2024

Intimate Partner Violence and Parent Perceptions of Their Emotional Bond to Their Children

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Intimate Partner Violence and Parent Perceptions of Their Emotional Bond to Their Children

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Presented to the Faculty of the

Graduate School of Clinical Psychology

George Fox University

In partial fulfillment

of the requirements for the degree of

Doctor of Psychology

in Clinical Psychology

Newberg, Oregon

Approval Page

Intimate Partner Violence and Parent Perceptions of Their Emotional Bond to Their Children

by

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has been approved

at the

Graduate School of Clinical Psychology

George Fox University

as a Dissertation for the Doctor of Psychology Degree

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April 24, 2024

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Abstract

As research on intimate partner violence (IPV) continues to grow and there are more ways of defining IPV and identifying its differing forms, a related topic of interest has become the impact IPV has on families (Fong et al., 2019). Similarly, research on IPV as a form of trauma and its implications is well-researched for both children and adults, as is the research on trauma and attachment (Cook et al., 2017). However, there seems to be a lack of research on how parent–child attachment is predicted by IPV. The present study aimed to assess how parent perceptions of their level of attachment is predicted by instances of IPV, using the Harm, Insult, Threaten, and Scream (HITS) domestic violence screening tool (Sherin, 2003) and the Revised Inventory of Parent Attachment (R-IPA; Johnson et al., 2003). The results of this study found a negative relationship between the parent age, and child age and the Communication scale on the R-IPA; child age was the most significant predictor of communication ($\beta = -0.54$, $p < .010$). Additionally, the results also show a positive relationship between the Communication Scale on the R-IPA and frequency of IPV ($\beta = 0.52$, $p < .010$). Finally, results show no significant relationship between the Trust/Avoidance Scale on the R-IPA and parent age, child age, or frequency of IPV. These results suggest that the Communication scale is a strong predictor of parents' perceptions of their attachment to their children. Therefore, treatment implications may be interventions that focus on building communication between parent and child, as a way to help increase connectedness and perceptions of attachment.

Keywords: IPV, attachment, children, domestic violence, parent–child attachment

Intimate Partner Violence and Parent Perceptions of Their Emotional Bond to Their Children

Chapter 1

As intimate partner violence (IPV) continues to be a public health concern in the United States, the research on the impacts of IPV continues to grow (Borrego et al., 2008; Juan et al., 2020; Rizo et al., 2011). Research on IPV is expanding based on identification of different types of IPV, ways of studying it, and how to intervene and prevent future instances of IPV (Ahlfs-Dunn & Huth-Bocks, 2016). A related topic of interest among scholars has been how IPV impacts families, the predictability of child behavioral outcomes (Fong et al., 2019) and parent–child relationships (Slade et al., 1999; Visser et al., 2016). However, among the research discussing parent–child relationships for families exposed to IPV, there seems to be a lack of research regarding how parent–child attachment is associated with IPV exposure.

Intimate Partner Violence

Forms and Rates of IPV

IPV is defined as "physical harm, sexual violence, psychological aggression, and/or control tactics from a current or former partner" (Fogarty et al., 2019, p. 2). There are multiple forms of IPV and as the recognition of IPV has become increasingly prevalent, additional categories and definitions emerge (Ahlfs-Dunn & Huth-Bocks, 2016). The most commonly identified categories of IPV are psychological or emotional violence, physical violence, and/or sexual violence (Ahlfs-Dunn & Huth-Bocks, 2016; Hammet et al., 2020). These broad categories of IPV provide general guidelines for identifying and defining types of IPV; however, research has suggested that each broad category has multiple additional identified forms of IPV within

them. For example, psychological violence could be insults or criticisms; however, it also includes disrespect, isolation, and/or breaking trust (Dodd, 2009). Although these broad categories of IPV exist, the modes of violence identified within each one tend to overlap between categories.

In general, it is estimated that one in every three to four women (Borrego et al., 2008; Fogarty et al., 2019) and one in six men (Dodd, 2009) will experience IPV in their lifetime. Although IPV has not been reported to vary across race, gender, social class, age, sexual orientation, disability, or lifestyle, the largest proportion of more severe and chronic violence is perpetrated by men against women (Dodd, 2009). Physical and sexual IPV is reported to have a lifetime prevalence of approximately 28%–33%, compared to the 48% reported for psychological IPV (Hammet et al., 2020). One might expect these rates to be reversed because physical IPV is discussed more readily than psychological IPV, however, psychological IPV tends to go unnoticed by people outside of the relationship because it does not result in physical evidence that another person could see after incidents occur.

Interestingly, research has suggested that psychological violence is a necessary part of IPV that almost always acts as a precursor to physical and/or sexual violence among partners (Hammet et al., 2020). In other words, psychological violence is often the first form of violence among partners, and is the most common form of IPV, regardless of whether it escalates to physical or sexual assaults. According to Hammet and colleagues, psychological IPV has a lifetime prevalence of almost 50% and is often not perceived as aggression by others because it is naturally covert and manipulative. Thus, the secretive nature of psychological IPV could play a role in its higher prevalence rates and the fact that it is often a precursor to physical and sexual abuse.

Impacts of IPV on Children

According to the Resource Center on Domestic Violence: Child Protection and Custody (RCDV:CPC; 2020), it is estimated that domestic violence occurs in approximately 30%–60% of families. Pregnancy is a particularly vulnerable time for many women, regardless of their relationship status, and research has previously suggested that 30% of all incidences of IPV begin during pregnancy (Mezey & Bewley, 1997). Additionally, it is suggested that one in four children are exposed to IPV in their lifetime (Fogarty et al., 2019). Children have previously been considered "silent victims" because they were often considered to be witnesses to IPV, rather than victims of direct abuse (Rizo et al., 2011). However, more recent research has suggested that children are often more directly involved in IPV. For example, a more recently identified form of IPV, that falls under the categories of psychological violence, is when the perpetrator uses the victim's child or children to force the victim to comply with their demands (Ahlfs-Dunn & Huth-Bocks, 2016).

This type of psychological violence could be carried out as verbal threats against the child, or it could escalate to physically harming the child until the victim—usually the child's mother—complies with the perpetrator's demands. In addition to using the parent's children as a coercive mechanism, children are often direct victims of psychological/emotional, physical, and/or sexual violence when IPV is present in the household. In the early 2000s, it was reported that in more than 50% of cases of adult violence, violence toward children was also involved (Dodd, 2009). However, recent rates of IPV that result in violence against children tend to be less readily available because more recent research on IPV and children focuses on future child outcomes, rather than on the instances of IPV themselves.

After being exposed to or experiencing IPV, children can develop many psychological, physiological, and behavioral problems (Borrego et al., 2008; Fong et al., 2019; Green et al., 2018; Juan et al., 2020; Rizo et al., 2011), such as higher rates of anxiety, depression, aggression, and delinquency (RCDV:CPC, 2020). Although IPV can result in a multitude of negative child outcomes, research has suggested that there are also protective factors that can help children build resilience against any adverse childhood experience (Rizo et al., 2011).

In fact, research has suggested that approximately 40% of children who have been exposed to IPV do not develop psychological or behavioral problems in the future (RCDV:CPC, 2020; Rizo et al., 2011). For example, relationships have been suggested as protective factors, such as strong connections with adults outside the family, or social or peer relationships, have been suggested as protective factors. In comparison, there have also been suggested internal protective factors such as personality, social skills, and coping mechanisms (RCDV:CPC, 2020). One of the most important factors suggested as a protective mechanism against child maltreatment is a secure parent–child attachment relationship.

Parent–Child Attachment

Attachment Styles

There are four major types of early child-caregiver/parent attachment styles and each one is linked to different child outcomes. Three of these attachment styles can be broadly categorized as insecure attachment: anxious, avoidant, and disorganized (Morton & Browne, 1998; Ross et al., 2016). These attachment styles are generally associated with negative child outcomes, and each is associated with specific parenting techniques. Parents of anxiously attached children tend to be overprotective resulting in the child being too attached; parents of avoidantly attached children are often withdrawn or uninvolved in their child's life but meet the child's basic needs;

and parents of disorganized attached children are either afraid of their child or are frightening to their child and the child responds unpredictably to the parent and other caregivers (Firestone, 2015). These forms of attachment can manifest in different ways, but all result in negative child outcomes and a poor parent–child relationship.

The fourth attachment style is known as the secure attachment and is often considered the ideal form of parent–child attachment (Boldt et al., 2020; Ebbeck et al., 2015; McIntosh et al., 2019; Morton & Browne, 1998; Ross et al., 2016; Sternberg et al., 2005). Parents of securely attached children are compassionate, attentive to their child's needs, and aid children in learning compassion and emotion regulation (Firestone, 2015). Based on the descriptions of the different parenting styles and child outcomes associated with each attachment style, it is clear how secure attachment would be the most ideal and beneficial to the child.

Importance of Secure Attachment

The parent–child relationship is often considered the most important relationship the child will have, which is why maltreated children and children in the foster care system are considered to be at high risk of poor outcomes (Ridings et al., 2017). People often expect children who do not have a supportive or secure attachment to their parent(s) or caregiver(s) to be at risk for future behavioral, psychological, and physiological problems because of the stressed importance of parent–child attachment. However, research has shown that the child only needs to develop a secure attachment with at least one prominent adult figure in their life (Mash & Wolfe, 2016) to gain many of the benefits of a secure attachment. This prominent adult figure could be a teacher, a childcare provider, a sports team coach, another family member, or others; the important aspect is the relationship, not who the relationship is with.

Research also suggests there is a critical period in which secure attachment must be developed to maximize the chances of children developing resiliency to help cope with adverse experiences (Morton & Browne, 1998). Furthermore, according to a review of literature conducted by Morton and Browne, attachment begins forming around the first 6 months of a child's life and should be developed no later than within the 1st year of life to maximize benefits. That being said, it is not impossible for a child to develop a secure attachment after the 1st year of life. In fact, research has suggested that the critical period should be expanded to ages 1 to 5 years old because once the child begins school, they have more regular interactions with multiple adults that they can build a secure attachment with (McIntosh et al., 2019). In spite of this suggestion, it is hard to say whether a child will or will not build a secure attachment after the 1-year critical period.

This secure attachment relationship is important because research has suggested that it helps build resiliency against adverse childhood experiences (Boldt et al., 2020; Ebbeck et al., 2015; Fong et al., 2019). In other words, secure attachment is thought to help children build a tolerance that aids them in overcoming adverse experiences that could potentially lead to negative future child outcomes. These adverse childhood experiences could be anything from bullying to abuse and maltreatment. Since mere exposure to IPV or other forms of violence is enough to alter a child's normal development (Ahlfs-Dunn & Huth-Bocks, 2016; Green et al., 2018; Mash & Wolfe, 2016), research on attachment and resilience has become increasingly important. Although a secure attachment is beneficial for all children, it is suggested to be extremely important for children who have been exposed to or have experienced IPV or other traumas in their lives.

Trauma, IPV, and Parent–Child Attachment

Trauma and Parent–Child Attachment

One of the most prominent forms of childhood trauma is maltreatment and/or abuse (Cook et al., 2017). Research has shown that childhood trauma can affect the parent–child relationship, especially when the trauma is caused by the parent. Furthermore, it is suggested that 80% of children who experience maltreatment develop insecure attachment types (Cook et al., 2017). Additionally, exposure to maltreatment during the critical attachment-building period has been shown to significantly impair the child's development and learning (Green et al., 2018). In their Australian study of maltreatment and developmental vulnerabilities in children age 5 years or younger, Green and colleagues found exposure to maltreatment increased the child's likelihood of having difficulties with physical health and well-being; social competence; emotional maturity; language and cognitive development; and communication. Furthermore, the results of their study highlighted that the number of forms of maltreatment the child was exposed to was a predictor of the severity of poor physical, social, emotional, and language and communication development (Green et al., 2018).

Given the importance of a secure attachment and the critical period for developing attachment, it is understandable how childhood trauma during this period can be extremely detrimental to overall child outcomes and development. However, one area of childhood trauma that is less researched in relation to attachment is childhood exposure to IPV and how it is associated with parent–child attachment styles.

IPV and Parent–Child Attachment

There is little research on the relationship between parent–child attachment and IPV; most of the research on the parent, usually the mother, and the child after exposure to IPV

focuses on therapeutic interventions, often with a child focus (Borrego et al., 2008; Dodd, 2009); the child's perception of their parent(s) (Sternberg et al., 2005); or on the mothers' parenting styles or techniques (Ahlfs-Dunn & Huth-Bocks, 2016; Fogarty et al., 2019). Although these areas of research are important, the relationship between IPV exposure and parent–child attachment is an area that is lacking. As mentioned previously, the focus tends to be on attachment and general maltreatment, or on IPV and future outcomes, rather than on IPV and attachment specifically.

One study conducted by Juan and colleagues (2020) suggested that a secure attachment style is beneficial in general, but has not been shown to be a protective factor against future problem behaviors for children who have experienced IPV. The focus of their study was on exposure to IPV as being a predictor of child aggressive behaviors, showing that a child who is displaying aggression by age 5 years is a strong predictor of aggression into later childhood. Juan and colleagues also noted that the development of early parent–child attachment may play a role in the development of aggression related to exposure to IPV. However, they suggested, based on their results, that IPV impacts parenting styles and behaviors, rather than the actual parent–child attachment (Juan et al., 2020).

Additionally, a meta-analysis conducted by McIntosh and colleagues (2019) highlighted that mothers who have experienced IPV view their attachment to their children as being poor. More specifically, the meta-analysis confirmed an inverse relationship between mother's experiences of IPV during the perinatal window and attachment security with that child, within the child's first 5 years of life. Interestingly, their analysis showed that the relationship between IPV and insecure child attachment is reduced throughout early development, which they suggest is due to children having more prominent adult figures in their life once they begin school

(McIntosh et al., 2019). Although these studies all suggest IPV has a negative impact on parent–child attachment, it is important to note that they both acknowledge there is a gap in the literature on this topic and propose that it should be studied further. Thus, this study aims to assess whether parents' perceived level of attachment to their child is related to their self-reports of IPV.

The Present Study

Study Rationale

As mentioned previously, there is a gap in the literature regarding how experiences of IPV might impact the parent–child relationship and attachment. Furthermore, the research that has attempted to address this relationship has yielded mixed results, suggesting the need for additional research. For example, some research suggests that, in general, a secure parent–child attachment is a protective factor against child problem behaviors and adverse experiences (Borrego et al., 2008), while other research suggests secure attachment may not provide protection for children who have experienced IPV (Juan et al., 2020). Thus, given the mixed results and overall lack of research, it is important for research regarding IPV and parent–child attachment to be continued.

Research Question and Hypotheses

This study aims to assess how the parent–child attachment relationship is associated with exposure to IPV. The overarching question being addressed is: How does exposure to IPV impact a parent's perception of their level of attachment to their child? More specifically, this study attempts to determine if the age of the parent, the age of the child, and the frequency of IPV are related to parent's perceptions of attachment to their child based on two subscales: Trust/Avoidance and Communication. First, I hypothesized that the age of the parent will impact

their level of attachment to their child. Second, that perceived level of attachment on all subscales will vary depending on the age of the child—each subscale yielding different results based on age. Finally, frequency of IPV will impact both subscales of perceived level of attachment, with more frequent experiences of IPV resulting in a weaker perception of parent–child attachment.

Chapter 2

Methods

This study is a cross-sectional research design using survey methodology to assess how the parent–child attachment relationship is associated with exposure to IPV. This study used the Harm, Insult, Threaten, Scream (HITS) domestic violence screening tool (Sherin, 2003) to assess the frequency of IPV the participant has experienced or is currently experiencing. To assess parent–child attachment, this study used the Revised Inventory of Parent Attachment (R-IPA) (Johnson et al., 2003) to assess the respondent's perceived level of attachment to their child in relation to two subscales: Trust/Avoidance, and Communication.

Sample

A power analysis conducted using the A-Priori Sample Size Calculator for Multiple Regression by Daniel Soper (Soper, 2006) yielded a minimum sample size of 45 participants, however, this study resulted in a total of 98 participants after data was cleaned. The power analysis was conducted using an anticipated modest effect size (.30); a modest effect size was chosen because there is no current research assessing the specific relationship between parent–child attachment and exposure to IPV. Additionally, the chosen desired statistical power level was .80 and the probability level was set at .05. Finally, the number of predictors was identified as three. The independent variables are based on demographic information, age of the parent and age of the oldest child, and the total score from HITS, the experience of IPV. The dependent variables are the summary scores received on each of the two subscales in the R-IPA.

Participants were recruited via crowd sourcing, using Amazon Mechanical Turk, asking them to respond to an electronic survey if they meet the study's inclusion criteria. Participants

could be male or female and at least 18 years of age. Participants needed to have experienced some level of IPV within the last 5 years and the respondent needed to be the IPV survivor, rather than the perpetrator. Additionally, all participants needed to have at least one child and they should have been the child's primary caregiver. Furthermore, the oldest child the participant was caring for at the time of completing the survey should not have been older than 5 years of age. If the participant was caring for more than one child at the time of the primary incidence of IPV, they should have responded to the R-IPA questionnaire with their oldest child in mind. Similarly, if their oldest children are twins, the participant should have responded to the R-IPA with their oldest (first born) twin in mind.

Measures

This study used an inclusionary screening form to select participants. It then combined a demographic questionnaire (see Appendix B) with two other questionnaires, one designed to assess IPV, and the other designed to assess parent–child attachment. The Domestic Violence Screening Tool (see Appendix C) was used to assess the respondent's frequency of IPV and the Parent–Child Attachment Measure (see Appendix D) was used to assess the respondent's perceived level of attachment to their child.

Inclusionary Screening Form

The Inclusionary Screening Form was the first thing the participant saw upon opening the website link to the survey. This screening form was used to determine the participant's eligibility for the study by asking four questions about the respondent and their child or children. The participant needed to respond "yes" to all four questions in the Inclusionary Screening Form to be included in the final dataset. The four questions were:

1. Are you at least 18 years of age?

2. Have you experienced intimate partner violence (IPV) within the last five years?
3. Are you currently the primary caregiver of at least one child?
4. Is the oldest child you are currently caring for five-years-old or younger?

Demographic Questionnaire

Demographic information was collected using a demographic questionnaire to gather information on the participants being assessed. This questionnaire was also used to provide insight into the current age of the parent and current age of the child the parent is referring to, as part of the final regression analysis. Additionally, questions such as race, gender, age, etc. were collected to provide a demographic profile of the sample population. The additional demographic information, aside from the ages of the parent and child, was used to conduct frequency analyses for a description of the overall sample. The questions in the demographic questionnaire ask about the following areas: (a) respondent age, (b) number of children the respondent is the primary caregiver for, (c) age of the respondent's oldest child, (d) number of years since the respondent was last involved in IPV, (e) respondent's biological sex, (f) respondent's gender identity, (g) respondent's race/ethnicity, and (h) the nature of the respondent's current partner relationship.

HITS Domestic Violence Screening Tool

The HITS domestic violence screening tool (Sherin, 2003) was used to assess frequency and types of IPV the participant is or has experienced in their lifetime. The HITS consists of four statements in which the respondent reports how often the identified IPV occurs or has occurred within their relationship. Specifically, the respondent reports how often their partner, (a) physically hurts them, (b) insults or talks down to them, (c) threatens them with harm, and (d) screams or curses at them. All measures on HITS are reported on a 5-point Likert scale from 1 (*never*) to 5 (*frequently*). The final score on the HITS will range from 4–20, therefore, a score of

greater than 10 is considered positive on HITS. In other words, the larger the final score on HITS, the more frequently instances of IPV are reported (Sherin, 2003).

HITS was originally designed to be used in a family practice setting to briefly assess IPV within a family or household. It is most commonly given to female respondents; however, studies of the efficacy of HITS when given to male respondents have shown to be equally reliable (Shakil et al., 2005). Since its creation, HITS has been used globally and in multiple languages to help assess IPV (Sherin, 2003; Billioux et al., 2017). Internal reliability for the HITS has shown to be good ($\alpha = 0.79$), using Chronbach's alpha. Furthermore, when compared with other measures of IPV, the HITS was also shown to result in strong internal validity, $r = 0.77$, $p < 0.001$ (Chen et al., 2007).

R-IPA

The R-IPA (Johnson et al., 2003) was used to assess the respondent's perceived level of attachment to their child. The R-IPA consists of 22-items and is derived from the 25-item Inventory of Parent and Peer Attachment designed by Armsden and Greenberg (1989). Each item is rated on a 5-point Likert scale and is answered based on how true the respondent feels the item is for them and their relationship with their child; 1 (*almost never* or *never true*) to 5 (*almost always* or *always true*). For example, respondents are asked to assess how true statements such as, "I get frustrated with my child," "My child expects too much of me," or "I get upset a lot more than my child knows about" are for them and their relationship with their child. Within the R-IPA, there are two subscales, Trust/Avoidance, and Communication, that each receive their own summary score to determine attachment. Trust/Avoidance consists of Items 1–4, 7–10, 12–13, 15–17, and 20–22, and Communication includes Items 5–6, 11, 14, and 18–19.

Furthermore, there are 15 statements included in the R-IPA that reflect a positive parent–child attachment relationship which should be scored as is. For example, statements such as "I trust my child" or "I feel my child is good" should be interpreted with a high score reflecting a positive relationship. In comparison, there are seven statements included in the R-IPA that reflect a negative parent–child attachment relationship and should be reverse scored. For example, statements such as "I feel angry with my child" or "I don't like when my children touch me" should be interpreted with a high score reflecting in a negative or poor relationship. The final scores will be interpreted based on the summary score, which combines both negatively- and positively-worded statements, in relation to the two subscales: Trust/Avoidance, and Communication (Johnson et al., 2003).

The R-IPA was established to create a parent-report measure for their perceived level of attachment to their child. To do this, Johnson and colleagues (2003) altered the Inventory of Parent and Peer Attachment, with permission from the authors, to reflect statements from the parent's point of view, instead of the child's point of view. Johnson and colleagues found the reliability to be strong for the R-IPA subscales: Trust/Avoidance ($\alpha = 0.91$) and Communication ($\alpha = 0.72$), using Chronbach's alpha.

Variables

One of the independent variables for this study was experiences of IPV as identified by the HITS. The other independent variables were the age of the parent and the age of the oldest child. There were two dependent variables identified using the R-IPA to determine parent's perceived level of attachment to their child: Trust/Avoidance, and Communication. All independent variables were assessed in relation to the attachment subscales identified in the R-IPA.

Study Procedures

Participants were asked to participate in an electronic survey. The first page of the survey gathered responses on an inclusionary screening form that will confirm the respondent meets all criteria to be included in the study. If the respondent answered "no" to any question on the Inclusionary Screening Form, their responses were removed. Next was an informed consent message detailing the purpose of the study, participant rights to privacy and safety, and contact information for the primary researcher. Once the survey had begun, participants could close the website browser to end the survey at any time.

Once the informed consent had been granted, the participants first answered the brief Demographic Questionnaire. Following the Demographic Questionnaire, participants were asked to respond to the HITS domestic violence screening tool. The survey ended with the R-IPA and a brief thank you message with the contact information of the primary researcher and resources to utilize in case of any distress caused by participating in this study. The entire survey took approximately 16 min on average to complete. Participants were paid $0.25 to complete the study in its entirety.

Data Cleaning and Analysis

Initially, 199 responses were collected via Amazon Mechanical Turk. Responses were filtered based on inclusionary criteria, completion time of more than 10 min, resulting in a final sample size of 98 participants. Since the study took participants an average of 16 min to complete, 68 responses were removed from the final sample because the respondent completed the study in 10 min or less. Next, another seven responses were removed because they answered "no" to one or more of the four inclusionary screening criteria questions. One response was removed because the respondent reported it had been more than 5 years since their last

experience of IPV. Finally, 25 responses were removed due to the respondent reporting their oldest child was 6 years old or older. These last two were removed because although the respondent answered “yes” to all inclusionary screening questions, the responses on the other questions contradicted that.

Demographic information was assessed to obtain general information on the sample population. Hierarchical multiple regression analyses were computed using the age of the parent in Model 1, the age of the child in Model 2, and adding frequency of IPV in Model 3 to predict reported levels of attachment based on Trust/Avoidance, and Communication. This helped determine whether the current age of the respondent and the current age of the child and the parent’s perception of their level of attachment to their child predict their self-reported perceptions of Trust/Avoidance and Communication as indices of parent–child attachment.

Chapter 3

Results

Demographic Information

Based on the demographic information collected (see Table 1), 69% of respondents were biologically male (*n* = 68) and 31% were biologically female (*n* = 30). Specifically, respondents ranged in age from 19–50 years old (*M* = 31.73; *SD* = 5.49; see Table 2). Additionally, 73% of respondents identified as cisgender male and 23% identified as cisgender female, the remaining respondents (4%) identified as either transgender or non-binary. Furthermore, 81% of respondents identified as White (*n* = 79), 1% as Hispanic/Latine (*n* = 1), 3% as African American (*n* = 3), and 15% Native American (*n* = 15). Moreover, 66% of the respondents reported the nature of their current partnered relationship as heterosexually partnered (*n* = 65), 32% reported being homosexually partnered (*n* = 31), 1% reported not being currently partnered (*n* = 1), and 1% did not disclose (*n* = 1).

Furthermore, 76% of respondents identified as having been or being the primary caregiver for one child (*n* = 74), 16% reported two children (*n* = 16), 7% reported three children (*n* = 7), and 1% reported four children (*n* = 1). The average age of the oldest child for all respondents was 4.2 years old (*SD* = 1.07; see Table 2), 82% of respondents reported the child's biological sex was male (*n* = 80) and 18% were biologically female (*n* = 18). Moreover, 21% of respondents reported it had been 4–5 years since they last experienced IPV (*n* = 21), 5% reported it had been 3–4 years (*n* = 5), 20% reported it had been 2–3 years (*n* = 20), 37% reported it had been 1–2 years (*n* = 37), 11% reported it had been less than one year (*n* = 11), and 5% reported they are currently experiencing IPV (*n* = 5).

Descriptive Scale Results

Finally, the average total score on the HITS domestic violence screening tool (see Table 3) was 14.51 (*SD* = 2.46; Range = 9–20). On the R-IPA (see Table 4), the average score on the Trust/Avoidance scale was 49.9 (*SD* = 4.2) and on the Communication scale it was 22.4 (*SD* = 4.03).

Trust/Avoidance Regression Analysis

The effects of the parent age, the child's age, and the frequency of IPV on parent perceptions of their attachment to their child based on the Trust/Avoidance scale of the R-IPA were examined (see Table 5). In Model 1 ($R^2 = .00$, $p > .050$), age of the parent did not significantly impact parent perceptions of their attachment to their children ($\beta = -0.02$, $p > .050$). In Model 2 ($R^2 = .01$, $\Delta R^2 = .01$, $p > .050$), age of the oldest child was added and did not significantly predict the parent's perception of their attachment to their child ($\beta = 0.08$, $p > .050$). Finally, in Model 3 ($R^2 = .01$, $\Delta R^2 = .01$, $p > .050$), total score on the HITS domestic violence screening tool was added and did not significantly predict parent perceptions of attachment to their children ($\beta = -0.10$, $p > .050$). Therefore, regarding Trust/Avoidance, there were no significant results, regardless of age of the respondent, age of the oldest child, or total score on the HITS.

Communication Regression Analysis

The effects of the parent age, the child's age, and the frequency of IPV on parent perceptions of their attachment to their child based on the Communication scale of the R-IPA were examined (see Table 6). In Model 1 ($R^2 = .12$, $p < .010$), there was a negative relationship between age of the respondent and communication ($\beta = -0.35$, $p < .010$); as age increased, communication decreased with a small effect. However, in Model 2 ($R^2 = .35$, $\Delta R^2 = .23$, $p <$

.010), when adding the age of the oldest child, results showed that the age of the child is more important than the age of the respondent; the age of the parent became trivial, 95% CI [-.027, .010], but the age of the child incrementally and more strongly predicted communication, $\beta = -0.54$, $p < .010$; 95% CI [-0.73, -0.35], with a medium effect. That is, as the age of the child increases, communication decreases. Finally, in Model 3 ($R^2 = .58$, $\Delta R^2 = .23$, $p < .010$), when adding the total score on the HITS Screening Tool, results showed that age of the child remains an important predictor of relationship though effect was small for this model, and that there is a positive relationship between HITS and communication, $\beta = 0.52$, $p < .010$; 95% CI [0.38, 0.66] with a medium effect. Thus, in general, as total score on the HITS increases, so does communication.

Summary

Overall, the population of this study is mostly White, male-identifying respondents, with one male child, who have experienced a high prevalence of IPV. When using age of respondent in Model 1, age of child in Model 2, and rates of IPV in Model 3, results were varied between the two scales on the R-IPA, Trust/Avoidance and Communication. In general, Trust/Avoidance showed no relationship with the parent's perceived attachment to their child, while Communication resulted in significant findings. That is, the Communications scale yielded significant results across all three predictor variables, with negative relationships between communication and parent age and child age, and a positive relationship between communication and total score on the HITS. Specifically, the age of the child was determined to be a significant predictor of rates of Communication with a small to medium effect size; as the child age increases, Communication decreases. After accounting for parental and child ages, HITS added significant incremental variance with a medium effect size, indicating that interpersonal violence

was an important factor in the frequency of parent–child communication independent of the child's age.

Chapter 4

Discussion

The results of this study suggest that a parents' levels of trust and avoidance are not predicted by parent age, child age, or frequency of IPV, which is somewhat expected given the age of the child and the items asked in the R-IPA. That is, the items on the R-IPA that fall within the Trust/Avoidance scale are dependent on the child having higher social emotional awareness and understanding than what is expected of a typical child 5-years-old or younger. For example, items such as, "My child respects my feelings" or "My child trusts my judgement" are not easily answered or determined when a child is this young, especially given the average age of the child in this study is just over 4-years-old.

Results of this study did not yield significant results regarding predictability of the Trust/Avoidance scale on the R-IPA using parent age, child age, and/or frequency of IPV. Contrastingly, the study yielded significant results regarding predictability of Communication based on child age and frequency of IPV. Specifically, the child's age appeared to be the most important predicting factor of changes on the Communication; as the child gets older, Communication decreases. These findings are likely due to safety and the child's language abilities, that is, younger children are more dependent on their parent and the parent is more responsible for communication as the child has fewer methods of communication.

The results from this sample suggest that of the two scales on the R-IPA, communication is the most important factor regarding attachment between parent and child in families who have experienced IPV. The implications of these findings regarding protecting this vulnerable population and providing interventions that can help increase parents' perceptions of their

attachment to their children to help build resiliency and connectedness for the child. For example, focusing interventions on increasing communication between parent and child may be more valuable than trying to build trust when attempting to build resilience and increase attachment.

Limitations and Suggestions for Future Study

Although this study yielded significant results, it is important to note that the accuracy of the representation of the general population is questionable given the method of retrieval. The results of the demographic information in this study are not representative of the general population and do not align with the expected demographics of the population of parents who are the survivors of IPV. Notably, 69% of respondents being biologically male does not accurately reflect current research on who is more likely to report being the survivor of IPV (Borrego et al., 2008; Dodd, 2009; Fogarty et al., 2019). Similarly, regarding population, the study is mostly White individuals who have male children, which is not a representative sample population. Thus, the results of this study should be interpreted with caution, at face value, and not generalized to the greater population, though they may apply well to White males with male children of a similar age.

As mentioned above, one of the most significant limitations of this study is the method of recruitment for participants, as it is not representative of the general population or the population of individuals who are the survivors and reporters of intimate partner violence. Thus, this research should be replicated using more intentional recruitment, such as recruiting at hospitals, domestic violence survival shelters, the Department of Social and Health Services offices, etc. However, it is imperative to maintain anonymity in responses to increase the likelihood of gaining participants who are responding honestly without fear of being reported or identified.

Another limitation of this study is the use of the R-IPA to measure attachment, as not all the items are age-appropriate for children 5 years old or younger. Many items require a higher level of social, emotional, and cognitive abilities than that of a typical child 5 years old or younger for accurate responding on behalf of the parent. Thus, making questions more difficult to answer and less relevant to the target population of this study. However, the R-IPA was selected because it is currently the only measure of attachment based on the parents' perceptions of their emotional bond to their child, whereas other parent–child attachment measures focus on the child's perception of their emotional bond to their parent. Therefore, a measure designed to assess parents' perceptions of their attachment to their child/children that is age appropriate for young children needs to be developed to increase the accuracy of measuring parent–child attachment among this population.

Summary

In this sample comprised of predominantly male parents and male children, the results highlighted parents' perceptions of their attachment to their children based on Communication and Trust/Avoidance when accounting for parent age, child age, and frequency of IPV based on total score on the HITS. Specifically, the study showed that none of these factors are predictors of attachment based on Trust/Avoidance. In contrast, the rates of Communication were predictable based on all three variables, interpersonal violence was a strong predictor of communication especially for younger children; younger parents tended to engage in more communication as well. These results suggest that Communication is an important factor in parents' perceptions of their level of attachment to their young children and provides insight into possible treatment implications to help build resiliency in this protected population.

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Tables

Table 1

Respondent and Child Demographic Information

Characteristic	*N*	%
Respondent biological sex		
Male	68	69
Female	30	31
Did not disclose	0	0
Respondent gender identity		
Cisgender male	72	73
Cisgender female	23	23
Transgender male	1	1
Transgender female	1	1
Nonbinary	1	1
Did not disclose	0	0
Respondent race/ethnicity		
White/Caucasian	79	81
Hispanic/Latine	1	1
African American	3	3
Native American	15	15
Asian	0	0
Pacific Islander	0	0
Other	0	0
Nature of current relationship		
Heterosexually partnered	65	66
Homosexually partnered	31	32
Not currently partnered	1	0.01
Did not disclose	1	0.01
Years since IPV		

Characteristic	*N*	%
Currently experiencing	5	5
Less than 1 year	11	11
1–2 years	37	37
2–3 years	20	20
3–4 years	5	5
4–5 years	21	21
Oldest child biological sex		
Male	80	82
Female	18	18
Did not disclose	0	0
Number of children		
One	74	76
Two	16	16
Three	7	7
Four	1	1
Five	0	0
Six	0	0
Seven	0	0
Eight	0	0
Nine	0	0
Ten	0	0
More than 10	0	0

Table 2

Respondent and Child Ages

Individual	*M*	*SD*
Respondent age	31.73	5.49
Oldest child age	4.2	1.07

Table 3

Harm, Insult, Threaten, and Scream (HITS) Domestic Violence Screening Tool Results

IPV	*n*	*M*	*SD*	*Mdn*	Trimmed	Mad	Min	Max	Range	Skew	Kurtosis	*SE*
HITS	98	14.51	2.46	15	14.44	2.97	9	20	11	0.02	-0.85	0.25

Note. IPV = intimate partner violence.

Table 4

Revised Inventory of Parent Attachment (R-IPA) Results

Scale	*n*	*M*	*SD*	*Mdn*	Trimmed	Mad	Min	Max	Range	Skew	Kurtosis	*SE*
Trust/avoidance	98	49.9	4.2	49.5	49.5	2.22	42	76	34	2.98	15.19	0.42
Communication	98	22.4	4.03	22.5	22.31	5.19	15	30	15	0.11	-1.25	0.41

Table 5

Predicting Parent Perceptions of Their Attachment to Their Children Using Trust/Avoidance as Criterion Through Hierarchical Regression of Parent Age, Child Age, and Total Score on the HITS Domestic Violence Screening Tool

Predictor	*b*	*b* 95% CI [LL, UL]	β	β 95% CI [LL, UL]	sr^2	sr^2 95% CI [LL, UL]	*r*	Fit	Difference
(Intercept)	50.41**	[45.43, 55.40]							
Age	-0.02	[-0.17, 0.14]	-0.02	[-0.22, 0.18]	.00	[.00, .04]	-.02		
								R^2 = .000	
								95% CI [.00, .04]	
(Intercept)	50.02**	[44.90, 55.14]							
Age	-0.05	[-0.22, 0.13]	-0.06	[-0.29, 0.17]	.00	[-.02, .02]	-.02		
Oldest child age	0.32	[-0.59, 1.22]	0.08	[-0.15, 0.31]	.01	[-.02, .03]	.05		
								R^2 = .006	ΔR^2 = .005
								95% CI [.00, .05]	95% CI [-.02, .03]
(Intercept)	53.04**	[44.43, 61.64]							
Age	-0.05	[-0.23, 0.13]	-0.07	[-0.30, 0.17]	.00	[-.02, .03]	-.02		
Oldest child age	0.20	[-0.75, 1.14]	0.05	[-0.19, 0.29]	.00	[-.01, .02]	.05		
HITS	-0.16	[-0.53, 0.21]	-0.10	[-0.31, 0.12]	.01	[-.03, .04]	-.10		
								R^2 = .013	ΔR^2 = .008
								95% CI [.00, .06]	95% CI [-.03, .04]

Note. A significant *b*-weight indicates the beta-weight and semi-partial correlation are also significant. *b* represents unstandardized regression weights. beta indicates the standardized regression weights. sr^2 represents the semi-partial correlation squared. *r* represents the zero-order correlation. LL and UL indicate the lower and upper limits of a confidence interval, respectively.

*indicates $p < .050$.

**indicates $p < .010$.

Table 6

Predicting Parent Perceptions of Their Attachment to Their Children Using Communications as Criterion Through Hierarchical Regression of Parent Age, Child Age, and Total Score on the HITS Domestic Violence Screening Tool

Predictor	*b*	*b* 95% CI [LL, UL]	β	β 95% CI [LL, UL]	sr^2	sr^2 95% CI [LL, UL]	*r*	Fit	Difference
(Intercept)	30.44**	[25.94, 34.93]							
Age	-0.25**	[-0.39, -0.11]	-0.35	[-0.54, -0.16]	.12	[.02, .24]	-.35**		
								R^2 = .119**	
								95% CI [.02, .24]	
(Intercept)	32.94**	[28.95, 36.93]							
Age	-0.06	[-0.20, 0.08]	-0.09	[-0.27, 0.10]	.01	[-.02, .03]	-.35**		
Oldest Child Age	-2.04**	[-2.74, -1.33]	-0.54	[-0.73, -0.35]	.23	[.09, .36]	-.58**		
								R^2 = .345**	ΔR^2 = .226**
								95% CI [.19, .46]	95% CI [.09, .36]
(Intercept)	17.14**	[11.74, 22.54]							
Age	-0.04	[-0.15, 0.07]	-0.05	[-0.20, 0.10]	.00	[-.01, .01]	-.35**		
Oldest Child Age	-1.39**	[-1.99, -0.80]	-0.37	[-0.53, -0.21]	.10	[.02, .18]	-.58**		
HITS	0.85**	[0.62, 1.08]	0.52	[0.38, 0.66]	.23	[.11, .36]	.66**		
								R^2 = .580**	ΔR^2 = .234**
								95% CI [.44, .66]	95% CI [.11, .36]

Note. A significant *b*-weight indicates the beta-weight and semi-partial correlation are also significant. *b* represents unstandardized regression weights. beta indicates the standardized regression weights. sr^2 represents the semi-partial correlation squared. *r* represents the zero-order correlation. LL and UL indicate the lower and upper limits of a confidence interval, respectively.

* indicates $p < .050$.

** indicates $p < .010$.

Appendices

Appendix A: Inclusionary Screening Form

1. Are you at least 18 years of age?

   Yes

   No

2. Have you been the target of intimate partner violence (IPV) within the last five years?

   Yes

   No

3. Are you currently the primary caregiver of at least one child?

   Yes

   No

4. Is the oldest child you are currently caring for five-years-old or younger?

   Yes

   No

Note: If the answer to any of these questions is “No” the participant is not eligible for the study and will not be presented with informed consent

Appendix B: Demographic Questionnaire

1. How old are you?
2. How many children do you have/are you currently the primary caregiver for?

    1 Child

    2 Children

    3 Children

    4 Children

    5 Children

    6 Children

    7 Children

    8 Children

    9 Children

    10 or More Children
3. How old is your oldest child?
4. What is the biological sex of your oldest child?

    Male

    Female

    Prefer not to disclose
5. How many years has it been since you were last involved in intimate partner violence (IPV)?

    I am currently experiencing IPV

    Less than 1 year

    1-2 years

2-3 years

3-4 years

4-5 years

More than 5 years

6. What is your biological sex?

Male

Female

Prefer not to disclose

7. What is your gender identity?

Cisgender Male

Cisgender Female

Transgender Male

Transgender Female

Nonbinary

Prefer not to disclose

8. What is your race/ethnicity?

Caucasian

Hispanic/Latine

African American

Native American

Asian

Pacific Islander

Other (Please specify)

9. What is the nature of your current partner relationship?

    Heterosexually partnered

    Homosexually partnered

    Not currently partnered

    Prefer not to disclose

Appendix C: Harm, Insult, Threaten, Scream (HITS) Domestic Violence Screening Tool

HITS Tool for Intimate Partner Violence Screening: Please read each of the following activities and circle the number that best indicates the frequency with which your partner acts in the way depicted.

How often does your partner?	Never	Rarely	Sometimes	Fairly Often	Frequently
1. Physically hurt you	1	2	3	4	5
2. Insult or talk down to you	1	2	3	4	5
3. Threaten you with harm	1	2	3	4	5
4. Scream or curse at you	1	2	3	4	5

Each item is scored from 1-5. Thus, scores for this inventory range from 4-20. A score of greater than 10 is considered positive

Appendix D: Revised Inventory of Parent Attachment (R-IPA)

Revised Inventory of Parent Attachment (R-IPA): Please read each statement and circle the ONE number that tells how true the statement is for you.

Note: If you have more than one child, please answer all statements with your oldest child in mind. Similarly, if your oldest children are twins, please respond to all statements with the oldest (first born) twin in mind.

Item	Almost Never or Never True	Not Very Often True	Sometimes True	Often True	Almost Always or Always True
1. My child respects my feelings	1	2	3	4	5
2. I feel my child is good	1	2	3	4	5
3. I wish I had a different child	1	2	3	4	5
4. My child accepts me as I am	1	2	3	4	5
5. I like to get my child's point of view on things I am concerned about	1	2	3	4	5
6. My child can tell when I'm upset about something	1	2	3	4	5
7. My child expects too much of me*	1	2	3	4	5
8. I get upset easily around my child*	1	2	3	4	5
9. When we discuss things my child cares about my point of view	1	2	3	4	5
10. My child trusts my judgement	1	2	3	4	5
11. I tell my child about my problems	1	2	3	4	5
12. I feel angry with my child*	1	2	3	4	5
13. I don't get much attention or credit from my child*	1	2	3	4	5

14.	I talk to my child about my difficulties	1	2	3	4	5
15.	My child understands me	1	2	3	4	5
16.	When I am angry about something my child often understands	1	2	3	4	5
17.	I trust my child	1	2	3	4	5
18.	I can count on my child when I need to get something off my chest	1	2	3	4	5
19.	If my child knows something is bothering me, she/he asks me about it	1	2	3	4	5
20.	I get frustrated with my child*	1	2	3	4	5
21.	I don't like being around my child*	1	2	3	4	5
22.	I am constantly yelling and fighting with my child*	1	2	3	4	5

Scores are calculated by summing the responses for each subscale:

Trust/Avoidance: Items 1-4, 7-10, 12, 13, 15-17, 20-22

Communication: Items 5-6, 11, 14, 18-19

Asterisk (*) indicates an item that needs to be reverse coded