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Family violence in traumatized refugee families: A mixed methods study of mother/child dyadic functioning, parental symptom levels and children's psychosocial adjustment

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Abstract

Research suggests that a parental trauma history may increase the risk of family violence and have a negative impact on parent/child dyadic functioning and on children's psychosocial adjustment. This study aimed at exploring mother/child dyadic functioning, and symptom levels in mothers and children's psychosocial adjustment in a sample of refugee families referred for treatment of family violence ($N=21$). The study entailed a mixed methods design consisting of a video recorded mother/child interaction using the structured observation method "the Marschak Interaction Method" and questionnaires. Children's psychosocial adjustment was measured using the Strengths and Difficulties Questionnaire. Mothers' symptom levels were measured by the Harvard Trauma Questionnaire and The Hopkins Symptom CheckList-25. Mother/child dyadic functioning was measured by the Marschak Interaction Method Rating System (MIMRS), and potential associations between scores on the MIMRS and mother/child symptom and psychosocial adjustment levels were explored using partial correlations. Results reveal that the majority of dyads showed signs of problematic/clearly dysfunctional behavior in one or more of the four domains: Structure, Engagement, Challenging and Nurture. Qualitative analyses of the material revealed a number of distinct ways in which the dyads' behavior was problematic/clearly dysfunctional. An association between maternal symptom levels and scores on the MIMRS could not be confirmed. An association was confirmed between maternal symptoms of anxiety, depression and post-traumatic stress disorder and children's psychosocial maladjustment. Furthermore, an association was found between scores on the MIMRS and children's health-related quality of life. Findings from the study have clinical implications and emphasize the need for future research.

Keywords: refugee, trauma, quality of dyadic relationship, family violence

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Introduction

The transgenerational transmission of trauma and violence in families is a well-established phenomenon (Yehuda et al., 1998). During the decades since the Holocaust a large number of studies based on clinical populations have documented how traumatic experiences may affect not just the survivor but may have an impact on the family system with potentially harmful consequences for offspring (Kellermann, 2001). More recently, research on the transmission of trauma has focused on other populations than Holocaust survivors and their offspring, such as victims of other types of trauma and nonwestern refugee populations. Similarly, to the research on Holocaust survivors and their offspring, studies including non-western refugee families point to the existence of a potential negative transgenerational transmission of trauma and trauma sequelae (Catani, Schauer, & Neuner, 2008; Dalgaard & Montgomery, 2017; Measham & Rousseau, 2010; Montgomery, 2011; Rousseau, Drapeau, & Platt, 1999; Rousseau, Rufagari, Bagilishya, & Measham, 2004; Weine et al., 2004). In a study of children of Vietnamese refugees using the Strengths and Difficulties Questionnaire (SDQ), Vaage et al. (2009) found that children of refugee parents born in Norway have significantly lower Total Difficulties Scores indicating a greater positive psychosocial adjustment than their Norwegian peers, however children's Total Difficulties Scores were positively associated with a paternal diagnosis of post-traumatic stress disorder (PTSD), suggesting a transgenerational transmission of trauma, in which children are negatively affected by parental post-traumatic symptoms (Vaage et al., 2011). Daud, Skoglund, and Rydelius (2005) compared 15 refugee families from Lebanon and Iraq, where parents had been subjected to torture, with a matched control group of 15 non-traumatized refugee families where the parents did not have a history of direct torture. This study found that children of tortured parents had more symptoms of anxiety, depression, post-traumatic stress, attention deficits, and behavioral disorders compared with the control group. Finally, a recent meta-analysis on the association between parents' PTSD severity and children's psychological distress, which included 42 samples found a moderate overall effect size $r=.35$, indicating that parental symptoms of PTSD influence children negatively (Lambert, Holzer, & Hasbun, 2014). From this research it can be concluded that, within clinical populations and among nonwestern refugees resettled in Western countries, there is evidence to suggest that a parental trauma history and subsequent PTSD symptoms can have a negative impact on the family system and may influence children negatively.

Trauma exposure and family violence in refugee families

The issue of family violence is globally recognized as a leading health problem with significant long-lasting consequences for the mental health and well-being of the victims (Krug, Mercy, Dahlberg, & Zwi, 2002). Research on the prevalence of family violence among refugees is scarce, but the few existing studies concerning such violence have found the prevalence rate to be as high as 30–50% (Hinton, Rasmussen, Nou, Pollack, & Good, 2009; Pittaway, 1991; Rees & Pease, 2006; Timshel, Montgomery, & Dalgaard, 2017). While much of the research on family violence has been carried out in the general population, few studies have been conducted in the context of refugee families resettled in Western countries. In a recent systematic review based on 15 studies, Timshel et al. (2017) identified risk and

protective factors associated with family violence in refugee families. The review concludes that family violence in refugee families must be seen as a result of accumulating, multiple risk factors on the individual, familial, societal and cultural level. At the individual level, parental trauma experiences/mental illness, substance abuse and a history of child abuse were found to be risk factors. Family level risk factors included parent–child interaction, family structure and family acculturation stress. At the societal level low socioeconomic status was identified as a risk factor. Cultural level risk factors included patriarchal beliefs, as males who were high on a measure of patriarchal beliefs were more likely to become perpetrators of domestic violence. Positive parental coping strategies were a protective factor. Although the review provides a preliminary insight into the etiology of family violence in refugee families, knowledge about the consequences of the violence for the family members and the intra-family dynamics within the violence affected refugee families is still much needed, which is where the present study contributes.

Researchers have conceptualized the refugee experience as a prolonged period of accumulating, multiple interacting stressors during pre-migration, flight and post-migration (Lustig et al., 2004; Fazel & Betancourt, 2018). Before and during flight refugees might experience war, torture, violence, and persecutions. After arrival into the resettlement country many face further stressors of asylum procedures, unemployment, family separations, losses, social, and cultural adjustment challenges, and thus the refugee experience may be described as a circle of disruptive and intertwined processes of traumatization, acculturation, uprooting and marginality (De Haene, Grietens, & Verschueren, 2007). Following the adverse trauma experiences and stress, refugees are at high risk of developing mental health disorders. In particular PTSD, depression and anxiety disorders are highly prevalent among refugee children and adults (Fazel, Wheeler, & Danesh, 2005; Fazel & Betancourt, 2018; Montgomery, 2011). A number of studies have found an association between PTSD and family violence both in the general population (Banyard, Williams, & Siegel, 2003; Leen-Feldner, Feldner, Bunaciu, & Blumenthal, 2011) and among war-veterans (Byrne & Riggs, 1996; Sherman, Sautter, Jackson, Lyons, & Han, 2006). A study by Catani, Jacob, Schauer, Kohila, and Neuner (2008), examining family violence in conflict areas in Sri Lanka found a significant association between earlier war exposure and symptoms of PTSD and the scope of family violence, which further suggests that the risk of family violence is significantly higher when a family member suffers from PTSD and/or other consequences of trauma.

Parental trauma, attachment representations and caregiving behavior

In an attempt to understand the transgenerational transmission of trauma and the differences in children's coping and psychosocial well-being within traumatized refugee families, theory and research suggest that attachment representations in both parents and children serve as key transmission factors for both vulnerability and resilience (Dalgaard, Todd, Daniel, & Montgomery, 2016; De Haene, Grietens, & Verschueren, 2010; van Ee, Kleber, & Mooren, 2012). Theoretically, parental secure attachment representations are proposed as a protective mechanism, whereas parental insecure or unresolved attachment representations are proposed as a risk factor associated with parental decreased emotional availability and compromised caregiving ability (van Ee, Kleber, Jongmans, Mooren, & Out, 2016). Parental

insecure or unresolved attachment representations may precede the war- and migration-related traumatic events or occur as a result of these, or they may occur as a combination of the simultaneous war trauma and attachment trauma, cumulating over the life-course (Riber, 2017).

The association between parental trauma and attachment representations or parental internal working models of the self and the self with child contains two different explanatory models. First, a parental insecure or unresolved attitude with respect to attachment may precede the war- and migration-related traumatic experiences and thus leave the individual more vulnerable to the subsequent development of posttraumatic symptoms in response to traumatic experiences. Second, the traumatic experiences brought on by war, migration and refugee status may be the direct cause of disruptions in the parental attitude with respect to attachment and thus be seen as the primary transmission factor between a parental trauma history and adverse child outcomes (De Haene et al., 2010). Within both explanatory models the consequences for the parent, child and dyad are similar, as a parental insecure or unresolved attitude with respect to attachment is associated with a number of emotional and behavioral changes within the parent/child dyad and with adverse consequences for the child (Madigan et al., 2006).

A large number of studies suggest that exposure to maternal psychopathology during early development may have a substantial impact on child self-regulation, emotional and psychosocial development (Brand & Brennan, 2009; Davis et al., 2004; Field, 2011). Studies have primarily focused on anxious and depressed mothers, but recent research suggests that maternal adverse childhood experiences and subsequent symptoms of PTSD may also have a profound and distinct negative impact on child self-regulation, emotional, and psychosocial development (Brand, Engel, Canfield, & Yehuda, 2006; Enlow et al., 2009; Kaitz, Levy, Ebstein, Faraone, & Mankuta, 2009; Lambert et al., 2014; Murphy et al., 2014; van Ee et al., 2012).

Symptoms of PTSD are associated with emotional withdrawal, which has been proposed as theoretical explanation for the finding that mother's suffering from a high level of PTSD symptoms show decreased emotional availability compared with mothers with lower symptom levels (van Ee et al., 2016). However, an elaboration on the explanation may be seen in the link between a parental insecure or unresolved attitude with respect to attachment and disruptions in parental interaction and caregiving behavior with the child. Theoretically, Main and Hesse (1990) proposed the concept of "*frightened or frightening behavior*" to describe the impact of unresolved parental attachment status on caregiving behavior. Unresolved loss or a failure to complete the mourning process following trauma or loss, may lead to a continuing existence of multiple conflicting representational models, that are disintegrated and cannot be organized to form a single coherent or non-self-contradictory whole. The failure to form an organized attachment representation is then thought to cause the parent to behave in a contradictory or disrupted manner when engaging with the child. Frightening parental behavior results in the paradoxical situation in which the parent at the same time is a source of comfort and a source of fear to the child. Thus, in stress-situations the child does not know what to do, and this may result in the development of a disorganized attachment pattern in the child (Hesse & Main, 2006). Hesse and Main (2006) further suggest that parental frightened or frightening behavior are often guided by parental fright and may take on three different forms; *threatening behavior*, *frightening behavior* and

dissociative behavior reflecting the evolutionary-based behavioral fright responses in mammals; fight, flight or freeze.

In a study of 45 low-income mothers and their 18-month-old infants, Lyons-Ruth and Block (1996) found that mothers exposed to childhood trauma are at elevated risk for developing hostile or emotionally withdrawn caregiving behavior and for establishing disorganized attachment relationships with their infants. Furthermore research suggests that the mother's victimization may cause her to display a type of hostility to her child similar to the one that she herself experienced in her own childhood, thus confirming a transgenerational transmission of trauma within the mother/child dyad (Murphy et al., 2014).

In summary, theory and research suggests that parental trauma exposure and psychopathology may increase the risk of maladaptive parenting behavior and dysfunctional dyadic interaction as a result of insecure parental attachment representations, which may have a negative impact on the child. Maternal symptoms of anxiety, depression and PTSD all increase the risk of insensitive and/or hostile maternal caregiving behavior, decreased maternal emotional availability and adverse child outcome (Barker, Jaffee, Uher, & Maughan, 2011; Goodman et al., 2011; van Ee et al., 2012). Previous studies suggest that the adverse child outcome may take on many different forms. The present study will explore the specific nature of the potential negative impact of maternal symptoms of anxiety, depression and PTSD on maternal behavior and dyadic function by using an observational method and by exploring children's psychosocial adjustment and subjective well-being as measured by the SDQ and The KIDSCREEN-10S Index.

Aim

The present study is a descriptive and explorative study of traumatized refugee families in which violence takes place or has taken place. The overall explorative research questions are

1. How is the dyadic functioning between mother and child, as measured when displayed in a play-based setting and observed using the Marchak Interaction Method?
2. How is the psychosocial adjustment and well-being of the child as measured by the SDQ and the KIDSCREEN 10S?
3. How are maternal symptoms of anxiety, depression, and PTSD related to dyadic functioning and psychosocial adjustment and well-being of the child?
4. Is dyadic functioning related to psychosocial adjustment and well-being of the child?

Hypothesis

In addition to the overall open-ended explorative research question, the study proposed the following hypotheses based on a review of the existing literature:

1. There would be a negative association between maternal symptoms of anxiety, depression and PTSD and markers of positive dyadic functioning.
2. There would be a negative association between maternal symptoms of anxiety, depression and PTSD and children's psychosocial adjustment and health-related quality of life.

3. There would be a negative association between markers of positive dyadic functioning and psychosocial adjustment and health-related quality of life in children.

Method

Participants

The present sample is a convenience sample. Families for the study were recruited, when they were referred for treatment of trauma-related family violence at a rehabilitation center for refugees in Denmark. Families were referred for treatment by social workers, child protection services or by their general practitioners, who had to have confirmed knowledge of the existence of family violence such as witness testimonies or police reports in cases where parents denied it. In order to be eligible for treatment at least one of the parents had to have received a formal diagnosis of PTSD, either prior to the referral or as part of the screening at the treatment center. The study thus includes both families in which physical child abuse and intimate partner violence is taking place/has taken place. During the families' first appointments at the treatment center the parents were informed about the study and asked if data from their clinical assessment could be used for the present study. If they agreed to this, they were asked to sign a consent form by their therapists. All families received treatment regardless of whether they wanted to participate in the study or not. The treatment for which the families were referred consists of interdisciplinary family and individual therapy. For a full description of the treatment model please see (*reference omitted to ensure anonymity during the peer-review process*). All data for the purpose of this study was obtained at baseline as part of the initial clinical assessment of the family.

Inclusion criteria

Families were included in the study, when they met the following inclusion criteria; at least one parent was a refugee with a history of trauma exposure associated with torture and/or organized violence. In some families only one parent was a legal refugee and the spouse came to Denmark via family reunification. These families were also included in the study. The referrer had to have knowledge of past or ongoing family violence within the family, and the family had to have at least one child age <18).

Exclusion criteria

Families were excluded when the parents did not have a history of trauma exposure and when all children within the family were placed in foster care or had left the family home. At the time of referral many parents denied the previous or ongoing family violence, but when the family accepted treatment they were still included in the study based on the report of family violence from the referrers (Table 1).

Ethics

Depending on their financial situation and the distance between the family home and the treatment center, some families were offered reimbursement of travel expenses, but no

Table 1. Sample characteristics.

N		Family type							
21		Single parent: 11							
		Two-parent: 10							
	Age/time in Denmark			Public benefits	Income		No formal education	Education	
	N	Mean age	Time in Denmark (years)		Employment	No income		≤10 years	>10 years
Mothers	21	40.14 (7.26)	11.9 (9.04)	19	0	2	3	9	8
Children	21	10.29 (4.42)							

The families' countries of origin included: Syria (7), Iran (1), Lebanon (2), Iraq (7), Eritrea (1), Yemen (1) and Afghanistan (2).

other compensation for participation was offered. Following written and oral information regarding the purpose of the study, participants signed a written consent form. The study was reported to the National Committee on Health Research Ethics in Denmark.

Procedure

The Marschak Interaction Method (MIM) was carried out with one child in each family. The therapists chose the target child based on their initial clinical assessment of the family. This study presents findings from The MIM carried out with mothers and a target child in each family. Self-report data is presented from the target child, except when the child was age ≤ 7 . In families with a target child age ≤ 7 the KIDSCREEN 10S could not be administered. In families with a target child age ≥ 8 the target child filled out the SDQ-S, but in families with a younger target child, the parental rating version of the SDQ was filled out by the mother. Questionnaires were completed at the treatment center in the presence of the therapists and an interpreter.

Measures

The MIM

The MIM is a play-based observational method designed to assess parent-child interactions and can be used with children aged between 1 and 18. The MIM consists of nine tasks, which the parent and child perform together while the session is videotaped allowing for clinicians and researchers to observe actual parent/child behavior with the purpose of identifying patterns reflecting the quality of the relationship (Jernberg, 1991; Marschak, 1960). The specific tasks and the order of tasks are adjusted depending on the age of the target child. In the present study the average MIM session lasted approximately 35 min.

For the purpose of this study the Marschak Interaction Method Rating System (MIMRS) was used. The MIMRS is a scoring system containing 42 items that are scored on a 5-point Likert type scale. The first four domains are; Structuring, Challenging, Engaging and Nurturing. For these domains, the observer rates the parent, child and dyad on how they approach and handle the domain on all tasks of the MIM. Each domain contains a number of descriptive items, which are rated on a 5-point Likert scale with a score of 0 indicating "clearly dysfunctional" and a score of 4 indicating "optimal" functioning. For each domain the range of scores are: Structure: 0–24 Challenge:0–24, Engage: 0–32 and Nurture:0–32.

The final domain: Separation-Reunion is based solely on the separation-reunion task of the MIM. In addition to the domains scores, the MIMRS measures 5 factor scores rating parental and child behavior and affect separately as well as a score measuring dyadic functioning as well as 15 items that are indicative of potentially harmful and dangerous behaviors (e.g. the parent is physically aggressive towards the child). Preliminary studies of the MIMRS provide support for the reliability and validity of the MIMRS (Hitchcock, Ammen, O'connor, & Backman, 2008; Martin, Snow, & Sullivan, 2008). For the purpose of the present study in which all video material had to be translated a decision was made to simplify the MIMRS by only using the first 4 domain scores, as these were deemed to be the most clinically relevant by the therapists and had an acceptable level of inter-rater reliability. The separation reunion task was omitted because it was deemed less appropriate with older children. In order to establish interrater reliability, the first 5 dyads (23.8% of the sample) were rated by three independent coders. The inter-rater agreement between the 3 coders was calculated for all 4 domain scores separately: Structure: ICC = .96 Challenge: ICC = .98, Engage: ICC = .97 and Nurture: ICC = .97. The rest of the sample was coded by two independent coders each. When coders disagreed a consensus coding was reached, and the consensus scores were used in the analyses.

Harvard trauma questionnaire (HTQ)

The maternal PTSD-symptoms were measured by the HTQ in the mother's native language (Arabic, Farsi) or in a few cases the English version with the assistance of an interpreter. The HTQ is a 30-item cross-cultural instrument designed for the assessment of trauma and torture related to mass violence and its sequelae. Each item is scored on a 4-point Likert scale. The questionnaire generates a DSM-IV PTSD score, which is what is reported within the present study. The score ranges from 1 to 4, and the recommended clinical cut-off is ≥ 2.00 (Shoeb, Weinstein, & Mollica, 2007). The HTQ has been validated in multiple languages and with various different populations (Kleijn, Hovens, & Rodenburg, 2001).

The Hopkins symptom CheckList-25 (HSCL-25)

The maternal symptoms of anxiety and depression were measured by the HSCL-25 in the mothers' native languages (Arabic, Farsi) or in a few cases the English version with the assistance of an interpreter. The questionnaire contains 25 items, 10 items measure symptoms of anxiety and 15 items measure symptoms of depression. Each item is scored on a 4-point Likert scale. The HSCL-25 generates separate scores for anxiety and depression symptoms, in addition to a total score. Each score ranges from 1 to 4 and the recommended clinical cut-off is ≥ 1.75 . The HSCL-25 is a widely used measure and the psychometric properties have been tested in various populations (Veijola et al., 2003).

The SDQ

To measure the psychosocial adjustment of the children, the study employed the SDQ (self-report or parent version depending on the age of the target child), which is a widely used brief screening tool available in the relevant languages. For the purpose of this study the Danish, Arabic, Farsi versions were used. The questionnaire contains 25 items consisting

of descriptions of the child's behavior over the past 6 months such as; "Often loses temper" which are rated as "Not True," "Somewhat True" or "Certainly True." The questionnaire was chosen to allow findings from the present study to be directly comparable with larger samples and because the psychometric properties of the questionnaire have been researched extensively with good results regarding both validity and reliability. The SDQ measures emotional symptoms, conduct problems, hyperactivity/inattention, peer-relationship problems, which may be combined as a total score measuring total difficulties. In spite of the brevity of the questionnaire, the SDQ has proven to be a useful tool for detecting psychopathology in children (Goodman, 2001; Thabet, Stretch, & Vostanis, 2000).

The KIDSCREEN-10S index

The KIDSCREEN-10S index is a brief 10-item self-report questionnaire measuring health-related quality of life (HRQoL) in children age ≥ 8 . The questionnaire consists of 10 items measuring well-being and subjective health, and each item is rated on a 5-point Likert type scale. The questionnaire generates one global score for HRQoL, with higher scores indicating greater HRQoL, and the psychometric properties have been tested extensively (Europe, 2006).

Qualitative analysis

During the coding of the MIM videos the coders wrote extensive written notes, which were used for the purpose of consensus coding and qualitative analyses of the video material. The final qualitative analyses of the coding notes and the video material were carried out by the first author and discussed with the second and third author in reaching consensus. The analysis was based on a theoretically informed coding schedule in which the four domains of the MIMRS served as the analytic categories, in which all the relevant notes and video material were noted.

Statistical analysis

Significance level was set to $p < .05$ (two-tailed). Preliminary tests of normality, Kolmogorov-Smirnov and Shapiro-Wilk, were carried out for the SDQ Scores, HTQ PTSD Scores, HSCL-25 Anxiety and Depression Scores, which did not violate the assumption of normality of the distribution. The statistical analyses consist of descriptive analyses and partial correlations. The small number of cases in the study precludes the possibility of multivariate linear regressions. Therefore, partial correlations are presented individually. Since ages in the sample vary considerably, from 2 to 17 years, all correlations were calculated partialling out the effect of age.

We are aware that, with so many correlations, there is an elevated risk of type I errors. However, since the present study is explorative, we have considered it important not to elevate the risk of type II errors by raising the alpha significance levels in our correlations.

Results

Qualitative findings

Based on the rating scale definitions within the MIMRS an average domain score of $X < 2$ is defined as either “problematic” or “clearly dysfunctional.” As shown in Table 2, the majority of mother/child dyads displayed markers of such malfunctioning within one or more of the four domains of the MIMRS. The following qualitative findings are presented in order to illustrate the specific ways in which the dyads displayed problematic or dysfunctional dyadic interaction.

Structure

As shown in Table 2, 16 dyads had average scores of $X < 2$ on the Structure domain. Through qualitative analyses it was possible to distinguish between two subtypes of maternal behavior within the sample with such low scores on the Structure domain. The first subtype consists of 12 mothers who primarily seemed to lack the ability or ambition to provide age appropriate structuring for their child. These mothers seemed almost afraid of the child’s potential negative reactions and thus gave in and failed to complete task as soon as the child showed any resistance or even just hesitance. An example of this was the mother who only attempted to engage in four of the nine tasks and decided to avoid presenting the remaining tasks to her child, presumably because she did not expect her child to comply with her instructions. Another finding was that the majority of the children displayed marked negative responses to the maternal lack of structuring. Examples of this was seen when the child looked away from the mother, left the table or started focusing on other things than the joint activity, when the mother displayed behavioral or verbal hesitance or a lack of structuring. Furthermore, the mothers within the first subtype often involved the child in all decisions even with very young children instead of guiding the child. An example of the was the mother who asked her 2-year-old: “*What should I teach you?*” Another defining characteristic for the subtype was, that these mothers seemed to either under- or overestimate the age-dependent cognitive abilities of the child and they generally failed to make any age-specific adaptations of the MIM tasks. The other subtype of behavior was displayed by four mothers with low scores on the Structure domain, who generally seemed to want to control all aspects of the situation allowing the child little or no influence or cooperative effort. These mothers gave the child clear but rigid instructions regarding all aspects of the child’s behavior such as telling the child how to sit still, to be quiet and how to hold the toys in a very specific and predefined manner allowing the child no autonomy and creativity within a situation that is intended to be a playful interaction. An extreme example of this intrusive parental behavior was the mother who performed the entire nine MIM tasks with her 2-year-old in only 10 min, by providing an extremely rigid and rapid structure, and by ignoring all her daughter’s very obvious signs of frustration. Within the test situation the daughter quickly became bored by the tasks as she was allowed no influence and her mother offered her little attention or support as she was either absorbed in reading the card or rushing through the tasks. The child was often distracted and looked away from the table, but the mother didn’t notice and there was almost no eye contact between the mother and her daughter within the entire test session. At one

Table 2. Family symptom and MIMRS scores.

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	% above cut-off
Family Child age (years)	10	2	17	14	13	10	13	7	8	9	2	11	16	2	11	15	9	10	15	14	6	
Mother HTQ: PTSD	3.10	1.00	4.00	2.40	4.00	2.94	3.50	3.81	2.06	2.75	2.40	2.75	2.94	1.00	2.94	2.69	3.44	3.94	2.50	2.31	2.00	2.78 (1.85)
Mother HSCL-25: Depression	3.10	1.00	3.87	2.47	3.80	3.27	3.73	3.27	1.47	3.07	2.90	2.80	3.13	1.40	3.00	2.50	3.40	3.93	2.26	2.50	3.71	2.88 (1.83)
Anxiety:	3.20	1.00	3.90	1.80	3.30	3.10	3.10	3.40	1.50	2.40	2.60	3.30	3.60	1.60	2.80	2.30	3.70	4.00	3.40	2.31	2.90	2.82 (1.83)
SDQ Total Difficulties Score	21	4	11	2	16	12	16	34	11	10	5	19	23	6	14	10	16	19	-	18	-	14.05 (7.64)
KIDSCREEN 105 HRQoL	39	-	27	21	21	37	50	-	35	48	-	31	26	-	43	43	49	47	26	30	-	36.64 (10.37)
MIMRS Structure: (range: 0-24)	7	3	3	3	5	12	14	7	3	13	10	14	7	0	18	9	9	3	7	9	8	7.8 (4.59)
Challenge: (range: 0-24)	8	3	4	1	2	12	14	8	4	13	8	16	6	0	18	10	10	4	9	6	8	7.8 (4.9)
Engage: (range: 0-32)	11	4	4	9	4	17	20	13	8	16	17	20	7	3	25	15	14	7	11	12	11	11.8 (6.03)
Nurture: (range: 0-32)	15	3	11	6	9	16	21	15	10	16	24	20	5	4	24	16	18	10	12	14	10	13.3 (6.15)

HTQ and HSCL 25 scores above the clinical cut-off are highlighted.

SDQ scores based on parental ratings are highlighted.

For the MIMRS scores equalling an average domain score of $X < 2$ are highlighted.

point the child started whimpering and the mother only briefly looked at her and made a brisk comment instead of comforting the child.

Challenging

Similar to the findings regarding the Structure domain 16 dyads had average scores of $X < 2$ on the Challenge domain. The dyads in which challenge presented a problem were most often characterized by mothers who displayed a compromised ability to interpret the child's communication. An example of this was seen in mothers who in the tasks that involve the child copying a block structure made by the parent intervened very quickly allowing the child very little time to figure out how to complete the task or mothers who made grossly inappropriate age-adaptions, typically by either under- or overestimating the actual age-dependent cognitive abilities of their child. An example of this was seen in the mother who rigidly instructed her preteen daughter on how to perform very simple tasks or in the dyad where the mother showed obvious signs of frustration when her 2-year old daughter was unable to quickly understand the instructions for the block building task. The perhaps most striking example of dysfunctional parental challenging skills was seen in a mother who in response to the task in which the parent is instructed to teach the child something new told her 11-year-old: *"I don't know what I should teach you, I never know what to teach you, I've got nothing more to teach you,"* after which there was a prolonged silence in which both mother and son looked away from each other.

Engagement

Fifteen dyads had average scores of $X < 2$ on the Engagement domain. Generally, the mothers in the dyads scoring low on the engagement domain showed many signs of clinical depression. Within the test situation the mothers in which engagement presented a problem appeared detached from both the situation and their child. Six mothers had slow facial mimic and speech and appeared very passive, sometimes even allowing the child to be in charge of structuring activities altogether. Several mothers, especially the ones with older children used irony and sarcasm to distance themselves from the test situation, which in 4 dyads led to a complete role reversal in which the child became over-engaged and was the one to continuously coach and encourage the mother to participate. An example of this was seen in a dyad where the mother ended up copying a block structure made by her son, and where the son told the mother that maybe they could make a drawing together, in response to the task where the instruction is to play a familiar game. The mother hesitated at first and said she didn't know how to draw, but the son convinced her to try and subsequently praised the mother's ability to draw, whereas the mother made no attempt to encourage her son's engagement. Another example of role reversal was seen in the dyad where the mother and her teenage son performed the task that consists of talking about a day in the imagined future life of the child. The son was the one to take the lead, with the mother looking away from the son and not asking any questions, thus violating basic premises for a reciprocal dialogue. The son sought his mother's attention and engagement and ended up telling her a narrative about how he as an adult would still live at home, go to work and return in time to cook his mother dinner.

Nurture

Fourteen dyads had average scores of $X < 2$ on the Nurture domain. The maternal behavior within these families was characterized by being remarkably unresponsive to their child's emotional communication, ignoring the child's gaze, attempts at physical interaction or even verbal comments asking the parents for affective affirmation. An example of a mother who continuously ignored the child's nurture seeking behavior was a dyad in which the 13-year old son complained about a stomach ache. The mother ignored his comments, and when he finally resorted to overt attention-seeking behavior by leaning in and resting his head and arms on the table saying that he did not feel well, the mother made no attempt to comfort him or even to interact with him, but simply kept sitting still and staring blankly at the camera. In eight dyads the maternal narrative regarding when the child was a baby was remarkably devoid of any emotion and showed elements of hostility. These mothers focused solely on behavioral or practical aspects such as saying: "you used to cry a lot and you would sleep in the pram" or "you were chubby and used to eat and sleep all the time." In at least eight dyads it is clear how the maternal symptoms of PTSD and depression compromises the maternal emotional availability, an example of this was seen in a mother and her teenage daughter, where the mother started to cry several times during the test situation. In response to the task that involves the parent teaching the child something new, the mother, encouraged by her daughter, began to tell her daughter about her childhood and country of origin. After a few neutral remarks the mother said: "I only remember the pain," she then started to speak in incomprehensible fragments mentioning the death of her father and other tragic facts mixed with descriptions of sensory inputs. She did not respond to her daughters' questions excepts, when her daughter asked: "how many sisters and brothers did you have?" In response to this question, the mother simply said: "I don't know" and continued her incoherent narrative about the death of her father. In other dyads scoring low on the nurture dimension, the children seemed indifferent to or even resistant when the mother displayed nurturing behavior, and the mother typically quickly withdrew. Finally, in four dyads, both mothers and children made ineffective attempts to be affectionate with one another, meaning that they both tried to initiate a cuddle, which the other did not respond to. An example of this was seen in the mother who attempted to get her 8-year-old son to sit on her lap. Another aspect of maternal behavior that lead to low scores on the nurture dimensions are the four mothers who showed overt hostility towards their child within the test situation and especially during the tasks, which are intended to promote nurturing behavior. An example of this hostile and almost aggressive verbal behavior was seen in the mother who in response to the task in which the parent is instructed to tell the child a story beginning with: "when you were a baby" told her 11-year-old son: "when you were a baby, you were so sweet (...) you are not anymore, these days you never listen or do as you are told," the son then protested and they ended up having a small argument over whether the son usually comply with his mother's instructions. A final finding was, that in several cases the child's behavioral and verbal appeal for the parent's attention, engagement and nurture was persistent despite obvious rejections from the parent.

Summary

In summary the qualitative findings suggest that the majority of dyads within the sample showed problems in dyadic functioning across all four domains of the MIMRS. Furthermore,

it is possible to identify a number of specific subtypes of dyads, who display problematic/clearly dysfunctional maternal behavior within the four domains.

Quantitative findings

In accordance with the exploratory nature of the present study preliminary analyses exploring all theoretically meaningful associations were carried out, which, perhaps because of the limited sample size, did not lead to many significant findings. A table of correlations is presented in Table 3.

One finding is however worth noting. The 4 domain scores of the MIMRS were all significantly correlated, thus providing preliminary evidence to support the internal consistency of the MIMRS as a global measure of dyadic functioning.

Based on the first proposed hypothesis, that there would be a negative association between maternal symptoms of anxiety, depression and PTSD and markers of positive dyadic functioning, correlations were carried out between maternal scores of PTSD, Depression and Anxiety and the 4 domain scores of the MIMRS while controlling for the age of the child. None of the analyses reached significance, and thus the first hypothesis could not be confirmed.

Based on the second hypothesis, that there would be a negative association between maternal symptoms of anxiety, depression and PTSD and measures of psychosocial adjustment and health-related quality of life in children, correlations were carried out between maternal symptom scores and children's scores on the SDQ and on The KIDSCREEN 10S while controlling for the age of the child. Statistically significant associations were found between maternal symptoms of PTSD, Anxiety and Depression and the children's symptoms of psychosocial maladjustment as measured by the SDQ Total difficulties scores: HSCL 25: $r=.619, p=.006$ (two-tailed) and HTQ: $r=.565, p=.015$ (two-tailed). Furthermore, correlations were carried out between maternal symptoms of anxiety, depression and PTSD and children's health-related quality of life scores as measured by the KIDSCREEN 10s while controlling for the age of the child. However, none of these analyses reached significance and thus the second hypothesis was only partially confirmed.

Finally, in order to test the third hypothesis, that there would be a negative association between markers of positive dyadic functioning and psychosocial adjustment and health-related quality of life in children, correlations were carried out between the 4 domain scores of the MIMRS and children's scores on the SDQ and the KIDSCREEN 10S while controlling for the age of the child. None of the analyses involving the SDQ scores reached statistical significance. However, for the analyses involving the KIDSCREEN10S, two were statistically significant and one came very close to statistical significance: Challenge: $r=.505, p=.05$ (two-tailed), Nurture: $r=.576, p=.02$ (two-tailed), Engage: $r=.472, p=.07$ (two-tailed) and Structure: $r=.429, p=.11$ (two-tailed), Thus the third hypothesis was partially confirmed.

Discussion

In this study, we explored mother/child dyadic functioning, maternal symptoms of anxiety, depression and PTSD and psychosocial adjustment and subjective well-being in children in a sample of 21 traumatized refugee families referred for treatment of family violence. In the

Table 3. Correlations.

Scales	HTQ Maternal PTSD	HSCL 25 Maternal anxiety	HSCL 25 Maternal depression	SDQ Total difficulties	KIDSCREEN 105 HRQoL score	MIMRS Structure	MIMRS Challenge	MIMRS Engagement	MIMRS Nurture
SDQ total difficulties	$r=.57^*$	$r=.62^*$	$r=.43^*$	-	$r=.11$	$r=.17$	$r=.23$	$r=.13$	$r=.19$
KIDSCREEN 105 HRQoL score	$r=.27$	$r=.22$	$r=.35$	$r=.11$	-	$r=.45$	$r=.52^*$	$r=.48$	$r=.56^*$
MIMRS structure	$r=.17$	$r=.19$	$r=.30$	$r=.17$	$r=.43$	-	$r=.96^{**}$	$r=.94^{**}$	$r=.89^{**}$
MIMRS challenge	$r=.19$	$r=.27$	$r=.27$	$r=.23$	$r=.51^*$	$r=.96^{**}$	-	$r=.93^*$	$r=.86^{**}$
MIMRS engagement	$r=.16$	$r=.15$	$r=.23$	$r=.13$	$r=.47$	$r=.95^{**}$	$r=.93^*$	-	$r=.89^{**}$
MIMRS nurture	$r=.41$	$r=.34$	$r=.39$	$r=.19$	$r=.58^*$	$r=.89^{**}$	$r=.83^{**}$	$r=.89^{**}$	-

*Correlation is significant at the 0.05 level.

**Correlation is significant at the 0.01 level.

following sections the potential interpretation and implications of the present findings will be discussed based on the theoretical framework presented in the introduction.

Maternal behavior and dyadic functioning

Qualitative analyses of the video material and coding notes revealed a number of distinct ways in which the dyadic functioning may be lowered within this population. A majority of the mothers struggle with providing their child with adequate structure within the test situation. Some mothers fail to provide their children with much guidance, which may be interpreted as an example of the phenomenon termed parental “frightened” behavior as described by Hesse and Main (2006). Another subtype of maternal behavior associated with low scores on the Structure domain was identified in mothers who display an overcontrolling parenting style consistent with the concept of parental “frightening” behavior. According to attachment theory both parental “frightened” and “frightening” behaviors are associated with unresolved parental loss or trauma, which fits well within the present sample (Lyons-Ruth & Jacobvitz, 1999; Lyons-Ruth & Block, 1996; Main & Hesse, 1990; Schuengel, Bakermans-Kranenburg, & Van IJzendoorn, 1999). Furthermore, the findings are consistent with a lack of emotional availability, which has also been found to be associated with maternal trauma and posttraumatic symptoms (van Ee et al., 2012).

Theoretically the findings regarding dyads, where structuring presents a challenge, make good sense as family violence is often proposed as a result of the traumatized parents’ compromised ability to maintain a normal caregiver/child relationship, in which the parent provides the child with guidance (Dalgaard & Montgomery, 2017). Similar to the findings regarding Structure, a majority of dyads displayed compromised dyadic functioning on the Challenge, Engage and Nurture domains. These findings may be interpreted as a confirmation of the established link between parental trauma and decreased parental emotional availability, sensitivity and anomalous parental care-giving behavior. Compromised dyadic functioning across all four domains of the MIMRS may also be interpreted as different aspects of parent/child role reversal, in which the child becomes the de facto caregiver within the parent/child dyad (Enlow et al., 2009, 2011; Hesse & Main, 2006; Lyons-Ruth & Jacobvitz, 1999; Main & Hesse, 1990; van Ee et al., 2012). Across all four domains of The MIM a majority of the mothers displayed behavior which may be interpreted as a result of their anxious, depressed and posttraumatic symptoms, and which clearly compromise their ability to interact with their child in a positive manner.

Maternal symptom levels, dyadic functioning and children’s psychosocial adjustment and subjective well-being

Using both a self-report and a parental version of the SDQ as a combined measure of children’s psychosocial adjustment constitutes a serious methodological flaw in the design of the present study, as studies point to systematic differences in these two methods for assessing child mental health (Montgomery, 2008). Within the present study the SDQ total difficulties mean scores were substantially larger for the self-report version ($N = 15$, $SDQ M = 15.7$) than for the parental ratings ($N = 4$, $SDQ M = 7.8$), which may tentatively be interpreted as an indication, that parents in this study may underestimate the actual level of

difficulties experienced by their child, and that using child self-report exclusively with a larger sample would have magnified the present findings. The justification for using the combined SDQ measure lies in the exploratory nature of the study and the pragmatic fact, that these were the only data available. Furthermore, findings should be viewed in light of the fact that knowledge about the particular population of traumatized refugee families affected by family violence is sparse.

Although the first hypothesis could not be confirmed statistically, the theoretical link between parental trauma and subsequent symptoms of anxiety, depression and PTSD and adverse parenting behavior and dyadic malfunctioning is supported by the fact that the vast majority of the mothers scored above the clinical threshold for both PTSD (90.5%), anxiety (85.7%) and depression (90.5%) and showed signs of dyadic malfunctioning as measured by the MIMRS. The lack of a statistically significant association between maternal symptoms of anxiety, depression and PTSD and The MIM Rating-Scale scores may at least in part be explained by the limited variability in both the symptom and The MIM Rating-Scale scores within the present sample. It should also be noted, that all correlations were in the expected direction, and that some of them were rather large (e.g., Maternal PTSD and MIMRS nurture, $r = 4.1$ and Maternal Depression and MIMRS Nurture, $r = 3.9$).

The fact that the second hypothesis was only partially confirmed is surprising. The association between maternal symptoms of anxiety, depression and PTSD and children's psychosocial adjustment as measured by the SDQ suggests the existence of a transgenerational transmission of trauma within the present sample and confirms the link between maternal anxious, depressive and posttraumatic symptoms and psychosocial maladjustment in children. However, the lack of a statistically significant association between maternal symptoms of anxiety, depression and PTSD and children's subjective well-being and health-related quality of life as measured by the KIDSCREEN 10S, suggests that children's subjective well-being and quality of life is less closely linked with maternal posttraumatic, anxious and depressive symptoms than would have been expected. Future research should explore these associations further within the present population.

The confirmation of the association between children's subjective well-being and quality of life (KIDSCREEN 10S) and the dimensions of The MIM Rating-Scale scores may be interpreted as a tentative indication of the clinical usefulness of the MIMRS and suggests that therapeutic interventions aimed at improving dyadic functioning may also have a positive impact on children's subjective well-being and quality of life.

The lack of a significant association between the children's psychosocial adjustment as measured by the SDQ and The MIM Rating-Scale dimensions is, however, puzzling and needs to be further explored in future research. One obvious interpretation is that the finding should be seen as a result of limited statistical power due to the low sample size, but it is also possible that children's psychosocial adjustment levels are more affected by other factors than dyadic functioning such as maternal symptom levels, which the findings regarding the second hypothesis in this study suggest.

Cultural sensitivity

When interpreting the present findings, the cultural sensitivity of the MIM should also be considered. Cross-cultural differences between both families, therapists and interpreters

may influence the present findings, as child-rearing behavior like most behavior is also culturally embedded. However, the four domains of the MIMRS all reflect aspects of dyadic functioning, which one may assume have some level of universality.

Within the present study most of the target children spoke Danish fluently, whereas most of the parents spoke no Danish. Despite skilled translators, this did somewhat affect the parental ability to structure the session and to challenge and engage their children appropriately. In many cases, the child clearly anticipated that their help was needed and attempted to translate between parent and therapists despite the presence of the interpreter. This became particularly evident in dyads where mothers were illiterate. Here, the child was sometimes the one to read the card, and since the card was both in Danish and in the respective native language, the child often chose to read it in Danish. This clearly posed a challenge for the mothers when attempting to structure the session. This challenge is highly relevant, as it can be interpreted in two ways. First, it may be seen purely as a source of bias as it provides the parents with a less optimal test situation. However, one may also argue, that the test situation mirrors many situations in everyday life, in which traumatized refugee parents with limited Danish proficiency are dependent on their child for translation, which then challenges the parental authority. Thus, the qualitative findings regarding the distinct ways in which parents struggle to provide their children with developmentally appropriate structure, engagement, challenge and nurture within the MIM test situation may be seen as shedding light on the specific everyday difficulties faced by highly traumatized parents and how this affects dyadic functioning.

Clinical implications

The MIM as an assessment method is highly valued by the therapists within the present treatment program, as the video material allows therapists to show the mothers what they mean, when they point to behavioral or emotional difficulties. The MIM also allows therapists to illustrate the things, which work well within the dyads, and thus The MIM offers a clinically useful way of assessing sources of both vulnerability and strength. However, the MIMRS needs to be validated within the present population in future studies. Findings from the present study regarding the specific ways in which traumatized mothers affected by family violence struggle to provide their children with adequate structure, challenge, engagement and nurture may guide future interventions aimed at improving dyadic interaction within this population.

Conclusion

The present study was exploratory in nature. Findings suggest that in traumatized refugee families affected by family violence dyadic functioning may be compromised, and that there are negative associations between maternal symptoms of PTSD, Anxiety and Depression and children's psychosocial adjustment. The qualitative findings regarding the specific ways in which traumatized refugee mothers struggle to provide their children with adequate: Structuring, Challenging, Engagement and Nurturing have important clinical implications and shed light on the potential utility of using the The MIM/The MIM Rating-Scale as a clinical assessment tool. This is further supported by the finding of an association between

dyadic functioning as measured by the MIMRS and children's subjective well-being as measured by the KIDSCREEN10S.

Limitations

The limited sample size, the diversity of cultural and ethnic backgrounds and the vast age differences of the target children within the present sample all pose serious threats to the generalizability of the present findings, and thus results from the present study should be viewed as tentative and aimed at guiding future research and interventions. The present sample is a convenience sample and the design of the study is based on the available measures, which form the basis of the clinical assessment of the families within the treatment center. The therapists chose the target child, based on an assessment of need, meaning, that they typically choose one of the children, who appeared to be affected by the turmoil within family. This constitutes a potential source of bias, and results should be interpreted accordingly. The lack of an assessment of attachment in parents and children and the fact that both the self-report version and the parental rating version of the SDQ were used as a single measure of children's psychosocial adjustment both constitute serious flaws in the design of the study and therefore results must be interpreted with caution.

Disclosure statement

No potential conflict of interest was reported by the authors.

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