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Resolutions of Control Episodes Between Well and Affectively Ill Mothers and Their Young Children

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Control interactions between 87 well and affectively ill mothers and their 15- to 51-month-old children were studied. Spontaneously occurring control interventions (conceptualized as episodes of interaction between mother and child) were coded from 90 minutes of videotaped interactions in a naturalistic laboratory apartment setting. The results suggest developmental changes in mother-child interaction in the 2nd to 4th years of life: the increase of the rate of immediate maternal success ($p < .05$*) and compromise (*$p < .05$*), on the decrease in maternal use of power (ultimate sucess by enforcement,* $p < .01$*). Well mothers achieved compromise with their children, particularly daughters, more often than did affectively ill mothers (*$p < .05$*). Affectively ill mothers more often than well mothers avoided confrontation with their children (*$p < .05$*). The impairments in control interventions of affectively ill mothers were exacerbated by the severity of the disorder.*

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The socialization and management of children's behavior is stressful and difficult for most parents (Patterson, 1980). When the parent has an affective disorder—major depression or bipolar illness—disruptions in the capacity to effectively manage childrearing interactions can be expected. There is evidence from self-report data (Anthony, 1975; Davenport, Adland, Gold, & Goodwin, 1979; McLean, 1976; Weissman & Paykel, 1974) as well as observational data (Belle, 1982; Hammen, 1985) indicating that depressed parents show a pattern of decreased effectiveness and involvement in childrearing, and increased friction and resentment toward their children. Patterns of overprotection and compulsive overinvolvement have also been reported.

Despite evidence of general impairments in the functioning of depressed parents, little is known about the impact of depression on specific childrearing processes, or about how the interactive styles of depressed parents may affect their children's development.

This study examined the impact of affective illness on mothers' management of frequently occurring interactions resulting from their interventions to influence or control their young children's behavior. Following a developmental psychopathology perspective (Rutter & Garmezy, 1983), we focused on interactive processes that not only might be sensitive to maternal psychopathology but also would be interpretable from the perspective of normative developmental processes in child development and in parent–child relationships occurring in the 2nd and 3rd years of life.

Two developmental themes organize recent research on socialization interactions during early childhood—the growth of parental control and the growth of children's autonomy. During this period parents begin to hold children responsible for their actions and dramatically increase their socialization demands (Dubin & Dubin, 1965; Hoffman, 1975; Maccoby & Martin, 1983). There are also two conflicting developments in children's responses to parental directives. There is an increase with age in children's capacity for self-regulation and in their ability to comply with the demands of caregivers (Kopp, 1982; Vaughn, Kopp, & Krakow, 1984). Paradoxically, there is also an age-related increase in overt resistance to parental limit setting. This growing "negativism" has been related to the development of children's autonomy and control striving (Wenar, 1982).

From a developmental perspective, parents face a difficult balance between control and autonomy during their socialization encounters with young children. As socializing agents they must preserve their ability to effectively control their children's behavior, but they must also adopt strategies that support their children's developing autonomy.

Recent research on parental management of socialization interactions has focused almost exclusively on the issue of parental control and has adopted children's compliance to parental directives as a principal criterion

of parental effectiveness (e.g., Patterson, 1982; Forehand, 1977). The hypothesis that a certain degree of autonomy granting may also index adaptive parental functioning in control interactions is implicit in earlier research on parental correlates of children's social competence. In particular, Baumrind (1971) described an authoritative parent style that consisted of a sensitive balance between firm parental control and a willingness to engage in verbal give-and-take with children during control interactions.

The autonomy-granting aspect of parental control was recently elaborated in a study (Kuczynski, Kochanska, Radke-Yarrow, & Girnius-Brown, 1987) that examined children's attempts to negotiate parental directives as a potential context for acceptable expressions of self-assertiveness and autonomy. It was suggested that parents might encourage autonomous behavior during control interactions by occasionally acquiescing to children's expressions of resistance in appropriate situations, by accepting mutually negotiated compromise solutions, or by overcoming children's resistance through the use of persuasive strategies rather than force.

In the present study, the control interactions of depressed, bipolar, and nondepressed mothers and their children were examined in terms of both effective control and maternal acknowledgment of children's autonomy. Many of the symptoms associated with depression—withdrawal, apathy, low self-esteem, self-preoccupation irritability, feelings of exhaustion, and, in bipolar illness, mood swings (e.g., Beck, 1967)—are likely to impair the capacity of depressed mothers to effectively control children's behavior in a way that is also supportive of their autonomous functioning.

One expectation was that depressed mothers may have difficulty in engaging in relatively long and effortful interactions (Kuczynski, 1984; Zussman, 1980) involving the joint resolution of conflict through mutual persuasion and negotiation of compromises. Instead, they may be expected to choose less effortful resolutions to conflict by enforcing obedience unilaterally, or by avoiding conflict altogether by immediately withdrawing from confrontation in the face of the child's resistance.

There is evidence that conflict avoidance may be one of the processes underlying maladaptive patterns of control in general, and disturbances in the interactions of depressed mothers and their children in particular. Weissman and Paykel (1974) suggested that mothers with major depression may avoid potentially stressful interactions with children either by rigid control and regimentalization of children or by physical and emotional withdrawal from interaction. Davenport et al. (1979) reported that mothers with bipolar illness engage in defensive maneuvers in order to avoid confrontation with conflict. Bugental (Bugental, Kaswan, Love, & April, 1971; Bugental & Love, 1975) also found a subtle pattern of avoidance in the controlling statements of parents of disturbed children. Mothers of well-

functioning children typically demonstrate an elevation in vocal assertiveness when making controlling statements to children, whereas mothers of disturbed children showed a decline in assertiveness in intonation when making controlling statements.

The focus on interactive patterns such as compromise, conflict avoidance, or unilateral enforcement required the development of new observational categories that keep intact entire episodes of control interactions and preserve the goal-directed qualities of interchanges between parents and children. In much of the recent research on socialization interactions the focus has often been on microscopic interchanges between parent and child behaviors such as parental command–child compliance sequences. Although the immediate impacts of discrete parent and child behaviors can be examined, protracted interactions occasioned by a parent's intervention are often fragmented and the structure and final outcomes of entire episodes of control are ignored.

In the present study an episodic approach was developed that uses a control episode as the unit of analysis. A control episode is conceptualized here as a sequence of behaviors exchanged between mother and child during the mutual process of resolving conflicts occasioned by the mother's attempt to influence her child's behavior. Episodes vary in the number of interchanges between partners and are considered to end when the original issue or purpose of the intervention is finally resolved in some way or dropped by both partners. A new macroscopic category, the episode resolution, surpasses the level of immediate reactions and behaviors of the participants, and is employed here to describe the final outcome and interactive quality of the entire episode from the mother's point of view.

Predictions concerning the resolutions of episodes focused on developmental change and on the impact of maternal affective illness. The following developmental predictions were based on previous research on changes in children's responses to control interventions: (1) Children's increasing capacity for self-regulation and compliance (Kopp, 1982) would be reflected by increase with age in the proportion of immediate cooperation with mother interventions. (2) Children's developing autonomy, accompanied by their increasing sophistication in negotiating in response to control interventions (Kuczynski et al., 1987), would be reflected by the increase in the proportion of compromise accomplished by mother and child after a process of mutual adjustment of the directive.

Several initial predictions were made concerning the impact of affective illness on mothers' management of control interactions: (1) Normal mothers would receive a greater proportion of immediate cooperation from their children than affectively ill mothers. (2) In the face of child resistance, affectively ill mothers would engage in fewer effortful interactions involv-

ing patient persuasion and negotiation. (3) Instead, they would be more likely to resolve conflict unilaterally (ultimate success by enforcement), or (4) they would prefer nonconfrontational, conflict-avoidant resolutions. (5) These impairments would be exacerbated by the severity of the affective disorder (impairment of functioning during the most severe lifetime episode).

The major focus of the analyses was on differences between normal and the combined groups of affectively ill mothers; however, the effects of severity of disorder were investigated separately for the unipolar and bipolar depressed groups.

METHOD

Subjects

Eighty-seven mothers and their young children (15 to 51 months, $\bar{X}$ = 31 months) were studied. The families were predominantly middle-class (Hollingshead $\bar{X}$ = 50) and were volunteers in a larger study of childrearing in families with and without parental depression.[4] Mothers were screened with the use of the Schedule for Affective Disorders and Schizophrenia (SADS-L), scored according to Research Diagnostic Criteria (Spitzer & Endicott, 1977). It was administered by a psychiatric nurse practitioner. The reliability of the diagnostic procedures, established by obtaining independent diagnoses of a sample of 10 interview by the staff of New York Psychiatric Institute, was 100%. Mothers without a history of any psychiatric disorder and those with a diagnosis of an affective disorder during the child's lifetime were accepted; mothers with other psychiatric diagnoses at the time of screening were excluded. Thirty-three mothers without history of psychiatric disorder and 54 mothers with a diagnosis of a major affective disorder (37—unipolar, 17—bipolar) were selected from the sample available at the time to participate in the current project. Mothers who received an affective diagnosis were further characterized for the severity of their illness with the use of the General Assessment Scale (GAS) (Spitzer, Gibbon, & Endicott, 1978). The GAS ratings range from 1 (requires continuous care and supervision) to 100 (superior functioning). The scale is divided into 10 diagnostic intervals (1–10, 11–20, etc.). The ratings were assigned to the mother's worst affective episode during her lifetime. The reliability of the GAS measure was established during the training phase between the main diagnostician and

[4]The present research is a part of the work *Longitudinal Study of Depressed and Normal Parents and Their Children,* NIMH Protocol 79-M-123, Marian Radke-Yarrow, principal investigator.

a psychiatric social worker regarding a sample of 10 interviews. In all the cases both clinical judgments fell within the same diagnostic interval and differed by no more than 5 points. The groups were matched by family SES and by age of children. There were 18 girls and 15 boys in the well group and 28 girls and 26 boys in the affectively ill group.

Procedures

Mother and child interacted in a homelike apartment (a suite of rooms with a kitchenette and a bathroom) in our laboratory, during two half-day sessions, which were videotaped through one-way mirrors. The apartment was furnished and equipped with basic household items, and the sessions were so structured that the natural flow of daily routines and activities was preserved, and elicited a variety of typical mother-child interactions. This study sampled 90 minutes of the interactions, covering situations varying in their psychological potential: encountering a new environment (arrival at the apartment—10 minutes); typical home meal routine, including household chores and socializing between mother and child (preparation of lunch, the meal and cleanup—25 minutes); mother's multiple involvement (telephone conversation—10 minutes); free time (20 minutes); mother's unavailability to the child (mother rest—15 minutes); opportunity for close and affectionate interaction (story time—10 minutes).

Coding of Interactions. An episodic approach was adopted in which the goal-directed and interactive nature of maternal intervention and child response were preserved. A control episode began with a mother's overt attempt to influence child behavior, either verbally or nonverbally. It could contain one or more interchanges between mother and child and ended when the initial issue of the intervention (as defined by the mother) was resolved in some way or dropped by both partners of the interaction. The coding categories included the initial goal and timing of mother intervention; physical, verbal, and affective strategies used by the mother; the child's response to the mother's control intervention; and the resolution of the episode.

The *resolution* of the episode was coded after the immediate reactions and behaviors of the participants had been described. For this judgment the observer was required to review the videotape of the entire interaction and, keeping in mind the mother's original request to the child, describe the final outcome of the entire episode from the mother's point of view. Four categories describe the episodes in which mothers confronted the child in the face of initial resistance; depending on the quality of her strategy and the child's level of interactive competence and cooperation, these episodes could be resolved by *ultimate maternal success by persuasion, ultimate success by enforcement,*

ultimate failure, and *compromise.* A separate category, *nonconfrontational resolution,* described episodes in which mothers withdrew from the interaction immediately after encountering child resistance. Two categories described episodes that did not call for confrontation, *immediate maternal success,* when the child complied to the mother's first intervention, and *unresolvable* episodes, which were so structured by the mother that no child response was logically appropriate. The categories describing episodic resolutions are presented in Table I.

Observer training in the coding system was continued until a criterion level of 80% was reached on each of the major coding categories between the principal coder, blind to the mothers' diagnosis, and one of the developers of the coding system. Subsequent reliability checks based on a sample of 16 randomly selected subjects yielded agreement levels ranging from 72% for

Table I. Resolutions of Episodes: Categories and Descriptions

Resolution	Description
Immediate maternal success	Child complies without resistance to initial maternal intervention.
Ultimate maternal success by persuasion	Child does not comply after maternal initial intervention; mother confronts child and through additional control attempts persuades/convinces child to comply.
Ultimate maternal success by enforcement	Child does not comply after maternal initial intervention; mother confronts child and unilaterally enforces compliance.
Ultimate maternal failure	Child does not comply after maternal initial intervention; mother confronts child, but her additional control attempts are unsuccessful in bringing about child compliance.
Nonconfrontation	Child does not comply after maternal initial intervention; mother does not make any additional control attempts.
Compromise	Child does not comply to maternal initial intervention. Mother confronts child and an interaction evolves, resulting in child's complying to a mutually agreed-on adjustment of maternal initial directive.
Unresolvable episode	Child is not given any opportunity to comply (mother gives too many or conflicting directions).
Disciplinary[a]	Mother intervenes after child behavior (positive or negative feedback); child compliance not applicable.

[a]This category was dropped from the analyses because of tangentiality to the main research questions of the study.

compromise and nonconfrontational resolution to 83% for unresolvable and disciplinary episodes, with an average reliability of 77% (percent aggreement). These reliabilities are within or above typically reported reliabilities for observational sequential data (Williams & Forehand, 1984).

RESULTS

Relative measures of frequencies of episodic resolutions were created to correct for the differences in number of control episodes in individual mother–child dyads. For the category of immediate maternal success, and for unresolvable episodes, number of instances was divided by the number of all control episodes. For other episodic resolutions, which assumed child responses other than immediate compliance, the number of remaining episodes was used as a denominator.

The developmental hypotheses were tested by computing correlations between the frequencies of episodic resolutions and age of child. To compare the well and affectively ill groups, multivariate analysis of variance for repeated-measures designs was used (Norûsis, 1985), followed by univariate analyses. A 2 × 2 between-subjects multivariate analysis of variance was performed on seven dependent variables (immediate success, ultimate success by persuasion, ultimate success by enforcement, ultimate failure, nonconfrontational, compromise, and unresolvable). Mother's diagnosis and child's sex were between-subjects factors. Age of child was used as a covariate. Family social economic status (SES – Hollingshead) was not significantly correlated with the frequencies of resolutions and therefore was not included in the analyses. To test the impact of the severity of maternal illness, partial correlations were computed between the frequencies of episodic resolutions and maternal GAS score, controlling for the age of child.

Characteristics of the Patterns of Interactions. Fifty-eight percent of mothers' control interventions with their young children ended in maternal immediate success – a finding consistent with published base rates on child compliance (Forehand, 1977). One percent of episodes were unresolvable from the very beginning. When the remaining episodes were considered, 46% ended in maternal ultimate success by maternal persuasion and 4% ended in unilateral maternal enforcement of child compliance (ultimate success by enforcement). In 22% of incidents the mother avoided confrontation with the child immediately by terminating her intervention when the child did not comply, and in 14% of the incidents they made additional control attempts but ultimately failed in pursuing their goal. Six percent of the incidents were resolved with a compromise between mother and child (Table II).[5]

[5]The numbers do not sum up to 100% because one category, disciplinary resolutions, was dropped from the analyses (see Table I).

Table II. Mean Frequencies of the Resolutions of Episodes

	Total sample $n = 87$		Mother diagnosis: Well $n = 33$		Mother diagnosis: Affectively ill $n = 26$	
Resolution	Girls $n = 46$	Boys $n = 41$	Girls $n = 18$	Boys $n = 15$	Girls $n = 28$	Boys $n = 26$
Immediate maternal success	.61	.55	.64	.53	.59	.56
Ultimate maternal success by persuasion	.44	.49	.43	.50	.44	.48
Ultimate maternal success by enforcement	.04	.05	.03	.06	.04	.05
Ultimate maternal failure	.15	.14	.13	.15	.16	.13
Nonconfrontation	.23	.21	.19	.19	.25	.22
Compromise	.08	.04	.12	.04	.06	.04
Unresolvable	.01	.01	.02	.01	.01	.01

[a]Controlled for the severity of disorder (GAS rating).
[b]$p < .05$.
[c]$p < .01$.

Table III. Correlations Between Frequencies of Resolutions of Episodes and Age of Child

	Age of Child		
		Mother diagnosis	
Resolution	Total sample $n = 87$	Well $n = 33$	Affectively ill[a] $n = 54$
Immediate maternal success	.20[b]	.29[b]	.18
Ultimate maternal success by persuasion	.02	−.04	.04
Ultimate maternal success by enforcement	−.27[c]	−.15	−.34[c]
Ultimate maternal failure	−.02	.01	−.03
Nonconfrontation	−.08	−.21	−.06
Compromise	.18[b]	.28	.21
Unresolvable	−.06	.23	−.21

[a]Controlled for the severity of disorder (GAS rating).
[b]$p < .05$.
[c]$p < .01$.

Developmental Changes in Patterns of Interactions. Table III presents the findings on the developmental changes in the resolutions of control episodes. The developmental changes were similar in direction for normal and affectively ill groups and reflected the increase in children's ability for self-regulation as well as the increase in child autonomy and negotiation skills between 15 and 51 months. There were significiant increases as a function of age in both frequency of immediate success ($r(87) = .20, p < .05$) and frequency of compromise between mother and child ($r(87) = .18, p < .05$). In addition, mothers gradually diminished the unilateral use of power when facing child resistance (ultimate success by enforcement ($r(87) = -.27, p < .01$).

Maternal Diagnosis and Patterns of Interactions. Multivariate analyses of variance comparing well and affectively disordered mothers[6] yielded the following effects: interaction between type of resolution and sex of child ($F(6, 78) = 4.20, p < .001$), and an interaction involving type of resolution, mother's diagnosis, and child's sex ($F(6, 78) = 2.41, p < .05$). Mean frequences of the resolution categories are presented in Table II. Subsequent univariate tests revealed that girls were more immediately compliant than boys (immediate success) ($F(1, 82) = 5.55, p < .05$), and that compromise resolutions were more frequent with girls than with boys ($F(1, 82) = 6.36, p < .05$).

The following interactions between mother's diagnosis and sex of child were found: for compromise ($F(1, 82) = 3.81, p < .05$) and a trend for immediate success ($F(1, 82) = 3.14, p < .10$). Subsequent Scheffé tests ($p < .05$) revealed that well mothers and their daughters reached compromise more often than any other group, and that well mothers received more immediate cooperation (immediate success) from girls than from boys.

Two main effects for mother's diagnosis were also found in the univariate analyses. However, in the absence of the corresponding multivariate effect they should be interpreted with caution.

Nonconfrontational resolutions were more frequent for affectively ill mothers than for well mothers ($F(1, 82) = 5.79, p < .05$). Episodes ending in compromise were more common for well mothers than for affectively ill mothers ($F(1, 82) = 5.93, p < .05$). No between-groups differences were found regarding ultimate success by persuasion.

Severity of Maternal Illness and Patterns of Interactions. Table IV presents the partial correlations (controlling for age of child) between the

[6]Exploratory comparisons of normal and uni- and bipolar depressed mothers regarding the mean frequencies of resolutions of episodes with the use of contrast tests and Duncan procedure did not indicate differences between the two clinical groups (uni- and bipolar). Therefore, the decision was made to combine both affectively ill groups and compare them against the normal group.

Table IV. Partial Correlations[a] of Frequencies of Resolutions of Episodes with Severity of Mother Affective Illness (GAS)[b]

	Severity of affective illness		
Resolution	All affective ill $n = 54$	Unipolar depressed $n = 37$	Bipolar depressed $n = 17$
Immediate maternal success	−.15	−.25	.43[c]
Ultimate maternal success by persuasion	.07	−.19	.23
Ultimate maternal success by enforcement	−.08	.23	−.43[c]
Ultimate maternal failure	.05	.10	.16
Nonconfrontation	−.21	−.03	−.45[c]
Compromise	.32[d]	.30[c]	.02
Unresolvable	−.01	.01	−.47[c]

[a]Controlling for age of child.
[b]Most severe depresive episode in mother's lifetime (GAS rating). The lower the severity rating, the more seriously ill the mother.
[c]$p < .05$.
[d]$p < .01$.

frequencies of resolutions and the severity of maternal disorder. Despite similar mean frequencies in the uni- and bipolor groups, the patterns of correlations were slightly different and therefore are presented for all affectively ill mothers, as well as separately for uni- and bipolar groups.

In the unipolar depressed group, the more seriously impaired the mother, the less likely she was to achieve a compromise resolution with her child when faced with the initial child resistance.

In the bipolar group, more seriously impaired mothers were more likely to resort both to enforcement to overcome child resistance and to nonconfrontational resolution. Finally, more seriously impaired bipolar mothers were less likely to be immediately successful in their interventions and were more likely to initiate unresolvable episodes in which no child response was logically appropriate.

DISCUSSION

The episodic approach to coding interactions used in this study made it possible to examine frequently occurring patterns of parent–child socialization interactions that have more often been the subject of clinical discussion

rather than direct measurement. Interactive concepts such as compromise, nonconfrontation, or ultimate success require judgments integrating mothers' original goals, final outcomes, and goal-directed strategies. These phenomena are difficult to reconstruct from microscopic analyses of discrete interchanges. The episodic categories were found to be sensitive both to developmental changes in mother-child interactions and to potentially dysfunctional patterns of interaction associated with maternal psychopathology.

The correlational analyses suggest several broad developmental changes in the nature of socialization interactions during early childhood that are consistent with emerging theory and research on developmental change in parent-child interactions. The finding that immediate compliance as indexed by the proportion of immediate successes in maternal control interventions increased with age of child is consistent with Kopp's (1982, 1987) suggestion that there are developmental changes in children's capacities for regulating their behavior according to external directives. Several other studies have found increases in immediate compliance with age during the preschool and early school-age years (Patterson, 1976; Simmons & Schogeen, 1963; Vaughn et al., 1984).

There is less research on the developmental underpinnings of the increases with age of compromise resolutions and concurrent decreases of unilaterally enforced successes. We speculate that these changes may reflect parental adaptations to child's increasing active resistance to parental control interventions. During the 2nd and 3rd years passive forms of noncompliance have been found to decrease, whereas attempts to negotiate parental demands have been found to increase with age (Kuczynski et al., 1987; Vaughn et al., 1984). It is not clear whether age changes in compromise and unilaterally enforced resolutions are direct reactions to children's increasingly sophisticated resistance strategies or are mediated by parental perception and acknowledgment of their children's growing autonomy.

Both immediate successes and compromise resolutions were more frequent in mother-daughter dyads than in mother-son dyads. These findings are consistent with reports that boys are less compliant and elicit more forceful strategies from parents than do girls (Milton, Kagan, & Levine, 1971; Hetherington, Cox, & Cox, 1982). Both finding were more apparent in families with well mothers than in families with effectively ill mothers.

The indication that control interactions of affectively disordered mothers and their daughters were more disrupted than those of nondepressed mothers is interesting when contrasted with research on the effects of divorce. There is evidence that boys tend to be more vulnerable to family stress (e.g., Hetherington et al., 1982; Rutter, 1970). The present findings suggest that some impairments in parent-child functioning during control interactions or in other facets of the parent-child relationship associated with maternal depression may be specific to the mother-daughter dyad.

Two overall differences in the way control interactions were managed in families with well and affectively disordered mothers were found. In situations where a mother's attempt to control her child was met with resistance, affectively disordered mothers were more likely to avoid confronting the child by immediately dropping their original demands, or, if they did persist, the interaction was less likely to be resolved by a mutually negotiated compromise.

There is little empirical research on the processes underlying conflict avoidance and compromise in parent–child interaction. However, two preliminary explanations for the differences in occurrence of these interaction patterns in dyads with depressed and nondepressed mothers can be offered.

One hypothesis is that depressed mothers may have difficulty in engaging in interactions requiring the expenditure of cognitive or emotional effort. It has been proposed (Kuczynski, 1984; Zussman, 1980) that a dimension of effortfulness may underlie different types of parent–child interaction and that the characteristics of the situation or of the parent, such as the presence of stress or depression, may disrupt the capacity to engage in effortful interactions. In this view, withdrawal from conflict at the first sign of resistance, and avoidance of relatively long and difficult negotiations that end in mutual adjustment of demands and expectations, may reflect a global unwillingness or incapacity to engage in social interactions requiring effortful solutions in conflict situations.

An alternative and possibly complementary explanation is that depressive symptoms including negative self-evaluations and decreased self-esteem, may foster a fear of confrontation and conflict. Fear of conflict has been noted not only in clinical studies (e.g., Weissman & Paykel, 1974; Davenport *et al.*, 1979) but also by behavioral researchers. Patterson (1982) suggests that parents of aggressive children react to misbehavior with anger and coercive responses but fail to confront the child and bring the control episode to a satisfactory conclusion. He speculated that "for many families the determining variable is fear. It is an avoidance of the pain that results from confrontation" (p. 225). Avoidance of interactions that are resolved by compromise may also reflect a fear of conflict because such interactions not only involve a temporary prolongation of conflict but also may elicit parental anticipations of failure and unacceptable retreat from original demands as a potential consequence of the negotiation process.

Although there were overall differences between the control interactions of mothers with and without affective illness, it is important to note that the affectively ill mothers varied in both the severity of their impairments and the type of disorder. An interesting feature of this research was the finding that, despite the lack of mean differences between the uni- and bipolar groups, the severity of mothers' disorder was associated with different patterns of interaction for the unipolar and bipolar subgroups of affective ill-

ness. Because there are few existing observational studies of bipolar mothers, the present evidence that the two groups can be distinguished on the basis of their social interactions must be considered as exploratory.

For the unipolar depressed sample, mothers with more severe impairments were less likely to achieve a resolution of compromise after children's initial resistance than mothers with less severe impairments. A more complex pattern of disordered mother–child interactions was associated with severity of bipolar illness. Mothers who were more severely impaired at the time of their most serious affective episode of depression experienced fewer immediate success when attempting to control their children's behavior. This finding may, in part, reflect less cooperation on the part of children of severely impaired mothers. Another possibility is that mothers with severe disorders may structure their initial control attempts so that compliance is less likely. Evidence for this interpretation was the finding that the incidence of unresolvable episodes increased with severity of bipolar disorder. However, because unresolvable episodes were very rare, this finding must be interpreted with caution. Two other interactive patterns associated with severity of bipolar illness concerned mother's responses to children's noncompliance. Seriously impaired mothers were more likely to avoid confrontation by giving up immediately when the child resisted and, when they did persist, were more likely to use unilateral enforcement strategies of resolving conflict.

In summary, mothers with affective illness were found to have difficulties in managing socialization interactions with young children. In particular, the present analyses of the structure and outcome of entire episodes of interaction suggest that affective illness may disrupt interactive processes involving confrontation and negotiation of conflict occasioned by children's noncompliance. Future work is necessary to clarify the implications of these disruptions for children's socialization and development of autonomous functioning.

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