INTIMATE PARTNER VIOLENCE AND ITS RELATION TO THE MOTHER-CHILD RELATIONSHIP

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B.A., San Jose State University, 2006

THESIS

Submitted in partial satisfaction of the requirements for the degree of

MASTER OF ARTS

in

PSYCHOLOGY
(Counseling Psychology)

at

CALIFORNIA STATE UNIVERSITY, SACRAMENTO

SPRING
2010
INTIMATE PARTNER VIOLENCE AND ITS RELATION TO
THE MOTHER-CHILD RELATIONSHIP

A Thesis

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Abstract

of

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From a family systems perspective, it is believed that the marital relationship is interrelated with the parent-child relationship, and was hypothesized in this study that mother-child relationships would be of poorer quality in families with a history of intimate partner violence (IPV) as compared to families without, particularly in the context of needed maternal authority. The sample consisted of 104 mother-child dyads with children ages two to eight years old. Dyads participated in three tasks that varied in amounts of necessary maternal authority, and were assessed with the Brief Emotional Availability Screener – Trianalog. Results showed no effect of IPV on the mother-child relationship under low maternal authority conditions. However, a trend that approached significance showed decreased relationship quality during the high maternal authority condition among dyads with IPV history. The findings are discussed with respect to future research and clinical implications are addressed.

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DEDICATION

This project is dedicated to my loving family and friends – I never could have done this without the support of my fiancé, my parents, my sister, and my friends.

Thank you for your encouragement and collaboration.
ACKNOWLEDGMENTS

I would like to acknowledge the research team at the U.C. Davis, CAARE Center for their collaboration, and for the use of their participant materials. I greatly appreciate the incredible amount of guidance and assistance by Dr. Susan Timmer; without her help, this thesis would not have been possible. I am also thankful for the support and assistance of Dr. Marya Endriga. Additionally, I would like to acknowledge my department chair, Dr. Lawrence Meyers, for all of his help throughout this process. His dedication and commitment to his students is inspirational.
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Chapter 1

INTRODUCTION

Context for Family Systems Theory

Family systems theory emphasizes interconnectedness among individuals, and consideration for context in assessing and treating individuals in therapy. Family systems theory is the basis for this thesis and will be discussed in detail. Prior to doing so, it is useful to trace the gradual development of a family focus in the field of psychology from its roots of an intrapsychic focus. Psychotherapy methods gradually swayed from a focus on the individual psyche to having a branch that focuses on the family context and influence. This first section traces the development of the field of psychotherapy and the process of expansion from the intrapsychic focus to the focus on family context.

The terms “psychoanalysis” and the “unconscious” were introduced in literature in the 1800s and 1700s, respectively, but conceptualizations of them and the roots of their development can be traced back far in time. In a comprehensive review regarding the development of the idea of the unconscious, Henri Ellenberger (1970) states, “Historically, modern dynamic psychotherapy derives from primitive medicine, and an uninterrupted continuity can be demonstrated between exorcism and magnetism, magnetism and hypnotism, and hypnotism and the modern dynamic schools” (p. 48). The links that Ellenberger points out traces the development of therapeutic practices
back to the ideas of shamans and exorcists. These early healers focused on inside the individual, which is a perspective that continued through the early theories of psychoanalysis (Freud, 1935).

In tracing back healing processes in time, Ellenberger (1970) provides a review of healing procedures that were used both for physical ailments as well as for mental and emotional problems that were conducted by shamans, mystics, and medicine men in ancient cultures. Similarities of these types of healing and current models of psychotherapy include the healer’s belief in her/his healing abilities, the patient’s trust in the healer, drawing out some kind of sickened part of the self, and social acknowledgment of the disease and the healing method (Ellenberger, 1970).

Another mode of healing that became widespread and popular was exorcisms. A specific exorcist, by the name of Johann Gassner (1727-1779), who was a Catholic priest and a well-renowned healer (Schaefer, 1909), became discredited in 1775, when a physician named Franz Mesmer (1734-1815) became the new popular healer with scientific ideas and methodology. Mesmer believed that people had an “animal magnetism,” a magnetic fluid within their bodies, varying in quantity depending on the health of the individual. He used magnets, as well as his own self, for healing sick people, and tried to assess the efficacy of his work by following a scientific framework (Mesmer, 1779/1980). Although Mesmer himself was also discredited in 1784 (Ellenberger, 1970), his disciples continued to utilize his ideas. Modifications to Mesmer’s technique were made so that a “magnetic sleep” was induced in patients,
freeing them to confide their fears and increasing their ability to confront situations that had been overwhelming or too anxiety-provoking when awake. The term “mesmerizing” grew out of this modified procedure (Ellenberger, 1970, p. 73). The magnetizer was expected to be in good mental and physical health in order to be able to heal the patient (Mesmer, 1779/1980). The magnetists found evidence for varying levels of consciousness through these processes. For example, upon awakening, patients failed to remember experiences they had while under, but were able to remember the experience in full when they were put under a second session of magnetic sleep.

The technique was re-titled as “hypnotism” in 1843 by Braid, and hypnotists continued to become more widespread and popular through the 1880s. Various methods to induce hypnosis were used, some borrowed from the ancient Egyptians such as the technique called fascination, which involves having the patient look at a slightly moving point (Ellenberger, 1970).

Two schools of hypnotism had a great impact on the field of psychotherapy around 1880 – the Nancy School and the Salpetriere School (Chertok, 1979; Ellenberger, 1970). Leaders in the Nancy School were Bernheim and Liebeault, both experimenting with the curative effects of hypnosis (Bernheim, 1947). Meanwhile, Charcot, at the Salpetriere School was also publishing work about hypnosis, although Charcot found it to be useful for conditions of “hysteria” (Guillain, 1959), while the Nancy School used it primarily for physical conditions (Bernheim, 1947). Psychiatrists
from various countries visited and worked with both schools. Sigmund Freud and Carl Jung received training, and worked at, the Salpetriere School with Charcot (Freud, 1935; Jung, 1912/1990).

Toward the end of the 1800s, new techniques of cathartic hypnosis were being used by various individuals, including work by Janet, Breur, and Freud (Ellenberger, 1970). During this time (1880-1900), the field of “dynamic psychiatry” began to be recognized as an “official medicine” (p. 254) and the term “psychotherapy” began to be used frequently (p. 321).

One philosopher who was extremely influential during this time was Friedrich Nietzsche. He wrote about psychological conceptualizations, and his ideas were a huge success in Europe in the 1890s. His ideas included that people have a certain amount of “psychic energy” that could be used toward various drives, that various beliefs a person may have are actually lies to oneself at an unconscious level, that dreams are representative of our unconscious, and even such terms as the “id” were originated in his works (Ellenberger, 1970, p. 273). He is attributed to have greatly influenced dynamic psychiatry, including psychiatrists such as Freud, Adler, and Jung. Various works, including Ellenberger’s (1970) extensive review of the unconscious and psychoanalysis, have found uncountable parallels between the work of Nietzsche and these psychologists.

Pierre Janet (1859-1947), although lesser famed, was one of the first psychiatrists who founded a “new system of dynamic psychiatry” and his system
provides the “link between the first dynamic psychiatry and the newer systems” (Ellenberger, 1970, p. 331). He spent part of his career at the Salpetriere Hospital with Charcot and coined the terms “subconscious” and “dissociation” (Van der Hart & Friedman, 1989). Janet focused on having a scientific methodological approach to psychology and defined “analysis” as a “means to break down a whole into its elements” (Ellenberger, 1970, p. 357). The “whole” that was being considered was a person’s psyche, rather than later conceptualizations that took into account the family as the “whole,” such as the theories by Adler, or those that will be talked about in the family systems theory summary. Janet used hypnosis, automatic writing, observation of behavior, discussion of dreams, letting the patient talk aloud at random, as well as working on “mental synthesis” of “subconsciously fixed ideas” (Van der Hart & Friedman, 1989).

Sigmund Freud (1856-1939) contributed a great deal to the field. Major publications of his began in the 1880s and continued until his death in 1939. He “made psychoanalysis a movement” with its “official doctrine, namely the psychoanalytic theory” (Ellenberger, 1970, p. 550). Some of Freud’s contributions include his conceptualizations of a psychological model, theories about neuroses, and theories about sexuality (Freud, 1935). His most original contribution, says Ellenberger, was the psychoanalytic method, which was a “new mode of dealing with the unconscious” (1970, p. 549). In Freud’s method of psychoanalysis, he did not use hypnosis, and instead used free association, analysis of dreams, and analysis of resistance and
transference, stating that these methods were superior to hypnosis because they “take hold deeper down nearer the roots of the disease” (Freud, 1935, p. 392). Psychoanalysis took place with only the individual patient and the focus was on uncovering and working through the problematic unconscious material within the patient’s psyche (Freud, 1935).

Alfred Adler (1870-1937), a medical practitioner who came to practice psychotherapy, developed his own conceptions about psychology and the application of those principles for treatment. Although he originally worked with Freud, his beliefs began to diverge from Freud’s over time. Adler believed that social effects are what lead to mental illness, and emphasized family effects and the effects of sibling order (Adler, 1929). His psychology, in stressing the social influence, considers the individual in a contextual way, as having “inter-connections” with family and environment (p. 60). Unlike other psychotherapists of the time, Adler “did not hesitate to talk with members of the family or friends of the patient in the latter’s presence…if he deem[ed] it necessary” (Ellenberger, 1970, p. 620). Adler strongly emphasized context: “For psychology, particularly for child psychology, it follows as a necessary corollary that we are always to draw interpretations and conclusions from the entire context and never from a single fact” (Adler, 1929, p. 64). Adler’s ideas are thought to come from his own sibling and familial experiences, various other psychologists of the time, Karl Marx’s socialist ideas, Nietzsche, and other philosophers (Ellenberger, 1970). Although Adler’s ideas did not gain in popularity in the organization-
establishing way that Freud’s did, Ellenberger argues that Adler’s ideas influenced many of the neo-psychoanalysts (e.g. Harry Stack Sullivan, Karen Horney, and Erich Fromm), aspects of Glasser’s reality therapy, aspects of Ellis’ rational therapy (Ellenberger, 1970), and certainly the field of family systems theory that will be discussed later in this thesis.

In the 1950s, family systems theory began to develop and it expanded the scope of psychotherapy to studying and treating the whole family, rather than solely the patient and her/his intrapsychic aspects of self. It is clear, especially from reviewing Adler’s theories, that these approaches had already begun to develop. However, they began to grow in popularity in the 1950s, as described in the following section.

The Development of Family Systems Theory

Although theorists such as Adler had already published information about the importance of including the family in assessment and treatment (Adler, 1929), it was not until the 1950s that a formalized family-based theory began to be developed in the field of psychology. In 1952, Bateson and his colleagues, in researching the possible etiology of schizophrenia, came to believe that it developed from repeated family interactions of a maladaptive nature. In studying family interactions of schizophrenic patients, they began to discover patterns of interactions such as the “double bind” that occurred not only in schizophrenic families, but also in average families (Bateson, Jackson, Haley, & Weakland, 1956). The Bateson Group formulated several principles that are core to family systems theory (Mangelsdorf & Schoppe-Sullivan, 2007). For
example, they observed cases in which psychotherapy treatment of only the identified patient resulted in an increased disturbance in other family members. These cases were evidence for the importance of including the entire family in therapeutic work (Bateson et al., 1956). Additionally, the Bateson Group described family members as being “caught up” in a family system that produces distress, as opposed to placing blame on one individual in the family (Bateson, Jackson, Haley, & Weakland, 1962). In this way, they began to formulate the “circularity” of family interactions, such that all individuals affect one another and affect the relationship system.

Don Jackson, a member of the Bateson Group, found that the group’s clinical observations fit with his ideas about family “homeostasis” (Jackson, 1957), which became a foundational concept in family systems theory. Repeated family interactions result in a habitual way of functioning that is comfortable for the family, and current researchers have termed this as the family’s “baseline” of functioning (Schermerhorn & Cummings, 2008). Changes in the family, for better or worse, can threaten to alter the family’s habitual ways of functioning. Because of the comfort of familiarity, the family has a “drive for homeostasis” and they will naturally find ways to return to previous ways of functioning as a family unit (Jackson, 1957; Mangelsdorf & Schoppe-Sullivan, 2007). Some families are able to adapt to stressors by altering family roles to accommodate changes, thus finding a new route to obtain general balance in the family. However, sometimes the drive for homeostasis leads to an emotional cost for a family member if that person sacrifices his or her own emotional well-being in an attempt to
stabilize the overall family system (Guerin & Chabot, 1992). On the other hand, family members may cling rigidly to familiar roles, which can also add additional stress. The Bateson Group’s publications are systemic in nature in their descriptions of family interactions in that they state observations about the circular effects that family members have on one another.

In 1958, Nathan Ackerman published a book that compiled his psychological casework with clients and their families and added to the budding family systems theory of the time. In it, he encouraged other members in the field of psychology to consider familial influences in their therapeutic work. He presented the need for a “family diagnosis” and argued that it was impossible to treat the “whole” person without taking into account the individual’s family and community life. Ackerman described the family as the primary unit for treatment and as having characteristics and symptoms in itself. He wrote about the family in this integrated view while simultaneously integrating the importance of each family member’s inner dynamics, thus exemplifying the ability to take into account the patient, the family, and the interactions among the two.

Additionally, Ackerman (1958) described ways of assessing the interaction of family members. He stated that

The relationship of mother and child is a two-way process…In estimating the quality of the interaction between mother and child …, we would be concerned with several phases of the interaction: the closeness of the relationship; the
pleasure the mother derives from it; the sense of fulfillment it offers her; the harmony or conflict of the relationship; [and] the specific oppositional patterns that emerge. Is the relationship a close or distant one emotionally? Is there empathy, communication, and a growing identification of the two persons? Is there mutual satisfaction and pleasure? (p. 166)

In this way, Ackerman began to formulate what aspects of interactions are paramount in the clinical assessment of parent-child interactional patterns. The questions that he posed about family qualities were dyadic, meaning that they took into account the bidirectional effects of one upon the other. Ackerman’s formulations of the family as the primary unit of treatment and his ideas for clinical assessment supplemented the development of family systems theory.

Jay Haley’s publication in 1963 further developed the theory of family systems. The first main concept that he presented was that psychopathology develops from conflicts within relationships rather than from intrapsychic conflicts within the self. Haley compared the traditional approach of psychoanalysis, in which symptoms were thought to develop from internal processes, to family therapy, in which “psychopathology in the individual is a product of the ways he deals with intimate relations, the ways they deal with him, and the ways other family members involve him in their relationships with one another” (p. 151). Haley illustrates the shift that occurred in the development of family systems theory, which was a shift from a focus on the individual’s psyche to a focus on the relationships between individuals.
Haley (1963) proposed a second concept, that psychopathology is a result of power struggles within relationships, and that each person struggles to have a “controlling influence” over other family members (p. 161). Haley provided numerous examples of children, even at very young ages, who were involved in power struggles. Coalitions can develop in family dynamics as a result of power struggles. An example is that a child’s behavior can be “given so much significance [that] the child is given power in a disturbed home – particularly being in distress gives him power” (p. 163). In this way, Haley thus described what he observed to be the underlying motivational force (i.e., a struggle for power) in the development of coalitions and difficulties in family dynamics.

Haley’s (1963) third concept is that an individual’s symptoms have a functional purpose within the family. He states,

The person with symptoms is serving some family function by experiencing the psychopathology; he is satisfying the needs of relationships in the family by serving a scapegoat function, he is holding the family together, he is providing a focus for family discontent, and so on. It is also said that when the family member with the presenting problem improves, other family members exhibit distress, symptoms, or the dissolution of the family unit is threatened. (p. 151)

By having some sort of function, the symptomatic adult or child therefore has a degree of control over the happenings of the family. This concept is interrelated with the concept of homeostasis proposed by Jackson (1957) in that the symptomatic behavior
often maintains familiar levels of family functioning and therefore is in service of family homeostasis. However, when children are in a position of having controlling influence over other family members, it is possible for the dynamic to undermine the parental authority. In summary, Haley’s contributions to family systems theory include the idea that psychopathology results from power struggles within relationships, and that symptoms have a function within the power struggles and family dynamics.

Another major contributor to the field of family systems theory is Murray Bowen, who worked extensively with families and developed a comprehensive formulation of family systems theory. His support of a systems perspective is described here: “There have been most promising results from the effort to view all emotional symptoms as evidence of family dysfunction rather than as intrapsychic phenomena” (Bowen, 1966, p. 352), and shows the movement’s expansion from the intrapsychic formulations of psychoanalysis. His theory incorporated the concepts of the undifferentiated family ego mass, differentiation of self, and triangles (Bowen, 1966). He formulated that family dysfunction and psychopathology were a result of a lack of differentiation from other individuals or from the central “ego mass” of the family. People with very little differentiation of self tend to be consumed with thoughts and feelings about another person and spend very little psychic energy focused on their own development of self. Common resulting familial patterns include marital conflict, dysfunction in one spouse, or transmission of the problem to one or more children. The latter pattern, he states, is the most common, and develops through a creation of
triangles within the family. Bowen wrote, “When tension increases, [a dyad] will involve outside members” (p. 356), thus “…permitting the tension to shift about within the triangle” (p. 368). By adding a third member into their focus, the tension on the original two-person subsystem decreases. The triangle that develops can appear stabilizing, but the original problem often goes unresolved and the new member of the triangle often takes on a role carrying the additional anxiety that was distributed. Treatment of the “triangled child,” Bowen stated, “involves helping one parent to establish an ‘I’ position and to ‘differentiate a self’ in the relationship with the child” (p. 373), which results in an increased ability for the parent to contain his or her own emotional process, thus allowing the child to focus on normal developmental tasks.

Bowen (1966) contended that simply treating the symptoms of the child was an ineffective approach, and that the child would continue to have difficulties. Bowen (similar to Haley, 1963) also observed a functional purpose in symptoms. By failing to address the child’s role in the family and the functionality of his or her symptoms within the family structure, the child would not be free to shift to a new way of being. Treatment involves helping the parents develop stronger differentiation of self (or “boundaries”) and then to work on their own marital problems within their relationship.

Salvador Minuchin, another key figure in family systems theory, also changed the face of theoretical approaches to therapeutic work with families. His theory conceptualized families in terms of the family structure, which he defined as their patterns of subsystems in the family, with each subsystem separated by boundaries.
Subsystems and boundaries are core constructs of his theory (Minuchin, 1974). The term “subsystems” refers to the multiple arrangements of individuals, dyads and triads that make up a family, and they can include the marital subsystem, the mother-child dyad, the father-child dyad, a stepparent-stepchild dyad, or a sibling dyad (or triad), to name a few. Additionally, each individual member of the family is a subsystem of the greater whole (Minuchin, 1974).

Minuchin (1974) defined boundaries as “the rules defining who participates and how” in family interactions (p. 54). He theorized that boundaries between subsystems can be too diffuse or too rigid, which can then lead to enmeshment or disengagement, respectively. Ideal boundaries are firm, but allow for flexibility when needed. Similar to Bowen (1966), Minuchin (1974) described dysfunctional triangles that can develop in families, although Minuchin used the concept of boundary problems to explain their development. For example, when the boundary around the parental subsystem becomes too diffuse, especially when in the presence of marital conflict, three possible dysfunctional triangular dynamics can develop, including triangulation, stable coalitions, or detouring. Triangulation occurs when the parents each pull for the child to side with them in an argument. A stable coalition develops when one parent joins in coalition with a child against the other parent, usually persisting over long periods. Lastly, detouring (a.k.a. “scapegoating” by Haley in 1963) occurs when parents reinforce deviance in their child because it allows them to detour their focus from their own marital problems onto parenting problems and child behaviors. The child thus
becomes one leg of a triangle upon which the parents’ marriage functions. As
mentioned earlier in Bowen’s (1966) work, these various triangular dynamics can
reduce the strain on one or both parents, but it can often be at the expense of the child’s
healthy socio-emotional development.

Another aspect of Minuchin’s (1974) theory is that there is an effective “power
hierarchy” between the parental subsystem and the children, in which “parents and
children have different levels of authority” (p. 52). He stated that “parenting always
requires the use of authority [and] parents cannot carry out their executive functions
unless they have the power to do so” (p. 58). When parents delegate too much power to
a child, “leaving the child to become the main source of guidance, control and
decisions….it can clash with his own childhood needs and exceed his ability to cope”
(p. 98). A common cause for the lack of an effective power hierarchy is a boundary that
is too diffuse between a parent and child, resulting in enmeshment. When a parent and
child are enmeshed, the line of authority becomes blurred. Minuchin, similar to Bowen
(1966), found that the most effective way to work with enmeshed parent-child dyads
was to strengthen the boundary and instill the parent with greater authority. Minuchin
also noted that “…only a weak parental subsystem establishes restrictive control, and
that excessive control occurs mostly when the control is ineffective” (p. 59).

Minuchin’s comprehensive formulation of the clear link between power and boundaries
was one of his many unique contributions to the field of family therapy.
Minuchin (1974) also expanded on the concept of circularity, previously put forth by the Bateson Group (Bateson et al., 1962). The concept, in current research, is also referred to as reciprocity or “reciprocal influence” (Schermerhorn & Cummings, 2008). Circularity refers to the circular interaction cycle of how family members’ interactions have back-and-forth effects on one another, as opposed to a linear cause and effect pattern. For example, “It is not simply the parent who affects the child, but also the child who affects the parent” (Mangelsdorf & Schoppe-Sullivan, 2007, p. 60). Relationships are reciprocal in nature and to look only at the influence of one member on the other is to leave out much of the dynamic interplay between the members. This back-and-forth quality of relationships and family interactions has been referred to as a “relationship dance” (Johnson, 2004). By studying the dance of a family, researchers can try to understand the effects that they have on one another. For example, if a child fails to respond to a mother, the mother may then state her request or “bid” in a harsher manner, which then may lead the child to retaliate or possibly to withdraw more, depending on their idiosyncratic system that has developed between them over time. On the other hand, in positive interactions, there can often be a beautiful back-and-forth quality. For example, if the child shows interest in the mother’s activity, the mother may respond with a smile and open for joining with the child, thus leading the child to seek further engagement, and resulting in both mother and child experiencing the interaction as pleasurable. As seen in these examples, a person’s behaviors are greatly influenced by interactions with others (Minuchin, 1974); that is, both family members’
behaviors and expressed needs reciprocally determine the other’s (Johnson, 2004).
Observing and assessing these circular interactions between family members can lead
to insight for potential growth areas in the family. The concept of circularity also refers
to how interactions affect the greater family as a whole, “Each instance represents one
thread interwoven into the fabric of family life and family experience, the whole of
which produces continuous change” (Schernerhorn & Cummings, 2008, p. 242). The
recurrence of family interactions creates a family personality, which can be difficult to
detect or change when basing therapeutic analyses upon only a single individual.

The main authors who have been discussed, namely the Bateson Group,
Ackerman, Haley, Bowen, and Minuchin, were foundational contributors to the field of
family systems theory, and the field of psychology was changed by their work. Current
researchers and therapists in the field of family systems theory have supported many of
the basic ideas presented by these researchers. In summary, the foundational principles
that underlie family systems theory include the ideas of wholeness, circularity,
homeostasis, and subsystems (Minuchin, 1985; Mangelsdorf & Schoppe-Sullivan,
2007). Each person is embedded in, and connected to, her or his world, culture, and
family. An individual is an interrelated, connected part of this greater “wholeness”
(Minuchin, 1974; Minuchin, 1985; Mangelsdorf & Schoppe-Sullivan, 2007).
Interactions among family members are circular in nature, with each person affecting
the other as well as the relationship system as a whole.
Emotional Availability

Family systems theorists describe the structure of the relationship dynamics among members in the overall family system. They note the wholeness of the system, the circular interplay among members, boundaries, and the power that is needed for parents to be authorities in the family. A few of the family system theorists, such as Ackerman (1958), discuss the importance of assessing the quality of the relationships among family members.

In 1980, Robert Emde put forth some basic constructs to assess when trying to understand the general features of the parent-child relationship, which is one of the various subsystems in a family. He differentiated between the assessment of parent-child attachment type, which was developed by Mary Ainsworth (Ainsworth, Blehar, Waters, & Wall, 1978) and focuses on the child’s attachment style, and the concept of emotional availability. Emde (1980) described emotional availability as “more general features, perhaps even principles of the infant-parent system” (p. 102). The concept of emotional availability is based on the reciprocal nature of the interactions of members of a family system. In other words, there is a “back-and-forth quality” that shapes experiences and leads to rewards (or the lack of reward) for each participant (p. 94). Emde proposed six main principles to assess parent-child emotional availability. The first principle, the pleasure inventory, refers to the pleasure “which infant and parent are finding in their interactions” (p. 102). When the rewards that each partner receives from the relationship are disrupted in some way, it can cause the parent-child system to
become locked in a non-rewarding back-and-forth dynamic of withdrawal, anger, or depression. An optimal, rewarding parent-child system includes “a balance of trust, affection, interest, and pleasure in interactions” (p. 102).

The second principle, individuality, takes into account the importance of assessing the individual characteristics of the mother and of the child. Emde (1980) emphasized the importance of assessing what the mother finds rewarding “in terms of her personality, her past experiences, her view of herself, [and] her expectations” (p. 103). The child should also be assessed in terms of temperament and other aspects of his/her personality. By assessing this component, Emde was attempting to determine the specific behaviors or interactions that would increase emotional availability in the dyad, based on their individual preferences or temperaments. For example, a child who is highly sensitive to over-stimulation may respond with withdrawal when a parent is highly energetic or intrusive, versus a child with a lower sensitivity to stimulation.

The third principle, clarity of emotional signaling, refers to how well each partner is “able to express what interests, what pleases, and what is being asked for” (Emde, 1980, p. 103). The ability to express needs and wants in an effective manner can have a great impact on the quality of the interaction between parent and child. The fourth principle for assessment is the range of emotions and their “appropriateness to particular situations” (p. 103). The fifth is the “ability of each partner to sustain an appropriate emotional tone…one that fosters reciprocal investment and exchange” (p. 103). Lastly, Emde recommended assessment of the “regulatory control” features in the
parent-child interactional system – including whether, when “one partner is less emotional… the other readjusts with more initiatives and emotional expressiveness” (p. 103). Although Emde proposed these six principles for assessment of parent-infant relationship quality, operationalized definitions of these principles were developed later.

Research during the same decade began to produce empirical studies on the nature of emotional availability. For example, Sorce and Emde (1981) designed a study to compare the effects of mother’s physical presence versus her emotional presence. The researchers found that although the physical proximity of the mother from her child was the same in each of their two conditions, the lack of emotional availability of the mother in the first condition resulted in decreased child exploration, decreased child positive affect, decreased bids towards the mother, and a business-like play style. Their design was the first that removed other confounds and directly tested for the effects on children of maternal emotional availability, rather than just physical availability. One limitation of this study was that the quality of the emotional availability itself was not assessed. The study specifically compared an absolute lack of emotional availability with an un-operationalized degree of emotional availability, whatever degree that was natural for each mother who participated in the study. Additionally, this study tested and conceptualized emotional availability from a linear perspective, such that emotional availability referred to a quality of the mother’s behavior, rather than as a dyadic construct that takes into account the circularity of familial relationship systems.
The concept of emotional availability (EA) became operationalized for research in the 1990s (Biringen & Robinson, 1991; Biringen, Robinson, & Emde, 1990). These researchers stressed the reciprocal nature of the construct, stating that it takes into account “both maternal and child behavior in a relational context. For a mother to be perceived as emotionally available by her child, she must display sensitivity and warmth, as well as provide a supportive and nonintrusive presence” (1991, p. 262). The authors go on to say, “Yet, the mother is not doing all the work…[and it is] therefore a mistake to view emotional availability as a solely maternal characteristic. The child’s… responsiveness to the mother… is a critical aspect of emotional communication in the mother-child dyad” (p. 262).

The reciprocal nature of the construct of EA is carried into each of the four components that comprised their scale. Their statement echoes the words of family systems theorists: “Behavior in a social situation is always influenced by the prior behavior of the other (Biringen & Robinson, 1991, p. 262; Haley, 1963). This first operationalized definition of mother-child EA included four components: maternal sensitivity, maternal nonintrusiveness, child responsiveness, and child involvement of the mother (Biringen et al., 1990).

The first component, maternal sensitivity, needs some clarification. The term “maternal sensitivity” was previously used by attachment researchers (Ainsworth et al., 1978), who defined it as having accurate perception and interpretation of the child’s cues as well as appropriate responsiveness to those cues. This is a linear
conceptualization in that it assesses the mother’s behaviors. However, for use in EA research, Biringen and Robinson (1991) redefined the term “maternal sensitivity” to include Ainsworth’s definition, but also added two other features that re-conceptualized it as a dyadic concept. The first feature they added was the mother’s ability to “negotiate mismatched or dissonant moments or events” within mother-child interactions (p. 263). The second feature added was an emotional component in that there should be a range of expressed emotions in the dyadic interactions, but the majority of the affect should be positive for an optimal rating in maternal sensitivity. Although this dyadic definition of maternal sensitivity began to lead the field in emotional availability research, the linear conceptualization of mother’s sensitivity toward her child did continue to prevail in some lines of research, such as research on attachment (De Wolff & van Ijzendoorn, 1997). A meta-analysis by De Wolff and van Ijzendoorn (1997) found that the linear conceptualization of maternal sensitivity did not account for as much of the child outcomes (i.e., attachment security) in their study as when other, more dyadic, aspects were also included, such as mutuality, synchrony, stimulation, positive attitude, and emotional support. By broadening the conception with the inclusion of dyadic components, researchers may be able to have better predictive capacity for child outcomes research.

The second component of the operationalized definition of emotional availability is maternal nonintrusiveness. This was conceptualized within “playful and everyday interactions,” as opposed to disciplinary situations. It is described as a way of
interacting that allows for the child’s development of autonomy. Optimally, the mother is able to provide a sense of “being available without being overwhelming” (Biringen & Robinson, 1991, p. 263). Doing this can lead to the child’s ability to distinguish self versus other, and it aids in the development of healthy boundaries in the dyad.

The third component of emotional availability is child responsiveness. This refers to the child’s pleasure and enthusiasm in the interaction, as well as the child’s responsiveness to the mother’s bids. Possible over-responsiveness, as well as under-responsiveness, is taken into account because a sense of autonomy is important for child development and over-responsiveness toward a mother can suggest “over-reliance and over-dependence on the mother” (Biringen & Robinson, 1991, p. 263).

The fourth component is the child’s involvement of the mother. This is a measure of the child’s “ability and willingness to include [the mother] in activities” (Biringen & Robinson, 1991, p. 263). This not only includes the child’s bids for the mother’s involvement, but also the mother’s responsiveness, which is what makes it a dyadic definition. Biringen and Robinson (1991) heavily emphasized the dyadic nature of emotional availability throughout their definitions.

As research on emotional availability in parent-child subsystems continued, the concept was expanded and re-defined to include three additional aspects: “structuring,” “nonhostility,” and “passivity” (Biringen et al., 1993, 1998). Parental structuring refers to the ability of the parent to structure interactions in a way that continues to engage the child (Easterbrooks & Biringen, 2000). Parental structuring behaviors include the use of
clues, suggestions, rules, regulations and expectations for the child and for the relationship (Biringen, 2000). This has a dyadic nature in that the parent’s attempts, combined with the child’s responses and engagement, create this concept (Biringen, 2000). The maternal scale of passivity refers to the parent’s continuous engagement with the child. The component of parental nonhostility refers to the parent’s “ways of talking to or behaving with the child that are not abrasive, impatient, or antagonistic” (Easterbrooks & Biringen, 2000, p. 124). The child’s response to the parent’s way of interacting is taken into account.

The assessment of emotional availability is context sensitive and is based on clinical judgment. The judgments are “holistic and clinically sensitive, not founded on counts of discrete types of behavior: for example, amount of parental smiling is less indicative of sensitivity than is a generally calm, contented, and relaxed emotional presence” (Biringen, 2000, p. 105). Another example is a “child who smiles a great deal might be appropriately responsive or may be displaying an overly pleasing style toward the interactive partner” (Easterbrooks & Biringen, 2005). Therefore, it is important to take the context of the interaction into account, rather than simply counting behaviors. By doing so, it allows the trained clinician to assess with greater accuracy the dyadic emotional availability in the parent-child subsystem. Furthermore, research has found support for using these reciprocal conceptualizations. For example, one study using twins found that although the mothers treated their twin children similarly, each twin’s responsiveness and engagement with his/her mother differed (Robinson & Little, 1994).
Therefore, the quality of the interaction cannot be solely based on parental behavior because it is clear from research of this sort that children relate uniquely with their parents, even within the same families. This finding supports the conceptualization of emotional availability as a reciprocal concept, taking the dyadic nature of the interactions into account, rather than a conceptualization as a linear, parental characteristic.

Recent research that uses the concept of emotional availability in parent-child subsystems has focused on determining variation in emotional availability within various subpopulations for purposes of risk assessment and screening for preventative interventions with families (reviewed in Emde, 2000). It can serve as a useful tool to assess for risk and prevention because assessments of emotional availability provide an indication of “how well things are going (or not) in the [parent-child] relationship in general” (Emde, 2000, p. 245). As will be discussed in the next section, familial experiences of intimate partner violence can disrupt boundaries, roles, and parent-child relationships in the family. Assessing emotional availability in these families with a history of intimate partner violence can serve as a useful clinical tool to identify families who are at risk and may be in need of mental health intervention.

**Intimate Partner Violence**

*Defining intimate partner violence.* Intimate partner violence (IPV) refers to “violence between sexually intimate couples of almost any age, education level, marital status, living arrangement, or sexual orientation” (Barnett, Miller-Perrin, & Perrin,
Various terms have been used throughout time, such as “domestic violence” and “battering,” and there is still inconsistency of terminology and definitions of terms among researchers. However, researchers recommend the term IPV because its definition includes a broader spectrum of violence (Barnett et al., 2005). It includes partners who have separated, which is important because the rates of IPV for separated couples is actually higher than for those couples who are married (and living together) or divorced (Bachman & Saltzman, 1995). The term IPV also includes individuals who are co-habiting, but who are not married. The severity of abuse for IPV ranges from “acts of mild verbal abuse to severe physical violence and even death” (Barnett et al., 2005, p. 251). The categories of IPV include emotional/psychological abuse, stalking, physical assaults, sexual assaults, terrorizing, injuries and homicides. There is commonly pervasive fear among women who are frequently victims of physical, sexual, and psychological abuse by their partners, and tend to be hypervigilant for signs of potential abuse. This life of hypervigilance, lack of power, fear, and victimization results in high levels of post-traumatic stress disorder among women who are victims of IPV (Barnett et al., 2005). Other common co-morbid conditions include depression, suicidality, anxiety, sleep disorders, eating disorders, lower self-esteem, substance use, and physical illness (Barnett et al., 2005).

**Historical context of IPV.** Various historical movements were responsible for bringing IPV into public awareness. Although women’s rights movements back in the 1800s had attempted to do so, it was not until the modern feminist movement in the
mid- to late 1900s that the issue truly made progress. Historical laws treated women as property of their husbands, and legally allowed for what is now termed IPV against women within the home (Barnett et al., 2005). The women’s movement in the 1800s attempted to bring change to the power differential between men and women, but “compared to the child abuse movement of roughly the same time period, [the women’s movement] was an abysmal failure” (Pleck, 1987, p. 109). The women’s rights movement in the early 1900s was focused on the right for women to vote. It succeeded in providing women with that right in 1920 with the 19th Amendment. However, in a review of the history of IPV, Barnett et al. (2005) stated that “the single-mindedness of the women’s suffrage movement proved somewhat costly to women more generally, for once they gained the right to vote, the equality movement lost steam” (p. 10). However, another feminist movement in the 1960s and 1970s had a more diverse focus. Among the various issues that were brought to light during this movement was the power differential between men and women, and victimization of women within families. One of the major turning points was the opening of a battered women’s shelter in England in 1971 that received public attention throughout the United States. The National Organization for Women (NOW) began to work toward increasing funding for battered women in the United States, and many other organizations such as the National Coalition Against Domestic Violence also served the movement against domestic violence (Barnett et al., 2005).
Prevalence rates and risk factors. Prevalence rates of the occurrence IPV are likely underestimating true rates because of an underreporting bias (Barnett et al., 2005). One study found that 22% of women and 7% of men report having experienced IPV at some time in their lives, and 1% in the survey reported having been physically assaulted by a partner or spouse in the previous year (Tjaden & Thoennes, 2000). Although violence is not limited to heterosexual relationships and victims may be varied, this thesis will focus specifically on the victimization of women in heterosexual relationships and the children who are exposed to this violence. A nationally representative survey found that 21-34% of women report being physically assaulted by a male partner during adulthood, and that 1.8 million women are severely assaulted each year in the United States (Straus & Gelles, 1990).

Younger women (ages 16-24), especially those with children, have higher prevalence rates of IPV. Lower income women also have higher rates, and their low income puts them at greater risk because of their financial dependence on their partner (Barnett et al., 2005). Higher rates of IPV have been reported among ethnic minority samples (e.g. Owen, Thompson, Shaffer, Jackson, & Kaslow, 2009). However, other studies found that after controlling for other variables such as socioeconomic status, ethnicity was no longer a significant contributing variable (Barnett et al., 2005).

Additionally, alcohol abuse by the perpetrator is often associated with higher prevalence rates of IPV (Barnett et al., 2005).
Children’s exposure to IPV. Children who live in violent homes are likely to witness the violence at some point in their childhood (Knutson, Lawrence, Taber, Bank, & DeGarmo, 2009). Per mother self-report, 76% of mothers who had been victims of at least some physical violence stated that the child was “in the same room for at least part of the encounter or in an adjacent room and aware of the acts” (Knutson et al., p. 165). Another estimate found that three to eighteen million children per year are exposed to some degree of IPV (Straus & Gelles, 1990). Similar to the historical movement of increasing awareness of IPV, research and advocacy for children’s exposure to IPV also gradually began with a few studies in the 1970s, to an outgrowth of research in the last two decades (Graham-Bermann & Hughes, 1998). In a telephone survey conducted by Mbilinyi and colleagues (Mbilinyi, Edleson, Hagemeister, & Beeman, 2007), approximately a third of 111 battered mothers reported that their children had been accidentally injured during an episode of IPV; and a quarter reported that their partner had injured their children intentionally when the child intervened. Additionally, nearly half of the mothers said they were injured trying to stop the abuser from hurting her child; and almost a quarter reported that their children were forced to watch her being physically or sexually abused (Mbilinyi et al., 2007). These staggering rates of child exposure and involvement in IPV speak to the fact that it is indeed a family problem that involves the children as well as mothers.

Children exposed to IPV have been found to have increased risk for a variety of psychological problems (Wolfe, Jaffe, Wilson, & Zak, 1985). Specific problems
observed in children who were exposed to IPV include both internalizing disorders (Chan & Yeung, 2009; Fantuzzo et al., 1991; Martinez-Torteya, Bogat, von Eye, & Levendosky, 2009; Ybarra, Wilkens, & Lieberman, 2007) and externalizing disorders (Chan & Yeung, 2009; Fantuzzo et al., 1991; Litrownik, Newton, Hunter, English, & Everson, 2003; Martinez-Torteya et al., 2009). One study also found that, after controlling for income, ethnicity, and exposure to community violence, preschool-age children who were exposed to IPV had reduced verbal intelligence scores compared to children who had not been exposed to IPV (Ybarra et al., 2007). Other symptoms of children who were exposed to IPV include conduct problems (Jouriles, Murphy, & O’Leary, 1989), decreased social skills (Fantuzzo et al., 1991), trauma symptoms (Chan & Yeung, 2009), anxiety and depression (Litrownik et al., 2003), disorganized attachment with mother (Zeanah et al., 1999), and even withdrawal behavior in infants (Crockenberg, Leerkes, & Lekka, 2007). However, some studies found that approximately 50% of children were resilient and did not have psychological problems (Jouriles et al., 1989; Martinez-Torteya et al., 2009).

Research in this area has primarily focused on assessing the individual psychological consequences for mothers and children who experience or witness IPV. However, some researchers have begun to look at the effects of IPV on various aspects of the parent-child relationship, an approach that is reflective of a family systems theory perspective.
*Spillover effect.* The term “spillover” in psychology refers to the “direct transfer of mood, affect, or behavior from one setting to another,” and involves expression in one subsystem of feelings that originated in another subsystem (Erel & Burman, 1995). A spillover effect has been supported by research, in that problems in the marital relationship are in fact found to spill over into the parent-child relationships (Erel & Burman, 1995). Findings of a spillover effect support the family systems perspective that there are inter-connections and reciprocal effects among the various subsystems in families. The marital relationship and the parent-child relationship are a part of the greater context of the whole family. Incidents and emotions that are characteristic of the family, such as pervasive fear from IPV, affect not only the involved parties but also the other members of the family, such as the children. Children may be traumatized by witnessing the violence or its aftermath, witnessing parents’ distress, or experiencing parents’ decreased emotional availability connected with incidents of IPV. Children also may be triangulated into marital conflicts, by trying to intervene, or through detouring (a.k.a. “scapegoating”), in which parents focus on child problems and parenting as a way to avoid the conflict in the marital relationship (Haley, 1963; Minuchin, 1974). Detouring in a family system acts as a stress-reducer on the marital relationship, but reinforces child behavioral problems. Although this may reduce strain between the adults, it can result in emotional rejection of the child (Erel & Burman, 1995; Krishnakumar & Cuehler, 2000). Family systems theory has been used by some of the current researchers to explain the spillover effect that occurs from the marital
subsystem to the parent-child subsystem in families with an IPV history. For example, Margolin, Gordis, and Oliver (2004) used family systems theory to explain their research findings of a “negative tone that pervaded throughout the family” (p. 753). They concluded, “A history of domestic violence appears to disrupt boundaries in the family system beyond its direct effects on parents’ behavior” (p. 766) and “without clear boundaries, conflict from the marital relationship may intrude on the parent-child relationship and alter the nature of that relationship” (p. 754).

A meta-analysis of 68 studies determined that there is a linkage of moderate magnitude between marital quality and parent-child relationships (Erel & Burman, 1995). The authors concluded that “positive parent-child relations are less likely to exist when the marital relationship is troubled” (p. 128-129). However, their analysis focused on varied levels of marital quality, as opposed to experiences of IPV. Several researchers have contended that IPV is not at the end of the continuum of poor marital quality, but is rather a separate concept (Hughes & Graham-Bermann, 1998; Jouriles et al., 1989; Krishnakumar & Cuehler, 2000). Conceptually, this implies that IPV history would have a stronger effect on the parent-child relationship than poor marital quality.

*IPV and the emotional bond between mother and child.* Although the father-child relationship is also likely to be disrupted by IPV (Margolin et al., 2004), the focus of this thesis is specifically on the mother-child relationship in families with a history of IPV. Cummings and Davies (1994) differentiated between two important qualities of mother-child relations, the first of which is “the quality of the emotional relationships
Researchers assessing the quality of mother-child emotional relationships in families with a history of IPV have found decreased overall relationship quality in the dyads (Cummings & Davies, 1994). For example, Holden and Ritchie (1991) observed interactions in 37 mother-child dyads with a history of IPV and 37 dyads without IPV history. They found that the dyads with a history of IPV had more frequent conflicts and that the mothers were less warm toward their children and attended to their children less throughout the interaction. Levendosky and Graham-Bermann (2000) also assessed differences in observed mother-child interactions between dyads with a history of IPV and those without by using 95 dyads of mothers and children (age 7-12) who “were videotaped in a 10-minute conflict situation in which they were asked to discuss two issues about which they disagree” (p. 82). The researchers found that mothers with a history of IPV were less warm toward their children. Other researchers using similar methodology found that mothers with a history of IPV showed more negative affect in interactions with their children (Margolin et al., 2004). In addition to the research using observational data, mother self-report measures also tend to show disruption in the quality of the mother-child relationship in families with IPV (e.g., Haight, Shim, Linn, & Swinford, 2007).

Research in this area has focused primarily on linear conceptualizations of parent-child relationship quality, as can be seen from the above findings that describe
characteristics of mothers’ behavior toward children. Dyadic assessments, as opposed to linear assessments, take into account the back-and-forth behavior of the mother and the child. However, only a handful of dyadic assessments have been used in assessing parent-child relationship quality among families with a history of IPV. Some researchers, such as Zeanah et al. (1999) have used attachment assessments, which are dyadic in nature, and have found that there are higher rates of disorganized attachments for infants whose mothers have a history of IPV. However, attachment-type is a specific aspect of relationship quality, as opposed to the general assessment of relationship quality that is measured by emotional availability (Emde, 1980). Timmer, Thompson, Culver, Urquiza, and Altenhofen (2009) measured observed emotional availability in mother-child dyads with and without a history of IPV and found that mothers with a history of IPV were more hostile and intrusive toward their children. Additionally, the researchers also found that the children in the dyads with a history of exposure to IPV were more responsive and engaging toward their mothers, a finding that represents some of the mixed research outcomes in this area (Timmer, Thompson, Culver, Urquiza, et al., 2009). Another group of researchers (Levendosky, Huth-Bocks, Shapiro, & Semel, 2003) used an observational assessment similar to emotional availability and did not find any differences in the mothers’ behavior, but did find that children with a history of exposure to IPV “interacted less positively with their mothers” (p. 283). Specifically, the children displayed less focused attention, less positive affect, fewer verbal interactions with their mothers, and remained at a further
physical distance from their mothers. Although these represent some mixed findings, there does appear to be an overall spillover effect from IPV to the emotional quality of the mother-child relationship.

*IPV and parenting practices.* In addition to the emotional relationship between a mother and her child, the second important aspect of the quality of mother-child relations, as defined by Cummings and Davies (1994), is parenting practices, which they defined as the “parents’ styles of interacting and disciplining children” (p. 88). This aspect of the mother-child relationship is especially relevant for this population because of the necessary use of power and authority in parenting practices, combined with the misuse of power in families with a history of IPV.

Minuchin (1974) described the necessity for parents to have an effective “power hierarchy” in their parental role, in that there needs to be a clear boundary between the parental subsystem and the child subsystem in the family that provides the parent with an optimal degree of authority (p. 52). Effective parental power has also been described by Biringen and Robinson (1991) in that a “moderate degree of parental control is optimal and is associated with higher self-esteem and better socio-emotional functioning in the child” (p. 261). This is in contrast to laissez-faire control, which is completely non-controlling, or authoritarian control, which is rigidly controlling (Biringen & Robinson, 1991). Researchers have found that children with behavioral problems often have parents who use inconsistent or lax discipline, coercive or power-assertive control techniques, and authoritarian parenting (Dishion, 1990; Levendosky &
Graham-Bermann, 2000). Timmer (2009) described effective power-usage in which the parent appears “self-assured and relaxed, unthreatened by protest of the child, and confident (rather than anxious) about the child’s ultimate compliance” (p. 17). This is in contrast to a description of ineffective power usage in which the parent “becomes very business-like and rigid, [uses] repeated prompts to [get the child to] comply if a child slows down, and [becomes] unable to carry on a conversation and support their children’s compliance” (p. 17). Having power in a parent-child relationship is a fundamental aspect to effective parenting, but the type of power used is most effective when it is done in a caring and supportive way.

In families with a history of IPV, power is often used in a hostile manner between the adults, and this dynamic is likely to spill over into the parent-child relationship. Power is one of the fundamental aspects in IPV, as is clear from Smith, Edwards, and DeVillis’ (1998) definition of battering – “a process whereby one member of an intimate relationship experiences vulnerability, loss of power and control, and entrapment as a consequence of the other member’s exercise of power” (p. 37). The unique role of power in IPV has led researchers to examine whether effective power-usage in parenting is compromised for mothers who have been victims of IPV. The research has been somewhat mixed, with some researchers failing to find a significant link between IPV history and mothers’ parenting practices (Levendosky et al., 2003). However, the majority of research has supported a link between IPV history and parenting difficulties. For example, one parenting trend that has been found by
researchers is that of inconsistency of discipline. Holden and Ritchie (1991) observed that mothers’ discipline was inconsistent with fathers’ discipline styles, to a greater degree in families with a history of IPV than in families without. Additionally, they determined that mothers’ discipline was inconsistent across time as well. Rossman and Rea (2005) also found parenting differences between mothers with and without a history of IPV. By means of mothers’ self-reports on their parenting styles, these researchers found that mothers with a history of IPV endorsed a greater number of parenting practices that were inconsistent, in that they vacillated between permissiveness and punitiveness.

Another finding by researchers is high levels of hostility and low levels of warmth in the parenting practices of mothers with a history of IPV. In an early study, Jouriles, Barling, and O’Leary (1987) gathered self-report data from 45 mothers with a history of IPV and found high levels of mother-to-child aggression, including both verbal and physical forms of punishment, which was subsequently linked to child behavioral problems. However, the researchers did not use a control group of mothers without IPV history, so they did not make conclusions about parenting differences. Other researchers who controlled for IPV history did find significant differences. For example, Levendosky and Graham-Bermann (2001) used a sample of 120 mother-child dyads that ranged from no history of IPV to a history of severe IPV. They found that the degree of IPV was a significant predictor of self-reported parenting practices,
including degrees of maternal warmth, control, child-centeredness, and effectiveness of parenting.

Some researchers have conducted studies in which a needed amount of parental power was manipulated in the research design. For example, Timmer, Thompson, Culver, Zebell, and Urquiza (2009) conducted a study in which 210 mother-child dyads engaged in three separate tasks that varied in the amount of parental power needed in order to complete the dyadic task. The researchers found that when power and authority were needed by mothers to get the children to complete tasks, the mothers with a history of IPV became more hostile and less sensitive, whereas the mothers without a history of IPV did not show these difficulties in power-exertion across the three tasks. Levendosky and Graham-Bermann (2000) hypothesized that “It may be that many of these women, because of their own experiences of battering, have a difficult time using their authority with their children” (p. 91).

IPV and parentification in children. The imbalance of power in families with a history of IPV may also affect the amount of power that is given to children in the family system. Minuchin (1974) provided descriptions of children who have too much power in a family, in that they take on a role that is elevated from the child subsystem into the parental subsystem. When children attempt to mediate or protect the mother from violence of the father, the child is displaying this type of elevated role (Anderson & Cramer-Benjamin, 1999). Although parentified behavior can have a caregiving quality, it can also have a punitive quality, in which the child behaves aggressively
toward other siblings or toward the parents in an attempt to have control or power. Other elevated roles include children who act as a “confidant” for a parent, an ally for either the victimized parent or the abusive parent, or when an older sibling acts as a protector or provides extensive emotional support for younger siblings in the context of IPV (Byng-Hall, 2002, p. 376). Another term for this elevated role is “parentification,” which is an expectation in the family that a child will take on a parental role. Parentification can become destructive when the expectations on the child are “excessive and developmentally inappropriate” (Byng-Hall, 2002, p. 377). The negative consequences of parentification include an increased risk of being harmed by the abuser and psychopathology (Cummings & Davies, 1994). Although child parentification does not occur in all families with a history of IPV, it is likely that it occurs at higher rates within this subpopulation because of these power dynamics that are present within a violent family.

Purpose of Study and Hypotheses

The overall purpose of this study is to examine the mother-child relationship for dyads with a history of IPV, as compared to those without. First, this study aims to find evidence to further support the spillover effect theory, such that the difficulties in a marital relationship with IPV spill over into the mother-child relationship. In this study, the emotional availability of mother-child dyads is assessed for dyads with IPV history and for those without. The first hypothesis is that the IPV-exposed mother-child dyads will have lower levels of emotional availability than non-IPV exposed dyads.
Second, this study attempts to find evidence for the relationship of IPV history and disruptions in the power and authority of the mother with her child. To do this, needed power is manipulated by having the mother-child dyads engage in three separate activities that vary in the amount of parental power required. The emotional availability of the dyad is assessed in the following three tasks: child-directed play, mother-directed play, and clean up. It is hypothesized that the dyads with a history of IPV, as compared to those without, will show less optimal scores in the activities that require more parental power.

Lastly, this study attempts to find evidence for a relationship between IPV history and child controlling behaviors. Child parentification (i.e., role reversal) is assessed for all dyads as part of a measure of overall emotional availability. The third hypothesis is that the mother-child dyads with a history of IPV will show a greater frequency of role reversal, either of the caregiving type or of the punitive type, as compared to the mother-child dyads without a history of IPV.
Chapter 2

METHOD

IPV History and Socio-Demographic Information

Information about families’ histories of IPV and children’s histories of abuse were obtained from therapists’ summaries, social workers’ reports, and research staff’s review of any available court records. The information available on the severity of violence was limited due to the general descriptions in the case files and court reports, such as “…children were exposed to domestic violence between their parents.” This vagueness of reporting led to global distinctions of children’s exposure to IPV. The dyads were coded as having a history of IPV if the case file stated that they had a positive history of IPV. The dyads were coded as not having a history of IPV if there was none noted in the file. Because of the reliance on primarily CPS reports for coding IPV occurrence, it was considered possible that there were dyads who had exposure to IPV that had not been reported and was not documented in their charts. Socio-demographic information was collected from caregivers pre-treatment using a brief questionnaire that included questions about ethnic identity, marital status, and educational history.

Participants

Participants included 104 mother-child dyads who were referred to UC Davis CAARE Center to participate in Parent-Child Interaction Therapy (PCIT) for treatment of children’s externalizing behavioral problems. In PCIT, the parent wears a “bug-in-
the-ear” device and receives guidance from the therapist, who views the session through a two-way mirror. The participants were assessed pre-treatment, which will be described in detail in the procedures section. Forty-seven dyads had a history of IPV and 57 dyads had no history of IPV. The children in the sample were between 3 and 8 years of age, with a mean age of 4.91 (SD = 1.31) years in the IPV group and 4.72 (SD = 1.27) years in the non-IPV group. In the IPV group, there were 21 girls and 26 boys. In the non-IPV group, there were 23 girls and 34 boys. Other group demographics are presented in Table 1, including ethnicity, child abuse history, foster care history, and mothers' age, and education levels. Children who had a history of physical abuse were excluded from the control group to prevent unintentional inclusion of children who were exposed to IPV without it having been reported.

Measures

The Brief Emotional Availability Screener – Trianalog (BEAS-T; Timmer, Thompson, Nelson, West, & Culver, 2010) was used to assess the quality of the parent-child relationship. The BEAS-T is a screening tool that is designed to measure dyadic emotional availability. Basic concepts of emotional availability (e.g., Biringen, 2000; Emde, 1980) were extracted and labeled individually in the creation of this measure. The screener is dyadic, in that every rating takes into account the context of the interaction and the response of the other member of the dyad.

The BEAS-T has four parent scales and three child scales. The four parent scales are sensitivity, hostility, control, and passivity, and the three child scales are
Table 1. *Demographic Data by History of Intimate Partner Violence (IPV)*.

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<td>(N = 47)</td>
</tr>
<tr>
<td>Ethnicity of child</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Caucasian</td>
<td>56.10</td>
<td>59.60</td>
</tr>
<tr>
<td>% African American</td>
<td>21.10</td>
<td>12.80</td>
</tr>
<tr>
<td>% Latino/a</td>
<td>10.50</td>
<td>14.90</td>
</tr>
<tr>
<td>% Other</td>
<td>12.30</td>
<td>12.70</td>
</tr>
<tr>
<td>Age of mother (years)</td>
<td>27.83 (6.46)</td>
<td>27.06 (4.54)</td>
</tr>
<tr>
<td>Mother – education level (years)</td>
<td>11.90 (1.81)</td>
<td>11.44 (1.97)</td>
</tr>
<tr>
<td>% Child neglect history</td>
<td>21.10</td>
<td>34.00</td>
</tr>
<tr>
<td>% Child physical abuse history</td>
<td>0.00</td>
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<td>% Child sexual abuse history</td>
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<td>11.10</td>
</tr>
<tr>
<td>% Child ever in foster care</td>
<td>33.30</td>
<td>41.90</td>
</tr>
<tr>
<td>% Court-mandated treatment</td>
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<td>40.40</td>
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</table>
responsiveness, engagement, and controlling behavior. Each of these seven scales is comprised of three subscales in which ratings range from 3 (optimal) to 1 (non-optimal), thus resulting in a 6-point range from 3-9 for each of the seven scales. Each set of three subscales were created by noting the three most characteristic features of the related scales of the full Emotional Availability Scales (EA 3rd Ed., Biringen, 2000). The subscales in each of the seven scales are similar to the full EA Scales in that they contain very similar characteristics of emotional availability within each of the seven scales. The full EA measure and the BEAS-T screener differ in that the coding of the BEAS-T is divided into multiple codes within each scale, rather than one overall code, but the components of the scales are the highly similar. The specific coding criteria are described in the BEAS-T coding manual (Timmer et al., 2010). The BEAS-T has shown acceptable internal reliability with coefficient alpha scores that mirror those of the EAS (West, Nelson, Timmer, Culver, & Thompson, 2009). BEAS-T scales correlate with the corresponding EAS scales, ranging from .47 to .71. Research by West et al. (2009) contains a more detailed analysis of evidence for construct validity and internal reliability of the BEAS-T.

*Parent BEAS-T scales.* The sensitivity scale is comprised of the following three subscales: affect quality, response quality, and engagement. Affect quality is a rating of the parent’s affect in the interaction, and includes the parent’s ability to remain relaxed and smooth, even when in conflict. Response quality refers to appropriately responding to the child’s cues and having a positive connection with the child. The engagement
subscale includes the ability of the parent to engage the child in the activity, to be flexible in the interaction, and to be consistently engaged in play.

The hostility scale includes the following three subscales: covert hostility, overt hostility, and physically overt hostility. Covert hostility is a rating of whether a parent displays any signs of hostility, such as a tone that reflects irritability, edginess, snappishness, or if the parent is excessively correcting of the child. Overt hostility refers to if a parent yells or threatens the child. Physical overt hostility is a rating for any instances of physical hostility of the parent against the child, such as hitting or pushing the child.

The control scale is comprised of verbal control, physical control, and directiveness. First, the verbal control subscale is a rating of the degree to which a parent interrupts a child, talks over the child, or dominates the conversation. Second, the physical control subscale refers to the degree to which a parent is physically invasive towards the child or provides the child with unneeded or unwanted help. Third, the directiveness subscale refers to the degree to which the parent is controlling in the interaction through directions or didactic questions, as opposed to having child initiated or balanced interactions.

The passivity scale is comprised of play, verbal, and authority. Passivity of play is a rating of the degree to which the parent is an active partner in the play and interaction with the child. The verbal passivity subscale refers to the degree to which
the parent is verbally withdrawn or fails to verbally structure interactions. Passivity of authority refers to the degree to which the parent has authority in the dyad.

*Child BEAS-T scales.* The scale of child responsiveness is comprised of affect, balance in the interaction, and responsivity. Child affect is a rating of the child’s affect and takes into account any oppositional responses of the child to the parent. The balance of interaction subscale is a rating of the degree to which both parent and child contribute appropriately to the play and have matched affect. Child responsivity is a rating of whether the child responds positively, negatively, or not at all to the parent’s bids or requests.

The child engagement scale is comprised of engagement, balance of attention, and behavior. First, the subscale of engagement refers to a rating of the frequency and appropriateness of a child’s bids for interaction with the parent. Second, balance of attention refers to the degree to which a child’s attention is balanced between the play and the parent. Non-optimal balance of attention can either reflect a child who pays no attention to the parent or who pays too much attention to the parent, thereby showing diminished autonomy in her or his own play. Third, the behavior subscale is a rating of the appropriateness of the child’s behavior in the interaction and includes negative behaviors such as yelling and aggressive behavior.

Child controlling behavior is the last scale, and includes three subscales of caregiving, punitive, and general bossiness. General bossiness refers to the degree to which a child tells the parent what to do during the interaction. The other two child
controllingness subscales are categorical, rather than being rated on frequency or intensity. A non-optimal score in caregiving is given to a dyad when the child shows behavior that is parentified in a way that is caretaking of the parent, and when the parent’s behavior shows that a role reversal has occurred in that the parent acts like a child and allows the child to act like the parent. This dynamic is referred to as role reversal of the caregiving type. A mid-range score (of a 2) in caregiving is given to a dyad in which the child makes attempts to be caregiving toward the parent, but the parent does not submit to a reversal of roles. An optimal score is given to a dyad when the child displays no caregiving behavior. The punitive subscale is rated the same way. A non-optimal score in punitive controlling behavior is given when a child uses punitive behaviors (e.g., name calling, excessive defiance, aggression) that are designed to humiliate the parent or to control the interaction, and the parent submits his/her authority to the child so that there is a reversal of the parent and child roles. This dynamic is referred to as role reversal of the punitive type. A mid-range score in the punitive controlling subscale is given when a child attempts to use punitive controlling behaviors, but the parent does not submit his/her authority and there is not a reversal of roles. The dyad is rated as optimal when there are no attempts by the child to use punitive controlling behavior.

Procedure

Observational assessment. Parent-Child Interaction Therapy (PCIT) includes a pre-treatment observational assessment of dyads for a total of 15 minutes in three semi-
structured play situations, each of which is five minutes long. Each parent receives
directions from the therapist through a “bug-in-the-ear” device. The first direction by
the therapist is for the parent to allow the child to choose an activity and to follow the
child’s lead in play. This first activity is called the child-directed interaction (CDI). The
second direction by the therapist is for the parent to change the activity and get the child
to play along with the parent according to the parent’s rules. This activity is the parent-
directed interaction (PDI) and requires the parent to use some of her/his authority and
power. The third set of directions given by the therapist is for the parent to have the
child clean up all of the toys without the parent’s help and then to have the child sit
quietly and wait for the therapist to return to the room. This last activity is called clean-
up (CU) and requires the most power and parenting skill from the parent in the
interaction.

Observational coding. In the current study, 25% of the videos were coded by
two coders for purposes of determining inter-rater reliability. Both coders were trained
using the BEAS-T and had met an 80% level of inter-rater reliability on training videos
prior to coding the tapes for inclusion in this study. When coding the tapes for
emotional availability using the BEAS-T, the coders watched the tape a single time,
pausing the tape between each activity to rate the dyad in the 21 subscales and to sum
the subscales to determine the scores for the seven overall scales. When two coders
worked together, there was no discussion between the coders until the scores had been
determined by each coder in order to maintain independent ratings. After the
Independent scoring was complete, and inter-rater reliability was calculated to be above 80%, a consensus process took place in which the coders compared scores and decided on a final score for each BEAS-T subscale. If the two coders did not agree on at least 80% of the scores (i.e., 17 out of 21 scores), the tapes were coded by an additional coder or coders. The other 75% of the videotapes were coded by a single coder. Additionally, the internal consistency of the BEAS-T was assessed. Cronbach alpha values ranged from 0.76 to 0.91, indicating acceptable levels of internal consistency. The alpha values and the inter-scale correlations are presented in Table 2.
Table 2. Pearson Correlation Coefficients and Cronbach Alphas for DVs.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Alpha</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Maternal Scales</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Sensitivity</td>
<td>0.91</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Hostility</td>
<td>0.87</td>
<td>0.58**</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Control</td>
<td>0.91</td>
<td>0.25*</td>
<td>0.35**</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Passivity</td>
<td>0.91</td>
<td>0.68**</td>
<td>0.22*</td>
<td>-0.27**</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Child Scales</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Responsive</td>
<td>0.82</td>
<td>0.60**</td>
<td>0.48**</td>
<td>0.21*</td>
<td>0.55**</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>6. Engagement</td>
<td>0.86</td>
<td>0.55**</td>
<td>0.51**</td>
<td>0.29**</td>
<td>0.48**</td>
<td>0.80**</td>
<td>-</td>
</tr>
<tr>
<td>7. Controlling</td>
<td>0.76</td>
<td>0.34**</td>
<td>0.27**</td>
<td>-0.16+</td>
<td>0.45**</td>
<td>0.38**</td>
<td>0.27**</td>
</tr>
</tbody>
</table>

N = 104; +p < 0.10; *p < 0.05; **p < 0.01
Chapter 3

RESULTS

Demographic Data

In order to determine whether there were any significant differences in the demographic data, such as abuse rates and education levels, between the IPV group and the non-IPV group, t-tests and chi-square analyses were conducted. It was determined that the only demographic variable that the two groups significantly differed on was in their rates of physical abuse, $t(102) = 45.3, p < .001$, such that more children in the IPV group had a history of physical abuse than the children in the non-IPV group. Additionally, there was a nonsignificant trend such that there were higher rates of other risk factors (e.g., neglect history and sexual abuse) within the IPV group than were in the non-IPV group. However, it was expected that the IPV group would have higher rates of abuse because research shows that IPV and abuse commonly co-occur (Tajima, 2000).

Maternal EA – Results of MANOVA

Separate analyses were conducted for the maternal scales and the child scales. The research design for the maternal scales was a 2 x 3 x 4 mixed design with one between-subjects factor and two within-subjects factors. The between-subjects factor is history of IPV, which is dichotomous and refers to whether or not the dyad has a history of IPV in the family. The first within-subjects factor is the activity, which
includes three five-minute parent-child activities: child-directed play, parent-directed play, and clean-up. The amount of authority needed by the mother in the interaction increases across each activity (e.g., the most authority is needed in the last activity, when the mother has to get the child to clean up the toys without the mother’s help). The type of maternal emotional availability, the second within-subjects factor, consists of four types: sensitivity, hostility, control, and passivity. The dependent variable in the design is comprised of ratings that reflect the emotional availability of the mother-child interaction. Higher scores indicate more optimal qualities of emotional availability in the mother-child interaction. All significant effects are reported with least squares means and standard errors. Effect sizes were evaluated using eta-squared based on the total within-subjects variance for within-subjects effects and total between-subjects variance for between-subjects effects.

In order to assess for significant differences, a three-way mixed multivariate analysis of variance (MANOVA) was conducted. Mauchly’s test of sphericity showed that the assumption of sphericity was violated for type of emotional availability. Therefore, the Greenhouse-Geisser adjustment was used for all analyses that contained this variable. In order to test the hypothesis that dyads with IPV history would have less optimal maternal scores than dyads without a history of IPV, regardless of the activity, the interaction between IPV history and emotional availability was examined, and was not significant, $F(1.66, 169.32) = .30, p = .83, \eta^2 < .001$. 
To test the hypothesis that dyads with a history of IPV, as compared to those without, will show less optimal maternal scores in the activities that require more maternal power, the interaction of IPV and activity was examined, and a trend was found that approached significance, $F(2, 101) = 2.71, p = .07, \eta^2 = .003$. The results of this interaction are presented graphically in Figure 1. This trend shows that the dyads with a history of IPV and the dyads without a history of IPV had similar maternal scores in the child-directed interaction and in the parent-directed interaction, but that the maternal scores of the dyads with a history of IPV tended to drop to a less optimal level of parent-child emotional availability in the clean-up interaction, which is the activity that requires the most maternal authority.

Other effects were significant in the analyses and are worth mentioning, but are not relevant to the hypotheses. Briefly, there was a significant main effect for activity, $F(2, 204) = 41.56, p < .001, \eta^2 = .04$, and for type of emotional availability, $F(1.66, 169.32) = 100.43, p < .001, \eta^2 = .33$. However, there was a significant interaction effect of activity and type of emotional availability, which supersedes the two main effects, $F(4.21, 429.28) = 4.19, p < .01, \eta^2 = .01$. The interaction of activity by type of emotional availability is presented graphically in Figure 2. Simple effects analyses were conducted to determine the nature of the interaction, and the Bonferroni adjustment was used to avoid alpha inflation. For maternal sensitivity, mothers had more optimal sensitivity in the child-directed interaction than they did in the parent-directed interaction or in the clean-up segment. Regarding maternal hostility, mothers had the
Figure 1. Interaction of activity (parent-directed, child-directed, clean-up) by IPV (history or no history of intimate partner violence) on maternal scores for quality of emotional availability. Higher scores indicate more optimal emotional availability.

least amount of hostility in the child-directed interaction, and had more hostility in the parent-directed interaction, and even more hostility in the clean-up segment. In maternal control, mothers were more optimal (i.e., less controlling and intrusive) in the child-directed interaction than they were in the parent-directed interaction or in the clean-up segment. For maternal passivity, the mothers were less passive (i.e., more optimally involved) in the child-directed interaction than they were in the clean-up segment.
Figure 2. Maternal emotional availability scores as a function of the type of emotional availability being measured and the type of activity (child-directed, parent-directed, and clean-up). Higher scores represent more optimal emotional availability.

Children’s EA – Results of MANOVA

The research design for the children, a 2 x 3 x 2 mixed design, is the same as that of the mothers, with one between-subjects factor and two within-subjects factors. The between-subjects factor is the presence/no presence of a family history of IPV. The first within-subjects factor is the activity: child-directed play, parent-directed play, and
clean-up. The second within-subjects factor is the type of child emotional availability, the two types of which are responsiveness and engagement. The dependent variable in the design is comprised of ratings that measure the emotional availability in the mother-child interaction. To assess for significant differences, a three-way mixed MANOVA was conducted.

First, in order to test the hypothesis that dyads with IPV history would have lower emotional availability than dyads without a history of IPV, regardless of activity, the interaction between IPV history and emotional availability was examined for the child scales, and was not significant, $F(1, 102) = .10, p = .75, \eta^2 = .001$.

Second, to test the hypothesis that dyads with a history of IPV, as compared to those without, will show less optimal child scores in the activities that require more parental power, the interaction of IPV and activity was examined. The interaction of IPV and activity was not significant, $F(2, 204) = 1.91, p = .15, \eta^2 = .01$.

Other effects were significant in the analyses and are worth mentioning, although they are not relevant to the hypotheses. Briefly, the main effect of emotional availability type was significant, $F(1, 102) = 44.58, p < .001, \eta^2 = .03$, such that children’s emotional availability was higher on the child engagement scale ($M = 6.34, SE = .15$) than on the child responsiveness scale ($M = 5.88, SE = .17$). Additionally, the main effect of activity was also significant, $F(2, 204) = 59.90, p < .001, \eta^2 = .30$, such that children’s emotional availability significantly differed in all three activities. The child scores were most optimal in child-directed interaction ($M = 7.03, SE = .13$), less
optimal in the parent-directed interaction ($M = 5.98, SE = .15$), and least optimal in the clean-up interaction ($M = 5.32, SE = .16$).

**Child Controlling Behavior**

The subscale of child controlling behavior was not included in the previous MANOVA because it is a new subscale that was added to the measure of emotional availability in parent-child dyads. To test the hypothesis that children with IPV exposure would display more controlling behaviors than children without IPV exposure, a MANOVA was performed with intimate partner violence as the between-subjects variable and activity (child-directed, parent-directed, and clean-up) as the within-subjects variable. The interaction of IPV and activity was not significant, $F(2, 204) = .78, p = .46, \eta^2 < .01$, and the main effect of IPV was also not significant, $F(1, 102) = .28, p = .60, \eta^2 < .01$.

*Role reversal of the caregiving type.* Although there were not significant differences in the overall scores of child controlling behavior (which is comprised of bossiness, caregiving behaviors, and punitive behaviors), additional analyses were conducted to specifically determine whether there were differences between the IPV and non-IPV groups in the frequency of role reversal behaviors.

In order to assess whether a greater number of dyads from families with a history of intimate partner violence displayed role reversal behavior of the caregiving type, dyads were coded dichotomously as having caregiving role reversal if they displayed it in any of the three activities (i.e., had a score of a “1” for caregiving role
reversal). As presented in Table 3, the number of dyads who displayed caregiving role reversal was 6.4% for the dyads with a history of exposure to intimate partner violence, as compared to 14% of the dyads without a history of exposure to intimate partner violence. To assess the significance of this difference between the two groups, Fisher’s exact test was performed rather than a Chi-square test because one of the cells had fewer than five cases. The difference between the groups, which was in the opposite direction than was hypothesized, was not statistically significant, ($p = 0.34$, Fisher’s exact test, two-tailed).

Table 3. Crosstab Results of IPV History on Child Caregiving Role Reversal ($N = 104$)

<table>
<thead>
<tr>
<th></th>
<th>Percentage</th>
<th></th>
<th>Percentage</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Caregiving Behavior</td>
<td>n</td>
<td>No Caregiving Behavior</td>
<td>n</td>
</tr>
<tr>
<td>IPV History</td>
<td>3</td>
<td>6.4 %</td>
<td>44</td>
<td>93.6 %</td>
</tr>
<tr>
<td>No IPV History</td>
<td>8</td>
<td>14.0 %</td>
<td>49</td>
<td>86.0 %</td>
</tr>
</tbody>
</table>

Role reversal of the punitive type. In order to assess whether a greater number of dyads from families with a history of intimate partner violence displayed role reversal behavior of the punitive type, dyads were coded dichotomously as having punitive role reversal if they displayed it in any of the three activities (i.e., had a score of a “1” for punitive role reversal). As presented in Table 4, the number of dyads who displayed
punitive role reversal was 29.8% for the dyads with a history of exposure to intimate partner violence, as compared to 12.3% of the dyads without a history of exposure to intimate partner violence. To assess the significance of this difference between the two groups, a two-tailed Chi-square test was performed. The difference between the groups was in the hypothesized direction, and was statistically significant, $\chi^2 = 4.90$, $p < .05$.

**Table 4.** Crosstab Results of IPV History on Child Punitive Role Reversal ($N = 104$)

<table>
<thead>
<tr>
<th></th>
<th>Punitive Role Reversal</th>
<th>No Punitive Role Reversal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>n</strong></td>
<td>Percentage</td>
<td>n</td>
</tr>
<tr>
<td>IPV History</td>
<td>14</td>
<td>29.8 %</td>
</tr>
<tr>
<td>No IPV History</td>
<td>7</td>
<td>12.3 %</td>
</tr>
</tbody>
</table>
Chapter 4

DISCUSSION

Summary

This study was designed to assess the relationship quality of mother-child dyads with a history of IPV as compared to those without. First, it was hypothesized that the IPV-exposed mother-child dyads would have lower levels of emotional availability than the non-IPV exposed dyads. This hypothesis was not supported in that there were no significant differences in the overall emotional availability of the IPV and non-IPV dyads. This finding failed to provide support for the spillover effect theory, such that the difficulties in a marital relationship with IPV spill over onto the mother-child relationship.

Second, it was hypothesized that by varying the needed amount of parental power, the dyads with a history of IPV, as compared to those without, would show less optimal emotional availability scores in the activities that required more parental power. The results supported this hypothesis, with a trend that approached significance in the hypothesized direction. IPV and non-IPV dyads had similar maternal emotional availability scores in the child-directed and parent-directed activities, but the IPV dyads had less optimal maternal scores than the non-IPV dyads in the clean-up activity. The clean-up activity requires the most maternal authority out of the three tasks, and it was hypothesized that the group differences would be largest for the activity with the most
authority required. Furthermore, the IPV dyads did have lower child scores than the non-IPV dyads in the clean-up activity, although this difference in child scores was not large enough to be statistically significant. Although support for the hypothesis was found in the maternal, but not the child, emotional availability scores, it is important to note that all of the scales take a dyadic approach in their scoring and it is the relationship under observation, rather than solely mothers’ behaviors. This finding shows that there is a relationship between IPV history and the emotional availability of the mother-child dyad within the context of needed maternal authority. Therefore, this finding lends support to the theory that the hostile misuse of power in IPV adult couples can spill over into difficulties in supportive and effective power usage of the mother with her child. Despite these differences between the IPV and non-IPV dyads, it is important to note that the results showed that when the groups were combined, there was an overall effect of the activity such that all dyads showed a linear decrease in emotional availability across the three activities. However, the IPV dyads decreased to a further extent in the clean-up activity than did the non-IPV dyads.

Third, the hypothesis that there would be higher rates of child parentified caregiving behavior among IPV-exposed dyads was not supported. There were no significant differences in the occurrence of parentified caregiving behavior between the two groups. This study did not find support for a relationship between IPV and parentification of children.
Integration with Previous Research

Although there has been a considerable amount of research that has supported the spillover effect from IPV history to individual child behavioral problems, there has been a paucity of research studying the potential relationship between IPV and the general quality of the mother-child relationship. Among the handful of research in this area, previous research findings include frequent mother-child conflicts, decreased maternal warmth (Holden & Ritchie, 1991), and more maternal negative affect (Margolin et al., 2004). Other researchers found child distancing behaviors, but no maternal differences among IPV dyads (Levendosky et al., 2003); and still other research found more optimal child responsiveness and engagement toward mothers among IPV dyads (Timmer, Thompson, Culver, Zebell, et al., 2010). The current study did not find support for a relationship between IPV history and quality of the mother-child relationship, except for when in the context of power, which is discussed in the next paragraph. It is possible that there are other factors that must be accounted for in order to make a more accurate determination about whether there is truly a relationship between IPV and mother-child relationship quality, such as controlling for the severity and frequency of IPV or for mother or child resilience factors.

Researchers who have studied the relationship between parenting practices and IPV have also had conflicting findings. Their research outcomes vary from no relationship between IPV and parenting (Levendosky et al., 2003) to findings of greater maternal inconsistency (Rossman & Rea, 2005), lower maternal warmth (Levendosky
& Graham-Bermann, 2001), higher maternal hostility, and lower maternal sensitivity (Timmer, Thompson, Culver, Zebell, et al., 2009). The results of the current study support a relationship between parenting practices and IPV history, such that dyads with a history of IPV decrease in relationship quality in the context of parenting practices to a greater extent than do dyads without a history of IPV.

Clinical Implications

The results of this study support other researchers’ findings that there are difficulties in the mother-child relationship for families with a history of IPV. However, there is an important implication of the findings of this study – that the difficulties are specific to the context of maternal authority. When maternal authority is needed in the mother-child relationship, these IPV dyads are at a disadvantage, and the children in these dyads may be at greater risk for emotional and behavioral difficulties. These children already have higher risk for emotional problems because of witnessing of IPV directly, but it is an added risk factor to have a debilitated mother-child relationship in the context of ensuring that a young child (age 2-8 in this study) is able to follow parental instructions. If a child is not provided the opportunity to respond to parental expectations in a safe context, the child is deprived of learning how to be safe and contained, to follow rules and respect limits, and to respect authorities. It logically follows that these children will have more difficulties in school with following directions and respecting teachers’ authority, thus leading to increased academic, behavioral, and emotional problems. It is imperative that clinicians identify the mother-
child dyads with difficulties in this area so that preventative work can be done with them while their children are still young. Although it is important for mothers to learn to use authority in a supportive and effective manner, it is also useful for therapists to work with children individually to teach children to respect limits within a safe therapeutic environment. Various therapeutic approaches address these aspects within a strong therapeutic relationship, one example of which is Child-Centered Play Therapy (Landreth, 2002). Meanwhile, mothers can work on strengthening parenting skills through various forms of parenting training that teach the ability to have authority without adding hostility. This could include individual therapeutic work with the mother focusing on reducing feelings of hostility, combined with the use of a form of teaching parenting skills (e.g., Barkley, 1997). These areas of growth for mothers and for children can later be transferred to their relationship through one of the various parent-child therapy approaches, such as Child Parent Relationship Therapy (Landreth & Bratton, 2005) or Parent-Child Interaction Therapy (Eyberg & Robinson, 1982).

Study Limitations

The information that was available on each family’s history of IPV was limited due to the source of the information. Rather than directly providing a questionnaire such as the Conflict Tactics Scale or a clinical interview aimed at assessing IPV, the information was gleaned from court reports and clinical files, which tended to have vague descriptions of IPV occurrence. Future researchers should obtain specific information about the severity and frequency of IPV in families, as well as whether the
child was witness to the IPV. Additionally, this study used a clinical sample in which all clients (both the IPV group and the non-IPV group) were referred specifically for child externalizing behaviors, and therefore these results may not generalize to other populations.

Conclusions

Mother-child relationships may appear to be functioning normally in certain situations; however, the relationship may show difficulty within the context of needed maternal authority. This finding provides additional clarity to the mixed findings in the field and may be one factor that can account for the varying results of other researchers. It is important for therapists to assess the mother-child relationship fully – both in playful interactions, as well as in directive interactions. By using a broad mother-child assessment strategy, therapists may be better equipped to identify possible difficulties in the mother-child relationship and thus develop therapeutic strategies that address each dyad’s specific difficulties.
REFERENCES


(Original work published in 1779)


