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ABSTRACT

This paper is a review of current research on the effects of children's exposure to domestic violence in the home in regard to their psychological well-being. Specific areas of focus include studies that examine general effects of witnessing domestic violence, the presence of trauma-like and posttraumatic stress disorder (PTSD) symptoms, potential moderators of the effects of domestic violence, and long-term effects on adult functioning of witnessing domestic violence during childhood. This paper examines various methodological issues in regard to definition of terms, sampling, and instrumentation. The research suggests a strong correlation between witnessing domestic violence and risk for behavior problems and psychological distress, including trauma-like symptoms and PTSD, depression, and low self-esteem. Evidence is also strong for the presence of negative long-term consequences for adults who witnessed or were exposed to domestic violence during childhood. Clinical implications of the findings as well as suggestions for future research are also discussed. (Contains 51 references.) (Author)

THE IMPACT OF DOMESTIC VIOLENCE ON CHILDREN'S PSYCHOLOGICAL WELL-BEING

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by

Anne C. Hill

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ON CHILDREN'S PSYCHOLOGICAL

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Being confident of this very thing,
that he who has begun a good work in you
will complete it until the day of Jesus Christ.
(Philippians 1:6, NKJ)

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THE IMPACT OF DOMESTIC VIOLENCE ON CHILDREN'S PSYCHOLOGICAL WELL-BEING

Introduction

The occurrence of violence within a child's family carries great potential for psychological as well as physical harm, which seems readily apparent. In fact, the literature on domestic violence has clearly established the significance of its impact upon both parents and their children. Margolin (1998) noted that witnessing violence between one's parents affects a child's very sense of safety and protection and has been associated with a variety of problems in children. Consequences may be both immediate and long-lasting, influencing the way family members respond to the world from that point forward.

Researchers have sought to understand what makes a difference in children's responses to domestic violence exposure. Although posttraumatic stress disorder is one response to domestic violence, not all children respond in this dramatic way. Some externalize and act out their distress, whereas others internalize and hold their pain inside, sometimes taking the blame for what has occurred. Clearly, children exposed to domestic violence have demonstrated a variety of problems in behavioral, emotional, and cognitive functioning, as well as long-term developmental problems (Edleson, 1999). Moderators of these effects may be particular child characteristics, race and

ethnicity, and parent-child relationship factors.

The nature and scope of the effects of domestic violence on children are the focus of this paper. Although not an exhaustive review, studies are included that paint a broad-stroke picture of this body of literature. Before reviewing pertinent studies, however, various methodological considerations will be addressed, including (a) disparity among operational definitions for domestic violence and its impact on children's psychological well-being, (b) variations in instrumentation utilized in the studies reviewed, and (c) inconsistencies in sampling and procedures. Specific areas of focus will include the following: (a) general effects of domestic violence, (b) domestic violence and posttraumatic stress disorder, (c) potential moderators of the effects of domestic violence, and (c) long-term effects of domestic violence during childhood. Finally, potential clinical implications and suggestions for future research will be presented.

Methodological Considerations

Various methodological considerations must be addressed when reviewing literature on the effects of domestic violence on the psychological well-being of children. The definition of terms, instruments, samples, and procedures used will be addressed prior to discussing the research.

Definition of Terms

Research in the area of domestic violence faces a particular dilemma in addressing its effects on children. Clearly, not all children experience acts of domestic

violence in the same way, which poses potentially confounding variables influencing findings (Duong, 2000).

Some children are witnesses, whereas others are also its victims. Being a witness may involve directly viewing adult violence, hearing it, and/or being used as a tool of the perpetrator. Furthermore, experiencing the aftermath of such violence can also be highly traumatic for children. Although early research referred to children as *witnesses* or *observers*, these terms have been replaced by the phrase *exposure to violence*, "which is more inclusive and does not make assumptions about the specific nature of the children's experiences with the violence" (Fantuzzo, Boruch, Beriama, & Atkins, 1999, p. 22).

Differences in definitions and other research methodologies have resulted in substantial variability in prevalence estimates and have made data comparison difficult across studies. Jouriles, McDonald, Norwood, and Ezell (2001) noted some of the conceptual, methodological, and practical difficulties in determining accurate prevalence rates in regard to exposure to domestic violence, rather than to its occurrence. These researchers also noted that there is no clear consensus about the construct being measured. Terms such as *wife abuse*, *battered women*, and *husband-to-wife violence* (terms that specify perpetrator and victim gender) are often used interchangeably with *marital violence*, *spouse abuse*, *domestic violence*, and *physically aggressive couples* (terms that apply to physical aggression between intimate partners, but do not delineate the perpetrator's gender). This disparity has implications, not only for documenting the prevalence of children's exposure to violence, but also in addressing other questions

pertaining to children and domestic violence.

Furthermore, some have classified families as violent based on only one violent act (e.g., pushed, grabbed, shoved, slapped, kicked, bit, hit with fist) within the stated time period. Others require the occurrence of multiple acts of violence to be classified as such. Still other researchers have argued that violence is much broader and should not be limited to acts of physical aggression, but also include familial conflict (e.g., verbal attacks) without a physical component (Jouriles et al., 2001).

Finally, neither has exposure to violence been well defined. Exposure may mean any of a range of possibilities, from listening to parents argue to hearing a parent being struck to actually watching the violence take place. Some children are aware of interparental violence, whereas other children may have experienced living in a violent household without explicit knowledge that physical or verbal aggression is happening between family members. Consequently, the nature and degree of exposure is not well delineated and consistent across the studies reviewed (Jouriles et al., 2001).

Instruments

In attempting to assess the effects of domestic violence on children, researchers have used a variety of instruments. The most common instruments in this field of research will be presented in this section of the paper, whereas the less frequently used assessment tools will be discussed within the context of the study in which they were utilized.

Conflict Tactics Scale. The Conflict Tactics Scale (CTS; Straus, 1979) was by far the most widely used instrument in the reviewed studies (Graham-Bermann, 1996;

Henning, Leitenberg, Coffey, Bennett, & Jankowski, 1997; Jouriles & Norwood, 1995; Kilpatrick, Litt, & Williams, 1997; Kolbo, 1996; McCloskey, Figueredo, & Koss, 1995; O'Keefe, 1994; Silvern et al., 1995). The CTS was designed to quantify the nature and extent of domestic violence through a self-report questionnaire completed by adults who have directed violence toward a spouse or child. In some studies, the CTS was modified so that one parent could answer the questions for both parents and report violence between both spouses that was witnessed by his or her child.

Form A of the CTS consists of 18 items that assess handling interpersonal conflict in intimate relationships in the following ways: reasoning (4 items), verbal aggression or psychological abuse (5 items), and physical violence (5 items). Items are presented in hierarchical order of social acceptability, starting with negotiation items (e.g., "Discussed an issue calmly") and ending with physical assault items (e.g., "Used a knife or gun"). Each item is ranked on a continuum from 0 (*least severe*) to 5 (*most severe*). The CTS has demonstrated moderate to high reliabilities (.70 – .88) and evidence of concurrent and construct validity (Straus, 1979).

A revised version of the CTS, Form N, was developed for use in a national survey and differs from Form A in several ways. It is used in face-to-face interviews rather than as a self-administered questionnaire. Form N also places a greater focus on Verbal Aggression (two added items) and Violence modalities (three added items). Finally, its range of response categories is greater (from 0 – 5 to 0.– 6), and some wording changes were made (Straus, 1979).

One study (Baker, 2000) used the Revised Conflict Tactics Scale (CTS2; Straus, Hamby, Boney-McCoy, & Sugarman, 1996). This adaptation of the CTS was designed to measure children's exposure to interparental verbal or physical aggression (violent responses) or reasoning (nonviolent responses) in dealing with interpersonal conflict, as well as to measure physical injury caused from assaults by a partner. The CTS2 is a self-administered, 62-item questionnaire that takes 10 to 15 minutes to complete. The Physical Assault subscale consists of 12 items divided into five minor (e.g., threw something at mother/father that could hurt, pushed and shoved mother/father, grabbed mother/father) and seven severe (e.g., used a knife or gun on mother/father, punched mother/father with something that could hurt, burned or scalded mother/father on purpose) assault items. Items are scored on a 7-point scale ranging from 0 (*never happened*) to 6 (*happened more than 20 times*). CTS2 scales have also demonstrated good internal consistency (.79 – .95).

Child Behavior Checklist. The Child Behavior Checklist (CBCL; Achenbach & Edelbrock, 1986) was the second most frequently used instrument in the reviewed studies (Graham-Bermann, 1996; Jouriles & Norwood, 1995; Kolbo, 1996; McCloskey et al., 1995; O'Keefe, 1994; Spaccarelli, Sandler, & Roosa, 1995). The CBCL is designed to assess the behavior problems of children (ages 4 – 16 years) as reported by a parent or parental substitute. This instrument consists of 113 items rating the child's behavior during the previous 6 months on a 3-point scale ranging from *not true* to *very often true*. In addition to a total behavior score, the instrument provides scores for externalizing (aggression, delinquency, undercontrol) and internalizing (anxiety,

depression, withdrawal) behaviors. These two broad factors have been frequently examined in research on children's behavior. Scaled scores are derived by converting raw scores to standard *T* scores on the basis of established norms related to age and sex. The CBCL has been shown to be highly reliable (test-retest = .95; inter-rater = .92).

Beck Depression Inventory. The Beck Depression Inventory (BDI; Beck, 1978), a brief self-report measure of depressive symptoms for adolescents and adults, was used in two of the reviewed studies (Maker, Kemmelmeier, & Peterson, 1998; Silvern et al., 1995). The 21 items of the BDI are rated for severity on a 4-point scale ranging from 0 to 3, with a total possible score ranging from 0 to 63. The internal consistency (.83) of the BDI has been established (Beck & Beamesderfer, 1974). Scores of 10 to 16 are categorized as mild (nonclinical) depression, whereas higher scores indicate moderate (17 – 29) and severe (30 – 63) depression.

Samples and Procedures

Certain methodological issues are of concern regarding samples and procedures in the research reviewed. Studying the impact of marital violence is a highly complicated issue. In addition to addressing problems inherent in differential definitions and instrumentation, its co-occurrence with other forms of abuse and exposure to violence must also be considered. In selecting assessment tools, researchers need to consider how accurately children are able to report spouse abuse or marital violence. It is important, therefore, to collect data from multiple sources, which may be significantly divergent (Edleson, 1999). Furthermore, some parents and children include descriptions of the aftermath and its effects in addition to recounting the actual experience.

In addition, the nature and extent of problems experienced by these children include a potentially overlapping range of factors and behaviors. Child characteristics, race and ethnicity, and parent-child relationship factors may confound findings. What the researcher chooses to examine is also varied and may include behavioral and emotional functioning, cognitive functioning, attitudes, and/or long-term developmental problems (Edleson, 1999).

Baker (2000) also noted problems with methodology in that "researchers tend to ask mothers to complete the child behavior checklists to obtain an indication of child adjustment. Rarely is additional information sought from a more objective source such as a teacher, daycare worker, or a neighbor" (p. 19). Relying on maternal perceptions may bias data since mothers themselves are frequently experiencing significant stress when they complete such questionnaires. Furthermore, by primarily choosing participants from battered women's shelters, samples may not be representative of children exposed to interparental violence, and findings may actually be more indicative of adjustment problems that result from living in the shelters ("shelter effect"). Finally, researchers typically do not control for childhood physical and sexual abuse although many of these children may be at high risk for such abuse.

Margolin (1998) also noted several methodological issues related to research on the impact of domestic violence in regard to children. Marital violence often co-occurs with other forms of abuse and exposure to violence. Researchers often fail to differentiate between domestic violence and other forms of marital conflict. Finally, studies vary in regard to measuring direct versus indirect effects of exposure to domestic

violence. With these methodological considerations in mind, the following review of the literature is offered.

Review of the Literature

Studies have focused on a number of issues in terms of the effect of domestic violence on children. This paper reviews some general effects, anxiety and worry, as well as the presence of PTSD symptoms in children from homes wherein they have been victims and/or witnesses to violence or abuse.

General Effects of Witnessing Domestic Violence

Duong (2000) conducted an exploratory study regarding mothers' perceptions of how violence between parents affects the children who have seen and/or heard it. The sample included 22 women (24 – 43 years; $M = 33.1$ years) who had one child (11 boys, 11 girls) between the ages of 3 and 16 years who had been either in visual or auditory range during parental conflicts. Forty-five percent of the children had witnessed both physical and verbal-emotional abuse, and 40% had witnessed only verbal-emotional abuse. Of the 22 participants, 45.5% were Caucasian, 27.3% were Hispanic, 18.2% were Asian American, and 9.1% were Native American. Slightly more than 77% had a college degree or graduate degree, and 68.2% were employed at the time of the study.

As part of the Human Options Personal Empowerment Program in Orange County, California, participants completed a questionnaire based on Ortiz's (1989) work regarding child witnesses to violence. Respondents were asked about whether their children had been aware of, or witnessed, violence in the home, the types of violence

witnessed, and the effect they believed that violence had on their children.

Duong's (2000) findings revealed that 65% of mothers reported that their children were influenced by the violence in the home, and 59.1% reported that the influence had had a negative impact on their children. Mothers stated that their children had difficulties with academics (31.8%), problems with shyness (27.3%), trouble in school (22.7%), and difficulty making friends (18.2%). However, this study utilized a small sample that lacked ethnic and geographic diversity. The researcher relied only upon mothers' perceptions; therefore, findings of the study may be biased because mothers may have tended to deny, minimize, or underreport the impact that exposure to domestic violence had on their children.

One major effect of domestic violence on the lives of children is that they tend to worry more than children who have neither seen nor been the victims of parental aggression. Graham-Bermann (1996) explored the types of concerns and worries that children reported regarding behavior of family members and the degree to which their worries were associated with the level of violence in the family. The relation among family worries, violence in the family, and individual child adjustment was also assessed. A sample of 121 children (aged 7 – 12 years) was selected from families with and without histories of domestic violence. The first group of 60 children (30 boys, 30 girls) and their mothers were selected from a battered women's shelter in one of four Midwestern cities that served both urban and rural populations. Sixty percent of the participants in the domestic violence group were from ethnic minority (primarily African American) families. The comparison group was comprised of 61 nonsheltered

children (29 boys, 32 girls) and mothers who were recruited through flyers distributed within the same Midwestern cities. Sixty-one percent of the participants in the comparison group were from ethnic minority (primarily African American) families.

Mothers completed the CTS and the CBCL, and children completed the Family Worries Scale (FWS). Graham-Bermann (1996) created the FWS, a 20-item child-report, to assess the child's worries and concerns about the people in his or her family. Using a Likert-type scale, the child is asked to rate the degree to which he or she worries about a specific event or action happening to or being perpetrated by his or her mother, father, sister, brother, and the child. Responses range from 1 (*never*) to 4 (*always*). The items were based on information gathered from more than 250 children who had participated in the Kids' Club, a 10-week program created in 1990 by Graham-Bermann for 7- to 12-year-old children whose families had experienced domestic violence. The FWS yields two factors (Vulnerable and Harmful) that have shown an internal reliability across the five family members (.77 – .88 and .81 – .87, respectively). One-week test-retest reliability was moderate (.62 – .84 and .59 – .74 for Harmful and Vulnerable factors, respectively).

Families in the domestic violence group had experienced more frequent violent events than did those in the comparison group, $t\,(1, 120) = 3.98, p < .001$. There were no sex or interaction effects on violence frequency. Comparisons between the two groups revealed that children in the domestic violence group were significantly more worried about the vulnerability of mothers, brothers, and sisters than were children in the comparison group, $F\,(5, 113) = 2.70, p < .05$. Dividing the children into two age groups

(9 years and younger; older than 9 years), Graham-Bermann (1996) found significant effects for age on the Vulnerability factor scores, $F(5, 113) = 4.22, p < .003$. Younger children were more worried about their fathers' vulnerability, $t(1, 108) = 2.52, p < .01$, and their own vulnerability, $t(1, 107) = 2.66, p < .01$, than were older children. Children in the domestic violence group were more worried about harmful behavior of siblings and somewhat worried about harmful behavior by their fathers and themselves. Strong trends were found for the domestic violence group among children's Internalizing symptoms and worry about the harmful behavior of brothers ($p < .003$), fathers ($p < .002$), and themselves ($p < .002$); and among children's Externalizing symptoms and worry about fathers' harm ($p < .003$) and sisters' harm ($p < .003$).

Graham-Bermann's (1996) study reveals several concerns of children from violent families. However, these findings are limited since the researcher relied on mothers as sole reporters of their children's adjustment. The inclusion of information gathered from multiple sources (e.g., teachers, childcare workers) would provide a stronger, more reliable assessment of children's behavioral adjustment to domestic violence.

Spaccarelli et al. (1994) examined the relationship of spouse violence against mother to other risk factors (e.g., low SES, parental history of alcohol abuse, parental divorce, child abuse or neglect, foster care placement, parental incarceration) for child psychopathology. A sample of 303 children in 4th through 6th grades (M age = 10.5 years) and their caretakers ($n = 291$) was selected from 10 inner-city schools in a large Southwestern city via flyers sent home with children, school newsletters, phone

solicitation, and door-to-door canvassing. The caretakers were 276 natural mothers, 3 adoptive mothers, 5 step-mothers, and 7 grandparents or other relatives. Half of the female caretakers were Anglo, 24% were Hispanic, 14% were African American, 4% were Native American, and 8% were classified as other. A majority of families were low to lower-middleclass (54% had annual incomes of $15,000 or less). There were male caretakers in the homes of 175 children in the sample (including 9 single fathers), and 79% of these men where interviewed. They included 96 natural fathers, 38 step-fathers, 3 adoptive fathers, 5 cohabiting boyfriends, and 4 grandfathers or other male relatives.

Spaccarelli et al. (1994) used the CDI, Harter's Self Perception Profile for Children (SPPC; Harter, 1985), and the Youth Hostility Scale (Cook, 1986) to assess the child participants. The SPPC was used to measure self-esteem. An internal consistency coefficient of .78 has been reported for its global self-worth subscale, and it demonstrated a subscale reliability of .70 for this study. The Youth Hostility Scale, an adaptation of the Child Behavior Checklist-Self Report form (Achenbach & Edelbrock, 1986), is a 28-item instrument of self-reported conduct problems. This instrument has demonstrated convergent and discriminant validity as a report of conduct problems (Gersten, as cited in Spaccarelli). In this study, its internal consistency reliability was .81.

Female caretakers completed the Child Behavior Checklist-Parent Form (Achenbach & Edelbrock, 1986), the Diagnostic Interview Schedule (DIS) to assess parental alcohol abuse, and the Short Michigan Alcoholism Screening Test (SMAST; Selzer, Vinokur, & Van Rooijen, 1975). Women were asked two maternal report items

regarding physical violence against them. One item was in regard to seeking medical care due to the violence. Men were also questioned about female partners' physical aggression against them, and 4% reported they had been victims of spousal violence. Since this study was selected from a larger generative study of children of alcoholics and not a study on domestic violence per se, specific data pertaining to the timing, severity, and frequency of violent incidents were not available, which is a definite limitation of the study (Spaccarelli et al., 1994).

Findings showed that spouse violence against mother was significantly correlated with children's self-reports of depression for both girls and boys, and with self-reported conduct problems and low self-esteem for girls. However, correlations between parental reports of child symptoms (depression, anxiety, conduct problems) and violence against mother were not significant (Spaccarelli et al., 1994).

Controlling for demographic and historical risk variables correlated with violence against mothers, multiple regression analyses revealed significant unique variance in girls' self-reports of conduct problems, but not in boys' reports. Violence against mother accounted for a limited 3% variance in girls' reports of depression, $F(6, 82) = 3.14, p < .08$, whereas other historical risk factors accounted for 9% of the variance. Although violence against mother did not account for significant variance in measures of boys' adjustment, demographic predictors (e.g., maternal education) accounted for significant variance in boys' reports of depression, $F(1, 82) = 4.75$, $p < .05$, and conduct problems scores $F(1, 134) = 8.35, p < .01$ (Spaccarelli et al., 1994).

The most significant finding of this study (Spaccarelli et al., 1994) was related to gender differences. Data revealed statistically significant variance in self-reported conduct problems in girls. One plausible explanation for this phenomenon could be that same-sex identification (girls with their mothers) causes acting out. However, girls may be more likely than boys to acknowledge problems verbally (via self-report items). Nevertheless, it is unclear why the girls reported more externalizing problems and not stereotypical depression. The age of the sample (4th – 6th graders) may have been a factor here as well. In addition, this study did not provide data needed to assess whether children had also been victims of physical or sexual abuse, factors that could account for some of the findings.

Another issue of concern in Spaccarelli et al.'s (1994) study is related to the differences between parents' and children's reports of children's mental health problems. Such disagreement between reports has been found in other studies, which is often a critique of studies that only include maternal reports. Furthermore, not much was said in regard to the 4% of fathers who reported they had also been victims of spousal violence. Clearly, more research needs to be conducted to investigate this issue.

McCloskey et al. (1995) also explored the effects of family aggression on children as perceived by mothers and their children, looking for links between domestic violence and psychopathology in children. The sample included 365 women (M age = 33.1 years, SD = 5 years) and one of their children (ages 6 – 12 years; M age = 9.2 years, SD = 1.95 years) who had been recruited from women's shelters (n = 64) or from community resources (n = 102). Participants in the comparison group

(n = 199) were recruited by posters in the community. The average number of children in respondents' homes was 2.9 (SD = 1.3). Anglo European women comprised 53.4% of the sample. Slightly more than 35% were Mexican Americans; 5.5% were African Americans; 4.4% were Native Americans; and 1.6% were Asians, Pacific Islanders, or others. All participants reported a low SES.

Following a telephone intake, McCloskey et al. (1995) conducted 2- to 3-hour interviews with mother and child separately. Mothers were given the CBCL and the Child Assessment Schedule (CAS; Hodges, 1986) to assess child psychopathology. The CTS was utilized as a measure of spousal and parent-child aggression (verbal and physical). The CAS is a 1-hour structured interview with separate versions for mother and child, with demonstrated high test-retest reliability (.80) on all subscales. McCloskey et al. asked all questions on the original CAS except a few concerning severe psychosis due to the low base rate.

Between-group comparison of the mean number of times (0 – 20+) women reported abusive acts against them in the previous year revealed that children of the battered mother group had been exposed to more frequent spousal abuse than were children of the comparison group. The most common form of abuse (being pushed or grabbed) was reported to have occurred an average of 12.7 times (SD = 7.2) among mothers in the battered group, whereas it reportedly occurred an average of 3.7 times (SD = 6.2) among mothers in the comparison group. However, conjugal violence in the battered group was frequently very brutal. Sixty-two percent reported being choked, 69% reported being beaten, and 28% reported more than 15 beatings (McCloskey et al.,

1995).

Family violence accounted for 12% and 56% of the variance in child psychopathology according to child and mother reports, respectively. Mothers and their children reported similar experiences and memories of family violence that influenced the mental health of the children. Fathers' biological paternity alone appeared to have no effect on the frequency of aggression toward the children. However, the risk of physical abuse increased for the target child if the husband was unrelated to the child but had fathered other children in the family, $F(1, 310) = 4.61, p < .05$. Violence against the mother also appeared to be a serious risk factor for incest (1.8% and 3.6% according to child and mother reports, respectively). Furthermore, mothers in the battered group reported that 25% of the target children (compared to 9.5% in the comparison group) had been sexually molested outside the home as well (McCloskey et al., 1995).

Two hundred forty-four children (ages 8 years and older) also completed the CAS, and their scores were compared to their mothers' scores ($r = .19, p < .001$). Mother and child scores varied in significance on individual subscales related to internalizing and externalizing disorders. For example, there was a significant correlation on the depression subscale ($r = .22, p < .001$), compared to a nonsignificant correlational trend for conduct disorders ($r = .12, p < .06$). This discrepancy is not surprising since children may not think of their own externalizing behaviors as maladaptive (McCloskey et al., 1995).

A few distinct patterns emerged for all the children according to their mothers. Attention-deficit/hyperactivity disorder was the most prevalent diagnostic category with

significant differences between sampling groups, F (2, 362) = 4.43, $p < .05$. Although separation anxiety had a low base rate in the comparison sample (8%), significantly more children of battered women (about 30%) met the clinical cutoff, F (2, 362)= 15.62, $p < .0001$. Children from violent homes were more at risk than those in the comparison group, with significant differences in the proportion of children appearing obsessive-compulsive, F (2, 362) = 3.32, $p < .05$, and conduct disordered, F (2, 364) = 7.24, $p < .001$. There was a nonsignificant trend distinguishing groups on major depressive disorder, F (2, 362) = 2.57, $p < .10$. These results reveal a shared perception of family events according to mothers' and children's reports about violence and symptoms. This finding indicates that mothers, although having troubles of their own, are able to accurately perceive some of the symptoms of their children (McCloskey et al., 1995).

Sternberg et al. (1993) studied the particular effects of different types of domestic violence experienced by children within their families. The researchers predicted that there would be gender differences in how children responded to domestic violence, expecting that boys would be affected more profoundly than would girls. A sample of 110 children (ages 8 – 12 years; 61 boys, 49 girls) and their parents were recruited through social workers from the Department of Family Services in Jerusalem and Tel Aviv, Israel. The children were from lower-class, two-parent families of Jewish origin; 75% of the families had parents born in Middle Eastern or North African countries. Children who were mentally retarded or who had been victims of sexual abuse were excluded from the sample. The sample was divided into four groups. Three groups were comprised of children who had experienced some form of chronic domestic

violence (at least one incident in the previous 6 months), and one matched group was included for comparison.

Group 1, the child abuse group, included children who had experienced physical abuse by one or both parents ($n = 33$; 18 boys, 15 girls). Group 2, the spouse abuse group, included children who had witnessed physical violence between their parents but who had not been abused themselves ($n = 16$; 8 boys, 8 girls). Group 3, the abused witnesses group, included children who had both witnessed and been physically abused by one or both parents ($n = 30$; 21 boys, 9 girls). Group 4, the comparison group, included children who had neither observed nor been victims of physical violence ($n = 31$; 14 boys, 17 girls; Sternberg et al., 1993).

Assessments included the CDI and the Youth Self-Report (YSR; Achenbach & Edelbrock, 1986) to assess depression and behavior problems. Parents completed the parent forms of the CBCL as a measure of their perceptions of their children's behavior problems. All questionnaires were translated from English to Hebrew and back to English again (Sternberg et al., 1993).

Analyses of data from child reports revealed significant differences in behavior problems and depressive symptoms between the domestic violence groups and the comparison group, $F(9, 244) = 2.78$, $p < .01$. Children in the child abuse and abused witness groups reported more internalizing and externalizing behavior problems than did children in the comparison group, $F(9, 244) = 2.78$, $p < .01$ Children in the spouse abuse group also reported more problems than did children in the comparison group; however, the differences were not statistically significant (Sternberg et al., 1993).

Although the main effect for sex was not significant according to child reports, multivariate analyses of group x sex revealed a significant interaction effect for externalizing behaviors. In the child and spouse abuse groups, girls reported more externalizing behavior problems (*M*s = 56.00 and 48.25, respectively) than did boys (*M*s = 44.06 and 45.50, respectively). However, fewer externalizing behavior problems were reported by girls in the abused witness (*M* = 46.22) and comparison (*M* = 39.82) groups than were reported by boys in these groups (*M*s = 50.71 and 43.29, respectively; Sternberg et al., 1993).

According to maternal reports, children in the domestic violence groups demonstrated significantly more externalizing behavior problems than did children in the comparison group, $F(1, 106) = 9.52, p < .01$. This was not the case with internalizing behaviors for the domestic violence groups in general. However, maternal reports showed an interaction effect of group x sex, $F(2, 105) = 4.09, p < 02$. Girls in the domestic violence groups were reported to have more externalizing (*M* = 69.91) and internalizing (*M* = 69.41) behavior problems than were boys (*M*s = 62.53 and 63.50, respectively). The opposite was true for the comparison group in that mothers reported that girls had fewer externalizing (*M* = 57.17) and internalizing (*M* = 61.65) problems than did boys (*M*s = 62.08 and 63.50, respectively). Interestingly, there were no group or sex differences in fathers' reports of behavioral problems (Sternberg et al., 1993).

A strength of this study by Sternberg et al. (1993) was the researchers' attempt to include paternal reports, even though fathers did not consistently participate in the interview process. Although important data were collected from parents and children

regarding the impact of domestic violence, the translation of instruments into Hebrew for use in Israel poses a challenge in regard to standardization of assessment tools that may not be culturally relevant or provide accurate information regarding attitudes toward and reporting of domestic violence. Furthermore, although the results showed some interesting and unpredicted gender differences, these researchers hypothesized no plausible explanations for findings of the study, nor did they sufficiently address issues regarding their applicability to Western cultures.

Domestic Violence and Posttraumatic Stress Disorder

Chemtob, Carlson, and Perrone (2000) examined the impact of witnessing their mothers' abuse on children's psychological functioning. This study was conducted to gather preliminary data to assist in the development of programs for victims of domestic violence and their children in Hawaii. The sample was comprised of 25 mothers (mean age = 35.4 years) who had be out of an abusive relationship for at least 6 months (M = 26.4 months) and one of their children (7 years of age or older; M = 11.2 years) who had been in the home at the time of the abuse. Participants were recruited through agencies that focused on domestic violence in the community. Persons employed by the Domestic Violence Clearinghouse and Legal Hotline or other such agencies reviewed mothers' files to ensure that criteria were met.

Mothers completed a demographic questionnaire and a number of other instruments. Chemtob et al. (2000) designed the Exposure to Domestic Violence/Abuse-Adult Scale as a structured interview to identify the frequency and degree of verbal, physical, and sexual abuse experienced by mothers, as well as abuse experienced and

witnessed by their children. Mothers were also given the Posttraumatic Diagnostic Scale (PTDS; Foa, Cashman, Jaycox, & Perry, 1997), a 49-item measure, to assess the presence of PTSD symptoms in the mothers. The scale is keyed to standard diagnostic criteria and provides a continuous measure of PTSD symptoms. It has high internal consistency and test-retest reliability. Dissociative experiences were measured by the 28-item Dissociative Experiences Scale (DES; Bernstein & Putnam, 1984), and dysfunctional parenting in disciplinary situations was assessed by the Parenting Scale (Arnold, Leary, Wolff, & Acker, 1993). Finally, mothers completed the State-Trait Anger Expression Inventory (STAS; Spielberger et al., 1985) and the Beck Depression Inventory (BDI; Beck, Rush, Shaw, & Emery, 1980) to assess their anger and depression, respectively.

Children were assessed for degree of traumatization using the Clinician-Administered PTSD Scale for Children and Adolescents (CAPS-CA; Nader et al., 1996). CAPS-CA was designed to assess children's intrusive experiences of domestic violence/abuse incidents (e.g., flashbacks, nightmares) and provides ratings of frequency and intensity of PTSD symptoms (Chemtob et al., 2000).

Chemtob et al. (2000) also used a structured interview designed for this study, the Exposure to Domestic Violence/Abuse–Child Scale, to assess the frequency and degree of verbal, physical, and sexual abuse experienced by the child, as well as their witnessing their mothers' abuse, police interventions, children's attempts to intervene, separation from their mothers, and shelter stays.

According to mothers' reports, 80% of the children had witnessed domestic violence at least monthly, and 40% witnessed domestic violence on a daily basis. Twelve percent of the mothers reported moderate to extreme sexual abuse of their children. The majority of the children reported witnessing verbal abuse (92%) and that the abuse was moderate to severe (68%). More than half of the children (60%) reported experiencing physical abuse, whereas only 4% reported experiencing sexual abuse. Children's reports regarding the abusive relationship indicated very high exposure to traumatic situations that was correlated with a high rate of PTSD (40 %) among the children. Furthermore, the researchers reported "a significant tendency for children to emotionally dissociate from their environment to an extent that was related to their mothers' tendencies to be depressed, to dissociate, and to be angry" (Chemtob et al., 2000, p. 23).

A strength of the Chemtob et al. (2000) study is that the researchers interviewed both mothers and their children rather than relying on a sole informant. Findings from both sources supported the hypothesis that children who are exposed to domestic violence suffer serious negative psychological consequences. This observation elucidates the need for adult workers in all settings (e.g., teachers, daycare workers) to pay close attention to children's symptoms and assess for domestic violence in the home, rather than labeling and/or isolating a child without understanding the underlying problems. Even so, the sample was small and had no comparison group. The severe degree of domestic violence (mothers had left the abusive relationship) may further complicate the issues since families with less severe levels of domestic violence were

excluded from the sample. The use of a structured interview rather than standardized instruments to assess participants also raises questions in regard to validity and reliability, making generalizability of findings or comparison with other studies difficult.

Kilpatrick et al. (1997) also hypothesized that witnessing domestic violence precipitates PTSD in children. These researchers selected a sample of 58 children from community agencies over a 6-month period. Twenty participants had witnessed domestic violence as reported by both child and mother (13 boys and 7 girls; *M* age = 8.1 years, *SD* = 1.7 years), and 15 had not witnessed domestic violence (5 boys and 10 girls; *M* age = 8.6 years, *SD* = 1.8 years). Children in both groups were Australians of Anglo-Saxon descent. A screening questionnaire assessed their exposure to domestic violence and other stressors that might precipitate PTSD, and 23 children were excluded because they had been exposed to one or more traumas (direct experience of sexual abuse, physical abuse, or assault; natural disasters; severe motor vehicle or other accidents; witnessing serious injury or death of another; severe or prolonged illness).

Kilpatrick et al. (1997) used the Child Post-Traumatic Stress Reaction Index (PTSRI; Pynoos & Nader, 1993) to evaluate the presence of PTSD and the CTS (Form N) to assess methods of conflict resolution (violence, verbal aggression, reasoning). The PTSRI uses a 5-point scale to assess the frequency of PTSD symptoms in relationship with a designated stressful event (i.e., parental fights). PTSRI scores were used to classify children's symptoms as mild (12 – 24), moderate (25 – 39), severe (40 – 59), and very severe (> 60).

Kilpatrick et al. (1997) found significant differences between PTSRI scores of child witnesses ($M = 36.7$, $SD = 6.5$) and nonwitnesses ($M = 8.6$, $SD = 3.0$) to domestic violence. In other words, findings revealed a significant association between witnessing domestic violence and the presence of PTSD ($\chi 2 = 31.172$, $df = 1$, $p < .001$), with most of these children demonstrating at least a moderate level of symptomology. However, findings from this study may be limited due the small sample size. Furthermore, since the interviewers knew whether or not the participants had witnessed domestic violence, they may have unwittingly engaged in response cueing.

Potential Moderators of the Effects of Domestic Violence

O'Keefe (1994) examined the relationship between observing marital violence and behavior problems children experience, with a particular focus on similarities or differences between mother-child aggression and father-child aggression. Participants were 185 children between the ages of 7 and 13 ($M = 9.50$ years, $SD = 1.99$) from 120 families. All children (94 boys, 91 girls) in the sample were temporarily residing with their mothers at shelters for battered women. Most of these mothers (98%) were biological parents, whereas only 59% of spouses or partners were biological fathers of their children. The sample was ethnically diverse (37% Hispanic, 21% Black, 42% Caucasian, and 85% were of low socioeconomic status.

The Parent-Child Version of the CTS was used as mothers' self-report of mother-child aggression, father-child aggression, and the frequency of both during the prior year. The Physical Aggression subscale of the CTS (form N) was used to assess the amount of violence witnessed by the child. A modified version of the scale was used to

include the following question after each item, "How often has this [aggressive act] occurred in front of (child's name)?" The CBCL was used to assess children's emotional and behavioral functioning (O'Keefe, 1994).

Results indicated that boys were the victims of significantly more father-child aggression than were girls ($t = 2.8$; $p = .006$). Although reports of observed marital violence were not significantly correlated with mother-child violence, observed marital violence was correlated with father-child aggression ($r = .28$; $p < .01$). In addition, the correlation between husband-to-wife violence witnessed and father-child aggression was significant ($r = .34$, p .01) though the relationship between wife-to-husband violence witnessed was not significantly associated with mother-child aggression (O'Keefe, 1994).

Findings from this study (O'Keefe, 1994) need to be interpreted with caution since it used only mother's reports of father aggression and of their children's behavior problems. Data from collaborative sources would have made the findings more reliable as mothers' potential bias would have been controlled. An additional caveat is that although the majority of mothers were the children's biological mothers, just over half spouses or partners were the biological fathers of the children in this study. This may have also contributed to potential bias in reporting.

Kolbo (1996) examined the relationship between children's exposure to family violence and their increased risk for both emotional and behavioral problems in a sample of children from Minneapolis and St. Paul, Minnesota. The researcher hypothesized that boys would have more behavioral and emotional problems than would

girls. Furthermore, he hypothesized that IQ, SES, and support would influence the relationship between children's exposure to family violence and the quality of their emotional and behavioral functioning. The 60 children (8 – 11 years; 30 girls and 30 boys) who participated in the study had been referred by their parents (58 female and 2 male) to three nonshelter agencies that provide education, supportive therapy, and self-help groups to families when violence is or has been occurring. Forty-four children (70%) were Caucasian, 4 were African American, 3 were Hispanic, 2 were Native American, and 7 were of other races. Sixty-five percent came from homes where parents earned less than $15,000 per year.

Kolbo (1996) used a number of instruments to test his hypotheses. Parents completed the CBCL and a modified version of the CTS that allowed one parent to answer questions for both parents, as well as report on interparental violence that had been observed by the child. A severity weighted scale was used to account for differences in the severity and the frequency of violence.

Children's IQ was extrapolated from their performance on the Block Design and Vocabulary subtests of the Wechsler Intelligence Scale for Children-Revised (WISC-R; Wechsler, 1974). These two-short forms have shown the highest correlation (.88) with the full scale IQ score (Silverstein, as cited in Kolbo, 1996). The children also completed the Supportive Relationship Questionnaire (SRQ), developed for this research to assess emotional support. This instrument has four sets of open-ended questions related to emotional, instrumental, informational, and social support. Finally, children completed the verbally-administered Self-Perception Profile for Children, which measures self-

perception and self-worth in five specific domains. Adequate levels of reliability and moderate to strong levels of validity have been reported for this measure.

All children in this study (Kolbo, 1996) had witnessed violence between their parents, and 97% of these children had also been targets of domestic violence. Findings indicated that increased exposure to violence was correlated with children's reports of decreased self-worth ($r = -.280, p < .05$) and parents' reports of more behavior problems in their children ($r = .259, p < .05$). The amount of support received by children was negatively correlated with behavior problems ($r = -.318, p < .01$) and positively correlated with self-worth ($r = .345, p < .01$). Higher IQ was associated with decreased behavior problems in children ($r = -.279, p < .05$) and increased self-worth ($r = .253, p < .05$).

Findings failed to support Kolbo's (1996) hypothesis that boys who were exposed to violence would display more emotional and behavioral problems than girls would. Instead there was a strong correlation between exposure to violence and behavioral problems in girls ($r = .52, p < .01$), but not for boys. Regression analysis examining mediating effects of IQ, SES, and support indicated that support mediated self-worth for boys (F change $(3,26) = 5.35, p < .05$), but not for girls.

Kolbo (1996) failed to include a comparison group in this study, and 97% of the children had been targets of violence themselves. Therefore, the differences between witnesses and nonwitnesses as well as the potential interaction effects of being a witness and being abused remain unclear. The researcher focused on gender differences and argued that differential responses were due to IQ variance. He hypothesized that girls'

greater behavioral problems was potentially attributable to their lower IQs, which may be an oversimplification of the issue at hand. Since research shows a high comorbidity between various forms of abuse and domestic violence, it could be that the girls had also been sexually abused and hence were acting out more.

Another hypothesis regarding gender is that it may also moderate whether or not various forms of violence or abuse occur in the first place. To explore this possibility, Jouriles and Norwood (1995) conducted a study on physical aggression towards children in households with domestic violence to test their hypothesis that children's gender moderates the relationship between the battering of women and aggression directed toward their children. Forty-eight mothers with one biological son and one biological daughter (ages 4 – 14 years) were selected from three women's shelters (two in rural communities, one in an urban community). Families were excluded from the study if they were non-English-speaking, if any they had any mental retardation or physical disability, or if there was medical evidence or suspicion of child sexual abuse. Of the 96 children (*M* age = 8.4 years, *SD* = 2.6 for boys; *M* age = 8.4 years, *SD* = 2.4 for girls), 54% of the families had boys that were older than the girls (average age difference = 2.1 years). In families in which the girl was older, the age difference averaged 2.0 years. Of the total sample, 48% were Mexican or Latin American, 33% were White, and 19% were African American.

Mothers completed the physical violence scale of the CTS, and both mothers and children completed the parent-child version of the CTS (P-CTS) to provide information regarding parental aggression. Mothers completed only the Externalizing Disorder scale

of the CBCL to assess children's externalizing behavior problems. Families were divided into two groups ("more extreme" and "less extreme" battering) based on the mothers' CTS scores. Results indicated that within families in the more extreme battering group, both fathers and mothers were more aggressive towards their sons than toward their daughters, $t\ (23) = 3.14$, $p < .01$, and $t\ (23) = 3.14$, $p < .01$ for fathers and mothers, respectively. This finding did not hold true, however, for families in the less extreme battering group (Jouriles & Norwood, 1995).

This study (Jouriles & Norwood, 1995) provides significant information about gender issues. Most researchers focus on paternal violence, whereas Jouriles and Norwood also explored the aggressive behavior of mothers. Both fathers and mothers in the extreme battering group were more aggressive toward their sons than they were toward their daughters. It is uncertain whether boys act out more in their distress than girls and then receive greater punishment (i.e., increased aggression against them). The socialization of boys and girls is usually perceived to be significantly different, and boys are usually labeled as more aggressive than girls. However, this does not always hold true in the literature. Clearly, more research is needed in this area.

An issue of concern in this study (Jouriles & Norwood, 1995) is that all participants were selected from shelters, which limits the generalizability of the findings to other levels of domestic violence. Also, as is typical in this body of literature, mothers were the sole informants reporting aggression within the home both for fathers and mothers, which presents bias and may lead to underreporting. Finally, only the externalizing disorder scale of the CBCL was used in this study, which may further

influence findings since some research has suggested that boys tend to be externalizers and girls tend to be internalizers. This restriction thereby sets limits on this data, which may not be accurately representative of gender-related issues.

Long-Term Effects of Witnessing Domestic Violence as a Child

Silvern et al. (1995) studied the relationship between retrospective reports of childhood exposure to parental partner abuse and adult reports of depression, trauma-related symptoms, and low self-esteem. A sample of 550 undergraduates (263 men, 287 women; 18 years of age and older) was selected from a state university. Nearly all had grown up in economically-privileged Caucasian homes.

Participants' responses to the CTS were used to identify increasingly violent behavior exhibited by parents towards each other or towards them when they were between the ages of 7 through 17 years. They also completed the Beck Depression Inventory (BDI; Beck, 1978), the Trauma Symptom Checklist (TSC-33; Briere & Runtz, 1989), and the Coopersmith Self-Esteem Inventory (CSEI; Coopersmith, 1981).

Trauma-related symptoms were assessed by the TSC-33, a brief measure of 33 items rated by frequency on a 4-point scale ranging from 0 (*never*) to 3 (*very often*) that provides a total score of 0 to 99. Internal consistency of the full scale was adequate (.89). Scores of 20 were considered indicative of mild trauma, whereas scores higher than 30 were considered indicative of high trauma-related symptoms (Briere & Runtz, 1989). Self-esteem was measured using the CSEI, which consists of 25 dichotomous items with high scores corresponding to high self-esteem. Although clinical norms for the CSEI are not available, it has demonstrated significant internal consistency (Coopersmith, 1981).

One hundred eighteen women (41.1%) and 85 men (32.3%) reported childhood exposure to parental partner abuse. Of the women who had observed parental partner abuse by mother and/or father as children, 51.7% reported child physical abuse and 34.2% also reported child sexual abuse. Among the men who had been exposed to parental partner abuse, 24.7% reported physical abuse and 11.8% reported child sexual abuse. Women's scores revealed a significant association between being a child witness of interparental abuse and adult depression, $F(1, 283) = 21.3, p < .0000$; adult self-esteem, $F(1, 263) = 31.5, p < .0000$; and adults' trauma-related symptoms, $F(1, 263) = 14.89, p < .0001$. Men's scores, however, showed a significant association only between being a child witness of interparental abuse and with adults' trauma-related symptoms, $F(1, 242) = 5.18, p < .02$ (Silvern et al., 1995).

In exploring plausible explanations for why women's scores were significantly higher than the men, a number of issues may be relevant. Silvern et al. (1995) focused on the relationship between being exposed to parental spousal abuse in childhood and internalizing aspects of adult adjustment. Women traditionally report or are more prone or sensitive to internalizing symptoms (especially depression which relates to having low self-esteem) than do men. If this study had included externalizing symptoms as a variable, then the picture may have been different since men are usually noted to have more acting out problems than women in response to trauma. However, this tends not to be supported in recent studies reviewed in this paper. Perhaps women were identifying with the victim—usually the mother who is being physically abused by the father—and are internalizing their anger and frustration.

Of the 118 women who reported exposure to parental partner abuse, more than half also reported child physical abuse, and more than one-third also reported child sexual abuse. The findings of this study by Silvern et al. (1995) may also reflect, not only the impact of domestic violence, but of child physical and sexual abuse as well. It is, therefore, not surprising that these women manifested more internalizing symptoms. In addition, gender differences in reports of these potentially confounding variables were significant. Of the men who reported exposure to parental spousal abuse, 42.0% also reported child physical abuse, and 11.8% also reported child sexual abuse. Women's higher scores on internalizing behaviors may be reflective of the higher incidence of child sexual abuse for women.

Another factor to be considered in interpreting these results concerns the economic status of the sample used. Although partner abuse is more frequently reported in low-income families, it may be difficult to determine its incidence in families in the higher income bracket who do not go to shelters, but perhaps handle matters in a discrete way. This study brings into question the myth that rich families and their children are not at risk for domestic violence and suggests that low income families are simply more available. Silvern et al. (1995) provided a comparative study that points out distinctions between research on short-term outcomes focusing on lower income families from a convenient shelter sample and retrospective studies of college students who may be from higher income families. Domestic violence affects children, not only who are from low SES families, but those are from high SES families. More retrospective studies such as this are needed to determine what differences, if any, exist between the two groups. In

addition, both men and women who reported experiencing parental partner abuse in childhood had significant trauma symptoms. This provides support for the belief that men and women exhibit trauma symptoms in the long-term as well as in the short-term.

Henning et al. (1997) hypothesized that adults who witnessed a same-sex parent being abused by a spouse would report more psychological distress than would adults who witnessed their opposite-sex parent being victimized by marital aggression. A sample of 1,452 undergraduates (914 women, 538 men), whose average age was 18.8 years (SD = 1.9), was drawn from introductory psychology classes at the University of Vermont in Burlington. Students were recruited during five consecutive semesters and were given points towards their final grade for participation. The average SES was high, and the majority of the participants were Caucasian (95%). Two percent were Asian, 1% were Hispanic, and 2% were classified as other ethnic groups.

Students completed the Physical Aggression Scale of the CTS to assess the severity of violence witnessed between their parents, as well as the type of outside intervention which had been required (e.g., medical care, shelter, police assistance, therapy). Adult psychological functioning was measured using the Global Severity Index of the Brief Symptom Inventory (BSI; Derogatis & Spencer, 1982) and the Youth Adult Self-Report (YASR; Achenbach, 1990; Achenbach, Howell, McConaughy, & Stanger, 1994). Data from the Parental Caring Subscale of the Parental Bonding Instrument (BSI; Parker, Tupling, & Brown, 1979) were also included in the analyses (Henning et al., 1997).

The BSI uses a 5-point scale to rate psychological symptoms as experienced during the previous week. It is widely used with both clinical and nonclinical populations and it has good internal consistency, test-retest reliability, and concurrent validity. The YASR (Achenbach, 1990; Achenbach et al., 1994) is a 137-item measure of adult psychological functioning. Respondents use a 3-point scale to rate level of agreement with each item regarding behavior or personality over the past 6 months. In this study the 37 items of the Internalizing scale (e.g., anxiety, depression, somatic complaints) and the 28 items of the Externalizing scale (e.g., delinquency, aggressiveness, showing off) were used. Alpha coefficients were .92 and .84, respectively.

Two hundred three respondents (14%) reported having witnessed physical aggression between their parents at least once before they were 16 years of age. Twenty-five percent of this sample witnessed only their mother being physically attacked by her spouse, 31% witnessed only their fathers being attacked, and 44% reported observing both parents physically attacking one another. These participants reported greater psychological distress than did those in the never-witnessed group as indicated by the Global Severity Index, $F\,(1, 1442) = 40.93, p < .001$; the YASR Internalizing subscale, $F\,(1, 1442) = 15.53, p < .001$; and the YASR Externalizing subscale, $F\,(1, 1442) = 22.72, p < .001$. Women reported more global, $F\,(1, 1442) = 11.72$, $p < .001$, and internalized symptoms, $F\,(1, 1442) = 29.24, p < .001$, than did the men. However, men reported more externalizing symptoms, $F\,(1, 1442) = 26.73, p < .001$, than did the women (Henning et al., 1997).

Henning et al. (1997) also evaluated the unique and combined effects of witnessing interparental physical conflict and additional childhood risk factors (physical abuse, verbal aggression, and parental alcoholism) that are typically associated with marital physical conflict. Results indicated that when risk factors are controlled for, witnessing interparental conflict continues to predict adjustment difficulties in regard to general psychological functioning and externalizing behavior, but not in regard to internalizing behavior. Although these researchers attempted to control for other risk factors to determine the unique effect of witnessing domestic violence, they failed to rule out the impact of childhood sexual abuse.

Working from psychodynamic and social learning theories that suggest experiencing violence in childhood impairs interpersonal functioning, Maker et al. (1998) studied psychological consequences for women who had witnessed parental physical conflict during childhood. They compared differences between witnesses and nonwitnesses on symptoms of depression, trauma, suicidality, antisocial behaviors, and violence in adult dating relationships. Using a multi-risk model including factors (physical abuse, sexual abuse, parental chemical dependency) that frequently coexist in violent homes, these researchers proposed that observing increasingly severe acts increases risk for poor psychological adjustment.

Maker et al. (1998) selected a sample of 131 women between the ages of 18 and 43 years ($M = 22.2$ years, $SD = 5.09$ years) from three community colleges in the Midwest. Caucasian women made up 69.6% of the sample, 14.5% were African American, and 3.8% were Asian American. Most participants (86.3%) had never been

married; however, 9.2% % were separated or divorced. The majority of the sample came from middleclass families as determined by Hollingshead and Redlich's (1958) two-factor index of social status.

Participants completed the parental violence scale of the CTS to assess parental violence and establish whether or not participants had been aggressors or victims in their own dating relationships. Maker et al. (1998) used the Trauma Symptom Checklist (TSC; Briere & Runtz, 1989), a self-report measure designed to distinguish adult survivors of childhood trauma form other clinical and nonclinical populations, to indicate symptoms of dissociation, anxiety, depression, and sleep disturbance experienced in the previous 2 months. Items related to sexual trauma were eliminated, leaving 27 items that were scored on a 3-point scale ranging from 0 (*never*) to 3 (*often*). The short form of the Beck Depression Inventory (BDI; Beck, 1978) was used to assess 13 depressive symptoms. Each item in the shortened version has four alternative statements graded to reflect the severity of the particular symptom. Internal consistency of the short form was high (.83).

Other questionnaires included the Childhood Victimization Questionnaire (Finkelhor, 1979) to assess childhood sexual abuse and physical abuse and the 74-item Antisocial Behavior Checklist, adapted from Zucker, Ham, and Fitzgerald and from Maker and Zucker (as cited in Maker et al., 1998) to tap antisocial behaviors in young women. Participants were asked to report retrospectively on parents' frequency of drug use using 18 items adapted from Foot's (1993) substance abuse survey. The nine items of the Short Michigan Alcoholism Screening Test (SMAST; Crews & Sher, 1992) was

used to assess parental alcoholism as reported by children.

Maker et al. (1998) found that 35.1% of women reported that they had witnessed acts of domestic violence between their parents. In 71% of the families, fathers more frequently enacted violence against mothers. Participants were divided into three groups: nonwitnesses ($n = 85$), witnesses to moderately violent acts ($n = 31$), and witnesses to severe violence plus any number of moderately violence acts ($n = 10$). Four respondents were excluded who did not complete the domestic violence measure. As predicted, the group of women who witnessed severe marital violence exhibited more violent behaviors themselves in their dating relationships compared to control and moderate-violence groups, $F\ (2, 112) = 7.44, p < .002$ and $F\ (2, 112) = 5.59, p < .006$, respectively. In addition, women who had witnessed severe marital violence showed a greater number of antisocial behaviors (e.g., stealing, truancy) than did women in the nonwitness group, $F\ (2, 112) = 3.42, p < .04$.

Due to the dearth of longitudinal data, Maker et al.'s (1998) study is a much needed addition to the research. Results of this study clearly indicate long-term negative consequences for the mental health of children who witness domestic violence. In particular, this study provides evidence that adults who witnessed domestic violence as children are more prone to repeat the violence in their own intimate relationships.

One limitation of this study (Maker et al., 1998), however, is that the sample was comprised only of women. This study needs to be replicated with men to get a balanced view as to how domestic violence affects both genders in the long-term. Furthermore, the sample was limited to college women in the Midwest. Other studies are needed that

include samples from other types of communities and other geographic regions to make findings more generalizable.

McNeal and Amato (1998) used longitudinal data from parents and their adult offspring to examine the long-term impact of marital violence for children, hypothesizing that marital violence is related to poor relationships with parents, dissatisfaction with life, low self-esteem, high psychological distress, and violence in intimate relationships. These researchers compared parents' reports of marital violence between 1980 and 1988 with their young adult offspring's personal problems as reported in 1992.

Data were gleaned from a longitudinal study by Booth, Amato, Johnson, and Edwards (1993) in which 2,034 married couples were interviewed by telephone in 1980. Subsequent interviews were conducted in 1983, 1988, and 1992. Of the couples re-interviewed in 1992, 575 had offspring (age range = 19 – 31 years, $M = 23$) who had been living in the parental household in 1980. The original researchers then interviewed 471 of these offspring, 420 of whom were included in the analysis by McNeal and Amato (1998).

Familial violence was measured by parental responses to three questions posed in the 1980 interview, and families were thereby placed in one of three groups: violent couples, high-conflict couples, and low-conflict couples. Other indicators of parental problems were included in the analysis such as divorce, substance abuse, and abuse towards the children. McNeal and Amato (1998) included the following control variables from the 1980 data: parents' years of education in ($M = 13.8$, $SD = 2.2$),

parents' income, sex of child (52% female), children's ages ($M = 23.9$, $SD = 3.5$), and offspring race (8% non-White).

Dependent variables from 1992 interviews included data regarding offspring's affection for parents as measured by the Affection for Parents Scale (Bengston & Schrader, 1982) and psychological well-being as measured by the Self-Esteem Scale (Rosenberg, 1965). Married or cohabitating offspring ($n = 163$) answered one question on relationship violence, and about 20% reported current relationship violence (McNeal & Amato, 1998).

As predicted, parental reports of marital violence between 1980 and 1988 were negatively correlated with offspring's reports of closeness to mothers (-.34, $p < .01$), life satisfaction (-.24, $p < .05$), and self-esteem (-.24, $p < .05$) in 1992. Parents' earlier marital violence was positively correlated with offspring's' distress (.35, $p < .01$) and relationship violence (1.06, $p < .05$) as reported in 1992. These findings support the hypothesis that parents' marital violence has negative long-term consequences for children. Exploring for evidence of gender differences, the researchers found interactions between parents' marital violence and offspring gender indicating a significant negative correlation between parental marital violence and daughter's affection for their fathers ($\beta = -.16$, $p < .01$), whereas this correlation was insignificant in regard to sons' affection for their fathers (McNeal & Amato, 1998).

McNeal and Amato (1998) provided a longitudinal study that utilized both parental reports and offspring reports to assess marital violence for the children, whereas most others studies in this area tended to rely on the retrospective reports of adults who

had witnessed violence as children. These researchers also addressed gender issues, and findings suggest that parents' marital violence is linked to poorer father-child relationships for daughters, but not for sons. However, the reason for these findings is unclear, leaving this area in need of greater exploration.

The design of McNeal and Amato's (1998) study limits its comparability with other studies. They asked participants about violence rather than using a standardized questionnaire. This method may have provided an overly simplistic way of classifying the three groups and measuring a variable as complex as violence (e.g., by asking just one question). Clearly more research is needed that can provide long-term data on domestic violence and its impact on children.

Baker (2000) conducted a study among 77 women to explore the long-term psychological effects of childhood exposure to interparental violence. Participants were placed in one of two groups: Exposure Only ($n = 36$) and Exposure and Abuse ($n = 41$). The women's ages ranged from 18 to 37 years ($M = 25.9$, $SD = 4.7$), and all had been exposed to interparental violence between the ages of 5 and 17 years. Participants were recruited from the San Francisco Bay Area community by flyers posted in various locations (e.g., student centers, community colleges, universities, coffee shops, libraries, grocery stores, internet community bulletin).

Participants were screened briefly by phone to determine if they met exclusionary criteria. Women who had been physically or sexually abused as adults, who had been exposed within the past 2 years to a serious accident or a natural disaster, who could not read at a 5th- to 7th-grade level, or who could not provide informed

consent or complete all questionnaires were excluded from the study. Those who remained were sent packets containing an informed consent form, the Trauma Symptom Inventory (TSI; Briere, Elliott, Harris, & Cotman, 1995), a demographic questionnaire, and an adapted version of the Revised Conflict Tactics Scale. Participants received financial compensation ($10.00) for participating (Baker, 2000).

The TSI is a 100-item instrument that assesses acute PTSD symptomology and chronic effects of childhood trauma. Respondents rate each symptom on a 4-point scale ranging from 0 (*never*) to 3 (*often*) as experienced during the previous 6 months The TSI has 3 validity scales and 10 clinical scales (Anxious Arousal, Depression, Anger/Irritability, Intrusive Experiences, Defensive Avoidance, Dissociation, Sexual Concerns, Dysfunctional Sexual Behavior, Impaired Self-Reference, and Tension Reduction Behavior). The clinical scales of the TSI have been found to be internally consistent with alpha coefficients ranging from .84 to .87. The scales have also demonstrated reasonable convergent, predictive, and incremental validity (Baker, 2000).

Findings of a MANOVA revealed that women in the Exposure Only group did not have significantly higher levels of trauma-related distress than women in the norm group. Independent *t* tests, however, revealed significant differences between the Exposure Only group and women from the normative sample on 9 of the 10 TSI subscales. Women in the Exposure Only group had significantly higher levels of depression ($t = 2.29$, $df = 34$, $p < .001$), and 19% of them had depression scores in the clinically significant range (T scores ≥ 65) indicating a high degree of symptomology. Women in the Exposure Only group also scored higher on the Anxious Arousal

($t = 3.48$, $df = 34$, $p < .001$), Intrusive Experiences ($t = 2.04$, $df = 34$, $p < .04$), Dissociation ($t = 2.92$, $df = 34$, $p < .01$), Anger/Irritability ($t = 2.29$, $df = 34$, $p < .001$), Dysfunctional Sexual Behavior ($t = 3.35$, $df = 34$, $p < .002$), Tension Reduction Behavior ($t = 2.83$, $df = 34$, $p < .007$), Sexual Concerns ($t = 2.19$, $df = 34$, $p < .04$), and Impaired Self-Reference ($t = 2.71$, $df = 34$, $p < .01$) scales (Baker, 2000).

In addition, Baker (2000) found that women in the Exposure and Abuse group reported significantly higher levels of trauma-related distress than did women from the normative sample, $F = 5.38$, $df = 10, 31$, $p < .0001$. Independent t tests indicated significant differences between the Exposure and Abuse group and the normative sample on Depression ($t = 5.36$, $df = 39$, $p < .0001$), Anxious Arousal ($t = 4.99$, $df = 39$, $p < .0001$), Intrusive Experiences ($t = 5.48$, $df = 39$, $p < .0001$), Defensive Avoidance ($t = 5.14$, $df = 39$, $p < .0001$), Dissociation ($t = 6.00$, $df = 39$, $p < .0001$), Anger/ Irritability ($t = 5.09$, $df = 39$, $p < .0001$), Dysfunctional Sexual Behavior ($t = 4.38$, $df = 39$, $p < .0001$), Tension Reduction Behavior ($t = 4.58$, $df = 39$, $p < .0001$), Sexual Concerns ($t = 5.34$, $df = 39$, $p < .0001$), and Impaired Self-Reference ($t = 6.79$, $df = 39$, $p < .0001$).

One limitation of Baker's (2000) study was the use of a normative sample rather than a matched control group. Despite relatively small sample size, however, these findings provide support for the hypothesis that witnessing domestic violence in childhood has long-term psychological consequences.

Summary and Suggestions for Future Research

Despite differences in participants' ages, ethnic backgrounds, and settings (shelters, community samples, colleges, different countries), results of the reviewed studies strongly suggest a correlation between witnessing domestic violence and risk for behavior problems and psychological distress, including depression, and low self-esteem. Children who are exposed to marital conflict may also develop trauma-like PTSD symptoms. Comparison of this group of children with children who are not exposed to domestic violence reveals higher risk for significant psychological distress as measured by various scales.

Long-term Effects of Domestic Violence

Research also supports the hypothesis that adults who witnessed domestic violence as a child are at risk for long-term psychological distress; however, there is a dearth of studies investigating the long-term impact on adults of exposure to childhood domestic violence. In one of the few studies addressing this issue, Silvern et al. (1995) found higher prevalence rates (36.9%) of spouse abuse than has been found in the general population (28%). One reason for this higher rate may be due to the fact that these findings are based on adult child (retrospective) reports rather than on maternal reports, which frequently have been shown to minimize events and their impact. Conversely, the use of retrospective information also holds potential for over-reporting or other methodological issues involved in relying on participants' memories of traumatic childhood experiences.

In short-term studies, researchers have relied on participants with lower SES, lower IQ, diverse racial groups, community samples, and those (usually children and their mothers) residing in shelters. Whereas, the few long term studies have tended to use college populations with higher SES, higher IQ, and more economically privileged groups. Too few studies have included different cultural groups. However, findings have consistently revealed negative long term consequences to children's mental health. These studies support the hypothesis that when children witness domestic violence in the home, it has a negative impact despite racial, ethnic, or economic differences. However, more longitudinal research is needed.

Difficulties in the Study of Domestic Violence

Since much of American society reflects the shame and secrecy of domestic violence (i.e., that what is done in the home should stay in the home), it may be more feasible to study violence in the community or schools. Usually the victim is the mother (as noted in the studies reviewed here), who is usually held to keeping the violence as a family secret, so her children may not readily talk about what is happening in the home.

Research on domestic violence and its effects on children lags behind that done in regard to other types of abuse (e.g., sexual, physical). Baker (2000) noted that research in this area is still in its infancy since the first published articles on domestic violence appeared in 1975—15 years after the first articles were published on physical child abuse. Perhaps society may not have considered domestic violence to be a problem for children, but rather for mothers. Children have been referred to as invisible victims. It also seems likely that many mothers may not have sought psychological help for their

children due to fear of their children being taken away from them. This may also explain why it is easier for researchers to conduct their studies with children and mothers who reside in shelters.

It is interesting to note that researchers may also be faced with the ethical issue of reporting emotional abuse when children are interviewed. In most of the studies, participating mothers seem to readily acknowledge that their children were negatively affected by domestic violence; however, few reported having taken their children for counseling or therapy.

Several other issues of concern are also apparent in the reviewed studies. Research methodology, potentially confounding variables, variability in assessment, over reliance on maternal reports, gender issues, and cross-cultural differences pose additional problems in the study of domestic violence's impact on the psychological well-being of children.

Methodological issues. Researchers in the reviewed studies varied significantly in their definitions of domestic violence and the various effects it may have on children. The concept of being a witness to domestic violence was often defined quite differently (e.g., observe, exposed to, heard). If a child only hears what is happening in the home, the impact may be different than if he or she observed the violence or were a victim of it as well. Some researchers preferred to use the term *exposed to* rather than *witnessed* domestic violence. Since there is little reference to female violence against men, the use of the term *domestic violence* may be a misnomer. Other commonly used terms include *marital violence*, *spousal violence*, and *families characterized by the battering of*

women.

Consideration of other issues may also be problematic in attempting to compare findings across studies. Some researchers required that domestic violence had been experienced within the previous 6 months or 1 year, whereas others had different time limits. Exclusion criteria for participants were also inconsistent, which could also affect results. Other potentially confounding variables (e.g., disruption in the family which may lead to relocation in shelters, separation and divorce, financial problems, loss of family and friends) are numerous and make definitive evidence hard to establish. In other words, it is not enough to say that children are at risk who live in homes where there is domestic violence, but there needs to be an increase in understanding about particular ways these children are impacted as well as the mediating variables that serve to protect them or fail to protect them.

Other forms of abuse. Children exposed to domestic violence in the home are at serious risk for other types of abuse such as incest. For instance, 28 new reports were filed with Child Protective Services over the course of the study by McCloskey et al. (1995). Other researchers found that children exposed to domestic violence in their homes were more at risk for being physically abused by the perpetrator. Many studies failed to clearly distinguish among various forms of abuse as potentially confounding variables although a few studies tried to tease out whether different forms of abuse would result in different outcomes. Some studies differentiated between groups of children who had witnessed domestic violence and those who had both witnessed domestic violence and been victims of abuse. Those studies that did control these

confounding variables obtained significant results, suggesting that children who both witness and are victims are at greater risk for emotional and psychological problems.

Variability in assessment. Inconsistencies in assessment procedures and instruments also make comparison among studies difficult. Many researchers developed there own assessment tools to determine the frequency and intensity of verbal, physical, and sexual abuse, whereas others relied on standardized instruments (e.g., CTS, CBCL, BDI). The most widely used scale in the research was the CTS, which measures the incidence and prevalence of spouse abuse. However, the CTS has also been criticized for a variety of reasons. It includes some forms of abuse to the exclusion of others, which may mean that some abuse will go unreported because nothing is asked about it. Other researchers limited its use to either the verbal or the physical aggression scale or modified its wording and scoring system.

Newly created instruments pose additional problems, as does the translation of otherwise standardized measures (e.g., Sternberg et al., 1993). Also researchers in the Sternberg et al. study suggested that there may have been a tendency for mothers in the study to report high levels of problematic behavior. This may reflect a cultural difference in the use of the CBCL, which was not standardized for use in Israel.

Over reliance on maternal reports. As with much of the research on children, the studies reviewed relied heavily on maternal reports, which may create specific biases based on mothers as victims of domestic violence. Paternal information is virtually absent from the data. Most instruments were completed by mothers who were frequently answering questions pertaining to fathers as well as to themselves. In other words,

generally only one perspective was obtained regarding violence partners may have perpetuated against each other. Additionally, participants may have denied, minimized, or over/under reported the impact that exposure to domestic had on their children. Honest, unbiased answers cannot be assumed.

Although research reveals that mothers are usually the victims in domestic violence situations, to gather information from one source alone naturally limits what can be known about what is happening in the home. Information from fathers would be helpful in understanding the situation. The only study (Sternberg et al., 1993) that included interviews with both fathers and mothers was conducted in Israel. These researchers found that mothers of children who were victims of domestic violence reported more externalizing behavior problems than did mothers in the comparison group. On the other hand, fathers of children who were witnesses of physical abuse were no more likely to report problem behaviors than were fathers of children in the comparison group. Perhaps fathers experienced greater difficulty filling in the questionnaire, especially if they were perpetrators of the violence. It is interesting to note that only 4% of the fathers interviewed (79% of men living at home) in another study (Spaccarelli et al., 1994) reported they had been victims of maternal victimization.

Feedback from other family members, siblings, and teachers may also be helpful; however, few studies acknowledged this dearth as a limitation. McCloskey et al. (1995) tried to interview both mothers and children and found significant differences between their reports in that family violence accounted for 12% and 56% of variance in child psychopathology according to child and mother reports, respectively.

Gender Issues

Exploration of gender issues is also relevant. Researchers have hypothesized that boys are more vulnerable to physical aggression than are girls, assuming that boys display more emotional and behavior problems than girls when exposed to violence in the home. Jouriles and Norwood (1995) found that both fathers and mothers were more aggressive towards their sons than towards their daughters. However, the sample used in this study was comprised of nearly half (48%) Mexican or Latin American, raising a question about the effect of cultural norms on aggression towards boys and girls.

Results are inconsistent in regard to whether boys are more negatively impacted by witnessing violence in the home than are girls. Some studies found no significant differences between the responses of boys and the responses of girls. Other studies revealed contradictory findings in that girls demonstrated more emotional and behavior problems than did boys. That mothers are usually the victims of domestic violence may impact girls as they constantly witness a same-sex parent as a victim of aggression. These findings may also be a product of differences in the way girls and boys respond to self-report questionnaires. Boys are generally socialized to avoid talking about emotional issues, which may affect the way they do or do not report them. However, findings suggest that girls are more at risk for behavior problems than was previously assumed. Perhaps girls identify more closely with their mothers as victims and are more distressed. The lack of a healthy male role model, sons identification with their fathers, or protecting their mothers and thereby becoming victims themselves also need to be addressed.

Cross-cultural Issues

Most of the studies were conducted with primarily Caucasian samples, and more research needs to be done in regard to cross-cultural issues. Although some studies were conducted in various settings (e.g., Hawaii, Australia, Israel), findings consistently revealed that children's well-being (emotional and psychological) are seriously affected when there is violence in the home. Other studies among ethnic populations (e.g., Hispanic American, African American) have not clearly articulated differences, if any, among different cultures. Most of the studies failed to analyze the potential impact of cultural or racial issues.

Clinical Implications of the Research Findings

Findings from the reviewed studies provide data that can inform the development and implementation of appropriate interventions designed to assist parents and children who are dealing with the problems inherent in domestic violence. Interventions for children, early intervention, psychoeducational programs, building or repairing parent-child relationships, and community support are among the ways clinicians and lay persons can help families prevent and/or deal with the impact of domestic violence on children.

Interventions for Children

A greater understanding of a child's perspective on domestic violence and the typical or unique ways he or she responds can inform treatment aimed at increasing resilience. For example, one way to develop positive self-esteem in children who have

witnessed domestic violence in the home is to promote violence awareness and help the child recognize that he or she did not cause the parental behavior. Also, in trying to understand how children interpret domestic violence and how it affects their behavior, adults can help children express their fears and worries about safety for themselves and other family members.

Teaching safety techniques can further increase children's resilience; therefore, education (e.g., gaining conflict resolution skills, recognizing healthy and unhealthy relationship patterns, learning to express anger in a positive rather than aggressive way) is extremely important in helping children cope with family violence, as well as with their own responses. A variety of techniques could be used to assist in this process, such as art, play therapy, and/or the use of videos. In cases when children are experiencing PTSD-like symptoms (e.g., nightmares, startle responses, flashbacks), it is important to educate the child about their own traumatic reaction in response to violence and help normalize their experiences. Also insuring that interventions are developmentally appropriate to the age and needs of the child is critical. For example, teenagers may benefit from learning to recognize violence in dating relationships and how to set healthy boundaries with the opposite sex.

Early Intervention

Longitudinal studies show that adults who witnessed domestic violence as children may have long-term psychological impairment. Therefore an essential component of treatment is early intervention to help avert the development of distressing symptoms. In particular, children who are seen in shelters should be considered for

individual and group therapy to help them deal with trauma and educate them about their responses, as well as ways to protect themselves if necessary (e.g., find an adult to help, get away to a safe place).

Families at risk for domestic violence (e.g., past history of abuse, drug/alcohol use) also need early identification by professionals in health, education, and the legal systems. Clinicians should be aware of the degree of risk for repeating abusive patterns and implement prevention awareness programs aimed at teaching about healthy family roles and boundaries and reminding families that violence in relationships is not acceptable.

Education

More emphasis on education of both parents and children about the effects of domestic violence is imperative. In many studies, although parents may acknowledge that their children are negatively impacted by witnessing domestic violence in the home, they do not refer them for counseling. Parents should be educated about the importance of the child getting treatment and should be offered appropriate referrals. Education programs aimed at increasing violence awareness and building positive images of healthy relationships should be implemented in schools, churches, and community groups that target children at risk. Additional research that focuses on developmental issues may help in developing age-appropriate interventions. Also important are programs aimed at increasing the knowledge base of professionals and other child-care workers so that they can learn to recognize possible signs (e.g., changes in behavior, trauma symptoms) that a child has been exposed to domestic violence.

Parent-Child Relationships

Research shows that parent-child relationships are frequently (if not always) negatively affected by domestic violence within the home. If the child has been separated from the perpetrator, it is important to work with the remaining parent in helping them understand the impact of what has transpired on the psychological functioning and behavior of the child. Children also need assistance in learning to express their fears, and parents need to learn how to be reassuring without discounting or blaming. Modeling is also an effective way to teach parents these skills, as well as how to set limits with their children in nonviolent ways.

Gender Issues

Findings of the research indicate that aggression tends to be directed more at boys than at girls by both parents, which should also inform the choice of interventions. Assisting families with boys may, therefore, be somewhat different than working with families who have girls. Even so, some studies show that girls behave as aggressively as boys do in reacting to domestic violence, which suggests that both parents and children need to be educated about a variety of ways children cope with domestic violence.

Community Support

Finally, an effective intervention program should raise awareness of the impact of domestic violence for the community at large. Books, pamphlets, seminars, church involvement, community advocate groups, and the media are all potential methods for helping educate the public regarding both short-term and long-term effects of domestic violence. A collaborative approach between law enforcement agencies, schools,

community groups, and mental health professionals is needed to help families in crisis and children who are exposed to domestic violence. Through greater understanding of the findings of research and building upon the work that has already been done, adults must work together to create a safer place for children.

REFERENCES

Achenbach, T. (1990). *Young Adult Behavior Checklist.* Burlington, VT: University of Vermont Department of Psychiatry.

Achenbach, T. M., & Edelbrock, C. S. (1986). *Manual for the Child Behavior Checklist and Revised Child Behavior Profile.* Burlington, VT: Queen City Printers.

Achenbach, T., Howell, C., McConaughy, S., & Stanger, C. (1994). Six-year predictors of problems in a national sample: III. Transitions to young adult syndromes. *Journal of the American Academy of Child and Adolescent Psychiatry, 34,* 658-669.

Arnold, D. S., O'Leary, S. G., Wolff, L. S., & Acker, M. M. (1993). The Parenting Scale: A measure of dysfunctional parenting in discipline situations. *Psychological Assessment, 5,* 137-144.

Baker, M. (2000). The long-term psychological effects of childhood exposure to interparental violence (Doctoral dissertation, California School of Professional Psychology, Berkeley/Alameda, 2000). *Dissertation Abstracts International, 61* (05), 2744B.

Beck, A. (1978). *Beck Depression Inventory.* Philadelphia: Center for Cognitive Therapy.

Beck, A. T., & Beamesderfer, A. (1974). Assessment of depression: The Depression Inventory. In P. Pichot (Ed.), *Modern problems in pharmacopsychiatry* (pp. 151-169). Basel, Switzerland: Karger.

Beck, A. T., Rush, J. A., Shaw, B. F., & Emery, G. (1980). *Cognitive therapy of depression.* New York: Guilford Press.

Bengston, V. L., & Schrader, S. (1982). Parent-child relations. In D. J. Mangen & W. A. Peterson (Eds.), *Research instruments in social gerontology: Vol. 2. Social roles and social participation* (p. 154). Minneapolis, MN: University of Minneapolis Press.

Bernstein, E. M., & Putnam, S. W. (1984). Development, reliability, and validity of a dissociative scale. *Journal of Nervous and Mental Disease, 174,* 727-735.

Booth, A., Amato, P. R., Johnson, D. R., & Edwards, J. N. (1993). *Marital instability over the life course: Methodology report for the four wave study.* Unpublished manuscript, Department of Sociology, Pennsylvania State University at University Park.

Briere, J., Elliott, D. M., Harris, K, & Cotman, A. (1995). Trauma Symptom Inventory: Psychometrics and association with childhood and adult victimization in clinical samples. *Journal of Interpersonal Violence, 10,* 387-401.

Briere, J., & Runtz, M. (1989). The Trauma Symptom Checklist (TSC-33): Early data on a new scale. *Journal of Interpersonal Violence, 4,* 151-163.

Chemtob, C. M., Carlson, J. G., & Perrone, P. A. (2000, October). *Domestic violence in Hawaii: Impact on mothers and their children.* A report by the Pacific Behavioral Health Services Corporation; University of Hawaii at Manoa; and the Crime Prevention and Justice Assistance Division, Department of the Attorney General, State of Hawaii.

Cook, C. (1986). *The Youth Self-Report Hostility Scale.* Unpublished manuscript, Program for Prevention Research, Arizona State University at Tempe.

Coopersmith, S. (1981). *Manual of the Adult Self-Esteem Scale.* Palo Alto, CA: Consulting Psychologists Press.

Crews, T. M., & Sher, K. (1992). Using adapted short MASTs for assessing parental alcoholism: Reliability and validity. *Alcoholism: Clinical and Experimental Research, 16,* 576-584.

Derogatis, L., & Spencer, P. (1982). *The Brief Symptom Inventory: Administration, scoring, and procedures manual.* Baltimore, MD: Clinical Psychometric Research.

Duong, B. (2000). *Children as invisible victims of domestic violence.* Unpublished master's thesis, California State University, Long Beach.

Edleson, J. L. (1999). Children's witnessing of adult domestic violence. *Journal of Interpersonal Violence, 14,* 1-22.

Fantuzzo, J., Boruch, R., Beriama, A., & Atkins, M. S. (1997). Domestic violence and children: Prevalence and risk in five major U.S. cities. *Journal of the American Academy of Child and Adolescent Psychiatry, 36,* 116-122.

Finkelhor, D. (1979). *Sexually victimized children.* New York: Free Press.

Foa, E. B., Cashman, L., Jaycox, L., & Perry, K. (1997). The validation of a self-report measure of posttraumatic stress disorder: The Posttraumatic Diagnostic Scale. *Psychological Assessment, 9,* 445-451.

Foot, A. (1993). *University of Michigan survey regarding alcohol and other drugs.* Unpublished report, University of Michigan Substance Abuse Center, Ann Arbor.

Graham-Bermann, S. A. (1996). Family worries: Assessment of interpersonal in children from violent and nonviolent families. *Journal of Clinical Child Psychology, 25,* 280-287.

Harter, S. (1985). *The Self-Perception Profile for Children: Revision of the Perceived Scale for Children.* Denver, CO: University of Denver.

Henning, K., Leitenberg, H., Coffey, P., Bennett, T., & Jankowski, M. (1997). Long-term psychological adjustment to witnessing interparental physical conflict during childhood. *Child Abuse and Neglect, 21,* 501-515.

Hodges, K. (1986). *The Child Assessment Schedule.* Unpublished instrument.

Hollingshead, A. B., & Redlich, F. C. (1958). *Social class and mental illness: A community study.* New York: John Wiley.

Jouriles, E. N., McDonald, R., Norwood, W. D., & Ezell, E. (2001). Issues and controversies in documenting the prevalence of children's exposure to domestic violence. In S. A. Graham-Bermann & J. L. Edleson, J.L. (Eds.), *Domestic violence in the lives of children: The future of research, intervention, and social policy,* (pp. 13-34). Washington, DC: American Psychological Association.

Jouriles, E. N., & Norwood, W. D. (1995). Physical aggression toward boys and girls in families characterized by the battering of women. *Journal of Family Psychology, 9,* 69-78.

Kilpatrick, K. L., Litt, M., & Williams, L. M. (1997). Post-traumatic stress disorder in child witnesses to domestic violence. *American Journal of Orthopsychiatry, 67,* 639-644.

Kolbo, J. R. (1996). Risk and resilience among children exposed to family violence. *Violence and Victims, 11,* 113-128.

Maker, A. H., Kemmelmeier, M., & Peterson, C. (1998). Long-term psychological consequences in women of witnessing parental physical conflict and experiencing abuse in childhood. *Journal of Interpersonal Violence, 13,* 574-589.

Margolin, G. (1998). Effects of domestic violence on children. In P. K. Trickett & C. J. Schellenbach (Eds.), *Violence against children in the family and the community* (pp. 57-92). Washington, DC: American Psychological Association.

McCloskey, L., Figueredo, A., & Koss, M. (1995). The effects of systemic family violence on children's mental health. *Child Development, 66,* 1239-1261.

McNeal, C., & Amato, P. R. (1998). Parents' marital violence: Long-term consequences for children. *Journal of Family Issues, 19,* 123-139.

Nader, K. O., Kriegler, J. A., Blake, D. D., Pynoos, R. S., Newman, E., & Weathers, F. W. (1996). *Clinician-Administered PTSD Scale for Children and Adolescents for DSM-IV.* Boston: National Center for PTSD.

O'Keefe, M. (1994). Linking marital violence, mother-child/father-child aggression, and child behavior problems. *Journal of Family Violence, 9,* 63-78.

Ortiz, E. T. (1989). *Human Options graduates: A follow-up study and needs assessment.* Newport Beach, CA: Human Options.

Parker, G., Tupling, H., & Brown, L. (1979). A parental bonding instrument. *British Journal of Medical Psychology, 52,* 1-10.

Pynoos, R. S., & Nader, K. (1993). *Child PTSD Reaction Index.* Unpublished test, Department of Psychiatry, University of California, Los Angeles.

Rosenberg, M. (1965). *Society and adolescent self-image.* Princeton, NJ: Princeton University Press.

Selzer, M. L., Vinokur, A., & Van Rooijen, L. (1975). A self-administered short Michigan Alcoholism Screening Test (SMAST). *Journal of Studies on Alcohol, 36,* 117-132.

Silvern, L., Karyl, J., Waelde, L., Hodges, W. F., Starek, J., Heidt, E., et al. (1995). Retrospective reports of parental partner abuse: Relationships to depression, trauma symptoms and self-esteem among college students. *Journal of Family Violence, 10,* 177-202.

Spaccarelli, S., Sandler, I., & Roosa, M. (1995). History of spouse violence against mother: Correlated risks and unique effects in child mental health. *Journal of Family Violence, 9,* 79-98.

Spielberger, C. D., Johnson, E. H., Russell, S. F., Crane, R. J., Jacobs, G. A., & Worden, T. J. (1985). The experience and expression of anger: Construction and validation of an anger expression scale. In M. A. Chesney & R. H. Rosenman (Eds.), *Anger and hostility in cardiovascular and behavioral disorders* (pp. 5-30). New York: Hemisphere.

Sternberg, K. J., Lamb, M. E., Greenbaum, C., Cicchetti, D., Dawud, S., Cortes, R. M., et al. (1993). Effects of domestic violence on children's behavior problems and depression. *Developmental Psychology, 29,* 44-52.

Straus, M. A. (1979). Measuring intrafamily conflict and violence: The Conflict Tactics Scales. *Journal of Marriage and the Family, 41,* 75-88.

Straus, M. A., Hamby S. L., Boney-McCoy, S., & Sugarman, D. B. (1996). The Revised Conflict Tactics Scales (CTS2): Development and preliminary psychometric data. *Journal of Family Issues, 17,* 283-316.

Wechsler, D. (1974). *Manual for the Wechsler Intelligence Scale for Children–Revised.* New York: The Psychological Corporation.

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