapa Māori models of health and wellbeing in mainstream psychological practice (Bennett, 2017; McNeill, 2009; Muriwai, Houkamau & Sibley, 2015; Pitama, Robertson, Cram, Gillies, Huria, & Dallas-Katoa, 2007). However, for decades Indigenous researchers have demonstrated the importance of traditional knowledge when it comes to flourishing interconnected family systems and the benefit for intergenerational wellbeing (McLachlan, Waitoki, Harris, & Jones; 2021; Pihama, Miller, Greensill, Te Nana, Campbell, & Lee-Morgan (2021). Reflecting on the broad and ongoing long-term consequences of childhood maltreatment and family harm mentioned in Chapter 1, not including Indigenous practices in the sphere of trauma and violence robs people of pathways to personal and familial wellbeing. Indeed, the failings of mental health, addiction, and forensic services to meet the needs of Māori and trauma experienced client groups was crucially highlighted in He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction (New Zealand Government, 2018a). Consequently, the interplay between inclusivity of theory and practice

with and by Indigenous populations was a key component in developing this thesis's direction and scope of coverage.

The multiple and lifelong issues associated with childhood maltreatment outlined in Chapter 1 illustrated the often-interconnected needs of affected adults and families. Over the last two decades, wrap-around care models have been a preferred approach for people who have multiple treatment and social needs (VanDen Berg, 2008). However, these models of care tend to be developed without collaboration with Indigenous communities and meaningful attention to cultural responsivity (Day, Davey, Wanganeen, Casey, Howells, & Nakata, 2008; Tapsell, 2017; Willmon-Haque & Bigfoot, 2008). At the same time, there has been a richness of Indigenous integrated models of care that facilitate intergenerational wellbeing through cultural knowledge and practices rather than diagnosis based (Kopua, Kopua, & Levy, 2021; McLachlan, Waitoki, Harris, & Jones, 2021). It is not only Indigenous communities and scholars calling for a redesign of commissioning and delivery of therapeutic interventions, but there has also been a notable movement away from diagnosis-based service delivery models in western countries. For example, Johnstone and Boyle (2018) proposed the Power Threat Framework, which focuses on understanding why someone is experiencing psychological distress, particularly relevant to past and present trauma, rather than focusing on a diagnosis. In response to the ongoing complex presentations of people who have complex and interconnected issues, including offending, Livesley (2012) proposed focusing on matching treatment models with where people are at in terms of readiness and treatment needs rather than determined by diagnostic categories. Arguably, the Power Threat Framework and Livesley's integrated treatment model can readily accommodate social,

interpersonal, and cultural matters aligning with the holistic focus of Indigenous models of intergenerational wellbeing.

In this section, the central critique of existing psychological theories relating to the intergenerational transmission of family trauma and violence is the absence of Indigenous experiences and knowledge. The wellbeing of family systems centres on children, parents, grandparents and beyond. Gender inclusivity is a given within Indigenous models, where wellbeing is discussed in a wholistic inclusive manner for all. In comparison, the theories outlined in Chapter 1 were developed when the deconstruction of mainstream gender norms was only beginning to be addressed, and the developers, by and large, were men. The following section of this chapter summarises the critique of the gender bias evident in the theories outlined in Chapter 1.

Gender and the Intergenerational Transmission of Family Harm

There is markedly more research related to men who are violent than for women, which is the opposite of trauma research (Kramer & Bowman, 2021; Gill, 2008). This section outlines the main gaps in the mainstream understandings of trauma and violence in terms of gender and summarises recent changes in focus.

Early research into IPV was heavily gendered and as such focused on the development of male models of battery and power theories premised on a patriarchal history that fostered male exertion of power and control over women (Dobash & Dobash, 1977; Dutton, 1995; Holtzworth-Monroe & Stuart, 1994; Strauss, 1977;). The Duluth model is a model of the battery of women by men that focused on placing the responsibility of victims' safety on governmental systems such as law enforcement and court (Pence, 1983). The

mechanism underlying male battery models focuses on IPV resulting from men growing up in a society that teaches them that they are superior to women and, as such, can use violence to control their partners (Jones, Worthen, Sharp, & McLeod, 2018; Voith et al., 2018). However, these conceptualisations do not reflect the trend for women to be increasingly convicted of violent crimes and that women prison population numbers are growing (Bevan, 2015; Morash, Kashy, Cobbina, & Smith, 2018). Carson (2015) identified that nearly 40% of female prisoners had committed violent offences such as assault or homicide. Kruttschnitt and Carbone- Lopez (2006) conducted qualitative interviews with 205 female inmates where the women talked about 106 violent crimes. Identified motivations for the violence included retribution for perceived acts of disrespect or occurring during the commission of another crime such as burglary. As a result, there has been increasing interest in the frequency and type of violent offences where women are receiving sentences of probation or on parole with the overall goal of understanding how to address violent behaviour within intervention recommendations and safety planning (Kaeble, Glaze, Tsoutis, & Minton, 2015).

There appears to be an underlying assumption when it comes to the offending literature that women tend to be violent only when protecting themselves from abuse or in retaliation or as a pre-emptive strike, so to speak. In reality, there is minimal research into the types of motivations for violent behaviour exhibited by women in the community and correctional settings, but this is beginning to change (Widom, Czaja, & Dutton, 2014). Morash et al. (2018) explored whether background variables such as past experiences of victimisation, substance use, mental health diagnoses, cognitive and emotional difficulties are associated with female violent behaviour. They identified three theoretical explanations in the current literature for female violence. Firstly, childhood traumatic experiences and their role

in developing mental health issues, such as PTSD, substance abuse (McDaniels-Wilson & Belknap, 2008; Scott, Dennis, & Lurigio, 2015). The second explanation was the more widely accepted role of cognitive distortions (justification) that support acts of violence and are addressed in offender programmes (National Institute of Corrections, 2014). Lastly, as previously identified in male offenders, the role of living in neighbourhoods where crime and violence are everyday occurrences (Baskin & Sommers, 1998; Brunson & Stewart, 2006; Cobbina, Morash, Kashy, & Smith, 2014).

New Zealand research conducted with women offenders identified four key trigger areas that led the 54 female participants to re-offend (offending type not specified): relationships issues; drugs, alcohol, and gambling; economic pressures, and lack of proper support networks and services (Bevan, 2015). They also identified that the women's underlying beliefs about themselves, their role in society, and their perception of worth influenced how they responded to the challenges they faced. Other research suggests gender differences in victimisation and IPV perpetration are due to different processes (Langhinricksen-Rohling, Neidig, & Thorn, 1995; Stith, Rosen, Middleton, Busch, Lundeberg, & Carlton, 2000). For example, men are more likely to externalise their emotional pain, which may link childhood maltreatment to the perpetration of family harm. In contrast, women are more likely to internalise the pain (Downey, Feldman, Khuri, Reynolds, & William, 1994), making them more susceptible to IPV (Jaffe, Wolfe, & Wilson, 1991).

There are limitations to understanding the complexities of family harm when adopting a gendered approach to theory development and research (Bowen, 2011; Dixon & Graham-

Kevan, 2011; Kruttschnitt & Carbone-Lopez, 2006; Polaschek, 2006). The most obvious challenge is that most men do not perpetrate family violence (Bartholomew, Cobb, & Dutton, 2015), but may be the victims of IPV from women partners. Major criticisms of patriarchal models of IPV are that both men and women have the propensity for violence (Strauss, 2008), not all men are violent towards women (Stark, 2010), and IPV is present amongst same-sex couples (Messinger, 2014). A study conducted by Desmarais, Reeves, Nicholls, Telford and Fiebert (2012) provides compelling evidence against a solely gendered view of violence as they found that the rates of IPV perpetration across six countries, as evidenced in 239 studies was comparable between men (23%) and women (19.3%). One may argue that by focusing on gender, we have limited our understanding of the aetiology of family harm and theory development from which efficacious interventions could be developed. Therefore, researchers such as Dixon and Graham-Kevan (2011) argue for a gender-inclusive approach to progress theory development and research. As a result, there has been increasing interest in the frequency and type of violent offences where women are receiving sentences of probation (Kaeble et al., 2015) or are on parole with the overall goal of understanding how to address violent behaviour within intervention recommendations and safety planning.

This section highlights the need for contemporary research into cycles of family harm to consider the potential for men and women to be both victims and perpetrators. Therefore, men and women were interviewed in this thesis to explore the interactions between childhood maltreatment and family harm perpetration. Thus, allowing for exploration of the lived experience taken together and separately of individuals and gender groups. One of the key findings from this chapter is the need for researchers to actively critical and not over-generalise. Thus, it is important to consider the context and positionality of the researcher to

understand their approach. Hence the following section outlines why I undertook this PhD to identify my positionality and stance.

About the Author

I am a consultant clinical psychologist who has been working in Aotearoa New Zealand, for the last 20 years. We have deemed it important that I identify who I am, why I chose to do this research later in life, and be open with the reader about potential bias. Especially given I am a non-Māori middle-aged woman conducting research with Māori and non-Māori men and women. It seems only fitting to provide a brief overview of my journey, given this thesis centres on the life stories of the people interviewed.

I was in my mid-20s and full of enthusiasm and passion for making the world a better place when I graduated as a Clinical Psychologist. In the first couple of years after graduating, I worked as the sole clinical psychologist developing and implementing therapeutic programs within the newly formed Youth Unit at Waikeria Prison. As a new graduate, it seemed best practice to view any assessment with a view to treatment that was holistic in nature and age appropriate. However, I felt like I went to a completely different type of university where the resiliency and complexity of the young men I was working with did not reflect what was written in texts. Over time, it became more and more apparent that they had been in the care of the state, had experienced significant childhood maltreatment, had mental health issues and were predominantly Māori. I then moved on to a role establishing the first forensics service at the child and adolescent mental health service for the Waikato DHB. In reality, I was working with the same families, but just the younger brothers and sisters of the young men I knew in prison. In this role, I worked alongside and advocated

for young people involved with child and family services (as it was called at the time) and police. However, the extent of chronic abuse and systemic failures for these young people continued to be obvious. I was also aware from the statistics and my ground floor experience, that the number of young women who were offending and coming to the attention of police and mental health services was increasing. I continued to be confused at the nature of the intergenerational transmission of trauma and violence because the young men and women I have worked with were determined not to become people who harm their family and partners but sadly, a proportion have.

Employing a scientist-practitioner model was the foundation of my clinical training. However, it was tough for me to find evidence-based psychological research that reflected the reality of the work I was doing. Specifically, there was minimal published research into best practices for working with Māori in mental health and wellbeing sectors or that incorporated living with the ongoing effects of intergenerational trauma. The majority of research I found in the area, if they did mention Indigenous populations, was often in the sections highlighting areas for future research. I also found it difficult to find literature that talked about what I should be doing for the young men and women I was working with and their whānau and families who had experienced significant childhood maltreatment. It always felt like we needed to do more than focus on violence prevention as we seemed to be missing a significant portion of their lives. In addition, I found myself asking what would help the young women I was working with who were living with the consequences of intergenerational transmission of trauma and violence?

These gaps became even more apparent as I was lecturing in mental health and wellbeing prior to undertaking this research journey. The students I was teaching struggled to find literature to support our commitment to working in partnership and honouring the principles of protection outlined in Te Tiriti o Waitangi in psychological theory and practice. This was essential for the non-Māori students I was teaching as they began their journey of being psychologists in Aotearoa New Zealand as outlined in our guiding documents; Code of Ethics New Zealand Psychological Society (2002), the Continuing Competence Programme (New Zealand Psychologist Board, 2018), and the Health Practitioners' Competence Assurance Act (Ministry of Health, 2019). Hence, another objective in doing this research was to help provide guidance and information to others working in areas of intergenerational trauma and violence in Aotearoa New Zealand. Thus, this PhD thesis is an academic endeavour involving talking with men and women, Māori and non-Māori, to explore the intergenerational transmission of trauma and violence. This approach seemed appropriate because the people I have worked alongside in my career taught me the most about being a psychologist, so partnering with them seemed the obvious choice for me. I could honestly take the stance of not knowing the answer and positioning myself as a collaborative investigator, given the gaps in understanding and critiques of traditional psychological theories outlined in Chapter 2.

However, it must be noted that after 20 years of practice as a clinical psychologist, try as I might, this was the lens through which I was analysing the interview content collected and the literature I was reading. Hopefully, my tendency to apply findings to practical applications in the 'real world' means that this thesis has utility for others in similar situations nationally and internationally. Nevertheless, it does mean that I needed to actively challenge

assumptions that I had accrued over time and potential bias clinical psychologists may have due to the focus of training and the literature practice is based upon (Rhodes & Langtiw, 2018). The next chapter outlines the research rationale and methodology employed in this thesis.

Chapter 3: Research Rationale and Methodology

Chapter 3 outlines the research rationale, aim and objectives of the three studies that make up the body of results of this thesis. The justification of the methodology chosen is then summarised, followed by a brief outline of the research design.

Summary and Rationale for Research

The phenomenon of family harm has been described across the globe, making it a universal problem that requires theoretical frameworks relevant to all cultures and genders (Alhabib, Nur, & Jones, 2010; García-Moreno, 2013). Research in this area is motivated by the desire to stop the detrimental consequences that echo through individuals, families, and communities (Kahui & Snively, 2014; Goddard & Pooley, 2019). Communities and scholars alike are calling for ongoing research that examines the interactions between childhood maltreatment and family harm to help guide family harm prevention initiatives and strategies (Braga et al., 2017; Goddard & Pooley, 2018; Farrington et al., 2017; Kimber et al., 2018; Kong, Roh, Easton, Lee, & Lawler, 2016; LaMotte et al., 2018; Malvaso et al., 2017; Voith et al., 2018; Widom, 2017). However, the traditional psychological theories relied upon to guide interventions were developed 40 odd years ago and do not consider cycles of family harm from Indigenous and gender-inclusive perspectives (Kramer & Bowman, 2021; Rhodes & Langtiw, 2018; Teo, 2018). Therefore, contemporary research must include space for Indigenous perspectives and knowledge and consider men and women who make up intergenerational family systems.

Most of the research on the link between childhood maltreatment and family harm outlined in Chapter 1, was based on information extracted from existing samples or relied heavily on outcome data from psychometric measures. These sampling techniques do not allow for further exploration of the responses or themes that emerge associated with childhood maltreatment and adverse life effects (Kruttschnitt & Carbone-Lopez, 2006; LaMotte et al., 2018). Therefore, it was decided that we would explore the relationship between childhood maltreatment and family harm perpetration by talking to people who have the lived experience of both enabling the collection of a rich and detailed data set. This will provide a rich and dynamic source of information to explore the pathways in this link that may or may not already be considered in existing models. Engaging people with lived experience to participate in research exploring the intricacies of human relationships and experiences is an established and effective methodology (Callaghan et al., 2016; Office of the Children's Commissioner, 2019; Øverlien, 2013; Ruwhiu et al., 2009). In doing so, following the major shift in doing research *with* people rather than *on* people (Hlavka, 2019; Rhodes & Lungtiw, 2018; Teo & Wendt, 2020; Tuhiwai Smith, 2012; Wendt & Gone, 2012). The importance of exploring the consequences of the intergenerational transmission of trauma and violence in terms of Māori and non-Māori men and women in Aotearoa was a critical issue giving this research a focus and impetus. Given the current national focus on people's experiences in the care of the state and others and the impact of mental health and addiction (New Zealand Government 2018a; New Zealand Government, 2018b; Office of the Children's Commissioner, 2020), this thesis's overarching aim and objectives were designed to explore and inform service development and provision. The following section outlines the

overarching research aim and objectives of the three studies that comprise the body of the research.

Research Aim and Objectives

The overarching aim of this thesis was to explore the links between childhood maltreatment and family harm perpetration. Ultimately, the research examined whether existing psychological theories explain the experiences of Māori and non-Māori men and women in Aotearoa. This was achieved by undertaking three studies that make up the body of this thesis. The objective of the first study was to explore the childhood maltreatment experiences of people removed from their family of origin as children who were responsible for harming family members. The purpose of the second study was to explore the relationship between childhood maltreatment and family harm perpetration from the perspective of Māori men and women. The third and final study examined the relationship between mental health and addiction issues and the cycle of family harm.

Research Design

The main features of the research design are described in the method section of the three manuscripts presented in Chapters 4, 5 and 6. However, this section provides an overview of the process of analysis employed and the rationale for the choice of thematic analysis. In addition, the following appendices can be found at the end of this thesis to provide additional information regarding the recruitment and interview process: Participant information sheet and consent form (Appendix B); Information sheet for programme providers, provider approval to host research, & flyer for participants (Appendix C); Initial interview protocol (Appendix D); Plans for managing participant risk (Appendix E); and the handout providing

information about other supports available (Appendix F). The Human Research Ethics Committee of the University of Waikato approved this research project, HREC#(Health)2018#56, (see Appendix G – Ethical Approval Letter).

Rationale for Thematic Analysis

The literature review in Chapter 1 identified the wealth of quantitative research that demonstrates the maltreatment-family harm link. Therefore, this research will not focus on replicating these findings. The unique complexities and intergenerational effects of trauma and family harm suggest significant heterogeneity that existing theories may not adequately account for. Therefore, the data from the interview sessions were analysed using the qualitative approach of interpretive thematic analysis steps outlined by Braun and Clarke (2006; 2012). This approach was chosen because it allowed for further exploration of participants' experiences and interpretations regarding childhood maltreatment and family harm perpetration (Creswell, 2014; Creswell & Plano Clark, 2011; Collins et al., 2006). Thus, thematic analysis (TA) was used to analyse the lived experience of the participants explanations for the link between childhood maltreatment and the perpetration of family harm.

However, a couple of supplementary features were added to the traditional process of TA. Given that KDR and the supervisory team were all women a Male Advisory Group was established to provide a consultancy level of involvement from the beginning of the research design through to analysis and reporting of findings. Two kaumātua (Māori elders) were part of the Male Advisory Group and provided feedback and guidance on culturally significant

emerging themes. In addition, supervision and consultancy were provided by BMA and KDR's professional cultural supervisor.

The following summarises the 6 phases of Braun and Clarke's (2006; 2012) thematic analysis that outlines how the data was analysed and key themes were drawn for the data set. The analysis was led by the first author (KDR) with regular input for the supervisory team Professor Nicola Starkey (NS), Professor Katrina Roen (KR) and Associate Professor Bridgette Masters-Awatere (BMA). For the purpose of confidentiality, each participant was given a pseudonym that they chose for themselves or was assigned by KDR. The primary researcher, KDR, conducted all of the interviews, and then the recordings were professionally transcribed. Subsequently, KDR reviewed all the transcripts by listening to the original recording while concurrently reviewing the accuracy of the transcripts, making changes as required. During this process, any other potentially identifying information about the participants, such as location, were removed to ensure anonymity. After each interview had been transcribed, a summary of the key points was sent to each interviewee for review and comment and an active dialogue was encouraged to ensure we understood the content and explanations people provided. In addition, quotes were also included, and permission was sought to include these quotes in presentations and manuscripts in the future.

- *Phase 1: Familiarization with data.* The 16 interview transcripts were read repetitively by KDR to foster familiarisation with the data set.
- *Phase 2: Generating initial coding.* KDR systematically read the entire data set and identified 67 codes. A table of code definitions was created to ensure consistency in assigning sections of transcripts to initial codes. The robustness of the coding framework was tested by NS, KR and BMA on sections of transcripts of the data set.

- *Phase 3: Searching for themes.* This phase involved arranging all of the initial codes and sorting them into themes. Subsequently, the 67 codes that were initially identified in phase two were grouped into 15 potential themes.
- *Phase 4: Reviewing themes.* The identified themes were reviewed and revised initially by KDR and then by co-authors on numerous occasions. The Male Advisory Group were involved in this stage regarding feedback on themes regarding gender. In addition to the consultation and collaboration provided by the two kaumātua who were part of the advisory group, additional cultural supervision and oversight were provided by BMA and KDR's professional cultural supervisor. Subsequently, some themes were expanded, discarded, or combined to produce meaningful themes that described information in the data. Appendix H includes the definitions of the final 13 themes and sub-theme definitions that reflect the coding framework used in the analysis of the interview content.
- *Phase 5: Defining and naming themes.* At this stage, summaries of the codes that fitted into each theme were collated and summarised by KDR, then reviewed by the wider team and subsequently named.
- *Phase 6: Producing the report:* The three manuscripts presented in this thesis and the thesis itself are how the analysis has been reported to date. There is the potential for further analysis that focuses on different questions.

Throughout the analysis process, participants were provided with updates of the process via email, text, or phone/video calls according to their preferred platform. Once the analysis was completed, participants and their families were invited to a presentation by KDR of the

findings of the three studies. Attendees were invited to provide written and/or verbal feedback at the presentation, or afterwards, to help shape and provide advice on the pertinence of the findings. Invitations were extended to the staff of the two key recruitment agencies and support workers so interviewees could be part of a crowd to provide an additional level of confidentiality. However, they were informed of this and were invited to an individual feedback session if this was their preference.

Chapters 4, 5 and 6 present the findings of this thesis in the form of submitted manuscripts for publication.

Chapter 4: Manuscript 1

Understanding the complex relationship between child maltreatment in care and family harm

Manuscript resubmitted to Children and Youth Services Review (11 June 2021)

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Abstract

Background: Stopping the intergenerational transmission of trauma and violence is essential for the wellbeing of children worldwide. Existing research highlights the link between childhood maltreatment and family harm in later life, but what happens when the maltreatment continues when a child is placed in care? *Objective:* To explore the childhood maltreatment experiences of people removed from their family of origin as children who were responsible for harming family members. *Participants:* The 16 adult participants (n=8 men, n =8 women) of our wider study were purposively sampled so that there was an equal number of Māori (Indigenous people of Aotearoa) and non-Māori (non-Indigenous people of Aotearoa). The focus of the current analysis is on the 7 participants who were removed from their family of origin and placed in care settings including adoption, foster care and residential settings. *Methods:* Qualitative semi-structured interviews and thematic analysis were employed to explore individuals' understanding and experience of their pathway from childhood maltreatment to family harm. *Results:* Without exception, participants described placement in the care of the state as an additional layer of abuse and neglect. Our analysis supports a relationship between adult incidences of family harm and the sparse relational and emotional experiences during the childhood of children in care. *Conclusions:* Better understanding of the role of emotions within relational contexts can contribute to targeted individual and group interventions to address family violence and the long-term effects of child maltreatment. Key intervention points are identified to interrupt the intergenerational transmission of trauma and violence.

1. Introduction

The phenomenon of violence within family contexts has been described across the globe (García-Moreno, 2013) and has ramifications for individuals, families, communities, and multiple governmental and non-governmental agencies (Goddard & Pooley, 2018; Kahui & Snively, 2014). Adverse life outcomes associated with childhood maltreatment are thought to stem from the variety of emotional (Chang, Kaczkurkin, Mclean, Foa, 2018), psychosocial, behavioral, cognitive, and physical (McKelvey, Selig & White-Mansell, 2017) and neurodevelopmental (Teicher & Samson, 2016) disruptions in typical human development. Consequently, many children and young people in the care of the state come to the attention of numerous government agencies, such as mental health and corrections later in life. In an attempt to address the trajectory from being in state care to youth offending, a welfare approach (in preference to a criminal approach) has been employed for young people offending in Aotearoa New Zealand (Office of the Children's Commissioner, 2020a). However, the pathways between childhood maltreatment and family harm for adults with experiences of being placed in care are underexamined. By exploring the underlying reasons between childhood maltreatment and family harm pathway we can better develop and target interventions to interrupt this progression.

1.1 Childhood maltreatment in state care

Experiencing childhood maltreatment can lead to children being removed from their family of origin and placed in state care. But rather than this being a place of safety and nurturing state care can lead to more experiences of maltreatment. Consequently, there has been a rise in international investigations regarding the abuse of children in state and faith-based

residential settings (Aboriginal Children in Care Working Group; 2015; New Zealand Government, 2018b). Ongoing adverse life outcomes associated with being in care are an important consideration when it comes to exploring the link with intergenerational trauma and violence. For example, data from the New Zealand Ministry of Justice (2018) study investigating offending indicators revealed that 87% of youth offenders had documented previous contact with state care and protection services. There is emerging evidence that poly-victimization (multiple forms and instances of abuse) increases the risk of the development of delinquency and psychosocial impairment (Ford, Grasso, Hawke, & Chapman, 2013; Kerig, 2018; van der Put et al., 2015). The consequences of poly-victimization go beyond diagnosable disorders such as posttraumatic stress disorder (PTSD) to include childhood behavioural problems such as reactive aggression, impulsivity, and disturbances in relating to others (Davis, Masters, Casey, Kajumulo, Norris, & George, 2018). These issues do not appear to dissipate with age but, continue to be observable in some young people (Ford, Elhai, Connor, & Frueh, 2010) and adults (Courtney & Maschi, 2013). For instance, Whitfield, Anda, Dube, and Felitti (2003) found that exposure to domestic violence, physical abuse and sexual abuse during childhood almost doubled the rate of violent behaviours including Interpersonal Violence (IPV) in adulthood.

1.2 Relationship between childhood maltreatment and family harm

One of the challenges in understanding the relationship between childhood maltreatment and family harm is related to the complexity and diversity of these experiences (Bell & Naugle, 2008). The victim-offender overlap is often acknowledged but the need to unravel its intricacies remains an important focus for researchers, especially for those interested in the

development and implementation of therapies to interrupt this pathway (Horan & Widom, 2015; Reid & Sullivan, 2012).

Theories used to explain the aetiology of family harm have tended to rely on attachment, emotion regulation, cognitive and behavioral theories. For instance, Bowlby's (1969) attachment theory continues to be called upon to help understand the mechanisms that are a result of childhood maltreatment in the perpetration of aggression and violence in later life especially towards intimate partners and children (Babcock, Jacobson, Gottman & Yerington, 2000; Dutton, Saunders, Starzomski, & Bartholomew, 1994; Riggs, 2010; Rodriquez & Tucker, 2011). However, other theorists propose that attachment is actually a measure of emotional regulation, where an inability to inhibit emotions develops into aggression and violence in personal relationships during arguments and conflicts (Fuendeling, 1998). Such findings are supported by research showing that children who are raised by parents with poor emotion regulation skills themselves, and who are exposed to more than one episode of abuse, are more likely to display emotion dysregulation and aggressive behaviour as early as the age of three (Hurren, Stewart, & Dennison, 2017; McKelvey, Selig, & Whiteside-Mansell, 2017). Alternatively, Schema theorists propose that childhood abuse disrupts the individual's internal working model of the world resulting in a tendency to distrust others, anxiety and fear that disrupts a sense of safety, and an increasing desire to control people and situations (Gay, Harding, Jackson, Burns, & Baker, 2013). Thus, a negative relational schema that is hypervigilant to rejection and abandonment may be part of the reason why individuals engage in IPV.

Social information processing theories postulate that the mechanism between experiencing childhood physical violence and subsequent perpetration of aggression and

violence relates to children developing a biased pattern of processing social interactions as having hostile and threatening intent (Widom & Wilson, 2015). These changes in social information processing are linked to an increased risk of IPV as individuals with childhood abuse histories are more likely to view partners' interactions with them as hostile and in turn are more likely to escalate the conflict in response (Taft & Murphy, 2007). Young and Widom (2014) found that adults who were maltreated as children were less accurate in their ability to process emotion. Fite, Stauffacher, Ostrov and Colder (2008) posit that these challenges with emotion regulation and emotion processing can interfere with an ability to generate and evaluate effective solutions to problems, thus increasing the chance of aggressive behaviours and IPV in responses to conflict. The common thread within each of these theories is the relevance of emotions in developing relationships. However, the role of emotions in the context of family harm are often underexplored in theory development. This leaves a gap in the translation of how to offer practical support emotional development for people who were maltreated as children and whose emotional development was interrupted. The complexity of emotions and relationality deserves further examination especially when working towards stopping the cycle of family harm.

1.3 Gaps in understanding the relationship between childhood maltreatment and family harm

There are several critiques of these well-known theoretical pathways linking childhood maltreatment and family harm. The critiques emerge from multiple disciplines concerned with the wellbeing of people and communities. Specifically, the psychological theories mentioned above position children as silent victims that at best can survive their childhood (Scarry, 1985). However, this conceptualization of children has been challenged by a number

of researchers in recent years (Hlavka, 2019). For example, Callaghan, Alexander and Fellin (2016) interviewed 27 children and found that the children could talk about their experiences of domestic violence in meaningful and insightful ways. Importantly, the children positioned themselves as actively trying to understand their environment and resist being placed in the role of a passive victim who could not interact socially and was emotionally impaired. Additionally, Ugazio (2013) argues that children actively try to make sense of the complexities of the relational and cultural contexts they live in. This is in line with an increasing acknowledgement that family violence does not solely exist within an intimate dyad but in patterns of relating to people within and outside the home (Dallos & Vetere, 2012; Øverlien, 2013). Consequently, in some research, children are viewed as capable of resisting the emotional, social negative impacts of childhood experiences of trauma. This raises a question about whether the silence around childhood maltreatment, particularly for children already in care settings, has more to do with the trivialization of children's experiences of abuse (Hlavka, 2019) than to do with the inability of children to express concern about their situation. Tipene and Green (2017) suggest that the trivialisation of children’s experiences reflects dominant cultural and gender norms and features in the systems children encounter. A way forward would be to talk with children and young people about their experiences of childhood maltreatment. Indeed, the Office of the Commissioner for Children (2019) in Aotearoa New Zealand interviewed 52 children and young people about their experiences of living in care and protection residences. The children's ideas of what positive changes needed to be made were very clear and insightful. Indeed, the report’s title is taken from a quote that summarises the conclusions, residences are “a hard place to be happy.”

The ongoing effects of intergenerational trauma are relevant to Indigenous populations, and this is often referred to as historical trauma (Brave Heart & DeBruyn, 1998; Kong, Roh, Easton, Lee, & Lawler, 2018). Historical trauma provides a conceptual framework for understanding how an individual's presentation can be affected by cumulative, intergenerational emotional and psychological effects (Pihama et al., 2014). This is particularly relevant when one considers the past and present overrepresentation of Indigenous populations in childhood maltreatment statistics. For example, of the 5,708 Aotearoa New Zealand children and young people in care of the state at the end of June 2017 (Lambie, 2018), 61% were Māori even though only 16.5% of the population of Aotearoa New Zealand identified as Māori in the 2018 census (Stats NZ, 2018). In Australia, recent research suggests that Aboriginal and Torres Strait Islander children experience maltreatment at seven and a half times the rate and are placed in care and protection services at nearly nine times that of non-Aboriginal and Torres Strait Islander Australian children and young people (Malvaso, Delfabbro, & Day, 2017). Drywater-Whitekiller (2014) suggest that an underlying mechanism for intergenerational abuse in Indigenous populations is the disruption that occurred to the cultural and familial structures as a result of colonisation. The subsequent interference with the architecture that previously bonded social groups together has been attributed to the high prevalence of IPV, substance abuse and out-of-home placements of Indigenous people (Campbell & Evans-Campbell, 2011; Willmon-Hague & BigFoot, 2008). However, the disproportionate representation of Māori in the state system is not just due to colonisation and generational trauma on the demand side, but also the unconscious and conscious biases on the side of the people involved in service delivery (Keddell, 2019).

1.4 Purpose of the present study

Existing psychological theories are utilized to understand the relationship between childhood experiences of maltreatment and family harm perpetration. But these theories were broadly developed and do not focus on the experiences of people who were removed from their family of origin and placed in in the care of others including the state. The experiences of Indigenous peoples removed from their family of origin was not considered in theoretical explanations of the intergenerational transmission of trauma and violence. Children with maltreatment histories were often positioned as victims who survive childhood rather than include the broader experiences inclusive of active resistance to abuse and neglect and the presence of health emotional and social interactions. The purpose of this study was to explore the experiences of childhood maltreatment when interviewees were removed from their family of origin and family harm perpetration as adults. To achieve this, we conducted in-depth interviews to explore participants' explanations for the pathways between childhood maltreatment and the perpetration of family harm.

2. Methods

2.1 Design

This study used semi-structured interviews and thematic analysis and took an iterative process between data collection and analysis. From the conception of this research, the emotional wellbeing of the participants was the main priority and guiding principle. The research was approved by our universities Human Research Ethics Committee (Health; 2018#56). To provide ongoing oversight of engagement and research practice, a male advisory group was established because the research team were all women. Two kaumātua

(Māori elders) were part of the advisory panel to ensure practices were safe from an Indigenous perspective. This was deemed important due to the cultural significance of this study and because three of the four members of the research team were of European descent (including the main researcher).

2.2 Participants

Selection criteria: Participants were selected based on identifying themselves as (i) having experienced childhood maltreatment that included one or more of the following forms of abuse: physical; sexual; emotional; neglect (emotional or physical), and (ii) having caused harm to their family as an adolescent or adult that was either known to the justice sector or was self-reported. To be considered eligible for the research project participants had to be over 25 years of age because this study focused on adults allowing them to reflect on their experiences.

Recruitment: Recruitment took place via non-governmental regional agencies that provide assessment and treatment for people who met the inclusion criteria. Each agency was initially sent a Service Provider Information Sheet, giving information about the research. The main researcher (KDR) was available to address any questions. After written consent was received from the manager of each agency, private practitioners who contracted into the agency (counsellors, psychologists, and social workers) were then provided with hardcopy and electronic versions of flyers and the participant information sheets to circulate to potential participants. There were 16 participants, all recruited from the North Island of Aotearoa New Zealand. Only one person who initially expressed interest in participating declined the researcher's offer to progress to the interview stage. The strategy of purposive sampling was employed to ensure eight men and eight women were interviewed with an

equal number of self-identified Māori (Indigenous people of Aotearoa) and non-Māori (non-Indigenous people of Aotearoa).

Relevant participant details: This study focuses on the analysis of the data from the 7 participants removed from their family of origin. Six of the men interviewed were removed from their family of origin including all four of the Māori men and two of the non-Māori men. Of this group of men one non-Māori and one Māori were adopted, and one was whāngai (an Indigenous customary practice whereby children are raised by extended family) who then went on to being placed in the foster care system. Only one of the women (Māori) interviewed was formally removed from her family of origin through adoption. Table 1 gives demographic details of the participants involved in the larger study and the subgroup that are the focus of the present analysis.

Table 1:

Number and ethnicity of participants placed in care settings and not in care.

	Māori (n = 8)	Non-Māori (n = 8)	**Total in care**
Men (n=8)	4 out of 4	2 out of 4	6
Women (n=8)	1 out of 4	0 out of 4	1
Total in care	5	2	**7**

The participants who were raised in care settings ranged in age from 40 to 65 years. All these participants were sexually abused on multiple occasions by multiple people, with all but one also experiencing childhood physical abuse from multiple people. All seven of the interviews occurred during 2018-2019.

2.3 Data Collection

Semi-structured interview: Prospective participants either contacted the main researcher (KDR) directly via phone or email or asked their key worker to initiate contact. Participants were offered the opportunity to meet face to face or talk further before meeting for the interview. At this stage, the participants were offered a copy of the Participant Information Sheet if they did not have one already. A suitable time and location for the interview were arranged and then confirmed the day before. Interviews took place in referral agencies or therapists' private office space. Participants were offered the option of bringing support people and one man in this study took up this offer. Their key workers were informed of the day and time of the interview in case participants wanted to talk with them afterwards for support or debriefing. Participants were reassured that the interview content was confidential unless there were concerns that their participation had put them at risk of harming themselves or someone else.

Before each interview began, the researcher went through the Participation Information Sheet with the participant and all queries were answered before consent was obtained. The interviews took up to 90 minutes and were audio-recorded for later transcription and analysis. The participants were interviewed using a broad and flexible semi-structured interview format to allow for the evolution of the types of questions and topics that were covered, as required for thematic analysis. Participants were offered $30 as a token of appreciation for their contribution.

At the beginning and end of the interview, participants were invited to open with a karakia (prayer) or whakatauki (proverb) of their own choice or one provided by the interviewer. This is consistent with cultural protocols and intended as a mark of respect.

There were seven main areas that made up the foundation of the interview broadly encapsulating; current circumstances; how they believed their experiences of childhood maltreatment impacted adult functioning, relationships, and family harm; key transition points; discussion about intergenerational trauma and violence and how this can be addressed; advice for others with this lived experience and the professionals working with them. Prior to leaving the interview room, the participants were provided with handouts outlining the contact details of services that they could engage if they felt distressed after the interview. Participants were contacted the next day via an option of their choice (phone, email, or in person) as a wellbeing check and reminder of services available.

2.4 Data Analysis

Preparing transcribed data: All interviews were conducted by the primary researcher, KDR and professionally transcribed. For the purpose of confidentiality, each participant was assigned or chose a pseudonym, and any identifying information was removed from transcripts. A summary of the key points was collated and sent to each participant requesting their feedback regarding accuracy and permission to use the quotes in research reports and publications.

Thematic Analysis: The data from the interviews were analysed using the interpretive thematic analysis as outlined by Braun and Clarke (2006). This approach was chosen because it allowed for a detailed analysis of the interviews and identify themes associated with childhood maltreatment and adverse life effects. The analysis was led by the first author (KDR) with regular input from the second author (KR) and co-authors (NS and BMA).

3. Results

The results of this study focus on the data extracted from the interviews with people placed in care as children and young people. The analysis of the interview content identified four areas as key to the to the people's understanding of the relationship between child maltreatment in care and family harm: physical abuse, sexual abuse, emotional abuse and neglect, and neglect of cultural identity.

3.1. Physical Abuse in Care Settings

For the participants in care, the level of physical abuse within their placements far exceeded any abuse they described from the family of origin. The physical abuse was severe, and in one case resulted in broken bones and traumatic brain injuries. As boys in foster placements, they were moved regularly not because of the abuse happening to them but due to external factors such as space and caregiver availability. These boys continued to experience physical and sexual abuse in multiple places. The only exception was one participant who described a positive brief safe placement that included being read to and full of play - a juxtaposition to the survival experiences described in the other state and church placements. The participants described the physical scars they still bear during the interview process almost as if to prove that this occurred. Perhaps a legacy of the need to be heard and believed that was not afforded to them as child reporters of abuse. The following quote from Manaia put into words the level of physical abuse and the sense of helplessness described by the participants.

> *" I would have been scared to say anything because I mean that first home, I was in was really horrible. You got straps, you got the wooden spoon. I remember a whole lot of us getting lined up one time because we had been playing in an abandoned*

*house in **[city],** and somebody had seen us, yelled at us, we all ran away out the window we went and that person went and told, came to the home and told the caregivers. So, we all got lined up as to who was jumping out the window. Nobody owned up to nothing, so we all got. The wooden spoon and I remember I was at the end of the line, the wooden spoon got broken on the arse of the kid next to me, so I got the jug cord instead because there was no more wooden spoon" (Manaia)*

Participants were not just the recipients of abuse; they were exposed to the abuse of the other children in their placements. Emotional distress and fear associated with the abuse towards fostered and adopted siblings were shared. They were not simply passive observers; in some instances, they tried to protect the other children from abuse, even if this resulted in physical punishment. Alternatively, others described offering emotional support or playful interactions to offer a form of emotional comfort after the abuse. For example, Moana described having had a loving and supportive childhood relationship with her adoptive brother. Her sense of loss and grief was palpable when she recalled the time he was removed from their home and placed elsewhere. These instances demonstrate active emotional lives ranging beyond anger and frustration and suggest that the children were not given adequate opportunity to experience emotions when interacting with others.

Three of the men referred to being placed in Boys' Homes (a term they used to describe the residential settings for children and adolescents they were placed in) and described this living environment as even more harmful than their other care experiences. They each experienced physical and sexual abuse from multiple perpetrators in these environments. They painted a picture of these residential settings as a place where one 'just survived', and this involved having to be violent in an attempt to show strength to prevent

victimization and ultimately to protect oneself physically and sexually. Consequently, they identified being placed in a Boys' Home as a direct pathway to prison, including sentences for IPV.

> *"Like any Boys' home you had to find your way into the lair I suppose…It was just a miniature jail system I suppose really when you think about it aay. They taught you how to live like …. That's why it was so easy to adapt from boys' homes to jail because you've already been in a situation like that. A similar situation even though it was a little bit different and you had older men in those jails but we went straight through CT [Correctional Training] youth, so basically it just taught you from boys' homes to jails, you adapted to it straight away." (Nikau)*

To narrow these experiences to a stimulus-response mechanism of survival denies the complexity of the relationships and emotions involved. It is worth using a conceptual approach that acknowledges children's ability to strive to make sense of their situations even from a young age. Participants articulated an understanding that they had to take care of themselves within care settings because nobody else was taking care of them. Ongoing attempts by participants to have agency over their own life was evident in the analysis of the interviews and they actively engaged in strategies to resist being a victim. Participants comments presented so far illustrates how children in care may be taught to live with violence and see violent ways of interacting as the norm.

3.2 Sexual Abuse in Care Settings

Men and women participants, who were adopted or fostered, experienced childhood sexual abuse from more than one person. They also described a connection to later events of

interpersonal violence, especially at times before, during and after sex. The anger, shame, distrust, and lack of protection from sexual abuse in care was linked to family harm in later life. For example, Caleb talked about bottled-up anger he attributed to sexual abuse and rejection from his biological family, contributing to his perpetration of family harm.

> *"Well with me it started when I was whāngai'd out, fostered out, into a [non-Māori] family…confused and rejection from my real parents. So, it was like I was unwanted, so with the sexual abuse on top of that I got real violent and real angry and that's the things that started, was the, from birth, six months old. Rejection." (Caleb)*

However, there were different ways the men and women were treated when they disclosed sexual abuse as adults. The sexual abuse was considered a critical factor in women interviewed being both a victim and perpetrator of IPV, and thus, therapy to address the childhood trauma was encouraged. Yet, when the men disclosed childhood sexual abuse to professionals involved in addressing their offending, trauma therapy was not offered. Their experiences highlight a gender bias amongst the professionals with their responses to childhood sexual abuse disclosures. However, the following quote from Caleb highlights that when afforded the opportunity to understand his family harm with childhood sexual abuse this was very therapeutic.

> *"It was a strange journey because a lot of my thoughts and things were just real anger and it wasn't until I started counselling that realising the top stuff was suppressing all the main stuff down the bottom you know and it was my abuse….my rejection and my sexual abuse that really that I covered with all the drugs that I didn't want to face….that's where I started getting free from all my anger and just people loving me for who I am and understanding and that's a lot of my journey was I*

needed someone to hear…I knew that a lot of my charges were violent, so the anger had to come from somewhere." (Caleb)

Given the high rates of abuse in care it is worth considering how and when therapeutic interventions might be offered to interrupt the path from being abused to learning how to live with violence and beginning to resort to interpersonal violence as an adult.

3.3 Neglect of Cultural Identity in Care Settings

Being adopted compounded the disconnection participants felt from family and ultimately added to a sense of childhood isolation and lack of protection. Three Māori participants identified an added layer of trauma related to the neglect and denial of their cultural identity. Nikau found out in adulthood that the name his foster family called him was not his birth name. He now chooses to go by his birth name because he associates his foster name with the extensive abuse he experienced in this home and subsequent residential placement. Additionally, using his birth name has become a steppingstone in him reclaiming his cultural identity. Caleb identified as being a whāngai child, was put into a New Zealand European family as a baby. Throughout the interview, he expressed anger and a sense of rejection, from his biological family, that pervaded all aspects of his life. Moana did not find out that she was Māori until adulthood because her adopted parents maintained that she was another ethnicity. Below, Moana highlights how important it was to know her cultural identity.

"it wasn't until there was a law change in the 80s and I was able to apply for my original birth certificate…and I got a letter from Social Welfare about my birth parents, and my mother was English and my father was Māori…but then I got this letter and it was like I'm Māori, holy crap, I actually belong, somewhere." (Moana)

Given the high rates of Indigenous children in care, it seems particularly relevant to consider interventions that promote cultural connections and help children retain a sense of belonging. As this is a significant opportunity to interrupt cycles of abuse and distress.

3.4 Emotional Abuse and Neglect in Care Settings

Although this paper primarily focuses on those in care it was interesting to note that all 16 participants associated the neglect of their emotional needs as children to the issues they had in later relationships with their partners and family. The lack of acknowledgment of their emotional world by caregivers and professionals reduced the opportunity for development and practice in expressing and regulating the range of human emotions. For the participants removed from their family of origin there was an extra layer of emotional neglect. Unlike children who stayed in their family of origin they did not talk about having any nurturing adult relationships and they had minimal, if any, contact with family or other supportive people. More importantly, what appeared to have had a long-lasting impact was the intolerance of expressions of emotions as children when in placements and residences. The carers' reactions to their childhood expressions of emotion frequently resulted in feeling invalidated and ultimately feeling that there was something wrong with them. Moana described no longer talking at home and mentally escaping to an imaginary world where a loving family lived. She later came to view her imaginary world as one that kept her safe. Her engagement with an imaginary world was conceptualised during therapy as dissociating from the abuse.

> *"....how did I come through that, and the simple answer is, I withdrew mentally ....I had created this dollhouse family and so that's where I retreated to and that's where I*

mostly existed. So, my detachment kind of stems from, well my detachment manifests as not being present." (Moana)

Participants described a change in their expressions of emotions from being overt in childhood, such as tantrums at school or crying, to attempts to mask their emotions from others in adolescence. The masks they put on to hide emotions were ones that were depictions of them as tough and strong. By early adulthood, extreme feelings of anger and frustration towards themselves and others was the predominant emotion when referring to their experiences of emotions.

"….masks were the ones we were pretty much talking about where you know you try and pretend you're something that you're not. But really deep down inside you just don't want to show people that so you're oh yeh trying to be tough….so the bigger you can get someone up there and knock them down, the more control you've got over other people and it is, it's just, it is just a mask. Just a coverup, hurt, cause you don't want everyone to know that you're really a woosy." (Nikau)

All participants connected the limited opportunities to communicate their feelings to patterns of violence towards intimate partners and children. The lack of physical and emotional expressions of love was something identified to be particularly harmful to their children. Participants believed that they harmed family and partners through a tendency to withdraw both physically and emotionally. A poignant example of this was when Oliver came to the realisation that his past abuse had impacted his relationship with his children when he was saying goodbye to his son, now a young man.

"We were saying goodbye it was just a fist grab and a shoulder thing, you know see you later bro, and he says hey how about a cuddle and you know, that's when I

started understanding some of the impacts is that I didn't cuddle my kids from probably that age. You know I'd do things with them and always be there for them, go to everything but that physical and emotional stuff was non-existent. You know like even saying I love you to them felt awkward and with [son], it was just an eye opener, oh a cuddle, yeh, and so I realised that was one of the impacts and that affected, that would have affected me yeh with the kids considerably." (Oliver)

A question asked of all interviewed was what they would do if we could go back in time and help them when they were 14 years of age. Unanimously they believed that adolescence was a pivotal time where people are open to support and therapy to address the adverse effects of childhood maltreatment. The participants remained hopeful that the intergenerational transmission of violence could be disrupted for the next generations as they were living evidence that it was possible. Emotional expression and development were identified as key to reducing family harm. Participants believed that support for establishing healthy ways to manage emotions and foster positive relationships would be beneficial across the lifespan. When Oliver asked what would help 14-year-olds in similar situations, he gave a reply that resonated with what all of the participants said.

"I reckon in a nutshell it comes down that as soon as there's any disclosure, everything's got to go towards that victim, everything….and they feel validated …. even for a kid ….because they wouldn't be embarrassed, they'd think oh you know I've done the right thing." (Oliver)

In summary, as children in care the participants developed strategies to cope with their emotional abusive and neglectful environments including, dissociation and learning to mask their feelings with tough and violent presentations. However, over time these strategies

interfered with their ability to express and experience emotions of others contributing to harm they caused their family and intimate partners in later life. The cumulative effects of the physical, sexual, and emotional abuse and overarching neglect provided limited opportunities to learn how to establish and maintain healthy interpersonal relationships. Therefore, our analysis supports an association between adult incidences of family harm and the sparse relational and emotional experiences during their childhood.

4. Discussion

Psychological theory helps to explain an individual's pathway from childhood maltreatment to their perpetration of family harm, but more work is needed to understand the complexities of this pathway. One of the underexplored aspects of the association between childhood maltreatment and family harm is the impact of the added level of maltreatment many have experienced when placed in the care of the state. The present study explored the relationships between childhood maltreatment and family harm link from the perspective of people who have lived experience of both. Our analysis takes a relational and emotional approach to theorising the relationship between childhood maltreatment and family harm for people who were placed in the care of the state as children. Such examination is especially important for developing theory-driven interventions to prevent further childhood maltreatment and family harm (Braga et al., 2017; Farrington, Gaffney, & Ttofi, 2017; Kimber et al., 2018; Kong, Roh, Easton, Lee, & Lawler, 2016; LaMotte, Gower, Miles-McLean, Farzan-Kashani, & Murphy, 2018; Malvaso et al., 2017; Voith et al., 2018; Widom, 2017).

Placement in state care can lead to additional maltreatment, beyond that which was inflicted by the family of origin. Our study highlighted that this abuse and neglect take

various forms, including repeatedly moving boys from one placement to another, thus severing any constructive relationships that might otherwise develop. Moreover, men in particular were actively discouraged from showing emotions as they were punished or ignored. In line with previous studies, all participants developed strategies to cope with their emotional abusive and neglectful environments including, withdrawing emotionally, or hiding their emotions behind masks (Lambie, 2018). Living in settings where it is unsafe to express emotions and not having one's emotional world acknowledged understandably can lead to long term difficulties in building and maintaining close relationships. This has implications for theory development regarding the pathways between childhood maltreatment and family harm. Specifically, our findings support theories that incorporate emotion processing in the context of interpersonal and family relationships when it comes to understanding the pathways between family harm and childhood maltreatment (Fite et al., 2008; Hurren, Stewart, & Dennison, 2017; Young & Widom, 2014). Put simply, these peoples' reality did not foster the necessary attachment and social/emotional learning opportunities such theories are based upon. There is an inherent warning in this study however, therapies solely based on childhood attachment issues may cause emotional harm to people poly-victimised in care by serving as a reminder of what they missed out on rather than what is in their power to change now. Therefore, our study suggests that an important step in to disrupting the intergenerational transmission of trauma and violence in people who have been in abusive care settings is to provide timely interventions to help them learn how to constructively express and process emotions when in relationships with others.

Our analysis positions children and young people as active participants, not passive victims, in their circumstances. Children and young people can be active and agentic in

developing an understanding that, in the absence of caring and responsible adults, they must take care of themselves (Callaghan, Alexander, & Fellin, 2016). In unison with contemporary scholars (Ugazio, 2013; Hlavka, 2019), we found that as children and young people the participants actively resisted being victims, instead making ongoing attempts to have agency, despite persistent situations of abuse and neglect. Therefore, to narrow these experiences to a stimulus-response mechanism of survival as more behavioral theories propose, denies the complexity of the relationships and emotions involved (Dellos & Vetere, 2012; Øverlien, 2013). Positioning children and young people as active and agentic would enable future research to draw attention to opportunities for constructive interventions to disrupt the intergenerational transmission of trauma and violence. Another valuable area of future research would be to ask children and young people about what systems would support them to safely disclose childhood maltreatment that occurs in the care of the state.

The intergenerational adverse impacts of removing Indigenous children and placing them in the care of the state and faith-based residences is increasingly acknowledged by decision-makers and academic scholars. Māori participants described being detrimentally affected by the removal not only of their families but of their cultural identity. Their voices join those who have engaged in the royal commission of inquiries in Australia (Royal Commission into Institutional Responses to Child Sexual Abuse, 2017) Canada (Aboriginal Children in Care Working Group, 2015) and Aotearoa New Zealand (The New Zealand Government, 2018b) into the abuse that occurred within the state and church-run facilities for children and young people. Aotearoa New Zealand has begun to consider changes to care and protection policies to ensure that Indigenous cultural identity is actively maintained in children placed in the care of other parties (Oranga Tamariki Ministry for Children, 2020b).

Indigenous populations privilege emotional connection to land, people, and ancestors (Pihama, 2014), which is in stark contrast to the emotional detachment experienced in the living environments described in this study. The importance of attachment is illustrated in the participants attributing reconnection to cultural knowledge and practices to their current journeys towards emotional wellbeing and interrupting the intergenerational transmission of trauma and violence.

Over the last decade, there has been an increasing call for research that explores gender-inclusive experiences regarding violent offending and family harm. Consequently, in this research we chose to interview both men and women whose lived experiences included childhood maltreatment and the perpetration of family harm. Our research highlights that professionals in health and social care have not reliably responded to boys/men with offers of support that could intervene in the intergenerational pattern of violence. For the men, this added a layer of invalidation of their experiences as children and added to a sense of isolation, shame, and stigma frequently highlighted in the literature regarding male childhood sexual abuse (Dorahy & Clearwater, 2012). It may be that professionals expect to hear about childhood maltreatment from girls/women, and that researchers focus more on the abuse of girls/women, thus leaving boy's and men's abuse underexamined and underacknowledged. By not asking about and following up on boys'/men's accounts of childhood maltreatment, professionals working in this area potentially miss opportunities to understand how their childhood sexual abuse impacts them and their current relationships and patterns of family harm. Therefore, it is essential to talk with all genders about their experiences of childhood maltreatment, and this means explicitly opening space for men to talk about experiences of

childhood maltreatment. By offering all genders trauma-related therapy, we can start to address some of the outlined inequities.

Our analysis supports a relationship between adult incidences of family harm and the sparse relational and emotional experiences during their childhood. The cumulative effects of the physical, sexual, and emotional abuse and overarching neglect restricts opportunities to learn how to establish and maintain healthy interpersonal relationships. To address this, we propose that when children are placed in care settings they would benefit from multiple and ongoing opportunities to practice expressing their emotions with the caregivers, social workers, psychologists, and teachers in their lives. To foster this, professionals would benefit from trauma-informed and emotion-informed training to enhance their abilities to support children in care. Given the number of Indigenous children in care, it seems particularly relevant to weave through all intervention's meaningful connections and engagement with their culture to reverse the historic trends for this to be neglected in those removed from their family of origin (Office of the Children's Commissioner; 2020c). To scaffold their emotional wellbeing, children placed in care should be offered the opportunity to engage in therapy to help them process and make sense of their experiences of childhood maltreatment and how to adapt to their new safe living environments. In due course, this would allow them to develop the skills needed to establish and maintain positive friendships and interpersonal relationships across their lifetime.

The transition into adolescence would be another critical intervention point to facilitate the acquisition of relational emotionality especially as peers and intimate relationships become a focus combined with emerging sexuality. In addition, for youth who have begun to engage violence within relationships, targeted dating violence programmes

should incorporate emotion and trauma informed elements to help stem the flow of intergenerational transmission of violence. This is a pertinent recommendation for the increasing implementation of dating violence programmes and healthy relationship initiatives aimed at young people (Wolfe & Temple, 2018). For soon-to-be parents with a history of maltreatment, whatever their age, interventions that focus on education and ongoing support in terms of emotional relationships with their own children would be an ideal transition point to focus resources.

Given the prevalence of abuse in care it is worth considering how and when therapeutic interventions might be offered to interrupt the path from being abused to learning how to live with violence and beginning to resort to interpersonal violence as an adult. Thus Table 2 provides a summary of ways emotional/relational practices can be incorporated across the lifespan by professionals and agencies involved in the care and protection of children and family harm intervention services. This table was developed from the findings of this study. Specific suggestions for professionals to redress gender and Indigenous-exclusive approaches whilst nurturing emotional/relational skills within social services and family harm interventions are outlined in Table 1. Implementation of these suggestions into practice and policy would incorporate notions of care and protection that have been absent from the lived experience of being placed into the ‘care’ of the state.

Table 2:

Implications for practice and policy to interrupt the intergenerational transmission of trauma and violence for people removed from their family of origin

Timing	Recommendations for change in practice
When placed in care settings	• Offer all children and youth the opportunity to participate in therapy to process traumatic experiences and help adjust to their new living environment. A core component to be emotion-focused interventions. Repeat after each placement change. • Actively support positive interpersonal relationships with peers, Indigenous activities, friendships, family to allow space for social-emotional skills to develop and thrive. • Weave through all aspects of their childhood meaningful connections and engagement with Indigenous connections and experiences.
Adolescence	• Ensure therapeutic programmes focus on emotional expression within intimate relationships. • Imbue therapy with Indigenous conceptualisation about healthy relationships. • Bring to the foreground the role of emotions in relational contexts in youth dating and violence prevention programmes. • Offer a return to trauma therapy to explore how their past experiences may impact emerging sexuality.
Adulthood	• Offer trauma therapy to all genders to help adjust to relational transition points such as beginning or ending intimate relationships. • Provide ongoing tangible steps to maintain and enhance Indigenous knowledge and healing practices. • Infuse family harm interventions with the acknowledgment of emotions in relational contexts.
When developing professional engagement	• Engage in ongoing professional training and competence of trauma-informed and Indigenous-informed principles and practice that are developmentally appropriate. • Consider all engagement between professionals and young people in care as opportunities to foster emotional expression and development.

The narratives of our participants are retrospective but our analysis of them is located within the current context and draws from documentation of ongoing issues in relation to children and young people in care. Table 2 outlines the recommendations for changes in practice and policies emerging from the findings of this study. More work must be done to translate the findings interaction. For example, how do we practically infuse family harm interventions with how people manage emotions in interpersonal relationships? What might be the tangible steps to maintain and enhance Indigenous knowledge and healing practices? This study supports the call for a complete overhaul of the current care and protection practices for Indigenous children. Contemporary considerations for whether this involves a partnership model with Iwi (tribes) and hapu (sub-tribe) or a Māori for Māori approach requires further work. Our study focused on the relationships between all childhood maltreatment and family harm and did not tease out the complexity of the interaction between abuse that happened within family of origin prior to the child going into state care. It would be useful for future research to examine the potentially compounding and complex interactions this may have with the pathways to family harm.

In conclusion, the results from this study support a relational and emotional pathway between childhood maltreatment and family harm. The 'in care' experiences described were largely absent of care but characterised by chronic poly-victimization. Boys and men felt invisible and were silenced when they tried to speak about their experiences of maltreatment, and this reduced access opportunities to break the intergenerational pattern of violence. Our analysis identified key intervention points for interrupting the intergenerational transmission of trauma and violence. These opportunities for intervention occur across the lifetime. Indigenous children and youth in care must have their cultural identity maintained and

developed as this is essential for their personal and interpersonal health and wellbeing. In summary, a better understanding of the role of emotions within relational contexts will help guide the development of targeted individual and group interventions to address the long-term effects of child maltreatment and family harm interventions.

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Chapter 5: Manuscript 2

Māori voices in healing intergenerational trauma and violence.

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Abstract

Psychologists in Aotearoa are frequently tasked with addressing the adverse outcomes of childhood maltreatment and family harm perpetration. Opportunities for hope and healing proffered by Indigenous practices are under-utilised in mainstream psychology. Through purposeful sampling, 16 semi-structured interviews with adult perpetrators of family harm were undertaken, seeking to explore the relationship with experiences of childhood maltreatment. This paper focuses on the interviews provided by 8 Māori (Indigenous people of Aotearoa) participants. Findings revealed two main themes entitled 'Culture of Silence' and 'Pathways to Wellbeing'. The wāhine (women, n=4) and tāne (men, n=4) described being isolated and silenced by adults within their home and community settings. The culture of silence was pervasive, as evident in the lack of inter-agency communication, further silencing Māori voices. Cultural beliefs and healing practices helped interrupt the intergenerational transmission of trauma and family harm. Three core concepts emerged as key to stopping family harm and helping heal adverse trauma outcomes as identified in the words of the participants: Wairua (spiritual connection), Pou (becoming a symbol of strength and support for self and others), and Tūrangawaewae (finding a sense of belonging). The findings are in unison with previous research highlighting the multiple pathways to wellbeing Indigenous knowledge and practice provide to stop the intergenerational transmission of trauma and violence.

Keywords: Childhood maltreatment; Family harm; Intergenerational trauma and violence; Indigenous psychology.

Introduction

The adverse effects of family harm reverberate through individuals, families, communities, and generations in multiple and detrimental ways (Kahui & Snively, 2014; Goddard & Pooley, 2019; Lambie, 2018). For these reasons, it is crucial that psychologists strive to understand the relationships between childhood experiences of maltreatment and family harm perpetration to stop the devastating cycle. The enduring consequences of intergenerational trauma and violence echo through Indigenous populations (Brave Heart & DeBruyn, 1998; Drywater-Whitekiller, 2014). Indigenous researchers have long highlighted the utility of drawing upon cultural knowledge when supporting people's psychological wellbeing (Glover & Hirini, 2005; Milne, 2005; Valentine, Tassell-Mataamua, & Flett, 2017). Yet, mātauranga Māori and kaupapa Māori models of health and wellbeing are not widely employed in mainstream psychological practice (Bennett, 2017; McNeill, 2009; Muriwai, Houkamau, & Sibley, 2015; Pitama, Robertson, Cram, Gillies, Huria, & Dallas-Katoa, 2007). This paper explores the relationship between childhood maltreatment and family harm perpetration and pathways to wellbeing.

Indigenous consideration of human psychology has long been a bedrock of knowledge and understanding (Nikora, Levy, Masters, & Waitoki, 2006; Levy, 2016). The significance of Indigenous psychology for Māori has long been highlighted in Māori models of wellbeing such as Te Whare Tapa Whā model (Durie, 1994); Te Wheke (Pere, 1984), Meihana Model (Pitama et al., 2007), Whānau Rangatiratanga framework (Superu, 2016; 2017), Te Pauawaitanga o Ngā Whānau model (Durie, 2001). Kaupapa Māori models contain a wealth of knowledge regarding family systems and the interconnected nature of

intergenerational wellbeing. Indigenous researchers Pihama, Miller, Greensill, Te Nana, Campbell and Lee-Morgan (2021) highlight traditional Māori and Hawaiian childrearing practices focused on wellbeing through loving, nurturing, and collective childrearing practices. McLachlan, Waitoki, Harris and Jones (2021) presented the Whiti Te Rā model for Māori practitioners to guide whai ora Māori (Māori clients) through traditional pathways to wellbeing.

Colonisation interrupted the passing on of traditional knowledge and disrupted the configuration of whānau and social bonds for Indigenous populations (Cavino, 2016; Ruwhiu, Ashby, Eruiti, Halliday, Horne, & Paikea, 2009). To understand the impact of historical trauma, we need to look beyond the individual to acknowledge the cumulative emotional and psychological effects across generations (Pihama, Reynolds, Smith, Reid, Smith, & Te Nana, 2014; Wirihana, 2014). Being placed in the care of the state results in loss of ties to cultural knowledge, practices, identity (Aboriginal Children in Care Working Group, 2015; Office of the Children's Commissioner, 2015). Gram, Gulliver, Ota and Wislon (2015) illustrate that the adverse effects of colonisation and systemic bias are part of the explanation regarding the overrepresentation of Indigenous children in the state's care. The recent public outcry about the removal of tamariki (children) Māori from whānau provided the impetus for the recent inquiries into state care and protection policies and practices (New Zealand Government, 2018; Office of the Children’s Commissioner, 2020).

Researchers and practitioners across disciplines endeavour to understand the relationship between childhood experiences of maltreatment and family harm perpetration to inform prevention and postvention strategies (Kimber, Adham, Gill, McTavish, &

MacMillan, 2018; Lamotte, Gower, Miles-McLean, Farzen-Kashani, & Murphy, 2018; Reid & Sullivan, 2012; Semiatin, Torres, Lamotte, Portney, & Murphy, 2017). To do this successfully, psychologists must take time to evaluate the theories that inform practise critically. For non-Māori psychologists practising in Aotearoa, this means actively engaging with mātaurangi Māori and Indigenous psychology. On an individual practitioner level, this allows non-Māori psychologists to enact the Treaty of Waitangi principles of participation and partnership outlined in the Code of Ethics New Zealand Psychological Society (2002), the Continuing Competence Programme (New Zealand Psychologist Board, 2018) and the Health Practitioners' Competence Assurance Act (Ministry of Health, 2019). On a service delivery level, the expectation of comprehensive and collaborative assessment and treatment development with Māori embeds the basic principles of participation and partnership as the core foundation. However, the principles outlined in these guiding documents only present the baseline for best practice expectations. Without the deeper exploration and understanding of Mātauranga Māori and Kaupapa Māori models, non-Māori practitioners' risk only using these models at a surface level, restricting the potential healing properties inherent in these models (McLachlan, Waitoki, Harris, & Jones; 2021).

Examining the relationship between childhood maltreatment and family harm perpetration within existing data samples and self-report questionnaires provides important information about prevalence. However, research that merely outlines prevalence does not explain contributing factors for the overrepresentation of Māori and other Indigenous populations in the cycle of family harm. Exploring the lived experience of the intergenerational transmission of trauma and violence through qualitative research allows for an in-depth exploration of experiential understanding. Methodologies that centre on

collaborative approaches to facilitate examining the intertwined contributing factors, such as the impact of nurturing or inhibition of cultural identity and knowledge. Therefore, we need more research to understand better the relationships between childhood experiences of maltreatment and family harm to guide the development of targeted individual, group, and community interventions. This study elicited retrospective personal narratives from adults regarding their insights into the relationship between childhood maltreatment and the perpetration of family harm.

Method

Design and Methodology

The current study employed a semi-structured interview format that allowed for a flexible approach to exploring interviewees' thoughts regarding the relationship between childhood maltreatment experiences and family harm perpetration. The research was approved by the Human Research Ethics Committee of Te Whare Wānanga of Waikato The University of Waikato (Health; 2018#56). The current study is part of broader doctoral research undertaken by the lead author (KDR) who is a non-Māori clinical psychologist who has worked in the area of childhood maltreatment and family harm for 20 years. Key motivations for undertaking this research were moral and ethical drivers to inform and challenge her clinical practice in the context of working alongside whai ora Māori and in her role as a teaching fellow educating undergraduate and graduate students in mental health and wellbeing. The research panel consisted of three women who regularly reviewed the research process, giving primacy to the people's psychological wellbeing. At the beginning of research development,

a male advisory panel was established to provide a gender balance to review the analysis (suggested by our central recruitment agency). It included two kaumātua (Māori elders) to help guide and shape the research throughout in terms of culturally safety and utility. Braun and Clarke's (2006; 2013) six-step interpretive thematic analysis was utilised to analyse the interview content. This approach allowed an iterative process to identify common themes in the interviewee's responses regarding the relationship between childhood experiences of maltreatment and family harm perpetration. The emerging analysis by KDR was also discussed within individual cultural supervision, under the guidance of co-author BMA, and with the kaumātua to challenge mainstream assumptions and facilitate an Indigenous lens to the thematic analysis.

Inclusion criteria: To participate, people had to be 25 years or older to allow for broad retrospective reflection regarding their experiences of the relationship between childhood maltreatment experiences and family harm. Participants self-identified experiencing childhood maltreatment including one or more of the following forms of abuse: physical; sexual; emotional; neglect (emotional or physical); and had caused family harm that was either known to the justice sector or was self-reported. The term family harm was chosen to be consistent with Aotearoa legal terminology and encompass all forms of harm, such as coercion, emotional and verbal abuse towards family members.

Recruitment: Three key agencies in the-North Island of Aotearoa that provide assessment and treatment for people who met the selection criteria were contacted regarding recruitment for this study. Initially, information about the research was sent to relevant agencies via a Service Provider information Sheet, inviting them to contact the lead

researcher (KDR) with any questions before providing written agency consent for recruitment. Approximately 70 counsellors, psychologists, and social workers within each agency were given participant information sheets and flyers (electronically and hard copies) to invite eligible people to participate.

Participants

Eight Māori participants, 4 tāne (men) and 4 wāhine (women), were recruited with an age range from 40 to 60 years. The people interviewed identified their iwi (tribe) connections which covered Ngāpuhi from the Te Tai Tokerau (Northland) region, through to Waikato Tainui, Ngāti Maniapoto, Te Arawa, Tūhoe, Ngāti Porou, Ngāti Tūwharetoa and Ngāi Tahu (South Island region). Each participant either chose their pseudonym or a pseudonym was assigned before transcription with ongoing care to remove any identifying information.

Interview Process

People interested in participating in this study contacted the main researcher (KDR) via email or phone directly or through their key worker. Prospective participants were invited to talk with the researcher about the Participant Information Sheet and have any queries answered. The interview date and time were arranged, and contact was made the day before reconfirming this was still suitable. All interviews were conducted by KDR in a private office space organised by the recruitment agency or their key worker. Those interviewed were invited to bring whānau or support people with them to be part of the process if they desired. Key workers were informed of the day and time of the interview to ensure the availability of post-interview debriefing should that be required. Three of the four wāhine and one of the tāne interviewed asked their counsellor/psychologist to remain in the room for the interview

process. One person invited whānau to remain during the interview process, and two had whānau meet the interviewer and chose to wait in another space when confident the interviewee was safe and informed about the interview process. The confidentiality of the interview content and each person's identity was assured unless they disclosed that they were at imminent risk of hurting themselves or others. In one instance, in consultation with the participant, a key worker and counsellor were informed that the interviewee had expressed recent suicidal thoughts and the study safety plan was employed. Upon follow up, this person reported feeling supported and encouraged by the process to tell their therapist about issues contributing to suicidal thoughts.

Before commencing the interview, the information sheet was reviewed with participants and any questions answered before obtaining consent. A karakia (prayer) or whakatauki (proverb) was recited (either by the researcher or participant) before and after the interview process to help create a safe space consistent with cultural protocols. A flexible semi-structured interview format was followed, exploring how maltreatment experiences as children had affected them personally and the relationship, if any, with later adverse life outcomes, including the perpetration of family harm. Thus, allowing the interviewee to lead the interview process with prompts from the interviewer to further explore pertinent issues. The interviewees were asked to reflect on the and relationship to childhood maltreatment and perpetuation of family harm were discussed. Near the end of the interview, the focus moved to what advice and wisdom they would like to pass on to others with similar lived experiences and the professionals working in this field. As an acknowledgement of participation, everyone interviewed was provided with a $30 supermarket voucher and were provided with the contact details of a range of services available if they required support at

any point. The day after the interview, participants were contacted as part of a wellbeing check and reminder of supports available.

Data Analysis

All interviews were audio-recorded to allow for transcription. Braun and Clarke's (2006; 2013) interpretive thematic analytic approach was utilised to analyse the interview content. This approach allowed an iterative process to explore the themes emerging from the interviewee's responses regarding the pathways between childhood maltreatment and family harm. The analysis was led by the first author and interviewer (KDR) with regular input from the second author (BMA) and co-authors (KR and NS). The male advisory and kaumātua group were also engaged in discussions about the emerging findings (not given access to raw data or interview transcripts) to provide input regarding responsivity and relevance to Māori.

A summary of the key points from each interview transcript was collated, including pertinent quotes. The summary was then sent to each participant to confirm accuracy, gain permission to use the quotes in research reports, and encouraging them to add or change anything they deemed pertinent. Opportunity to meet or talk through the summaries was offered to facilitate a collaborative research approach 'with' the participants. Participants were kept informed about what was happening with the progress and nature of the research analysis at regular intervals. Interviewees engaged invited to engage in regular communication and provided feedback about what should be included in subsequent presentations and publications. These strategies aimed to provide a collaborative nature to the research Near the end of the research project, interviewees and key workers attached to the recruitment agencies were invited to attend an interactive workshop where findings were

presented. Care was taken to ensure that interviewees were not identified throughout, instead were part of the wider audience gathered under the auspice of presenting findings and seeking feedback from people interested in stopping the intergenerational transmission of trauma and violence.

Results

The wāhine and tāne interviewed described multiple experiences of maltreatment that were ignored and actively silenced, contributing to a culture of silence surrounding childhood maltreatment evident on individual and systemic levels. The neglect of physical and emotional needs was manifest during interactions with social services, amplifying cultural isolation as children. However, intergenerational patterns of trauma and violence were disrupted by reconnection to cultural identity and mātaranga Māori. The following section outlines the critical interview findings for the four wāhine Māori, and four tāne Māori interviewed captured in the themes entitled 'Culture of Silence' and 'Pathways to Wellbeing'.

Culture of Silence

One of the main threads throughout the interviews was that the wāhine and tāne interviewed did not feel like they were heard. This experience's breadth was pervasive emerging from within their living environments as children through to the professional and government agencies involved in their lives. The descriptions did not reflect the commonly referred to 'code of silence' around abuse but rather a systemic culture of silence.

No-one stopped it: The first sub-theme of the 'Culture of Silence' was given title of 'no one stopped it.' As children, the wāhine and tāne described being ignored when they

disclosed abuse and the adults minimised what they were saying, thinking, and feeling. Childhood experiences of being ignored were amplified by the lack of intervention on the part of adults to stop the abuse by the adults charged to care for them (such as family, teachers', and social service employees). Three of the interviewees were removed from whānau as babies and two in mid to late childhood. For the 4 interviewees removed from whānau and placed in non-whānau placements experiences of abuse and neglect occurred at the hands of people charged with their care such as foster parents and group home staff. The lack of intervention was confusing and disturbing when recalling the severity of their physical injuries that included bruises and lacerations, to broken bones in some cases. Manaia was removed from his parents and subsequently placed in multiple foster homes, wherein all but one he was sexually and physically abused. The following is an example of the lack of communication between professionals acknowledging Manaia's pain and suffering.

> *"I've been to fuckin 48 schools in my life….I wasn't settling well in them so they* ***[school and social welfare agency]*** *were moving me from school to school cause schools couldn't handle me…. nobody asked why I was the problem you know. We'll try this school then you know I got a hiding if I got sent home....I'm more angry now* ***[as a grown man]*** *at the system because I'm more aware of what was going on, what wasn't going on and what could have happened and those things weren't happening because nobody was listening to a 7-year-old, nobody was doing what I wanted to do, nobody came and said to me….are you happy here* ***[in foster placement]****?" Manaia*

For any child having to adjust to a new school, new rules and routines and make new friends are a big step and stressful life event. Children in care often change schools to move

closer to their new placement (described by the tāne who were in the care of the state), and the above quote from Manaia puts into words how challenging this can be. As an adult reflecting on his childhood experiences, he recognised that the reason for the changes was not addressed. Furthermore, engagement in a transition process to each school in a meaningful and developmentally appropriate manner did not occur. The more critical realisation for Manaia was regarding the way adults charged with his care framed him as bad, punishing him and changing schools rather than seeking to understand what was happening to him. Had those adults provided Manaia with appropriate support that sought to understand the underlying problem (the abuse inflicted upon Manaia) adulthood may have been very different.

Childhood isolation: A sub-theme of the culture of silence was entitled 'childhood isolation' and captured repeated experiences of being physically and emotionally isolated from others (neglect). As a child, being isolated contributed to behaviours that maintained a distance from strength-based connections that would have enabled positive attachment and emotional development. More specifically, being ignored meant being taught to ignore their own needs and wants as children. Furthermore, positive role-modelling regarding relationships were not regularly observed or personally experienced. The sense of being invisible as a child resulted in the interviewees at times withdrawing from intimacy and love in various ways as apparent in the following quote from Daphne.

> *"I didn't know what love was…. How to receive love and how to give love are two different things, um how to accept love, self-love, self-worth. I did not have those back then you just got on with it." Daphne*

This led to a form of silencing of their own needs and wants that was evident when describing scenarios of family harm. For example, Nikau attributed the abuse he experienced in multiple care and juvenile correctional settings with feeling void of emotions. He attributed ongoing issues with feeling and expressing emotions with instances of family harm particularly struggling to process the emotions of family members and partners in his life.

> *"How things were, um when growing up it* ***[physical, emotional, and sexual abuse in care]*** *had affected me, because it affected me mentally, emotionally, and how I dealt with life, um at that young age…. It affected my youth, 20s, 30s. Sometimes a lot of it* ***[emotion]****, it was like a void, there was a big void, silly as that sounds, but it was like that too." Nikau*

Our analysis of the transcripts revealed an extra layer of systemic neglect evident in the information provided by reflecting a lack of intervention from the schoolteachers and social services. For example, all the Māori tāne interviewed were removed from their family of origin and placed in non-Māori run foster or adoptive homes. The neglect of Māori identity and connection to whānau, hapū (kinship group) and iwi (extended kinship group) lead to a deep sense of loss. Caleb was placed with a non-Māori family when he was a baby and described a sense of isolation, rejection, and shame about this amongst his friends at school.

> *"Oh, yeh that, the whole me being brown and them being white* ***[adopted parents],*** *that was the main thing when I was going to school. Hey, you've got a white mother and, yeh, you know. But I didn't know how to answer it….but I had always brought that thing that I was ashamed because I had a different mother and yeh that was the start of my journey, the downward spiral I think and being rejected." Caleb*

Ultimately, what was evident was an additional level of cultural isolation on top of a childhood that was characterised as isolated. As adults looking back, there was a palpable sense of grief at the loss of not only knowing and living with whānau, but of a lost connection and relationship with their whenua, ancestors, hapu and iwi. In addition, they were losing opportunities to learn established kawa and protocols for managing the complexity of family life. Moana, was not told her true ethnicity by her adoptive parents, completely denying her access to her cultural identity. Thus, representing another layer of silence and isolation through the lack of acknowledgment of her cultural heritage.

> *"I had no whakapapa…. I felt really just there…. then I was gifted my whakapapa … So, my identity played a huge role in my wholistic wellbeing, not just for me but for my descendants…. They want to hear the stories; they want to know where I've come from…. With that identity came the whakapapa of health, mental health you know what they were like, which you know is really important too." Moana*

In this quote, we can see that eventually knowing her whakapapa (genealogy) was a gift that opened to Moana the wealth of kaupapa Māori values and principles she found essential to her adult journey towards healing and wellbeing. The wāhine and tāne were clear that stopping the intergenerational transmission of trauma and violence was a hard and an ongoing process but were steadfast in a commitment to protect and nurture future generations. The following section summarises the key aspects the people interviewed attributed to changing the trajectory from psychological distress, trauma, and violence to stopping the intergenerational transmission of trauma and violence.

Pathways to Wellbeing

Freedom in adulthood to engage in te ao Māori were associated with personal wellbeing and improving interpersonal and familial relationships. The following section summarises the 'pathways to wellbeing' interviewees described that gave them a voice to talk about their lives and make sense of their childhood experiences of maltreatment and how these impacted them as adults. Each person had their own journey towards wellbeing and stopping the cycle of harm, but all started out on this journey to change for the benefit of their children and younger family members. The nature of structural supports that helped varied, for instance, Candace found becoming active in the life of her marae essential to helping her continue to heal. Caleb found engagement with faith-based social networks with others who had similar life experiences very beneficial. Three core concepts emerged in our analysis that encompassed the pathways to wellbeing: Wairua, Pou, and Tūrangawaewae. These headings are derived from the words of the participants and illuminate their understanding of the concepts, and thus may or may not reflect accepted translations/understanding of these words.

Wairua (spirituality): A crucial step in facilitating the transition from feeling isolated and ignored was enhancing an understanding of wairua. A spiritual connection to the land was a source of rejuvenation and strength essential for the eight people interviewed mental health and wellbeing. Hence, incorporating time in nature, whether in the bush, mountains, river, or beach, was part of their wellbeing strategies. As part of understanding, cultural identity came with a reconnection to ancestors who were present unconditionally, resulting in a sense of belonging and support via a spiritual realm. The importance of spiritual

connection is evident when Aroha attributed her tūpuna (ancestors) for saving her life in many ways.

> *"I think one of the things that does get a lot of people who have experienced trauma, though, is wairua, so the fact that we don't talk a lot about that, or we talk about it in colonising ways, is really, I wouldn't have gotten here if it hadn't of been for my ancestors." Aroha*

The presence of a spiritual realm provided a source of unconditional listening even when they were hurting themselves and others. Indeed, this provided an essential source of steadfast support, a stark contrast to their childhood experiences. Both the wāhine and tāne described communicating with tūpuna as children over the course of time. Thus, spiritual connections provided a sense of protection and strength that was absent during childhood, as highlighted in the following quote from Moana:

> *"In the end I'm saying son…. the only people you need to trust is your tūpuna…. that know you. They are the only ones that are driving you….. That's what I do, that's who I trust. Like when I get an A+ I take it up to my Tūpuna who are on my wall and I celebrate with them." Moana*

For three of the people interviewed, the spiritual connection identified was with God (from differing religious beliefs systems). For example, after being in and out of juvenile residential facilities and prison, Caleb said that he began to change when he "met" God in prison. In the following quote, we can see that Caleb found a place to belong in his spiritual connection) with God and the family of Christian tāne who continued to walk alongside him.

"My rejection and my sexual abuse that really that I covered with all the drugs that I didn't want to face. At the time I was going through **[a faith-based]** *counselling realising I wasn't to blame, and other people encouraged me. That's where I started getting free from all my anger and just people loving me for who I am and understanding and that's a lot of my journey was I needed someone to hear…. I have helped people that abuse other people, and I won't look at them like I want to give them a hiding or something, I just say to them you need help, you need help." Caleb*

Caleb was steadfast in his commitment to creating a safe home for his partner, tamariki, mokopuna (grandchildren), and helping other men wanting to stop the intergenerational transmission of trauma and violence. This commitment was evident in the interviews content of the others and is explored in the following section entitled Pou.

Pou (steadfast and reliable): A link between engaging with cultural identity to locating their voice was a key aspect of healing and interrupting the transmission of trauma and family harm. Nevertheless, it is essential to acknowledge that it was more than a desire to stop family harm rather a steadfast commitment to being a point of change in the family and a facilitator of the transmission of health and wellbeing. Daphne's quote highlights her journey towards change by understanding her role in her children and grandchildren's life as one of safety and consistency. Like Moana's message to her son, Daphne talked to her children about learning to become their own Pou.

"Inconsistency is huge, I think in my generation…. Our kids don't know to trust us because we are supposed to be their Pou…. we are supposed to be who they come to….. They're all trying to find somebody to love. So that's their consistency there,

their Pou is the other person. They're trying to make the other person their constant, their base, their foundation, their everything. Now they're coming to me going mum what do I do…. I've been able to stand in my truth and be consistent in it, and they're starting to trust me." Daphne

Daphne articulated her realisation that she can rely on and validate herself and in turn, act as the cornerstone that can now exist for her children and her mokopuna to change the patterns of violence that existed before. To validate themselves and not seek validation in from others is the essence of this quote, a concept of challenging a belief system not dissimilar to that used within psychological cognitive and schema therapies. The willingness to face the reality of the harm caused and make personal changes echoed through all the interviews. In the face of generations of trauma and violence, the honesty, strength, and conviction to begin this change was quite remarkable and is exemplified in the following quote from Manaia.

"…. that's a whole other generation ***[children in his family]*** *and I'm glad. And I think the only proud thing I have to stake claim on is that, as far as all that ugly shit goes it stops right with me. Because they're not going to carry that on, they're going to be a policeman or famous sportsman and do really well in life." Manaia*

The overarching sentiment of everyone was the belief that family harm stopped with them. Moreover, evident in the interview content was an emerging awareness that the changes that were being made on individual, family group and societal levels were significant and provided hope. For example, Nikau's observation about how the current generation has made changes so that children are seen and heard is poignant for two reasons. Firstly, he

described himself as being at the beginning stages of wanting to change and was still involved with the justice system. Secondly, the tone of this comment was one of wonder and astonishment as if he were observing for the first-time children expressing emotions and that these were heard and validated.

> *"Anger came as a result of a lot of that abuse because when you get abused you've got no say in it, you can't, you can't stand up because you're little. You know back in our era, it would've been, it was ok to be seen. But not heard! And those were part of the old concepts of what that generation had brought us up in…. So really, we have no voice compared to as what the voices* ***[of children]*** *today. You know you get a lot of youth that can, or a lot of children that actually are quite open* ***[with thoughts and feelings]****." Nikau*

Nikau's comment highlights that efforts to stop family harm and focus on the intergenerational transmission of hope and wellbeing are seen and heard and can be inspiring and motivating for others.

Tūrangawaewae (a place to stand): Through cultural reconnection all the wāhine and tāne expressed a sense of feeling validated with a destined place in the world. Thus, providing a sense of belonging and an identity that they could proudly talk about instead of their childhood experiences. Aroha described a framework she developed based on a Māori concept of belonging that has helped her regain her voice and be an active agent in her life.

> *"I have a tūrangawaewae and at one stage it was woven for me and I didn't understand that I could weave it for myself. So, in my mind and how I'm thinking of it*

now is that the tūrangawaewae is the relationships, the connections in life .... I have come to understand that I weave my own tūrangawaewae, my own standing place and that has to be firm and so I took ***[supportive people]*** *with me I'm weaving them into my tūrangawaewae, so when I go into shaky places, I have got a firm place to stand." Aroha*

Caring for and looking after others was a critical foundation identified as something that gave life purpose and meaning and a sense of belonging to something bigger than themselves. For example, all expressed a desire that their life story could act as a roadmap for others' wellbeing. The following quote from Candace represents the message that pervaded all the interviews regarding the next generation. A message of hope and the essential role of human decency when thinking about people who have a history of childhood maltreatment and family harm.

"When you've got all that rubbish going around in your head it's all negative. All you want to do is hurt yourself and that's sad ay, cause they're beautiful people. It doesn't matter what walk of life they came from, they have a right to be respected and to be loved and accepted just for who they are." Candace

Inherent in Candace's quote was her appreciation of the existence of mauri (life force) and beauty within everyone; an aspect of humanity that can be forgotten within experiences of abuse and trauma as children and within institutions but never lost.

Knowing whānau who have similar lived experiences provided solace and connection robbed when removed from living with whānau. For example, in addition to the sense of

isolation and removal from his family due to sexual abuse, Brian described a sense of isolation and separation from his family as he thought he was the only gay person in his family. Learning later in life that an aunty, and one of the only family he recalled as being "whole" was lesbian, provided reassurance he was not alone and gave a sense of kinship he had not previously felt.

> *"She wasn't married, and this is back in late 70s, she had no children, she was a teacher, and she was interested in travelling the world…. She was lesbian…. To know about my aunty….would have been nice to know about ….her life but never got to. Cause that was all taken away from me you know, from my uncle from what he did you know. And that's where I sort of just went wayward." Brian*

For Brian, knowing he was not the only gay person in his family and having a positive role model in his aunty later in life was the beginning of a healing journey from a sense of shame and isolation related to his sexual identity. He described feeling increasingly proud of who he is and feels he belongs to a long line of takatāpui (individuals who identify as gay, lesbian, bisexual, transgender, intersex) who provide models for healthy relationships part of a family going forward.

To summarise, it was not one element that helped the wāhine and tāne interviewed to stop family harm perpetration and move towards personal and familial wellbeing. It was many aspects occurring in multiple ways over time. The experiences of being ignored and silenced as children were inverted when their voice was finally heard, and the process of healing began through values and practices inherent in the essence of mātauranga Māori and kaupapa Māori models.

Discussion

The findings of this study reinforce the importance for psychologists working in the area of childhood maltreatment and family harm perpetration to engage in trauma and Indigenous-informed practises to stop the intergenerational transmission of trauma and violence. For these 8 participants, intergenerational patterns of trauma and violence were healed through their reconnection to Indigenous knowledge and practices. Our analysis revealed three key components critical to stopping family harm perpetration and facilitating psychological wellbeing: Wairua (spiritual connection), Pou (becoming a symbol of strength and support for self and others), and Tūrangawaewae (finding a sense of belonging). The findings outlined in this paper support the ever-increasing compendium of knowledge that demonstrates that Indigenous understandings and practice facilitate the intergenerational transmission of hope and healing (Durie, 2001; Cooper & Rickard, 2016; Fox, Neha & Jose, 2018; Tapsell, 2020). Therefore, Indigenous Māori psychologists working from kaupapa Māori perspectives is essential to healing intergenerational trauma. Equally, there is a need for non-Māori psychologists to actively engage in cultural supervision and training to eliminate the intergenerational transmission of trauma and violence.

The launchpad for healing and self-determination has repeatedly been identified is a return to Māori value systems to restore a sense of purpose, meaning and progress towards positive life outcomes (Ruwhiu et al., 2009; Cooper & Rickard, 2016; Fox, Neha & Jose, 2018). As evident in the experience of Manaia, childhood maltreatment resulted in a sense of isolation amplified by the lack of support and intervention from professionals. However, reconnection to whenua, whakapapa and ancestors provided Moana and Aroha with strength

and support to pivotal to their healing journey. These findings are in alignment with kaupapa Māori models of health and wellbeing that highlight the importance of reconnection with forbearers, Hā a Koro Mā, a kui Mā (Pere, 2017) and spiritual and faith-based figures, Waiuratanga (Valentine, Tassell-Mataamua & Flett, 2017). Therefore, interventions to stop the intergenerational trauma and violence and facilitate psychological wellbeing must include the essential component of Wairua.

One of the core facets of relating to others is expressing and responding to emotions in ourselves and others. However, childhood experiences of maltreatment can interfere with the processing of emotions in relational contexts and have been linked to family harm perpetration (Young & Widom, 2014). For example, Daphne linked the lack of love she experienced as a child to her struggles in adulthood to know how to love herself or others. Nikau linked the void of emotions evident in care settings with ongoing issues relating his adult experiences with expressing and feeling emotions to family harm. Consequently, exploring the nature and experience of whatumanawa (emotions) is an important pathway for stopping family harm perpetration and can be fostered through engagement with kaupapa Māori models such as outlined in Pere's (2017) Te Wheke model. Therefore, our findings highlight the importance of including kaupapa Māori models to help people better understand the role of emotions within relational contexts to stop the transmission of trauma and violence. For this recommendation to be achieved, services must allow Indigenous Māori psychologists to work from kaupapa Māori perspectives and for non-Māori psychologists to foster and continually develop their understanding of working within Kaupapa Māori practices to eliminate the intergenerational transmission of trauma and violence.

It is important to note that the wāhine and tāne interviewed did not suggest that childhood neglect and abuse were an excuse for family harm perpetration, but instead, it helped them make sense of their reactions. But what was clear was the ongoing and detrimental impacts of the abuse and neglect that occurred for the interviewees removed from whānau and placed into non-Māori settings. The pain and suffering experienced outweighed any harm experienced within whānau settings prior to removal. The critical sentiment running through the interviews was the desire to positively change for themselves and future generations, aligning with kaupapa Māori models of wellbeing. Such as Superu's (2016; 2017) Whānau Rangatiratanga conceptual framework that highlights elements of kotahitanga (collective unity) and manaakitanga (responsibilities to honour the mana, authority, of others). Daphne's conceptualisation that she was becoming a model of strength of her family, as her own Pou, offers a beautiful challenge to previous beliefs around hopelessness and powerlessness. Through cultural reconnection, the wāhine and tāne expressed a sense of feeling validated a sense of belonging, Tūrangawaewae. Caring for and looking after others was a critical foundation that gave life meaning and a sense of belonging to something bigger than themselves. Ultimately fostering supportive relationships that provided opportunities to talk through issues and psychological distress, a stark contrast to childhood experiences. Therefore, fostering reconnection to people and places where people have a sense of purpose and belonging is a key aspect of healing and interrupting the transmission of trauma and family harm.

One of the major recommendations that stand out in the narratives of the people interviewed is the need for all of us demand that tamariki receive a high level of care and nurturing. The devastating impact of the cultural isolation was evident in the experiences of

Caleb and Moana and reflected an additional layer to the culture of silence. The information emerging from the ongoing national and international inquiries into the abuse of Indigenous children in state care confirm that the effects of childhood maltreatment can continue into adulthood (Aboriginal Children in Care Working Group, 2015; Office of the Children's Commissioner, 2015). Manaia and Nikau linked the chronic abuse and neglect they experienced in state care placements to psychological and interpersonal challenges. Therefore, non-Māori psychologists must ensure that our practices do not further silence Māori from talking about their childhood maltreatment experiences or minimize the impact abuse within the context of state care. One way to ensure this is to employ trauma-informed practices. At the heart of trauma-informed principles is enabling people's voice with past traumatic experiences, so childhood experiences of silencing and powerlessness are not replicated (Short, Cram, Roguski, Smith & Koziol-Mclain, 2019; Wirihana, 2014; Pihama et al., 2017). The five key trauma-informed principles are safety, trustworthiness, choice, collaboration, and empowerment (Dempster-Rivett, 2019). These principles are intertwined with kaupapa Māori values such as those of Kaitiakitanga (guardianship), Manaakitanga, Rangatiratanga (leadership) that brings people together and the anchoring and protective aspects of Wairuatanga. Ultimately, non-Māori psychologists working in trauma and Indigenous informed ways would not replicate the childhood experiences of being ignored and isolated.

Our analysis clearly showed that all the people interviewed experienced multiple times where they did not feel heard or kept safe from the adults in their lives. Therefore, one of the implications of this study is that for non-Māori psychologist working in the area of trauma and violence to enable spaces for Māori to talk about lived experiences of

intergenerational trauma and violence in all forms. Specifically, ensuring the voice of Māori is integral to the development and implementation of programmes to address the intergenerational transfer of trauma and violence. Our study focused on the reflections provided by people who had harmed their families and the relationship with childhood experiences of maltreatment. In the future, it would be beneficial to extend this research to talk to whānau, such as partners, children and parents, which would provide valuable insights into contributors and inhibitors of the intergenerational transmission of trauma and violence. The age group of the interviewees ranged between 40-60 years of age. It would be helpful to explore the intergenerational transmission of trauma and violence with younger and older cohorts. Ongoing research is needed to guide and support partnership models and Māori for Māori approaches in developing and implementing programmes to address adverse impacts of childhood maltreatment.

In conclusion, the findings of this study highlight the importance of infusing Indigenous psychological approaches to facilitate the intergenerational transmission of hope and wellbeing. Three core concepts were identified in breaking the cycle of family harm and healing childhood maltreatment: reconnection with Wairua, becoming a beacon of strength and support for self and others, Pou, and finding a sense of belonging and Tūrangawaewae. Therefore, psychologists need to create therapeutic environments where Māori are free to engage in cultural beliefs and healing practices for personal and familial wellbeing.

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Glossary of Māori terms

This glossary identifies Māori words used in this article. The English version reflects the researchers' interpretation, often based on how the Māori word was used by participants. The terms presented here are in alignment with Health Research Council of New Zealand terminology (HRC, 2010).

Māori	**English**
Hapū	Kinship group
Iwi	Extended kinship group, tribe
Kaitiakitanga	Guardianship
Karakia	Prayer, incantation
Kaumātua	Māori elders
Kotahitanga	Collective unity
Manaakitanga	Cultural and social responsibility Respecting the mana (authority) of others
Mātauranga	Traditional knowledge
Mokopuna	Grandchildren
Pou	Steadfast and reliable; becoming a symbol of strength and support for self and others*
Rangatiratanga	Leadership
Tāne	Men
Tamariki	Children
Tangata whenua	Indigenous people
Takatāpui	Individuals who Identify as Gay, Lesbian, Bisexual, Transgender, Intersex
Te ao Māori	Māori worldview
Tūrangawaewae	A place to stand, finding a sense of belonging*
Tūpuna	Ancestors
Wairua	Spirit; spiritual connection*
Wairuatanga	Spirituality
Wāhine	Women
Whai ora Māori	Māori clients
Whakatauki	Proverb
Whakapapa	Genealogy
Whānau	Family
Whatumanawa	Emotions

* Interpretation as emerged from the interview content.

Chapter 6: Manuscript 3

Is the time for siloed models of care ending? Examining the complex outcomes associated with childhood experiences of maltreatment and the perpetration of family harm

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Abstract

Childhood maltreatment experiences have cumulative and adverse impacts on mental health and contribute to the intergenerational transmission of trauma and violence. Research that only focuses on one adverse outcome does not capture the reality of living with multiple adverse trauma effects. This study aimed to investigate the nature of mental health issues within the context of childhood experiences of maltreatment and later perpetration of family harm. Thematic analysis was employed to explore the relationship between childhood maltreatment and family harm from people with the lived experience of both. An equal number of Māori (Indigenous people of New Zealand) and non-Māori men and women (n=16) were interviewed using a semi-structured format. All interviewees reported adverse trauma reactions stemming from childhood maltreatment, including mental health, suicidal thoughts, and self-harm; alcohol and substance use; and the perpetration of family harm. Interviewees described these challenges as interconnected with childhood experiences of maltreatment rather than separate. However, engagement in timely and specialist support for the complex array of issues was an identified gap. For instance, only eight interviewees received formal mental health support over their lifetime, a concern given the level of suicide and self-harm reported. The findings of this study support the implementation of responsive and adaptive integrated models of care that are Indigenous and trauma-informed to serve the complex needs of people living in a cycle of family harm.

Keywords: Childhood maltreatment; Mental health; Forensic; Family harm; Intergenerational trauma and violence.

Introduction

The intergenerational transmission of trauma and violence within family contexts is widely recognised within academic and lay settings (Widom & Wilson, 2015; Kimber, Adham, Gill, McTavish, & MacMillan, 2018; Merrick & Gunn, 2018). Adverse life course trajectories continue to motivate research, policy, and practice to stop repeating cycles of family harm. However, assessing and treating issues arising from family harm is complicated by the heterogeneity of experiences and presentations. So, there is a critical need for research to inform mental health and family harm services that are simultaneously trauma and Indigenous-informed. A recent report by the New Zealand Office of the Auditor General (2021) called for an urgent improvement in how key governmental agencies work together to address family and sexual violence. The urgent need for meaningful partnerships with Māori (Indigenous people of New Zealand) has been identified as a key focus going forward by government agencies tasked with addressing the needs of Māori in terms of intergenerational health and wellbeing across health, justice and care and protection services (New Zealand Government, 2018; Ministry of Health, 2021a).

Childhood maltreatment, aggression, and family harm

Childhood experiences of maltreatment are linked with an increased likelihood of contact with juvenile justice services (Malvaso, Delfabbro, & Day, 2017; Doolan, Najman, Mills, Cherney, & Strathearn, 2013). Externalized problematic behaviors are the main reason why maltreated youth come to the attention of justice systems (Braga, Gonçalves, Basto-Pereira, & Maia, 2017; Fox, Perez, Cass, Baglivio, & Epps, 2015). In a Canadian study, Van Wert, Trocme and Faloon (2017) found that 30% of children in the child welfare system had

documented aggressive and violent behavior at home, school and the community compared to 1 to 4% in the general population. Predictably adverse childhood experiences are prevalent in adults who offend (Bevan, 2017; Farrington, Gaffney, & Tofi, 2017; Widom, 2017). When investigating the prevalence of abuse in US prisoners, Courtney and Maschi (2013) found that up to half reported multiple forms of other types of childhood traumatic experiences such as; witnessing violence, death of family members, foster care placements or parental substance abuse. Hence, exploring the rates and consequences of poly-victimization is an emerging area of interest regarding the maltreatment-offending link (Baglivio & Epps, 2016; Hurren, Stewart, & Dennison, 2017; Kerig, 2018; Schlesinger & Lawston, 2011).

Research suggests that the relationship between intimate partner violence (IPV) and trauma exposure in childhood is significant (Richards, Tillyer, & Wright, 2017; Widom & Dutton, 2014). Morris and Windle (2015) analyzed data from a longitudinal study of approximately 500 youth and found that exposure to IPV and extreme discipline by parents predicted the occurrence of dating violence. LaMotte, Gower, Miles-McLean, Farzan-Kashani, and Murphy (2018) found that of 94 men presenting for IPV intervention services, 43.6% reported one or more adverse childhood events and believed this had influenced the way they engaged in current relationships. So, it is not surprising that a significant proportion of people involved with justice services regarding family harm perpetration have histories of childhood maltreatment. However, this link is often overlooked in treatment design and delivery for programmes to address the cycle of family harm (Voith, Logan-Greene, Strodthoff & Bender, 2018; Kong, Roh, Easton, Lee, & Lawler, 2018).

Childhood maltreatment, mental health and substance use issues

Mental health and addiction issues are documented trajectories for people with childhood trauma histories. Specifically, there is an increased risk of developing internalizing and psychiatric disorders such as Post-Traumatic Stress Disorder (PTSD), depressive and anxiety disorders, alcohol and substance abuse, borderline personality disorder and suicidal behavior (Boppre & Boyer, 2021; Davis, Masters, Casey, Kajumulo, Norris, & George, 2018; Garland, Pettus-Davis, & Howard, 2013; Rosenstein, Ellison, Walsh, Chelminski, Dalrymple, & Zimmerman, 2018). In addition, experiences of poly-victimization have been linked to an increased risk of mental health issues and suicidal and self-harming thoughts and behaviors (Baglivio & Epps, 2016; Ford, Elhai, Connor, & Frueh, 2010). Historically, research has focused on men who offend, however more recently, there has been increasing attention on offending pathways for women. For example, Broidy, Payne and Piquero (2018) identified pathways between early childhood abuse, internalized symptoms such as mental health issues and chronic involvement in offending for women.

The relationship between childhood maltreatment and family harm suggests that there would be an overrepresentation of mental health and addiction problems in offending populations. Indeed, Indig, Gear and Wilhelm (2016) found that compared to the general population, New Zealand prisoners were three times more likely to have a mental health diagnosis and four times more likely to have a lifetime diagnosis of PTSD. Staggeringly, they found that 52% of women prisoners met lifetime diagnoses of PTSD, accentuating the need for clinicians working in correctional and forensic services to consider the impact of past trauma on current presenting problems. In a study of men in forensic inpatient settings in Canada, Hilton and Radatz found (2018) that compared to non-violent and violent offenders,

men who perpetrated interpersonal violence (IPV) had more identified treatment needs. In addition, it can be challenging for people with multiple issues to navigate traditional health care models as they do not fit neatly into one diagnostic criterion. It can be arduous for clinicians to categorize complex presentations into diagnoses, complicating decisions regarding the order and availability of therapeutic interventions.

Evolving models of care

Traditional models of care within mental health settings have evolved around commissioning services based on psychiatric diagnosis (Boyle, 2020). For over a decade, there has been an increasing call for a move towards a more trans-diagnostic approach that acknowledges the more profound underlying and interconnected nature of people's experiences. For example, Barlow et al. (2010) proposed a unified protocol for a trans-diagnostic approach to treat emotional disorders, acknowledging the overlap observed in disorders such as anxiety and depression. More recently, Johnstone and Boyle (2018) advocated for a Power Threat Framework as an alternative to diagnostic approaches. Put simply, the Power Threat Framework focuses on understanding what has happened to people and how that is impacting on their current presentation rather than focusing on what is wrong with them (Harper & Cromby, 2020). Livesley (2012) proposed an integrative framework for treating people with personality disorders that allow for complex presentations. Livesley's framework highlights the utility of employing different treatment models at different stages of readiness for change, acknowledging that people have a variety of needs that change over time. The developments of integrated models of care mentioned above are not explicitly designed to address the cycle of family harm but can address the previously outlined adverse effects. One way to bolster

our understanding of the cycle of family harm and the link with mental health is to incorporate lived experience into research and development.

Approaching service delivery from an integrative view aligns closely with Indigenous models that do not focus on diagnoses rather holistic and intergenerational wellbeing (Kopua, Kopua, & Levy, 2021; McLachlan, Waitoki, Harris, & Jones, 2021). Indigenous health and wellbeing models contain a wealth of knowledge and healing practices that are essential components to facilitate health and wellbeing transmission (Smith, 2019; Willmon-Haque & Bigfoot, 2008; Pihama, Reynolds, Smith, Reid, Smith, & Te Nana, 2014). However, Indigenous repositories of wisdom are often overlooked and undervalued in mainstream research and service delivery development. Existing systems and wrap-around services continue to fail to meet the needs of Māori reflected in the ongoing over-representation of Māori in care and protection, mental health, and family harm services (New Zealand Government, 2018; Office of the Auditor General, 2021). Addressing this inequity and bias is a high priority in New Zealand, resulting in a complete redesign of the health system, which includes a separately funded and fully endorsed Māori Health Authority based on Māori health and wellbeing world views and practices (Ministry of Health, 2021b). Any examination models of care and the impacts of the intergenerational transmission of trauma and violence must include a partnership with Indigenous peoples.

Purpose of the present study

Understanding the complexities of living with adverse trauma reactions could help guide the development and implementation of services that better address the needs and help stop the cycle of family harm. Research that focuses on one type of adverse outcome arising from childhood maltreatment does not allow for an in-depth examination of the impact of living

with multiple adverse outcomes across the lifespan. Specifically, adverse trauma outcomes such as mental health and substance use issues may also contribute to the pathways between childhood maltreatment and family harm perpetration. This study examined the relationship between mental health and addiction issues and the cycle of family harm. It is crucial to include the experiences of Indigenous peoples in research regarding intergenerational transmission of trauma and violence to inform service development and evaluation. Therefore, this study included an equal number of Māori and non-Māori men and women to allow for an Indigenous inclusive approach.

Materials and Methods

Design

The present study used a broad and flexible semi-structured interview format to explore participants' reflections upon their pathways from childhood maltreatment to family harm. Approval to conduct this research was provided by the human research ethics committee of The University of Waikato (Health: 2018#56). This study forms part of the authors PhD. Purposeful sampling was used to ensure the inclusion of an equal number of men (n=8) and women (n=8) of both Māori (n=8) and non-Māori (n=8) descent as self-identified by the interviewees. The interviews were conducted in four sets, beginning with four men and four women until all 16 interviews were completed. This allowed for an iterative process of data analysis to occur and the identification of themes as part of the analysis process. The wellbeing of the people interviewed was prioritized throughout the research process. This involved establishing a male advisory panel to foster a gender-inclusive approach, given the research panel consisted of four women. Two kaumātua (Māori Elders) were invited to be

part of the panel to ensure the establishment of the research, and subsequent data collection and analysis was anodyne from an Indigenous perspective.

Participants

The 16 participants were recruited from the North Island of New Zealand. To be considered eligible, the interviewees had to be at least 25 years of age to allow for time to have passed to reflect on the link between childhood maltreatment and their perpetration of family harm. The people who took part identified as experiencing one or more of the following forms of childhood maltreatment: emotional, sexual, physical, and emotional and physical forms of neglect. Regional agencies responsible for providing services for people who met the eligibility criteria were approached about participant recruitment for the study. Agency managers were initially contacted via email and provided a service provider information sheet regarding the study and offered a meeting to discuss the research in more detail and answer any questions. Once written permission was received from each agency, key workers were provided with flyers and participant information sheets (hardcopy and electronic versions) to discuss with potential participants.

Data Collection

Potential participants emailed or made phone contact directly or via their recruitment agency. Any questions about the research were discussed, and the opportunity to meet before the interview was offered. Interviews were conducted in a private office space, either in their counsellor or psychologist's rooms or at the referral agency at a date and time that suited each participant. Each participant was invited to have support people in the room or nearby during the interview process. The participant's key worker was informed of the date and time of the

interview so they would be available to be contacted by the participant before, during or after the interview to provide an added level of support. The participant information sheet was reviewed before the interview proceeded, providing another opportunity for questions and concerns to be addressed. Due to the interview content's sensitive nature, every effort to maintain participants' confidentiality was employed throughout the research process, unless the imminent risk to themselves or others was disclosed (occurred in one instance).

Each interview took up to 90 minutes and followed a semi-structured interview format that covered topics related to childhood maltreatment experiences and how they saw this linking to subsequent harm of their family and partners. Areas covered included impacts on them personally and interpersonally at key points across their lifetime. For example, exploration of experiences regarding psychological distress, mental health and substance use and suicidal thoughts and behaviors. The semi-structured interview examined how they thought the adverse trauma effects and intergenerational transmission of trauma and violence could be interrupted, including advice for others in similar situations and for the professionals working with them. Each interview was encapsulated with either a karakia (prayer) or whakatauki (proverb) with the content and language chosen by each interviewee to foster a culturally inclusive environment and had a clear beginning and end. Interview content was audio recorded for later transcription and analysis. At the end of the interview, each participant was provided with a $30 supermarket voucher to thank them for their contribution and a list of support agencies and after-hour contact numbers if required. Also, each participant was contacted the following day via a medium of their choice to check on their wellbeing and provide a reminder of support services they could contact regarding the topics covered in the study.

Given the sensitive nature of the content of the interviews, care was taken to keep the identity of the people interviewed anonymous. A pseudonym was assigned to each participant before professional transcription, and any possible identifying information was removed. Each participant was sent a summary of the main points arising from their interview and were invited to make any edits or clarifications either electronically or in-person, and permission was sought for the use of anonymized quotes. The author remains in contact with the people interviewed to provide them with updates about publications and presentations regarding this study and the wider research project.

Data Analysis

Braun and Clarke's (2006; 2013) six-step qualitative approach of interpretive thematic analysis was employed to analyze the interview content. One of the main observations during the analysis was how prevalent and interconnected mental health and addiction issues were when all the people were talking about their pathways from childhood maltreatment to family harm perpetration. Therefore, this study focused on exploring the relationship between childhood maltreatment, mental health and addiction issues and family harm perpetration.

Results

Analysis of the interviews revealed a complex interplay between childhood maltreatment, mental health challenges and family harm perpetration. The complexity of the adult experiences of ongoing adverse life outcomes associated with childhood maltreatment was evident in all the interviews conducted regardless of gender or ethnicity. The interviewees did not view mental health challenges as separate from their childhood experiences of maltreatment and family harm perpetration. Instead, regarded adult adverse trauma reactions

and mental health issues as interconnected with all aspects of their lives, as reflected in the following quote from Pearl.

> *"All things that happen in your childhood do play out and affect you later on and in all experiences." Pearl*

Each of the men and women interviewed had been involved with multiple governmental and social services, such as justice services and trauma-focused therapy. Everybody interviewed talked about having significant challenges with mental health issues that would have met clinically relevant thresholds and described instances of wanting to end their life or self-injurious behaviors. However, only eight received formal mental health support but they still experienced considerable barriers to accessing and meaningful engagement with services. In addition, six of the men and seven of the women described having issues relating to substance use issues, most notably alcohol misuse. Seven of the people interviewed had served prison sentences. At the time of the interview, all but two women were formally engaged in trauma-focused therapy (either individually or group). The people interviewed were aged between 25 to 65 years, and all the interviews were conducted between 2018-2019.

The following sections outline the complex interconnections between adverse trauma reactions stemming from childhood maltreatment, including mental health, suicidal thoughts, self-harm, alcohol and substance use, and the perpetration of family harm.

Mental health

The men and women described intermittent periods during adulthood where they struggled with various mental health issues. Living in unpredictable and violent homes as children was associated with feelings of constant fear and hypervigilance and contributed to a generalized

sense of worry, fear, and distrust of people's motives. In retrospect, interviewees identified experiencing intense feelings of depression characterized by low mood and a sense of hopelessness. The intensity of their psychological distress was often minimized or missed entirely by the people in their lives. For example, Opal was having very regular and intense times of wanting to die but hid her desire, like she hid the abuse that was taking place at home.

> *"Definitely, like I would act so happy so nobody ever would know um like laughing, smiling during the day I guess for my friends, but on the inside, I was always like, not good, and like, was real suicidal and just and especially at home." Opal*

Opal's experience mirrored others who referred to hiding their innermost feelings. In addition, the psychological distress may have been hidden due to shaping and grooming from childhood experiences. For example, interviewees were also actively groomed to deny their emotional world and lie about what was happening to them. The following quote from Paul highlights how he felt he had to live between the two worlds of the outward image of a happy family and the reality of the violence at home.

> *"The picture everybody painted was that life was good right, you know like that we were just another normal family, and it was not." Paul*

Learning to hide the reality of life at home had long term consequences for Paul in his intimate relationships. He recalled times when family harm occurred as partners wanted him to talk about his feelings, and he would get angry and annoyed at this, responding in ways to stop them from trying to get behind the walls he had created.

> *"I met a counsellor once and she said to me….that I was still functioning on an emotional level as like an 18-year-old because that was kind of where **[life stopped]***

*in essence yeh, yeh kind of where life stopped and then I became kind of disconnected and so that was where everything just kind of took off from there [**family harm**] and I just locked everything else away and that's when the walls went up and stuff like that I guess." Paul*

Understandably it may take time for people to talk about the mental health struggles due to the silence about internal emotional states being reinforced during childhood. Opal was the youngest person interviewed, yet over her lifetime, received multiple diagnoses such as separation anxiety disorder, oppositional defiant disorder, recurrences of major depressive disorder and bipolar disorder.

*Opal: "[**as a child**] I was real clingy, very very very clingy and I'm pretty sure I had separation anxiety....at 12 or 13, I was really depressed….very internalized as well, looking back on it....I've been recently diagnosed with bipolar.*

Interviewer: What was that like? To get that diagnosis.

*Opal: Very validating because I had been trying so hard, like all year and lately I've just kept being so rejected and they were like trying to throw antidepressants at me and so much like rage towards that and so much anger towards the mental health system and even now I'm still mad at them….But it was very validating because I knew something was wrong for like a long time and um yeh it's nice to [**understand**]."*

What was interesting in Opal's case was that she was newly engaged in trauma-focused counselling and was beginning to explore how her experiences of childhood maltreatment interplayed with her emotional wellbeing. For example, at the time of the interview Opal's therapeutic team was exploring a diagnosis of PTSD with her as a more

holistic understanding of her experiences. Opal's experiences illustrate the complexity of mental health presentations and the limit of professionals' ease of understanding the complex interplay of mental health and adverse trauma reactions.

Struggling with emotions and thoughts was linked with challenges within social settings and in incidences of family harm. The following quote from Nikau highlights how the strong emotions resulting from childhood maltreatment were connected to aggression and violence in various contexts in later life.

> *"Well for me anyway, there's a lot of anger, there's a lot of anger in there and when I sometimes thought that sometimes letting that out not realizing that I've let it out, that other people have seen it [**childhood maltreatment**], like woah, far out that's ugly, it's ugly shit[**violence, family harm**], it's issues man you know what I mean?" Nikau*

Being hypervigilant to threats to themselves and others helped interviewees 'survive' their childhood environments but had an adverse effect in later life interpersonal relationships. The men and women interviewed described experiencing dissociation or mental and physical withdrawal from people which interviewees attributed to adverse trauma reactions. For example, they developed fantasy worlds as children that echoed throughout adulthood at times of stress. Additional strategies to escape unwanted emotions and thoughts about adverse childhood experiences included drug and alcohol use or focusing on crime or violence as a distraction from distressing thoughts and memories of childhood maltreatment.

Retrospectively, all the interviewees identified times of family harm when wanting to escape challenging feelings or memories that were triggered. For the people who had histories of childhood sexual abuse (15/16), the need to withdraw/escape before, during and after sexual contact to manage adverse trauma reactions at times was linked to incidences of

interpersonal harm. Indeed, memories of past traumatic events interrupted their sleep or led to nightmares. The issues with sleeping and emotional disturbances were linked by interviewees to memories of past trauma, resulting in cumulating distress and incidences of family harm.

Suicidal and self-harming thoughts and behaviors

Throughout the interviews, there was a strong sense of surprise by participants that they were still alive. Not just due to having survived the violence and neglect of their childhood, but the suicidal ideation (described by all) associated with the psychological distress attributed to the effects of childhood maltreatment that reverberated throughout adulthood. The following quote from Nikau illustrates the chronicity and severity of suicidal thoughts and behaviors linked to childhood maltreatment.

> *"A lot have gone through it [**childhood maltreatment**] and a lot of haven't survived it also, you know like last week a guy didn't survive it, you know he unfortunately he gave up, I felt like giving up last week, I'm happy I didn't. I was listening to my voice in my children." Nikau*

Although it had been decades since experiencing childhood maltreatment, Nikau still experienced suicidal ideation at times. This following quote from Manaia captured the significant mental health challenges that waxed and waned over the course of his life. Here Manaia summarises years of feeling like dying and his initial annoyance at the involvement of services when he made serious attempts to take his life.

> *"There's been quite a few a times when I very nearly didn't, you know I've [**attempted suicide**], a few times, um….or threatened to or got fuckin interrupted….there was those moments where, it is, it's just tiring you know." Manaia*

Interspersed between times of wanting to die were times of self-harming as a means of managing periods of intense emotions. The genesis of self-harm began in late childhood or adolescence. For example, Adam recalled beginning to self-harm as a child in response to feelings of anger and isolation after he was sexually and physically abused in state-run care.

> *"I used to cut a lot and so you know and then you wonder why you grew up so fucked, so you go home to a fucked home environment you know it's like yeh absolutely, hey listen our social welfare homes were just fuckin pits of fuckin abuse, and they were honestly, they were just it's like no boys, no choice." Adam*

There was also an element of risk-taking, using fighting and injury to self-harm and potentially a way of increasing the chances of dying. For example, Aroha recalled taking risks with her physical safety and provoking people and situations that may hurt or kill her.

> *Aroha: "I used to do really high-risk taking behaviors, I used to jump off a lot of things, in front of a lot things….*
>
> *Interviewer: Were you Russian rouletting in some ways?*
>
> *Aroha: Yeh yeh definitely, I used to get into a lot of street fights or challenge people twice my size."*

The responses above highlight a complex interplay between ongoing effects of childhood maltreatment experiences, suicidal and self-harming thoughts and behaviors and family harm perpetration.

Alcohol and substance use

Alcohol and substances were discussed as part of a coping strategy for living with childhood maltreatment's long-term consequences. Alcohol and substances served many purposes, including avoiding difficult recollections of childhood maltreatment and avoiding associated

psychological distress. The following quotes illustrate the links made between substance use childhood maltreatment beginning during the use through to adulthood.

"I grew up on drugs….that was my escape, unfortunately." Adam

"It was a way of burying my pain and trying to cope with my broken life, yeh it was easier to get drunk than to face it, yeh and I didn't want to deal with it anyway cause it hurt too much." Candice

Interviewees talked about using alcohol or substances to help them fall and stay asleep at some point in their life. However, this developed into more serious substance use over time as illustrated in the following quote from Dean regarding nightmares and intrusive thoughts about childhood sexual abuse.

"Through my twenties, cannabis to sleep, I had quite a bit of cannabis…. When meth hit, I never ever smoked meth, but I snorted and speedball, like kilos of the shit because of the euphoric high that it used to give you, and you felt bulletproof on the stuff….but cannabis was the tool to sleep." Dean

For Dean, feeling bulletproof was linked to an extreme desire to present as strong and tough, so no other man would ever hurt him like the man that sexually abused him as a child. For Brian, substance use was associated with feeling happy, which evaded him when not using.

*"For me, it was, I mean, I was happy I was just happy, I was fuckin high as a kite (laugh) I could walk around and not feel the stigma or the shame of what had happened [**a reference to childhood sexual abuse**] and not think about it." Brian*

The interviewees often linked aggression and family harm with mental health, alcohol consumption, and substances as evident in the previous quotes. However, it is important to

note that once people developed an understanding of the interconnected nature of adverse effects of childhood maltreatment, they could make sense of their experiences and move towards psychological health and wellbeing. For example, there is hope proffered in the words of Brian, that when he found support that allowed him to talk about all areas of his life, he found the help and support he had been looking for since childhood.

> *"I was at a point in my life where I was drug-dependent, and I had nothing going for my life [**referring to suicidal ideation**] and once I went to the counselling sessions, it gave me a lot of tools to empower me, and a lot of my problems was that because I had been sexually abused [**as a child**]." Brian*

In summary, the men and women interviewed were seen by multiple governmental and social services over their lifetimes. However, an integrated and trauma-informed response was missing regarding access and engagement to therapeutic services. The lack of easily accessible and amalgamated services is a worrying gap given the range and severity of the adverse trauma reactions associated with the cycle of family harm outlined in this study.

Discussion

Increasingly research is investigating the influence of multiple factors on the intergenerational transmission of trauma and violence (Dixon & Graham-Kevan, 2011; Widom, Czaja, & Dutton, 2014). However, previous research focused on the pathways between adverse childhood events and either IPV or abuse towards children (LaMotte, 2018; Richards, Tillyer, & Wright, 2017). Nevertheless, this study demonstrates the complex interaction between trauma and mental health challenges evident both at times of IPV and family harm. Ultimately, services need to acknowledge and accommodate the contribution of

mental health and trauma in maintaining the cycle of family harm. Therefore, the significant implication of this study is the need for people to access a suite of opportunities to engage in therapy to address the multiple adverse life outcomes associated with the cycle of family harm.

The participants reported that navigating entry criteria and interagency rules and divisions when living with ongoing adverse trauma reactions was a major barrier to access and meaningful engagement with services. The narratives provided by Adam, Nikau, Aroha and Candace put into words the underlying emotions and often misunderstood expressions of distress and trauma. Yet only eight of the people interviewed were seen by a mental health professional in their lifetime, reflecting unmet treatment needs. These findings resonate with those of Indig et al. (2016) that found that just under half of the prisoners with mental health diagnoses met with a mental health professional. No variance was evident when gender and ethnicity were considered in the current study, suggesting systemic issues with access and engagement with mental health professionals. A childhood where abuse was not noticed or effectively stopped can result in trust issues that could make advocating for one's rights to service a considerable obstacle. Traditional models of care at times appeared to mirror the chaos and lack of communication of the environments the people interviewed lived in as children. Therefore, the findings of this study highlight the importance of streamlining trauma-informed services to accommodate the diverse treatment needs of people living with the consequences of the cycle of family harm.

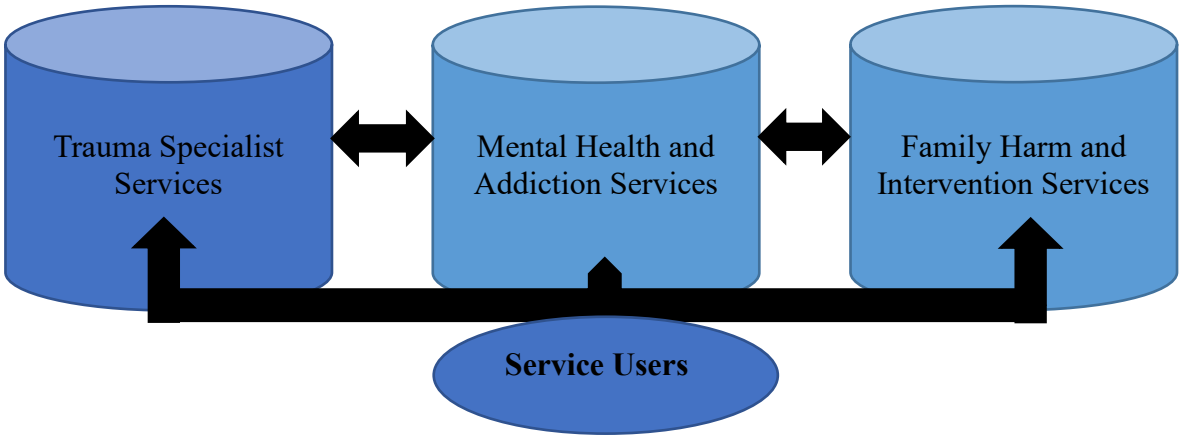
One of the major implications of this study is the need to purposefully develop services to meet the needs of Māori given the existing difficulties in equity of access to health care. Wrap-around models of care are a well-proven approach for service delivery, especially

when input from multiple services is required (VanDen Berg, 2008). However, they are often not designed in culturally responsive ways or in collaboration with Indigenous communities (Day, Davey, Wanganeen, Casey, Howells, & Nakata, 2008; Tapsell, 2017; Willmon-Haque & Bigfoot, 2008). In support of the call for Indigenous-informed service development and provision, the Māori men and women interviewed in this study did not have positive experiences in terms of access and engagement with mental health services. Therefore, the findings of this study underscore the need for Indigenous partnerships in all aspects of service provision to increase responsivity and engagement. Firstly, it is vital to embed partnerships with Indigenous providers throughout mental health and family harm intervention services (Ministry of Health, 2021a). Secondly, through active commissioning and resourcing of services run for and by Indigenous peoples such as the newly established Māori Health Authority in New Zealand (Ministry of Health, 2021b). Of course, this recommendation echoes calls for the review and improvement of systems for all Indigenous peoples worldwide.

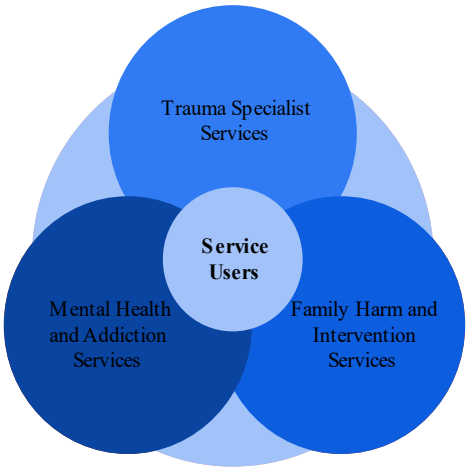
The findings of this study highlight the need for care reflexive models of care that can meet the multiple treatment needs as they pertain to the cycle of family harm. Figure 1 outlines an integrated model of care instead of siloed models for people with histories of childhood maltreatment, family harm, and mental health and addiction issues. Placing the service user at the centre and packaging supports around them is highly recommended, instead of siloed models that require navigation within and between specialist services. An essential aspect of this model of care is that services adjust models and therapeutic strategies to meet the needs of service users. Implementation of any framework should be infused with Indigenous health care models, and partner with services run for and by Indigenous people.

Figure 1: Integrated rather than a siloed model of care for people with histories of childhood maltreatment, family harm perpetration, mental health, and addiction issues.

Traditional siloed model of care requiring service users to navigation between and within systems



Integrated model of care where systems wrap around servicer users



One of the critical implications of this research is the urgent need for integrated models of care deft at accommodating and responding to the complex and interconnected needs of people living with the intergenerational effects of trauma and violence. Reliance on psychiatric diagnosis to help guide administrative decisions regarding funding and access to services does not meet the complex needs. One way to achieve this is for specialist services to adopt approaches that favor conceptualizations of issues that incorporate social-relational and cultural matters, such as those outlined in the Power Meaning Framework (Johnstone, 2020). Helping people make meaning of life experiences and general patterns associated with adverse trauma reactions can also help address mental health and interpersonal reactions (Johnstone & Boyle et al., 2018). Currently there is a wellspring of Indigenous integrated service provision models that are not based on diagnosis rather centred on intergenerational wellbeing through a return to cultural knowledge and practices (Kopua, Kopua, & Levy, 2021; McLachlan, Waitoki, Harris, & Jones, 2021). Many of the people interviewed described considerably emotional difficulties. Thus, a transdiagnostic approach for emotional disorders, such as Barlow et al. (2010) proposed, might be more beneficial than models of care based on a set diagnosis. Indigenous health care models are inherently holistic and do not focus on diagnosis, thus providing future research into practice and policy development and implementation. Livesleys' (2012) integrated treatment approaches for Personality Disorders provides a solid foundation to build models of care to address the heterogeneity of challenges experienced across time as outlined in this study. For example, this model allows for treatment approaches to be reflexively called upon to meet the changing needs of people who experience chronic and various challenges over time. Using the experiences outlined in this study, more acute interventions that manage suicide and self-harming presentations could

be adopted when needed. Then, there could be pathways of either trauma focused interventions, mental health and addictions, or family harm perpetration interventions.

This research provides a snapshot in time of the experiences of 16 Māori and non-Māori men and women in New Zealand and subsequent recommendations for service provision. Ultimately, the findings demonstrate that people of all genders and ethnicities experience intergenerational trauma and violence. Further research that fosters a better understanding of the relationship between childhood maltreatment and family harm is required to guide therapeutic interventions that match the needs of the people affected. For example, researching the types and timing of interventions for people living with adverse childhood maltreatment and family harm. In addition, ongoing research into Indigenous-informed and led approaches to address the intergenerational transmission of trauma and violence is highly recommended. Given the extent of the complexity of the presenting issues evident in this study, a valuable area of future research would be into the appropriateness of providing trauma-focused therapy alongside family harm and mental health and addiction services. Interestingly, the analysis of the interview content did not reveal substantive gender differences. One hypothesis for the lack of gender differences may be that the impact of chronic and diverse experiences of childhood maltreatment results in similar challenges that outweigh gender differences. Hence, exploring the consequences of poly-victimization is an important area of future research when investigating the relationship between childhood maltreatment and family harm perpetration for all genders.

The reported findings signal how the interviewees made sense of their experiences at the time of interviewing and represent a subgroup of people who perpetrate family harm and may not reflect the experience of others. However, interviewees had received trauma-based

therapy at some point and have had time to reflect on their journey and think about the links between childhood and adult experiences. An exciting area of further research would be to employ a longitudinal study design to follow the ongoing experiences of people from earlier points in terms of challenges and progress towards healing and wellbeing. Future research regarding populations not engaged in therapeutic support would add to our understanding of the process of the cycle of family harm. This study emphasizes the importance of including the voice of people with lived experience in research. For example, Opal eloquently described the benefit she found for having multiple people helping her on her healing journey in an integrated manner. Consequently, programme and service development and evaluation addressing the consequences of family harm should build in consumer feedback.

In conclusion, the findings of this study highlight the interconnected nature of ongoing adverse life outcomes as part of the pathway from childhood maltreatment to family harm perpetration. The analysis revealed that interviewees did not separate lived experiences into distinct adverse outcomes, such as mental health and substance use challenges. The time for separating people based on presenting issues, to be dealt with by different siloes, has come to an end. These findings suggests that the problem does not lie with the individual rather the models of care that do not facilitate a flexible, responsive, and seamless treatment approach. Service providers and those responsible for commissioning services need to acknowledge the complexity of the pathways between childhood maltreatment and family harm. To this end, building a sustainable and erudite workforce capable of operating with the intricacies evident in the cycle of family harm is required. Through the development of integrated person-centred approaches, therapy can be adapted to meet the treatment needs of individuals and their families to address the intergenerational cycle of trauma and violence.

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Chapter 7: General Discussion

The overarching focus of this thesis was to explore the links between childhood maltreatment and family harm perpetration. The research also examined whether existing psychological theories reflect the experiences of Māori and non-Māori men and women in Aotearoa New Zealand. Challenges with emotions within relational contexts and times of psychological distress were associated with IPV and family harm incidences regardless of gender or ethnicity (Chapter 6). Across all studies, the interconnected pathways between childhood maltreatment and family harm perpetration were complex and interacted differently over time within and between individuals. This heterogeneity of presentation points to the need for multifactorial and contextual explanations to stop the intergenerational transmission of trauma and violence.

Chapter 6 revealed that all 16 interviewees described experiencing adverse trauma reactions that included mental health and addiction issues and periods of self-harming and suicidality. Family harm perpetration in adulthood was linked with limited opportunities in childhood to foster the ability to express and respond to emotions with others (Chapter 4). Experiencing multiple forms of childhood abuse over time, and by different perpetrators, was associated with more severe long-term adverse life outcomes in the overall sample. But the adverse life course trajectories were amplified for people removed from their family of origin and placed in non-kin settings where chronicity of the poly-victimisation and lack of adult support continued. The analysis presented in Chapter 5 highlighted the additional layers to the culture of silence surrounding experiences of childhood maltreatment when explored alongside non-Māori. The resultant cultural isolation robbed Māori of meaningful connection

to social supports and sense of intergenerational purpose and connection. However, reconnection to Indigenous knowledge and practices were pivotal in fostering intergenerational transmission of hope and wellbeing.

It was clear that the interviewees conceptualised their lived experience as an interrelated matrix where multiple adverse outcomes of childhood maltreatment contributed in different ways over their lifetime to instances of family harm. At various points mainstream psychological theories had merit in explaining the cycle of family harm. For example, akin to the cognitive and schema theories outlined in Chapter 1, interviewees talked about the childhood belief that people could not be trusted and an amplified need to protect oneself from being hurt and interfering with later intimate and familial relationships. Likewise, social learning and behavioural theories had utility in explaining the repetition of interpersonal violence for the people who experienced poly-victimisation especially noticeable for the people in state care. However, in line with the critiques of the theories outlined in Chapter 2, all of the studies identified social-cultural and contextual factors beyond individual pathways emphasised in traditional theories (Brave Heart & DeBruyn, 1998; Campbell & Evans-Campbell, 2011; Kramer & Bowman, 2018; Pihama et al., 2014; Teo, 2018; Rhodes & Langtiw, 2018; Willmon-Hague & BigFoot, 2008). The way forward is to embed theoretical understandings and the resultant practical application with feedback informed practice in collaboration families and communities. Accordingly, it is incumbent on the psychologists collectively to evolve theoretical understandings of the intergenerational transmission of trauma and violence that are culturally and gender sensitive.

The long term adverse intergenerational impacts of colonisation, and systemic bias outlined by Indigenous scholars over the last couple of decades were evident in the interview content of the Māori men and women interviewed (Brave Heart & DeBruyn, 1998; Drywater-Whitekiller, 2014; Pihama, Reynolds, Smith, Reid, Smith, & Te Nana, 2014; Wirihana, 2014). The active silencing of the childhood experiences of abuse and neglect led to cultural isolation that amplified the sense of loneliness and silencing when Māori interviewees were placed away from whānau (Chapter 5). Mainstream psychological theories regarding the cycle of family harm do not actively incorporate the relationship of the external factors associated with colonisation with the intergenerational transmission of trauma and violence (Cavino, 2016; Drywater-Whitekiller, 2014; Ruwhiu, Ashby, Eruiti, Halliday, Horne, & Paikea, 2009). While multifactorial models acknowledge social-cultural factors, such as the World Health Alliance Model of Violence (2017), these do not expressly incorporate Indigenous perspectives. Māori interviewees were clear that reconnecting to Indigenous practices and knowledge helped facilitate healing from the harm caused by childhood experiences of maltreatment and family harm (Chapters 4 and 5). Henceforth, what is required is a broadening of the view of psychological theories of intergenerational trauma and violence to account for the historical trauma of colonisation and its long tail of enduring adverse consequences for Indigenous communities. For instance, SLTs and multifactorial models can easily incorporate the adverse impacts of historical trauma when explaining current permutations of the cycle of family harm (Bartholomew, Cobb, & Dutton, 2015; Bell & Naugle, 2008; World Health Organization; 2017). Cognitive and schema theories do not need to solely focus on thoughts and beliefs of an individual but have the plasticity to include intergenerational beliefs born from historical grief and loss (Young, Klosko, & Weishaar,

2003). Therefore, it is not the theories in and of themselves that are problematic it is the myopia of the people that use them that needs to be addressed.

Attachment theories are often used to explain the relationship between childhood maltreatment and family harm perpetration (Alink et al., 2012; Crittenden & Ainsworth, 1989; Dutton, 1995; Hildyard & Wolf, 2002; Streeck-Fischer & van der Kolk, 2000; Schofield & Beek, 2005). However, traditional attachment theories focus on dyadic or child and primary caregiver disruptions to the attachment. Nevertheless, for Indigenous peoples, the loss of attachments to land, ancestors, cultural knowledge, and identity are all devastating losses that disrupt essential social bonds and connections (Aboriginal Children in Care Working Group, 2015; Cavino, 2016; Cram, Gulliver, Ota & Wilson, 2015; Pihama, 2014; Ruwhiu, et al., 2009). The importance of cultural attachment is beautifully captured in the importance of reconnection with land, spirituality and knowledge highlighted in the healing journeys presented in Chapter 5. Therefore, a key implication of this thesis is the need to draw upon kaupapa Māori models of health and wellbeing that encapsulate broader definitions of attachment such as with forbearers, Hā a Koro Mā, a kui Mā (Pere, 2017) and spiritual and faith-based figures, Waiuratanga (Valentine, Tassell-Mataamua, & Flett, 2017). In doing so, traditional attachment theories can be adapted and evolved to broaden what is considered attachment to reflect the reality of Indigenous people's experiences.

As outlined in Chapter 1, issues with emotion regulation have been linked to IPV and family harm and tend to focus on the individual ability to manage their internal emotional world (Chang et al., 2018; Hurren, Stewart, & Dennison, 2017; Riggs, 2010; Young & Widom, 2014). One aspect of this is the importance of expressing and responding to emotions

when interacting with others (Chapter 4). Hence, a childhood bereft of healthy emotional interactions with others was a core contributor to instances of family harm. In short, the findings of this thesis that the relational context within healthy relationships grows and develops, or violence occurs, which is often missing from existing psychological theories (Van Der Merwe & Wetherell, 2020). Whereas Indigenous psychological understandings of the world prioritise the interconnectedness of individuals, whānau and communities, which in turn is deemed integral to models of health and wellbeing (Durie, 1994, 2001; Nikora, Levy, Masters & Waitoki, 2006; Levy, 2016; Pere, 1984; Pihama, et al., 2014; Pitama et al., 2007; Superu, 2016; 2017; Willmon-Haque & Bigfoot, 2008). Thus, the collective understanding of how we can support familial wellbeing has been negatively impacted by a focus on mainstream theories at the cost of underutilising well established Indigenous psychologies (Bennett, 2017; McNeill, 2009; Muriwai, Houkamau, & Sibley, 2015; Teo, 2018; Teo & Wendt, 2020). Going forward, we must undertake research that encapsulates multiple perspectives and cultural understandings of human experience to truly seek to understand how to stop the intergenerational transmission of trauma and violence.

Interviewees were motivated to participate in this research out of a desire to help stop the maltreatment of future generations and provide guidance on ways to break the cycle of intergenerational harm (Chapters 4 and 5). Their positions were indicative of an altruistic motivation that was purposeful and represented a commitment to growth and development. This is in stark contrast to the way children who experience maltreatment and adults who perpetrate family harm are often positioned in research and theory development (Scarry, 1985; Hlavka, 2019; Ruwhiu et al., 2009). For example, the analysis showed childhood acts of empathy and emotionally responsive relationships with siblings and friends challenging

the narrowed explanation of the cycle of family harm to the lack of adult attachment and positive social and emotional skills (Callaghan et al., 2016). People who experience abuse and neglect in childhood also experience the range of human emotions and relationships and consequently should not be reduced to narratives of victimhood. Someone who harms family members is not just a perpetrator but someone who is also trying to resist generational patterns to the best of their ability and in accordance with the help and resources available. Consequently, psychological theories regarding the interactions between childhood maltreatment and family harm perpetration need to move beyond a victim-perpetrator lens to a more holistic and relational view of the lived experience.

Chapter 2 highlighted the increasing research into the differences and similarities for men and women in what in terms of contributing factors relating to IPV and family harm, which in turn is challenging theoretical understandings and guiding service delivery (Bowen, 2011; Bevan, 2015; Dixon & Graham-Kevan, 2011; Morash et al., 2018; Stilth et al., 2000; Widom et al., 2014). Interestingly, the analysis found that both men and women broadly described a similar relationship between childhood experiences of maltreatment and family harm perpetration. The main gender difference was evident in how adults and professionals responded to interviewees disclosure of childhood maltreatment, especially when it came to sexual abuse. Specifically, professionals did not offer boys and men support or referral to specialist trauma services the men felt may have helped them stop the intergenerational transmission of trauma and violence. For the men, this added a layer of invalidation of their experiences as children added to a sense of isolation, shame, and stigma frequently highlighted in the literature regarding male childhood sexual abuse (Dorahy & Clearwater, 2012; Easton, 2014). This raises the question of whether researchers exploring the link

between childhood maltreatment and family harm examine the experiences of men and women in a way that allows space for men to explore the impacts of trauma and women family harm perpetration. The gender bias evident in the findings of this thesis may have permeated through research into the theories that explain the cycle of family harm, leaving boys and men's abuse underexamined and underacknowledged (Kramer & Brett, 2021; Weiss, 2010). A key goal of theories is to inform practice; therefore, if we want to protect boys and girls and men and women from family harm, we need to develop gender-inclusive theories. Henceforth, it is important to include men and women in research regarding the cycle of family harm and exploration of the relevance of existing theories, as done in this thesis. Until we include all genders in research of this nature, we cannot conclude whether theories are relevant for different genders or in different contexts.

In summary, one of the major recommendations of this thesis is that we keep investigating the phenomenon of the cycle of family harm for us to understand the diversity and heterogeneity of the relationship between childhood maltreatment and family harm perpetration. To this end, we need to ensure we consider all communities, cultures, and genders alike to expand our understanding to stop future generations from repeating the cycle of family harm. The need to continue exploring the influence of multiple factors on the intergenerational transmission of trauma and violence is in line with academic scholars and clinicians worldwide (Braga et al., 2017; Callaghan et al., 2016; Dixon & Graham-Kevan, 2011; Goddard & Pooley, 2018; Farrington et al., 2017; Kimber et al., 2018; Kong et al., 2016; LaMotte et al., 2018; Malvaso et al., 2017; Voith et al., 2018; Widom et al., 2014; Widom, 2017). Ultimately, a better understanding of the childhood maltreatment-family harm link will guide the development of targeted individual and group interventions to address the

long-term effects of child abuse in family harm intervention programmes. The next section of this chapter explores the practical implications of the findings of the three studies that make up the body of findings in this thesis.

Practical Implications

Implications for children and young people who experience maltreatment

This section outlines implications for all children with maltreatment experiences and hones into specific recommendations for children and young people in care settings with specific supports for nurturing Indigenous children. Chapter 4 outlined key intervention points for children, adolescents, and adults to interrupt the cycle of family harm. The overarching implication across the life span is the need to imbue all interventions with opportunities to foster an understanding of the role of emotions within relational contexts.

The people who participated in this thesis did not experience one-off experiences of abuse but multiple experiences of abuse that included multiple forms of abuse by multiple perpetrators. In line with previous research investigating the complex impacts of ACES, the cumulative effects of poly-victimisation added to the sense of isolation and loneliness (Baglicio & Eeps, 2016; Boppre & Boyer, 2021). Therefore, a major recommendation is for therapy for children and young people who experience abuse and neglect to focus on emotional expression in relational contexts alongside existing trauma therapy models such as trauma-informed cognitive behavioural therapies for children and adolescents and attachment therapies. Although an important word of caution, for people who were removed from

biological parents and placed in care, focusing on this attachment may not be helpful but rather act as a reminder of the absence of this and increase resistance to therapy.

Another implication was that children and young people with maltreatment experiences must be offered support to engage in developmentally appropriate social activities to allow space for social-emotional skills to develop and thrive (Chapter 4). For example, peer support or youth worker facilitated engagement to help foster positive interpersonal relationships with peers (Gardner, Burk, & Montes, 2020). Not only does this address feelings of isolation, but it ensures access to the essential learning and development opportunities, friendships and group participation in team sports and cultural activities afford. To stop the intergenerational transmission of trauma and violence in relational contexts, we need to prioritise friendship development because friendships are the core foundational elements of healthy emerging intimate relationships.

Adolescence was identified as a key transition point given emerging sexuality and the establishment of intimate relationships (Chapter 4). Thus, the practical implication is the need for therapeutic support for youth with maltreatment histories to navigate the added landscape of emotional experiences within the context of how to navigate intimate relationships and sexuality. For instance, bringing to the foreground relational emotionality in youth dating and violence prevention programmes to stop later intimate partner violence by fostering healthy relationship patterns (Wolfe & Temple, 2018). A return to trauma-focused therapy should be offered at this point also to help youth make sense of their present reactions to intimacy and sexuality in the context of past maltreatment. It will be essential to infuse such therapies with Indigenous knowledge and practices regarding healthy relationships. Ultimately, fostering

children and young people's ability to understand their emotions will help their current situations and emotional wellbeing and improve later intimate relationships.

Ongoing training and development opportunities in responding to disclosures and supporting children after disclosures are essential. Training regarding trauma informed ways of working is vital to help the families/caregivers understand the behavioural and emotional challenges as part of adverse trauma reactions and thus be responded to accordingly (Johnstone & Boyle, 2019; Harper & Cromby, 2020; Van Wert et al., 2017). However, all such training needs to be employed universally and in an ongoing manner to act as reminders and ensure new staff are informed, and knowledge does not dissipate over time. These implications are important for all children and young people, the following section focuses on specific implications for when removed from families of origin.

Implications for practice and policy regarding children and young people placed in the care of the state

For the interviewees in this research, being placed in the care of the state resulted in additional experiences of abuse and neglect that far exceeded previous experiences in terms of chronicity and severity. Henceforth, professionals involved in the care and protection of children removed from their family of origin must provide the highest level of care in alignment (Aboriginal Children in Care Working Group, 2015; Royal Commission into Institutional Responses to Child Sexual Abuse, 2017; The New Zealand Government, 2018b). Children placed in care should be offered the opportunity to engage in therapy to help them process and make sense of their childhood maltreatment experiences and adapt to their new safe living environments. Ultimately, the goal would be that learning to express and process

emotions with others from a young age will disrupt patterns that contribute to family violence incidents later in life.

Removing Indigenous children from family networks can result in many adverse consequences that reverberate through generations, such as loss of cultural knowledge, identity and relationships with people and places (Aboriginal Children in Care Working Group, 2015; Office of the Children's Commissioner, 2019). The Māori men and women interviewed in this thesis articulated the devasting effects of loss of cultural connectedness and the subsequent cultural isolation when in the care of the state. Alternatively, reconnection to cultural beliefs and healing practices were identified as crucial contributors to stopping the cycle of family harm. Therefore, it is essential that every effort is made to continue to keep cultural connections in take for children placed in care. Currently, several strategic level changes are in the pipeline to redress harmful practices in Aotearoa for tamariki Māori in the care of the state (Office of the Children's Commissioner, 2020). Indigenous cultural identity and connectedness must be prioritised for children placed care as outlined in reports produced by The Office of the Commissioner for Children (2020) and The United Nations Declaration on the Rights of Indigenous People (United Nations, 2007). The principles of Te Ao Māori should be central to policy and service provision for tamariki Māori (Williams, Ruru, Irwin-Easthope, Quince & Gifford, 2019). Therefore, on a practical level, it will be necessary to provide external oversight of agencies charged with the care of children to ensure that the lack of oversight that led to the systemic abuse will never happen again.

Another important practical implication is the provision of regular trauma-informed support and training for caregivers to help manage any behavioural and emotional challenges

evident in the narratives outlined in Chapters 4, 5, and 6. By providing caregivers, social workers, psychologists, and teachers with the tools to help develop children's ability to express emotions and respond to the emotions of others endows the building blocks for health nonviolent interpersonal relationships later in life. In addition, trauma-informed therapeutic supports should be offered after each placement change to help adapt and adjust to new familial structures and ways of living. The role of people providing therapeutic support is also to monitor their ongoing psychological wellbeing and intervene and follow through with meaningful actions when further abuse is reported.

Family harm prevention and intervention initiatives

Relationships with intimate partners and family members evoke a broad range of human emotions. However, minimal experiences of the communication and expression of emotions within relational contexts as children were associated with ongoing interpersonal relationship issues and incidences of family harm perpetration. The findings outlined in Chapter 4 highlight the importance of helping people with histories of childhood maltreatment understand how to express and respond to emotions within relational contexts. Therefore, the significant implication of this thesis is that family harm prevention and intervention programmes must be infused with ongoing education and opportunities to practice and develop skills to communicate and respond to emotions within the contexts of familial relationships.

This thesis demonstrated that people are willing to talk about how they see past childhood experiences of maltreatment affecting current relationships. Perhaps it is professionals and clinicians' absence of following up this link that is something that holds

progress back (Kramer & Bowman, 2021). Thus, it is recommended that assessment and treatment processes must allow space for people to talk about and make sense of how their experiences of childhood maltreatment are affecting them currently. In addition, it will be essential for professionals working with people who have histories of being in the care of the state as children to provide space for people to explore how this experience was for them and how it affects them in the current intimate and familial relationships. Active engagement in exploring relationships between childhood maltreatment experiences and a person's perpetration of family harm would provide rich ground to help remediate some other emotional areas of neglect and build upon these in adult relationships. Therefore, people who have a history of family harm perpetration should not be reduced to being seen as receivers of therapy but as active participants and their healing with strong motivation and inspiration to make a difference for the next generations.

The findings described in Chapters 4 and 5 highlight the benefits of embedding Kaupapa Māori models into family harm prevention programmes as they expertly incorporate emotions within the relational contexts of whānau, hapu and iwi (Glover & Hirini, 2005; McLachlan, Waitoki, Harris, & Jones, 2021; Milne, 2005; Reid, Varona, Fisher, & Smith, 2016). Three key concepts were important to breaking the cycle of family harm: reconnection with Wairua, becoming a beacon of strength and support for self and others, Pou, and finding a sense of belonging and Tūrangawaewae (Chapter 5). Thus, initiatives aiming to stop the intergenerational transmission of trauma and violence would benefit from including these three concepts throughout course of therapy. These concepts will be particularly important to include in any support and therapy programmes for people who were removed from whānau as children given the lack of cultural and social connections inherent in engagement with

whānau, hapu and iwi when placed in non-in settings. Further remediating the loss of access to traditional knowledge and practices of collective childrearing already interrupted by the process of colonisation (Cavino, 2016; Drywater-Whitekiller, 2014; Ruwhiu et al., 2009; Mikaere, 1994). The findings of Chapters 4 and 5 demonstrate that any intervention to reduce the intergenerational transmission of violence for people who have been in state care must be provided with space to examine childrearing practices in care. For example, the work of Pihama et al. (2021) provides a framework for reconnecting people to traditional Māori and Hawaiian traditional nurturing and collective childrearing practices that would be valuable for parenting programmes.

The 'in care' experiences described were largely absent of care but characterised by chronic poly-victimisation. Boys and men felt invisible and were silenced when they tried to speak about their maltreatment experiences, which reduced access opportunities to break the intergenerational pattern of violence. Thus, the practical implication of these findings is that it is essential to talk with all genders about their experiences of childhood maltreatment. This means explicitly opening space for men to talk about experiences of childhood maltreatment and for women to talk about family harm perpetration. By not asking about and following up on boys'/men's accounts of childhood maltreatment, professionals working in this area potentially miss opportunities to understand how their childhood sexual abuse impacts them and their current relationships and patterns of family harm. By offering all genders trauma-related therapy, we can start to address some of the outlined inequities.

Integrated models of care for people with childhood experiences of maltreatment, family harm perpetration, mental health and addiction issues.

The findings outlined in Chapter 6 revealed the interconnected relationship between adverse trauma reactions stemming from childhood experiences, mental health and addiction issues, and family harm perpetration. Thus, integrated models of care are required to address the complex range of issues experienced by people living with the consequences of the cycle of family harm, including severe emotional and psychological distress, substance use, suicidality, and self-harming behaviours. Consequently, the major implication is the need for access to a suite of therapeutic options to accommodate the contribution of mental health and adverse trauma reactions in maintaining the cycle of family harm.

Wrap around models of care have been employed worldwide to address gaps in treatment provision and streamline services for over two decades (VanDen Berg, 2008). However, these are not developed and implemented to prioritise trauma, and Indigenous informed practices (Day, Davey, Wanganeen, Casey, Howells, & Nakata, 2008; Tapsell, 2017; Willmon-Haque & Bigfoot, 2008). Therefore, all professionals should be trained in trauma-informed principles and practice across family harm, mental health and addiction services and not just see trauma as a distinct issue to be managed by trauma specialists alone. In addition, models of care to address the adverse outcomes of childhood maltreatment must work in partnership with Indigenous peoples to ensure responsivity through active incorporation of traditional practices for intergenerational healing and wellbeing (Fox, Neha, & Jose, 2018; Ministry of Health, 2021a; Ruwhiu et al., 2009; Singer, Bennett-Levy, & Totumah, 2015; Tapsell, 2017). The findings reported in Chapters 5 and 6 also support the active resourcing and funding of services developed by and for Indigenous people, such as

currently beginning to occur through the Māori Health Authority in New Zealand (Ministry of Health, 2021b).

Focus is turning to redesign health and mental health services nationally and internationally in response to the systemic issues of access to timely and responsive care (New Zealand Government, 2018a; Singer et al., 2015; Yung, 2016). Entry to such services must be person and whānau centric and take responsibility for support with access to the appropriate treatment rather than require the individual to navigate the system, if not fight the system. One way would be to provide key workers that stay with the person and family through the process to facilitate the experience of accessing the care they need, whether it be mental health, drug and alcohol, trauma specialists or family harm prevention services. This recommendation aligns with the service model delivery being rolled out in Australia that centres on multidisciplinary adult mental health centres and satellites that privilege accessibility and a stepped care approach (Australia Government, 2021). Oversight and governance of integrated services is needed to focus on the needs of the service users and their families and ensure prompt seamless flow of access to appropriate services. It will be essential for services to be at minimum trauma-informed and, at best, include access to specialist family harm and child maltreatment prevention and specialist treatment services. Otherwise, we risk continuing the debilitating silencing of the emotional and psychological needs experienced by the people who participated in this thesis.

Another barrier to truly integrated models of care capable of dealing with the complex issues associated with the cycle of family harm is that funding models in mental health and addiction systems still rely on psychiatric diagnosis. Hence, a practical implication of Chapter 6 is employing models that can adapt to individual and family presenting needs that can

change and adapt over time. One model that could be employed as part of integrated services for people with complex presenting issues would be the Power Meaning Framework (Johnstone, 2020). The benefit of this model is that built into it is an ability to help address trauma, mental health, and interpersonal issues to reflect treatment need (Johnstone & Boyle et al., 2018). People with significant emotional disorders could consider approaching this from a transdiagnostic model such as proposed by Barlow et al. (2010). For more severe emotion dysregulation issues, Livesley's (2012) integrated treatment approaches for personality disorders are well placed to accommodate the heterogeneity of issues outlined throughout this thesis. Therefore, responsive integrated models of care exist, but the issue sits with access to treatment based especially when a psychiatric diagnosis is required before support can begin.

In summary, there is an urgent need for care models that cater to the complexity and interconnectedness of the challenges of the lived experience of the cycle of family harm. Transformative change will take leadership and bravery to counter the tendency to avoid setting out definite plans of change due to fear of adverse consequences if not perfect. We can avert this by building monitoring and adapting and evolving as the needs and workforce capacity reveal themselves in the fullness of time.

Strengths and Limitations

Understanding the internal processes behind the cycle of family harm is complex due to the unseen nature of psychological processes. The secrecy that often surrounds family harm within family systems and the societal culture of silence maintains the intergenerational transmission of trauma and violence. The strength of this research lies within the approach of

talking to adults and asking them to retrospectively reflect on how they make sense of the relationship between lived experiences of childhood maltreatment and family harm perpetration. The methodological approach of analysing retrospective accounts allowed for the passage of time to process past experiences and learn what helped address the adverse consequences of the cycle of family harm. In addition, interviewing people who had received or were still receiving trauma-focused therapy built on the therapeutic foundation of meaning-making of past through to current experiences. As illustrated in the findings of Chapter 6, this is a vulnerable population, and by having close contact with trauma-focused services, support was immediately available if the process of participating in this research increased risk to self or others. Thus, allowing the research to be safely conducted with a cohort of people who may otherwise not have their voices heard as often deemed too risky from a research perspective. The findings of this thesis provide important insights relevant to the contemporary issues at the forefront of the redesign of child services and mental health and addiction issues in Aotearoa New Zealand.

A limitation of the applicability of the findings of this research was the focus of the recruitment criteria to people involved in trauma specialist services. Therefore, further research is needed to explore the cycle of family harm for people who have not engaged in therapy or recruited from services focused on family harm prevention programmes. In addition, being placed in the care of the state or faith-based services was not a recruitment criterion, but findings suggest that further research with this population is needed to broaden the understanding of this link with the cycle of family harm. Neither was having mental health and addiction issues but given the prevalence of this reported in Chapter 6 and other related research conducting similar but targeted research of this group of people would be

beneficial. The findings regarding being removed from care reflect the experiences of 30-40 years ago, and it would be interesting to conduct similar research with younger people to explore the relationship in the current context.

Recommendations for Future Research

It is recommended that more researchers explore the link between childhood experiences of maltreatment and family harm perpetration from the lived experience of different groups of people to inform theory development. Research that accommodates the complexity and heterogeneity of living with the multiple adverse consequences of family harm allows for the development and implementation of programmes that meet treatment needs rather than require them to fit narrow models of care. Qualitative research allows for a deeper exploration of the key contributors and issues that quantitative demonstrate. In addition, qualitative research allows people to say what did and did not work in terms of changing the trajectory towards intergenerational hope and healing. By privileging the voice of people with lived experience in research and evaluation, we show that the people are not doomed to repeat family harm, instead they are active participants that researchers and programme providers need to include in the fight to stop the intergenerational patterns.

In the context of health and care and protection transformations in Aotearoa New Zealand, it is essential that the lived experience of people be utilised to inform the development, implementation and evaluation of initiatives going forward. In doing so, we do not replicate the culture of silence that permeated the interviewees' experiences in this thesis. Indigenous partnerships and leadership in research and service development are essential to

stop the intergenerational transmission of trauma and violence within family systems and systemically.

Further research is needed to explore the lived experience of younger and older Māori and non-Māori men and women. Widening the research parameters to include whānau and family members will broaden the perspectives regarding the pathways into and out of intergenerational trauma and violence. Conducting longitudinal studies that follow children and young people with childhood maltreatment experiences would provide valuable information into life course trajectories and away from repeating cycles of family harm and ongoing adverse trauma reactions. Such research could also help inform questions around gender similarities and differences and the role of poly-victimisation in the cycle of family harm.

The complex and interconnected relationship between family harm perpetration and childhood experiences of maltreatment, adverse trauma reactions, mental health and addiction issues, indicate that more research is required to inform how models of care and specialist services are deployed. This could include how to infuse family harm programmes with trauma-informed practice and the timing of engaging trauma and mental health specialist services. In addition, research is required into the value of transdiagnostic and integrated models for conceptualising and addressing the complex adverse trauma presentations and psychological distress for people with histories of childhood maltreatment and family harm perpetration.

Conclusions

This thesis provides a detailed examination of intergenerational transmission of trauma and violence for 16 people living in Aotearoa New Zealand. A unique contribution of this thesis was the use of purposive sampling to ensure an equal number of Māori and non-Māori men and women contributed perspectives on the cycle of family harm. Whilst each person's experiences were distinct, the overall relationship between childhood maltreatment and family harm perpetration was complex and interacted across time in different ways. Mainstream theories need to evolve to include the adverse impact of limited opportunities for emotional expression and responses within childhood's permeated with maltreatment on interpersonal relationships in family settings. Existing theories need to expand to incorporate contextual factors including in the ongoing adverse impact of colonisation on Indigenous peoples when examining intergenerational trauma and violence. Research must embrace multiple perspectives and Indigenous understandings of human psychology to explain and stop cycles of family harm. Families consist of all genders, and as such, the research needs to include the perspectives and experiences of all genders to truly investigate the pathways and interactions between childhood maltreatment and family harm perpetration.

The findings of this thesis have highlighted areas for improvement when it comes to care and protection services, family harm prevention and models of care for supporting the complex adverse outcomes associated with childhood maltreatment and family harm. Specifically, all people affected by childhood maltreatment and family harm should be offered trauma-focused therapy concentrating on emotions within interpersonal contexts to reduce further family harm perpetration. Family harm prevention and intervention services

should be developed with and by Indigenous peoples embedding Indigenous knowledge and practices. Finally, models of care must be responsive and reflexive according to the needs of the person and their family, adapting to suit the service user rather than requiring service users to navigate and fit siloed models of care.

In conclusion, we need to continue to work towards developing theoretical explanations of the intergenerational transmission of trauma and violence in culturally and gender sensitive ways. Whilst the lived experiences presented in this thesis shone a light on the devastating harm adults do to children; it also highlighted the power and hope in the words of the of the interviewees and the researchers who fight for change for the betterment of future generations. To this end, I will leave the last words of this chapter to Candace.

*"When you've got all that rubbish going around in your head, it's all negative. All you want to do is hurt yourself and that's sad aay. Because they're [**people affected by family harm**] beautiful people, it doesn't matter what walk of life they came from, they have a right to be respected and to be loved and accepted just for who they are." Candace*

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Appendix A: Copy of Article Published in The Practice: The New Zealand Corrections Journal

Development and implementation of trauma-informed training for women's corrections facilities in Aotearoa New Zealand

Kirsty Dempster-Rivett

Consultant Clinical Psychologist

Acknowledgments

The Trauma-Informed Training outlined in this article was collaboratively designed by: Kerry Consedine, Principal Practice Adviser – Office of The Chief Probation Officer; Bryony Jackson, Learning and Development Designer; Hannah McGlue, Principal Adviser Women's Strategy; and three clinical psychologists with expertise in trauma; Sonya Bakker, Kirsty Dempster-Rivett and Dr Jane Freeman-Brown.

Keywords: Department of Corrections Women's Strategy; Wahine – E rere ki te Pae Hou; Trauma-Informed Training for Women's Corrections Facilities.

Introduction

In 2017, the Department launched a four-year Women's Strategy, Wahine – E rere ki te Pae Hou. The Strategy acknowledges that the majority of women managed by the Department of Corrections have chronic histories of trauma as evidenced by recent research (Bevan, 2017; Indig, Gear & Wilhelm 2016). The overarching goal is to create environments where women feel safe and therefore can focus on the interventions and activities, they need to build offence free lives. This article summarises the one-day pilot training package that has been delivered to all women's prisons in Aotearoa New Zealand.

Trauma-informed practices have existed for some time in mental health services and more recently within care and protection spaces. However, it is a relatively new approach within correctional settings both nationally (McGlue, 2016) and internationally (Miller & Najavits, 2012; Benedict, 2014; Tam & Derkzen, 2014). The move towards trauma-informed care within the British Isles has been gaining momentum (Miller & Najavits, 2012). Hannah McGlue (personal communication, May 11, 2018) met with the Women's Strategy Team in the Scottish Prison Service and investigated how they have implemented trauma-informed practice. In summary, they provide day-long training for all staff and ongoing support to prison management teams. In America, a trauma-informed approach has been employed by The Rhode Island Department of Corrections Women's Facilities (Benedict, 2014). The data emerging from this project is promising and suggests significant improvement for both the women and staff. For example, between 2011 and 2012 there was a 62% drop in inmate on

staff assaults and a 54% drop in inmate on inmate assaults and a 60% drop in suicide attempts (Bissonette, 2013; as cited in Benedict, 2014).

Trauma effects can arise from a woman's personal experience and can be cumulative across generations. The ongoing effects of intergenerational and historical trauma are of particular relevance for indigenous populations (Pihama, et al., 2014). In response to the disproportionate representation of native Hawaiian women, the Women's Community Correctional Centre developed a Trauma Informed Care Initiative based on an indigenous concept of "pu'uhonua' – a place of refuge" (Patterson, Uchigakiuchi & Bissen, 2013). The guiding principle of this approach was to focus on creating a safe space that nurtures healing from a personal, family and community perspective.

For some, the concept of trauma-informed practice seems vague and hard to link to the everyday running of prison life. This is complicated by the fact that the term trauma is often used in everyday language to reflect a variety of experiences from a "traumatic staff meeting" to a "devastating earthquake". However, when it is broken down to its purest form, trauma-informed practice reflects the desire for staff to feel more confident in responding to people experiencing the ongoing effects of trauma, so the wellbeing and safety of all is improved. The trauma-informed practice values derived from the International Programmes outlined above provided the foundation of this training from start to finish. The similarity of these principles is closely linked to the Te Tokorima a Māui – Kaupapa Māori Values that are already part of Corrections language and practice (Table 1).

Table 1: Similarities between Trauma Informed Practice Principles and Te Tokorima a Māui – Kaupapa Māori Values

Trauma Informed Practice Principles	Te Tokorima a Māui –Kaupapa Māori Values
Safety: The activities and the physical settings ensure the physical, emotional and cultural safety of prisoners.	**Kaitiaki/Guardianship:** Care, protect, guardianship, following our practices and processes.
Trustworthiness: The activities and physical settings maximise trustworthiness through task clarity, consistency (over time and staff), transparency re expectations and processes, honesty, and interpersonal boundaries.	**Manaaki/Respect:** Care, respect, safety for all people.
Choice: The activities and physical settings maximise prisoner choice and control over factors that impact on them.	**Rangatira/Leadership**: Leadership, bringing people together.
Collaboration: The activities and physical settings maximise power-sharing and the participation of prisoners in decisions that impact on them.	**Wairua/Spirituality:** Anchors us to a point in time, helps connect us to others, links to resilience.
Empowerment: The activities and physical settings maximise prisoner autonomy and self-determination and support them building skills to achieve this.	**Whānau/Relationships:** Connectedness, family.

Core components of the Trauma Informed Practice Training Package

Becoming trauma-informed does not mean staff will be expected to "treat" trauma symptoms, but rather identify the ongoing effects and interrupt and de-escalate when they occur (based on the concept of psychological first aid). An early part of the training focused on introducing the difference between a traumatic event and ongoing trauma experiences. For example, being in a car accident is a traumatic event but it does not automatically mean a person will develop post traumatic stress disorder. However, symptoms of ongoing trauma reactions can be varied, including: unwanted and distressing memories of the trauma event, distressing dreams, and flashbacks where the individual feels as if the trauma event is recurring. Participants were encouraged to think about ways people attempt to cope with the

ongoing experience of trauma that can impair their ability to engage fully in everyday life. For example, people can go to lengths to avoid being reminded of an event or even the negative feelings associated with the event. These coping strategies do serve a function but can cause harm themselves, such as: using substances to reduce flashbacks, acting out to go to a secure unit to avoid being around people, self-harm to stop emotional pain, or zoning out of reality and missing important information.

The prison environment can readily trigger trauma-related responses in ways which can be confusing and difficult to manage for both the women and staff. Introducing a basic understanding of the brain's response to the threat was used to help explain the individual and varied trauma reactions (basic neuropsychology). The potential link between a woman's strong emotional reactions to a seemingly neutral situation was discussed in relation to the triggering of memories. Common prison procedures such as strip searches, double bunking, and night-time safety checks were presented as understandable times when women's trauma-responses might be triggered. Exposure to multiple events from a young age can have an adverse effect on the development of the areas of the brain responsible for emotional and behavioural regulation. Interpersonal challenges staff faced were discussed in the context of the ongoing negative impacts, such as social relationships, interactions with authority figures, and issues with attachment.

The section on historical trauma provided a launch-pad for staff to think about practical ways traditional Māori healing processes could be integrated into day-to-day life in prison. To develop a sense of what can be done, Wirihana's (2014) three key areas that promote healing

and wellbeing were introduced. Firstly, the use of traditional protective factors in the context of nurturing intergenerational family environments. Secondly, Māori methods of healing such as waiata, motoeatea, haka, and whakanoa. Thirdly, the use of traditional stories to support historical collective and individual trauma. The focus on what "can" be achieved despite the confines of prison regulations aimed to provide hope and a sense of empowerment for staff. Groups were encouraged to reflect on themes and practical activities that emerged and take these back to the managers and teams.

A fictional case study, based on common experiences of women in prison, was used to highlight how past traumatic events can impact on current emotions and behaviours. Staff were encouraged to think about how routine prison activities may trigger trauma responses (cell confinement, being handcuffed) and identify practical strategies that could be used to reduce the likelihood of subsequent trauma reactions (see Table 2 for examples).

Table 2: Examples of Practical Strategies that can be employed to enhance Trauma-Informed Practice.

Common Effects of Trauma/Potential Triggers in Prison Context	Trauma-Informed Strategies for Staff
Safety: women are often hyper-aware of possible danger. They may have a sense that all people are potentially dangerous or feeling trapped in confinement like they did when their abuse was occurring.	- Ask women what makes them feel unsafe and put measures in place where you can - Explain searching processes before they happen - Knock on doors before entering cells - Limit loud noises where you can.
Trust: women may have difficulty trusting others, even those who are trying to help them. This can stem from abuse from caregivers who they once trusted, or experiences of grooming where someone was initially kind but this resulted in abuse.	- Follow through on promises - Allow women to decide what personal information to disclose, and when - Discuss confidentiality with women – and when you do have to share what they tell you - Be patient as it may take time before they trust.
Choice: traumatic events often take away choice and if a choice is continued to be taken away women could withdraw.	- Provide opportunities for choice where you can, even if it is as simple as where they sit in a room - Provide women with programme options and let them choose what to do - Where there is no choice in a situation, explain why.
Collaboration: women who have suffered violence and abuse have usually been treated as "less" than others around them. This can lead to feelings of helplessness or defensiveness when told what to do.	- Ask for women's input on decisions about them – offender plans, parole reports - Remain calm during incidents, use a conversational tone - Seek input from a range of people that work with them.
Empowerment: women need skills to break away from their former lives, and should be encouraged to figure out what they can do for themselves (in prison and in the future).	- Refer to a woman's strengths when you can - Celebrate accomplishments as part of routine interactions with women - Ask women what they need, and provide it where you can.

The facilitators gave high priority to taking care of staff throughout the training due to the sensitive nature of the topic. The training ended with a section on staff welfare that ensured staff knew about additional options such as the Employee Assistance Programme, Welfare Officers, and peer support. Benefits of self-care were also discussed in terms of enhancing staff emotional resiliency so they can continue to react in a trauma-informed manner.

Summary

The overall goal of this training was to help staff understand that some of the more difficult behaviour displayed by women in prison could be explained as trauma survival behaviours. While it is not possible to remove all triggers from a prison environment, the ability to recognise when a woman has a trauma response and respond to it in a trauma-informed way can help de-escalate situations and teach emotion regulation skills. By taking a trauma-informed approach in the work with all women, we seek to avoid re-traumatisation and provide a safe space for them to focus on enhancing their wellbeing and reducing their chance of re-offending.

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Appendix B: Participant Information Sheet and Consent Form

Participant Information Sheet

Study title: **Childhood Maltreatment: Exploring the Mechanisms Behind the Link with Family Harm**

You are invited to take part in a study that explores the pathways that help explain why some people who have experienced childhood abuse go on to cause family harm. Whether or not you take part is your choice. If you don't want to take part, you don't have to give a reason, and it won't affect any support you receive from *<referring agency>*.

This sheet will help you decide if you'd like to take part. It sets out why we are doing the study, what your participation will involve and what will happen after the study ends. We will go through this information with you and answer any questions you may have. You do not have to decide today whether or not you will participate in this study. Before you decide you may want to talk about the study with other people, such as family, whānau, friends, or social service providers. Feel free to do this.

If you agree to take part in this study, you will be asked to sign the Consent Form on the last page of this document. You will be given a copy of both the Participant Information Sheet and the Consent Form to keep.

Who am I and what is the purpose of the study?

Kia ora, my name is Kirsty Dempster Rivett and right now I am a student at the University of Waikato working towards a Doctor of Philosophy. For the past 20 years, I have worked as a clinical psychologist helping youth/rangatahi who have experienced traumatic events in their childhood. Over this time, I have begun to wonder whether there is a theoretical framework that could help all of us better make sense of why some people who experience abuse during their childhood go on to cause harm in their own family/whānau.

Therefore, I have decided to go back to basics and talk with survivors about what ***they*** think are the pathways that link childhood experiences of abuse to family harm. The main goal of this research is to develop a theory to help identify these underlying pathways so we can all better understand how this happens and make changes.

You can choose to participate if

- You are over 25 years of age.
- During your childhood, you experienced one or more of the following forms of abuse: physical; sexual; psychological; neglect (emotional or physical).
- You have done harm to someone in your family or whānau.

What are the possible benefits of this study?

- By taking part in this research, you will help develop new ways of understanding and breaking the cycle of violence,
- The theory that evolves from this research will help us help other survivors so they can move forward.
- Your story will help us understand how to look after our children/tamariki who have experienced childhood maltreatment.
- You may also find it helpful to talk through these issues with me; often people who take part in this kind of research report that they found talking through their story was good for them.

What will my participation in the study involve?

If you volunteer for this study, we will meet together at <*referral agency*>., for up to one and a half hours depending on how much you have to say. You are more than welcome to bring along a support person. During the interview, I will ask you questions about your life. At any time, if you would like to have a break, or to end our time together, you just have to tell me. After you leave the interview, if you change your mind within 7 days, and want to not be in the study, you can just let me or your key worker know, and I will destroy your information.

I understand that what we are talking about is deeply personal and could be upsetting. So, I want you to know that you only need to share what you feel comfortable with, and you do not have to answer all my questions. To help you feel supported, I will let your key worker know the day and time we are meeting just in case you want to talk to them afterward.

What we talk about is confidential, unless I am worried that our time together has put you at risk of hurting yourself or someone else. If I am concerned, I will talk with you first about what we can do to reduce the likelihood of harm. If I am still worried, I may need to break confidentiality to talk with your key worker or someone from <*referral agency*> so we can work together to reduce your risk. I will also check in the following day to make sure you're okay and provide suggestions of additional support if needed.

At the end of your interview, I will offer you a voucher to say thank you for contributing your information to my research.

What happens after we meet together?

Your identity will be kept strictly confidential once we have met. I will give you a false name that I will use on all your information so it cannot be linked to you. The original documents for this research will be kept in a locked drawer in a locked room at the University of Waikato. Once the interview has been transcribed, I will send you a summary of the key issues and themes so you can make any comments or corrections you think are needed. You can choose how you would like to review the transcription (for example, via email, or mail, or by meeting me in person). Once you have approved this summary, it will become part of my research that I put together for a Doctorate of Psychology Degree. When I have completed this part of my research, I can offer you a summary of my findings which I expect should be available in the next 2 to 3 years.

I expect to share the overall findings of this research at workshops/conferences, in academic journal articles or book chapters. I am interviewing a number of people for this study. Please be reassured that you will not be identified by name in any information presented on this research in the future. It is possible that I may find something you have said to be particularly helpful and may want to use it as a direct quote. However, I will ask your permission to use a direct quote from you before I include it in any written work.

All documents and interview notes relating to you will be destroyed within 5 years after any scientific publications that come out of the study (the anonymized computer file with the numbers that were taken from your interview may be kept for longer but cannot be linked to you).

Who do I contact for more information or if I have concerns?

If you have any questions, concerns, or complaints about the study at any stage, you can contact:

Kirsty Dempster-Rivett, PhD candidate, The University of Waikato/Te *Whare* Wānanga *o* Waikato
Email: kld@students.waikato.ac.nz
Phone: 07 856 2889 or mobile 021 299 7839

OR

Chief PhD Supervisor: Professor Nicola Starkey – School of Psychology, The University of Waikato Te Whare Wānanga o Waikato
Email: nicola.starkey@waikato.ac.nz
Phone: 07 837 9230

This research project has been approved by the Human Research Ethics Committee of the University of Waikato under HREC#(Health)2018#56. Any questions about the ethical conduct of this research may be addressed to the Secretary of the Committee, email humanethics@waikato.ac.nz, postal address, University of Waikato, Te Whare Wānanga o Waikato, Private Bag 3105, Hamilton 3240.

Consent Form

The University of Waikato
Te Whare Wānanga o Waikato

Please tick to indicate your consent to the following	
I have read and had explained the Participant Information Sheet in a way I understand.	
I am satisfied with the answers I have been given regarding the research and know I can ask questions at any time.	
I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study up until 7 days after the interview.	
I understand that my information will be kept confidential unless there is a risk of serious harm towards me or others. I understand that I won't be named in any reports, presentations or publications arising from this research.	
I understand that Kirsty will want to check in with me the day after the interview.	
I wish to receive a summary of the results from the study.	Yes ☐ No ☐

Please send a copy of the interview transcript and/or the final summary of the research to the address below:

_____

Declaration by participant:

I hereby consent to take part in this study.

Participant's name: _____ Phone Number: _____

Signature: _____ Date: _____

Declaration by the researcher:

I have given a verbal explanation of the research project to the participant and have answered the participant's questions about it.
I believe that the participant understands the study and has given informed consent to participate.

Researcher's name: _____

Signature: _____ Date: _____

Appendix C: Information Sheet for Programme Providers,

Provider Approval to Host Research, & Flyer for Participants

Service Provider Information Sheet

Study title: **Childhood Maltreatment: Exploring the Mechanisms Behind the Link with Family Harm**

Who am I and what is the purpose of the study?

Kia ora, my name is Kirsty Dempster Rivett, and I am currently a student at the University of Waikato working towards a Doctor of Philosophy. For the past 20 years, I have worked as a clinical psychologist helping youth/rangatahi who have experienced traumatic events in their childhood. Over this time, I have begun to wonder whether there is a theoretical framework that could help all of us better make sense of why some people who experience abuse during their childhood go on to cause harm in their own family/whānau.

Therefore, I have decided to go back to basics and talk with survivors about what ***they*** think are the pathways that link childhood experiences of abuse to family harm. The main goal of this research to develop a theory to help identify these underlying mechanisms so we can all better understand how this happens and make changes.

Clients are eligible to participate if

- They over 25 years of age;
- During their childhood, they experienced one or more of the following forms of abuse: physical; sexual; psychological; neglect (emotional or physical);
- They have caused family harm (either self-reported or identified through the criminal justice system).

What are the possible benefits of this study?

- That their story will provide insight and wisdom we can take forward to help us all take care of our children/tamariki who have experienced childhood maltreatment;
- The lived experience of the people who take part in this research will help develop new ways of understanding and breaking the cycle of violence;
- That the theory that evolves from this research will help us help other survivors so they can move forward.

What will their participation in the study involve?

I would like to interview service users who have a history of childhood maltreatment and who have also perpetrated family harm. If they are willing to volunteer for this study, we will meet at <*referral agency*>. This should take no longer than an hour and a half. They are more than welcome to bring along a support person. If at any time they would like to have a break or end our time together just need to tell me. Your clients can decide that they do not want to participate in this research at any point up to 7 days after our interview by simply letting me, or their key worker know.

I understand that what we are talking about is deeply personal and could be upsetting. Therefore, throughout the interview process, I will reassure them that they only need to share what they feel comfortable with and do not have to answer all my questions.

To help them feel supported, I will let their key worker know the day and time we are meeting just in case they want to talk to them afterward. What we talk about is confidential, unless I am worried that our time together has put them at risk of hurting themselves or someone else. If I am concerned, I will talk about this with them first about what we can do to reduce the likelihood of harm. If I am still worried, I will need to break confidentiality to and talk with their key worker or someone else from <*referral agency*> so we can work together to reduce your risk. I will also check in the following day to make sure they're okay and provide suggestions of additional support if needed.

I will also be offering participants a voucher to thank them for their participation.

What happens if I am worried about my client's safety/wellbeing after the interview?

If you as service providers are worried about your client after our interview, please don't hesitate to call me. If I am not available my professional supervisor, Laurette Longman has agreed to be a backup support for you. She is a clinical psychologist that has been doing trauma work for nearly 20 years and runs an ACC accredited company. Alternatively, my chief PhD supervisor Devon Polaschek is also a Clinical Psychologist with over 20 years' experience and is happy to be another backup support person.

Laurette Longmann; Director/Clinical Psychologist
Triskele Assessment & Therapy Services Limited
Phone: 078383696 / 0276971686

What happens after I meet with your client?

Their identity will be kept strictly confidential once we have met. I will give them a false name that I will use on all your information so it cannot be linked to you. The original documents for this research will be kept in a locked drawer in a locked room at the University of Waikato.

Once the interview has been transcribed, I will send them a summary of the key issues and themes so they can make any comments or corrections they think are needed. They can choose how they would like to review the transcription (for example, via email or meeting me in person). Once they have approved this summary, it will become part of my research that I put together for a doctorate of psychology. When I have completed this part of my research, I will offer them a summary of my findings which I expect should be available in the next 2 to 3 years.

All documents and interview notes relating to your clients will be destroyed within 5 years after the end of this study (the anonymized computer file with the numbers that were taken from their interview may be kept for longer but cannot be linked to them).

I may also share the overall findings of this research at workshops/conferences, in academic journal articles or book chapters. Please be reassured that they will not be identified by name in any information presented on this research in the future.

How I will share my findings with you and how you can contribute

A feedback session will be offered on the premises of Male Survivors Trust Waikato with workers from the service providers that the participants were recruited from.

Who do I contact for more information or if I have concerns?

If you have any questions, concerns, or complaints about the study at any stage, you can contact:

Kirsty Dempster-Rivett, PhD candidate, The University of Waikato/Te Whare Wān*anga* o Waikato
Email: kld@students.waikato.ac.nz
Phone: 07 856 2889 or mobile 021 299 7839

OR

Chief PhD Supervisor: Professor Devon Polaschek – School of Psychology, The University of Waikato Te Whare Wānanga o Waikato
Email: devon.polaschek@waikato.ac.nz
Phone: 07 837 9230

This research project has been approved by the Human Research Ethics Committee of the University of Waikato under HREC#(Health)2018#56. Any questions about the ethical conduct of this research may be addressed to the Secretary of the Committee, email humanethics@waikato.ac.nz, postal address, University of Waikato, Te Whare Wānanga o Waikato, Private Bag 3105, Hamilton.

Provider Approval to Host Research

THE UNIVERSITY OF WAIKATO
Te Whare Wānanga o Waikato

Childhood Maltreatment: Exploring the Mechanisms Behind the Link with Family Harm

Approval Form for Service Providers

I have read the Information Sheet for Service Providers in this study and have had it explained to me. I understand what my agency is being asked to do in this study, including the following:

1) Inform eligible service users about the project
2) Allow Kirsty to contact and interview service users
3) Provide a room for interviews
4) Have agency staff members available to provide backup to Kirsty if a participant becomes distressed during the interview and/or may be at risk of harming themselves or another person.

□ My agency agrees to host this research project under the conditions set out in the Information Sheet for Programme Providers.

Name of Agency: _____

Name: _____

Role _____

Signed: _____

Date: _____

Flyer for Participants

THE UNIVERSITY OF WAIKATO
Te Whare Wānanga o Waikato

Research Project on the Link Between Childhood Abuse and Family Harm

The information we collect will help us understand how to better address the effects of child abuse and family harm.

How can you help?

I would like to interview you. The interview could take up to 1.5 hours.

I would like to ask you about your childhood abuse and how you see this linking to your current family relationships including causing family harm.

Participation in this study is 100% your choice and it will not affect anything about your contact with <*this agency*>.

If you are interested in being a part of this research, please talk to [*insert name of agency contact*], who will be happy to arrange a time for you to meet with me. After that you can decided whether you want to be part of the research. You are welcome to bring a support person if you want.

Kirsty Dempster-Rivett – Primary Researcher, University of Waikato

Email: kld@students.waikato.ac.nz

Appendix D: Initial Interview Protocol

INITIAL INTERVIEW PROTOCOL

Note, this is the initial interview protocol that will evolve and change according to the nature of Grounded Theory Research. Consequently, this will be amended as themes and areas of interest emerge over the course of the research.

1. *Introductions*
2. *Talk through the information sheet*
3. **Sign consent form**
4. *Turn on audio-recorder*
5. *Invite opening Karakia and/or use this whakatauki:*

Ma te korero ka movie, ma te mohio ka marama, ma te mareama ka matau, ma te matau ka ora te iwi

Through discussion we learn, through learning we are enlightened, through enlightenment we are empowered, through empowerment the wellbeing of the people is achieved.

6. *The broad summary of interview structure*: I have an idea of the areas I want to cover today but we are not limited to these because I am interested in what ***you*** think is relevant and important. You only need to tell me what you want, and you don't have to answer any questions that you do not feel comfortable with. I hope that by the end of our time together you have felt comfortable enough to share your insights and wisdom on child abuse and its link to family harm. At the end, I will bring us back to some of the things that I see as ***hope*** from what you have shared. This way we end our time together acknowledging the vulnerability and bravery in talking about past abuse but focusing on what we can do to make a difference. We can let your key worker know if you need extra awhi/support today.

Main areas to cover:

7. *Current situation/things that are going well and not so well:*
   Not limited to but including:
   - Employment;
   - Home life;
   - Hobbies.
8. *Do you see any link between how things are for you now and your experiences of child abuse?*
   Prompts:
   - Effects on forming and maintaining intimate relationships/friendships;
   - How you cope with stress/emotions;
   - How do you think others perceive you;
   - Identity (concepts of masculine identity/culture);
   - Any particular event/trauma that stands out as a link with family harm and or emotional struggles.

9. *Links between perpetration of family harm and childhood abuse.*
   Prompts
   - What, if anything, about your upbringing, do you think is relevant to your family violence perpetration?
   - Have you ever been a victim of family violence? How do you think this impacts your relationship with your current partner/children?
   - Do you think historical trauma/intergenerational violence has had an effect on you and your family?
10. *When people look back over their life they can identify when they started to go down a path towards not so good behaviors/coping styles. For example, the people they started hanging out with as teenagers? Can you identify times like this?*
    Prompts:
    - Placement changes;
    - Difficulties at school;
    - Peer group;
    - Engagement in not so good coping strategies such as alcohol/anger;
    - The way they thought about their future;
    - Feelings of hopelessness/sadness/anxiety.
11. *When you look back over your childhood and teenage years, what do you think you or others could have done differently to stop you moving on to causing family harm?*
    Prompts:
    - Looking for ways they thought, felt and behaved;
    - Professionals/whānau/peers.
12. *Now you are older, what advice would you give yourself as a child and teenager?*
13. *What advice would you give professionals who are trying to help adults who have a history of child abuse and have caused family harm as adults?*
14. *If this information has not arisen from the interview, gather participant details*
    - Age
    - Ethnicity
    - Occupation
    - Children (living with or not?)
15. *Review:*
    - Is there anything else you would like to add?
    - Is there any question you thought I might ask but haven't that you think might be useful?
    - Do you have any questions for me?
    -
16. *Invite closing Karakia and/or use this whakatauki:*

E kore ahau e ngaro. He Kakano i ruia mai. i Rangiatea
I can never be lost. I am a seed born of greatness. Descended from a line of chiefs

Appendix E: Plans for Managing Participant Risk

Risk of Self-harm

1 Identify from what the participant has said during data collection that there may be an issue with an imminent and serious risk of self-harm

2 Use active listening and make empathic statements (if practical to do so) and gather more information about the issue to help identify whether the risk of self-harm is imminent and serious.

3 If I believe unequivocally that a serious and imminent risk of self-harm exists, I will advise the participant that I will need to take some action to ensure their immediate safety and discuss with him how we can best manage that risk. At this stage, I might see whether a staff member can sit with them, or, alternatively, whether there are family or friends who can. If the risk of self-harm continues to be imminent and serious, I will contact the Mental Health Crisis Assessment and Home Team (CAHT). If s/he refuses to stay on-site while I contact the CAHT, then, at the very least, I will discuss the situation with a family member of close friend of the participant and ascertain their ability to ensure the participant's safety. I will then contact Chief Supervisor as soon as is practical and appropriate for advice as to how to proceed.

4 If I am very concerned but not completely certain that the risk is imminent and serious, I will advise the participant that I am concerned about what s/he is saying and need to discuss the concerns I have further with Chief Supervisor. I will ask participant to stay at the office while I do this. If s/he agrees, I can also discuss it with his agency worker, but either way I must contact Chief Supervisor and advise her of the event and discuss as needed.

5 I will do this while in the room with the participant (if necessary), or ideally nearby to encourage them to remain at the Service Provider office while I seek advice. If Chief Supervisor is not available, I will contact the back-up person Laurette Longman to manage the risk. I will proceed to work through these steps, contacting Chief Supervisor /Clinical Supervisor again and as many times as necessary.

6 After the incident is resolved, I will record the event and actions, and fully debrief with Chief Supervisor /Clinical Supervisor (to ensure that I feel I am sufficiently supported and that a senior clinician has shared adequately in the responsibility for the decision-making etc.).

7

If the situation does not reach the level of imminent and serious risk requiring immediate safety action, then I will still endeavour to contact Chief Supervisor to discuss the situation, and use a selection of the strategies below (depending on the history, nature, and severity of the risk):

- With their permission, inform an agency worker or another third party who can help (e.g., a family member).

- Encourage the participant to access the support s/he needs from the people he trusts (e.g., agency worker, friends, family, kaumātua, religious, community or cultural leaders or professionals).
- Provide the participant with the contact details of a free, local counselling agency
    - E.g., Mana Social Services Trust in Rotorua (http//www.manasocialservcestirus t.org.nz/contacts.php)
    - E.g., Evolve Peer Support Trust in Hamilton (https://www.neighbourly.co.nz/organisation/evolve-peer-support)
- With their permission, consider a referral to local mental health service, or recommend the participant go to their GP
- With their permission, contact any other relevant agencies they are already involved with who may be able to help (e.g., counselling agency, alcohol and drug programme)

Risk of Harm to Another/Others or to Participant from Another/Others

The immediate responses are very similar to those for harm to self. The key principles are:

1. Wherever possible, I will first discuss with the participant my view of what he is saying and gather as much additional information as possible to ensure that I have a clear picture of the basis for my concern.
2. I will contact Devon for advice regardless of whether I ultimately think the situation reaches the threshold of imminent and serious.
3. I will not discuss the risk with others in the agency without the participant's permission unless I judge that the risk is imminent and serious and I believe that the agency is in a position to help.
4. The main difference in our response to the risk of harm to another/others will be with which emergency services are contacted. If there is an imminent and serious risk of harm to another, I will need to attempt to contact the person/people who are at risk. That may involve a wider breach of confidentiality. For example, I may need to ask the agency if they have a contact number for the other person. If, however, there are clear, serious, and imminent threats to a person whose identity is also clear, I may need to ring the police. If the participant himself is at imminent and serious risk from another person I may also need to call the police, after first ascertaining (if possible) whether a protection order is already in place. I may also need to call the Crisis Assessment and Home Team (CAHT) if the situation appears to be related to current acute mental disorder.
5. If the recent victim is a child, then following the guidelines for Psychologist regarding mandatory reporting of suspected child abuse, I would call Oranga Tamariki outlining the disclosure.

Response if the participant discloses they have recently been violent towards an adult:

- If the abuse is current and they disclose worries that they may hurt this person again or indeed that they might be at risk imminently then I will follow the

protocol for imminent risk outlined in Appendix F section risk of harm to another/others;

- If they are no longer in close contact with the victim (i.e., due to relationship break up), I will encourage them to seek additional help to address their potential in the future to harm others. This could involve voluntarily telling their Key Worker or talk with a counsellor.

Strategies I will use if not immediately contacting police/crisis service:

- Use active listening and give the participant an opportunity to settle (if practical and appropriate);
- Possibly develop a safety plan with the participant outlining how they will minimize the risk of harm to the person/people (if practical and appropriate);
- Encourage the participant to pass on the information to an agency worker or another third party who can help minimize the risk (if practical and appropriate). Facilitate that discussion with the participant if requested;
- Provide the participant with the contact details of a free, local counselling agency (if practical and appropriate);
- Encourage them to contact the police or a lawyer themselves if their own safety is threatened.

Appendix F: Handout Providing Information About Other Supports Available

Hei āwhina, Hei tautoko

Assistance and Support

If you or your whānau need to talk now

Aoteroa wide	Contact
If you or your whānau need to talk now	……..
Tautoki – suicide helpline	0508 828 865 (0508 TAUTOKO
Lifeline	0800 543 354 (0800 LIFELINE)
Depression helpline	0800 111 757 – depression.org.nz
Youthline	0800 376 633 or free TXT 234
The Lowdown – youth depression	thelowdown.co.nz or free TXT 5626

For help with specific issues

Rape Crisis	0800883330
Male Support Services, Waikato (Bay of Plenty)	07 8584112 or 0800677289 Text Mike: 0274414749 www,waikatosurvivors.org.nz
ACC Sensitive Claims (where you can find counsellors and psychologists in your area	0800101996 claims@acc.co.nz
Alcohol and drug helpline	0800 787 797
OUTLine – sexuality & gender	0800 688 5463 (0800 OUTLINE)

Appendix G: Letter Confirming Ethical Approval

The University of Waikato
Private Bag 3105
Gate 1, Knighton Road
Hamilton, New Zealand

Human Research Ethics Committee
Karsten Zegwaard
Telephone: +64 7 838 4892
Email:humanethics@waikato.ac.nz

THE UNIVERSITY OF WAIKATO
Te Whare Wānanga o Waikato

4-Sept-2018

Kirsty Dempster-Rivett
By email: kld@waikato.ac.nz

Dear Kirsty

UoW HREC(Health) 2018#56 : Childhood Maltreatment: Exploring the Mechanisms Behind the Link with the Perpetration of Family Harm

Thank you for submitting your amended application HREC(Health) 2018#56 for ethical approval. We are now pleased to provide formal approval of your project, within the parameters outlined within your application.

Please contact the committee by email (humanethics@waikato.ac.nz) if you wish to make changes to your project as it unfolds, quoting your application number with your future correspondence. Any minor changes or additions to the approved research activities can be handled outside the monthly application cycle.

We wish you all the best with your research.

Kind regards,

_____

Karsten Zegwaard PhD
Acting Chairperson
University of Waikato Human Research Ethics Committee (Head of Ethics Committee)

Appendix H: Summary of 13 Themes and Codes

Name	Description
Childhood Isolation	**This theme refers to the sense of isolation expressed during childhood and comprises of 6 sub-themes**
Black sheep of the family	When participants refer to themselves and others being the black sheep of their family.
Childhood Isolation	When participants talk about feeling isolated from others during childhood and adolescence. They may not use this exact word but words to this effect.
Culture	Whenever participants make reference to culture in general or the experience of their culture in particular. May also include culture-specific terms or words.
Died	When participants refer to the death people they have known, including impact on themselves and others. May include associated terms such as death, died.
Invisible	When participants refer to the death people they have known, including impact on themselves and others. May include associated terms such as death, died.

Name	Description
Lonely	When participants talk about experiencing a sense of loneliness during childhood or later in life.
Childhood Sexual Abuse	This theme is related to the adverse effects of childhood sexual abuse thought ppts lifetime. There are 5 sub-themes.
Gender	When participants refer to words inclusive of gender such as boys, men girls, woman, gender stereotypes.
Sexual abuse	When participants talk about their experience of sexual abuse, including within their family and by non-family members. This can be about sexual abuse during childhood, adolescence, adulthood. It may also refer to sexual abuse of siblings, children, or their exposure to the sexual abuse of others. May include words such as grooming.
Sexual abuse within family	When people refer to sexual abuse happening within family contexts.
Shame	When participants refer to experiencing a sense of shame.
Talking about sex	When participants talk about sexual relationships with other people. This may include within the context of partnerships,

Name	Description
	short-term sexual relationships, or one-off experiences as adults.
Trust	When participants refer to trust, trusting or not trusting.
Emotions and Thinking	This theme consists of five sub themes where they refer to thinking, thoughts, feelings, and emotions. The Node masks could also go here as often holds descriptions of hiding how they truly felt and underling issues.
Angry	When participants refer to themselves or others anger or feeling angry. May also include phrases such as aggression in the absence of physical violence.
Fear	When participants refer to themselves or others feeling fear or being afraid or scared.
Fucked up	When participants refer to future generations, including their own familial line or future generations in general.
Out of control	When participants talk about themselves or another person being out of control.

Name	Description
Thinking and emotions	When participants identify thinking and emotions within a particular experience, upon reflection, or a pattern in general.
Emotions	Whenever the participants talk about experiencing emotions or the emotional impact of childhood maltreatment. This is a child node to thinking and emotions as pulled out the references to emotions separate to thinking to include here for ease of analysis.
Family Harm	This theme refers to when the participants talked about Family Harm in reference to violence towards others or towards themselves. They may not use this term specifically but is clear in the descriptions and include physical and sexual violence and coercive control. This section also includes a sub theme about intimate relationships and the challenges they referred to.
Intimate relationships	When participants talk about their intimate relationships across the lifespan.
Violence towards children	When participants talked about violence towards children.

Name	Description
Violence towards me	When participants referred to an intimate partner being violent towards them. This may include sexual violence, physical violence, verbal violence, or emotional violence.
Violence towards them	When participants refer two being violent towards an intimate partner. This can include sexual violence, physical violence, verbal violence, and emotional violence.
Friends and Play	This theme captures the issues participants described in establishing and maintaining friendships across their lifespan. The subtheme of play was included as it was the lack of play and lack of friendships that were apparent in the interview content and the impact this had on adulthood and knowing how to play with children and grandchildren.
Friends - Mates - Brotherhood	When participants make reference to their own experience of having friends which can include words such as mates or sense of brotherhood.
Play	When participants talk about playing or play in reference to themselves or others.

Name	Description
Growing up with Heaps of Violence	This theme consists of 9 sub themes. This theme refers to ways participants referred to growing up in family systems and environments where they or others experience multiple instances and types of violence/harm. For example, "heaps of violence".
Growing up with heaps of violence	When participants refer to growing up in family systems and environments where they or others experience multiple instances and types of violence/harm, for example, "heaps of violence".
Impacts people differently	When participants refer to experience of childhood maltreatment affecting people in different ways, for example, it "impacts people differently."
Intergenerational	When participants talk about family violence or trauma, having an intergenerational component about themselves and others. This may include phrases such as "passing down the line" or others indicating a similar concept.
It was the norm	When participants refer to experiences of childhood maltreatment, family violence or abuse as being "the norm"

Name	Description
	within their immediate or extended family, and more broadly such as a reference to within the neighbourhood.
My children	Anytime the participants refers to their own children in the context of their childhood experiences or how they treat their children
My Father	When participants talk about their father in reference to themselves, other family members, or in general.
My Mother	When participants talk about their mother in reference to themselves, other family members, or in general.
Neglect	When participants refer to experiences of neglect, either of physical or emotional or psychological neglect. They may not refer to this word directly, but neglect is inherent in descriptions provided.
Poor	When participants talk about their childhood as being poor or use other terms to indicate material hardship.
In Care	This theme captures the experiences of being "in care" which might include a reference to social workers, CYFS, Oranga

Name	Description
	Tamariki, church-based care facilities. This theme comprises of 5 sub-themes.
Adopted	When participants talk about the experience of being adopted, including reference to the siblings and parents adoptive.
Boys home	When participants refer to boys' homes, whether about their specific experience or the topic in general.
Foster Parents	When the participants refer to their foster parents or the experience of being in a foster family.
In care	When participants make reference to the experience of being "in care" which might include a reference to social workers, CYFS, Oranga Tamariki, church-based care facilities.
Whangai	Whenever participants talk about Whangai about themselves or in general.
In Trouble	Refers to engagement with Police and the Justice and Correctional systems as children, youth, and adults.
Jail - Prison	When participants refer to their experience of going to and being in jail/prison.

Name	Description
Police - cops	When participants talk about police/cops in reference to their own experiences or what they observed happening to others or how other people in their life perceived police/cops.
Just Surviving	Encompasses they ways in which participants talked about their childhood in terms of survival and/or the strategies they employed to survive when they were young.
Just run away	When participants talk about running away from home or placements as children and young people.
Just surviving	When participants talk about their childhood in terms of survival and/or the strategies they employed to survive when they were young.
Masks	When participants refer to pushing on a wearing a mask to high the true inner thoughts and feelings.
Mental Health and Addictions	Theme encompasses the mental health and addiction struggles participants outlined and linked with experiences from childhood maltreatment to family harm perpetration. There are 6 sub themes recorded here. The Node masks could also go

Name	Description
	here as often holds descriptions of hiding how they truly felt and underling issues.
Dissociate	When participants talk about the experience of dissociating, this can include reference to the term dissociate, feelings of dissociation, derealisation, withdrawal from a situation occurring to them.
Drugs - Alcohol	When participants refer to their past or current use of drugs, alcohol, or the use by others. This is inclusive of the colloquial terms such as weed, pot, downers.
Memories	When participants make reference to memories of their childhood and how they have had an impact on their life.
Mental Health	When participants make reference to their mental health. This can include specific diagnoses or more colloquial references such as mental breakdowns.
Self-harm	When participants talk about self-harm in reference to themselves or others.

Name	Description
Suicide	When participants refer to suicide in reference to themselves or others such as family, friends, or acquaintances.
No one Stopped It	Theme encapsulates the lack of intervention by adults to end their childhood treatment. This can refer to family members, professionals, or any other adult with whom they had contact.
No one stopped it	When participants use phrases that refer to the lack of intervention by adults to end their childhood treatment. This can refer to family members, professionals, or any other adult with whom they had contact.
Not Heard	When participants talked about experiences of not being herd by people around them when they talked about childhood maltreatment or thoughts and feelings in general.
School - Teachers	When participants talk about the experience at school. This may include references to specific teachers., principals, peers.
Silenced	When participants refer to being silent, silenced by others around them (mostly adults) or other phrase describing not having a voice.

Name	Description
Social Services	When participants referred to Social Services, they have been engaged in th0orughout their lifetime.
Pathways to Wellbeing	Theme captures the ways participants found helpful in changing the intergenerational transmission of trauma and violence and maintaining wellbeing. My children are also included in this theme (as well as the theme family harm) for ease of analysis as it contains many descriptions of how children were their motivator for changing patterns of family harm and maintaining pathways to wellbeing.
Counselling	Whenever participants talk about their experience of counselling, including ways, it was helpful or not helpful.
Current relationship	Whenever the participant refers to their current relationship. This also includes reference to the absence of being in the current relationship.
Fourteen year old self	When participants talk about/reflect/imagine how we could have helped them when they were still 14 years of age.
Future Generation	When participants refer to future generations, including their own familial line or future generations in general.

Name	Description
Got a Job	When participants refer to getting a job and what this meant to them.
Music	When participants talk about the impact of music and their life.
My Children	Anytime the ppt refers to their own children in the context of their childhood experiences or how they treat their children
Physical being - Nature	When participants use a phrase about their physical well-being and the impact of being in the natural environment.
Self belief - self love	When participants talk about self-belief or self-love or general statements about what they believe about themselves.
Support Groups	When participants refer to support groups in general or reference to themselves.
Supporting Others	When participants refer to helping and supporting other people.
Supportive Family	When participants refer to family members, they describe as being supportive. They may refer to them as being caring, protective, therefore them when they needed them in any way throughout the lifetime.

Name	Description
Supportive People	When participants refer to people in their life, they describe as being supportive. They may refer to them as being caring, protective, or there when they needed them in any way.
Writing	When participants talk about their writing.
Wairua	Theme captures the importance participants placed on spirituality and connection to Wairua. For ease of analysis, I have included physical being sub theme in here as well as in Pathways to Wellbeing as this was also strongly connected to spirituality.
Physical being - Nature	When participants use a phrase about their physical well-being and the impact of being in the natural environment.
Spirituality	Whenever participants talked about spirituality or spiritual connections such as to God.
Wairua	Whenever participants talk about Wairua.

Appendix I: Co-Authorship Forms

THE UNIVERSITY OF WAIKATO
Te Whare Wānanga o Waikato

Co-Authorship Form

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This form is to accompany the submission of any PhD that contains research reported in published or unpublished co-authored work. **Please include one copy of this form for each co-authored work.** Completed forms should be included in your appendices for all the copies of your thesis submitted for examination and library deposit (including digital deposit).

Please indicate the chapter/section/pages of this thesis that are extracted from a co-authored work and give the title and publication details or details of submission of the co-authored work.

Chapter 4: Manuscript 1 (pp.49-82)

Dempster-Rivett, K. L., Roen, K., Masters-Awatere, B., & Starkey, N. (2021). Understanding the complex relationship between child maltreatment in care and family harm. Manuscript submitted for publication.

Nature of contribution by PhD candidate	Kirsty developed the research question and study methods in collaboration with co-authors; collected and analysed the data and wrote the manuscript with advice and feedback from primary co-author Katrina and Bridgette and Nicola.
Extent of contribution by PhD candidate (%)	70%

CO-AUTHORS

Name	Nature of Contribution
Katrina Roen	Assistance developing research questions and methods; provided feedback and support for data collection, analysis and writing of the manuscript.
Bridgette Masters-Awatere	Assistance developing research questions and methods; advice regarding analysis; review of drafts.
Nicola Starkey	Assistance developing research questions and methods; advice regarding analysis; review of drafts.

Certification by Co-Authors

The undersigned hereby certify that:

- the above statement correctly reflects the nature and extent of the PhD candidate's contribution to this work, and the nature of the contribution of each of the co-authors; and

Name	Signature	Date
Katrina Roen	Kath Roen	15/12/21
Bridgette Masters-Awatere	B Masters-Awatere	10/12/2021
Nicola Starkey	Nicola Starkey	10/12/2021

THE UNIVERSITY OF WAIKATO

Co-Authorship Form

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Website http://www.waikato.ac.nz/sasd/postgraduate/

This form is to accompany the submission of any PhD that contains research reported in published or unpublished co-authored work. **Please include one copy of this form for each co-authored work.** Completed forms should be included in your appendices for all the copies of your thesis submitted for examination and library deposit (including digital deposit).

Please indicate the chapter/section/pages of this thesis that are extracted from a co-authored work and give the title and publication details or details of submission of the co-authored work.

Chapter 5: Manuscript 2 (pp.89-123)

Dempster-Rivett, K. L., Masters-Awatere, B., Roen, K., & Starkey, N. (2021). Māori voices in healing childhood maltreatment and breaking the cycle of family harm. *New Zealand Journal of Psychology*. Manuscript accepted for publication.

Nature of contribution by PhD candidate	Kirsty developed the research question and study methods in collaboration with co-authors; collected and analysed the data and wrote the manuscript with advice and feedback from primary co-author Bridgette and Katrina and Nicola.
Extent of contribution by PhD candidate (%)	70%

CO-AUTHORS

Name	Nature of Contribution
Bridgette Masters-Awatere	Assistance developing research questions and methods; provided feedback and support for data collection, analysis and writing of the manuscript.
Katrina Roen	Assistance developing research questions and methods; advice regarding analysis; review of drafts.
Nicola Starkey	Assistance developing research questions and methods; advice regarding analysis; review of drafts.

Certification by Co-Authors

The undersigned hereby certify that:

- the above statement correctly reflects the nature and extent of the PhD candidate's contribution to this work, and the nature of the contribution of each of the co-authors; and

Name	Signature	Date
Bridgette Masters-Awatere		15/12/21
Katrina Roen		10/12/2021
Nicola Starkey		10/12/2021