 Effects of Intimate Partner Violence and Maternal Posttraumatic Stress Symptoms on Children’s Emotional and Behavioral Functioning

Kristin W. Samuelson
Caroline Cashman

**ABSTRACT.** Research has documented the detrimental effects of intimate partner violence (IPV) on children’s emotional and behavioral functioning. This study examines the hypothesis that a child’s response to witnessing IPV is most influenced by the mother’s psychological health. We examined the relationships among IPV (as witnessed by children), mother’s posttraumatic stress symptomatology (PTSS), and children’s emotional and behavioral problems. Analyses revealed that mothers’ PTSS, and not amount of violence witnessed, predicted children’s emotion dysregulation.

**KEYWORDS.** PTSD, domestic violence, emotion regulation, exposure to domestic violence

Kristin W. Samuelson, PhD, is an Assistant Professor at the California School of Professional Psychology at Alliant International University, San Francisco, CA.

Caroline Cashman, MA, is a graduate student at the California School of Professional Psychology at Alliant International University, San Francisco, CA.

This study was supported by Alliant International University.

Submitted: August 7, 2006; Revised: April 2, 2007; Revised: October 12, 2007; Revised: October 31, 2007; Accepted: October 31, 2007.

Address correspondence to: Kristin W. Samuelson, California School of Professional Psychology at Alliant International University, One Beach Street, Suite 100, San Francisco, CA 94133. Phone: 415-955-2119 (E-mail: Ksamuelson@alliant.edu).

Journal of Emotional Abuse, Vol. 8(1/2) 2008
Available online at http://jea.haworthpress.com
© 2008 by The Haworth Press. All rights reserved.
doi:10.1080/10926790801986007
One third of American children are estimated to have witnessed intimate partner violence (IPV) in their homes (Straus, 1992). IPV not only poses a threat to the physical health and psychological well-being of women involved in these violent relationships, but also threatens the well-being of children living in violent families. Reviews of research efforts documenting the impact of IPV on children have concluded that exposure to IPV has a detrimental effect on children’s functioning (Edelson, 1999; Fantuzzo & Lindquist, 1989; Fantuzzo & Mohr, 1999; Margolin & Gordis, 2000; also see Kracke & Hahn, this issue). Children exposed to IPV exhibit depression, aggressiveness and oppositionality, and problems with social, school, and cognitive functioning. Reviewers have cautioned that methodological problems, such as heterogeneity of the population, overreliance on samples of convenience (shelter samples), and poor discrimination of the constructs of child abuse and exposure to IPV, restrict the applicability of these findings (Edelson; Fantuzzo & Lindquist).

There are several possible explanations as to why children of battered women exhibit psychological problems. The first is that witnessing family violence is traumatic. Children who witness life-threatening violence between their parents are more likely to exhibit posttraumatic stress symptoms (PTSS) of their own (Pynoos & Eth, 1985). Alternatively, children of battered women may experience psychological problems because they are more likely to be maltreated themselves. In a review of IPV studies, Margolin (1998) found that between 45–70% of children exposed to IPV are also victims of physical abuse.

The third explanation is that IPV causes deleterious psychological consequences in the mother, making her less capable of caring for her children and responding to their needs. A history of IPV is associated with various psychological disorders that may interfere with a mother’s relationship with her child, including depression, anxiety, personality disorders, substance abuse, and posttraumatic stress disorder (PTSD; Resnick & Acierno, 1997). Mothers, who are counted upon to provide nurturance and protection to their children, may be less able to do so when they are victims of violence, and it has been suggested that women with trauma histories may display impaired parenting skills (Hughes, 1982). These mothers are also likely to have difficulties attending to the emotional needs of their children. In their study of behavioral problems in children of battered women, Wolfe, Jaffe, Wilson, and Zak (1985) found that maternal stress variables accounted for 19% of the variance in children’s behavioral functioning. Similarly, in a study of preschoolers living in neighborhoods with high rates of community violence, maternal
distress mediated the relationship between child exposure to violence and child behavior problems (Linares et al., 2001). These studies support the notion that IPV can have an indirect impact on children's functioning through its effect on maternal functioning.

One of the most troubling mental health outcomes for battered women is PTSD. Studies have shown that 45–84% of battered women in community samples meet diagnostic criteria for PTSD (Astin, Lawrence, & Foy, 1993; Astin, Ogland-Hand, Coleman, & Foy, 1995). Symptoms of PTSD frequently found in battered women include re-experiencing symptoms such as intrusive thoughts, nightmares, and flashbacks; avoidance symptoms such as emotional numbing, feelings of detachment from others, and anhedonia; and hyperarousal symptoms such as sleep disturbance, hypervigilance, difficulty concentrating, and startle response (Saunders, 1994).

Relatively few studies have examined the impact of maternal PTSD on parenting and children's functioning. One exception, a study of battered women and their preschool-aged children (Lieberman, Van Horn, & Ozer, 2005), found that maternal PTSD mediated the relationship between maternal life stressors and child behavior problems. Chemtob and Carlson (2004) found that among mothers who had experienced IPV, those who had PTSD were more likely to be quick and impulsive in their actions toward their children. While some studies have examined the impact of trauma and PTSD on parenting and children's behavioral symptoms, no studies have examined the impact of maternal PTSD on emotion regulation difficulties in children. A child's ability to emotionally regulate is learned through interaction and dependent on the mother's ability to bond, connect, and provide a functional emotional regulatory model. The mother-child bond is thought to be a mechanism through which a child learns to self-soothe and modulate his/her own emotions (Cassidy, 1994), and if this bond is hindered by the mother's psychological health, then a child may be prevented from learning emotional regulation skills.

More evidence for the impact of parental PTSD on children is provided through studies of Vietnam veterans. While much of this research is focused on males with war-related PTSD, this substantial body of research provides valuable insight into the mechanisms by which parental PTSD affects children. In one study, children of veteran fathers with PTSD frequently exhibited symptoms similar to their fathers, such as symptoms of depression, anxiety, low frustration tolerance, and outbursts of anger (Harkness, 1993). Jordan and colleagues have documented elevated levels of family adjustment problems and poorer parenting skills in male Vietnam veterans (Jordan et al., 1992). Ruscio, Weathers, and King
(2002) examined the relationship between Vietnam veterans' PTSD symptomatology and their perceived quality of relationship with their children, finding that the avoidance cluster of PTSD most strongly related to perceived quality of relationship. These results suggest that emotional numbing and detachment, symptoms from the avoidance cluster, underlie parent-child relationship problems from the perspective of the parent. In their study of 250 male veterans designed to replicate and extend Ruscio et al.'s study, Samper, Taft, King, and King (2004) found that after controlling for depression, avoidance symptoms were associated with less parenting satisfaction and a poorer quality of parent-child relationship. These results suggest that emotional numbness associated with PTSD is distinct from emotional constriction sometimes found in depression.

These findings further build a case for the importance of studying emotion regulation in the children of parents with PTSD. Taken together, the results of these studies suggest that parents with PTSD may be emotionally disengaged and inaccessible to their children, less able to help their children form a secure attachment, and less able to teach them to modulate their affect and regulate their own emotions. This study seeks to further existing research by looking not only at exposure to IPV, but also maternal posttraumatic stress symptoms (PTSS) as predictors of child difficulties. Secondly, this study expands upon current research by exploring the hypothesis that maternal PTSS is associated with emotion regulation difficulties in the child, as well as child behavior problems.

METHODS

Participants

Participants were 30 women who had experienced IPV in the past but had not been in a violent relationship for at least six months, and who had at least one child between the ages of 5 and 18 years with whom they lived. Participants were recruited from the community, but not from shelters as added stressors in the shelter environment can impact both the mothers' and children's psychological adjustment. Participants were recruited through flyers posted at various community agencies throughout San Francisco and an advertisement on an online community message board. The sample was made up of 47% African-Americans, 37% Caucasians, 13% Hispanics, and 3% Asian Americans. The mean age of the participants was 39.5 years, with an age range from 23–58 years ($SD = 8.67$).
Participants had a mean of 2.3 children ($SD = 1.4$; range: 1–7 children). Mean education level was 14.57 years ($SD = 2.03$). Most participants were high school graduates (96.8%), most had some college education (90.3%), and 35% were college graduates. Fifty percent of the women were not employed, 13.3% were employed part time, and 36.7% were employed full time. Fifty percent of the women reported their annual income to be less than $20,000 a year, 27% between $20,000 and $40,000, and 23% over $40,000. The majority of the women (60%) were single, 27% were divorced, 10% were married, and 3% were widowed. All of the women reported that their batterers were men. Each mother was asked to answer questions about only one of her children. The women’s children whom they reported on ranged in age from 5 to 18, with a mean age of 11.4 years ($SD = 4.1$). Eighteen of the children were male and 12 were female.

**Procedure**

Participants were interviewed about their experience of IPV and asked to complete a battery of self-report measures as well as parent-report measures about their children. Participation time ranged from 1–2.5 hours, and interviews were administered by clinical psychology graduate students. Participants were paid $25 for their participation and received referrals to various local agencies for follow-up support. Because of the sensitive nature of the interview questions, informed consent included a statement that if it were revealed during the interview that the child had been harmed, the interviewer would contact appropriate authorities. Child Protective Services was consulted on three cases over the course of the study. Caseworkers informed the authors that two cases did not meet criteria for a filed report; a report was filed on the remaining case. Because parents were informed of the necessity to report child abuse, the actual prevalence of child maltreatment may be underrepresented in this sample.

**Measures**

*Background Information Questionnaire*

Participants were asked to provide personal data such as age, marital status, ethnicity, current occupation, level of education, household income, history of mental health interventions, number of children in the family, and the children’s ages, as well as provide brief information about the violent relationship (their relationship to the batterer, his relationship to the children, and any legal consequences following the violence).
Conflict Tactics Scale 2 (CTS2)

The mother's experience of and the extent of IPV, as well as the child's degree of witnessing the IPV was assessed through the CTS2 (Straus, 1979; Straus, Hamby, Boney-McCoy, & Sugarman, 1996), a self-report questionnaire that assesses the occurrence and frequency of particular behaviors during interpersonal conflicts. The CTS2 has five subscales: Negotiation, Psychological Aggression, Physical Assault, Sexual Coercion, and Injury. Each question on the CTS2 asks the participant to indicate the frequency of the corresponding conflict resolution tactic on a seven-point Likert scale ranging from 0 (never) to 6 (more than 20 times). The CTS2 was administered as an interview, and the participants were asked to answer questions about their batterers' behaviors toward them and their children's experience of witnessing those behaviors (physical assault subscale only). The amount of IPV was obtained by scoring the midpoints of each response category in the physical assault subscale, according to the directions of the CTS2 manual (Straus et al.). The mothers also reported on both their own and the batterers' acts of abusive behaviors toward the target children. Internal reliability coefficients for the scale range from .79 to .95 (Straus et al.). In this study, reliability was high (α = .97).

PTSD Checklist (PCL)

The mother's severity of PTSS was assessed through the PCL (Weathers, Litz, Herman, Huska, & Keane, 1993), a 17-item self-report measure that corresponds to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association, 1994) criteria for PTSD. The measure includes questions corresponding to the DSM-IV's five re-experiencing symptoms, seven avoidance and numbing symptoms, and five hyperarousal symptoms. Respondents are asked to indicate the extent to which they have been bothered by each symptom in the past month on a 5-point Likert scale ranging from 1 (not at all) to 5 (extremely). The PCL demonstrates excellent internal consistency (.94) and test-retest reliability (.88 for a one-week interval). Sensitivity in identifying PTSD ranges from 0.78 to 0.94 and specificity ranges from 0.83 to 0.86 (Blanchard, Jones-Alexander, Buckley, & Forneris, 1996). In this study, the internal reliability of this measure was .95.
Emotional Regulation Checklist (ERC)

Children’s emotional functioning and regulation was assessed through the ERC (Shields & Cicchetti, 1997). The ERC is a 24-item measure of children’s self-regulation completed by the mother. Of interest to the present study was the Lability/Negativity subscale, which assesses processes including affective lability, angry reactivity, and emotional intensity. The internal reliability coefficient reported by the authors for this subscale was .96. Validity has been established through positive correlations with observers’ ratings of children’s self-regulatory abilities (Shields & Cicchetti). In this study, the internal reliability was .83 for the Lability/Negativity subscale.

Child Behavior Checklist (CBCL)

Children’s behavioral functioning was assessed through the CBCL (Achenbach, 1991), a parental report measure of child psychopathology. The CBCL assesses for children’s internalizing and externalizing symptoms on a 3-point scale ranging from 0 (not true) to 2 (very true or often true). This measure has high reliability and validity (Achenbach), and in this study, the internal reliability was .97.

Data Analysis

Bivariate correlations were conducted to examine the associations between demographic variables (mother and child’s age, mother’s education level, and income), child’s witnessing of IPV, child’s own maltreatment, mother’s PTSS, and child’s emotional and behavioral functioning. t-tests examined differences between child’s ethnicity and gender on independent and dependent variables. Although multivariate analyses are cautioned against with a sample size this small, the presence of significant bivariate correlations suggests that hierarchical multiple regression analyses would be useful to assess the unique variance in child’s mental health outcomes explained by mother’s PTSS, above and beyond the extent of the child’s own maltreatment of witnessing of IPV. Two hierarchical regression analyses were conducted, with ERC lability/negativity score and CBCL total score as the dependent variables, respectively. In each regression, any significant covariates were entered into the first step, the degree to which the child witnessed IPV was entered into the second step, the degree to which the child experienced maltreatment was entered into the third step, and mother’s PTSS were entered into the final step.
RESULTS

Characteristics of the mothers and statistics regarding IPV histories are presented in Table 1. Of note, 53% of the mothers reported being physically or sexually abused as a child, and 57% had been in other violent intimate relationships. Ninety percent of the mothers had sought mental health services in their lifetime, and 10% had been hospitalized for psychiatric reasons. Sixty percent had sought mental health services for their children. Seventy-seven percent of the children witnessed IPV, while only 10% were maltreated themselves, according to mother’s report. Forty-three percent of children witnessed severe physical violence, which included watching their mothers being punched, hit, choked, or burned.

There were no significant correlations between demographic variables (mother and child’s age, mother’s education level, income) and independent and dependent variables. There were no significant differences between children’s ethnicities on any independent and dependent variables. There were gender differences on the CBCL total score, with girls ($M = 46.08, SD = 35.2$) scoring significantly higher than boys ($M = 26.0, SD = 17.5$), $t(28) = -2.03, p = .05$. Examining the subscales of the CBCL, this overall difference appears to be due to the significant difference between girls ($M = 12.00, SD = 9.45$) and boys ($M = 5.71, SD = 1.43$) on the Internalizing scale, $t(28) = -2.21, p = .036$, as there were no significant differences on the Externalizing scale.

<table>
<thead>
<tr>
<th>TABLE 1. IPV and maltreatment histories of mothers and children</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Characteristic</strong></td>
</tr>
<tr>
<td>Mother abused as child</td>
</tr>
<tr>
<td>Other violent intimate relationships</td>
</tr>
<tr>
<td>Psychiatric services sought for self</td>
</tr>
<tr>
<td>Inpatient psychiatric hospitalization for mother</td>
</tr>
<tr>
<td>Psychiatric services sought for child</td>
</tr>
<tr>
<td>Verbal abuse experienced in relationship</td>
</tr>
<tr>
<td>Physical abuse experienced in relationship</td>
</tr>
<tr>
<td>Severe physical abuse experienced in relationship</td>
</tr>
<tr>
<td>Abuse involving injury experienced in relationship</td>
</tr>
<tr>
<td>Sexual abuse experienced in relationship</td>
</tr>
<tr>
<td>Physical abuse witnessed by child</td>
</tr>
<tr>
<td>Severe physical abuse witnessed by child</td>
</tr>
<tr>
<td>Child physically abused</td>
</tr>
<tr>
<td>Child Protective Services involvement</td>
</tr>
</tbody>
</table>
Correlational analyses revealed that children's emotional regulation difficulties were related to mothers' PTSS, $r = .68$, $p < .01$, and that children's internalizing and externalizing behaviors were also related to mothers' PTSS, $r = .60$, $p < .01$. Scores associated with amount of IPV witnessed were significantly related to CBCL scores, $r = .39$, $p < .05$, but not to emotional regulation difficulties. Correlations between child maltreatment and child outcome variables were also not significant; however, the potential underreporting of child maltreatment and the resultant small percentage of children in the sample (10%) with child maltreatment histories may affect this analysis.

Hierarchical multiple regression analyses were conducted to determine if mother's PTSS predicted child's mental health outcome, above and beyond the child's witnessing of violence and/or own maltreatment (see Table 2). Examining the Emotional Regulation/Negativity and Lability Index of the ERC as an outcome variable, extent of child witnessing was entered in the first step and was not a predictor of child's negative and labile emotion. The child's own maltreatment score, as measured by the CTS-2, was entered in the second step and was also not a significant predictor. Mother's PTSS severity was added in the third step and was a strong predictor of child's negative and labile emotion, $R^2$ change $= .433$, $\beta = .67$, $p < .001$, accounting for 43% of the variance in child's emotional regulation difficulties.

Examining total CBCL score as an outcome variable (see Table 3), child's gender was entered first into the regression model and explained a significant amount of the variance in child's behavior, $R^2_1 = .133$, $\beta = .364$.

**TABLE 2.** Hierarchical regression analysis for variables predicting children's emotional regulation/negativity and lability

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>SE</th>
<th>$\beta$</th>
<th>$p$</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Step 1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amount of Violence Witnessed by Child</td>
<td>0.01</td>
<td>0.07</td>
<td>.02</td>
<td>.91</td>
<td>-.14, .15</td>
</tr>
<tr>
<td><strong>Step 2</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amount of Violence Witnessed by Child</td>
<td>0.03</td>
<td>0.08</td>
<td>-.09</td>
<td>.7</td>
<td>-.21, .14</td>
</tr>
<tr>
<td>Child Maltreatment</td>
<td>0.34</td>
<td>0.39</td>
<td>.2</td>
<td>.39</td>
<td>-.45, 1.13</td>
</tr>
<tr>
<td><strong>Step 3</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amount of Violence Witnessed by Child</td>
<td>0.02</td>
<td>-0.06</td>
<td>-.05</td>
<td>.76</td>
<td>-.15, .11</td>
</tr>
<tr>
<td>Child Maltreatment</td>
<td>0.12</td>
<td>0.3</td>
<td>.07</td>
<td>.69</td>
<td>-.49, .73</td>
</tr>
<tr>
<td>Mother's PTSS (PCL Total)</td>
<td>0.3</td>
<td>0.06</td>
<td>.67</td>
<td>.001</td>
<td>-.16, .43</td>
</tr>
</tbody>
</table>

Note: $R^2 = .000$ for Step 1; $\Delta R^2 = .028$ for Step 2; $\Delta R^2 = .433$ for Step 3 ($p < .001$).
TABLE 3. Hierarchical regression analysis for variables predicting children's total CBCL score

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>SE B</th>
<th>β</th>
<th>p</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Step 1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child Gender</td>
<td>20.08</td>
<td>9.89</td>
<td>.36</td>
<td>.05</td>
<td>−20, 40.37</td>
</tr>
<tr>
<td><strong>Step 2</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child Gender</td>
<td>15.65</td>
<td>9.84</td>
<td>.28</td>
<td>.12</td>
<td>−4.57, 35.87</td>
</tr>
<tr>
<td>Amount of Violence Witnessed by Child</td>
<td>0.41</td>
<td>0.233</td>
<td>.32</td>
<td>.09</td>
<td>−0.07, 0.89</td>
</tr>
<tr>
<td><strong>Step 3</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child Gender</td>
<td>16.89</td>
<td>10.73</td>
<td>.31</td>
<td>.13</td>
<td>−5.20, 38.99</td>
</tr>
<tr>
<td>Amount of Violence Witnessed by Child</td>
<td>0.46</td>
<td>0.28</td>
<td>.35</td>
<td>.11</td>
<td>−.11, 1.03</td>
</tr>
<tr>
<td>Child Maltreatment</td>
<td>−0.44</td>
<td>1.36</td>
<td>−.07</td>
<td>.75</td>
<td>−3.23, 2.36</td>
</tr>
<tr>
<td><strong>Step 4</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child Gender</td>
<td>19.45</td>
<td>8.03</td>
<td>.35</td>
<td>.02</td>
<td>2.87, 36.03</td>
</tr>
<tr>
<td>Amount of Violence Witnessed by Child</td>
<td>0.49</td>
<td>0.21</td>
<td>.38</td>
<td>.03</td>
<td>.07, .92</td>
</tr>
<tr>
<td>Child Maltreatment</td>
<td>−1.27</td>
<td>1.03</td>
<td>−.21</td>
<td>.23</td>
<td>−3.39, .86</td>
</tr>
<tr>
<td>Mother's PTSS (PCL Total)</td>
<td>0.98</td>
<td>0.22</td>
<td>.61</td>
<td>.001</td>
<td>.54, 1.42</td>
</tr>
</tbody>
</table>

Note: $R^2 = .133$ for Step 1 ($p = .05$); $\Delta R^2 = .094$ for Step 2; $\Delta R^2 = .003$ for Step 3; $\Delta R^2 = .358$ for Step 4 ($p < .001$).

$p = .05$. The extent of the children's witnessing of violence was added in the second step and was not a significant predictor. The child's own maltreatment score was entered in the third step and was also not a significant predictor. Finally, mother's PTSS score was added in the fourth step and accounted for a significant change in variance, $R^2_{\text{change}} = .358$, $\beta = .609$, $p < .001$; however, this finding should be interpreted with caution. The 95% confidence interval for $B$ for the variable PCL total encompassed the value 1.0, and is thus beyond the scope of this study to identify specifically whether mothers' PTSS contributes to an increase in CBCL scores or a decrease in CBCL scores among children for this sample.

**DISCUSSION**

Results indicate that a mother's PTSS as a result of her IPV predicted children's emotional functioning, as reported by the mother, after accounting for the extent of the child's witnessing the IPV or the child's own history of maltreatment. Interestingly, neither maltreatment nor extent of witnessing of violence predicted emotion regulation difficulties. These results suggest that a mother's PTSS play a critical role in the child's emotional development,
and that the mother's psychological health may in fact influence her child's development more than the child's actual exposure to violence.

This study extends previous researchers' work examining the relationship between maternal PTSD and child behavior (Lieberman et al., 2005) by focusing on emotional functioning outcomes in children of battered women with PTSD. Results suggest that children of mothers with PTSS (including feelings of detachment and estrangement, emotional numbness, and emotion dysregulation) are more emotionally negative and labile. This finding is particularly concerning considering that emotional dysregulation in children can lead to problems in interpersonal relationships, academic problems, and difficulties coping with their environment (Eisenberg et al., 1995; Fabes et al., 1999), putting children at long term developmental risk even after they have been removed from the violent family environment.

One possible explanation for these results is that mothers experiencing posttraumatic stress may not be effective models in how to manage or regulate emotions. Furthermore, a mother's ability to express and feel emotion is a powerful factor in her ability to form a close bond with her child, and this ability is often impaired in PTSD. Finally, if a mother's PTSS are inhibiting her child's ability to have an emotionally satisfying relationship with her, the child may experience more negative emotions and have a more distressing emotional life.

An alternative explanation for these results may be that children of mothers with PTSS show more emotional negativity and lability as a result of acting out in a way that elicits more attention from an emotionally detached mother. A child of such a mother may express more extreme fluctuations of emotion so as to require the mother to intervene and attend to the child's emotion, as these mothers may not be responsive to more subtle emotional expressions in their children if they are themselves numb to emotion.

A final possibility, and a limitation of the design of the study, is that mothers who have PTSS may rate their children as emotionally negative and labile when the children's emotional regulation is actually within a normal range. As this study used a mother's report of children's emotional regulation, it is unknown how well these reports indicate children's actual emotional functioning, as opposed to a mother's subjective view of her child's emotional functioning. Mothers who are emotionally numb or have affect dysregulation may have difficulty understanding or tolerating the expression of emotions in others. It is possible that these mothers may find any emotional expressivity from their children overwhelming, and therefore may be over-pathologizing their children's emotional functioning.
The study’s heavy reliance on self and other-report measures represents a major limitation of the study, as they do not necessarily assess how participants and their children actually behave but instead how participants choose to report the behavior. Maternal reports may misrepresent children’s emotional problems as a result of mothers’ own desire for help, degree of defensiveness, and psychological distress (Hughes, 1988). Several studies have shown that maternal distress can impact mothers’ rating of their children’s behavior on the CBCL and other measures, with some studies finding that distressed mothers evaluate their children more negatively than they might otherwise (Breslau, Davis, & Prabucki, 1988; Dix, 1991; Forehand, McCombs, & Brody, 1987; Jouriles & Thompson, 1993; Richters, 1992). In contrast, there is some evidence in the literature that mothers may underreport children’s behavioral symptomatology. For example, in their study of discrepancies between parental and adolescent reporting of behavior on the CBCL, Seiffge-Krenke and Kollmar (1998) found that mothers underreported their children’s internalizing symptoms in comparison to the children’s own report. In addition, research with battered women suggests that mothers’ preoccupation with her safety during a violent relationship may divert her attention from her child, leading her to overlook or minimize the emotional impact of the child’s exposure to violence (Peled & Edleson, 1992). In Chemtob and Carlson’s (2004) study, mothers with PTSD were more likely to underestimate distress in their children. In addition, 91% of the mothers with PTSD had not obtained psychiatric services for their children, compared to 46% of the mothers without PTSD.

Another limitation of the study is its small sample size, which limits the stability of these results and the ability to directly test which aspects of PTSD are related to children’s adjustment. Future research should attempt to replicate these findings with a larger sample and examine the unique roles of PTSD symptom clusters on parenting and children’s adjustment. In addition, research should utilize children’s reports of their own functioning, as well as teacher reports of children’s functioning to eliminate single informant bias resulting from maternal reports, with additional assessment around how the children experience their mothers’ emotional functioning. Observational data would also be a useful addition to this research. In particular, observing the quality of the mother-child interaction and the emotional processes occurring during this interaction would shed some light on the mechanisms by which a mother’s PTSS impede her child’s emotional functioning.

Given the strong association between mothers’ PTSS and the children’s emotional development, interventions should focus on treating the mother’s PTSS. Many interventions for IPV focus on removing the
mother from the violent environment and dealing with the immediate aftereffects of the violent relationship. However, PTSS can exist long after the abuse has ended, and the results of this study suggest that interventions that target these symptoms could have positive implications for children. Cognitive behavior therapies show the most empirical support for treating PTSD (Foa & Meadows, 1997), and cognitive trauma therapy for battered women (CTT-BW; Kubany et al., 2004), which includes PTSD education, stress management, exposure, self-monitoring of negative self-talk, and modules on guilt, self-advocacy, and assertiveness is particularly effective. In addition to treating PTSD symptoms, interventions that target improving parent-child interactions are needed. There is increasing empirical support for the view that therapies targeting the parent-child relationship improve outcomes for children exposed to community violence (Laor, Wolmer, & Cohen, 2001; Linares et al., 2001). Treatments directed at developing affect management skills in both the mothers and their children, such as dialectical behavioral therapy (Linehan, 1993), might be particularly helpful in improving parent-child interactions.

REFERENCES


