Maternal Dissociation, Emotional Acceptance and Child Emotion Regulation: A Study of Residents in a Family Homeless Shelter for Victims of Domestic Violence

Brian S. Mueller

Graduate Center, City University of New York

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MATERNAL DISSOCIATION, EMOTIONAL ACCEPTANCE, AND CHILD EMOTION REGULATION:
A STUDY OF RESIDENTS IN A FAMILY HOMELESS SHELTER FOR VICTIMS OF DOMESTIC VIOLENCE

by

Brian S. Mueller, M.A.

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This manuscript has been read and accepted by the Graduate Faculty in Psychology in satisfaction of the dissertation requirement for the degree of Doctor of Philosophy.

Margaret Rosario, Ph.D.

Date

Chair of Examining Committee

Joshua Brumberg, Ph.D.

Date

Executive Officer

Denise Hien, Ph.D.

Elliot L Jurist, PhD., Ph.D.

Lesia Ruglass, Ph.D.

Benjamin Harris, Ph.D.

Supervisory Committee

THE CITY UNIVERSITY OF NEW YORK
ABSTRACT

MATERNAL DISSOCIATION, EMOTIONAL ACCEPTANCE, AND CHILD EMOTION REGULATION: A STUDY OF RESIDENTS IN A FAMILY HOMELESS SHELTER FOR VICTIMS OF DOMESTIC VIOLENCE

by

Brian Mueller

Adviser: Professor Margaret Rosario

The present study examined the relationships between maternal dissociation, mothers’ self-described parenting behaviors in child emotion regulation, and the emotion regulatory capacity of their children. These relationships were investigated in a sample of predominately low-income African-American and Latino mothers and children residing in a domestic violence shelter. In this study, I investigated a mediational model relating maternal dissociation, mother’s acceptance of child emotions, and child difficulties in emotion regulation and behavior. I predicted that mothers who reported more dissociative experiences would demonstrate less awareness and acceptance of emotions when they responded to children’s sadness, fear, happiness, and anger. I also predicted that the children of those mothers with more dissociation would experience more difficulties with emotion regulation and behavior problems. Finally, I predicted that mothers who demonstrated more emotional acceptance would have children with fewer emotional and behavioral problems, and that emotional acceptance would mediate the relationship between maternal dissociation and child emotional and behavioral problems.

Results provided support for two of the three relationships present in the model, but not for the mediational model as a whole. Mothers who reported more dissociation demonstrated less acceptance of their children’s emotions. Mothers with more dissociation also reported more intervention when their children were upset or disruptive, an indicator of child emotion...
regulation difficulties. However, no relationship was found between maternal emotional acceptance and child emotion regulation. The relationships identified between study variables added to the small but growing literature on dissociation and parenting. The finding suggests that, through direct and indirect effects on child emotion regulation, maternal dissociation may be implicated in the intergenerational transmission of the effects of trauma.
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This project is dedicated to my wife, Laurie, and daughter Lucy, for their love and inspiration.
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Chapter 1: Introduction and Literature Review

The present study examined the relationships between maternal dissociation, mothers’ self-described parenting behaviors in child emotion regulation, and the emotion regulatory capacity of their children. These relationships were investigated in a sample of predominately low-income African-American and Latino mothers and children residing in a domestic violence shelter. In this study, I investigated a mediational model relating maternal dissociation, mother’s acceptance of child emotions, and child difficulties in emotion regulation and behavior (see Figure 1). I predicted that mothers who reported more dissociative experiences would demonstrate less awareness and acceptance of emotions when they responded to children’s sadness, fear, happiness, and anger. I also predicted that the children of those mothers with more dissociation would be experiencing more difficulties with emotion regulation and behavior problems. Finally, I predicted that mothers who demonstrated more emotional acceptance would have children with fewer emotional and behavioral problems, and that emotional acceptance would mediate the relationship between maternal dissociation and child emotional and behavioral problems.

More research is necessary to determine the ways that parental trauma history is associated with deficits in parenting and a range of negative child outcomes. This study provides information about the understudied impact of dissociation in the relationship between maternal trauma and child emotion regulation, applicable to the homeless population studied, and perhaps to other populations of families with a high incidence of maternal trauma history, including homeless families without a domestic violence history, and other low-SES families (Anooshian, 2005; Bassuk et al., 1996).
The meta-emotion model of parent-child emotion regulation (Gottman, Katz, & Hooven, 1997) is used in this study as a framework for understanding the impact of parental dissociation on parent-child interactions that affect development of child emotion regulation. The literatures on dissociation and on the impact of dissociation on parenting will be reviewed, along with literature on the relationship among maternal trauma, mediators other than dissociation, and parenting behavior.

![Conceptual model of relationship between maternal dissociation and child emotion regulation, partially mediated by maternal acceptance and awareness of child’s emotions.](image)

**Figure 1.** Conceptual model of relationship between maternal dissociation and child emotion regulation, partially mediated by maternal acceptance and awareness of child’s emotions. Path c represents the direct effect of dissociation on child emotion regulation, while path c’ represents the reduced but non-zero effect after partial mediation by emotional acceptance. Minus and plus signs represent the direction of effects.

**Emotion Regulation, Meta-Emotion, and Parenting Behavior**

Beginning with the parent-infant attachment relationship, emotion regulation is a set of skills and capacities, developed in interpersonal contexts, to manage levels of arousal, including both the child’s intrinsic processes and interpersonal behaviors (Cole & Teti, 1994; Fonagy, Jurist, Gergely, & Target, 2002; Lyons-Ruth, 2003). More precisely, emotion regulation can be
defined as “the extrinsic and intrinsic processes responsible for monitoring, evaluating, and modifying emotional reactions…to accomplish one’s goals” (Thompson, 1994, pp. 27-28).

In a series of both longitudinal and cross-sectional studies on the development of emotional self-regulation in school-aged children, Eisenberg and colleagues demonstrated relationships between parenting emotion regulation behaviors, child emotion regulation, and child behavior problems. In a longitudinal study with 186 parent-child dyads (Eisenberg et al., 2005), researchers found parental warmth and support predicted greater child effortful control, an executive function capacity associated with emotion regulation, and fewer child externalizing problems. By using a three-wave design, with measurements two years apart, the researchers were able to demonstrate that effortful control mediated the relationship between positive parenting behaviors and reduced externalizing problems. Another study (Eisenberg et al., 2001) with 155 parent-child dyads demonstrated that parents’ emotional expressivity and discussion of emotion, along with parental warmth, were negatively related to child externalizing problems, a relationship mediated by child emotional expressivity. In a third study (Eisenberg, Fabes, & Murphy, 1995), the researchers specifically examined parental attitudes and behaviors toward their children’s negative emotions. Parental behaviors that were focused on helping their children solve problems were associated with more positive assessments by teachers of their children’s social skills and coping. In contrast, parental responses that minimized their children’s negative emotions were associated with poorer social skills and coping. While temperament is a factor in child emotion regulation (Kagan, Reznick, & Snidman, 1987), this line of research provides strong evidence that parental behaviors around emotion regulation affect a child’s ability to regulate her own emotions.
This study uses the theoretical framework of meta-emotion (Doohan, Carrere, & Taylor, 2004; Gottman et al., 1997; Katz, Maliken, & Stettler, 2012) to investigate the impact of parental dissociation on child emotion regulation. As with the Eisenberg studies, meta-emotion theory is concerned with how parents transmit adaptive emotion regulation to their children. In addition, as the name implies, the concept of meta-emotion rests on the parent’s feelings about feelings. Gottman and colleagues cite Ginott (1965) as a principal influence in developing meta-emotion as a theory that emphasizes a welcoming parental stance toward emotion, and emotional communication and understanding. The three factors comprising meta-emotion are awareness, acceptance, and coaching of emotions (Gottman et al., 1997). Each factor is a necessary precondition for the next, that is, for a parent to be accepting of emotions, she must first be aware of them, and the parent must be both aware and accepting to act as a coach. Thus meta-emotion is a multidimensional and cumulative process that includes perception (awareness), thoughts and feelings (acceptance), and behaviors (coaching). This study uses the term “emotional acceptance” to capture a positive parental stance toward feelings in children, that is, the positive end of the meta-emotion spectrum. As in the meta-emotion literature, parents at the low end of the meta-emotion spectrum are described as being “emotion dismissing” (Gottman et al., 1997; Katz et al., 2012).

The meta-emotion framework assumes that parenting behaviors around emotions in the pre-school years are critical in helping a child develop emotional intelligence (Salovey & Mayer, 1990) and the ability to self-soothe in the face of negative emotions. Emotion coaching parents foster these regulatory capacities in the child by welcoming the child’s emotional moments as opportunities for intimacy and teaching. In this way, positive meta-emotion is a factor distinct from parental warmth, in that warmth principally refers to the parent’s feelings for the child,
whereas positive meta-emotion, or emotion coaching, is grounded in the parent’s feelings about feelings, both their own and their child’s.

In contrast to the welcoming stance toward the emotional states observed in emotion coaching parents, emotion dismissing parents tended not to be aware of subtle or even obvious cues that their children were experiencing negative emotion (Gottman, Katz, & Hooven, 1996). Based on their initial research, Gottman and colleagues characterized the relationship that emotion dismissing parents had with feeling states: “This State Was Often So Aversive for Them That They Tended to Prefer Not to See It at All, So They Wouldn’t Have to Deal With It” (Gottman et al., 1997, p. 84, italics and capitalization in original). The researchers ascribed the meta-emotion of “fear” to low awareness, along with a tendency to view the child’s negative emotion as “toxic” (p. 83). Gottman and colleagues do not include dissociation in the meta-emotion model. However, since disruption of awareness, or “not seeing” an aversive state, can be understood as a component of dissociative experiences, the model lends itself to the study of the impact of parental dissociation on the development of child emotion regulation.

The awareness-acceptance-coaching framework of meta-emotion theory has empirical support. Parents high on the awareness, acceptance and coaching variables had children with higher vagal tone, a physiological indicator of the ability to self-soothe (Gottman et al., 1997; Porges, 1994). In a previous study (Gottman & Katz, 1994), the authors found that vagal tone was a protective factor for children exposed to marital conflict, lending support to the idea that the regulatory processes enhanced by emotion coaching were essential to children’s well-being. Children with parents high in emotion coaching were also found to have more and better peer relationships at school age (Gottman, 2001). Because creating and maintaining school-age peer relationships involves different interpersonal processes from the “talking about feelings”
involved in emotion coaching, the authors argued that, as with vagal tone, coaching does not simply teach interpersonal skills but helps set in motion a flexible, adaptable capacity in the child.

There are both areas of overlap and differences between the concepts of emotion coaching and mentalization, another well-known theoretical framework for understanding the development of emotion regulation. Mentalization refers to the understanding of the behavior of oneself and of other people in terms of mental states (Slade, 2005). Beginning in infancy, in a benign situation, the child is mentalized by the parent who holds in mind a representation of the child as a being with thoughts, feelings, and intentions. Through the child’s interactions with the mentalizing parent, this same capacity to understand the self and others in terms of mental states is fostered in the child (Fonagy, Gergely, Jurist, & Target, 2002; Fonagy & Target, 2008). Emotion coaching does implicitly require a mentalizing stance on the part of the parent toward the child. However, emotion coaching is a narrower concept than mentalization, both developmentally and functionally. Coaching is not understood to start as early as mentalization, as coaching is mainly communicated verbally, starting in the pre-school years rather than in the pre-verbal period of infancy. Emotion coaching theory also does not claim to be involved in, or require, the child’s acquisition of cognitive capacities such as theory of mind, as is the case with mentalization. Rather, emotion coaching is manifested in beneficial parental behaviors in response to the child’s feelings, giving rise to the physiological and emotional self-regulatory capacities in the child that have been previously described. Both conceptual frameworks would benefit from research into clarifying the relationship between mentalization and emotion coaching, as has been done, for example, with the relationship between mentalization and the narrower but related concept of alexithymia (Taylor & Bagby, 2013).
While emotion coaching and meta-emotion were originally conceived of as being of particular importance in the pre-school and early school age years, there is support for a relationship between parental emotion coaching and child emotion regulation for older children as well. In a longitudinal study of 244 families including middle school and late elementary school aged children, maternal emotion coaching was associated with better anger regulation and fewer externalizing behavior problems when measured during adolescence three years later (Shortt, Stoolmiller, Smith-Shine, Eddy, & Sheeber, 2010). The longitudinal design of this study provided particularly strong evidence for the lasting effects of parental emotion coaching on child emotion regulation.

Another study focusing on depressive symptoms in adolescents provided additional evidence for the effects of maternal meta-emotion on emotion regulation in older children, and for the independent effects of the three components of maternal meta-emotion, awareness, acceptance, and coaching (Katz & Hunter, 2007). Among these older children (average age 13 years), the mother’s acceptance of her own emotion was the most powerful predictor, having a beneficial effect on the child’s self-esteem, depression, and behavior problems. Emotion coaching was also related to reduced adolescent behavior problems. Lastly, and unexpectedly, maternal awareness of adolescent emotion, the first building block of positive meta-emotion, was related to lower child’s self-esteem. One possible explanation for this negative finding could be that causality runs from the child to the parent, that is, children who are experiencing stronger negative emotions express those feelings with greater strength, resulting in greater parental awareness. Another possible explanation is that the parents who are aware of their children’s feelings, without being accepting or coaching their children in how to handle them, express a hypervigilance or preoccupation with negative affect that negatively affects child self-
esteem. More simply, it could be that for the adolescents in this study, more privacy in their emotional life was beneficial for their self-esteem. The effect of acceptance in this study also raises the possibility that parental meta-emotion factors may affect children differently depending on the child’s developmental stage. It could be that for adolescents, emotional acceptance becomes more salient than emotion coaching, in comparison with school-aged or pre-school-aged children.

The present study was conducted with mothers who have, at the least, experienced recent trauma in the form of domestic violence, and are heading up their families under the major ongoing stressor of homelessness. While meta-emotion theory and the meta-emotion interview were developed with a relatively low-risk population of mostly intact, middle-class families (Gottman et al., 1997), the framework has been used in studies with families under greater stress, including traumatic stress. Of particular relevance to the participants in the present study is research conducted by Katz and Windecker-Nelson (2006), which looked at the effect of emotion coaching on child behavior problems among pre-school aged children exposed to domestic violence. In a study of 130 families in a community based sample, rather than a shelter based sample, the researchers did not find a deficit in emotion coaching. Furthermore, they found that in children for whom maternal coaching was high, there was no relationship between domestic violence exposure and child behavior problems. In contrast, when maternal coaching was low, domestic violence was associated with higher levels of behavior problems. In other words, the beneficial effects of positive maternal meta-emotion in this study negated the harmful impact of domestic violence exposure on child emotion regulation.

While the Katz and Windecker-Nelson study (2006) looked at children exposed to domestic violence, the authors urge caution in generalizing their findings to a shelter population,
in which mothers may be likely to be depressed, have other emotion regulation difficulties, or be focusing on basic survival needs to the exclusion of emotion coaching. This caution, along with other findings about the effects of the stresses of shelter life on research (Fraenkel, Shannon, & Hameline, 2009) informed modifications to the meta-emotion interview used in this study.

**Emotion Regulation in Children Exposed to Domestic Violence**

Children’s appraisals and coping skills play an important protective role in facing various types of violent exposure. A review by Holt and colleagues (Holt, Buckley, & Whelan, 2008) found that children who can self-soothe and modulate their emotions were better able to buffer the stress experienced from exposure to violence. Further protective factors for children exposed to high marital discord included cognitive flexibility and the ability to tolerate change. Parental protective factors for these children included parental warmth and support, in addition to the beneficial effects of maternal meta-emotion described above. In contrast, studies suggest that mothers and children who have multiple stressors (domestic violence and homelessness), and do not have adequate emotion regulation skills may be at a particular risk for poorer outcomes (Buckner et al., 1999; Haber & Toro, 2004; Repetti, Taylor, & Seeman, 2002).

Intimate partner violence can extend to violence among other family members, and is a risk factor for the direct physical and sexual abuse of children (Holt, Buckley, & Whelan, 2008; McGee, 2000; Osofsky, 2003; Shipman Rossman & West, 1999). One review of thirty-five studies (Edelson, 1999) found the co-occurrence of child and maternal abuse to range from 30–60% in most studies. An earlier review of 31 studies, conducted by Appel and Holden (1998), found that child abuse co-occurred with the abuse of the mother in 40% of cases. Osofsky (1999, 2003) found the rate of child physical abuse and neglect in homes where domestic violence occurs to be 15 times the national average. As with adults, children who experience cumulative
violence, as witnesses to domestic violence and victims of maltreatment, experience more severe negative outcomes than children who have experienced only one form of violence (Osofsky, 2003). Such direct experiences of abuse put a heavy burden on children’s emotion regulation abilities.

In addition to the increased risk of child abuse that goes with domestic violence, witnessing domestic violence or intimate partner violence is a risk factor for psychological and behavioral difficulties in children. Exposure to domestic violence has been found to increase externalizing problems, including aggression and hyperactivity (Paterson, Carter, Gao, Cowley-Malcolm, & Iusitini, 2008), and internalizing problems, including depression (Howell, 2011). Research is needed in order to understand the development of children’s protective factors to cope with these experiences.

**Dissociation**

Dissociation is a broad concept that includes a variety of experiences that can occur in the wake of trauma. The DSM 5 defines dissociation as a “disruption of and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control and behavior” (American Psychiatric Association, 2013). According to this broad definition, dissociation includes a wide range of alterations of consciousness, from everyday experiences of absorption and daydreaming, through more pronounced experiences of detachment and depersonalization, to the divisions between parts of the psyche characteristic of Dissociative Identity Disorder. The literature on the various forms of dissociation and their relationship to traumatic experiences and to PTSD is reviewed below.

**Dissociation and early experience.** According to attachment theory (Bowlby, 1969/1982), human infants possess a number of inborn motivational systems. The attachment
system is a set of infant behaviors activated by fear or pain, which increase the infant’s sense of “felt security” by increasing proximity to the caregiver. Repeated experiences of attachment activation and caregiver response give rise to internal working models, cognitive-affective schemata of interactions with caregivers that predict caregiver response and shape the future expression of attachment-related behaviors. Both secure and insecure attachment styles represent a singular, coherent internal working model of the caregiver and the attachment relationship. Secure attachment behavior, in which the infant seeks the caregiver and is readily soothed by her presence, indicates an internal working model of a caregiver who is readily available and expected to make an attuned response. Insecure attachment is also an expression of attachment behavior guided by a coherent internal working model -- for instance, avoidant attachment behavior seems to be guided by an internal working model of a caregiver who is consistently unavailable.

Attachment researchers since Bowlby (1973) have theorized that infants may develop contradictory, unintegrated internal working models of caregivers and themselves faced with a caregiver who is frightening or who maltreats the infant. Disorganized attachment in infants, expressed in simultaneous approach and avoidance toward the caregiver, contradictory emotional expressions, or trance-like states (Main & Solomon, 1990), seems to be guided by contradictory models as described by Bowlby. Barach (1991) and Liotti (1992) have theorized that disorganized attachment is a dissociative experience and a precursor to adult dissociation. Liotti (1992, 2006) elaborated this thinking into a hypothesis that the dissociative experience of rapid switching between incompatible working models led to disorganized infant behavior.

Two prospective longitudinal studies established a strong link between, on the one hand, disorganized attachment and parental unavailability, and on the other, adult dissociation. The
first (Ogawa, Sroufe, Weinfield, Carlson, & Egeland, 1997), found that the mother’s psychological unavailability in infancy accounted for 19% of the variance in dissociation at 19 years old (as measured by the Taxon subscale of the Dissociative Experiences Scale). When disorganized and avoidant attachment were added to the model, 28% of the variance in adult dissociation was explained. Surprisingly, childhood trauma after infancy was not predictive of adult dissociation. This finding led Lyons-Ruth (2003) to theorize that adult dissociation grew out of what she terms the “parent-infant dialog” (p. 883), both vocalized and non-verbal interactions between parent and infant. According to her view, disorganized attachment was one component of a parent-infant dialog that can lead to adult dissociation for the infant. The study provides evidence for significant effects from negative interactions in the dialog that may be subtle to the observer, rather than focusing on more overt traumatic factors leading to dissociation, such as physical abuse. However, a meta-analysis of 2,108 adults found a significant, medium sized relationship between childhood trauma and adult dissociation (Cohen’s $d = 0.52$ to $d = 0.56$: van IJzendoorn & Scheungel, 1996), suggesting trauma must be considered a factor in the etiology of dissociation.

In a second prospective study, Dutra and colleagues (Dutra, Bureau, Holmes, Lyubchik, & Lyons-Ruth, 2009) followed 56 low-income subjects from infancy to 19 years old. The authors used extensive and varied methods to assess parent-child interaction, child attachment, and adult attachment style. The AMBIANCE coding protocol was used to measure disrupted communication by the parent, including frightened and frightening behavior, unresponsive, unattuned responses, and behavior that is intrusive or exhibits role confusion. Forty-six percent of this high-risk sample of infants was categorized with disorganized attachment in infancy, while 29% had experienced physical or sexual abuse before age 7. The study found an even
greater effect for early parental care than in the 1997 study, as 50% of the variance in adult dissociation was predicted by quality of early care. Childhood trauma did not account for a significant amount of variance, even when entered into the regression before quality of care. Significant parental quality of care predictors included flatness of affect and (lack of) positive affective involvement at home, and disrupted communication on the AMBIANCE scale in the lab. While physical and sexual abuse did not predict adult dissociation, verbal abuse did, replicating a finding by Teicher and colleagues (Teicher, Samson, Polcari, & McGreenery, 2006). The authors concluded that “the hypothesis that emerges is that a parent-child affective dialogue that repeatedly signals the parent’s reluctance or refusal to respond to infant fear or distress shapes the child’s corresponding mental organization” (Dutra et al., 2009, p. 388). This formulation dovetails with meta-emotion theory in emphasizing the effects of the parent’s feelings about emotions on the child’s emotion regulation capacities (Gottman et al., 1997).

**Dissociation and Parenting.** Early studies of dissociation and parenting involved case studies and exploratory studies of parents diagnosed with a dissociative disorder such as Dissociative Identity Disorder, formerly Multiple Personality Disorder (Benjamin, Benjamin, & Rind, 1996; Kluft, 1987). Not surprisingly, these patients struggled as parents. Researchers focused on child abuse and inconsistent parenting behavior, caused by amnesia or shifting between alter personalities, as outcomes in these case studies.

More recent empirical literature on dissociation and parenting practices indicates that dissociation plays a role in child maltreatment. Egeland and Susman-Stillman (1996) found that mothers observed to have maltreated their children had Dissociative Experiences Scale scores in the clinical range, significantly higher than did mothers who did not abuse their children. In another study of 223 undergraduate mothers using the Child Abuse Potential Inventory, a
measure that predicts whether someone is at risk of perpetrating child maltreatment, Narang and Contreras (2000) found that dissociation was strongly related to abuse potential \( (r = 0.54) \), and that dissociation mediated the relationship between mother’s own child abuse history and child abuse potential. These findings were replicated in a study with young mothers and children (Narang, 2002). These studies, along with others that found high rates of dissociation, depersonalization and amnesia among violent offenders (Moskowitz, 2004), point to a role for dissociation in violent behavior, and in mediating the transmission of child abuse from one generation to the next (Widom, 1989). In a refinement of their model, Narang and Contreras (2005) found that family affective environment moderated the effect of physical abusive history on dissociation, with positive family affective environment serving as a protective factor.

Other studies have examined the role of dissociation in parental inconsistency. In a study of 40 boys and their parents, Mann and Sanders (1994) found relationships between parental dissociation, permissive parenting style characterized by inconsistent discipline, and child dissociation. Another study of 93 parents referred to child protective services found that dissociation, but not depression, was significantly related to parent inconsistency in applying discipline (Collin-Vezina, Cyr, & Pauze, 2005). Chu and DePrince (2006) examined the role of dissociation in fluctuations of parenting style. While dissociation did not predict inconsistent parenting as hypothesized, dissociation did predict permissive parenting. When they focused on subjects with a history of betrayal trauma, that is, abuse perpetrated by a parent or significant other, the authors found that children with such a history were more likely to have a mother who had also experienced betrayal trauma. The researchers theorized that the altered information processing which marks dissociation may have impaired the ability of mothers in their study to monitor their children’s environment and detect danger cues, putting their children at higher risk.
In sum, the limited literature on parental dissociation and its effects on children shows that, among parents who have themselves been abused, dissociation is associated with child abuse potential. There is mixed evidence for the relationship between parental dissociation and inconsistent discipline. There is support for a relationship between parent dissociation and child dissociation.

**Peritraumatic dissociation.** Peritraumatic dissociation refers to dissociative alterations in consciousness that occur close to the time of a traumatic event (Spiegel, 1991). Dissociative alterations include the absence of fear, analgesia, time slowing down, depersonalization and detachment, reported by as many as 95% of survivors of near-death experiences including falls (Heim, 1892), automobile accidents, and near-drowning (Noyes, Hoenk, Kupperman, & Slymen, 1977; Noyes, Kletti, & Kupperman, 1977). Dell (2009) has argued that these dissociative experiences, which terminate when the life threat passes, are most usefully thought of as evolutionary adaptive survival-enhancing responses to danger, rather than either as a psychological defense or as a stress-related breakdown of cognitive functioning.

Another dissociative behavior that seems to have evolved in animals as a response to threats from predators is tonic immobility, or feigned death. This Tonic immobility is characterized by paralysis, muscle tension, an inhibition of vocalizing, and subjective reports of absence of pain, but not absence of fear (Heidt, Marx, & Forsyth, 2005). Unlike dissociative responses to falls, tonic immobility is predictive of future PTSD, with correlations as high as 0.49 (Fuse et al., 2007; Heidt et al., 2005).

In addition to these survival-enhancing peritraumatic processes, trauma can induce a persistent dissociative response, by creating or amplifying a dissociative structure in the personality. Some researchers (e.g. Spiegel, 1991) have argued that dissociating at the time of a
trauma predicts future PTSD and other problems. However, Briere, Scott and Weathers (2005) found that immediate peritraumatic dissociation is unrelated to subsequent PTSD, while persistent dissociative symptoms are highly related to subsequent PTSD.

**Structural dissociation.** The division of the personality into two or more relatively unintegrated parts, each with at least the beginnings of its own independent subjectivity, is known as structural dissociation (Nijenhuis, Van der Hart, & Steele, 2006; Nijenhuis & Van der Hart, 2011). Structural dissociation represents the capacity for an individual to maintain a separation between mental contents, presumably because they cause too much pain or anxiety (Nijenhuis & Van der Hart, 2011). The separate parts can become progressively more organized, stable and elaborated. In the extreme, the result is a collection of “alter” personalities, each of which has amnesia for periods when consciousness is held by another part, as in Dissociative Identity Disorder. Janet (Ellenberger, 1970), and initially, Freud (Breuer & Freud, 1893) understood their hysterical patients with conversion symptoms to be suffering from a structural division of the personality, in response to a combination of trauma and predisposing individual factors (Dell, 2009). According to a current model, structural dissociation is characterized by an initial split into an emotional personality and an apparently normal personality when faced with trauma (Nijenhuis, Van der Hart, & Steele, 2006). Faced with additional traumatic experiences or other difficulties, further splits and elaborations can occur. There is ongoing debate as to whether structural dissociation is a different process from normal or non-pathological dissociation (e.g., Nijenhuis & Van der Hart, 2011), or whether they differ only in degree on a single continuum of dissociative experience (e.g., Butler, 2004, 2006).

**Absorption.** The central characteristic of non-clinical everyday dissociative experiences is absorption -- that is, involvement in some part of conscious experience in a way that alters the
sense of relationship with the self or surroundings (Butler, 2006). The construct of absorption is closely related to that of openness to experience, a trait that can have both positive and negative effects (Glisky, Tatares, Tobias & Kihlstrom, 1991). Absorption can also be conceptualized as a tendency to narrow attention, reducing the associations in consciousness, resulting in an experience similar to getting lost in a book or movie. This subjective experience of narrowed attention has been linked to state-dependence (Dalenberg & Paulson, 2009). State-dependence as a trait refers to the degree to which a person’s ability to recall information is affected by whether or not the person is in the same state, for instance, feeling a similar emotion or level of arousal, as when the information is learned. High state dependence may be a precursor for structural dissociation (Spiegel, Hunt, & Dondershine, 1988). In addition, Allen and colleagues found high levels of absorption to be linked to psychotic symptoms (Allen & Coyne, 1995), and profound detachment, described by the researchers as becoming “absorbed in nothing” (Allen, 1999, p. 164).

**Dissociative cognition.** Cognitive researchers have found differences that are related to dissociation in various measures of attention. On a set of Stroop interference tasks, Freyd and colleagues (Freyd, Martorello, Alvarado, Hayes, & Christian, 1998) found that high dissociators exhibited more interference than low dissociators. That finding was replicated and extended in two studies (DePrince & Freyd, 1999, 2004) which showed that 1) high dissociators performed better on a divided-attention task; 2) in a free-recall task, high dissociators remembered more neutral words and fewer trauma-related words; and 3) high dissociators reported a greater trauma history. The authors argue, in line with betrayal trauma theory, that these studies show that dissociators are advantaged in their ability to divide attention, and use this ability adaptively to keep threatening information out of awareness. Other trauma-related studies (e.g. McNally,
Metzger, Lasko, Clancy, & Pitman, 1998) using a directed-forgetting paradigm, have not found
differences in performance related to dissociation or trauma exposure. However, DePrince and
Freyd (1999) have questioned the utility of directed forgetting in that it can encourage rehearsal,
which can obscure the effects of dissociation.

The betrayal trauma theory of dissociative cognition posits that dissociation, through
divided attention, is adaptive in that it allows an individual to manage the double bind of being
abused by a caregiver. That is, for survival, there are times when it is adaptive to keep the abuse
from consciousness and other times when it should be allowed into awareness. Other researchers
have found dissociation adaptive in other contexts. For instance, McGiffin and colleagues
(McGiffin et al., 2012) found differences in the relationship between dissociation and inhibitory
control when comparing two trauma-exposed groups, one with PTSD and one without. For the
group without PTSD, higher dissociation was correlated with better inhibitory control on a
Stroop task, while for the PTSD group, higher dissociation was correlated with worse
performance.

Other studies with findings of cognitive enhancements associated with high, non-
pathological dissociation, include a visual search task in which high dissociators seemed to have
increased attentional deployment to negatively valenced words, decreasing reaction time
(DeRuiter, Phaf, Veltman, Kok, & vanDyck, 2003). In a review of the literature on high non-
pathological dissociation, DeRuiter, Elzinga and Phaf (2006) theorize that this cognitive style is
characterized by a strong ability to create or recreate conscious experiences, based on underlying
abilities in elaboration learning, working memory, and attention. In similar fashion, Dorahy
(2006) argues that non-pathological high dissociators may begin with greater abilities in
attention, working memory and memory encoding, and use these capacities to best advantage by
dividing attention and processing information in multiple streams. Not all findings in this area support a cognitive-ability view of dissociative cognition, however. For instance, one study (Amrhein et al., 2008) found lower working memory among high dissociators. The interaction of trauma history and dissociative capacity may account for these differences (McGiffín, personal communication), and merits further study.

**Compartmentalization and detachment.** A number of theorists of dissociation (Allen, 2001; Cardeña, 1994; Holmes et al., 2005; Putnam, 1997) have noted a distinction between, on the one hand, alterations in consciousness such as derealization and depersonalization, and on the other, a non-integration of mental systems, such as amnesia, conversion disorders, or Dissociative Identity Disorder. In a review, Holmes et al. (2005) argue for using the terms “detachment” and “compartmentalization” respectively for these two categories of dissociative phenomena, and studying them as separate entities. This view is similar to that of structural dissociation theorists (Nijenhuis, Van der Hart, & Steele, 2006), in that it sees compartmentalizing experiences as qualitatively different from milder experiences such as absorption (a mild experience of detachment). By including detachment, Holmes and like-minded theorists also account for a variety of dissociative experiences that are not captured by structural dissociation: psychotic levels of absorption, derealization, and depersonalization.

**Dissociative Subtype of Posttraumatic Stress Disorder (PTSD).** Because trauma can induce both dissociation and PTSD symptoms, researchers have explored the relationship between them. One study of Vietnam veterans with PTSD found that Dissociative Experience Scale scores were grouped into two clusters, with a majority endorsing normal levels of dissociation and about 30% endorsing dissociation at clinical levels (Waelde, Silvern, & Fairbank, 2005). A similar clustering was found in a study of survivors of childhood sexual
abuse (Ginzburg, Koopman, Butler et al., 2008). Using a confirmatory factor analysis, Steuwe, Lanius, and Frewen (2012) found that the dissociative symptoms of Depersonalization and Derealization loaded on a separate factor from PTSD, with 26% of subjects falling in the dissociative subtype. Lanius et al. (2010) also found consistent differences in physiological arousal and patterns of brain activation between dissociative and non-dissociative PTSD patients during re-exposure (reading a trauma-related script). A study with 492 veterans (Wolf et al., 2012) found three subtypes, low severity PTSD, higher severity PTSD, and 12% in a dissociative, severe PTSD group.

These findings, along with the accepted understanding that both dissociation and PTSD can result from trauma, have led to the question of whether a causal relationship exists between dissociation and PTSD. One causal formulation is that trauma causes dissociation, which causes PTSD, among other outcomes. This model is aligned with van der Kolk’s categorization of primary, secondary and tertiary dissociation (van der Kolk, 1996), which describes peritraumatic dissociation as the beginning of a dysregulated response to trauma. As noted above, however, it is probable that there are multiple types of peritraumatic dissociation in response to life threat, some more benign than others.

Alternative models for the relationship between PTSD and traumatic dissociation are 1) a component model, that dissociation and PTSD are both potential components of an overall response to trauma, and 2) a subtype model, that PTSD along with high dissociation is a distinctive subtype of PTSD. Cluster analyses of trauma symptoms (Waelde, 2005), and of brain imaging in trauma survivors (Steuwe & Lanius, 2012) support the model of PTSD-with-dissociation as a subtype of PTSD. However, both models were found to be supported in a two-part review of 25 cross-sectional studies on the relationship between dissociation and PTSD.
The authors found that dissociation and PTSD symptoms were just as highly correlated with each other ($r = .49$ to $r = .91$) as PTSD symptoms were with themselves. Also, dissociation symptoms and PTSD symptoms were correlated in how they change over time in response to treatment. Trauma exposure and dissociation were moderately correlated ($r = 0.36$ to $r = 0.42$). In the PTSD subtype, the authors also found that detachment symptoms (derealization/depersonalization) were the most common types of dissociative symptoms, making it likely that some dissociative process other than structural dissociation (which is characterized by experiences of compartmentalization) was at work. This distinction supports the study of parental dissociation as distinct from parental PTSD as a risk factor in the development of child emotion regulation. Parental PTSD has been shown to negatively impact child emotion regulation (Yasai, 2012). Further research is needed to compare the impact of parental dissociation in the presence and absence of PTSD. As the McGiffin (2012) study of dissociative cognition showed, dissociation can either promote or impede cognitive functioning, depending on the presence or absence of PTSD symptoms.

**Dissociation, sex, age, race and ethnicity.** Dissociation levels have not been found to differ between women and men when measured using the Dissociative Experiences Scale, in either non-clinical samples (Carlson & Putnam, 1993; Ross, Joshie, & Currie, 1990) or clinical samples (Bernstein & Putnam, 1986; Spitzer et al., 2003). Self-reported dissociation levels among adults have been found to decrease slightly with age (Carlson & Putnam, 1993; Ross et al., 1990).

The research on dissociation and race and ethnicity has been mixed. In one study of male combat veterans suffering from PTSD (Branscomb, 1991), no differences were found in levels of
self-reported dissociation between white and African American participants. However, in another study of male veterans being treated in a Veterans Administration substance abuse clinic, African American participants reported higher levels of dissociation than whites (Dunn, Paolo, Ryan, & Van Fleet, 1993). Among male and female police officers who had been exposed to a traumatic event, Hispanic officers reported having experienced slightly more peritraumatic dissociation symptoms at the time of the event than either white or African-American officers. This study did not assess longer-term levels of dissociation.

Among non-clinical samples, findings for racial and ethnic differences in dissociation levels have been mixed as well. In one study conducted with Hispanic undergraduates at a Puerto Rican university, dissociation levels were no different from findings among undergraduates in other international studies conducted in England, Scotland, and the United States (Martinez & Taboas, 2000). In another study, conducted at a single university in the United States, no differences in dissociation levels were found among groups of students who identified as African American, Hispanic, and Asian American; however, all three groups had mean dissociation scores that were significantly higher than the mean score of white students (Douglas, 2009). Furthermore, for Asian and African American students, but not for white or Hispanic students, higher levels of dissociation were related to lower levels of depression. This finding raises the possibility that not only may dissociation function as an adaptive coping mechanism, but that there may be cultural factors in whether dissociation functions in this way for an individual. Further research is needed in this area.

**Dissociation Summary.** Dissociation refers to a combination of processes, serving multiple functions. Dissociative responses can be transitory and adaptive, in the cases of everyday absorption and evolutionarily-based responses to life threat. Dissociative cognitive
style appears also to be adaptive for non-traumatized individuals. Other, more serious forms of
dissociation are associated with an impairment in functioning, including tonic immobility,
structural dissociation, dissociative subtype of PTSD, and response to early parental
unavailability. However, there is some debate over the adaptive function of even chronic
dissociation, which betrayal trauma theorists conceptualize as an adaptive, rather than
pathological, response to trauma. As a phenomenon linking trauma, parenting behaviors, and
child attachment and emotion regulation, dissociation merits continued study.

**Studying a Risk Factor in a Population of Multi-Stressed Families**

Any study of a psychological risk factor (in this case, dissociation) carries the danger of
pathologizing families that may be dealing with multiple, mutually reinforcing social and
economic stressors, including racial discrimination, poverty, histories of violence, and the
interruption of family and community ties associated with living in shelter. The present study of
families in a shelter for victims of domestic violence was conducted with the understanding that
the participant families are multi-stressed (Madsen, 1999), drawing on individual, family and
extrafamilial strengths and resources to cope with adversity. Consistent with classic studies of
resilience in children (Garmezy, 1993, Masten et al., 1993; Rutter, 1987; Werner, 1995), and
with female survivors of domestic violence (Humphreys, 2003), participants used a variety of
active strategies to reduce the impact of negative life events, promote self-efficacy, and open up
new opportunities (Rutter, 1999).

**Conclusion**

The literature on trauma, dissociation, and parenting supports clinical anecdotal evidence
that parental dissociation negatively affects a parent’s ability to be an attentive and consistent
caretaker. The extant research provides some evidence that parental dissociation has a modest
relationship with child maltreatment, along with mixed data on the relationship between dissociation on the one hand and both inconsistent discipline and permissive parenting style. To date there has been no quantitative or qualitative exploration of how dissociation relates to parents’ self-described attempts to help children regulate their own emotions. Through analysis of interviews, this study aimed to explore specific mechanisms by which parent dissociation might impede child emotion regulation, including potential problems with emotion perception, acceptance, affect matching, response matching, and providing a goal state. The study also extends knowledge about the relationship between parental dissociation and child emotion regulation by using well-established, multi-component measures completed by both parent and child. The study focused on a group of mothers and children that was exposed to potentially traumatizing experiences and to the chronic stresses of shelter life. A better understanding of the relationship between the dissociative effects of trauma in mothers and effects on child emotion regulation will inform the development of specific clinical and community interventions to help these families and others at similarly high levels of risk.

**Statement of Hypotheses and Qualitative Insights**

The study focused on the extent to which maternal psychological functioning, specifically dissociation, is associated with the mother’s acceptance of the child’s emotions, and with child emotion regulation as assessed by both parent and child. Relationships have been found between dissociation and other maternal factors affecting child emotion regulation, including abuse potential, and inconsistent parental discipline. Therefore a partial, rather than full, mediational model was proposed (see Figure 1, page 2), in which maternal emotional acceptance explains a significant part of the effect of dissociation on child emotion regulation. I hypothesized that:
1. Maternal dissociation is associated with more child emotion regulation difficulties (model path c).

2. Maternal dissociation is associated with less acceptance of child’s emotion (model path a).

3. More maternal emotional acceptance is associated with less child emotion regulation difficulties (model path b).

4. Maternal emotional acceptance partially mediates the relationship between maternal dissociation and child emotion regulation (model path c’ will be less than c, but not equal to zero).

Examples drawn from the qualitative data of differences in child emotion regulation strategies between mothers experiencing high and low dissociation were also compared for themes of parents’ awareness and acceptance of their own and their children’s emotions.
Chapter 2: Method

Larger Study

This study made use of archival data collected during a larger study focused on homeless families living in the shelter system (Fraenkel, 2006; Fraenkel et al., 2005). Using qualitative and quantitative measures, the larger study explored the multiple stressors faced by families living in shelter, and the coping strategies used by individual family members and by families as whole systems. The larger study also examined the effectiveness of Fresh Start for Families, a multiple family discussion group designed to promote coping and resilience among homeless families (Fraenkel et al., 2009). The Fresh Start program was designed to provide support for families coping with the stressors of residing in the shelter and with the mental health effects of domestic violence. The program included discussion sections with whole families and also separate discussion spaces for parents and children to identify and to begin working through strong negative emotions related to past trauma and current stressors in a contained and age-appropriate format. The objectives of the group were to help foster coping and resilience at the family system level, to foster emotion regulation skills in both parents and children, and to assist parents in attuning to and responding to their children’s emotions. The program consisted of a six-week manualized multiple family discussion group with two additional weeks, one before and one after the group, in which pre- and post-intervention data were collected.

The larger study was IRB-approved, and was conducted at two locations: a homeless family shelter in the South Bronx and a shelter specifically for women and children who are homeless due to domestic violence in Northern Manhattan. The archival data for the present study were collected at the HELP USA domestic violence shelter, the specific location of which is confidential. Families typically reside at HELP Harbor for about 8 to 9 months while they
work to obtain permanent housing. Mothers also participated in job training, searching for employment and a variety of social services.

**Recruitment process of the larger study.** Women and children were recruited to join the larger study, and were given the option to join the multiple family discussion groups. The study used a convenience sample, in which trained members of the research team (doctoral Psychology students) contacted individual families on the shelter roster by phone calls to units and mailbox notices. The shelter staff and case managers also assisted in alerting residents about the research and discussion group.

Interested families were scheduled to meet in person with a research assistant to go over the details of both the research and the discussion groups, and to sign the consent form. Mothers were then asked to participate in a semi-structured interview that took between 30 and 60 minutes. The interview had two main sections. The first section covered families’ emotions around becoming homeless, living in the shelter, the ongoing challenges they faced, and the ways in which each family member coped with his or her emotions. The second section was the Emotional Acceptance Interview used in this study. With consent, children were also interviewed separately by a research assistant. Participants who declined the interview, declined to be recorded, or did not complete both parts of the interview were still invited to complete the packet of quantitative measures and to participate in the group.

With consent, parent and child interviews were audio-recorded. The mothers’ questionnaire packet consisted of 13 measures of demographics, information about their own feelings and behaviors, their children’s feelings and behaviors, and about family coping strategies. Children completed a smaller packet including measures about their own emotions and how they handle them; and about family characteristics. Mothers were compensated with
$25 for completing all or part of the interview and $25 for completing the questionnaire packet. After completing the multiple family discussion group, mothers received a post-intervention questionnaire packet, and were compensated an additional $25 for its completion. Children were compensated with a $10 gift certificate for completing their packet. Participants were reminded and encouraged to complete their questionnaires by research assistants. Measures were either returned in-person to a research staff member or brought to a family group session. Research assistants then checked packets for completeness, addressed any questions and provided assistance when requested.

Participants

The present study used archival data completed prior to the multiple family discussion group by the subset of the larger study’s sample that was residing in the domestic violence homeless shelter and that completed the measures under study here. Families were included if they completed both parent and child questionnaires, along with the emotional acceptance interview. For families with completed measures for two or more children, one child was chosen at random for inclusion in this study. The IRB approved the present study of anonymous archival data as not meeting the definition of human subjects research.

Of the 33 mother and child pairs that successfully completed the quantitative measures, a subset of 20 completed the emotional acceptance interview, and it is these 20 who form the sample for the present study. All families included in this study were English-speaking. Mothers ranged in age from 26 to 53 years old, with a mean age of 35.6 (SD = 7.3), and a median age of 34. Their children ranged in age from 6 to 14 with a mean age of 10.3 (SD = 2.3), and a median age of 10. There were equal numbers (50%) of male and female children. No further demographic or educational information was available for the children in this study. About two
thirds of the mothers identified as African American, and about one third identified as Hispanic. The racial identification of the children by their mothers was similar. Complete demographic data are presented for mothers and children in Tables 1 and 2 respectively. For comparison, both tables also contain demographics for the 13 mother-child pairs from the larger study who completed the questionnaires but not the interview, and were thus not included in the present study. There were no significant demographic differences between the 20 mothers and children included in the present study and the 13 that were not.
Table 1
Maternal Demographic Characteristics

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Study Participants (n = 20)</th>
<th>Participants not Included in Current Study (n = 13)</th>
<th>Effect Size</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>%</td>
</tr>
<tr>
<td>Mother’s Age</td>
<td>35.60</td>
<td>7.29</td>
<td></td>
</tr>
<tr>
<td>Citizenship</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>US Citizen</td>
<td>80</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education: At least High</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>School Graduate or GED</td>
<td>80</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>65</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td>35</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>25</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed</td>
<td>80</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weeks In Shelter</td>
<td>22.36</td>
<td>20.54</td>
<td></td>
</tr>
</tbody>
</table>

Note. Participants not Included in Current Study refers to participants who completed the quantitative measures of the larger study, but not the Emotional Acceptance Interview. All variables for the two groups were compared using an independent samples t-test without a significant result. Cohen’s d indicates the effect size of the differences between the participants included and not included in the current study.
Table 2  
*Child Demographic Characteristics*

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Study Participants (n = 20)</th>
<th>Participants not Included in Current Study (n = 13)</th>
<th>Effect Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Age</td>
<td>10.26 2.26 %</td>
<td>9.90 2.51 %</td>
<td>0.15</td>
</tr>
<tr>
<td>Child Sex (Girls)</td>
<td>50 67</td>
<td>67</td>
<td>0.33</td>
</tr>
</tbody>
</table>

*Note.* Participants not Included in Current Study refers to participants who completed the quantitative measures of the larger study, but not the Emotional Acceptance Interview. All variables for the two groups were compared using an independent samples t-test without a significant result. Cohen’s *d* indicates the effect size of the differences between the participants included and not included in the current study.
Procedures

Recruitment and measure administration procedures are described above in the Larger Study section. All data records were deidentified and stored anonymously.

Mothers’ Measures

**Dissociative Experiences Scale.** The Dissociative Experiences Scale (DES; Bernstein & Putnam 1986; Carlson & Putnam, 1993) is a 28-item self-report measure designed to assess the degree to which participants experience dissociation. Rather than asking about a specific time frame, the measure asks “to what degree the experience described in the question applies” to the participant. Some DES questions describe relatively common experiences, for example “Some people find that they sometimes are able to ignore pain.” Other items tap into less common experiences, for instance, “Some people have the experience of feeling that their body does not seem to belong to them.” Each question is followed by a horizontal scale of marks on the page, anchored with Never (0%) at one end of the scale to Always (100%) on the other. An individual’s score is computed by taking the mean of the 28 items on the measure.

The psychometric properties of the DES have been extensively studied. Test-retest reliability coefficients of the DES have been found to range from .79 to .86, with split-half reliability coefficients ranging from .83 to .93 (Bernstein & Putnam, 1986; Frischolz et al., 1990). Bernstein and Putnam (1993) reviewed numerous studies that provide support for the establishment of construct and criterion validity for the DES. One meta-analysis found the DES to have excellent convergent validity with other dissociation questionnaires and interviews (Cohen’s $d = 1.82, N = 5,916$; van IJzendoorn & Schuengel, 1996), and good predictive validity for dissociative disorders (Dissociative Identity Disorder, Cohen’s $d = 1.05, N = 1,705$).

Factor analyses have led to two main competing factor models of the DES. One is the
three-factor model first proposed with the scale (Bernstein & Putnam, 1986), representing three categories of dissociative experience: Amnesia, Absorption and Imaginative Involvement, and Derealization/Depersonalization. However, the scale developers, along with Waller (Carlson & Putnam, 1993; Waller, Putnam, & Carlson, 1996) suggest that the three factors may be an artifact of the positive skew of most DES data. For this reason, the three-factor model was not used for hypothesis testing in the current study. However, because those factors do have some limited empirical support, and correspond to meaningful theoretical categories of dissociative experiences, the three factor subscales were included in the secondary analysis.

The Dissociative Experiences Scale has been widely used as a screening instrument for dissociative psychiatric disorders. There have been two main approaches to determining clinical levels of dissociation. One approach has been to use a cutoff score of 30, which has been found to have good sensitivity (76%) and specificity (76% to 85%; Carlson et al., 1993). The other has been to use eight infrequently endorsed items from the Amnesia and Depersonalization subscales on the DES as a clinical subscale, the DES Taxon Scale (Waller, Putnam, and Carlson, 1996). Utilizing a cutoff score of 30 on the Taxon scale has been found to have somewhat greater sensitivity (87%) than the overall score (Waller, Putnam, and Carlson, 1996). However, the test-retest reliability of the Taxon scale has been low ($r < 0.3$), and the construct validity of the DES-Taxon has not been established. For this reason, the widely used DES clinical cutoff of 30 (Carlson & Putnam, 1993), rather than the Taxon scale is used in this study.

The overall DES mean score for the study sample was 17.70 ($SD = 13.79$) and scores ranged from 0.36 to 61.07, out of a possible range of 0-100. Three participants (15%) had scores above the clinical cutoff of 30, indicating the likely presence of either a dissociative disorder or PTSD with dissociative symptoms (Carlson & Putnam, 1992). Distribution of DES scores was
found to be leptokurtotic and positively skewed; therefore, a square root transformation was performed prior to hypothesis tests. Scores showed excellent internal consistency (alpha = .91).

**Emotional Awareness and Acceptance Interview.** This interview and coding of responses were based on the principles underlying the Meta-Emotion Interview developed by Gottman, Katz, and Hooven (1997), and modified by Katz and Carrere (2004). Meta-emotion is conceptualized as a continuous dimension, ranging from “emotion dismissing” at the lower end of the scale, to “emotion coaching” at the upper end, with three cumulative components, emotional awareness, emotional acceptance, and coaching of child emotions. The meta-emotion interview was initially developed with a low-risk sample of parents and children, rather than the sample of multiply-stressed families in the present study. In order to maximize variation in the current sample, the interview used here was designed mainly to capture the two more basic components of positive meta-emotion, awareness and acceptance of the child’s emotions. While the measure did include 20% emotion coaching items, in that parents were asked how they intervened with their children, 80% of the items concerned emotional awareness and acceptance.

Earlier versions of the meta-emotion interview have also included items asking the participant about their own early emotional experiences. However, prior interview-based research with shelter residents that focused on early experience, collected by the research team involved in the current study, yielded data with little variation (Fraenkel, 2010). Accordingly the interview administered here focused on recent interactions between parent and child, as follows:

1A. Tell me about a recent time or incident when your child was sad (or other emotion). How could you tell? What did they say or do? (NOTE: If the parent can’t come up with a specific memory, which is quite common when
something has happened repeatedly, ask): Well, can you tell me about how it usually goes when your child is sad – a typical time?

1B. How did you feel and what did you do?

1C. How did your child respond to you?

After parents were asked about a time when their child was sad, they were then asked about “happy or excited”, “scared or nervous” and “angry or frustrated” episodes. For each emotion, the interview was coded for the presence (1) or absence (0) of the following elements:

1. Recall of an episode, or of a typical event associated with the emotion.

2. Matching evidence for the labeled emotion (for instance, the parent knew the child was sad because he was crying, said he was sad, or had a sad expression.

3. Parent made a reasonably attuned response to the child, for instance, in the case of sadness, a comforting or empathically inquiring response.

4. The parent’s report of her own emotion during the episode was congruent and/or explicable (for instance, “I knew it was going to be okay,” “When she’s sad I feel sad too,” or “When she’s sad I feel angry, because I don’t want anything to happen to my children to make them sad.”)

5. Parent’s reasonably attuned response had an intelligible goal (for instance, a response to sadness had the goal of comforting, or understanding)

This scale creates a 6-point summed score for each emotion, ranging from 0 to 5, and a 21-point overall score (0 – 20) for the 4 different emotional states in the interview. Interviews were transcribed either by the principal investigator or other research assistants. All transcriptions were reviewed by the principal investigator. Interviews were independently coded by the principal investigator and one other Psychology doctoral student after reviewing the Meta-
Emotion Interview and coding system (Doohan, Carrere, & Taylor, 2004; Katz, Gottman, & Hooven, 1996). Twenty-five percent of the sample was used to assess inter-rater reliability, using an intraclass correlation coefficient (ICC) for the emotion-level subscales. Reliability was high (ICC[2, 2] = .93, $p < .01$), as was internal consistency (alpha = .92). Interview scores ranged from 4 to 19, out of a possible 0 to 20. Distribution was normal. Scores on this interview are referred to in the Results section as Acceptance scores.

In the past, different iterations of the Meta-Emotion Interview have included different sets of specific emotions. The original interview (Gottman, et al., 1996) was composed of questions about two negative emotions, sadness and anger. A revised interview (Katz & Carrere, 2004) was broadened to include sadness, anger, pride, and love/affection. The interview in the current study included one positive emotion, happy, and three negative emotions, sadness, anger, and fear.

The inclusion of positive emotions in the meta-emotion interview can be thought of in at least two ways. On the one hand, it is conceivable that a parent’s emotion-dismissing responses would only be engaged by negative emotions, in which case, questions about a positive emotion would be irrelevant to the variable being studied. On the other hand, investigation of a positive emotion question could serve to make the measure more sensitive at the low end of the scale. For instance, it could be the case that both moderately and extremely emotion-dismissing parents would have low scores on an interview comprised only of questions about negative emotions, whereas positive emotions might be tolerable to the moderately dismissing parent but intolerable to the extremely dismissing parent. In that case, positive emotion questions would capture variation that negative emotion questions would miss.
Maternal Intervention: Child Regulation Index. The Child Regulation Index (Katz & Gottman, 1986) is a 45-item questionnaire about child emotion regulation, completed by a parent. The measure contains a 14-item scale concerning specific ways in which parents have acted to calm their child, control temper tantrums, or restrict inappropriate behavior. While originally termed the Downregulation Scale, the scale will be referred to in this study as the Intervention Scale, as the term “downregulation” is now widely used in a neurological context. Intervention scale items include how often in the past week caregivers told their child to “Stop interrupting,” or to “Simmer down.” Responses are given on a 5-point, Likert-type scale ranging from “Never” (1) to “Very Often” (5). An individual’s Intervention score is computed by summing the scores for the 14 scale items; higher scores represent more maternal intervention. The intervention scale has acceptable internal consistency (Cronbach’s alpha = .74; Katz & Gottman, 2002) and correlates with externalizing behavioral problems (Gottman, et al., 1996).

In this study, intervention scores on the Child Regulation Index were normally distributed, with acceptable internal consistency (alpha = .75). Summed scores ranged from 16 to 50, out of a possible range of 14 to 70.

Child Behavior Checklist (CBCL). The CBCL (Achenbach, 1991) is a general behavioral measure of a wide range of childhood problems related to attention, thought, affective, social, somatic complaints and aggressive behavior. There are two versions of the CBCL that target different age ranges: one for children between 1½ and 5 years of age (revised in 2000), and the version used in this study for children from 6 to 18 years of age. The CBCL measures 118 behavior problems rated on a scale from 0 to 2, and takes between 15 and 17 minutes for the parent to complete. The CBCL has three global scales: internalizing, externalizing and total behavior problems. This study used the total behavior problems score, referred to as Behavior or
Child Behavior. Summed raw scores for these subscales are converted into T-scores according to the appropriate gender and age-group norms for each subject. T-scores are used for norms comparison, while total scores are used as study variables, as recommended by Achenbach (1991). The CBCL is a widely-used, well-validated measure of children’s adjustment. The measure has been normed with both clinical and non-clinical populations, with socioeconomic status and race having little effect on scale scores (Achenbach & Edelbrock, 1991).

In this study, scores on the CBCL were normally distributed, showing excellent internal consistency (alpha = .93). Seven participants (35%) had CBCL Total T-scores at or above 63, indicating that they were in the clinical range based on scale norms (Achenbach 1991, Achenbach & Rescorla, 2000). These scores represent an expected range and distribution for children with similar levels of exposure to interpartner violence (McFarlane et al., 2003).

**Child Self-Report Measure**

**Children’s Emotion Management Scale (CEMS).** Children completed a self-report measure of emotion regulation, the Children’s Emotion Management Scale (Shipman & Zeman, 2002; Zeman, Shipman & Penza-Clyve, 2001; Zeman, Shipman & Suveg, 2002). The CEMS assesses emotion management styles for both sadness and anger. The measure contains 23 items and uses a 3-point Likert-type format (1: hardly ever, 2: sometimes, 3: often).

Three emotion management factors were identified using factor analysis, yielding three subscales (Zeman et al., 2002) for the combined responses to sadness and anger. The measure contains subscales for Inhibition (masking or suppressing an emotional expression), Emotion Regulation Coping (perceptions of coping with anger and sadness through constructive control of emotional behavior), and Dysregulated Expression (culturally inappropriate expression of sadness or anger). Subscale scores are generated by summing the relevant item scores. Higher
scores on the Inhibition and Dysregulated Expression scales represent more of those problematic emotion regulation behaviors, while higher scores on the Coping scale represent more adaptive emotion regulation behaviors (alpha ranged from .61 to .79). The scales were normally distributed, with adequate to good internal consistency.

In a community sample of mostly white fourth- and fifth-grade children, construct validity was established in relation to measures of anger and sadness regulation completed by parents and peers (Zeman et al., 2001). Test-retest reliability for the six scales ranged from .61 to .80, with coefficient alphas between .62 and .77, in a sample of maltreated children (Shipman, Zeman, Penza, & Champion, 2000) and African-American youth (Perry-Parrish & Zeman, 2008).

**Differences in Study Variables Depending on Whether Participants Completed Interview**

As noted above, of the 33 mother and child pairs that successfully completed the quantitative measures, a subset of 20 completed the emotional acceptance interview, and it is these 20 who form the sample for the present study. Student’s t-test was used to assess for systematic differences of study variable scores between the 20 participants included in the present study and the 13 participants not included, with results presented in Table 3. Of note is the high level of dissociation among the group of mothers who did not complete the emotional acceptance interview and were not included in the present study, significantly higher than the mothers included in the present study. Almost half, or 6 of the 13 mothers not included had scores above the commonly used clinical cutoff for the dissociation measure used in this study (mean Dissociative Experiences Scale score = 31.05, $SD = 25.33$, Clinical Cutoff = 30). This finding suggests that there may have been a systematic difference between mothers who completed the interview and those who did not: As a group, the 13 mothers who did not complete the interview seem to have been experiencing significantly more psychological
Table 3

Differences in Study Variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>Study Participants (n = 20)</th>
<th>Participants not Included in Current Study (n = 13)</th>
<th>Effect Size</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
</tr>
<tr>
<td>Dissociation</td>
<td>17.70</td>
<td>13.79</td>
<td>31.95</td>
</tr>
<tr>
<td>Child Behavior Problems</td>
<td>54.84</td>
<td>12.02</td>
<td>52.45</td>
</tr>
<tr>
<td>Intervention by Mother</td>
<td>34.90</td>
<td>11.08</td>
<td>30.23</td>
</tr>
<tr>
<td>Child Inhibition</td>
<td>1.98</td>
<td>0.44</td>
<td>2.00</td>
</tr>
<tr>
<td>Child Coping</td>
<td>2.13</td>
<td>0.47</td>
<td>2.06</td>
</tr>
<tr>
<td>Child Dysregulation</td>
<td>1.84</td>
<td>0.51</td>
<td>1.72</td>
</tr>
</tbody>
</table>

*Note. Participants not Included in Current Study refers to participants who completed the quantitative measures of the larger study, but not the Emotional Acceptance Interview. All variables for the two groups were compared using an independent samples t-test. Cohen’s d indicates the effect size of the differences between the participants included and not included in the current study. *p = .05

Data Analysis

All questionnaires were scored by hand by research assistants from the Fresh Start research team. Questionnaires were then rescored by entering each item for each measure into SPSS, calculating overall scores, and checking the results against the hand-calculated scores. If less than 10% of items were blank on a questionnaire, missing items were imputed by using subscale average score. The Emotional Acceptance Interview was scored independently by two coders.

Descriptive statistics were generated for demographic items and subscale scores. Relationships among variables (mother’s rating of child emotion regulation and behavior, child’s self-rating of emotion regulation, Emotion Awareness/Acceptance Interview score, maternal dissociation, and demographics) were evaluated using correlation analysis. The one demographic variable found to be significant in the initial correlation analysis, maternal age, was added as a
first step in the regression hypothesis tests to adjust for its influence. Dissociation and Acceptance scores were centered about the mean, and their product was then calculated. Two-step linear regression was then used to test the hypothesis that maternal emotional acceptance mediated the relationship between maternal dissociation and child emotion regulation, with the product term entered as a second step after the main effects, to test for an interaction.

Analysis for mediation followed the conditions set out by Kraemer (Kraemer, Kiernan, Essex, & Kupfer, 2008). The first condition to be met was that there be a relationship between predictor and mediator, that is, between dissociation and emotional acceptance. The second condition required one of two situations: First, that a significant relation exists between acceptance and child emotion regulation after adjusting for dissociation and any covariates. Or, second, that a significant interaction exists between dissociation and acceptance on child emotion regulation, suggesting that the relation between acceptance and child emotion regulation depends on the degree of maternal dissociation.

Secondary analyses were then performed. First, differences between positive (happy) and negative emotions on the emotional acceptance interview were investigated using a randomized block ANOVA. Based on those findings, an Acceptance of Negative Emotions score was calculated for each participant, by summing all interview items for Sad, Angry, and Scared emotions. These scores were centered about the mean and multiplied by the centered dissociation score to create a product term, which was entered as a second regression step after the main effects to test for an interaction. The regression used for hypothesis testing was then performed again, using the Acceptance of Negative Emotions score in place of the Total Emotional Acceptance score.

Two additional secondary analyses were performed. Relationships between emotional
acceptance, child emotion regulation, and the three subscales of the dissociation scale, Amnesia, Depersonalization/Derealization, and Absorption, were analyzed using Pearson product-moment correlation. Finally, salient themes from the emotional acceptance interview for future research were highlighted. This was an interview and, thus, mothers’ comments were recorded. Their comments are noted here.
Chapter 3: Results

Descriptive Statistics

Means and standard deviations are reported for all variables below, and are presented along with skewness and kurtosis data in Table 4. Scales were considered normal if the absolute value of the standard error for both skew and kurtosis was less than two.

Table 4
Reliability, Range, Means, Skewness, Kurtosis for Predictor, Mediator, and Criterion Variables

<table>
<thead>
<tr>
<th>Measure</th>
<th>N</th>
<th>Cronbach’s alpha</th>
<th>Range (Possible)</th>
<th>Mean (SD)</th>
<th>Skewness (SE)</th>
<th>Kurtosis (SE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dissociation</td>
<td>20</td>
<td>.908</td>
<td>(0-10)</td>
<td>3.91</td>
<td>0.313</td>
<td>1.283</td>
</tr>
<tr>
<td>Emotional Acceptance</td>
<td>20</td>
<td>.920</td>
<td>(0-20)</td>
<td>13.79</td>
<td>-0.639</td>
<td>-0.520</td>
</tr>
<tr>
<td>Intervention by Mother</td>
<td>20</td>
<td>.753</td>
<td>(14-70)</td>
<td>34.90</td>
<td>0.058</td>
<td>-1.589</td>
</tr>
<tr>
<td>Child Behavior Problems</td>
<td>19</td>
<td>.930</td>
<td>(0-100)</td>
<td>54.84</td>
<td>-0.869</td>
<td>0.988</td>
</tr>
<tr>
<td>Child Emotion Inhibition</td>
<td>18</td>
<td>.714</td>
<td>(1-3)</td>
<td>1.98</td>
<td>-0.704</td>
<td>-0.375</td>
</tr>
<tr>
<td>Child Emotion Coping</td>
<td>18</td>
<td>.790</td>
<td>(1-3)</td>
<td>2.13</td>
<td>-0.115</td>
<td>-1.300</td>
</tr>
<tr>
<td>Child Emotion Dysregulation</td>
<td>18</td>
<td>.606</td>
<td>(1-3)</td>
<td>1.84</td>
<td>0.116</td>
<td>-0.571</td>
</tr>
</tbody>
</table>

Note. Statistics for dissociation are based on square root transformation of the original scores.

Relationships among Study Variables and Demographics

Pearson product-moment correlations were run to assess for systematic relationships between maternal age, child age and study variables (see Table 5). As noted above, Maternal age was significantly related to Intervention, so it was included in the hypothesis testing regression analyses.
Table 5
Pearson Correlations between Mother’s Age, Child’s Age, and Study Variables

<table>
<thead>
<tr>
<th></th>
<th>Dissociation</th>
<th>Meta-emotion</th>
<th>Intervention</th>
<th>Child Behavior</th>
<th>Child Inhibition</th>
<th>Child Coping</th>
<th>Child Dysregulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother’s age</td>
<td>-.17</td>
<td>.09</td>
<td>-.62**</td>
<td>-.08</td>
<td>.32</td>
<td>.08</td>
<td>-.01</td>
</tr>
<tr>
<td>Child’s age</td>
<td>.11</td>
<td>-.32</td>
<td>-.03</td>
<td>.30</td>
<td>.01</td>
<td>-.11</td>
<td>-.26</td>
</tr>
</tbody>
</table>

*p=< .05, **p=< .01.

Student’s t-test was used to assess whether the means of study variables varied systematically with categorical demographic variables, including mother’s level of education, employment status, race/ethnicity, and children’s sex (see Tables 6-9). Of note, in relation to the mixed findings on race, ethnicity and dissociation in the literature, there was no significant difference between the mean dissociation score for African American participants and that for Hispanic participants. A relationship existed between mother’s employment status and mother’s rating of child behavior problems, so employment was included in the regression of behavior problems on dissociation and emotional acceptance.

Table 6
Differences in Study Variables Based on Mother’s Level of Education

<table>
<thead>
<tr>
<th></th>
<th>High School or Lower</th>
<th>College or Higher</th>
<th>t</th>
<th>df</th>
<th>p</th>
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<tbody>
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<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
<td></td>
</tr>
<tr>
<td>Dissociation</td>
<td>3.48</td>
<td>1.45</td>
<td>4.26</td>
<td>1.69</td>
<td>-1.10</td>
</tr>
<tr>
<td>Acceptance</td>
<td>12.50</td>
<td>5.44</td>
<td>15.37</td>
<td>3.66</td>
<td>1.34</td>
</tr>
<tr>
<td>Intervention</td>
<td>36.91</td>
<td>11.74</td>
<td>32.44</td>
<td>10.36</td>
<td>-.89</td>
</tr>
<tr>
<td>Child Behavior</td>
<td>57.36</td>
<td>8.91</td>
<td>51.38</td>
<td>15.30</td>
<td>-1.07</td>
</tr>
<tr>
<td>Child Inhibition</td>
<td>1.89</td>
<td>0.48</td>
<td>2.13</td>
<td>0.35</td>
<td>1.13</td>
</tr>
<tr>
<td>Child Coping</td>
<td>2.11</td>
<td>0.51</td>
<td>2.16</td>
<td>0.43</td>
<td>.21</td>
</tr>
<tr>
<td>Child Dysregulation</td>
<td>1.82</td>
<td>0.40</td>
<td>1.88</td>
<td>0.67</td>
<td>.25</td>
</tr>
</tbody>
</table>
Table 7
*Differences in Study Variables Based on Mother’s Employment Status*

<table>
<thead>
<tr>
<th></th>
<th>Employed</th>
<th></th>
<th>Unemployed</th>
<th></th>
<th>t</th>
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<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dissociation</td>
<td>4.06</td>
<td>.77</td>
<td>3.87</td>
<td>1.75</td>
<td>.21</td>
<td>18</td>
<td>.83</td>
</tr>
<tr>
<td>Acceptance</td>
<td>13.95</td>
<td>2.74</td>
<td>14.06</td>
<td>5.29</td>
<td>.07</td>
<td>18</td>
<td>.94</td>
</tr>
<tr>
<td>Intervention</td>
<td>37.50</td>
<td>12.47</td>
<td>34.25</td>
<td>11.05</td>
<td>.51</td>
<td>18</td>
<td>.61</td>
</tr>
<tr>
<td>Child Behavior</td>
<td>65.00</td>
<td>8.87</td>
<td>52.13</td>
<td>14.71</td>
<td>2.06</td>
<td>17</td>
<td>.05*</td>
</tr>
<tr>
<td>Child Inhibition</td>
<td>1.88</td>
<td>0.48</td>
<td>2.01</td>
<td>0.44</td>
<td>-.52</td>
<td>16</td>
<td>.61</td>
</tr>
<tr>
<td>Child Coping</td>
<td>1.83</td>
<td>0.46</td>
<td>2.21</td>
<td>0.45</td>
<td>-1.49</td>
<td>16</td>
<td>.15</td>
</tr>
<tr>
<td>Child Dysregulation</td>
<td>2.00</td>
<td>0.78</td>
<td>1.80</td>
<td>0.43</td>
<td>.69</td>
<td>16</td>
<td>.50</td>
</tr>
</tbody>
</table>

* *p=< .05

Table 8
*Differences in Mediating and Criterion Variables Based on Mother’s Race/Ethnicity*

<table>
<thead>
<tr>
<th></th>
<th>African-American</th>
<th></th>
<th>Hispanic</th>
<th></th>
<th>t</th>
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<tbody>
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<td>SD</td>
<td>M</td>
<td>SD</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dissociation</td>
<td>4.15</td>
<td>1.47</td>
<td>3.45</td>
<td>1.83</td>
<td>.94</td>
<td>18</td>
<td>.36</td>
</tr>
<tr>
<td>Acceptance</td>
<td>13.89</td>
<td>4.13</td>
<td>12.95</td>
<td>6.73</td>
<td>.35</td>
<td>15</td>
<td>.73</td>
</tr>
<tr>
<td>Intervention</td>
<td>35.67</td>
<td>11.21</td>
<td>34.80</td>
<td>14.11</td>
<td>.13</td>
<td>15</td>
<td>.89</td>
</tr>
<tr>
<td>Child Behavior</td>
<td>53.73</td>
<td>14.85</td>
<td>57.20</td>
<td>7.52</td>
<td>-.48</td>
<td>14</td>
<td>.63</td>
</tr>
<tr>
<td>Child Inhibition</td>
<td>2.02</td>
<td>0.35</td>
<td>1.90</td>
<td>0.51</td>
<td>.56</td>
<td>14</td>
<td>.58</td>
</tr>
<tr>
<td>Child Coping</td>
<td>2.01</td>
<td>0.44</td>
<td>2.20</td>
<td>0.51</td>
<td>-.76</td>
<td>14</td>
<td>.46</td>
</tr>
<tr>
<td>Child Dysregulation</td>
<td>1.76</td>
<td>0.56</td>
<td>1.90</td>
<td>0.45</td>
<td>-.49</td>
<td>14</td>
<td>.63</td>
</tr>
</tbody>
</table>

*Note. Analysis excludes participants who endorsed multiple categories of race/ethnicity.*
Table 9
Differences in Mediating and Dependent Variables Based on Children’s Sex

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th></th>
<th>Female</th>
<th></th>
<th>t</th>
<th>df</th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dissociation</td>
<td>4.42</td>
<td>1.33</td>
<td>3.39</td>
<td>1.33</td>
<td>-1.49</td>
<td>18</td>
<td>.15</td>
</tr>
<tr>
<td>Acceptance</td>
<td>13.10</td>
<td>4.55</td>
<td>14.47</td>
<td>5.26</td>
<td>-.621</td>
<td>18</td>
<td>.54</td>
</tr>
<tr>
<td>Intervention</td>
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<td>10.91</td>
<td>31.20</td>
<td>10.48</td>
<td>1.547</td>
<td>18</td>
<td>.14</td>
</tr>
<tr>
<td>Child Behavior</td>
<td>51.78</td>
<td>15.17</td>
<td>57.60</td>
<td>8.15</td>
<td>-1.058</td>
<td>17</td>
<td>.31</td>
</tr>
<tr>
<td>Child Inhibition</td>
<td>1.94</td>
<td>0.42</td>
<td>2.01</td>
<td>0.47</td>
<td>-.328</td>
<td>16</td>
<td>.75</td>
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<tr>
<td>Child Coping</td>
<td>2.17</td>
<td>0.35</td>
<td>2.09</td>
<td>0.58</td>
<td>.384</td>
<td>16</td>
<td>.71</td>
</tr>
<tr>
<td>Child Dysregulation</td>
<td>1.80</td>
<td>0.58</td>
<td>1.89</td>
<td>0.45</td>
<td>-.378</td>
<td>16</td>
<td>.71</td>
</tr>
</tbody>
</table>

**Bivariate Correlations**

Pearson product-moment correlations indicated that at least two of the hypothesized relationships were present in the study data (see Table 10). As expected, mothers who reported more dissociation were less accepting of child emotions \((r = -.47, p < .05)\). Mothers who reported more dissociation also reported more intervention with their children \((r = .48, p < .05)\). Formal hypothesis testing for these relationships follow in the “Tests of Model” section.

Table 10
Pearson Correlations between Predictor, Mediator and Criterion Variables

<table>
<thead>
<tr>
<th></th>
<th>Dissociation</th>
<th>Acceptance</th>
<th>Intervention</th>
<th>Child Behavior</th>
<th>Child Inhibition</th>
<th>Child Coping</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acceptance</td>
<td>-.47*</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intervention</td>
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<td>-.09</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Child Behavior</td>
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<td>-.05</td>
<td>.47*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child Inhibition</td>
<td>.09</td>
<td>.14</td>
<td>-.22</td>
<td>-.25</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child Coping</td>
<td>-.02</td>
<td>-.17</td>
<td>-.15</td>
<td>.26</td>
<td>.05</td>
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<tr>
<td>Child Dysregulation</td>
<td>-.12</td>
<td>.30</td>
<td>-.17</td>
<td>-.04</td>
<td>.13</td>
<td>-.15</td>
</tr>
</tbody>
</table>

*p<=.05
Tests of Model (Figure 1)

Direct effects (Hypotheses 1, 2, and 3) were tested by regression, controlling for maternal age. The partial meditational model was then tested (Hypothesis 4). Child emotion regulation was operationalized using three measures: Mother-reported intervention (Child Regulation Index), mother-reported behavior problems (Child Behavior Checklist total score, CBCL-T), and child-reported emotion regulation tendencies (Child Emotion Management Scales, CEMS).

**Hypothesis 1:** *Maternal dissociation will be associated with child emotion regulation difficulties (model path c).* Separate regressions were performed for each of the five criterion scales measuring child emotion regulation, using the mother’s total dissociation score on the DES as the predictor variable (see Table 1). Intervention was the one criterion variable that was predicted by dissociation. The regression model accounted for 54% of the variability in the intervention index ($R^2 = .54, F[3, 16] = 6.26, p < .01$). More maternal dissociation predicted more maternal intervention with the child, a relationship of medium effect size ($\beta = .45, p < .05$). Hypothesis 1 was partially supported.
Table 11
Linear Regression Examining Association of Dissociation and Emotional Acceptance on Child Emotion Regulation Variables
(N = 20).

<table>
<thead>
<tr>
<th></th>
<th>Intervention by Mother</th>
<th>Child Behavior</th>
<th>Child Inhibition</th>
<th>Child Coping</th>
<th>Child Dysregulation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>β</td>
<td>ΔR^2</td>
<td>β</td>
<td>ΔR^2</td>
<td>β</td>
</tr>
<tr>
<td>Step 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother’s age</td>
<td>-.54**</td>
<td>.02</td>
<td>.35</td>
<td>.04</td>
<td>-.13</td>
</tr>
<tr>
<td>Dissociation</td>
<td>.45*</td>
<td>.13</td>
<td>.16</td>
<td>-.22</td>
<td>.00</td>
</tr>
<tr>
<td>Acceptance</td>
<td>.17</td>
<td>-.02</td>
<td>.19</td>
<td>-.29</td>
<td>.31</td>
</tr>
<tr>
<td>Step 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interaction</td>
<td>-.07</td>
<td>.08</td>
<td>-1.46†</td>
<td>-.16</td>
<td>-1.14</td>
</tr>
<tr>
<td>Total R^2</td>
<td>.55*</td>
<td>.10</td>
<td>.32</td>
<td>.09</td>
<td>.12</td>
</tr>
</tbody>
</table>

Note. Acceptance = Mother’s Emotional Acceptance; Interaction = Dissociation x Emotional Acceptance. Mother’s age included as covariate.
†p < .10, *p < .05, **p < .01. All other p values exceeded .20.
**Hypothesis 2:** Maternal dissociation will be associated with less acceptance of child’s emotion (model path a). Scores for the Emotional Acceptance Interview (N = 20) were regressed on the mother’s self-reported total dissociation score on the DES. The model accounted for 22% of the variability in the Emotional Acceptance Interview ($R^2 = .22$, $F[2, 17] = 2.42, p < .05$). Mothers who reported more dissociation demonstrated less acceptance of their children’s emotions, a significant relationship of medium effect size ($\beta = -.47, p < .05$). Hypothesis 2 was supported.

**Hypothesis 3:** Maternal emotional acceptance will be associated with less child emotion regulation (model path b). The five measures of child emotion regulation were regressed on emotional awareness interview scores in order to evaluate this hypothesis. There were no significant relationships between the study variables (see Table 11). Hypothesis 3 was not supported.

**Hypothesis 4:** Maternal emotional acceptance will partially mediate the relationship between maternal dissociation and child emotion regulation. Because there was a relationship between maternal dissociation and intervention (model path c; $\beta = .45, p < .05$), the mediation hypothesis was tested, using the Kraemer conditions for mediation testing (Kraemer et al., 2008). For mediation to occur, two conditions had to be satisfied. The first condition, that there be a non-zero relationship between predictor and mediator was met, as there was a significant medium effect between dissociation and emotional acceptance (model path a; $\beta = -.47, p < .05$). However, the second condition required either a relationship between intervention and emotional acceptance, or a relationship between intervention and the interaction between dissociation and emotional acceptance. Neither relationship was found, therefore, condition two was not met and mediation was not found (see Table 10).
For the four other child emotion regulation measures, Behavior, Inhibition, Coping, and Dysregulated Expression, there was no relationship with dissociation. Therefore, mediation was ruled out by Kraemer’s rules. Hypothesis 4 was not supported. See Figure 2 for a summary of hypothesis testing results.

Figure 2. Findings of the current study. The hypothesized relationships were found between dissociation and emotional awareness, and between dissociation and intervention, an indicator of child emotion regulation. No significant relationship was found between emotional acceptance and intervention, or between the interaction of dissociation and acceptance on the one hand and maternal intervention on the other. Therefore, the possibility of mediation was ruled out.

* $p = .05$

**Interaction:** There was one marginally significant but counterintuitive finding for an interaction: When maternal dissociation was low, more maternal emotional acceptance led to greater child inhibition of emotion, a less adaptive emotion regulation strategy. The meaning of this marginal finding, that two positive maternal factors would interact to increase a negative child emotion regulation strategy, is unclear and is not consistent with the hypothesized relationships or with the other findings in this study.
Secondary Analyses

**Emotional Acceptance Interview, Subscale Analysis.** Subtotals were derived for each of the four emotions (sad, happy, scared, angry) included on the emotional acceptance interview and analyzed by a randomized block ANOVA (see Table 12). The means comparison yielded significant differences among the emotions ($F[3, 16] = 5.05, p = .01$). Post hoc comparisons between the within-subject mean scores using Student’s t-test revealed pairwise differences of small to medium effect size between the mean Happy score on the one hand and the mean scores for the three negative emotions on the other.

Table 12

*Randomized Block ANOVA, Emotional Acceptance Interview Subscales (N = 20)*

<table>
<thead>
<tr>
<th>Acceptance of Emotion</th>
<th>Cohen’s $d$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Happy</td>
<td>--</td>
</tr>
<tr>
<td>Angry</td>
<td>.29†</td>
</tr>
<tr>
<td>Scared</td>
<td>.39*</td>
</tr>
<tr>
<td>Sad</td>
<td>.49**</td>
</tr>
</tbody>
</table>

*Note. Overall, $F(3, 16) = 5.05, p = .01$. Cohen’s $d$ represents effect size of difference from mean Acceptance of Happy Emotion score.  
†$p < .10$, *$p < .05$, **$p < .01$*

Because the randomized block ANOVA indicated a difference between the one positive emotion (Happy) and the negative emotions (Sad, Scared, and Angry), hypothesis tests were repeated to explore the effects of the acceptance of negative emotions only. This score was calculated by summing all items on the emotional acceptance measure for Sad, Scared, and Angry emotions. After calculating an interaction term by centering and multiplying this score by the centered dissociation score, effects on child emotion regulation were tested using a two-step regression (see Table 13). Results using this Acceptance of Negative Emotions score did not
differ significantly from those derived using the overall Acceptance of Emotions measure (see Table 11).

The Acceptance of Positive (Happy) Emotion scores were not normally distributed, exhibiting negative skew, or a ceiling effect. All but 2 of the 20 participants scored at or near the highest score for this measure. Therefore, a separate analysis was not conducted for the effects of Acceptance of Positive Emotion.
Table 13
Linear Regression Examining Association of Dissociation and Acceptance of Negative Emotions on Child Emotion Regulation.

<table>
<thead>
<tr>
<th></th>
<th>Intervention by Mother</th>
<th>Child Behavior</th>
<th>Child Inhibition</th>
<th>Child Coping</th>
<th>Child Dysregulation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>β</td>
<td>ΔR^2</td>
<td>β</td>
<td>ΔR^2</td>
<td>β</td>
</tr>
<tr>
<td><strong>Step 1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother’s age</td>
<td>-.54**</td>
<td>.06</td>
<td>.37</td>
<td>.16</td>
<td>.05</td>
</tr>
<tr>
<td>Dissociation</td>
<td>.41*</td>
<td>.04</td>
<td>.20</td>
<td>-.10</td>
<td>-.01</td>
</tr>
<tr>
<td>Acceptance of Neg. Emotion</td>
<td>-.09</td>
<td>-.15</td>
<td>.27</td>
<td>-.07</td>
<td>.33</td>
</tr>
<tr>
<td><strong>Step 2</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interaction, Diss x Neg. Emotion</td>
<td>-.10</td>
<td>.19</td>
<td>-.45†</td>
<td>-.05</td>
<td>-.17</td>
</tr>
<tr>
<td><strong>Total R^2</strong></td>
<td>.53*</td>
<td>.07</td>
<td>.35</td>
<td>.01</td>
<td>.14</td>
</tr>
</tbody>
</table>

*Note. Acceptance of Neg. Emotion = Mother’s Acceptance of Negative Emotions, Diss x Neg. Emotion = Dissociation x Mother’s Acceptance of Negative Emotions. Mother’s age included as covariate. †p < .10, *p < .05, **p < .01. All other p values exceeded .20.
**Dissociative Experiences Scale, Subscale Analysis.** As noted, hypothesis tests were performed using the total dissociation score. In order to investigate whether more specific dissociative processes may have been independently influencing the study variables, Pearson product moment correlations were derived among the three subscales of the DES (Amnesia, Derealization/Depersonalization, and Absorption), the emotional acceptance interview scores, and the child emotion regulation measures (see Table 14). The subscales were highly correlated with one another. However, no significant relationships were found between each subscale score and child emotion regulation variables. This finding supported the use of the DES Total score as the measure of dissociation used in this study.

Table 14
*Pearson Correlations between DES (dissociation) subscales, mediating and criterion variables (N = 20)*

<table>
<thead>
<tr>
<th>Measure</th>
<th>Dissociation Total</th>
<th>Dissociation: Amnesia</th>
<th>Dissociation: Derealization/Depersonalization</th>
<th>Dissociation: Absorption</th>
</tr>
</thead>
<tbody>
<tr>
<td>DES Dereal/Deperson</td>
<td>.74**</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>DES Absorption</td>
<td>.63**</td>
<td>.78**</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Acceptance</td>
<td>-.24</td>
<td>-.03</td>
<td>-.12</td>
<td>-.26</td>
</tr>
<tr>
<td>Child Behavior</td>
<td>-.04</td>
<td>.30</td>
<td>.10</td>
<td>-.26</td>
</tr>
<tr>
<td>Intervention</td>
<td>.12</td>
<td>.13</td>
<td>.20</td>
<td>.02</td>
</tr>
<tr>
<td>Child Inhibition</td>
<td>-.23</td>
<td>-.17</td>
<td>-.36</td>
<td>-.20</td>
</tr>
<tr>
<td>Child Coping</td>
<td>.25</td>
<td>-.27</td>
<td>-.34</td>
<td>-.20</td>
</tr>
<tr>
<td>Child Dysregulation</td>
<td>-.12</td>
<td>-.15</td>
<td>-.24</td>
<td>-.01</td>
</tr>
</tbody>
</table>

*Note. DES Dereal/Deperson=Dissociation Derealization/Depersonalization Subscale; DES Absorption=Dissocation Absorption Subscale*

*p < .05, **p < .01.
Qualitative Insights from Emotional Acceptance Interview

The Emotional Awareness and Acceptance interview, based on the Meta-Emotion Interview (Gottman et al, 1997, Katz & Carrere, 2004), captured a wide range of variability, with a range of 4 – 19 out of a possible 0 – 20. Low scores indicated a “dismissing” parenting meta-emotion philosophy. Higher scores indicated parents who were aware and accepting of feelings, and likely to see emotional episodes in life as opportunities for closeness and learning with their children.

Most participants who did not score in the upper range of the measure appeared to have difficulty with one or more specific emotions asked about in the interview. For instance, one parent, asked about a time when her child was sad, described having heard from school that he had pushed another student at school using a desk, pinning the other student against the wall. Whether or not her son had actually been feeling sad, the mother described behaviors associated with aggression, rather than sadness. Another mother described her son as happy and boisterous, in an episode when they were going to the supermarket and walked past a group of men violently beating another man in the street. The behaviors this mother attributed to her son seemed to indicate frightened, rather than happy, emotion. In these cases, mothers labeled what seemed to be fairly clear behavioral indicators for one emotion as belonging to another.

For some participants, being asked to recall a child’s emotion-related episode led to feelings of their own that were difficult to contain. One mother, asked to think of a time her child was sad, described having to tell her daughter that they could not afford dance lessons that her daughter was interested in. The mother became tearful as she recalled her daughter’s disappointment, and seemed to become preoccupied with a sense of having failed her daughter through the rest of the interview. When subsequently asked about a happy episode, she again
described the disappointment about the dance lessons. For at least two other mothers, being asked for an episode in which their children were scared prompted a vivid retelling, verging on re-experiencing, of a terrifying escape from an abusive partner, thwarting an attempt by that partner to run off with the children, or in one case, a fire. Interviewers used both supportive and perspective-taking interviewing techniques to help participants keep from being overwhelmed by feelings in these cases.

It is important to note that many participants showed significant strengths in describing emotional states, differentiating between their own feelings and their children’s, responding empathically without being themselves overcome with the sadness, anger, or fear described by their children. Parents often described episodes of negative feelings as ending in increased closeness with their children, with a hug or a comforting word. Several parents, asked for a time when their child was happy, described their children being proud of a success at school. The interviewees consistently took pride themselves in their children’s academic accomplishments.

Some parents did not score high on emotional acceptance because they consciously were choosing another approach to emotion management. If there was one overarching theme in the interviews, it was that parents saw themselves as mediating between their children and a harsh world. Some saw that role as a call to protect their children from painful feelings. These parents would talk about consciously hiding their fear, sadness, or worry from themselves and their children, because, in the words of more than one parent, “one of us has to be strong.” In contrast, other parents saw their mediating role as one which called them to get their children to face up to reality. This approach was exemplified by one parent who described her son crying when doing his homework because he was frustrated. Asked by the interviewer how she felt about his tears, this parent responded that she did not care. Elaborating, she repeated that she did
not care, and explained that, because her son was an African-American boy in a special education class, his future was jail and getting caught up in the system if he did not succeed in his education. This mother was aware of her son’s emotional state, and did not seem to be dismissing it, in the sense of seeing his feelings as toxic or intolerable. Rather, she seemed to be making a conscious judgment that disregarding his feelings and insisting that he complete his work were ultimately matters of his survival.

These parents who were either trying to shield their children, or make their children face a difficult reality, seemed to have a meta-emotional coaching philosophy that was neither dismissing nor coaching. They seemed to feel that there was simply not the space in their current circumstances for thinking and talking about feelings as ends in themselves.
Chapter 4: Discussion

Both mothers and children exhibited a wide range of functioning on the measures employed in the study. Despite being residents in a family domestic violence homeless shelter, 85% of mothers scored below the clinical level for dissociation. On the report of child behavior problems completed by mothers, two-thirds of the children scored in the normal range. On the other child emotion regulation measures, both the mothers and children reported a wide range of functioning. Despite multiple stressors, including a history of domestic violence and being currently housed in a homeless shelter, a majority of the adults and children indicated signs of resilience on the measures used in this study.

The model under investigation proposed that maternal emotional acceptance would mediate a relationship between maternal dissociation and child emotion regulation (see Figure 1). It was hypothesized that mothers who reported more dissociation would demonstrate less acceptance of their children’s emotions, and would have children with more emotion regulation difficulties. It was also hypothesized that more emotional acceptance by the mother would be related to less child emotion regulation difficulties. Finally, it was hypothesized that emotional acceptance on the part of the mother would partially mediate the relationship between maternal dissociation and child emotion regulation difficulties.

Two of the three relationships in the model were supported, but not the mediational model as a whole (see Figure 2). As hypothesized, mothers who reported more dissociation were less accepting of their children’s emotions, and reported making more interventions with their children in response to specific behaviors. No significant relationship was found between maternal emotional acceptance and child emotion regulation.
The literature on trauma, dissociation, and parenting provides some evidence that parental dissociation negatively affects a parent’s ability to be an attentive and consistent caretaker. Studies have linked parental dissociation with child maltreatment, and with inconsistent parental discipline. The present study has added to the current body of research on dissociation and parenting by exploring how dissociation relates to child emotion regulation, and to the level of emotional acceptance present in parents’ self-described attempts to help children regulate their own emotions.

**Relationship between Maternal Dissociation and Maternal Emotional Acceptance**

The study provided support for the hypothesized link between maternal dissociation and maternal emotional acceptance. Mothers who reported more dissociative experiences were found to be less aware and accepting of feelings. In the case of mothers with high levels of dissociation, this finding may be a result of globally attenuated awareness. That is, high dissociation may have led to or been part of a response to trauma which affected reality testing and made it difficult to be aware and responsive overall. However, it could also be that the effects of dissociation were particularly pronounced with regard to emotion, an interpretation that has empirical support. Studies have found dissociation to be positively related to alexithymia (difficulty identifying and describing feelings), and this link has been used to support a model in which alexithymic traits contribute to dissociation (Grabe, Rainermann, Spitzer, Gansicke, & Freyberger, 2000). A reversed causal relationship between alexithymia and dissociation is consistent with the structural dissociation model, in which a person may be unable to become aware of feeling states inconsistent with the “personality” or self-state with which he or she is currently identified (Nijenhuis & van der Hart, 2011). This view of a state-dependent,
partial inability to become aware of certain emotions is also consistent with dissociation in the relational psychoanalytic sense (Stern, 1987; Bromberg, 1998).

Dissociation is a broad term which may represent an adaptive defense for some participants, and a maladaptive psychological process for others. In a study by McGiffin et al. (2012), conducted with trauma-exposed participants, the relationship between dissociation scores and performance on a Stroop inhibition task was positive for participants with PTSD, but negative for participants without PTSD. It is possible that this varied effect of dissociation on a measure of executive functioning may have implications for the participants in this study when called upon to help their children regulate negative feelings. Offering a child a response to negative feelings that is both empathic and containing creates a complex set of demands that include both inhibition and emotional openness. It may be that dissociation as a defense would be helpful for less traumatized mothers but unhelpful for mothers experiencing more PTSD symptoms.

In an effort to clarify the processes involved in emotional difficulties, Gross and Jazaieri (2014) have distinguished between emotion regulation failure, in which case a person is not using a regulation strategy when it would be helpful, and emotion misregulation, in which case the person is using a form of regulation that is poorly matched to the situation. This distinction may help clarify the difference between adaptive and maladaptive modes of dissociation. For less traumatized participants, dissociative and other defenses are available to be chosen, in a more or less conscious way, as emotion regulation strategies. More traumatized participants may be facing a no-win situation, in which they either experience aversive trauma symptoms or become caught in a maladaptive dissociative process that may alleviate some suffering but creates new problems in functioning.
With regard to the emotional acceptance interview, responses indicated that in addition to negative meta-emotion (dismissing), emotional dysregulation may have been playing a role in decreased emotional acceptance for some mothers. Seen through the lens of trauma and its sequelae, future research could investigate possible links between PTSD and dysregulation on the one hand, and between dissociation and emotional dismissing on the other, in order to better integrate meta-emotion theory into the study of families exposed to violence.

Qualitatively, mothers demonstrated widely ranging levels of awareness, acceptance, and coaching of their children’s emotions. However, those responses to their children’s emotions appeared to be shaped by more factors than are captured by the concept of meta-emotion, conceived of as a spectrum ranging from emotion dismissing to emotion coaching. Some parents with low scores would be more accurately described as emotionally dysregulated than emotion dismissing. These parents were able to recall a child emotion but then became preoccupied and even overwhelmed with the emotion themselves. Still others described themselves as choosing not to focus on or join their children’s negative emotions, as a matter of survival.

These two negative factors, which we might call dysregulation and survival-mode parenting, are not meta-emotions themselves, in that they do not represent intrinsic attitudes, or feelings about feelings in the same fashion as “emotion dismissing” and “emotion coaching,” in the meta-emotion literature. Yet it was apparent in the results of this study that dysregulation can affect a parent’s capacity to be aware and accepting of her child’s emotions, and that parents in survival mode had other priorities than helping their children to recognize and manage their own negative feelings. Meta-emotion researchers have touched upon both of these complicating factors, without yet incorporating them into a cohesive model of emotion regulation (Doohan et al., 2004; Katz & Windecker-Nelson, 2004). Because maternal meta-emotion has been shown to
be a protective factor for children exposed to domestic violence (Katz et al., 2012; Katz & Windecker-Nelson, 2006), more research is needed on the interplay of dysregulation, and what is here termed survival-mode parenting, along with more of the well-researched components of meta-emotion, in the population studied here.

**Relationship between Maternal Dissociation and Child Emotion Regulation**

The test of the relationship between maternal dissociation and child emotion regulation yielded divergent results on the two mother-completed measures of child emotion regulation. Mothers with higher dissociation reported having to downregulate or *intervene* more with regard to their children’s behavior; however, high-dissociation mothers did not report *observing* significantly more behavior problems in their children. One possible explanation for this finding might be that dissociation simply led mothers to intervene more, or to think they were intervening more, in their children’s behavior. By this line of reasoning, the present study would offer no support for the proposition that maternal dissociation has any relationship with child emotion regulation. It would also run counter to the research findings that dissociation is associated with parenting that is permissive (Chu & DePrince, 2006; Mann & Sanders, 1994) or inconsistent (Collin-Vezina, Cyr, & Pauze, 2005), findings that suggest that dissociative parents would be less, rather than more likely to downregulate their children.

One possible alternative explanation for the present study’s findings on maternal dissociation and child emotion regulation is that two effects occurred. First, maternal dissociation led to greater child emotion regulation difficulties. Second, maternal dissociation caused mothers to be less aware of those difficulties, unless they directly affected the mother and led to a maternal intervention. In cases where the mother was experiencing more dissociation, intervening behavior was indeed elevated (rather than just being perceived to be elevated),
evoked by a greater number of behavioral expressions by the dysregulated child that directly impinged upon the parent. At the same time, the higher-dissociating mother’s decreased awareness of her child caused her to miss behaviors that were more subtle (“There is very little he/she enjoys”) or that did not directly impinge upon the mother (“Cruel to animals”), captured by items included in the behavioral observation measure but not in the intervention measure. This possible scenario could explain the divergent findings between the behavioral observation and intervention measures completed by the mother.

In contrast to the findings on the mother-completed measures, no relationships were found between maternal dissociation and the three scales of the child-completed emotion regulation measure. It is possible that the hypothesis was simply incorrect, and that dissociation is not a factor in child emotion regulation, or is not significant in comparison to other factors such as child temperament, attachment style, peer and sibling relationships, or other parent or child characteristics. Alternatively, because dissociation is a multidimensional concept, it could be that certain dissociative processes in the mother represent beneficial adaptive defenses, in contrast to other, more pathological dissociative processes. Such differences could have complex and contradictory effects on the parent-child interactions that foster adaptive child emotion regulation. It is also possible that this study was insufficiently powered to overcome the additional sources of variation introduced by using measures completed by different participants (mother and child).

In addition, children were subject to a number of varied contextual factors independent of maternal dissociation. For instance, in the emotional acceptance interviews, several mothers revealed that their children had widely differing experiences of the father (or mother’s partner), and of the move into the shelter. Some children had preserved positive feelings about the father,
for instance, one mother recalled her child being sad at having to leave his father; another, asked about a happy episode for her child, described her son’s excited reaction to learning that he would see his father in the near future. In stark contrast, a mother described how her daughter’s father had threatened to shoot the daughter after she had called the police about his violent behavior toward the mother. Another talked about her children’s frightened reactions when their father had tried to abduct them. In addition to having these widely varying experiences, ranging from the benign to the traumatic, the children in this study likely varied with regard to exposure to violence between adult partners (Osofsky, 2003) and in their own abuse history (Edelson, 1999), two significant factors in child emotion dysregulation (Holt et al., 2008).

One other factor that may have weakened the relationship between maternal dissociation and the measures completed by child participants is the range of contexts to which children referred in their self-reports. Children were simply asked to endorse the frequency of statements such as, “I keep my cool,” and “I try to calmly deal with what is making me feel sad,” and may have done so with regard to home, school, and peer contexts. In contrast, measures completed by mothers about their observations of and interventions with their children drew mainly on child behavior when the child and parent were together. It is possible that emotion regulation difficulties related to maternal dissociation were most evident in the context of interactions between mother and child, in which case, we would expect to find a stronger relationship between dissociation and mother-completed measures than between dissociation and child-completed measures. Therefore, future studies of maternal dissociation and child emotion regulation will need additional power when using child-completed measures.

The secondary analysis of dissociation subscales (amnesia, depersonalization/derealization, and absorption) revealed no significant relationships with the child emotion
regulation measures used in this study, including the intervention scale, which was positively related with the DES Total score. In other words, overall severity of dissociation, rather than elevation in a specific dissociative process, was more closely related to maternal interventions to downregulate children. Because there is some debate about the validity of the DES subscales as independent factors (Carlson & Putnam, 1993), further assessment of the relationships between specific dissociative processes and child emotion regulation measures should be undertaken using more recently developed dissociation measures, such as the Multidimensional Inventory of Dissociation (Dell, 2006).

**Relationship between Maternal Emotional Acceptance and Child Emotion Regulation**

The present study did not find a hypothesized link between maternal emotional acceptance and child emotion regulation. The hypothesized relationship between maternal emotional acceptance and child emotion regulation is based on findings in the literature on parental meta-emotion, by Gottman, Katz, and their colleagues (Gottman et al., 1996; Katz et al., 2012). The researchers found that positive parental meta-emotion was associated with a number of measures of child emotion regulation, including physiological measures (Porges, 1995), child self-reports, and observational reports of child peer relations (Katz and Gottman, 1996). Parental meta-emotion was found to be a factor in children’s emotion regulation distinct from parental warmth (Katz et al., 2012). Positive meta-emotion was found to have three central characteristics, each of which was necessary for the next: emotional awareness, emotional acceptance, and emotion coaching behavior.

However, the premise that emotional awareness and acceptance, not necessarily accompanied by emotion coaching behavior, would predict better child emotion regulation may not be correct. The present study is the first to test this relationship. Gottman and colleagues did
find that emotional awareness in and of itself was actually negatively correlated with child emotion regulation (Gottman et al., 1996). The researchers speculated that for parent-child dyads with high emotional awareness and low child emotion regulation, the emotional displays of dysregulated children were creating high levels of awareness in parents. Other explanations of this negative relationship are possible, including a parental preoccupation with negative emotion. In any event, it is certainly possible that a parent could have high emotional awareness, but have a “dismissing” as opposed to coaching parenting meta-emotion philosophy.

One might also speculate that a parent might be negatively preoccupied with their child’s emotion. For instance, a depressed parent might be attuned to negative emotional cues from their children, or even have a negative bias in perceiving neutral cues from their children, as part of the overall negative cognitive biases that accompany depression. Such a depressed parent could both be aware of and accept sad feelings in the child, yet could lack the coaching component needed to help the child gain a regulatory perspective about negative feelings. Alternatively, it could be that the levels of dysregulation among the children in this study are elevated due to the stresses they have experienced and are currently experiencing as shelter residents. While the children did vary on measures of emotion regulation, they may be more dysregulated as a group than children in other circumstances. This possible overall level of dysregulation may be attenuating the effect of emotional acceptance on the part of the mothers.

**Mediational Model**

The model proposed in this study, in which emotional awareness and acceptance (an aspect of parental meta-emotion) mediated the relationship between maternal dissociation and child emotion regulation was not supported. One possible reason could be that the relationship between parental meta-emotion and child emotion regulation is itself more complex than has
been modeled here. In a review, Katz et al. (2012) found evidence for mediators including emotional competence, and moderators including child temperament, involved in the relationship between parental meta-emotion and child emotion regulation. Temperament, along with other genetic factors and social factors may have significant effects on child emotion regulation independent of effects of parenting. Future studies that controlled for those factors could be more successful in identifying the mediating relationship proposed in the present study.

**Study Limitations**

While the present study has contributed to the literature on maternal dissociation and child emotion regulation, the study had several limitations. The study had a small sample size, which limited power, increasing the risk of undetected effects. The study was conducted among African-American and Hispanic mothers and children. The families were predominately low-income and were living in a shelter for victims of domestic violence. The generalizability of the study is limited to families who share these demographic characteristics. Certainly, comparison groups, had they been available, would have both introduced more variability and increased the generalizability of this study. Comparison with residents in a general homeless shelter, and with families which have experienced violence and are not housed in a shelter would be useful for understanding the findings reported here. Such comparisons would address methodological concerns raised by Aldao (2013), who, recognizing that emotion regulation always occurs within a context that includes demographic, subjective, and situational factors, has emphasized using comparison groups in order to begin to consistently account for contextual variables in emotion regulation research.

The study was conducted with a convenience sample, rather than random sampling, which could have led to sampling bias. The mothers who participated not only agreed to
participate in the group intervention which was the focus of the larger study, but also made themselves available for an extended interview, of which the Emotional Awareness Interview was a part. The elevated levels of dissociation among participants who did not complete the interview suggest that high levels of psychological distress may have led to lower levels of participation in the research reported here. In addition, relationships between the self-selection of the families to participate on the one hand, and the effects measured in this study on the other, could have influenced the data in different ways. Mothers could have sought out the multiple family group because they were more traumatized, or were experiencing more behavior problems with their children than other shelter residents. On the other hand, mothers who participated could have represented a particularly resourceful and help-seeking portion of the shelter population.

Mothers in this study may have been reluctant to disclose information about themselves or their children. Parents living in a shelter are routinely asked to give information to shelter staff, social services workers, real estate agents, and others, all of whom have the power to influence the life circumstances of families housed in the shelter in unexpected ways (Fraenkel, Shannon, & Hameline, 2009). Participants may therefore have been judicious in the information that they shared with us. We did not assess whether this potential bias, present in any self-report study, was amplified in any systematic way for these shelter residents. In addition, the Research Assistants who conducted the interviews were motivated to create an alliance with the participants and to encourage them to join the multifamily discussion group. These factors may have led assistants to reinforce psychologically-minded responses by participants, or otherwise introduce bias into how the participants responded.
The fact that this study made use of archival data meant that the measures were restricted to those used in the parent study. For example, in this study the Dissociative Experiences Scale (DES) was used to measure maternal dissociation. While the DES has been widely used in research for close to 40 years, the measure was originally conceived as a broad screening measure for dissociative disorders (Bernstein & Putnam, 1986). More recently, new measures of dissociation have been developed which directly address some of the variety of dissociative experiences discussed in the literature review of this study. Two such measures, the Multiscale Dissociation Inventory (MDI; Briere, Weathers, & Runtz, 2005) and the Multidimensional Inventory of Dissociation (MID; Dell, 2006) could bring more precision to relationships between specific maternal dissociative characteristics and child emotion regulation. A related concern is that the study did not include an assessment of maternal emotional functioning when not experiencing dissociative symptoms. Such a measure might complement the dissociation measure by giving an indication of the parent’s relative strengths in emotional functioning.

In a similar fashion, measurements of child emotion regulation were limited in that they did not include a measure of child dissociation, and did not include direct observation of child emotion regulation by researchers. Child emotion regulation was assessed through child self-report and by reports by the mother; the latter can be open to bias by the mother’s emotional state, among other factors (Levendosky, 2003).

The structure of the emotional acceptance interview may have amplified the effects of maternal reactions to sad emotions in their children. In the interview, the one positive emotion, happy, directly followed sad (the full interview sequence was sad, happy, scared, angry). Most participants earned close to full scores in their responses to questions about happiness. However, it is possible that participants who became more dysregulated or dismissing in response to
sadness may not have recovered fully when asked about happy feelings, leading to lowered scores for both emotions, an effect that seemed clearly evident in at least one interview. In this way, mothers who had difficulty responding to sad emotions may have received lower scores that parents who had the same difficulty with scared or angry feelings in their children. The interview might be improved by asking about a happy episode first, followed by episodes involving negative emotions.

Finally, there may be confounding, unmeasured factors which caused systematic variation in both predictor and criterion. One possible confounder is the amount of violence toward the mother to which the child was also exposed, either as witness or victim. Such shared experiences could be hypothesized to cause both greater maternal dissociation and poorer child emotion regulation, influencing the measured relationship between those two variables of the study. A solution in future studies would be to include a trauma exposure measure for both parent and child.

**Directions for Future Research**

The goal of this study was to explore a possible relationship between maternal trauma and child emotion dysregulation. The impact of trauma on mothers in this study was operationalized using a measure of dissociation. Maternal emotional acceptance was the hypothesized mediator by which maternal dissociation was hypothesized to affect child emotion regulation. The model received partial support from the current study, which suggests that the model can be improved for future research in a number of ways.

First, maternal trauma could be measured with more breadth and specificity using trauma exposure measures for both mother and child. Using a multidimensional dissociation measure and a post-traumatic stress measure in conjunction would provide a more complete picture of
trauma symptoms. As Carlson and colleagues have noted (Carlson et al., 2012; Dalenberg & Carlson, 2012), dissociative experiences and PTSD symptoms are as highly correlated after a traumatic event in both their intensity and their course of improvement or lack thereof.

Second, the study could control for other psychiatric factors, particularly symptoms of depression in the mother, in investigating the impact of maternal trauma symptoms on child emotion regulation. At least one prior study with residents in a general family homeless shelter found over four fifths of the adult shelter residents to be depressed (Weinreb et al., 2006).

Third, as noted above, the mediators by which traumatic emotion dysregulation is transmitted from one generation to the next require continued study. This study did not find maternal emotional acceptance to mediate maternal dissociation and child emotion regulation. However, emotion coaching, of which emotional acceptance is a necessary constituent, should be investigated as a mediator, as coaching has been shown to be a set of parental behaviors associated with a variety of measures of child emotion regulation. It is possible that coaching may be disrupted by maternal dissociation, leading to lower child emotion regulation capacity.

Fourth, a child dissociation measure, either the Child Dissociation Checklist (Putnam, 1997), or the Adolescent Dissociative Experiences Scale (Armstrong, Putnam, Carlson, Libero, & Smith, 1997) would considerably enrich a study of the relationship between maternal dissociation and trauma symptoms on the one hand, and child emotion regulation on the other. This study demonstrated a direct effect of maternal dissociation on child emotion regulation. However, since maternal dissociation has been shown to be positively related to child dissociation (Chu & DePrince, 2006), it could be that child dissociation mediates the relationship between maternal dissociation and child emotion regulation difficulties. A study investigating this effect would also necessarily clarify the relationship between child dissociation and other
child emotion regulation problems. There is also work to be done in understanding how maternal dissociation and child dissociation are related. Since maternal dissociation is related to an increase in child abuse potential by the mother (Egeland & Susman-Stillman, 1996; Narang & Contreras, 2000), it could be that the relationship between maternal and child dissociation is mediated by maternal maltreatment. At the same time, we know that subtle factors of maternal early attunement can have large effects on child dissociation (Lyons-Ruth, 2003).

By clarifying the ways in which parental dissociation and trauma symptoms interact with child dissociation and emotion regulation, we could begin to understand with more specificity how protective factors, such as parental meta-emotion, are helpful. A greater knowledge of specific sets of behavioral and relational patterns will increase the clinical impact of this area of research, by providing clinicians with information as to how to intervene with families to reduce the impact of parental trauma on children.

In conclusion, the present study demonstrates a relationship between a mother’s level of dissociative experiences and her level of acceptance of her child’s emotions. A relationship was also found between maternal dissociation and child emotion regulation. A predicted mediating effect by maternal emotional acceptance on the relationship between maternal dissociation and child emotion regulation was not supported in this study. As the study of dissociation continues to grow, its role in parenting research must grow as well, in order to strengthen at-risk families and to dampen the intergenerational reverberations of trauma.
Appendix: Measures Used in the Study

Demographic Information About You

1. Current relationship status (Please check all that apply):
   Single Have a Boyfriend: _____________Not living together___________Living together Have a Girlfriend: __Not living together___________Living together
   ____Married______Separated______Divorced______Widowed
     a. If married or living together, for how long: _____________
     b. If separated or divorced, for how long: _____________
     c. If widowed, for how long: _____________
     d. Number of previous marriages: _____________

2. Date of birth: ______________   3. Sex: __Male____Female

4. Place of birth: ________________ City ______________ State ______________ Country

5. Country of citizenship: ________________

6. Education: ____Grade school _____Some high school _____High school grad/GED
   _____Some college _____College grad _____Some grad school _____Grad school grad

7. Religious affiliation: ________________ Active? __Yes ____No

8. Ethnicity: ____Asian or Pacific Islander _____Black _____Hispanic _____Native American
   ____White _____Other: ________________

9. Primary language? ____English _____Spanish _____Creole _____French _____Other

10. Date left last permanent residence? ______________
11. Date first entered shelter system? _______

12. Date entered Bronx HELP-Harbor? _______

13. For how many years and/or months total have you worked since you were 18? (Please do not count time in which you were not employed between jobs) _______

14. Are you currently employed? _____ Yes _____ No
   If yes, start date? _______  Where? ______________________
   Hours/week? _____  Hourly wage? _____  Medical benefits? _____ Yes _____ No
   If no, date of last employment? ________
   Are you currently interested in obtaining employment? _____ Yes _____ No

15. Are there any current barriers that you believe might prevent you from working or finding employment? _____ Yes _____ No
   If yes, which of the following? _____ Childcare issues _____ Substance abuse
   _____ Lack of work skills _____ Physical health or disability _____ Mental illness
   _____ English deficiency _____ Domestic violence _____ Felony Conviction
   _____ On Probation or Parole  Other: ____________________________

16. What do you consider to be your most positive qualities and strengths as a person? ____________________________________________
DES

This questionnaire consists of twenty-eight questions about experiences that you may have in your daily life. We are interested in how often you have these experiences. It is important, however, that your answers show how often these experiences happen to you when you are not under the influence of alcohol or drugs.

To answer the questions, please determine to what degree the experience described in the question applies to you and choose the button which corresponds to the percentage of the time you have the experience. The left of the scale, labeled 'Never', corresponds to 0% of the time, while the right of the scale, labeled 'Always', corresponds to 100% of the time; the range covers 0% to 100% in 10% increments.

1. Some people have the experience of driving or riding in a car or bus or subway and suddenly realizing that they don't remember what has happened during all or part of the trip.

(Never) 0 0 0 0 0 0 0 0 (Always)

2. Some people find that sometimes they are listening to someone talk and they suddenly realize that they did not hear part or all of what was said.

(Never) 0 0 0 0 0 0 0 0 (Always)

3. Some people have the experience of finding themselves in a place and having no idea how they got there.

(Never) 0 0 0 0 0 0 0 0 (Always)

4. Some people have the experience of finding themselves dressed in clothes that they don't remember putting on.

(Never) 0 0 0 0 0 0 0 0 (Always)

5. Some people have the experience of finding new things among their belongings that they do not remember buying.

(Never) 0 0 0 0 0 0 0 0 (Always)

6. Some people sometimes find that they are approached by people that they do not know who call them by another name or insist that they have met them before.
7. Some people sometimes have the experience of feeling as though they are standing next to themselves or watching themselves do something and they actually see themselves as if they were looking at another person.

8. Some people are told that they sometimes do not recognize friends or family members.

9. Some people find that they have no memory for some important events in their lives (for example, a wedding or graduation).

10. Some people have the experience of being accused of lying when they do not think that they have lied.

11. Some people have the experience of looking in a mirror and not recognizing themselves.

12. Some people have the experience of feeling that other people, objects, and the world around them are not real.

13. Some people have the experience of feeling that their body does not seem to belong to them.

14. Some people have the experience of sometimes remembering a past event so vividly that they feel as if they were reliving that event.
15. Some people have the experience of not being sure whether things that they remember happening really did happen or whether they just dreamed them.

16. Some people have the experience of being in a familiar place but finding it strange and unfamiliar.

17. Some people find that when they are watching television or a movie they become so absorbed in the story that they are unaware of other events happening around them.

18. Some people find that they become so involved in a fantasy or daydream that it feels as though it were really happening to them.

19. Some people find that they sometimes are able to ignore pain.

20. Some people find that they sometimes sit staring off into space, thinking of nothing, and are not aware of the passage of time.

21. Some people sometimes find that when they are alone they talk out loud to themselves.

22. Some people find that in one situation they may act so differently compared with another situation that they feel almost as if they were two different people.
23. Some people sometimes find that in certain situations they are able to do things with amazing ease and spontaneity that would usually be difficult for them (for example, sports, work, social situations, etc.).

24. Some people sometimes find that they cannot remember whether they have done something or have just thought about doing that thing (for example, not knowing whether they have just mailed a letter or have just thought about mailing it).

25. Some people find evidence that they have done things that they do not remember doing.

26. Some people sometimes find writings, drawings, or notes among their belongings that they must have done but cannot remember doing.

27. Some people sometimes find that they hear voices inside their head that tell them to do things or comment on things that they are doing.

28. Some people sometimes feel as if they are looking at the world through a fog so that people and objects appear far away or unclear.
Emotional Awareness/Acceptance Interview

Now I’m going to ask you some questions about what your child(ren) is/are like when they’re feeling different emotions.

1A. Tell me about a recent time or incident when your child was sad. (How can you tell? What do they say or do, look like, who do they go to, if anyone?)
   (NOTE: If the parent can’t come up with a specific memory, which is quite common when something has happened repeatedly, ask): Well, can you tell me about how it usually goes when your child is sad – a typical time?
   1B. How do you feel and what do you do?
   1C. How does your child respond to you?

2A. Tell me about a recent time or incident when your child was happy or excited. Please describe for each child. (How can you tell? What do they say or do, look like, who do they go to, if anyone?)
   2B. How do you feel and what do you do?
   2C. How does your child respond to you?

3A. Tell me about a recent time or incident when your child was scared or nervous. Please describe for each child. (How can you tell? What do they say or do, look like, who do they go to, if anyone?)
   3B. How do you feel and what do you do?
   3C. How does your child respond to you?

4A. Tell me about a recent time or incident when your child was angry or frustrated. Please describe for each child. (How can you tell? What do they say or do, look like, who do they go to, if anyone?)
   4B. How do you feel and what do you do?
   4C. How does your child respond to you?
# Child Behavior Checklist for Ages 6-18

**Child's Full Name:**

**Child's Gender:**
- Boy [ ]
- Girl [ ]

**Child's Age:**

**Child's Ethnic Group or Race:**

**Today's Date:**

**Child's Birthdate:**

**Grade in School:**

**Not Attending School:** [ ]

**Parents' Usual Type of Work:**
- Father:
  - Type of Work:
  - Type of Work:
- Mother:
  - Type of Work:
  - Type of Work:

**This Form Filled Out By:**
- Print your full name:

**Your Gender:**
- Male [ ]
- Female [ ]

**Your Relation to the Child:**
- Biological Parent [ ]
- Step Parent [ ]
- Grandparent [ ]
- Adoptive Parent [ ]
- Foster Parent [ ]
- Other (specify) [ ]

---

### I. Please list the sports your child most likes to take part in. For example, swimming, baseball, skating, skateboarding, bike riding, fishing, etc.

<table>
<thead>
<tr>
<th>None</th>
<th>Less Than Average</th>
<th>Average</th>
<th>More Than Average</th>
<th>Don't Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### II. Please list your child's favorite hobbies, activities, and games, other than sports. For example, stamps, dolls, books, piano, crafts, cars, computers, singing, etc. (Do not include listening to radio or TV.)

<table>
<thead>
<tr>
<th>None</th>
<th>Less Than Average</th>
<th>Average</th>
<th>More Than Average</th>
<th>Don't Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>c.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### III. Please list any organizations, clubs, teams, or groups your child belongs to.

<table>
<thead>
<tr>
<th>None</th>
<th>Less Active</th>
<th>Average</th>
<th>More Active</th>
<th>Don't Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c.</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

### IV. Please list any jobs or chores your child has. For example, paper route, babysitting, making bed, working in store, etc. (Include both paid and unpaid jobs and chores.)

<table>
<thead>
<tr>
<th>None</th>
<th>Below Average</th>
<th>Average</th>
<th>Above Average</th>
<th>Don't Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Be sure you answered all items. Then see other side.*
Please print. Be sure to answer all items.

V. 1. About how many close friends does your child have? (Do not include brothers & sisters)
   - None
   - 1
   - 2 or 3
   - 4 or more

2. About how many times a week does your child do things with any friends outside of regular school hours?
   (Do not include brothers & sisters)
   - Less than 1
   - 1 or 2
   - 3 or more

VI. Compared to others of his/her age, how well does your child:
   a. Get along with his/her brothers & sisters?
   b. Get along with other kids?
   c. Behave with his/her parents?
   d. Play and work alone?
   - Worse
   - Average
   - Better
   - Has no brothers or sisters

VII. 1. Performance in academic subjects.

<table>
<thead>
<tr>
<th>Check a box for each subject that child takes</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Reading, English, or Language Arts</td>
</tr>
<tr>
<td>b. History or Social Studies</td>
</tr>
<tr>
<td>c. Arithmetic or Math</td>
</tr>
<tr>
<td>d. Science</td>
</tr>
<tr>
<td>e.</td>
</tr>
<tr>
<td>f.</td>
</tr>
<tr>
<td>g.</td>
</tr>
</tbody>
</table>

2. Does your child receive special education or remedial services or attend a special class or special school?
   - No
   - Yes—kind of services, class, or school:

3. Has your child repeated any grades?
   - No
   - Yes—grades and reasons:

4. Has your child had any academic or other problems in school?
   - No
   - Yes—please describe:
     When did these problems start?
     Have these problems ended?
     Does your child have any illness or disability (either physical or mental)?
   - No
   - Yes—please describe:

What concerns you most about your child?

Please describe the best things about your child.
Please print. Be sure to answer all items.

Below is a list of items that describe children and youths. For each item that describes your child **now or within the past 6 months**, please circle the 2 if the item is **very true or often true** of your child. Circle the 1 if the item is **somewhat or sometimes true** of your child. If the item is **not true** of your child, circle the 0. Please answer all items as well as you can, even if some do not seem to apply to your child.

<table>
<thead>
<tr>
<th>0 = Not True (as far as you know)</th>
<th>1 = Somewhat or Sometimes True</th>
<th>2 = Very True or Often True</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 1 2  1. Acts too young for his/her age</td>
<td>0 1 2  32. Feels he/she has to be perfect</td>
<td>0 1 2  33. Feels or complains that no one loves him/her</td>
</tr>
<tr>
<td>0 1 2  2. Drinks alcohol without parents’ approval (describe):</td>
<td>0 1 2  34. Feels others are out to get him/her</td>
<td>0 1 2  35. Feels worthless or inferior</td>
</tr>
<tr>
<td>0 1 2  3. Argues a lot</td>
<td>0 1 2  36. Gets hurt a lot, accident-prone</td>
<td>0 1 2  37. Gets in many fights</td>
</tr>
<tr>
<td>0 1 2  4. Fails to finish things he/she starts</td>
<td>0 1 2  38. Gets teased a lot</td>
<td>0 1 2  39. Hangs around with others who get in trouble</td>
</tr>
<tr>
<td>0 1 2  5. There is very little he/she enjoys</td>
<td>0 1 2  40. Hears sounds or voices that aren’t there (describe):</td>
<td>0 1 2  41. Impulsive or acts without thinking</td>
</tr>
<tr>
<td>0 1 2  6. Bowel movements outside toilet</td>
<td>0 1 2  42. Would rather be alone than with others</td>
<td>0 1 2  43. Lying or cheating</td>
</tr>
<tr>
<td>0 1 2  7. Bragging, boasting</td>
<td>0 1 2  44. Bites fingernails</td>
<td>0 1 2  45. Nervous, high-strung, or tense</td>
</tr>
<tr>
<td>0 1 2  8. Can’t concentrate, can’t pay attention for long</td>
<td>0 1 2  46. Nervous movements or twitching (describe):</td>
<td>0 1 2  47. Nightmares</td>
</tr>
<tr>
<td>0 1 2  9. Can’t get his/her mind off certain thoughts, obsessions (describe):</td>
<td>0 1 2  48. Not liked by other kids</td>
<td>0 1 2  49. Constipated, doesn’t move bowels</td>
</tr>
<tr>
<td>0 1 2  10. Can’t sit still, restless, or hyperactive</td>
<td>0 1 2  50. Too fearful or anxious</td>
<td>0 1 2  51. Feels dizzy or lightheaded</td>
</tr>
<tr>
<td>0 1 2  11. Clings to adults or too dependent</td>
<td>0 1 2  52. Feels too guilty</td>
<td>0 1 2  53. Overeating</td>
</tr>
<tr>
<td>0 1 2  12. Complains of loneliness</td>
<td>0 1 2  54. Overtired without good reason</td>
<td>0 1 2  55. Overweight</td>
</tr>
<tr>
<td>0 1 2  13. Confused or seems to be in a fog</td>
<td>0 1 2  56. Physical problems without known medical cause:</td>
<td>0 1 2  a. Aches or pains (not stomach or headaches)</td>
</tr>
<tr>
<td>0 1 2  14. Chews a lot</td>
<td>0 1 2  57. Headaches</td>
<td>0 1 2  b. Headaches</td>
</tr>
<tr>
<td>0 1 2  15. Cruel to animals</td>
<td>0 1 2  58. Nausea, feels sick</td>
<td>0 1 2  c. Problems with eyes (not if corrected by glasses) (describe):</td>
</tr>
<tr>
<td>0 1 2  16. Cruelty, bullying, or meanness to others</td>
<td>0 1 2  59. Other (describe):</td>
<td>0 1 2  d. Problems with ears (not if corrected by hearing aids) (describe):</td>
</tr>
<tr>
<td>0 1 2  17. Daydreams or gets lost in his/her thoughts</td>
<td>0 1 2  60. Rashes or other skin problems</td>
<td>0 1 2  e. Other (describe):</td>
</tr>
<tr>
<td>0 1 2  18. Deliberately harms self or attempts suicide</td>
<td>0 1 2  61. Stomachaches</td>
<td>0 1 2  f. Other (describe):</td>
</tr>
<tr>
<td>0 1 2  19. Demands a lot of attention</td>
<td>0 1 2  62. Vomiting, throwing up</td>
<td>0 1 2  g. Other (describe):</td>
</tr>
<tr>
<td>0 1 2  20. Destroys his/her own things</td>
<td>0 1 2  63. Other (describe):</td>
<td></td>
</tr>
<tr>
<td>0 1 2  21. Destroys things belonging to his/her family or others</td>
<td>0 1 2  64. Other (describe):</td>
<td></td>
</tr>
<tr>
<td>0 1 2  22. Disobedient at home</td>
<td>0 1 2  65. Other (describe):</td>
<td></td>
</tr>
<tr>
<td>0 1 2  23. Disobedient at school</td>
<td>0 1 2  66. Other (describe):</td>
<td></td>
</tr>
<tr>
<td>0 1 2  24. Doesn’t eat well</td>
<td>0 1 2  67. Other (describe):</td>
<td></td>
</tr>
<tr>
<td>0 1 2  25. Doesn’t get along with other kids</td>
<td>0 1 2  68. Other (describe):</td>
<td></td>
</tr>
<tr>
<td>0 1 2  26. Doesn’t seem to feel guilty after misbehaving</td>
<td>0 1 2  69. Other (describe):</td>
<td></td>
</tr>
<tr>
<td>0 1 2  27. Easily jealous</td>
<td>0 1 2  70. Other (describe):</td>
<td></td>
</tr>
<tr>
<td>0 1 2  28. Breaks rules at home, school, or elsewhere</td>
<td>0 1 2  71. Other (describe):</td>
<td></td>
</tr>
<tr>
<td>0 1 2  29. Feared certain animals, situations, or places, other than school (describe):</td>
<td>0 1 2  72. Other (describe):</td>
<td></td>
</tr>
</tbody>
</table>

PAGE 3  Be sure you answered all items. Then see other side.
<table>
<thead>
<tr>
<th>Item</th>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>57. Physically attacks people</td>
<td>0 1 2</td>
<td></td>
</tr>
<tr>
<td>58. Picks nose, skin, or other parts of body</td>
<td>0 1 2</td>
<td>(describe):</td>
</tr>
<tr>
<td>59. Plays with own sex parts in public</td>
<td>0 1 2</td>
<td></td>
</tr>
<tr>
<td>60. Plays with own sex parts too much</td>
<td>0 1 2</td>
<td></td>
</tr>
<tr>
<td>61. Poor school work</td>
<td>0 1 2</td>
<td></td>
</tr>
<tr>
<td>62. Poorly coordinated or clumsy</td>
<td>0 1 2</td>
<td></td>
</tr>
<tr>
<td>63. Prefers being with older kids</td>
<td>0 1 2</td>
<td></td>
</tr>
<tr>
<td>64. Prefers being with younger kids</td>
<td>0 1 2</td>
<td></td>
</tr>
<tr>
<td>65. Refuses to talk</td>
<td>0 1 2</td>
<td></td>
</tr>
<tr>
<td>66. Repeats certain acts over and over; compulsions</td>
<td>0 1 2</td>
<td>(describe):</td>
</tr>
<tr>
<td>67. Runs away from home</td>
<td>0 1 2</td>
<td></td>
</tr>
<tr>
<td>68. Screams a lot</td>
<td>0 1 2</td>
<td></td>
</tr>
<tr>
<td>69. Secretive, keeps things to self</td>
<td>0 1 2</td>
<td></td>
</tr>
<tr>
<td>70. Sees things that aren't there</td>
<td>0 1 2</td>
<td>(describe):</td>
</tr>
<tr>
<td>71. Self-conscious or easily embarrassed</td>
<td>0 1 2</td>
<td></td>
</tr>
<tr>
<td>72. Sets fires</td>
<td>0 1 2</td>
<td></td>
</tr>
<tr>
<td>73. Sexual problems</td>
<td>0 1 2</td>
<td>(describe):</td>
</tr>
<tr>
<td>74. Showing off or clowning</td>
<td>0 1 2</td>
<td></td>
</tr>
<tr>
<td>75. Too shy or timid</td>
<td>0 1 2</td>
<td></td>
</tr>
<tr>
<td>76. Sleeps less than most kids</td>
<td>0 1 2</td>
<td></td>
</tr>
<tr>
<td>77. Sleeps more than most kids during day and/or night</td>
<td>0 1 2</td>
<td>(describe):</td>
</tr>
<tr>
<td>78. Inattentive or easily distracted</td>
<td>0 1 2</td>
<td></td>
</tr>
<tr>
<td>79. Speech problem</td>
<td>0 1 2</td>
<td>(describe):</td>
</tr>
<tr>
<td>80. Stares blankly</td>
<td>0 1 2</td>
<td></td>
</tr>
<tr>
<td>81. Steals at home</td>
<td>0 1 2</td>
<td></td>
</tr>
<tr>
<td>82. Steals outside the home</td>
<td>0 1 2</td>
<td></td>
</tr>
<tr>
<td>83. Stores up too many things he/she doesn't need</td>
<td>0 1 2</td>
<td>(describe):</td>
</tr>
<tr>
<td>84. Strange behavior (describe):</td>
<td>0 1 2</td>
<td></td>
</tr>
<tr>
<td>85. Strange ideas (describe):</td>
<td>0 1 2</td>
<td></td>
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<tr>
<td>86. Stubborn, sullen, or irritable</td>
<td>0 1 2</td>
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<tr>
<td>87. Sudden changes in mood or feelings</td>
<td>0 1 2</td>
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<tr>
<td>88. Suits a lot</td>
<td>0 1 2</td>
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<tr>
<td>89. Suspicious</td>
<td>0 1 2</td>
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<tr>
<td>90. Swearing or obscene language</td>
<td>0 1 2</td>
<td></td>
</tr>
<tr>
<td>91. Talks about killing self</td>
<td>0 1 2</td>
<td></td>
</tr>
<tr>
<td>92. Talks or walks in sleep (describe):</td>
<td>0 1 2</td>
<td></td>
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<tr>
<td>93. Talks too much</td>
<td>0 1 2</td>
<td></td>
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<tr>
<td>94. Teases a lot</td>
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<tr>
<td>95. Temper tantrums or hot temper</td>
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<tr>
<td>96. Thinks about sex too much</td>
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<tr>
<td>97. Threatens people</td>
<td>0 1 2</td>
<td></td>
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<tr>
<td>98. Thumb-sucking</td>
<td>0 1 2</td>
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<tr>
<td>99. Smokes, chews, or sniffs tobacco</td>
<td>0 1 2</td>
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<tr>
<td>100. Trouble sleeping (describe):</td>
<td>0 1 2</td>
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<tr>
<td>101. Truancy, skips school</td>
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<tr>
<td>102. Underactive, slow moving, or lacks energy</td>
<td>0 1 2</td>
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<tr>
<td>103. Unhappy, sad, or depressed</td>
<td>0 1 2</td>
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<tr>
<td>104. Unusually loud</td>
<td>0 1 2</td>
<td></td>
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<tr>
<td>105. Uses drugs for nonmedical purposes (don't include alcohol or tobacco) (describe):</td>
<td>0 1 2</td>
<td></td>
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<tr>
<td>106. Vandalism</td>
<td>0 1 2</td>
<td></td>
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<tr>
<td>107. Wets self during the day</td>
<td>0 1 2</td>
<td></td>
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<tr>
<td>108. Wets the bed</td>
<td>0 1 2</td>
<td></td>
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<tr>
<td>109. Whining</td>
<td>0 1 2</td>
<td></td>
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<tr>
<td>110. Wishes to be of opposite sex</td>
<td>0 1 2</td>
<td></td>
</tr>
<tr>
<td>111. Withdrawn, doesn't get involved with others</td>
<td>0 1 2</td>
<td></td>
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<tr>
<td>112. Worries</td>
<td>0 1 2</td>
<td></td>
</tr>
<tr>
<td>Please write in any problems your child has that were not listed above:</td>
<td>0 1 2</td>
<td></td>
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</table>
**Child Regulation Index**

Your Relationship to the Child:  
- Mother  
- Father

**INSTRUCTIONS:**
Below is a list of things that parents tend to do to encourage their children to behave in ways they prefer them to behave. We would like you to indicate how often you found yourself telling your child to do each of the things listed below THIS WEEK. If your answer to a question is NEVER, circle “1”. If you told you child to do what is indicated in the question RARELY, circle “2”; if you did so a FEW TIMES, circle “3”; if you did so SEVERAL TIMES, circle “4”; and if you did so VERY OFTEN, CIRCLE “5”.

<table>
<thead>
<tr>
<th>HOW OFTEN DID YOU TELL HIM/HER TO:</th>
<th>NEVER</th>
<th>RARELY</th>
<th>A FEW TIMES</th>
<th>SEVERAL TIMES</th>
<th>VERY OFTEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Keep quiet</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. Stop doing the same thing over and over again.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. Sit down</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. Play nicely</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. Be still</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. Stop interrupting</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. Share</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. Stop hitting or biting</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. Stop crying</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. Simmer down</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>11. Go outside</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>12. Be considerate of others’ feelings</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>13. Pay attention</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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</tr>
<tr>
<td>14.</td>
<td>Stop saying that some smell is “yukky”</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td>Let me talk on the phone even though he/she is excited about telling me something</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>16.</td>
<td>Leave me alone so that I can finish something I need to get done</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>17.</td>
<td>Go play with a friend when he/she seemed bored and couldn’t find anything to do</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>18.</td>
<td>Get to bed when he/she was too excited to go to sleep</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>19.</td>
<td>Stop saying that something a friend did was “yukky”</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>20.</td>
<td>Eat his/her food when he/she was acting up during a meal</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>21.</td>
<td>Stop clinging to me</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>22.</td>
<td>Stop yelling</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>23.</td>
<td>Stop being so finicky with his/her food</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>24.</td>
<td>Stop throwing things</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>HOW OFTEN DID YOU:</td>
<td>NEVER</td>
<td>RARELY</td>
<td>A FEW TIMES</td>
<td>SEVERAL TIMES</td>
<td>VERY OFTEN</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>25. Encourage your child to talk to a new babysitter</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>26. Encourage your child to answer the doctor’s questions</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>27. Tell your child to be friendly to a stranger visiting your home</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>28. Calm him/her down when he/she was afraid of being left alone or abandoned</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>29. Help him/her get over being afraid of the dark</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>30. Encourage your child to play with an unfamiliar pet</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>31. Calm him/her down when he/she was upset</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>32. Encourage him/her to join in an activity that was unfamiliar</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>33. Soothe him/her when he/she was disappointed about not getting a desired toy</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>34. Calm him/her down when he/she was very excited</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td></td>
<td></td>
<td>NEVER</td>
<td>RARELY</td>
<td>A FEW TIMES</td>
<td>SEVERAL TIMES</td>
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</tr>
<tr>
<td>35.</td>
<td>Told your child to play with a child she/he doesn’t know</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>36.</td>
<td>Encourage your child to explore an unfamiliar place</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>37.</td>
<td>Tell your child to talk to an adult s/he doesn’t know</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>38.</td>
<td>Encourage him/her to be adventurous</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>39.</td>
<td>Cheer him/her up when he/she was sad</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>40.</td>
<td>Help him/her relax after being nervous at a scary movie</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>41.</td>
<td>Soothe him/her when he/she was sad about losing a favorite toy</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>42.</td>
<td>Help him/her when he/she was mad</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>43.</td>
<td>Sooth him/her when he/she was mad</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>44.</td>
<td>Comfort him/her when he/she was sad about a failure</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>45.</td>
<td>Encourage him/her to invite friends over to the house</td>
<td>1</td>
<td>2</td>
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</table>
# Children's Emotion Management Scales-Anger and Sadness (CEMS)

<table>
<thead>
<tr>
<th>Question</th>
<th>Hardly Ever</th>
<th>Sometimes</th>
<th>Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. When I am feeling sad, I control my crying and carrying on.</td>
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<tr>
<td>2. I hold my sadness in.</td>
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<tr>
<td>3. I hold my anger in.</td>
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<tr>
<td>4. I stay calm and don't let sad things get to me.</td>
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<tr>
<td>5. I keep my cool.</td>
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<tr>
<td>6. I whine/fuss about what's making me sad.</td>
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<tr>
<td>7. I attack whatever it is that makes me very angry.</td>
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<tr>
<td>8. I hide my sadness.</td>
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<tr>
<td>9. I hide my anger.</td>
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<tr>
<td>10. When I'm sad, I do something totally different until I calm down.</td>
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<tr>
<td>11. When I am angry, I do something totally different until I calm down.</td>
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<td></td>
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</tr>
<tr>
<td>12. I get sad inside but don't show it.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. I get mad inside but I don't show it.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. I can stop myself from losing control over my sad feelings.</td>
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<tr>
<td>15. I can stop myself from losing my temper.</td>
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<tr>
<td>16. I cry and carry on when I am sad.</td>
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<tr>
<td>17. I lose my temper.</td>
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<tr>
<td>18. I try to calmly deal with what is making me feel sad.</td>
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<tr>
<td>19. I try to calmly settle the problem when I am angry.</td>
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<tr>
<td>20. I do things like mope around when I am sad.</td>
<td></td>
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<tr>
<td>21. I do things like slam doors when I am angry.</td>
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<tr>
<td>22. I'm afraid to show my sadness</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>23. I'm afraid to show my anger.</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
References


research, and clinical applications (pp. 833–856). New York: The Guilford Press.


victims and psychiatric patients. *Journal of Nervous and Mental Disease, 164*, 401-407.


