EFFECTS OF MALADAPTIVE FAMILY FUNCTIONING ON CHILD EMOTION REGULATION: A STUDY AMONG CHILDREN AND MOTHERS WHO HAVE EXPERIENCED DOMESTIC VIOLENCE

by

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ABSTRACT

EFFECTS OF MALADAPTIVE FAMILY FUNCTIONING ON
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DOMESTIC VIOLENCE

By

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This study examined the hypothesis that, in families in which domestic violence and homelessness occurred, families who have better family functioning, including communication, affective expression, and affective involvement, will have children who demonstrate better emotion regulation (ER) skills. Sixty-one families with children between the ages of 4-16 who were living in a domestic violence shelter participated in the study. Mothers completed questionnaires about family functioning and their child's ER) shortly after entry to the shelter. To further explore the relationship of family functioning and child ER, a subgroup of 23 families were given additional mother and child self-report measures on ER, as well as a projective measure.

Bivariate correlational analysis confirmed the study hypothesis that among mothers in a domestic violence shelter who provided data on their family's functioning, significant associations were found between poorer family functioning and mothers' reports of poorer child ER. As hypothesized, each of the family functioning dimensions of communication, affective expression, and affective involvement, were significantly associated with children's ER. In addition, the subgroup study that used children's self-report of ER also provided strong, but not statistically significant associations between mother-reported family functioning and how the children reported their own ER

functioning. Children self-reported poorer ER when mothers reported poorer family functioning.

This study demonstrates that dimensions of family functioning are directly tied to children's ER capacity. These findings suggest clinical interventions for families experiencing domestic violence and homelessness should be targeted to more fundamental processes of family communication and emotion coaching between mothers and children. Such interventions to improve child ER as a proximal outcome should have long lasting effects on children's adjustment among children in these families. Further, as this study has shown, a large proportion of families recruited had normative family functioning, and the majority of children had strong ER skills, despite enduring extraordinary stresses. Taken from the perspective of identifying resilience and not only deficit, families who already have stronger family functioning need to be encouraged to continue to keep open lines of communication and helped to process the emotions that both mothers and children experience as they enter a domestic violence shelter.

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CHAPTER 1: INTRODUCTION

Overview of Study

This study examined the link between family functioning and child emotion regulation. More specifically, these linkages were examined in a sample of low-income mothers and children that experienced domestic violence and lived in a domestic violence shelter. It hypothesizes that: families who have experienced domestic violence who have relatively better family functioning, including better communication, affective expression, and affective involvement, will have children who demonstrate better emotion regulation skills. The following sections of Chapter 1 will cover: a statement of the problem and the significance of the study; clinical and community intervention implications. Chapter 2 will review the literature, Chapter 3 reports study methods, Chapter 4 discusses study findings, and Chapter 5 is the discussion and study implications.

Statement of the Problem and Significance of Study

Clinical Experiences Informing the Study

This study grew out of two experiences: 1) an investigation of the theoretical literature on child development and risks to children who have witnessed domestic violence, specifically, the development of emotion regulation capacities; and 2) my first hand experiences working with the Ackerman Institute Center for Work and Family in conjunction with HELP Harbor in New York City. HELP Harbor is a domestic violence shelter for mothers and children operated by HELP USA, one of New York City's largest providers of temporary shelter and services to the homeless. I helped to develop and deliver mental health and other support services to families at HELP

Harbor who were survivors of family domestic violence. Specifically, while conducting multiple family group (MFG) interventions with mothers and children in the shelter, I observed that some families seemed to be coping well, while others were more stressed, disorganized, and facing multiple crises. Children seemed to do better when families displayed positive family functioning. Specifically, families appeared to function better if they were able to utilize better emotion communication skills, such as initiating family conversations about feelings. In addition, when mothers were emotionally involved with their children and able to provide emotional support to them and help them to label, express, and manage their emotions, these children seemed better able to identify and talk about emotions and ways to cope with them. They were also more focused, had less emotional outbursts, and less aggression.

These observations led me to become interested in examining more closely the role of emotion regulation in children and families. Specifically, I explored various components of family functioning, including communication, affective expression, and affective involvement, and how they may be linked to emotion regulation in children. This study extends the Center's prior focus on family emotion regulation to examine more closely how family functioning effects children's development of emotion regulation skills.

Definition of Child Emotion Regulation

Emotion regulation (ER) as a construct has received increasing attention in recent years, in both the theoretical and empirical literature. Some theorists identify ER as solely an internal state (including physiological arousal and attentional processes), although most describe it as having several components. These components include a)

internal dimensions of understanding and recognizing one's own emotions and appropriately modulating or coping with them; b) a social component of understanding and recognizing the emotional state of peers and family members; c) and a behavioral component involving responding appropriately in interpersonal situations (Eisenberg, et al., 2005; Penza-Clyve & Zeman, 2002; Sheeber, Allen, Davis, &, Sorenson, 2000; Simpson, Hughes, & Snyder, 2006; Thompson, 1990, 1991, 1994; Zeman, Cassano, Perry-Parish, & Stegall, 2006).

This study used Thompson's (1990, 1991, 1994) definition of ER which is one of the most widely accepted in the field. Thompson defines ER as the intrinsic and extrinsic processes that recognize and control emotional reactions, including how intense they are and how long they last in order to accomplish personal goals. Thompson's definition is particularly relevant as key child researchers of ER have built their work on this model (Campos, Mumme, & Kermoian, 1994; Cicchetti, Ganiban, & Barnett, 1991; Cole, Michel, & Teti, 1994; Fainsilber-Katz & Windecker-Nelson, 2006; Zeman, et al., 2006).

Child Emotion Regulation and Family Functioning

Many theoretical frameworks for the development of child ER focus on the individual infant/child-mother pair (e.g. Fonagy, Gergley, Jurist, & Target, 2002; Fonagy & Target, 1998). Although for infancy this dyad is the most important relationship and provides a critical foundation to child emotional development, as the child grows, the family system becomes an essential contextual contributor influencing children's ongoing emotional development (Blechman, 1990; Cummings, Goeke-Morey, & Papp, 2002; Saarni & Crowley, 1990). Importantly, however, the extensive

studies on early attachment and the mother-child dyad have not been adequately extended to explore the ways in which family functioning contributes to child ER beyond infancy and early childhood (Byng-Hall, 1995; Sheeber, et al., 2000). Further, although there is now a growing empirical literature exploring aspects of parental influences on child ER in older children (see Chapter 2 for a review of the work of Eisenberg, 1995, 1996, 1997, 1998, 1999, 2001, 2005; Cole, Teti, and Zahn-Waxler, 2003; Davidov and Grusec, 2006; and Ramsden and Hubbard, 2002), again most studies measure only parent-child dyads rather than measuring important dimensions of overall family functioning.

Family functioning has been defined by family theorists using several different frameworks (for example, the Circumplex Model: Olsen, Sprenkle & Russell, 1979; and the McMaster Model: Epstein, Baldwin, & Bishop, 1983). Each of these frameworks incorporate such central dimensions of family functioning as emotional bonding, family communication, adaptability under stress, and family roles. Of these two frameworks, however, the McMaster Model focuses more specifically on the "process tasks" that families must accomplish to nurture the development of each family member (Skinner, Steinhaurer, & Santa Barbara, 1983, 1984). Thus, measures derived from the McMaster model more adequately tap specific family processes rather than only dimensions of global functioning described in the Circumplex Model (as are measured by the FACES III scale, Olsen, et al., 1979). The process dimensions assessed by the McMaster-based Family Assessment Measure (FAM-III) used in this study include problem solving, communication, role definitions, affective/emotion responsiveness, affective involvement, and behavioral control. Thus, for purposes of this study the McMaster

Model of family functioning was used as the framework to identify the aspects of family functioning that are hypothesized to affect child ER.

The Effect of Family Violence on Family Functioning

It is estimated that about 1.5 million women are survivors of intimate partner violence annually in the U.S. (Jaffee, 2005). In addition, between 3.3 and 10 million children in the US have witnessed domestic violence in their families, and almost 1 million children are victims of abuse or neglect (Chemtob & Carlson, 2004). Children who witness family violence or who are themselves direct victims of violence are known to be at high risk of poor outcomes, including conduct problems, anxiety, depression, poor peer relations and poor school performance (Margolin & Gordis, 2000; Sternberg, Baradaran, Abbott, Lamb, & Guterman, 2006). Although extensive services have been put in place to treat children who have directly been victims of family violence, child development researchers have suggested that it is equally important to study the psychological effects on children of witnessing family violence (Chemtob & Carlson, 2004; Kitzmann, Gaylord, Holt, & Kenny, 2003; Sternberg, et al., 2006). For example, in a meta-analysis of 118 studies, Kitzmann et al. (2003) found that children who had not been victims, but who had only witnessed inter-parental violence had similar negative symptoms to those who were directly victims of abuse. Because of the increased risk for poor mental and physical health outcomes, these children and families present an important public health problem and a group at high need for mental health intervention. It is also essential that research be conducted to determine the best ways to support such families and children. Among the approaches that can be most useful

are to identify key pathways, such as family functioning and its effect on child ER that may predict risk and resilience, so that targeted interventions can be most successful.

Clinical and Community Intervention Implications

A number of studies have noted the need for further research specifically on children who witness violence (Jaffee, 2005; Kitzmann & Beech, 2006; Osofsky, 1999) and research that collects information from the child in addition to the parent (Buckner, Bassuk, Weinreb & Brooks, 1999; Sternberg, et al., 2006). Such research is needed in order to identify children at higher risk of poorer outcomes as well as to target models for clinical intervention. All the children in the present study have witnessed or experienced family violence in some way because their mothers are residing in a shelter for domestic violence victims. In addition, some may have also been victims themselves, a group for which more research and clinical interventions have been focused. Because of the much greater number of children who are witnesses to violence than are directly abused, as noted above (Chemtob & Carlson, 2004) it is important to understand the unique issues this under studied population faces.

Additionally, although this is not an intervention study, the outcomes provide information about family functioning and the relationship of such functioning to the development of children's ER skills. Such information may inform how to design interventions to more appropriately help children and families involved with domestic violence address their stressful situations. Finally, this study may have implications for another large group of children – those experiencing homelessness, whether or not due directly to domestic violence. Studies have show that homelessness is a risk factor for violence and for consequent child aggression (Anooshian, 2005; Buckner, et al., 1999).

Exposure to violence can come from a variety of sources, both inside and outside of the family, including: partner violence, parental violence directed at children, living in geographically dangerous areas, close living quarters with many family members, inadequate resources to care for families, and time on the street. These conditions can result in extreme social isolation of families, poor family functioning, and concomitant lack of appropriate environments in which children or parents learn or practice ER skills (Anooshian, 2005).

CHAPTER 2: REVIEW OF THE LITERATURE

This study was derived from theoretical perspectives and empirical studies of the development on ER in children. The richest work on child ER has been conducted in the early childhood period. As a result, a review of this important foundational period is provided. In contrast, less theory and studies have extended into latency or middle childhood where a broader family context comes into play. As a result, the study also explored constructs of family functioning and how the contextual issues of the family affect children's ER. Finally, because the families in the study were survivors of domestic violence, the specific dynamics in families who have survived domestic violence are explored. This chapter will provide a review of the literature in these three major domains: the development of child ER, family functioning and its influence on child ER, and how family functioning is affected by the experience of domestic violence and homelessness.

Theoretical and Empirical Perspectives on Child Emotion Regulation

As noted in Chapter One, ER as a construct has received increasing attention in recent years. Nevertheless, as an emerging area of study, there is a lack of consensus on the definition of ER (Simpson, et al., 2006). Some have defined ER as solely an internal state (including physiological arousal and attentional processes), others describe it as having several components. These components of child ER typically include: a) internal dimensions of understanding and recognizing one's own emotions and appropriately modulating or coping with them; b) a social component of understanding and recognizing the emotional state of peers and family members; c) and a behavioral component involving responding appropriately in interpersonal situations (Eisenberg, et

al., 2005; Penza-Clyve & Zeman, 2002; Sheeber, et al., 2000; Simpson, et al., 2006; Thompson, 1990, 1991, 1994; Zeman, et al., 2006).

The most widely accepted definition of ER in the field was constructed by Thompson (1990, 1991, 1994). In this definition ER consists of the intrinsic and extrinsic processes that recognize and control emotional reactions, including how intense they are and how long they last (intensity and temporal features), in order to accomplish personal goals. Thompson's definition has been used extensively by child development researchers (Campos, et al., 1994; Cicchetti, et al., 1991; Cole, et al., 1994; Fainsilber-Katz & Windecker-Nelson, 2006; Zeman, et al., 2006).

Theoretical Perspectives on the Development of Child Emotion Regulation

To gain a comprehensive understanding of ER it was necessary to explore theoretical perspectives surrounding the earliest period of development, particularly the mother-infant relationship. In looking at the nature and evolution of the environment and earliest relationships we can see that this time accounts for fundamental developments in a child's personality structure, including the ability to regulate emotions, define self, and interact appropriately with both one's internal and external worlds. On this issue, Winnicott's thinking about early relationships and the ways in which the mother-infant interaction creates the possibility for healthy or maladaptive ego development, object relations, integration of personality and ER are extremely helpful.

At the center of Winnicott's theory is the study of *both* the infant and the environment, which encompasses the mother. As Winnicott points out, it is not possible to think about the infant alone (1960b). In fact, he notes that early emotional

development cannot be separated from the environment in which the infant is nurtured, as the infant herself has not yet established a separateness; a knowledge of self and therefore others (Winnicott, 1967; 1945). At this stage the infant is highly dependent on maternal care. When maternal care is consistent and reliable the infant may gradually "build up" memories of such care forming a "unit" with the mother which allows the infant to rely on the ego-support of the mother to live and develop (Winnicott, 1960a). This period of ego-support enables the infant to "go-on-being" in spite of her not yet being able to control, or to feel responsible for, what is good and bad in the environment. As his theory progresses, Winnicott leads us to understand that this early relationship is essential to the developing child because it facilitates the merged and dependent child's move towards integration and eventually individuation (1960a). These are the beginnings of the essential processes of ego development, including ER.

This journey towards separateness and independence in the process of ego development is reinforced by an accumulation of positive memory experiences and confidence in the environment. When the baby is in a safe "holding environment", the baby is able to see in the mother an image of herself, and thus the baby is reflected by the mother and given back her own self (Winnicott, 1967). When this occurs, the baby is seen and therefore exists. What follows is a confidence to look and perceive and thus her growing independence is again reassured. Of course the process described above is based on health. That is, in a "good enough" environment, the mother's predictability in meeting the child's needs and bringing the world to the child bit by bit allows the child to move from a subjective experience of illusion of an object, to an object objectively perceived. The infant can now begin to see the mother as a separate object

that also has an inside and can be related to as separate (Winnicott, 1945). These are large developmental advances that mark the infant as a whole person, with her own internal life, psychic reality, and the development of a core, true self, (Winnicott, 1960a). All of this contributes to a child's emerging capacity to regulate emotions through analyzing and interpreting the environment and understanding self versus other control.

When a good enough environment does not occur, the infant developmental progress can be interrupted. The criterion for the emergence of a "true self" relates to the capacity of the environment to deliver a mother who can "well enough" devote herself to the infant, particularly for the first 6 months of life. This means that she is both mentally and physically healthy, but also that there are resources in the family that allow such devoted care giving. Even with the best intentions and optimal maternal functioning, it is possible that the environmental pressures on a family would result in a somewhat compromised ability to provide what Winnicott describes as "primary maternal preoccupation" (1945). Applying Winnicott's theory to an understanding of the broader family context, it can be seen that the mother-infant relationship can be highly influenced by factors beyond solely the mother's individual capacity (e.g. poverty, domestic violence, homelessness).

The longer the infant is able to experience a good enough environment, the stronger the ego and emerging ER capacity. Conversely, when there are failures in the environment, the baby's early defenses are ignited, helping the infant to hide and keep safe the isolated core. Instead of giving back to the baby her unique creativity and spontaneity, the mother responds by inserting her own gesture, her own mood, or her

own defenses (Winnicott, 1960b; 1963; 1967). A mother's capacity to give back to the baby is particularly impaired when there is poor family functioning, particularly in the case of domestic violence.

As Winnicott notes, the best defense against impingements of the "true self" is the organization of what he calls the false self. The false self is described as a primitive defense mechanism whose objective is to protect the true self from invasion and exploitation. Thus, this false self is organized as a defensive self, interacting and reacting to the outside world (Winnicott, 1960a; 1960b). In reviewing Winnicott's theory, it becomes clear that the development and, thereafter, security of a true self is central to individual development. What follows appears to be a delicate dance, a to-and-fro balancing between those parts of the self which are true and protected and those which relate to the external world. This can be a precarious balance to maintain, particularly in those whose integration of self is not secure.

Although Winnicott's theory does not speak in the vernacular of "emotion regulation", his theory of false self describes a child that is unstable and vulnerable to both internal changes and changes in the external environment. The lack of a solid sense of self suggests a difficulty "regulating" or balancing between true and false self states. The fluctuation between these self's and the feelings connected to them could very much be thought of as difficulty regulating or maintaining stable emotions both within oneself and relating to the external world.

Building on Winnicott's perspectives, several other more contemporary theorists also contribute to understanding the development of ER. Fonagy and Target (1998) and Fonagy et al. (2002) use attachment as a framework, but then argue that attachment per

se is not the important construct. Their review of research about the stability and predictive power of early attachment suggests that early attachment status alone is not sufficient to establish psychopathology or healthy behavior. While insecure or disorganized attachment has more powerful long-term predictive power for childhood and adult problems, outcomes for those with secure attachment vary wildly. Trying to explain this difference, Fonagy and Target argue that it is the self-regulatory aspect of early relationships that are more important than the view of attachment as a working model of relationships that is carried into future interactions.

They argue that it is the ER derived from the Interpersonal Interpretative Mechanism (IIM) that is crucial. The organizing aspects of the IIM, what others may call object relations and still others structural theory, focus on the underlying processes that regulate drives and adaptation to reality. Fonagy and Target recognize that early experience gives expression to the underlying biobehavioral and genetic predispositions of the infant. The environment thus leads to the unfolding of the child's potential and establishes initial trajectories that set up vulnerabilities or resilience. In contrast to Winnicott's emphasis on the relational and emotional aspects of this process, more important to Fonagy and Target are not the representations of early relationships or internal working models, but that such early relationships provide the context for brain development of self-regulatory and attention processes that allow for social competence.

Taking the view that early relationships affect information processing control systems, Fonagy and Target (1998) describe how three key processes are affected: 1) stress response; 2) regulation of attention; and 3) reflective functioning. In terms of the

stress response, maternal interactions prime and modulate physiological responses to basic needs such as hunger, pain, and discomfort. Excessive arousal results in hormone levels that bathe the brain in ways that affect structure and process for ongoing interactions with the environment. Hypo- or hyper-arousal primed by these physiological changes can result in persistent orientation to threat and activation of stress responses, dysregulation and impulsivity, poor anxiety tolerance and poor modulation of aggression. This results in lack of appropriate social responsiveness, lack of empathy, lack of ability to follow directions, and lack of ability to self-monitor emotions. Fonagy and Target point out the important process of the caregiver to divert attention from distress to the soothing actions of the caregiver. This process facilitates the child's internalization of the caregiver's actions to create self-soothing, allowing the child to develop the ability to both focus behavior and inhibit behavior which is so fundamental to self-regulation.

Finally, Fonagy and Target describe how these processes lead to the development of what they call reflective functioning. They focus on the importance of caregiver mindfulness of the infant's state and ability to "name" and react appropriately to the mood of the infant. Caregivers who are preoccupied, depressed or have other inhibitions to this attunement to the child will compromise the child's ability to represent its own psychological states. This seems to reflect what Winnicott means when he describes the mother who is not able to offer an adequate holding environment or reflect or mirror back to the infant her own self. These interactions are crucial to self-regulation and to interpreting and communicating in interpersonal contexts.

Cibul (1997) and Slade (1999) extend the story of the development of early ER by examining more thoroughly the processes on the maternal side. While hinted at in Winnicott's "good enough mother" concept, Cibul explicitly describes the necessity of the mother to perceive her children's internal states as related to her ability to perceive her own internal states. Cibul notes that failure in the mother's capacity to identify her own feeling states leads to poor emotion signaling, attunement, and mirroring. These compromise the infant's ability to identify their own feelings, creates anxiety and disrupts the ability to self-regulate. On the other hand the caregiver's appropriate responses makes possible the modulation and containment of strong emotions. The capacity to use emotions as self-signals is essential to tolerate disruptive feelings and maintain ER. Slade (1999) points out a lack of reflective functioning capacity in the parent inhibits the development of this skill in the child because the acknowledgement and symbolization of emotion and feeling states is not able to be reflected back to the infant or child. Similar to Winnicott, Slade argues that this process of maternal reflective functioning allows a child to tolerate and regulate their own emotional/affective experience, including the ability to know and express their needs, moderate their behavior, and understand their own and other's mental states. It is also possible that interaction with a child can improve parental emotion regulation because of the frequent interchanges between parent and child.

Another noteworthy aspect of ER, is how complicated the process can be as children try to navigate the management and regulation of their own emotions and needs. Calkins (1994) and Thompson and Calkins (1996) describe this as a "double-edged sword." They discuss that while both the internal and external environment are

important in the process of ER, they highlight the fact that different contexts are complex and can have multiple and at times competing goals for the child. This is particularly important for children who are in less than optimal parenting environments where there is less predictability and more disruptions. These theorists make an important contribution as they explicate how a child has many choices for reaction in a situation, such as expressing distress, containing anger, showing empathy or defensively becoming aroused and aggressive. The path chosen depends on both the child's internal equilibrium and the needs and interpretation of the social situation. Children who learn ER in an impaired "less than optimal mother" situation such as where the mother is depressed or inadequately attuned, or where there is martial conflict or abuse; exhibit sadness, irritability, helplessness, and guilt, compromising their ability to self-regulate.

In sum, these theoretical perspectives consistently describe how the early environment, specifically mother-infant interactions, set the stage for the child's developing capacity for ER. Each indicate how deficits in maternal-child relationships can inhibit the child's ability to identify their own emotion states, read the emotion states of others, and appropriately express and modulate emotions. Although not explicit, these theorists also imply that the maternal-child relationship is affected by the broader family context and social stressors. Again, in the context of multiple social stressors and poor family functioning such as in domestic violence and homelessness, a family's ability to produce a mother/caregiver who can attend closely and be "preoccupied" with the child may be compromised. This study explored how these ideas can be logically extended to the ways in which dimensions in broader family

functioning, such as communication, affective expression, and affective involvement influence the continued development of a child's ER.

Empirical Studies on the Development of Child Emotion Regulation

This part of the chapter focuses on studies that were conducted in late preschool and elementary school to early adolescent aged children, similar to the age range included in this study. Thus, there will only be a brief review of the extensive literature that has been conducted on infant-maternal interactions; much of which does confirm the theoretical discussions earlier in the chapter about the essential role of early care-giving on the development of ER.

There is ample evidence that appropriately sensitive and reactive maternal interaction regulates infant arousal, can promote positive vs. negative expressed emotion, and can result in infants that demonstrate more self-regulation. When mothers are directed to be unresponsive, infants look away, show signs of distress, and use less optimal forms of regulation. Observations of infant reactions to the sound of the caregiver have shown that infants at an early age begin to modulate their distress by calming even before being picked up. Sensitive care giving is also associated with less negative behavior (crying, fussing) in early infancy, and infants classified as insecurely or avoidant in attachment, as measured in laboratory settings, use self stimulation (e.g. thumb sucking, withdrawal) more frequently as a regulating mechanism. Laboratory evidence also shows that the infant or toddler's temperament interacts with the maternal style and attachment classification in the face of a novel (e.g. stressful) situation. For example, mothers who push inhibited children toward arousing objects undermine the child's self-regulation strategies. Finally, the role of the mother in creating the

opportunity for mentalization has been investigated by counting verbalizations between mothers and infants in observational studies. Infants who were rated as more secure had mothers whose verbalizations seemed to better match the infant's actual cues. For a good summary of these studies, see Eisenberg, Cumberland, and Spinrad (1998), and Fonagy and Target (2002).

Research on ER in older children has focused on varying aspects of ER. One of the most extensive sets of empirical studies has been conducted by Eisenberg and her colleagues. Eisenberg's work has looked extensively at the relationships among parental warmth, children's ego control, emotion expressiveness, and externalizing behavior problems. Her work also explores the construct of "effortful control", conceptualized as the shifting of attention and modulation, inhibition or initiation behaviors related to the control of internal emotion states and external expressions of emotion (Eisenberg, et al., 2005).

In work a decade ago, Eisenberg et al. (1995) found that for a group of 82, 6-8 year-olds (mostly white and middle class) followed longitudinally for two years, low levels of aggression and disruptive behavior as rated by teachers were associated with low negative emotionality, high behavioral regulation, and low rates of nonconstructive coping. When all factors were considered in the model, the child's coping behavior was more important than their level of emotionality. In other words, children who were volatile emotionally functioned well as long has they had good emotion coping/ER skills. As a result, this study supports the notion of behavior or ER being more salient than actual level of expressiveness or emotionality. However, this study did not explore parental influences on child ER. Another Eisenberg paper (Eisenberg, Fabes, &

Murphy, 1996) did explore how parental reactions were associated with children's ER. This study found that punitive or non-responsive reactions of parents to negative emotions in children resulted in dysregulation of behavior and dysregulation of emotion in young children.

In a later paper with this same group of children, (Eisenberg, et al., 1999) parents were ask to rate their response to children's negative reactions and parents were classified into punitive, distressed or minimizing categories. Parents and teachers also rated children's problem behavior, emotion intensity, and ER (defined as attentional skills, ability to delay gratification etc.). Children were followed from age 6-8, to 8-10, and finally from age 10-12. Data were collected from parents and teachers at each age. Here, parental reactions to the child's negative emotions were assessed and the effect on children's ER was measured and compared to the level of children's social behavior at school and at home over time. Results, using structural equation modeling, showed different and stronger patterns for boys, but confirmed a relationship between parent's punitive and distressed reaction patterns to both children's lack of ER and to externalizing negative emotions. Over time, parent's punitive reactions were associated with later externalizing behavioral issues and poor ER as reported by both parents and teachers. Thus, there appears to be empirical confirmation of the theoretical construct that parental/family functioning affects children's ER. Eisenberg concludes that child behavior can elicit negative and nonsupportive parental reactions which in turn are not useful for the child learning to manage emotions.

In 1997, Eisenberg et al. published the first of a series of papers that followed 199 predominately white, middle and working class children in kindergarten through 3rd

grade. The goal was to describe the correlates of positive social functioning as related to differences in ER, emotionality and resilience (defined as functional ego strength). Both teachers and parents rated the child's behavior and attention, and children were observed completing a stressful puzzle task. Teachers also rated the child's social popularity. Eisenberg concluded that emotion and behavioral regulation are different constructs and have a complicated relationship with social functioning. For example, children with attentional difficulties still had positive social outcomes if they had stronger ego resiliency. In this study, ego resiliency was defined as ability to delay gratification, follow appropriate rules, understand social rules etc. Attentional control was a robust mediator of social competency even for children who were prone to negative emotions. Thus, even if a child had aggressive tendencies, if they had adequate attentional control, they were still able to maintain adequate peer relationships. Further, follow up of these children for another two years found the attentional control dimension to be even more important in predicting behavior problems, and again more important for children with intense negative emotions (Eisenberg & Zhou, 2000).

In two cross-sectional studies, Eisenberg also explored the relationship of parent emotional expressivity to children's emotional expressivity and behavior problems (Eisenberg, Gershoff, et al., 2001; Eisenberg, Losoya, et al., 2001). In the Eisenberg, Losoya, et al. article, 169 second through fifth graders, mostly white and middle to upper income were studied. A mother-child interaction looking at slides with positive and negative emotions was observed and coded, in addition to codes of child emotional expressions and parental and teacher ratings of behavior and ER. Again, using structural equation modeling, they found that parental discussion of emotions, positive

parental emotions and parental warmth were directly and indirectly associated with lack of externalizing behavior problems. One mediating variable was children's unregulated emotion. Those children who had better regulation had fewer externalizing problems. They suggest that this is because parental warmth leads to emotional security which reduces externalizing behavior. Also, parents who discuss emotions are concerned with their child understanding other's emotions. They tend to link other's emotions to their own experience, and thus help children understand how they feel and how to relate to emotional contexts. This empirical study again seems to reinforce the theoretical work as described earlier in this chapter about the importance of the maternal-child relationship to the child's appropriate development of ER capacity.

A more recent study (Eisenberg, et al., 2005) followed the above sample for three waves of additional data collection. The results provided strong support for the hypothesis that children's emotional control (EC) mediates the relationship of parental warmth to children's externalizing behavior. They found a longitudinal relationship between parental warmth and positive emotional expressivity in mid-elementary school, predicting EC two years later, which in turn predicted lower behavior problems in adolescence. In the Eisenberg, Gershoff et al. (2001) study, similar report measures were used with 202 somewhat younger children (ages 4.5-8 years), all selected because of having internalizing or externalizing behavior problems based on a standardized checklist. In addition, children's attention, ER, and mother-child interaction were observed by giving them a puzzle task. Similar to the study above, structural equation modeling found that mothers' positive and negative expressed emotions predicted child ER, which in turn affected externalizing behavior problems and social competence as

rated by parents and teachers. However, this empirical study concluded that it could not speak to the exact processes whereby parental emotion affects children's ER. They speculate that emotional arousal in children, due particularly to negative parental emotions may: disrupt learning about ER, inhibit motivation to comply with or internalize parental ER demands, and affect emotional security – all of which dysregulates the child.

The fundamental conclusions of Eisenberg's work about the relationship of parental emotional expression, mediated by child ER, on child aggression, is echoed by a 2002 study by Ramsden and Hubbard (2002). This study used a more diverse child sample, (67% White, 23% African American, 8% Hispanic), of fourth graders and their mothers. Both mothers and teachers rated the children on ER and teachers rated child aggressiveness. Mothers also reported their level of family emotional expressiveness and types of emotion coaching they performed. Only negative emotions proved to have significant relationships, not positive emotions. For example, higher levels of negative emotion expression and lower levels of maternal acceptance of child emotion were related to lower ER in the children. Lower ER was in turn related to higher levels of aggression as rated by the teachers. In addition, the relationship of the emotional coaching variables to ER and aggression was weak. Therefore, it appears the actual level of family emotion expression was more important than what the mothers' tried to teach about ER. Further, the level of negative family emotional expressiveness had significant effects on ER only for girls. Thus, girls were found to be particularly vulnerable to negative parental emotionality.

While Ramsden and Hubbard (2002) found only negative, and not positive emotion affected child ER, Rydell, Berlin, and Bohlin (2003) found that regulation of positive emotion (as well as anger) affected externalizing behavioral problems at home and school. Their sample was of Swedish children in day-care, followed for four years. Like Eisenberg, they also found that unregulated emotion (or emotionality) along with poor ER predicted externalizing problems, but feel that they are separate and not mediated relationships. Thus, they conclude that both excessive emotion (exuberance, anger or fear) and lack of ER capacity, affect behavioral difficulties. Because both exuberance and anger were related to externalizing problems, they conclude it is the ER capacity of the child that is important, regardless of whether the emotion is negative (e.g., anger), or positive (exuberance). Unfortunately this study did not investigate parental variables. In a follow-up study, Rydell, Thorell, and Bohlin (2007) found the same relationships for older children (8-9 year olds), however, as with the earlier study, no parent or family functioning measures were collected.

Two additional studies that did specifically attempt to tease out the parent-child emotional interaction variable are useful here. While Ramsden and Hubbard's (2002) study found weak and confusing relationships between parental reported emotion coaching, child ER and behavior, Cole et al. (2003) and Davidov and Grusec (2006) used careful observational studies in addition to parental reports and ratings to examine the parent-child processes. Cole et al. (2003) focused on mutual child-mother exchanges in preschool dyads. The mothers and children were given a frustrating and a positive task. In dyads where children had no reported conduct problems, there was evidence for reciprocity of positive emotion despite an experimentally manipulated

frustrating situation. Mothers of children with dysregulated behavior would react angrily or irritated if the child's exuberance/excitement continued for too long during the positive task; these mothers also sometimes laughed at their child's frustrations, and children, in turn, laughed at the mother's irritation. In contrast, mothers whose child was more emotionally regulated were less angry in response to excitement, avoided annoyance or irritation, and responded to the child's anger in a more helpful way.

Lastly, Davidov & Grusec (2006) investigated the links between parental warmth and responsiveness to distress and four child outcomes among 106 middle class 6-8 year-olds. The outcomes were regulation of negative affect, regulation of positive affect, empathy and prosocial behavior toward peers, and peer acceptance. Methods included simulated observational sessions with the mother and child separately, along with rating scales completed by the mother and teacher. Both mothers' and fathers' responsiveness to child distress were significantly related to better negative ER by the child, and mothers' responsiveness was specifically related to more empathy and prosocial behavior among child. Warmth did not emerge as a significant predictor of negative ER in contrast to some of the Eisenberg studies. However, warmth did predict positive ER. The authors suggest that parental responsiveness facilitates a child's understanding of how to respond to the concerns of others and helps them develop an adaptive regulatory style that takes into account the feelings of peers, thus promoting empathic and helpful behavior. Warmth, on the other hand, did not in and of itself provide the learning opportunities modeled by parental responsiveness, thus explaining why those relationships were not strong.

In sum, this review of empirical studies establishes that particular dimensions of parental functioning significantly contribute to children's ER. For example, reciprocity of positive emotion in the family, parental responsiveness to children's emotions, parental expression and control of both positive and negative emotion, and parental discussion of emotions, have been shown to be associated with the development of better child ER. As a result, the empirical work strongly supports the theoretical frameworks that have hypothesized how ER develops in children. In addition, research has identified specific aspects of parental functioning that promote child ER in age groups from the later preschool years through early adolescence. Together these two streams of literature strongly support the hypothesis of this study, which holds that the family environment as a whole, and dimensions of family functioning similar to those already examined at the parental level (e.g. parental acceptance and reaction to children's emotionality, parental warmth and positive parental emotional expression), are another important contributor to child ER.

Family Functioning and Child Emotion regulation

Family Functioning

As introduced in Chapter One, family functioning has been defined using several different frameworks (including the Circumplex Model: Olsen, et al., 1979; and the McMaster Model: Epstein, et al., 1983). These frameworks incorporate dimensions such as emotional bonding, family communication, adaptability under stress, and family roles. For purposes of examining the dimensions within a family that may promote or deter from optimal child development, particularly the development of ER, the McMaster Model focuses on the "process" tasks that families must accomplish to

nurture each family member (Skinner, et al., 1983, 1984). The process dimensions assessed by the McMaster-based Family Assessment Measure (FAM-III) used in this study include communication, affective expression, and affective involvement. Thus, for this study the McMaster Model of family functioning was used as the framework to identify the aspects of family functioning that are hypothesized to affect child ER.

Theoretical justification for examining family processes as defined by the McMaster model come from an understanding of family systems theory (Steinglass, 1987). Family systems theory draws on constructs from biology and medicine to posit certain principles by which families can be understood as dynamic organizations in which there are multiple perspectives and influences that add up to a "whole" that goes beyond the individual parts (Cummings, Goeke-Morey, & Papp, 2003). Cummings et al. (2003) further point out that the family is made up of multiple subsystems, including the marital relationship and parent-child relationships. Although it has been traditional to consider that the most important relationship for child development is that of a dyadic relationship with a parent, a systems perspective suggests that the level of functioning within the family as a whole can have an effect on children's development (Cummings, et al., 2003; Sroufe & Fleeson, 1988). In addition, Cummings et al. (2003) point out how upheavals in the martial/partner relationship (e.g., interpartner violence) may create emotional risks for children. Conversely, strengths in the overall family environment may buffer against negative consequences of tensions in one of the family subsystems.

Cummings' work also focuses on the construct of children's "emotional security" in the context of family functioning. By emotional security he means a state

of feeling in control and being able to regulate emotions. He notes that family conflict creates disruptions in family processes, including poor adaptation and organizational functioning. For children, family conflict creates a context which challenges children's well being and emotional security. He suggests that lack of emotional security is typified by children's inappropriate interpretation of emotions and dysfunctional responses to emotionally charged events both within and beyond the family (Cummings & Keller, 2006).

Empirical Studies Linking Family Functioning to Child ER

Although much has been written about family functioning and family treatment, empirical studies linking family functioning to child ER have only begun to emerge. For example, Nixon and Watson (2007) hypothesized that the type of family emotional expressiveness reported by the mother, and the handling of family conflict, would affect preschoolers' understanding of emotionally charged situations. They found that children interpreted a puppet vignette differently if mothers reported positive versus negative emotional expression in the family, and less versus more marital conflict. They concluded that children from homes with poorer emotional relationships (their definition of poor family functioning) have less adaptive interpretations of emotional situations and therefore will function less well with respect to emotional control and social cognition. Similarly, Lunkenheimer, Shield, and Cortina (2007) used a family interaction task for 8-11 year olds to measure parent emotion socialization of children as either providing coaching or as being emotionally dismissing. For those children whose parents were dismissing, children evidenced poorer emotion regulation as reported by parents and teachers, as well as more behavior problems.

In a similar vein, two studies by Valiente explored the relationship of parent emotional expressiveness and family functioning to children's ER. A longitudinal study that followed children from age 6 to 10 years found mothers' expression of positive and negative emotion affected the level of children's effortful control, which in turn predicted children's behavior problems at follow-up two and four years later (Valiente, et al., 2006). A cross-sectional study (children's mean age = 9.6 years) described parental 'effortful control' and 'family chaos' and their association with children's self-reported effortful control, as well as self-reported externalizing behavior problems. High levels of family chaos, which could be characterized as poor family functioning, were associated with low levels of parent positive reaction to children's emotions. Further, children who reported better effortful control had parents who had high levels of positive reactions (Valiente, Lemery-Chalfant, & Reiser, 2007).

Another study with college-age youth found similar associations between family functioning and emotional functioning as a young adult. This study relied on youth self-report of family expressiveness of positive and negative emotions in the family (as a dimension of family functioning). They found youth with families that valued both positive and negative expression, e.g. validated emotional states and encouraged communication about them, were more positively expressive than those who reported more emotionally-negative family environments (Clark & Phares, 2004). A similar college-age youth study explored the relationship of family functioning to youth emotional expression and ER, specifically the ability to cope with feelings (McCarthy, Lamber, & Scraphine, 2004). This study concluded that adaptive families, e.g. ones that encourage emotional bonds and provide emotional support, assist children in the

development of ER strategies that in turn helps them adaptively manage both positive and negative emotions in the family. Although retrospective and correlational in design, these two young adult studies suggest that better family functioning (e.g. communication of positive and negative emotions or provision of emotional support) positively affects children's ability to regulate their emotions (e.g. understand, express and manage emotions).

Thus, while ER is a key construct in child development, and there is an extensive literature that links ER to children's functioning (see for example, Snyder, Simpson & Hughes, 2006) there is much to be learned about how family functioning influences the development of children's ER. Conceptually, child ER has been related to parenting practices and the emotional climate of the family (Morris, Silk, Steinberg, Myers, & Robinson, 2007). Existing studies however, have examined only a few aspects of family functioning and have not examined broader conceptual models of family functioning such as the McMaster model. Similarly, these studies for the most part examined only one aspect of child ER, rather than simultaneously studying its multiple, interrelated facets (such as control of emotional expression and adaptive emotional coping).

The present study adds to our knowledge about the relationship of family functioning to child ER because it used well established, multi-component measures of both family functioning and child ER, and the study focused on a group of families that were exposed to highly emotionally negative experiences that likely challenge their emotional regulatory capacities. A better understanding of the relationship between

family processes and child emotion regulation will inform the creation of specific clinical interventions to assist these at-risk families.

Domestic Violence, Homelessness, and Family Functioning

This section will review salient information about the occurrence of domestic violence in families, with particular focus on how it affects children. It will also review the relationship between domestic violence and family homelessness. In the final section, it will explore what is known about how the experience of domestic violence affects family functioning. Violence in families is an important public health issue, and epidemiologic studies suggest that rates at which children witness or are a victim of domestic violence are increasing (Graham-Berman & Edleson, 2001). The link between domestic violence and homelessness is very strong because to find safety, mothers and children often have to leave their residence. It is estimated that 25% of domestic violence survivors become homeless, and conversely that 92% of homeless women have experienced domestic violence (National Law Center on Homelessness and Poverty, 2008). The fastest growing segment of the homeless population is mothers with young children (Toro, 2006). Research on risk factors for family homelessness suggests that homelessness is merely an extreme end of a continuum of risk for poor families with children (Buckner, et al., 1999). But, despite this overlap between poverty, homelessness and the occurrence of domestic violence, studies suggest that domestic violence may be independently associated with a risk for homelessness. Further, research suggests that such mothers and children may be particularly at risk of poorer outcomes (Haber & Toro, 2004).

Domestic Violence and Homelessness

It is estimated that about 1.5 million women and about 800,000 men are survivors of intimate partner violence annually in the U.S. (Jaffee, 2005). In addition, between 3.3 and 10 million children in the US have witnessed domestic violence in their families, and almost 1 million children are victims of abuse or neglect (Chemtob & Carlson, 2004). Children who witness family violence or who are themselves direct victims of violence are known to be at high risk of poor outcomes, including conduct problems, anxiety, depression, poor peer relations, and poor school performance (Margolin & Gordis, 2000; Osofsky, 1999; Sternberg, Baradaran, Abbott, Lamb, & Guterman, 2006).

One of the salient issues in researching the effects of domestic violence is that there are varying definitions. For example, some studies only count physical abuse, whereas other researchers encompass verbal abuse, control, restrictions on social contact and ability to work or leave the home, and refusal of resources (such as food, clothing etc.) as equally negative situations for women and children (Jouriles, McDonald, Norwood, & Wzell, 2001). Further, violence is conceptualized on a continuum of martial/partner problems from verbal conflict to overt physical abuse. Most researchers of the effects on children of domestic conflict and violence suggest that harmful effects on children's psychological functioning occur much earlier on this continuum than previously assumed (Buckner, 2008; Jouriles, et al., 2001; Masten, A.S., Miliotis, D., Graham-Bermann, S.A., Ramirez, M., & Neeman, J., 1993). This highlights that children may be significantly negatively impacted by the "lower" end of the spectrum, witnessing family arguments, even without being exposed to overt

physical abuse. However, because of the difficulties in adequately defining and studying these families, much less is known about children who are witnesses to conflict or violence, but not victims.

Thus, although extensive services have been put in place to treat children who have directly been victims of family violence, child development researchers have suggested that it is equally important to study the psychological effects on children of witnessing family violence (Chemtob & Carlson, 2004; Kitzmann, et al., 2003; Sternberg, et al., 2006). For example, Kitzmann et al. 2003, as well as Sternberg, et al. 2006 reviews of multiple studies found children who had witnessed, but not experienced, domestic violence had similar negative symptoms. Further, the author's speculated that witnessing violence might have a more powerful effect on younger children, because it occurs during a critical period for developing emotional capacity to appraise and respond to conflict. However, while younger children had more *externalizing problems,* they found negative effects on *internalizing* behavior spanned the age range from 4- to 14-year olds. One of the weaknesses of this study (and others examining child outcomes of family violence) is that it depended on mother-report of children's emotional responses. The authors suggest that the mother's own interpretation of the situation and stress may be projected onto children, thus distorting their ability to accurately assess their children. This provides a strong argument for the importance of multiple, independent measures of children's emotional reactions.

Understanding the effects of the combination of homelessness and witnessing violence in the family on children is also important. Hicks-Coolick, Burside-Eaton, and Peters (2003) suggest that at least half of homeless children have witnessed or

experienced domestic violence. Anooshian (2005) also suggests that witnessing or being victimized by violence is an important risk factor for most homeless mothers and children. She indicates that a major outcome of violence among homeless families is a scarcity of social attachments and a lack of high quality social interactions for both mothers and children. Among homeless children who have witnessed violence, she contends that their social interaction and coping capacity is particularly jeopardized, including factors such as lacking trust in family and peers, failure to resolve emotionally charged situations, and the use of violence and intimidation in relationships both inside and outside the family. The underlying mechanism for negative child social capacity, according to Anooshian, is the parenting process which is undermined by parental stress. Homeless parents are under extreme amounts of stress and thus can model poor relationships and react harshly and negatively to their children, which contributes to children's lack of ER, lack of ability to read social cues appropriately, and to the development of maladaptive coping strategies.

Nevertheless, studies of homeless families have shown that mother-child interactions are not necessarily consistently poorer compared to matched community samples of similar socioeconomic status, with both groups likely at similar risk of violence exposure. For example, Harber and Toro (2004) summarized studies of homeless mothers with children that looked at maternal warmth, child cognitive and social stimulation, as well as reported social support for their children, and found inconsistent results. The mixed research findings show no consistent pattern of poorer outcomes among the children or poorer maternal skills. The authors suggest that these findings require further investigation to help clarify the effects of homelessness and

domestic violence on both maternal and child behavior. In yet another study, Garcia Coll, Buckner, Brooks, Weinreb, and Bassuk (1998), found no consistent differences in the psychological functioning of poor children comparing those in homeless shelters with those living in the community. Further, they point out there are conflicting findings on maternal pathology as well as child outcomes. Huntington, Buckner, and Bassuk (2008) also found that almost 47% of homeless children grouped according to behavior problems, adaptive functioning, and achievement were doing well in all three domains.

Similar findings come from studies of families experiencing domestic violence, but not homelessness. Levendosky, Huth-Bocks, Shapiro, and Semel (2003), for example, found that in a community recruited sample of mothers of young children, while self-reported incidence of physical partner abuse was associated with mothers' distress reactions, it was also associated with positive mother-reported parenting effectiveness and reports of child attachment. The authors suggest this is due to over-compensation in parenting by mothers who have experienced violence. These mothers also did not report higher behavior problems in their children. However, the authors also found that in observing the interactions of mothers and children, "process variables" (such as attentional focus, physical proximity, and level of verbal interactions) were poorer among those who had experienced violence compared to those who had not. Osofsky (1999) describes these "process" problems as a result of the parent being emotionally unavailable and less sensitive or responsive to the child, the effect of which can be withdrawn or disorganized child behaviors. The Levendosky et al. (2003) study thus suggests that there may have been a bias in mothers reporting

better functioning than was actually occurring. Similar to the Sternberg et al. (2006) study noted above, this study points to the importance of assessing the children's outcomes using more than mother-report, as is planned in the proposed study.

Finally, in studies that explicitly focused on mothers and children in battered women's shelters, Hughes, Graham-Bermann, and Gruber (2001), also found that there were groups of children and mothers who faired relatively well. Those that were doing well or were only in a minor way distressed, comprised 62% of the cases among the predominantly White sample. Factors that were associated with these more resilient groups included mothers who used less verbal aggression and were less depressed and anxious, suggesting overall better family functioning, even in the context of on going partner abuse. In a similar study of predominantly African American women, the authors report 52% of the sample doing fairly well. In this study, positive parenting attributes and somewhat less psychological abuse in the family identified children who were doing better (Hughes, et al., 2001). Of note, Hughes et al. in part attribute the positive outcomes of the resilient children to their ability to regulate emotions. In addition, a strength of these studies was that children self-reported on some of the measures, thus child adjustment was not just viewed through mothers' reports.

One issue accounting for these conflicting findings may be the length of homelessness, or the length of exposure and severity of the violence. Donahue and Tuber (1995), for example, found homeless children's aspirations were significantly correlated with the length of shelter stay, and Buckner et al. (1999) found child self-reported internalizing problems (e.g., depression, anxiety) varied according to length of time in a shelter. Harber and Toro (2004) and others (Margolin & Gordis, 2004; Prinz

& Feerick, 2003) point out the need for careful selection and definition of samples in terms of type and length of violence exposure and homelessness, as well as the need to understand underlying processes in the functioning of homeless families and those exposed to violence. This includes the need to turn from solely a deficit model to looking for both risk and protective factors within families.

In particular, Harber and Toro (2004) suggest that a relevant focus is on the family environment. Focusing on how the family functions may help to explain the risks for homelessness and violence in families as well as how family members will react to the experience of domestic violence and loss of housing (similar to the Hughes, et al., 2001, studies reported above). The level of mother distress, for example, was the most predictive factor associated with internalizing and externalizing child behavior scores among both homeless and poor but housed children in a study by Buckner et al. (1999). A similar relationship between mothers' self-reported depression, anger, and PTSD symptoms and children's emotional reactions was found by Chemtob and Carlson (2004) among 50 mother-child pairs who had experienced or witnessed verbal, physical or sexual abuse. This suggests that family functioning patterns unrelated to the experience of domestic violence and homelessness may vary and in turn predict children's outcomes. Thus, it is clear from these studies that there is a need to understand both the risk and the adaptive factors in family functioning that effect families in the face of domestic violence and housing disruptions.

The Effect of Domestic Violence on Family Functioning and Child ER

Consistent with calls for more a comprehensive examination of risk and resilience factors for children who experience domestic violence, and for understanding

how domestic violence affects family functioning (Prinz & Feerick, 2003), studies have begun to emerge that explore the link between family functioning and children's ER in this population. Although these studies have not used a theoretically driven definition of family functioning, or conceptually linked measures of family processes, they have examined dimensions of family systems and hypothesized that they are related to child ER for children who have witnessed family violence. As a result, even though they did not directly access family functioning, these studies all conclude that important dimensions of family and parental interactions are associated with children's ER. They show that positive family interaction in the face of violence can be a protective factor for children because of its influence on helping children understand, express, and modulate emotions more skillfully.

For example, Buckner, Mezzacappa, & Beardslee (2003) measured the type of family emotional support and parental monitoring provided to children. This study examined very low-income mothers and children who had experienced homelessness and domestic violence. They collected data on 155 youth ages 8-17 and their mothers, and identified characteristics of children who were defined as "resilient." Resiliency was conceptualized as having good global functioning, and the absence of behavior problems and mental health symptoms. Data were collected by interview and self-report directly from children as well as parents. Children were also given a Q-sort to establish self-regulatory capacity. The self-regulatory items included those that fit within the definition of ER, such as "is planful, thinks ahead', "is reflective, thinks and deliberates before speaking and acting", "is inappropriate in emotional behavior:", or "has rapid shifts in mood, is emotionally labile". Among the 29% of children in their

study who were categorized as resilient because of absence of behavior problems or other mental health symptoms (e.g., depression), one of the significant factors differentiating them from the rest of the sample was strong self-regulatory skills, including good "executive function and emotion regulation skills." Further, Bucker et al. also found key factors related to the ways mothers' interacted with their children associated with these positive self-regulation and ER skills. A positive family environment, as measured by instrumental and emotional support available to the family, and parents who "monitor" their children carefully (e.g. demonstrate care and concern for the child and supervise them closely), was associated with an increase in children's resilience. Unfortunately, the authors measured only a few aspects of the family environment instead of overall family functioning. Therefore, the study was not able to examine if there were additional family functioning aspects outside of positive support and parental modeling of emotions that may have affected resiliency in children.

Maughan & Cicchetti (2002) drew similar conclusions about the effects of domestic violence and child maltreatment on child outcomes. They assessed the ER of 88, 4- to 6-year-old children who were either maltreated or witnessed domestic violence, and a control group of 51 children who were not exposed to these stresses in response to an anger simulation task. Children's reactions were videotaped and coded for various emotional responses. They found that children who had witnessed violence, not those who were maltreated directly, had more problematic behaviors in the simulation task compared to the control group of children without violence exposure or victimization. While they did not directly measure family functioning, they theorized

that variation in children's dysregulated emotional expression was due to the effect of inter-parental verbal or physical abuse on parenting skills. Specifically, "…it is detrimental changes in parenting that result from inter-adult violence that lead to children's emotional and behavior problems, not inter-adult violence directly." (Maughan & Cicchetti, 2002, p. 1537). Unfortunately, by failing to collect data specifically on family functioning, their hypothesis about the effects of parental interactions on children's ER was mostly speculative.

Kliewer et al. (2004) also studied 9-13 year-old children exposed to community or domestic violence to assess both parent-child interactions and child ER in relation to adjustment. Although this study also does not measure overall family functioning, they did measure child ER and dimensions of family affect and communication both through child self-report and observing a parent-child interaction. They found that the quality of the caregiver interactions, specifically around the tolerance of a range of children's emotions, and regulation of parent's own emotions in the interaction with the child were associated with better ER in children and ultimately fewer adjustment problems.

Finally, Gottman (2001) has noted that parental meta-emotional development (e.g. their thoughts about emotions) is one critical moderating variable for children's emotional reactions to parental discord. He suggests that parents with good "emotion coaching" styles can help protect children from the poor outcomes associated with family violence. Emotion coaching involves five concepts: 1) the parent being aware of the child's emotions; 2) the parent's ability to use children's negative emotions as teaching opportunities rather than to be dismissed or reacted to in kind; 3) the parent helps the child label, discuss and process emotions; 4) the parent provides empathy for

the child's emotional state by communicating understanding and acceptance of the emotional situation; and 5) then helping the child problem solve by setting limits, defining inappropriate behavior, and identifying successful strategies to cope with emotions. In contrast, parents are "emotion-dismissing" if they do not have the language for describing emotions, do not identify and process emotional content in interactions with other adults or their children, and perceive negative emotions as only deleterious, rather than issues that need to be understood, managed, and worked through. He hypothesized that the emotion coaching skills result in children and parents developing an emotional self-awareness that promotes physiological self-regulation and appropriate attentional processes that in turn lead to social competence and emotional intelligence. Further, he hypothesized that the presence of such communication patterns in families are protective for children when there is martial discord.

Cupach and Olson (2006) further amplify the relationship of Gottman's "emotion coaching" or "emotion regulation theory" to an important construct in family functioning. In fact, they suggest that Gottman's conceptualization of emotion regulation theory is a "theory of family communication" (p. 217). This is because the theory reflects ways in which parents communicate with their children to regulate emotions such that children learn interpersonal communication competencies from the family interactions. They contend that families with strong emotion coaching and communication buffer children when family conflict occurs. Also, when positive parent-child communication is present, all family members (adults and siblings) also tend to have more positive communication and conflict resolution. As a theory of family communication, emotion coaching has particular relevance to family conflict

according to Cupach and Olson. This is because conflict can occur, but it becomes destructive only if it cannot be regulated or managed appropriately. When conflict is respectful and leads to constructive communication and problem solving instead of escalation, families can maintain a positive balance and avoid excessive negativism, criticism, and defensiveness. They suggest that validation of this theory is necessary to determine the variability of emotional dismissiveness or emotional coaching styles among families, and how these relate to child and family outcomes such as adult partner violence, child abuse, school and social behaviors of children, and intergenerational transmission of child abuse.

Gottman's theory of emotional coaching and family communication has been tested in a community sample of families with preschoolers, some of who reported domestic violence (Fainsilber-Katz & Windecker-Nelson, 2006). In the Fainsilber-Katz and Windecker-Nelson (2006) study, mothers' emotional coaching skills were found to reduce poor behavioral outcomes among the children. Although this study's family measures address a more comprehensive construct of family functioning, children's ER was not measured directly. Rather, only child behavior ratings were used as outcomes. Therefore, there is still a need to directly link measures of family communication and emotion coaching directly to measures of children's ER.

Conclusions and Study Hypotheses

In conclusion, research has begun to explore some of the aspects of family functioning, including family communication, affective expression, and affective involvement, and their impact on child ER for families experiencing domestic violence. In addition, most of the existing studies conclude that the family environment is an

important factor in how well children are able to express and modulate emotions within these families. There is also strong evidence that ER skills are important correlates for child adjustment. At the same time, there are many gaps in the research. For example, no studies could be found that simultaneously measured family functioning and child ER directly. Further, many studies also fail to use a measure independent of parental report to determine the level of ER or overall adjustment of children. This means that the parent's own level of distress may influence the way they define their children's functioning and may not accurately reflect children's capacities or outcomes.

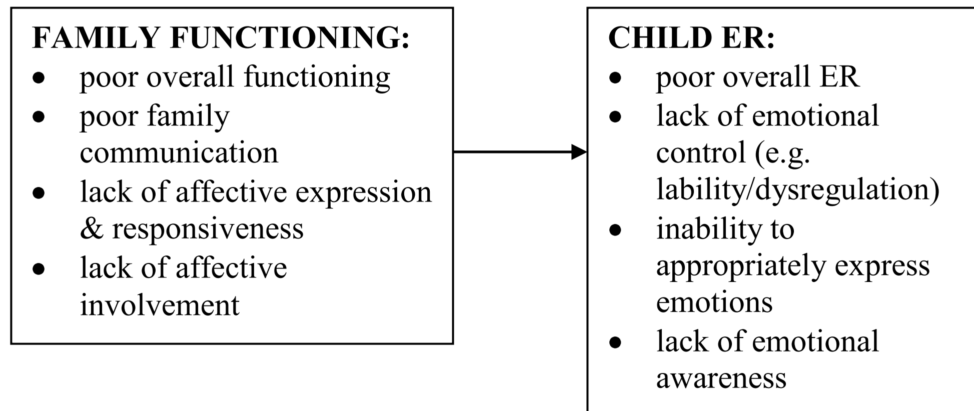
In addition, none of the studies have adequately used a comprehensive, theoretically driven construct of family functioning, nor have they adequately accounted for the multiple dimensions that define child ER (e.g. understanding, expressing and modulating emotion). It is important to utilize a more comprehensive conception and measurement of family functioning that examines dimensions including communication, affective expression, and affective involvement. This is especially important in this early stage of research into the relationship between family functioning and child ER. Thus, this study extended the current research on family functioning and children's ER. Specifically, it examined multiple aspects of family functioning and its effect on the various constructs that constitute child ER for families who have experienced family violence and homelessness.

The study focused on the extent to which variations in family functioning, especially family communication, affective expression, and affective involvement, are associated with child ER. The overall study hypothesized that:

In families where homelessness and domestic violence have occurred, those who have better family functioning, including communication, affective expression, and affective involvement, will have children who demonstrate better ER skills.

The hypothesis was examined using cross-sectional mother-reported family functioning data from the FAM-III, and the mother-reported Emotion Regulation Checklist data for a sample of 61 families with children ages 4-16. To further explore the relationship of family functioning and child ER, a subgroup of the sample was given additional mother and child self-report measures on ER, as well as a projective measure. The use of additional self-report and projective data was important because mothers' ratings of children's ER may be influenced by their own level of emotional functioning and distress (Sternberg, et al., 2006). As a result, data assessing mothers' emotional functioning and children's self-report measures were utilized. The model is shown in Figure 1. This model hypothesizes that family functioning is a causal factor in child ER. However, it is possible that this is actually a bidirectional relationship that would need further study in a longitudinal design. The direction of the relationship could not be addressed by the current study.

Figure 1. Conceptual Model



CHAPTER 3: METHODS

The data for this study were collected as part of a larger study that examined the challenges and coping approaches of homeless families (Fraenkel, 2006; Fraenkel, et al., 2005; Fraenkel, et al., 2005) and the effectiveness of a shelter-based multiple family discussion group intervention in fostering family resilience (Fraenkel, Hameline, & Shannon, in press). The larger study was conducted at two HELP USA Tier II shelters: a general homeless family shelter in the South Bronx, and a shelter specifically for women and children homeless as a result of domestic violence. The data for the present study were collected at the domestic violence shelter. This shelter is located in a northern Manhattan neighborhood of New York City (its precise location is confidential). Most occupants are lower-income persons of African and Latino descent. The shelter has individual family units consisting of a galley kitchen, private bathroom, living space and sleeping space. Units are furnished. Women go through an intake process with the city's emergency shelter organization that takes about a month before they are assigned to Tier II shelters. The building has 52 units and has about 50-52 families in residence at a time. Women and their children stay at HELP Harbor for approximately 8-9 months while they are looking for permanent housing, seeking work, and engaged in social services. The children are enrolled in local public schools; some continue at the schools from their previous neighborhood.

Participants

The present study's analyses utilized pre-intervention data from a sample of 61 mother-child pairs collected over several years. All mothers in the sample completed the same family functioning and child ER measures. In addition, out of the 61

participants, a subgroup of 23 more recently recruited families were also given additional measures on ER for both children and mothers. As a result, 38 families completed data on family functioning and child ER (FAM-III and ERC) from 2000-2006; and 23 families completed the FAM-III and ERC, as well as child self-report measures (EESC, CEMS) and projective data (TAT) on mothers and children from 2007-2008, for a total of 61 participating families. The study included English-speaking mothers of children ages 4-16. They were identified to be contacted using the shelter's roster of families. Families were approached individually by a trained member of the research team through collaboration with shelter case managers, phone calls to units, and mailbox notices. Families were recruited on an on-going basis, generally one to six months after they entered the shelter, with the goal of completing recruitment in time to include the families in the multiple family discussion group intervention.

Families were included in the analyses if they completed data provided by the mother on herself and one child in the target age range. Families who had children outside of the age range (e.g., infants and toddlers; older teenagers), did not complete data collection, or left or were discharged from the shelter unexpectedly were not included in the study.

Procedures

Recruitment Process

After being contacted by phone and told about the general nature of the study and group, those women who were interested in possibly participating were scheduled for an in-person meeting with a research assistant to review the details of participation and to have them sign the consent forms. All mothers participated in a semi-structured

interview. In the past the interview was about one-two hours in length that explored the history of the woman's most recent experience of domestic violence and how and when she decided to leave the battering partner; the challenges faced living in the shelter and how she and her children have coped; and suggestions about how to make the group program useful for her and her children. More recently, a 30-60 minute interview was conducted with mothers and children separately, followed by a 30-minute conjoint interview. The focus of the more recent interview was mostly on the emotions experienced in being/becoming homeless and living in the shelter, and how both parent and child handled their emotions. Additionally, the parent interview explored the parent's view of her child's feelings, and how she responded to her child's emotions. All parents were then given a packet of questionnaires to complete on their own and return after one week (and before starting the multiple family discussion group program).

For the subgroup of more recent participants, both children and parents were given packets to complete on their own to return before the start of the group. Mothers in the subgroup were typically scheduled for a second session to complete one projective measure (the Thematic Apperception Test, TAT). The subgroup was targeted to families of children ages 7-15, in order to have the children respond independently to questions about ER. Children in the subgroup were assisted in reviewing the questionnaires at their confidential interview session and were given the TAT at that time. A group administration session for both mothers and children one week prior to the start of the group was also conducted to answer questions and to assist in completion of questionnaires.

Both the interview and the TAT sessions were audio recorded. The mothers' questionnaire packet included demographic information, information about their own feelings and behaviors, information about their children, and about their family functioning. Children completed scales about emotions experienced and how they managed them; and about family communication and other aspects of family functioning (see detailed description of instruments below). Mothers received $25 for the interview and $25 for completing the questionnaire packet. A post-intervention packet was also distributed and another $25 was given when that was completed. Children received a $10 gift certificate for returning their packet. Follow up reminders were given several times to encourage as many participants as possible to provide complete data.

Packets were returned personally to a research staff member or brought to a multiple family discussion group session as described above. Packets were checked for completeness and questions addressed. Both parents and children were helped to complete packets if they requested assistance.

Multiple Family Discussion Group Intervention

Families were told about the program (called: Fresh Start for Families) at the time of initial contact, and were told that they could participate in the research without participating in the multiple family discussion groups. Group participation was also not contingent on research participation, although all families that did elect to participate in the group completed the research. Likewise, all who elected to participate in the research indicated their interest in participating in the group, although some were placed in housing or discharged from the shelter before the next group cycle. The larger

program's central focus was to provide support for families in their coping with life in the shelter, and to address the psychological effects of their traumatic experiences with domestic violence. The more recent program focused on helping parents and children identify and process strong emotions associated with their numerous challenges and stressors. The program goal was to help parents and children to enhance their own ER abilities, as well as to help parents soothe their children and assist their children to emotionally regulate themselves. The manualized program combined multiple family sessions and time for mothers and children to meet in separate groups. It was conducted over six weeks, with an additional first and last sessions used to collect pre- and post-intervention data.

Measures

Mothers were administered 13 measures, including a demographic questionnaire, and the two measures for the present study, the FAM-III (Skinner, H.A., Steinhaurer, P.D., & Santa Barbara, J., 1994), and the Emotion Regulation Checklist (Shields & Cicchetti, 1997).

Demographic Questionnaire

Mothers provided information about age, ethnicity, martial and partner status, country of birth, and education.

Family Functioning

The family functioning measure used was the FAM-III (Skinner, et al., 1994). The FAM-III is one of the most widely used self-report measures of family functioning (Touliatos, Perlmutter, & Straus, 1990). Further, since it is derived from the McMaster/Process model of family functioning it is well suited to explore the specific

family functioning dimensions that may be related to ER within the family. Importantly, it has specific subscales that address constructs that may be central to the transmission of ER skills to children, such as a communication subscale, an affective expression subscale, and an affective involvement subscale (Tutty, 1995). The FAM-III has 50 items from which are derived a total score, seven subscales, and two additional scales, Social Desirability (7 items) and Defensiveness (8 items). The subscales that comprise the total score are: Task Accomplishment (5 items), Role Performance (5 items), Communication (5 items), Affective Expression (5 items), Affective Involvement (5 items), Control (5 items), and Values and Norms (5 items). The Task Accomplishment subscale measures successful achievement of developmental and crisis tasks (e.g. "We deal with our problems even when they are serious."). The Role Performance subscale measures allocation/assignment of activities to family members, agreement or willingness of family members to assume the assigned roles, and actual enactment of prescribed behaviors (e.g., "Family duties are fairly shared."). The Communication subscale assesses whether family members send clear messages and are open to the messages (e.g., "We take time to listen to each other."). The Affective Expression subscale measures the range, quality and appropriateness of affective communications (e.g., "When someone is our family is upset, we don't know if they are angry, sad, scared or what."). The Affective Involvement subscale measures the degree and quality of family member's interest in one another (e.g., "We feel loved in our family."). The Control subscale measures the processes by which family members influence and manage each other (e.g., "If we do something wrong, we don't' get a chance to explain."). The Values and Norms subscale taps how culture and background

influence task definition and accomplishment in the family (e.g., "We have the same views on what is right and wrong."). For purposes of this study, all subscale scores and the total score were converted to standard scores as indicated in the FAM-III Manual (Skinner, et al., 1994). The total standard score was used to define overall family functioning. The study also specifically examined data from the subscales Communication, Affective Expression, and Affective Involvement.

Steinhauer, P.D, Santa-Barbara, J., & Skinner, H. (1984) describe how disturbed family systems are characterized by overall communication and affective communication difficulties (e.g. unspoken resentments become expressed in unpredictable and angry ways, preventing appropriate communication even on neutral topics). Further, families where there is low interest and concern for one another (low affective involvement) provide little nurturance and support and often destructive or self-serving interactions instead of appropriate support and meeting of members' emotional needs. Thus, this measure provided a multidimensional view of family functioning, family communication, affective expression, and affective involvement, which this study hypothesized affects child ER.

The format of the FAM-III is a 4-point Likert scale (strongly agrees, agrees, disagrees or strongly disagrees). The FAM-III has been found useful for both research and clinical diagnostic purposes (Feindler, Rathus, & Silver, 2003; Grotevant & Carlson, 1989; Tutty, 1995). It was standardized on 475 families representing a range of socioeconomic backgrounds, and clinical (psychiatric, school-related, or legal problems) versus nonclinical status. Norms are provided in the inventory manual (Skinner, et al., 1994). Discriminant validity was tested comparing families with and

without alcoholic and depressed fathers and with other general problems. Subscale scores were significantly different between each group. In addition, concurrent/construct validity was tested by comparing the FAM-III to the FACES, and the FES. Correlations were significant and high, in the range of .82-.94 between the FAM-III total score and Family Environment Scale (FES) (Moos & Moos, 1981) subscales of idealization, cohesion and expressiveness. Tests of the overall scale's internal reliability resulted in a Cronbach's alpha of .93 for adults and .94 for children. Alphas for the subscales were acceptable although somewhat lower for adults and similar for children: .67 for Task Accomplishment, .73 for Role Performance, .73 for Communication, .74 for Affective Expression, .78 for Affective Involvement, .71 for Control, and .70 for Values and Norms. Scoring allows calculation of percentile and standardized t-scores to indicate where the family falls compared to norms, the latter of which were used for analysis in this study.

Child Emotion Regulation

Mother-Report Measures

For the total sample (n=61), children's ER was measured using the Emotion Regulation Checklist (ERC: Shields & Cicchetti, 1997, 1998). The ERC is a parent-report questionnaire of the child's ability to control and appropriately express emotions. It was derived from a Q-sort designed to test items reflective of a well-regulated child. Designed for school age children, there are 24 items using a 4-point Likert scale through which the parent rates how characteristic each statement is of their child ('almost always' characteristic to 'rarely/never' characteristic). The scale measures positive and negative emotionality, regulation, lability, intensity, flexibility, and

situational appropriateness of affective responses. There are two subscales. The lability/negativity subscale measures mood swings, anger, and dysregulation of either positive or negative emotions. The ER subscale measures emotion understanding, equanimity, and empathy. The Chronbach's alpha reliabilities are high, at .96 for the lability/negativity subscale and .83 for the ER subscale.

The ERC has been used with low-income parents to understand developmental psychopathology of children and pathways to development of adaptive and maladaptive characteristics (Shields & Cicchetti, 1997). In testing the validity of the measure, construct, convergent, and discriminant validity were examined and the scale appropriately discriminated children who experienced maltreatment and those who did not. Thus, this scale is quite appropriate to tap into ER in this sample.

Child Self-Report Measures

For the subgroup of more recent participants, children received two additional self-report measures of ER. These were the Emotion Expression Scale for Children (EESC: Penza-Clyve & Zeman, 2002) and the Children's Emotional Management Scale (CEMS: Shipman & Zeman, 2002; Zeman, Shipman, & Penza-Clyve, 2001; Zeman, Shipman, & Suveg, 2002). These are described in turn below.

Emotion Expression Scale for Children (EESC). The EESC was adapted from a prior scale developed for adults. It was designed to provide a measure of degree of emotion awareness, and degree of willingness or reluctance to express negative emotion. The scale was originally developed for children ages 9-13, but has been used in both somewhat young and older children than this age range (8-14 years old). There are 16 items with responses on a 5-item Likert scale which children use to endorse how

much the statement is true for them, from ‘not true at all’ to ‘extremely true’. Factor analysis resulted in two subscales, one on level of emotional awareness and one on degree of willingness/reluctance to express emotion. Internal reliabilities of the two subscales are high (.83 and .81 respectively). Concurrent validity was tested with other scales such as the CEMS, the Affect Regulation Interview, the Child Depression Inventory, the State-Trait Anxiety Inventory for Children, and the Children’s Somatization Inventory. The authors report that poor emotional awareness is fundamentally related to negative affect regulation and is associated with internalizing problems.

Children’s Emotional Management Scale (CEMS). The CEMS is a 23-item scale that combines two separate scales, one on management of sadness and one on management of anger. There are three factors for each emotion: inhibition, dysregulated expression and ER coping. The scales use a 3-point Likert scale asking the child to report if the item is ‘hardly ever’, ‘sometimes’ or ‘often’ true of the way they handle their emotional response. Based on a community sample of mostly white 9-12 year old children, the internal reliability scores ranged from .62 to .77 for each subscale with test-retest reliability of .61-.80. Construct validity has been examined using other measures of sadness, regulation, aggressive behavior, and psychological adjustment, including the EESC and the other scales listed above that were used in the development of that instrument. The scale has been used to differentiate children who have experienced maltreatment from a community sample of children who were not maltreated. In addition, the anger subscales in a study of over 200 middle class boys and girls predicted internalizing and externalizing symptoms. Dysregulation of sadness

also positively predicts internalizing symptoms and negatively predicts externalizing symptoms.

Projective Measure

The subgroup participants, both mothers and children, were also administered the Thematic Apperception Test (TAT: Morgan & Murray, 1935). The TAT is a widely used projective measure used in the study of personality and the interpretation of behavior. The TAT consists of a series of black and white cards with pictures on them, each card presenting a certain amount of ambiguity and representing a range of evocative scenarios. In viewing the cards, a wide variety of thoughts and feelings may be attributed to the scenes. As a result, it can be used to assess participants' affect development and maturity from stories they tell to the series of pictures. The TAT provided a contrast to the self-report questionnaires listed above which ask directly about a variety experiences and tendencies the child may have with emotions and emotional expression on a Likert scale. As a projective test, the TAT examined these issues more indirectly – by evaluating what happened in the story, such as the themes in the content of a story in response to the stimuli, as well as the organization and manner in which they tell the story. In this sense, on projective tests there is not a single, objective answer, rather responses can be a collection of the external and intrapsychic. As such, projective tests are designed to present the subject with less external structure. Non-projective tests, on the other hand, are highly structured, and have a "unique and verifiable answer" that is determined based on the test (Rapaport, 1950, p. 347). Thus, using the TAT provided distinct information on emotions and affect maturity for both mothers and children in the subgroup. Combining this measure with self- and other-

reported scales provided multiple, independent assessments, thus allowing for a more complete and nuanced assessment of ER. Further, using the TAT allowed for an assessment of a mother's own affect maturity, providing important information about the effect of a mother's own emotional state on her assessment of her child. Similarly, using TAT data to assess child affect maturity also provides another assessment of child ER in addition to mother-report and child self-report data, thus providing an assessment from multiple perspectives.

The TAT is suitable for participants four years of age and older. Mothers and children were administered the TAT separately. The standard procedure for administration of the TAT was used, in which each card was presented in turn, and the participant was asked to tell a story about it created from five questions: What's happening now? What led up to it? What will happen in the future? What are the people thinking? What are the people feeling? Prompts were given on the first two cards only that encouraged (but did not require) responses these questions. For the present study, five cards were selected to have differing levels of affect. This was done to give a range of possible emotional responses as well as to not emotionally overwhelm the respondents. The five cards selected for use in the study were: cards 1, 2, 8BM, 13MF or 15[1] and 18GF. Cards 1 and 2 are considered less affect laden, while the last three are considered strongly affect laden.

In order to assess affect maturity on the TAT responses the Thompson Affect Maturity Scale derived from the TAT (Thompson, 1985) was used. The Thompson scale provided an additional measure to access both the mothers' and the child's own

[1] Some subjects were given card# 13MF, and some subjects were given card# 15 because about half-way through the study a parent objected to card #13MF being administered. Therefore, card #15 was chosen to substitute card #13MF as an equivalent affectively charged card.

affect maturity. This measure was conceptualized by Thompson (1985) to assess emotional maturity from TAT responses and is rated on a 5-point categorical scale. Thompson suggests there are two components of affect, a cognitive component, e.g. understanding and properly labeling the emotion, and an intentional component, e.g. being able to identify to whom affect is directed, such as the situation, person, or objects. She also points out that internal representations of self and others are crucial to mature emotional development, and that the organization of emotions into systems is affected by multiple streams of development (e.g. object permanence, attachment). Building on Anna Freud (1963), Thompson's work suggests that emotions have a developmental line and affect is organized at different levels, primitive to mature. Early and undifferentiated states of emotion overwhelm the person and interfere with separating one's own emotions from the emotions of the person they are directed to. Developmentally, children in the sensorimotor or preoperational stages have difficulty conceptualizing self and other emotions and if they are upset about something, can project that the parent or other object are actually upset or angry with them. Further, earlier developmental stages of emotional awareness will prevent children (and adults) from understanding mixed or contradictory emotional states, such as being angry at someone's actions, but simultaneously understanding that the person's intention was positive.

Thompson suggests that simultaneous levels of emotional functioning occur in both children and adults, but for clinical purposes it is helpful to determine the "characteristic" level of functioning (Thompson, 1985), thus modal ratings are used to indicate this characteristic functioning. According to Thompson, affect maturity

involves the ability to tolerate affect and includes dimensions of reality testing, e.g., accurately understanding the cause of the emotion; being able to accurately attribute emotions to self and others; being able to identify the person who is the target of the emotions; accurately naming emotions; and whether or not the emotions are appropriate to the situation. Thompson used this framework to categorize projective responses, such as those from the TAT, into five levels (see Appendix B, Table 16 for detailed description of the five levels). Thompson used clinically trained raters to categorize responses. Thompson reports 89% agreement by item, and 93% overall agreement within one point by clinicians. Internal reliability for subjects was reported using a coefficient of concordance. Concordance of ranks of subjects for each response card was calculated and resulted in a concordance of .29, meaning there was a modest but significant tendency for subjects to respond similarly across individual cards.

TAT responses for the present study were audio taped and transcribed. Two City College clinical psychology doctoral students who were trained on the Thompson Affect Maturity Scale (1985) and who reached .85 level of inter-rater reliability rated each response. The trained scorers were not provided any information about the study, and thus were unaware of the study hypotheses.

Data Analysis

Data Management

All questionnaires were scored by research assistants. Missing items were imputed using subscale average score if less than 10% of items were blank. Data were entered into SPSS for analysis. All data were double scored for accuracy. Initial frequencies were examined for outliers and checked to raw data.

Data Analysis

Descriptive statistics were generated for all demographic items and subscale scores (n=61). Initial inter-correlation matrices were examined using key demographic variables, total family functioning score and the three subscales of interest, and the two subscales of the ERC. Significant associations were then entered into a regression model with each ERC subscale as the dependent variable. This analysis was used to examine the overall study hypothesis that better family functioning will predict better child ER. For a sample size of 61 mother-child pairs there is 80% power at the .05 level (two tailed) to detect significant correlations at r=.35, trends at the p=<.10 for correlations of r=.30 and trends at the p=<.20 for correlations r=.25 (Hulley, Cummings, & Wolfers, 2007). Since this is a study that is exploring cross sectional hypotheses that have not been tested before in the literature, and not intervention outcomes, the analytical approach was to examine patterns of significance and trends in the association between mothers' reports of family functioning and their child's ER. Attention was paid in drawing conclusions and in the discussion to Type I errors that could be drawn from conducting multiple comparisons, but Bonferonni corrections were not made. However, because the subscales of the FAM-III were strongly correlated, multicollinearity was addressed in constructing the regression models by entering each subscale and the overall score separately, and then step-wise.

Subgroup Analysis

In the subgroup (n=23), the analysis model described above was repeated, using the child self-report measures from the EESC and CEMS in addition to the mother-reported ERC. After examining the inter-correlation matrix, there were no statistically

significant associations between demographics and family functioning and the child self-report scores, although patterns were found. Thus, subsequent regression analyses were not conducted. Due to limited power, this subgroup study was primarily exploratory. It was designed to examine the relationship of family functioning, especially family communication, affective expression, and affective involvement on children's own self-reported ER. Nevertheless, there was approximately 80% power to detect significance of correlations at $r=.41$ at the $p=<.10$ level and $r=.28$ at the $p=<.20$ level with this subgroup analysis following calculations provided by Hulley, Cummings, Browner, Grady, and Newman (2006) as well as by Hulley et al. (2007).

Finally, the Thompson Affect Maturity score derived from projective material was used to investigate two further questions: 1) Was there concordance between mothers' affect maturity scores and their child's affect maturity scores?; and 2) How was family functioning associated with mothers' affect maturity? The TAT transcripts were also used to illustrate examples of mother and child ER resilience and, in contrast, poor ER functioning that can be useful for clinical understanding of children and families in such stressful situations. Data analysis consisted of three steps. The modal affect maturity score across the five cards was calculated for each mother and child. Second, the individual card affect maturity scores and the modal overall affect maturity score for mothers and children were correlated. This explored the question of whether mother and child affect maturity were related. Finally, bivariate correlations were run between the modal affect maturity scores for the five mothers' cards and modal score with demographic indicators (mothers' age, education, ethnicity), and with the family functioning scales, and between the five child cards and modal score and the family

functioning scales. This explored how personal level of mother affect maturity and some demographic characteristics were associated with family functioning, as well as whether levels of family functioning as reported by mothers were reflected in the children's TAT responses. As with the overall study, Bonferroni corrections were not applied. The sample size was too small to power the analyses to detect anything but large correlations. Therefore, the goal was to examine possible concordance patterns in mother and child responses, and caution was used in interpreting the results.

CHAPTER 4: RESULTS

Demographic Results

The mean age of the mothers who participated (n=61) was 33.30 (S.D.=8.00, range=20-56 years). The percentage of women who were born in the United States was 70.49%, and 77.00% of the women were United States Citizens. With regards to marital status: 4.90% were married, 52.50% were single, 32.80% were separated, 3.30% were widowed, and 6.60% recorded "other". The women's racial background was: 62.30% African American, 23.00% Hispanic, 4.90% Caucasian, and 9.80% recorded "other". In terms of level of education: 42.60% had attended some high school or less, 23.00% had completed high school or a GED, and 34.40% completed some college or were college graduates (see Table 1).

The mean age of the children who participated (n=61) was 9.31 (S.D.=2.70, range=4-15 years). The participants were 45.90% male and 54.10% female. The racial background of the children was: 63.90% African American, 22.90% Hispanic, 1.60% Caucasian, and 11.40% "other" (see Table 2).

Descriptive Results

As a first analytical step, means and standard deviations were examined for all variables. Where available, comparisons to normative data or indications of the clinical significance of the scores were made. The following section reports the descriptive and normative data for each study variable.

Family Assessment Measure (FAM-III)

Descriptive statistics reveal that the mean standard scores the for the Family Assessment Measure (FAM-III) (n=61) subscales are as follows: Task Accomplishment

is 52.79 (S.D.=14.0), Role Performance is 57.57 (S.D.=11.2), Communication is 56.16 (S.D.=10.6), Affective Expression is 55.08 (S.D.=11.7), Affective Involvement is 52.00 (S.D.=12.7), Control is 56.30 (S.D.=12.8), Values & Norms is 55.15 (S.D.=11.9), Social Desirability is 46.07 (S.D.=7.9), Defensiveness is 51.48 (S.D.=13.6), and the Overall Rating is 55.00 (S.D.=10.4) (see Table 3.)

The mean subscale and total scale scores on the FAM-III (n=61) as rated by mothers in this study were within the normal range. However, the standard deviations were large and a significant proportion of the mothers indicated ratings in the clinically significant range indicating poor family functioning. More than a quarter of the sample (n=61) indicated poor functioning on Role Performance and Communication subscales, while around one third reported poor functioning on the Task Accomplishment, Affective Expression, Control, and Values and Norms subscales. In addition, the scores showed that almost one-third had high defensiveness in their responses, so it is possible that actual family functioning could be much poorer than mothers indicated (see Table 3).

The authors characterize the problems with scores in the clinically significant range (Skinner, Steinhauer, & Santa-Barbara, 1995). For example, families cannot respond appropriately to change, lack mutual understanding, have inappropriate expression of emotions, and rigid or chaotic interaction patterns (see Table 4).

Emotion Regulation Checklist (ERC)

The mean score for the Emotion Regulation Checklist (ERC) (n=61) Lability/Negativity subscale is 1.93 (S.D.=.5), and the mean score for the ERC Emotion Regulation subscale is 3.11 (S.D.=.5) (see Table 5.)

Scores on the ERC (n=61) suggest that this sample of children had somewhat lower Emotion Regulation subscale scores compared to normal grade school children ages 5-12 (Fujiki, Spackman, Brinton, & Hall, 2004) and a community sample of young children ages 4-7 (Blandon, Calkins, Keane, & O'Brien, 2008), and somewhat higher Lability/Negativity subscale scores (Blandon, et al., 2008; Keane & Calkins, 2004). Norms for the Blandon et al. 2008 study, for example, were 1.72-1.90 for the Lability/Negativity subscale and 3.33-3.40 for the Emotion Regulation subscale among young children from diverse SES and ethnicity groups drawn from community child care programs and followed for two to four years. Scores one standard deviation (SD) above or below the mean are considered problematic. Lability/Negativity subscale scores one SD above the mean and Emotion Regulation subscale scores one SD below the mean were calculated as a percent of the sample (n=61) (see Table 5). Thus, almost 38% of children in this sample were reported by mothers to have Lability/Negativity subscale scores in the problem range, i.e. more than one SD above the mean; and 46% were reported to have Emotion Regulation subscale scores in the problematic range, i.e. greater than one SD below the mean indicating of poorer ER.

Emotion Expression Scale for Children (EESC)

The mean score for the Emotion Expression Scale for Children (EESC) (n=23), Poor Emotional Awareness subscale is 22.78 (S.D.=7.7). The mean score for the Expressive Reluctance subscale is 21.13 (S.D.=6.8) (see Table 6).

The EESC has two subscales: eight items that relate to poor awareness of emotion, with higher scores indicating poorer awareness; and eight items relating to unwillingness to express emotion, again with higher scores indicating less willingness

to express emotion. Scores from the 23 children in the present study indicate they are substantially less aware of their emotional state and also less willing to express emotion compared to the normative sample that was used to develop the scale (Penza-Clyve & Zeman, 2002) (see Table 6).

Children's Emotional Management Scale (CEMS)

The mean scores for the Children's Emotional Management Scale (CEMS) (n=23) subscales are as follows: Sadness Inhibition is 2.12 (S.D.=.58), Sadness Emotion Regulation Coping is 2.18 (S.D.=.37), Sadness Dysregulated Expression is 1.72 (S.D.=.49), Anger Inhibition is 1.96 (S.D.=.50), Anger Emotion Regulation Coping is 1.99 (S.D.=.51), Anger Dysregulated Expression is 1.97 (S.D.=.63), Summed Inhibition is 4.08 (S.D.=.96), Summed Emotion Regulation Coping is 2.10 (S.D.=.39), Summed Dysregulated Expression is 3.69 (S.D.=.95) (see Table 7.)

The Children's Emotion Management Scales –Anger and Sadness consist of 23 items that produce three factors for each emotion: Inhibition, Emotion Regulation Coping, and Dysregulation. A summed Inhibition and Dysregulation score, and a mean Emotion regulation Coping score were also calculated. Paired t-tests were used to examine differences between sadness management and anger management. There was no significant difference between levels of sadness and anger inhibition; children expressed equal inhibition to expression of both feelings. However, there was a trend to more dysregulation for anger (n=23, t=-1.93, p=.067) and a significant difference in children's report of coping. Children were much more able to cope with sadness than with anger (n=23, t=2.23, p=<.05). Examining the means reported in a normal sample of 6-12 year olds reported by Shipman and Zeman (2001), it appears the study sample

had more inhibition, less coping strategies, and more dysregulation. See Table 7 for study means and normative means reported by Shipman and Zeman (2001).

Thematic Apperception Test (TAT)

The individual card means and the overall modal scores for the Thompson scoring of the Thematic Apperception Test (TAT) (n=23) cards for parents and children are provided in Table 8. It can be seen that the overall modal scores for both parents and children are below three, reflecting a fairly low level of affect maturity. Interestingly, mean scores for children were higher than parent mean scores on all cards except the first one. This is counter-intuitive, and may be because children were given more prompts than parents in administration, rather than indicating a true difference. Interestingly, however, this result fits with what has been observed clinically during the Multiple Family Group intervention, where children have appeared to develop greater hyper-vigilance to parental shifting affects.

To illustrate the Thompson scale results, examples of a range of affect maturity scores from the transcribed TAT responses for mothers and children for the more affect-laden cards are provided. An example of a low (e.g. a score of two on the Thompson Affect Maturity scale) scored affect maturity mother response to Card 18GF is:

> Looks like a woman, looking at somebody. I don't know where her fingers are, I don't know. She looks like a sad look in her face. I don't know if the person died themselves there, or if she kill her. Because she seems to have her hands digging into their neck or her face. They're not holding her, like I don't know. I don't know if…her eyes look sad, her arms, her arms are, maybe she's expressionless, I don't know. Looks like, I don't know if she's holding the person or if somebody falls you would try to hold grab shoulders, but she has the lady by the side of her neck so….maybe she's sad that she had to kill her, I don't know.

An example of a low scored (e.g. a score of two on the Thompson Affect Maturity scale) child response to Card 8BM is:

> But what is this, can you just tell me? Ok. One day there was a boy… named Deshawn and he wanted to get a tattoo and it hurted. He started bleeding and his mom came in the room and said 'where is my son?' So then the boy came back from home, I mean from the tattoo place, and then the mom said go in your room and clean it. He started getting the broom and sweeping. And then the mom came in the room and saw the tattoo it started bleeding. And the end. *Thinking?* He wanted a tattoo. *Feeling?* It was hurting.

In contrast, an example of a high Affect Maturity score (e.g. score of four on the Thompson Affect Maturity scale) for a mother to Card 18GF is:

> I don't know whether she hurt that person, or that person fell down the stairs and hurt themselves and she's like, she's in shock and she doesn't know how to feel about that person, because she loves them but she dislikes them. So she doesn't know whether she should be upset that they're hurt or she should be happy that why finally happened to that person happened because she's thought about them getting hurt and wanting them to get hurt, and it happened and now she doesn't really know how to feel about it. She doesn't know if she should be upset about it or she should be happy about it because she's always wished it to happen.

Similarly, an example of a high scored Affect Maturity score (e.g. score of four on the Thompson Affect Maturity scale) for a child response to Card 8BM is:

> What's happening now, he's probably having surgery, um before he probably got shot. Afterwards he might be okay or die. What's the other one? *Thinking? Feeling?* Um, he might not be thinking anything because he's kind of out of it (one operated on). He's probably thinking, he's probably anxious (1st man in back scene) don't know if he can do it. He's probably feeling sorry. He's probably feeling…is he by himself or is he like holding the gun? *It's up to you.* Um, he probably feel guilty.

While the high and low scored Affect Maturity responses show the extremes of the scale, the majority of the scored responses fell within the middle, or a score of three on the Thompson Affect Maturity scale. An example of a middle Affect Maturity scored mother response to Card 15 is:

> Oh no! What is that? Oh my God. Ok what's happening now is, uh, he is or she is, he she is visiting the cemetery. What happened in the past is that their her his mother died. What he's feeling is very blue. What he's thinking is that if his mother was alive today he would tell her what he's feeling and what he's feeling is very sad.

Finally, an example of a middle (e.g. score of three on the Thompson Affect Maturity scale) scored Affect Maturity child response to Card 8BM is:

> But like they torturing him if he's alive…he look like he don't want to see it. Um, they look mad or something, yeah, they look mad. Um, before this he probably had to fight them, maybe, uh, yeah. And after this he be dead probably, they be happy and he be traumatized. That's it.

Outcome Analyses

The overall study's hypothesis (n=61) was: In families in which homelessness and domestic violence has occurred, those who have better family functioning, including communication, affective expression, and affective involvement, will have children who demonstrate better ER skills. To examine the hypothesis, bivariate correlations were conducted among demographics, the FAM-III subscales and the subscales of the ERC. Table 10 shows the correlation matrix.

Associations Among Family Demographic Variables

At the bivariate level, mothers' age is associated with older child age and with greater education (r=.607, p=<.001, r=.314, p=<.05). Mothers' citizenship is significantly positively associated with having a female child in the study (r=-.276, p=<.05). This is likely a spurious association since there is no logical reason for this correlation. Mothers' age is also associated with better, but not significant, scores on the FAM-III Affective Expression subscale and lower scores on the Lability/Negativity subscale of the ERC (r=-.190, p=<.20).

Associations of Family Demographics with the FAM-III and ERC

Mother education level is significantly associated with a lower FAM-III Overall score pointing to more positive family functioning (r=-.258, p=<.05). Mothers' education is also negatively associated as a trend with the FAM-III Communication subscale (r=-.249, p=<.10). Similar to the above findings concerning the FAM-III Overall score, this means that mothers with better education also reported better family communication scores. In addition, mothers' education was negatively associated as a trend with mothers reporting lower scores on the ERC Lability/Negativity subscale for their study child (r=-.214, p=<.10). This means that mothers with more education reported their children as being less labile/negative. Further, lower scores on the ERC Lability/Negativity subscale are negatively associated with child age at the non-significant level (r=-.182, p=<.20), with older children demonstrating lower lability/negativity (e.g. lower scores on the ERC Lability/Negativity subscale). Child gender is not associated at even the trend level with any of the family functioning or emotion regulation subscales. However, there is a strong association for mothers who are reporting on a female child for purposes of the study, to report better scores on the FAM-III Affective Expression subscale (r=-.165, Table 10). Note that a randomly selected child in the age group was included in the study, however, mothers may have multiple children in the age group.

Family Functioning (FAM-III) and Child ER (ERC)

Not surprisingly, the FAM-III Communication, Affective Expression, and Affective Involvement subscales and the FAM-III Overall score are highly significantly correlated with each other (p=<.001) (Table 10).

Specifically examining the correlations between the FAM-III (various aspects of family functioning) and the ERC (mothers' report of child ER), the overall study hypothesis was confirmed. There is a significant positive association between the FAM-III Communication ($r=.538$), Affective Expression ($r=.374$), Affective Involvement ($r=.469$) subscales, and the Overall FAM-III ($r=.522$) and the ERC Lability/Negativity subscale (all at the $p=<.001$ level). This indicates that the more poorly the mother rates family functioning on these dimensions and overall, the more labile and negative they also rate their child's ER. The opposite holds true for the association between family functioning and the Emotion Regulation subscale of the ERC. Mothers who indicated more positive family functioning (lower scores on the Overall FAM-III, FAM-III Communication, Affective Expression, and Affective Involvement subscales), rate their child in the study as having better ER (high scores on the ERC Emotion Regulation subscale). The negative associations between the ERC Emotion Regulation subscale, the Overall FAM-III ($r=-.402$, $p=<.001$) and the three FAM-III subscales: Communication ($r=-.266$, $p=<.05$), Affective Expression ($r=-.368$, $p=<.001$), and Affective Involvement ($r=-.417$, $p=<.001$) are all significant. Thus, the hypothesized relationship between family functioning and child ER is strongly demonstrated at the bivariate level. In addition, as expected, there is also a highly significant negative correlation between the ERC Lability/Negativity subscale and the ERC Emotion regulation subscale ($r=-.405$, $p=<.001$), since a higher score on the Lability/Negativity subscale means poorer functioning and lower ER.

Based on the bivariate correlations, regression equations were developed with each ERC subscale as the dependent variable. Model 1 (see Table 11) used just mothers' education and the FAM-III Overall score. Model 2 (see Table 11) used mothers' education and the three FAM-III subscales. Model 1 was significant ($F=10.69$, $p=<.001$), Adjusted R Square=.244. In this model the FAM-III Overall score, controlling for mothers' education was the significant predictor. Model 2 which included mothers' education, FAM-III Communication, Affective Expression, and Affective Involvement subscales overall significantly predicted the ERC Lability/Negativity subscale score ($F=6.3$, $p=<.001$), Adjusted R Square=.261. Thus, overall family functioning significantly predicts the child's ERC Lability/Negativity. In addition, among the FAM-III subscales (Communication, Affective Expression, and Affective Involvement), Model 2 demonstrates that family Communication is the strongest predictor of ERC Lability/Negativity controlling for both mothers' education and the other FAM-III subscales (Affective Expression and Affective Involvement).

The two regression equations were repeated using the ERC Emotion Regulation subscale as the dependent variable (see Table 12). Model 1 which used only mothers' education and the FAM-III Overall score also significantly predicted the ERC Emotion Regulation subscale ($F=5.29$, $p=<.01$), Adjusted R Square=.125. Model 2 which includes mothers' education, FAM-III Communication, Affective Expression, and Affective Involvement subscales was less robust, but still overall significantly predicted the ERC Emotion Regulation subscale score ($F=3.1$, $p=<.05$), Adjusted R Square=.124. Thus, as above, overall family functioning also significantly predicted the ERC Emotion Regulation subscale (Model 1). In addition, among the FAM-III subscales

(Communication, Affective Expression, and Affective Involvement), Model 2 demonstrates that Affective Involvement is the strongest predictor of ERC Emotion Regulation (at the trend level) controlling for both mothers' education and the other FAM-III subscales (Communication and Affective Expression).

Subgroup Analyses

The subgroup study (n=23) was designed to examine the association of mothers' report of family functioning with children's self-reported ER. The 23 children and families in the subgroup were somewhat different than the overall group: more were U.S. citizens (91% vs. 77%), more were African American (74% vs. 62%), and mothers were older (M=36.9 years vs. M=33.3 years), and slightly better educated (39% had some college vs. 34%). There were also more male children (52% vs. 46%). Children were between 7 and 15 years of age (younger children were not enrolled).

Subgroup Study Association Between FAM-III and ERC

The relationship between the mother-reported FAM-III subscales and the mother-reported ERC subscale scores was examined to verify that for the subgroup sample, the relationship between the FAM-III and the ERC remained as reported for the overall study sample. The correlations had the same pattern as with the overall study sample of families: the ERC Lability/Negativity subscale score was significantly associated (p=<.01) with the FAM-III Overall score and each FAM-III subscale score even for this smaller sample of mothers and children. In addition, while not as strongly associated, the same pattern held between the ERC Emotion Regulation subscale scores and each FAM-III subscale score (except the FAM-III Communication subscale) at the trend of p=<.10 level (see Table 13).

Associations Between FAM-III and CEMS and EESC

Once it was established (as noted above) that the association between the FAM-III and ERC were similar to the overall study sample, bivariate correlations were then examined between study demographics and each FAM-III subscale (Overall FAM-III, FAM-III Communication, Affective Expression, and Affective Involvement) and the child self-report subscales for the CEMS and the EESC (Table 14).

Sample size affects the power to detect differences in this subgroup study. However, there are patterns that indicated that when mothers rated dimensions of family functioning poorly, they are correlated with children's self-reported poor ER. The less well functioning the family according to the mother, the less well regulated the children according to the child (see Table 14). For example, the Expressive Reluctance subscale scores reported by children on the EESC were associated with poor FAM-III Communication subscale scores as reported by the mother (r=.297, p=<.20). Strong but not significant associations were also seen between the child Expressive Reluctance subscale scores, and mother-reported FAM-III Affective Expression scores (r=.217). This suggests that children who are reluctant to express emotion had families whose mothers reported poorer family communication, and less affective expression. These findings further confirm the overall study hypothesis that family functioning, especially dimensions of communication and affective involvement, are associated with children's ER. Thus, both a mother's report of the child's ER functioning and the child's own report appear to be consistently associated with family functioning dimensions.

Associations Between ERC and CEMS and EESC

Further exploration was conducted to assess the relationship of the mother's rating of child ER and the child's self-report of their ER (see Table 15). While there were no significant findings, strong negative correlations were found between the mothers' ERC Emotion Regulation subscale scores and several measures of children's self-report of ER. For example, children with higher mother-rated ERC Emotion Regulation subscale scores reported lower EESC Poor Awareness subscale scores, and lower EESC Expressive Reluctance subscale scores (r=-.231, r=-.132 respectively). In addition, children with higher mother-rated ERC Emotion Regulation subscale scores reported lower CEMS Inhibition subscale scores (r=-.225). Thus, children whose mothers' rated them as having more capacity for ER rated themselves as more aware of their emotions, more able to express their emotions, and less inhibited in expressing their emotions.

Further, mothers' ratings of ERC Lability/Negativity were positively associated with the children's EESC Expressive Reluctance subscale scores (r=.284, p=<.20), and negatively associated with the children's CEMS Coping subscale scores (r=-.204). Thus, children who reported better coping had mothers who reported them as having lower lability, and children who self-reported trying to hold in emotion were rated by mothers as more labile.

Associations Among Child Self-Report ER Measures

Among the child measures, child scores on the EESC Poor Awareness subscale were significantly associated with the Dysregulation (r=.630, p=<.01) and Inhibition (r=.542, p=<.01) subscale scores on the CEMS, but not the CEMS coping subscale (Table 14). This suggests that children with poorer ER experience this poor functioning

in dimensions of awareness, dysregulation, and inhibition. However, they are less aware of their coping skills, positively or negatively.

Associations of Mother and Child Scores on the TAT

The last step of the subgroup analysis was to examine the TAT scores using the Thompson scoring method. First, internal consistencies of the scores on the five cards for mothers and children were examined to determine whether the same level of affect maturity was expressed on each card. It was found that mothers' scores were highly internally consistent (alpha=.73) whereas children's were not consistent (alpha=.28). Therefore, any correlations between children's affect maturity scores and other measures must be viewed as highly exploratory. No significant correlations or trends were found between individual cards. This suggests that mothers and children were not found to have similar levels of affective maturity, on individual cards as measured by the Thompson TAT scoring method. Lack of concordance between mothers and children may be due to the lack of internal consistency in children's responses. For this reason, the overall mode was examined using a paired correlation. This association was in the negative direction, meaning that mothers with overall poorer affect maturity on the TAT cards had children with higher affect maturity ($r=-.479$, $p=<.05$). This finding is hard to interpret and may reflect problems in the small sample size, inconsistencies in administration of the cards to children and mothers (e.g., perhaps children received more prompts), or the lack of internal reliability of the children's responses as noted earlier. It is also possible that from a systems perspective, these results reflect that children may try to compensate for their parents' lack of maturity by being more mature themselves.

Relationship Between TAT Scores and FAM-III

Table 9 shows the bivariate correlations among mothers' FAM-III scores and their TAT individual card and overall modal scores. A consistent pattern of strong negative correlations was obtained in the hypothesized direction, e.g., mothers reporting better family functioning on each subscale and overall had higher affect maturity responses on the TAT (higher TAT scores were associated with lower FAM-III scores which indicate better family functioning). Mothers' overall modal response to the TAT cards was significantly negatively associated with the overall FAM-III score (r=-.446, p=<.05), and nearly significantly negatively associated with the Communication and Affective Involvement subscale scores (r=-.352, p=<.10, r=-.403 and p=<.10 respectively).

Table 9 also shows a further analysis conducted to see if the children's TAT scores were associated with mother-reported family functioning. The patterns of association were inconsistent and non-significant for most of the cards. However, one card (18GF) was significantly positively correlated with FAM-III Affective Expression (r=.467, p=<.05), FAM-III Involvement (r=.560, p=<.01), and FAM-III Overall (r=.478, p=<.05) subscale scores. In addition, the children's modal scores were found to be significantly positively correlated with FAM-III subscale scores (FAM-III Communication, r=.425, p=<.01; FAM-III Affective Expression, r=.551, p=<.01; FAM-III Involvement, r=.500, p=<.05; and FAM-III Overall, r=.473, p=<.05). This means that better affect maturity in children was associated with *poorer* mother-reported family functioning. Given the inconsistencies in children's scores this may be a

spurious finding. However, as mentioned above, this may also be a result of children overcompensating for poor overall family functioning.

Summary of Findings

In sum, the overall study collected data from 61 mothers and 23 children participating in a larger study of family functioning among mothers and children in a domestic violence shelter. The mothers were on average in their mid-30s, were predominately US citizens, and of African American and Hispanic ethnicity. Mothers provided data on 61 children age 4-15, 54% of whom were female. The subgroup study collected self-report data from 23 children and included families who were demographically slightly different than the overall study. However the pattern of findings concerning the relationship of mother-reported family functioning on the FAM-III measure to mother-reported child ER as measured by the ERC was the same for both groups.

The hypothesis of the study was confirmed: among mothers in a domestic violence shelter who provided data on their family's functioning (using the FAM-III, a well respected measure of perceived family interactions), significant associations were found between poorer family functioning and a mother's report of her child's ER. As hypothesized, each of the dimensions of Communication, Affective Expression, and Affective Involvement tapped by the subscales of the FAM-III, were significantly associated with children's ERC Lability/Negativity subscale scores and ERC Emotion Regulation subscale scores. Mothers rated their children as more labile/negative when they also rated their family functioning as poorer overall, as well as on the dimensions of communication, affective expression, and affective involvement. Similarly, mothers

rated their children's ER more poorly when they rated their overall family functioning and each of the dimensions of communication, affective expression, and affective involvement more poorly.

In addition, the subgroup study that used children's self-report of ER also provided strong, but not statistically significant associations between mother-reported family functioning and how the children reported their own ER functioning. Children self-reported EESC Expressive Reluctance when mothers reported poorer FAM-III Communication, Affective Expression, and Affective Involvement.

Finally, data from scoring the TAT cards provided some contradictory results with regard to the association of family functioning with children's affect maturity, and between mother and child affect maturity. While mothers' TAT scores and FAM-III scores were associated consistently in the hypothesized direction (e.g., mothers with better affect maturity scores on the TAT reported better family functioning), children's scores followed an inconsistent or opposite pattern. In addition, children's and mothers' scores were not correlated as was expected. Because children's scores were highly internally inconsistent, the puzzling findings of the TAT may be due to small sample size, differences in administration between children and parents, as well as the affect maturity score not being a reliable measure for children. However, as noted above, the results may also reflect children being more mature themselves to overcompensate for their parents' lack of maturity.

CHAPTER 5: DISCUSSION

This study of family functioning and child ER grew out of investigating the theoretical literature on child development and risks to children who have experienced domestic violence and homelessness, and clinical experiences working in a family domestic violence homeless shelter in New York City. My clinical experience delivering mental health and support services at a HELP Harbor shelter, led to me observe a range of coping strategies and family functioning among mothers and children. Families appeared to function better if mothers were emotionally involved with their children, provided emotional support, and helped their children label, express, and manage their emotions. The children, in turn, seemed to have been more focused, less emotionally labile, and demonstrated less disruptive behavior when mothers were more emotionally attuned. These observations led me to the study design and to hypothesize that:

> In families in which homelessness and domestic violence has occurred, those who have better family functioning, including communication, affective expression, and affective involvement, will have children who demonstrate better ER skills.

Summary of Study Findings

Mothers and children in the present study were recruited from a domestic violence homeless shelter population shortly after their arrival at the shelter. They were largely minority families (85% African American or Hispanic), poorly educated (43% of mothers had not completed high school), unmarried (53%), and they were mostly U.S. citizens (77%). Mothers were in their early 30’s, while the study child was around

age nine. Despite their many social-contextual disadvantages, a wide range of mother-reported family functioning and child ER was found. This finding is consistent with Hughes et al's (2001) study of women and children in domestic violence shelters, which reported women and their children functioning surprisingly well psychologically and behaviorally. The present study's mean family functioning scores were within the normative range, with only a subset of families reporting clinically significant family functioning difficulties, ranging from approximately one-quarter to one-third of the study sample on the individual FAM-III subscales (Table 3). In addition, while Levendosky et al. (2003) suggest that mothers may be socially biased to report better functioning either because of overcompensation or fear of social service interference with their families, the present sample reported no clinically significant scores on the Social Desirability subscale of the FAM-III (although about one-third were in the clinical range for Defensiveness). Similar to the family functioning scores, mother-report of child ER in this study also revealed a range of functioning. Scores were in the normal range for over one-half to two-thirds of the children on the two subscales of the ERC (Table 5).

The study sample's relatively normal range of functioning affirms the calls to examine homeless and violence-affected families from a lens of resilience, not just deficits (Harber & Toro, 2004; Huntington, et al., 2008; Margolin & Gordis, 2004; Prinz & Feerick, 2003). Indeed, Hughes, et al. (2001) specifically linked other measures of child resilience among children in domestic violence shelters to capacity for ER. Further, in the Buckner et al. (2003) study of homeless children, a distinguishing factor of the 29% of children identified as resilient was self-report of

characteristics that fit within the definition of ER, such as thinking ahead or anticipating, appropriate emotional behavior, and low lability. While Buckner et al. (2003) also found the ways mothers interacted with their children (such as supervising them closely) to be associated with children's positive ER skills, they did not use constructs or measures of family functioning.

The present study has extended the prior work on families in domestic violence shelters by specifically examining the association of family functioning and child ER. It has demonstrated that there is a strong link between mothers' perception of dimensions of family functioning and how well their child is emotionally regulated among families residing in a domestic violence shelter. The evidence is compelling because it includes both mother-report, and child self-report of ER, and uses a theoretically driven and well-tested measure of family functioning (FAM-III: Skinner, et al., 1994). In contrast, many other studies of families exposed to domestic violence and homelessness that sought to characterize family functioning and ER have either not used a comprehensive measure or construct of child ER functioning (Fainsilbert-Katz & Windecker-Nelson, 2006), have not obtained self-report data from children (Sternberg, et al., 2006), or have not used a theoretically-comprehensive conceptualization of family functioning (Buckner, et al., 2003).

The associations between mothers' ratings of family functioning and mothers' ratings of children's ER were statistically significant for both overall family functioning, and the three FAM-III subscales (Communication, Affective Expression, and Affective Involvement). As hypothesized, overall family functioning as well as the dimensions of family Communication, Affective Expression, and Affective

Involvement tapped by the subscales of the FAM-III, were significantly associated with mother-reported ratings of children's ERC Lability/Negativity subscale scores and ERC Emotion Regulation subscale scores (Table 10). When mothers rated their family functioning as poorer overall, and on the dimensions of communication, affective expression, and affective involvement, they also rated their children as more labile/negative and as having poorer ER.

This association is in line with findings of Levendosky et al. (2003) and Osofsky (1999) that "process variables" can affect maternal-child interaction among families affected by domestic violence – for instance, the impact on children when the mother is emotionally unavailable and less sensitive and responsive. In the present study, one of the process variables describing mother-child interactions in families was measured by the FAM-III Communication subscale (Skinner, et al., 1994). The present study found that mothers who did not accurately identify their child's emotional state, or understand the reasons behind their child's emotions, and failed to communicate this to the child (as measured by FAM-III Communication subscale) tended to view their child as emotionally unpredictable (ERC Lability/Negativity subscale). These findings of the study are concordant with the clinical observations of my colleagues and supervisor working with families in the shelter. For example, mothers often mistook children's dysregulated behavior as disruptive and personally challenging, while the child may have in fact been acting out behaviorally to cover feelings of fear and insecurity. Lack of communication could perpetuate this mismatch in understanding and result in the child becoming increasingly out of control.

Another process variable characterized as inadequate expression of emotions or inhibition, or inappropriate expression of emotions, was measured by the FAM-III Affective Expression subscale (Skinner, et al., 1994). In the present study, mothers who rated their families as inappropriately or inadequately expressing emotions, also rated their children high on the ERC Lability/Negativity subscale (i.e. more labile and negative). As observed clinically among the study sample, this research finding is reflected by mothers who tried to downplay or avoided addressing the family stressors and transitions, rather than facilitating discussion with their children to give voice to their fears and uncertainties. This in turn resulted in children's difficulties processing and interpreting what was happening to them, again negatively affecting their emotional control.

Finally, a process measure characterized as poor involvement among family members, or relationships that are narcissistic or symbiotic was measured by the FAM-III Affective Involvement subscale (Skinner, et al., 1994). In the present study, mothers who rated their families as inadequately involved, also viewed their children as more labile and negative (i.e. higher scores on the ERC Lability/Negativity subscale). In the shelter situation, these mothers were often overwhelmed or preoccupied with stressors, resulting in the need for children to act out in order to gain attention and needed support. Thus, from the perspective of anecdotal clinical observations, the present findings make sense: mothers who recognized and reported poorer family functioning on the dimensions of Communication, Affective Expression and Affective Involvement, also reported their children being in less control emotionally.

Similar to the association between the FAM-III subscales and the ERC Lability/Negativity subscale as described above, significant negative correlations were also found between ratings of family functioning (i.e. FAM-III subscale scores) and mothers' reports of children's ER (i.e. scores on the Emotion Regulation subscale of the ERC measure). For each family functioning subscale (FAM-III Communication, Affective Expression, and Affective Involvement) mother-rated child ERC Emotion Regulation subscale scores were lower when mothers rated the family functioning subscale in the poorer (high) range. Thus, in the present study, children were rated as not only being more labile/negative if the family functioned more poorly, they were also rated as having poorer ER skills.

While the study confirmed its overall hypothesis, and all the associations between subscales of the FAM-III and the ERC are strong and theoretically and quantitatively consistent, the validity of the findings are somewhat compromised by the fact that mothers rated both family functioning and the child's ER. Thus, mothers who perceive poor family functioning may inaccurately rate their child's ER because their view of the child is clouded by their own emotion regulation and sense of the overall family functioning. Sternberg et al. (2006) grappled with the problem of a mother projecting their own interpretations and stresses onto their perception of a child's ER and recommended independent measures of child ER. Some studies have instituted observational ratings of the interactions of mothers and children (Levendosky, et al., 2003), however that can be expensive and time consuming, and was not possible in this shelter. Thus, the present study instead involved administering self-rating scales of ER to a subgroup of children between the ages of 7 and 15, and to supplement the

quantitative data with projective data drawn from the TAT (scored by the Thompson Affect Maturity Scale, 1985) for both mothers and children in the smaller subgroup sample.

The subgroup sample was demographically slightly different from the overall sample, however the patterns of relationships between mother-reported family functioning and mother-reported child ER were identical. Because of small sample size (n=23), the subgroup findings were not statistically significant. However, they show definitive patterns of relationships between mother-reported family functioning and some aspects of children's self-report of ER that affirms the relationship between family functioning and the child's perception of their own ER (Table 13).

Specifically, the FAM-III subscales for Communication and Affective Expression were positively correlated with children's self-report of reluctance to express emotion (EESC Expressive Reluctance subscale) at a level in which they likely would be statistically significant with a larger sample. Thus, children whose mothers' reported poorer communication/miscommunication in the family, and less expression of emotion, were more reluctant to reveal their emotions. Once again, the research findings echoed our clinical observations: mothers who were emotionally dysregulated had difficulty acknowledging their children's emotions and left little room for their children to express their own needs. These children get the message that their own emotions do not have a place in the family, and they tend to look "inhibited" (i.e. expressively reluctant).

None of the other child self-report subscales from the subgroup attained a pattern of relationships to family functioning. However, that children reported

expressive reluctance when their families had poor communication and affective expression is consistent with Gottman's (2001) work on parenting and child emotion regulation. His work deals with the buffering effects of an emotion-regulating parent-child relationship in families with domestic violence. Gottman conceptualizes parental 'emotional coaching' (e.g. parental awareness and labeling of child emotion, ability to use negative child emotion as a learning opportunity, parental empathy, and assisting the child with problem solving) as helping children to cope well with family violence situations by facilitating positive communication among family members. This positive communication buffers the family members from the stressful situation. In contrast, Gottman suggests that parents who are 'emotion-dismissing' do not discuss emotions or process emotional situations, and who perceive negative emotions as only destructive rather than needing acknowledgement and working through, prevent children from learning emotional self-awareness and appropriate self-regulation. The similarities of Gottman's emotional coaching skills with those measured on the FAM-III subscales are striking. Cupach and Olson (2006) even suggest that Gottman's concept of emotion coaching is actually a theory of family communication. As a result, the present study's findings support Gottman's theory.

Another valuable aspect to the subgroup study was to see if children and mothers agreed on their perception of the child's ER. While there were no significant associations due to low sample size, an association at the $p=<.20$ level was found between mother-reported lability/negativity and child self-reported scores on expressive reluctance. Child self-reported poorer emotional coping was also strongly, but not significantly associated with higher mother-reported lability/negativity. Thus, children

whose mothers' reported them as more emotionally out of control and negative, reported themselves to be reluctant to express emotion, as well as having poor coping skills. While reluctance to express emotions may appear to be adaptive, in fact, the scale authors suggest that children who hold in emotion are more dysregulated because they cannot process emotional content and it ends up being expressed inappropriately (or in a dysregulated form) (Penza-Clyve & Zeman, 2002) (Table 14).

Moderately strong negative correlations (but not significant) were also found between the mothers' ERC Emotion Regulation subscale ratings and several measures of the child's self-report of ER (Table 14). Children whose mothers rated them as having more capacity for ER, rated themselves as more aware of their emotions, more able to express their emotions, and less inhibited in expressing their emotions. Thus, the findings of the subgroup study suggest that there is some congruence between mothers' perceptions of their children's ER and the children's own self-report of ER, which gives further strength to the findings of the overall study.

Finally, the use of Thompson Affect Maturity scoring (Thompson, 1985) on several TAT cards administered to both mothers and children in the subgroup proved to contribute inconsistent and contradictory findings. For mothers, there was a strong and predicted relationship between reported family functioning and affect maturity scores on the TAT (see Table 9). Mothers who responded to the TAT cards with more affect maturity also reported better family functioning in the areas of Communication, Affective Expression, and Overall. However, mothers' and children's affect maturity individual card scores were not significantly correlated. In fact, the actual correlations were in a negative direction, and the modal correlation was significant in the negative

direction, totally contradictory to the above pattern of findings that explored various aspects of children's self-report of ER, mothers' report of the child's ER, and mothers' report of family functioning. The Thompson score findings would mean that children with better affect maturity had mothers with poorer affect maturity. Because it was found that children's scores on the TAT were highly inconsistent, it appears that these findings may be due to the TAT not being a reliable measure of children's ER if used statistically. In addition, it is possible that the TAT findings were affected by differences in administration between children and parents (with children given more prompts), and small sample size. It is also possible that more work needs to be done to strengthen the reliability and validity of the Thompson scoring system. Future studies using the Thompson scoring would also need to assure administration consistency.

Alternatively, it may be that these data point to an interesting phenomenon. At least for some families, children may respond to mothers with poor ER by overcompensating and actively working to regulate their own emotions as a way to regulate their mothers' emotions. The findings might indicate that when parents do not function well in some essential ways central to the role of being a parent, children become "parentified," developing greater emotional or behavioral skills than their parents and are recruited unconsciously to care for their parents emotional needs (Bassuk & Weinreb, 1994). Conversely, when parents have higher ER abilities, this may free their children to become dysregulated in ways that could be anticipated for families that have suffered trauma and violence.

Clinical Implications

Focusing on child ER as a key developmental construct is important because it is a psychological foundation for the intrapsychic functioning of individuals (Gross & Thompson, 2007), and has been linked to a wide range of child functional outcomes. As noted in the literature review, theoretical perspectives describe how the early environment, specifically the maternal-infant relationship, lays the foundation for a child's capacity for developing ER (Calkins, 1994, 1996; Cibul, 1997; Fonagy & Target, 1998; Fonagy, et al., 2002; Slade, 1999; Winnicott, 1945, 1960a, 1960b, 1971b). Each theorist highlights how deficits in maternal-child interactions can inhibit the child's ability to identify their own emotional states, read the emotional states of others, and appropriately express and modulate emotions. Importantly, these theorists also imply that the maternal-child relationship is affected by the broader family context and social stressors. As a result, families faced with multiple social stressors, such as those in this study who are both survivors of domestic violence and homeless, have increased strains on family functioning. These strains may undermine a mother's ability to be consistently attuned and adaptively "preoccupied" with her child, potentially negatively impacting a child's ability to learn ER skills.

In addition, there is a great deal of empirical support for the family-developmental theory of children's ER (Cole, et al., 2003; Davidov & Grusec 2006; Eisenberg, et al., 1995, 1996, 1997, 1998, 1999, 2000, 2005; Eisenberg, Gershoff et al, 2001; Eisenberg Losoya, et al., 2001); Fonagy & Target, 2002; Ramsden & Hubbard, 2002). In these studies, such interactions as parental discussion of emotions, parental responsiveness to children's emotions, and parental expression and control of both

positive and negative emotions, significantly affect a child's development of ER skills. Thus, both the theoretical and empirical literature provided a sound rationale for the study hypothesis, which holds that the family environment as a whole, as well as specific dimensions of family functioning, are all central contributors to the development of child ER.

It is important to note that only limited studies have been conducted about the way parent-child processes contribute to the development of child ER among families that have suffered violence and trauma. The present study's sample was selected initially on the basis of convenience – I, my mentor, and colleagues have been conducting other research and a family support program in a domestic violence shelter when the idea for this study germinated. However, conducting the study with this sample of families provided a useful opportunity to examine the relationship between family dynamics, parent ER and child ER that extends prior studies, such as, Buckner et al. (2003), Chemtob and Carlson (2004), Fainsilber-Katz and Windecker-Nelson (2006), Harber and Toro (2004), Hughes et al. (2001), Kliewer et al. (2004), Levendosky et al. (2003), Maughan and Cicchetti (2002), and Osofsky (1999). As the present study has shown, a large proportion of sample families recruited from this domestic violence shelter had normative family functioning and the majority of children have strong ER skills, despite enduring the extraordinary stresses of domestic violence and homelessness. Taken from the perspective of identifying resilience and not only deficit, the study has established that mothers and children bring with them a range of functioning. It also points to areas where clinical intervention may bolster those families who are not so resilient.

In recent years, interventions for children in domestic violence situations have often focused on teaching conflict resolution skills and how to stay safe (Sullivan, Bybee, & Allen, 2002). Although sometimes focused on identifying and appropriately expressing feelings, these interventions have been largely atheoretical, or based on social learning theory as a model for how children learn (e.g. witnessing violence perpetuates violence; Alexander & Warner, 2003). The present study has demonstrated that the transactional processes in the family that constitute family communication about emotion – what Gottman (2001) calls meta-emotional development – are a key factor in helping mothers and children meet the psychological challenges of domestic violence. Cupach and Olson (2006) go further to link the processes of family communication about emotional events to the capacity for conflict resolution and problem solving.

Thus, the present study's overall finding – that dimensions of family functioning are directly tied to children's ER capacity – can inform the design of more targeted clinical interventions. Rather than focusing solely on conflict resolution and problem solving skills, the study suggests that these skills may arise out of children's capacity for ER that is contingent on a more fundamental process of communication and emotional coaching between mothers and children. In a community sample of young children and mothers who reported domestic violence, Fainsilber-Katz and Windecker-Nelson (2006) found that mothers with better emotion coaching skills had better-adjusted children (as measured by standardized mother-report behavioral ratings). They did not examine how the child's ER capacity is related to overall child behavioral adjustment.

The present study suggests that interventions to improve child ER as a proximal outcome may have long-lasting effects on children's adjustment among children who experienced domestic violence and homelessness. This means that families who already have stronger communication, affective expression, and affective involvement need to be encouraged to continue to keep open lines of communication and helped to process the emotions that both mothers and children experience as they enter a domestic violence shelter. For those families who do not communicate about emotions, fail to recognize and understand the emotional state of other family members, or try to inhibit or block off the expression and processing of family members' experiences, clinical interventions need to focus on opening up communication. This means helping mothers and children to recognize and validate each other's emotions, identify appropriate ways to express emotion, and collaboratively work on ways to modulate and regulate their reactions in the face of strong stressors. Although work on ER skills can be initiated in short-term groups (such as the Multiple Family Group Intervention at the present study's shelter), other families may need long-term family and individual therapy to deal with trauma and be more emotionally regulated and available.

Study Limitations

While the present study expanded the knowledge base about family functioning and children's ER among families experiencing domestic violence and homelessness, it has several limitations. First it is limited by the characteristics of the sample. The participants were predominately African American and Hispanic, low-income women with limited education, and their children. It was also limited to women who could speak and read English. For this reason the study findings cannot be generalized to

women and children of other ethnicities or income and educational backgrounds. While the findings may be important to understanding the characteristics of family functioning and child ER for similar families, the findings may not apply to families who have more internal and external resources to address domestic violence.

Second, an additional limitation to the study sample is that information on the type, severity and exposure to abuse was not collected. As noted in Chapter Two (Domestic Violence, Homelessness, and Family section) there are varying definitions in studies examining “violence” (Jouriles, et al., 2001). This may be due to challenges in adequately defining and assessing these dimensions. In this study, because the details of the violence were not collected, a broad conception of violence has been used. Therefore a more nuanced assessment of the effect of varying levels and types of violence within the sample was not conducted. A further limitation of the study was that information was also not gathered about the type and level of exposure to abuse the children experienced. This means that in this study it was not possible to distinguish those children who witnessed abuse from those who were direct victims of abuse or both. This limits generalizability to other populations that may have experienced more or less severe domestic violence or child victimization.

Third, given that this was a convenience sample of families that entered a domestic violence shelter over a period of 5 years, the study’s findings are limited in their generalizability by the sample recruitment process. Families were not randomly selected, nor was it in the researchers’ control which families chose to participate and return the extensive study data. In addition, data are not available on the number of families approached to participate in the study, nor the number that accepted or declined

to participate. Thus, it is not clear whether the study was biased more toward families who were functioning well or more poorly. Families who were better functioning and well organized might have found it easier to complete the study materials, while less well functioning families might have been motivated because they felt participation would bring more services (although the informed consent process made it clear that study participation would have no impact on service provision). However, the range of actual scores on the FAM-III measure illustrates that families who enrolled had a wide range of positive to negative family functioning. This distribution in family functioning scores provides evidence that the study sample was not unduly biased, at least on this dimension.

Fourth, because there was no control sample of families of similar socio-economic and racial/ethnic background that had not been exposed to domestic violence. The obtained findings cannot be assumed characteristic of families that have experienced domestic violence. The findings may in fact be more characteristic of families in general. Likewise, there was no control sample, nor a comparison to housed poor families. The present study does not claim to establish patterns of family functioning and child ER for families of a particular social location or with particular experiences regarding violence. Rather, the study findings should be understood as adding to literature of the relationship between family functioning and child ER, among a convenience sample of families who have experienced domestic violence and homelessness.

Fifth, another source of bias in the study is that because of resource and time constraints, systematic, independent observations of family functioning or child ER

were not possible (i.e. the present study measures were self and other report as well as projectives). As noted in other studies of families who have experienced domestic violence (Levendosky, et al., 2003; Sternberg, et al., 2006) mothers may be biased to portray their family as functioning more positively. On the other hand, the finding that none of the families reached the clinical cutoff on the Social Desirability subscale of the FAM-III indicates that the sample may have been fairly open and realistic in rating their families. However, the potential for bias still exists, and 29% did reach the clinical cut off on the Defensiveness subscale. In addition, mothers were not assessed for their level of distress at the time of data collection. Not knowing the mothers' level of overall functioning may also impact how accurate they are as reporters on both family functioning and child ER. Nevertheless, there was some congruence between mother and child ratings of the child's ER which indicates that the mothers' perception of their children's functioning was not totally related to their own level of functioning.

Finally, while sample size did not affect power to find significant results in the overall study, it did affect power to detect differences in the subgroup study. The patterns of findings in the subgroup confirm the overall study hypothesis, but were limited. The sample size meant that definitive results were not found on the relationship of mother ratings of family functioning and the child's self-report of ER, and that some inconsistency and contradictory results were found using the Thompson TAT scoring. However, with the exception of the TAT, the congruent patterns that were found in the association of both mother-report measures and the child self-report measures lead to the strong possibility that with a larger sample size, confirmation would be obtained.

Future Research

This study contributes to the literature that demonstrates that families who have experienced domestic violence and homelessness have characteristics of both resilience and risk (Garcia Coll, et al., 1998; Harber & Toro, 2004). It has also focused on underlying processes in family functioning as key factors in promoting adjustment and positive outcomes for children through the mechanism of helping children develop ER skills. Prior research explored some aspects of family functioning and its effect on child ER for families at risk of family violence and homelessness. These studies highlighted how important ER skills are for child adjustment (Buckner, et al., 2003; Maughan & Cicchetti, 2002; Kliewer, et al., 2004; Fainsilber-Katz & Windecker-Nelson, 2006). However, none of the studies used a comprehensive theoretically driven construct of family functioning, nor have they adequately accounted for the multiple dimensions that define child ER (e.g. understanding, expressing, and modulating emotions).

The present study has attempted to move the field forward by using a well respected measure of family functioning (FAM-III: Skinner, et al., 1994), and examining various dimension of child ER from the perspective of both mother-report (Shields & Cicchetti, 1997) and the child's own assessment (EESC: Penza-Clyve & Zeman, 2002; CEMS: Shipman & Zeman, 2002; Zeman, et al., 2001; Zeman, et al., 2002). The study was also enriched by gathering projective data from the TAT from both mothers and children on ER. Future studies are needed to help solidify and expand these findings. First, the study should be replicated with additional and more diverse families to confirm the link between family functioning dimensions and children's ER.

Data should also be collected on the length and severity of domestic violence, as well as the children's victimization status. As with the present study, multiple dimensions of family functioning should be tapped, including communication, affective expression, and affective involvement. It will also be important to make sure this relationship is examined for a wide range of family backgrounds, including age, ethnicity, income, immigration status, and family history, including those exposed and those not exposed to domestic violence. Data that identifies if these processes are universal, or more relevant to different types of families, will allow for development of more culturally congruent family interventions.

Second, studies with larger sample sizes that collect information directly from children on their perceptions of their own ER are needed. Due to its small sample size, the present study did not have the statistical power to fully explore children's views of their own ER. Such studies would also benefit from independent observations or independent respondent ratings of the children's adjustment. Only a few studies in the field so far have used observations or teachers' reports of a child's adjustment, instead relying on maternal report of the child which can be biased (Levendosky, et al. 2003; Sternberg, et al., 2006). The relationship of mothers' ER and children's ER also needs to be further examined. Studies that collect information not only on family functioning dimensions, but on mothers' ER, will help identify how to better intervene with mothers and children in these high risk situations in order to develop the maternal emotional coaching skills that seem to be a key mediator in children's capacity for ER. Further exploration and development of the use of a projective measure, such as the TAT, will also be needed if it is to be included in such studies. The present study seemed to verify

that the TAT was a reliable measure for mothers, but too inconsistent to use in statistical analyses on children's affect maturity.

Third, it will be important to modify clinical interventions for families experiencing domestic violence and homelessness and test whether such interventions can improve family functioning, parental emotional coaching, and development of parental and child ER over time. This is because cross sectional studies have suggested that it is the effect of domestic violence on family functioning and communication, not the actual violence, that accounts for children's adjustment (Buckner, et al., 2003; Kliewer, et al., 2004; Maughan & Cicchetti, 2002). This will require incorporation of measurement of these constructs in intervention studies. To date there are no published intervention studies that have focused specifically on modifying family functioning, communication, and ER. However, the larger study in which this dissertation is embedded is currently collecting data on just such an intervention. Finally, longitudinal follow-up studies will be needed to confirm that proximal improvements in family functioning and ER in parents and children associated with intervention promote longer-term adjustment of families and children.

In conclusion, the present study has demonstrated that underlying family functioning processes account for children's ER capacity among families who have experienced domestic violence and homelessness. Families with relatively strong family functioning, including communication, affective expression, and affective involvement, have children who are less labile and less negative, have better ER skills, and are less inhibited. These children are therefore more able to process the

extraordinary stressors inherent in such a difficult transition, providing psychological strengths that will enable them to cope with and meet the challenges they face.

APPENDIX A

Tables of Quantitative Results

Table 1
Parent Demographics
(n=61)

Demographics	Means (S.D.) or percent	Range
Parent Age	33.30 (8.0)	20-56
Place of Birth: % united states	70.50	
U.S. Citizen:	77.00	
% Yes		
Marital Status:	4.90	
% Married		
% Single	52.50	
% Separated	32.80	
% Widowed	3.30	
% Other	6.60	
Race: % African American	62.30	
% Hispanic	23.00	
% Caucasian	4.90	
% Other	9.80	
Education: % some high school or less	42.60	
% High school grad/GED	23.00	
% Some college/college grad	34.40	

Table 2
Child Demographics
(n=61)

Demographics	Means (S.D.) or percent	Range
Age	9.30 (2.7)	4-15
% Male	45.90	
% Female	54.10	
Race: % African American	63.90	
% Hispanic	22.90	
% Caucasian	1.60	
% Other	9.80	
% Missing	1.60	

Table 3
Scores on FAM-III General Scale
(n=61)

Subscale	**Standard Score Mean (SD)**	**Range**	**Percent above clinical cutoff**
Task Accomplishment	52.79 (14.0)	24-98	33%
Role Performance	57.57 (11.2)	28-94	27.9%
Communication	56.16 (10.6)	32-98	26.2%
Affective Expression	55.08 (11.7)	26-92	31.1%
Affective Involvement	52.00 (12.7)	34-88	19.7%
Control	56.30 (12.8)	26-92	34.3%
Values and Norms	55.15 (11.9)	30-86	33%
Social Desirability	46.07 (7.9)	24-60	0%
Defensiveness	51.48 (13.6)	20-82	29.5%
Overall	55.00 (10.4)	34-93	24.6%

Table 4
Problems Characterized by Clinical Significant Elevated FAM-III Subscale Scores

Subscale	**Family Problems**
Task Accomplishment	Failure of family to perform basic tasks; cannot respond appropriately to changes in family life cycle; difficult to develop solutions to family issues.
Role Performance	Disagreement regarding family roles; inability to adapt new roles.
Communication	Poor communication, lack of mutual understanding among family members, inability to clarify confusions.
Affective Expression	Inadequate expression of emotions or inhibition of emotions; expression not in appropriate response to the context.
Involvement	Absence of involvement among family members or overly narcissistic or symbiotic; insecurity and lack of autonomy of members.
Control	Extremely rigid or chaotic (opposite) patterns; use of control to shame or destroy; power struggles; interferes with ongoing family routines.
Values and Norms	Confusion and tension about family values; conflict of family values and outside culture; rules subverted; inappropriate latitude in behavior.

Table 5
Mother-Report of Child's Functioning on the ERC
(n=61)

ERC Subscale	Mean (SD)	Range	% 1 SD deviation from norm
Lability/Negativity	1.93 (.49)	1.13-3.20	37.7%
Emotion Regulation	3.11 (.46)	2.12-4.0	45.9%

Table 6
Child Self-Report Scores on the EESC
(n=23)

EESC Subscale	Mean (SD)	Range	Normative Mean (SD)
Poor Emotional Awareness	22.78 (7.7)	10-37	15.61 (6.4)
Expressive Reluctance	21.13 (6.8)	11-36	17.33 (6.5)

Table 7
Child Self-Report Scores on the CEMS
(n=23)

Subscale	Mean (SD)	Range	Normative Mean
Sadness Inhibition	2.12 (.58)	1-3	N/A
Sadness ER Coping	2.18 (.37)	1.2-2.8	N/A
Sadness Dysregulation	1.72 (.49)	1-2.67	N/A
Anger Inhibition	1.96 (.50)	1-2.75	N/A
Anger ER Coping	1.99 (.51)	1-2.75	N/A
Anger Dysregulation	1.97 (.63)	1-3	N/A
Summed Inhibition	4.08 (.96)	2-5.25	3.6 (.98)
Summed ER Coping	2.10 (.39)	1.44-2.78	2.32 (.50)
Summed Dysregulation	3.69 (.95)	2.0-5.67	3.44 (.86)

Table 8
Parent (n=23) and Child (n=22) Scores on the TAT

Card	Parent score mean (SD)	Mode and range	Child score mean (SD)	Mode and Range
Card 1	2.52 (1.3)	3.0 (0-4)	2.32 (1.3)	3 (0-3)
Card 2	1.96 (1.3)	3.0 (0-4)	2.32 (1.3)	3 (0-4)
Card8BM	1.17 (1.4)	0 (0-3)	1.91 (1.5)	3 (0-4)
Card13MF15	1.52 (1.6)	0 (0-4)	1.77 (1.5)	3 (0-4)
Card18GF	1.87 (1.4)	3 (0-4)	2.05 (1.5)	3 (0-4)
Mode	2.26 (1.2)		2.5 (1.2)	

Table 9
Correlations between FAM-III subscales and Parent (n=23) and Child (n=22) TAT scores

	FAM Communication	**FAM Affective Expression**	**FAM Involvement**	**FAM Overall**
Parent TAT				
Card1	-.224	-.196	-.087	-.223
Card2	-.254	**-.302#**	-.205	**-.377+**
Card8BM	**-.367+**	**-.305#**	**-.346#**	**-.420***
Card13MF15	-.266	-.221	-.244	-.224
Card18GF	-.206	-.042	-.011	-.216
Mode	**-.352+**	**-.403+**	-.254	**-.446***
Child TAT				
CCard1	.170	.149	**.355#**	.171
CCard2	.085	-.202	,156	.009
CCard8BM	.031	.250	-.013	.086
CCard13MF15	-.090	.018	-.046	.042
CCard18GF	**.416+**	**.467***	**.560****	**.478***
Mode	**.425***	**.551****	**.500***	**.473***

Significance Level (2-tailed): *=p<.05, **p=<.01, +p=<.10. #=p<.2

Table 10
Correlations Among Key Mother-Report Study Variables
(n=61)

Variable	1	2	3	4	5	6	7	8	9	10	11
1. Mom age	1.00										
2. Mom citizenship (1=yes)	-.046	1.00									
3. Education	**.314***	.059	1.00								
4. Child age	**.607*****	-.161	-.042	1.00							
5. Child gender (1=male)	-.129	**-.276***	-.128	.041	1.00						
6. FAM Communication	.029	-.093	**-.249+**	-.078	-.019	1.00					
7. FAM Affective Exp	.124	.002	-.095	.109	-.165	**.626*****	1.00				
8. FAM Involvement	.103	.044	-.048	-.012	-.089	**.753*****	**.758*****	1.00			
9. FAM Overall	.037	-.008	**-.258***	-.012	-.083	**.884*****	**.810*****	**.887*****	1.00		
10. ERC Lability/Neg	**-.190#**	-.085	**-.214+**	**-.182#**	.096	**.538*****	**.374*****	**.469*****	**.522*****	1.00	
11. ERC Emotion Reg.	.023	.054	.114	-.100	-.024	**-.266***	**-.368*****	**-.417*****	**-.402*****	**-.405*****	1.00

Significance Level (2-tailed): *p=<.05, ***p=<.001, +p=<.10, #p=<.20

Table 11
Regression Analysis for Variables Predicting ERC Lability/Negativity Subscale (n=61)

Variable	***B***	**SE *B***	**β**
Model 1			
Mothers' Education	-.617	.718	-.099
FAM Overall	.343	.081	**.487****
Model 2			
Mothers' Education	-.647	.740	-.104
FAM Communication	.298	.116	**.431***
FAM Affective Expression	.021	.101	.033
FAM Affective Involvement	.055	.104	. 096

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

Table 12
Regression Analysis for Variables Predicting ERC Emotion Regulation Subscale (n=61)

Variable	***B***	**SE *B***	**β**
Model 1			
Mothers' Education	.074	.393	.023
FAM Overall	-.138	.044	**-.386****
Model 2			
Mothers' Education	.404	.409	.128
FAM Communication	.039	.064	.110
FAM Affective Expression	-.061	.056	-.192
FAM Affective Involvement	-.096	.058	**-.328+**

*p=<.05, **p=<.01, +p=<.10

Table 13
Correlations Among Key Mother-Report Study Variables for Subgroup
(n=23)

Variable	1	2	3	4	5	6	7	8	9	10
1. Mom age	1.00									
2. Education	.361+	1.00								
3. Child age	.330#	-.191	1.00							
4. Child gender (1=male)	-.481*	-.196	-.201	1.00						
5. FAM Communication	.051	-.289#	.098	.029	1.00					
6. FAM Affective Exp	.184	.026	.115	-.205	.567**	1.00				
7. FAM Involvement	.102	.091	-.030	-.104	.729**	.705**	1.00			
8. FAM Overall	.085	-.201	.196	-.126	.882**	.814**	.780**	1.00		
9. ERC Lability/Neg	-.125	-.190	-.127	.072	.626**	.698**	.612**	.693**	1.00	
10. ERC Emotion Reg.	.098	.007	-.295#	.232	-.185	-.375+	-.366+	-.300#	-.441*	1.00

Significance Level (2-tailed): *p=<.05, **p=<.01, +p=<.10, #p=<.20

Table 14
Correlation of Mother-Report Family Functioning Variables with Child Self-Report Emotion Regulation Variables (n=23)

Variable	1	2	3	4	5	6	7	8	9	10	11	12	13
1. Mom Age	1.00												
2. Education	**.361***	1.00											
3. Child Age	.124	-.191	1.00										
4. Child Gender (1=male)	**-.481***	-.196	-.201	1.00									
5. FAM Communication	.051	**-.289+**	-.098	-.029	1.00								
6. FAM Affective Exp	.184	-.026	.115	-.205	**.567****	1.00							
7. FAM Involvement	.102	-.091	-.030	-.104	**.729****	**.705****	1.00						
8. FAM Overall	.085	-.201	.196	-.126	**.882****	**.814****	**.780****	1.00					
9. EESC Poor Awareness	.033	.134	.067	.065	-.052	.096	.044	-.048	1.00				
10. EESC Expressive Reluctance	.078	.076	.083	.111	**.297#**	.217	.114	.173	**.564****	1.00			
11. CEMS Combined Dysregulation	.112	.021	-.033	-.032	-.044	-.078	.053	-.074	**.630****	**.273#**	1.00		
12. CEMS Combined Inhibition	**.280#**	**.304#**	.114	-.177	.028	.129	.194	-.005	**.542****	**.551****	**.436***	1.00	
13. CEMS Combined Coping	-.012	.060	-.059	.245	-.147	.014	-.110	-.079	.016	-.007	.001	.177	1.00

Significance Level (2-tailed): *p=<.05, **p=<.01, +p=<.10, #p=<.20

Table 15
Correlation of Mother-Report of Emotion Regulation with Child Self-Report of Emotion Regulation
(n=23)

Variable	**1**	**2**	**3**	**4**	**5**	**6**	**7**
1. ERC Emotion Regulation-Mom Rpt	1.00						
2. ERC Lability-Mom Rpt	**-.441****	1.00					
3. EESC Poor Awareness-Child Rpt	-.231	.078	1.00				
4. EESC Expressive Reluctance-Child Rpt	-.132	**.284#**	**.564****	1.00			
5. CEMS Combined Coping-Child Rpt	.011	-.204	.016	-.007	1.00		
6. CEMS Combined Dysreg.-Child Rpt	-.109	.083	**.630****	**.273#**	.001	1.00	
7. CEMS Combined Inhibition-Child Rpt	-.225	.079	**.542****	**551****	.077	**.436***	1.00

Significance Level (2-tailed): *p=<.05, **p=<.01, +p=<.10, #p=<.20

APPENDIX B

Tables of Measures

Table 16

Thompson Affect Maturity Scale (1985)

Level 0: Unable to identify affect
Level 1: Emotions are purely event like in character Little differentiation within the affect event; Emotion is attributed more to the situation as a whole (includes self, object, surround) and not to any individual facet of the situation (e.g. whole scene described as sad, with everything in it having an undifferentiated quality of sadness); Emotions may have a atmospheric or mood-like quality; Characters may seem to be immersed in the affect-event – while character is in the event it colors all reality for him/her, but when event changes it is not integrated as part of the self's history
Level 2: Emotions are still predominately event like – but now rudimentary attribution of the emotion to self and others (but not on basis of their being individuated selves with inner psychological reality) Emotions attributed indiscriminately on the basis of external features of the characters (expressions and expressive actions are not yet differentiated from the affect); Story teller may attempt to 'read' emotions from expressive appearances (e.g. a smiling face must indicate some sort of happy situation); Affect state (not seen as psychological state) and it retains event-like properties, but role of self and other is more predominant than in level one; Emotion may seem like it is a happening emanating from outside the self or lodged inside the self – i.e. person 'has' the emotion rather than 'being' happy etc.; Implication affect can be warded off, expelled, or eliminated; Affect state is still irreversible – with event coloring all reality and self-object reps; Mixed/contradictory feelings not possible – but may see rapid alternation of affects attributed to part selves or part objects (e.g. storyteller may switch subject emotions several times in succession without any integration of these affects); So several different affect states may be evoked successively (rather than at same time); As each state is event-like it redefines the situation, the reps of self and other and the evaluation of the target or object of the emotion.
Level 3: Emotions now attributed to persons (but not in a fully independent way) Self and other may be enveloped into the same emotion; No understanding that two people may experience the same emotion but for their own individual reasons (if some explanation is given it is the same for both); Feelings are attributed to the self (for single subject) but rationalized feelings is concordant with the immediate situation; Slightly more differentiation – self and other may be assigned complementary affects (but not rationalized in an individual way); Affect of the other may differ from that of the self – it is still assigned in an egocentric way (it's the expected response to the self's own feeling); Reversals of affect may occur b/w self and other (e.g. first one is feeling guilty, then the other) becomes unclear who is experiencing affect or if both are; Mixed/contradictory affects make their appearance (attributed to subject at same time rather than in succession) – but affects remain largely independent of each other, do not interact and are not integrated into reversible structure (e.g. He's happy she loves him; he's depressed b/c he wants to join his unit.); Affect state is now seen as a psychological state to be attributed to the subject (but still largely irreversible) E.g. good feelings are caused by a good object; bad feelings by a bad object – with no recognition of the object's independent existence, characteristics, etc.; Hints of the realization that affects have to be dealt with by the self (they will not simply pass away) – but expressed through magical, Pollyannaish resolution (e.g. he'll get over it or he'll be happy again); Suggests substation of another affect event that is attributed to the self but not integrated with the previous one (seems that new event is invoked to counter-pose the original feeling – so that there is some relationship b/w the two rather than simply replacing one for the other)
Level 4: Affects are now clearly attributed as psychological states to individual persons Affect is more individualized expression of the person's characteristics; Extended temporal integration is still not carried out – so attribution of individualized affect states tends to be not so much in terms of subjects enduring personality as in terms of relatively superficial external or stereotyped ways of individuating a person (e.g. role, sex, occupation or immediate features of person's reaction to the situation); Mixed/contradictory emotions attributed to the subject - brought in juxtaposition to each

other so there is some recognition of the contradiction and conflict and some attempt to resolve it; Way-station in development of reversibility – mixed emotions are not wholly independent (but integration of mixed emotion into hierarchy or full reversibility is not yet achieved) E.g. of a solution to a conflict (he's pulled in two directions – he loves her but he wants to get away. He finally leaves and manages to forget her); Cause, object and target of the emotion may now have mixed attributes, causing conflicts and attempts at resolution, but still not fully resolved in a hierarchical scheme allowing a complex view of a fully independent object; Affects have lost their predominately event like character – so sense that affect-states do not pass away without a trace, and they may change the self and themselves undergo modification
Level 5: Reversibility has been achieved Self and other are perceived as individuated affective beings with enduring inner dispositions that affect their emotional responsiveness; Affects a persons experiences are clearly modified by and stem from his uniqueness as a person (as compared to others); Self and other assigned affects in terms of their uniqueness as persons and are individuated uniquely even when they react in terms of their roles (or sex); Mixed/contradictory emotions may often be experienced, but conflicting emotions now modify each other and may be placed in a wider perspective (he's torn b/w his love for her and his wish to join his unit); Conflict is not eliminated and can be intensified since simple defenses against affect such as denial or minimization are no longer facilitated by the affective organization – so reversibility is achieved; Cause or object of the emotion may be evaluated independently of the affect and states of the self are seen as contributing to the affect; Affects are clearly seen as needing to be integrated into the self's history (rather than passing away, being replaced by other affects or being undone through forgetting or action); Sense a person can tolerate this, emotion will be integrated, some realistic sense of how long this will take and how it will take place and that the self may be modified by the feeling; May show evidence of reflective self-awareness concerning affects – person may experience a reaction to his feeling or show awareness of how he is reacting or of what effect he might have on others (e.g. he's depressed over how angry he is, and wishes he could be more tolerant)

Table 17
FAM-III Subscale Questions

Task Accomplishment
When things aren't going well it takes too long to work them out We deal with our problems even when they are serious We spend too much time arguing about what our problems are When problems come up, we try different ways of solving them We never let things pile up until they are more than we can handle
Role Performance
We can't rely on family members to do their part One family member always tries to be the center of attention Family duties are fairly shared My family expects me to do more than my share We agree about who should do what in our family
Communication
We take the time to listen to each other My family lets me have my say, even if they disagree When I ask someone to explain what they mean, I get a straight answer We argue about who said what in our family I never know what's going on in our family
Affective Expression
When someone is upset, we don't find out until much later When our family gets upset, we take too long to get over it When someone in our family is upset, we don't know if they are angry, sad, scared, or what We tell each other about things that bother us I can let my family know what is bothering me
Involvement
My family tries to run my life We feel close to each other We don't really trust each other You don't get a chance to be an individual in our family We feel loved in our family
Control
If we do something wrong, we don't get a chance to explain Punishments are fair in our family We hardly ever do what is expected of us without being told When I ask why we have certain rules, I don't get a good answer When you do something wrong on our family, you don't know what to expect
Values and Norms
We argue about how much freedom we should have to make our own decisions The rules in our family don't make sense We are free to say what we think in our family We have the same views on what is right and wrong It's hard to tell what the rules are in our family
Social Desirability
My family and I understand each other completely Some things about my family don't entirely please me

My family is not a perfect success We are as well adjusted as ay family could possibly be I don't see how any family could get along better than ours My family could be happier than it is I don't think any family could possibly be happier than mine
Defensiveness
We sometimes hurt each others feelings Sometimes we avoid each other We never get upset with each other We always admit our mistakes without trying to hide anything We have never let down another family member in any way Some days we are more easily annoyed than others Sometimes we are unfair to each other We never get angry in our family

Table 18
Direction of Measures

Measure	High Scores	Low Scores
FAM-III	Poorer Functioning	Better Functioning
ERC Lability/Negativity	Poorer Functioning	Better Functioning
ERC Emotion regulation	Better Functioning	Poorer Functioning
EESC Poor Emotional Awareness	Poorer Functioning	Better Functioning
EESC Expressive Reluctance	Poorer Functioning	Better Functioning
CEMS Sadness Inhibition	Poorer Functioning	Better Functioning
CEMS Sadness ER Coping	Better Functioning	Poorer Functioning
CEMS Sadness Dysregulation	Poorer Functioning	Better Functioning
CEMS Anger Inhibition	Poorer Functioning	Better Functioning
CEMS Anger ER Coping	Better Functioning	Poorer Functioning
CEMS Anger Dysregulation	Poorer Functioning	Better Functioning
CEMS Summed Inhibition	Poorer Functioning	Better Functioning
CEMS Summed ER Coping	Better Functioning	Poorer Functioning
CEMS Summed Dysregulation	Poorer Functioning	Better Functioning

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