

Children Exposed to Intimate Partner Violence: Exploring Factors that Promote Resiliency

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## Abstract

### Children Exposed to Intimate Partner Violence: Exploring Factors that Promote Resiliency

Kimberly P. Foley, MA

An estimated 3.3 (Carlson, 1984) to 10 million (Straus, 1992) children are exposed to intimate partner violence per year. Exposure to IPV has been shown to have a profound impact upon children's cognitive, behavioral, and emotional functioning. Until recently, the majority of research examining children's experiences of IPV approached the field from a deficits perspective; choosing to examine the negative impacts IPV had upon children. This study instead explored the effects of IPV upon children from a resiliency perspective; choosing to examine the adaptive functioning children displayed despite experiencing this trauma. This study explored previously identified constructs such as maternal psychopathology, maternal severity of IPV, child proximity to IPV, family support, and the parent-child relationship upon behavior problems and adaptive functioning in children. Results demonstrated a multitude of factors that were related to child resiliency and offered insight regarding possible treatments for women, children, and families who have experienced IPV. Limitations, implications, and future directions are also elucidated.

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## Review of Relevant Literature

Intimate partner violence (IPV) has a long standing and clandestine history of existing within relationships (Edleson, 1999a). IPV is usually regarded as a private matter that most individuals are reluctant to discuss, which presents challenges in identifying and accessing the children most in need of assistance (McAlister Groves, 1999). Besides the obvious physical aspects of IPV, the stigma of abuse bears shame and embarrassment for the men, women, children, and extended social networks implicated in the violence. Arrest information may be published for the entire community to scrutinize. Perpetrators risk losing employment, community-elected positions, or face legal ramifications (Bragg, 2003), placing the family in jeopardy of losing the income they depend upon for housing, food, clothing, or even social status. Women fear their violent partners will retaliate with escalating levels of violence if charges are brought against them. Cases of IPV are also challenging to prosecute and women's lives may be scandalized during legal proceedings. Women with older male children may hesitate to leave violent relationships as these children may not be permitted in emergency housing residences. Some women and children may not leave violent homes because they fear their perpetrator will harm the family pet (Becker & French, 2004). Thus, a multitude of factors contribute to children's prolonged exposure to IPV and pose a challenge for service delivery.

### *Female Perpetrators of Violence Against Males*

While this study will focus on male perpetrators of violence against females, it would be a mistake not to acknowledge that males are also victims of IPV. While both sexes experience IPV, it is more commonly female partners who are the victims of abuse and suffer the most severe consequences (AMA, 1992; APA, 2001; Fergusson, 1998). Most female violence perpetrated against male partners results from female partners defending themselves or resisting

a violent attack from an intimate partner. Women are less likely to initiate IPV, but may engage in defensive violence to protect themselves or their children (Martin, 1997; Mazur Abel, 2001).

*Male Perpetrators of Violence Against Females*

Definitions of IPV have fluctuated across historical periods, cultures, countries, beliefs, and value systems (Becker & French, 2004). As knowledge regarding IPV has developed, the current nomenclature of IPV has replaced antiquated terms such as wife abuse, spouse abuse, partner abuse, battering, and domestic violence (AMA, 1992). Previous terminology alienated large segments of the population by failing to acknowledge that not all intimate partners are married or cohabitate. Furthermore, IPV often manifests in forms above and beyond physical violence (Bragg, 2003). This presents a particular challenge in defining IPV that does not generate bruises or broken bones as evidence of violence. The American Psychological Association's Task Force on Male Violence Against Women defines male violence against females as:

physical, visual, or sexual acts that are experienced by a woman or girl as threat, invasion, or assault and have the effect of hurting her or degrading her and/or taking away her ability to control contact (intimate or otherwise) with another individual (Koss, Goodman, Browne, Fitzgerald, Puryear-Keita, & Russo, 1994, p. xvi).

Therefore, IPV may encompass such acts as physical violence, sexual violence, psychological violence, verbal-emotional violence, and financial manipulation (Bragg, 2003; Lehmann, 1997).

Physical violence encompasses pushing, punching, slapping, throwing objects, kicking, choking, using weapons, and homicide (APA, 2001; Bragg, 2003). Sexual violence may manifest in forced sexual acts such as rape, unwanted touching (APA, 2001), sexual name calling, unfaithfulness, and false accusations (Bragg, 2003). Psychological violence includes terrorizing a

partner, physical and social isolation from support networks such as friends and family, threats of harm to partner or self, and intimidation (AMA, 1992; APA, 2001). Verbal-emotional violence includes name calling, criticizing, put-downs, ignoring, yelling, humiliation, threatening, swearing, extreme jealousy, insulting, and lying (AMA, 1992; Bragg, 2003). Financial manipulation includes controlling all financial resources such as money and credit cards, checking and savings accounts, bills, and paychecks and not permitting the partner access to these resources or records (Bragg, 2003). Thus, the most comprehensive definition of IPV should include any covert or overt aggressive act between intimate partners including, but not limited to, physical violence, sexual violence, psychological violence, verbal-emotional violence, and financial manipulation.

Challenges arise when defining IPV between adults; it is even more difficult to characterize what constitutes exposure to IPV for children. Historically, witnessing a violent event has been defined as “being within visual range of the violence and seeing it occur” (Edleson, 1999a, p. 840). However, children who do not visually witness IPV may still be affected by its impact and repercussions. Therefore, Holden (2003) argued that “‘exposed’ is a better term than ‘witnessed’ or ‘observed’ because it is more inclusive of different types of experiences and does not assume that the child actually observed the violence” (p. 151). Thus, the word “exposed” is being used increasingly in the literature as the definition encompasses multiple forms of children’s exposure to IPV (Bragg, 2003).

Many parents believe their children are shielded from IPV as the violence does not occur when they are present (i.e., children are sleeping or at school) (Edleson, 1999a); however, many of these children report that violence is present in their lives (Edleson, 1999a; Holden, 2003). Children exposed to IPV accurately describe violent events that they did not directly witness, but

rather overheard (Bragg, 2003; Edleson, 1999a). Additionally, experiencing the repercussions of IPV may be as devastating upon children as having actually witnessed the violent event (Edleson, 1999a). Some of the consequences of IPV for women include physical injuries, doctor visits, hospitalization, police involvement, and emergency shelter residence (Edleson, 1999a).

Holden (2003) postulated that children may experience IPV in multiple ways such as having been exposed prenatally, intervening during violence, being victimized during violence, being forced to participate in violence, being present during violence, overhearing violence occur, witnessing the short- and long-term effects of violence, and overhearing information regarding violence. Therefore, the most comprehensive definition of children exposed to IPV should include intervening, being injured during a violent event, participating in violence, witnessing, hearing, and experiencing the aftermath (Edleson, 1999a) of any covert or overt aggressive act between intimate partners including, but not limited to, physical violence, sexual violence, psychological violence, verbal-emotional violence, or financial manipulation.

#### *Theories Regarding Intimate Partner Violence*

Human aggression is most commonly defined as any physical or verbal behavior that an individual purposefully commits in order to intentionally injure and/or harm another individual (Bushman & Anderson, 2001; Myers, 1999). Furthermore, the perpetrator of aggression typically believes that their intended victim will be driven to avoid this violence (Bushman & Anderson, 2001). Within the realm of aggression exists two subtypes: hostile aggression and instrumental aggression. The major distinction between the two forms involves the intention of the perpetrator to inflict harm (Bushman & Anderson, 2001). Hostile aggression is spontaneous violence motivated by intense rage which is utilized as a method by a perpetrator to inflict physical or emotional injury upon an individual. Alternatively, instrumental aggression is the use of violence

that is utilized to achieve a specific goal other than harming an individual (Bushman & Anderson, 2001; Myers, 1999). Moreover, hostile and instrumental aggression may be differentiated in several other manners: goal of the behavior, anger, and thought and planning. First, in hostile aggression, harm is the main goal of violent behaviors compared to instrumental aggression in which harm is utilized only in an effort to achieve another goal. Second, in hostile aggression, anger is always present whereas in instrumental aggression anger may or may not be present in violent actions. Lastly, in hostile aggression little consideration is given to the consequences of behavior in contrast to instrumental aggression which tends to involve thought and deliberation regarding the consequences of behavior (Bushman & Anderson, 2001).

Research regarding IPV would benefit greatly from examining more closely the specific types of aggression utilized by both male and female partners involved in IPV relationships. It is important to consider the distinction between these types of aggression when critically reviewing the literature and when designing research projects targeting this population. Many projects have not made the distinction between these two types of aggression when assessing IPV prevalence (Fergusson & Horwood, 1998; Gleason, 1995; Henning, Leitenberg, Coffey, Bennett, & Jankowski, 1997; Kilpatrick & Williams, 1998), which may then inaccurately reflect the amount and severity of bidirectional IPV in these relationships. For example, female partners who experience IPV may strike their violent male partner in order to stop that partner from being violent towards them. In this example, the female partner is using violence, not with the intention of harming her partner, but rather to achieve the goal of ceasing the violence being directed towards her. However, The Revised Conflicts Tactics Scale (Straus et al., 1996), a commonly used form to assess IPV, does not differentiate between hostile and instrumental aggression and

the female partner in this example would be classified as using violence against her male partner even though the function of her behaviors was much different than the function of his behaviors.

The most well-supported hypothesis regarding IPV is that aggressive behaviors are learned and reinforced through the family system and society (Bragg, 2003; Edleson, 1999b; Myers, 1999; Trocki & Caetano, 2003). Observational learning and social learning theory postulate that aggressive behaviors are learned by witnessing others utilize aggressive behaviors (Edleson, 1999a) and noting the consequences (positive or negative) of those aggressive behaviors (Myers, 1999). This theory may explain why children who are exposed to IPV consider aggressive behaviors to be an acceptable means of conflict resolution (Bragg, 2003; Edleson, 1999a; Edleson, 1999b). Research has supported the contention that children of parents who demonstrate aggression in intimate partner relationships either utilize or experience aggressive tactics in their own interpersonal relationships (AMA, 1992; Edleson, 1999a; Myers, 1999). Therefore, social learning theory presents a strong argument for an intergenerational transmission of acceptability for the use of violence as a means of conflict resolution (Feldman, 1997).

#### *The Impact of Exposure to Intimate Partner Violence Upon Children*

The subsequent section contains data garnered from previous research studies conducted in the field of child exposure to IPV. A wide range of percentages will be present regarding exposure rates, behavior problems, social adjustment, cognitive functioning, et cetera. The results presented vary between studies as a result of different ages of participants, exposure to different forms of IPV, and different definitions of what constitutes IPV.

Previously, it was believed that only intimate partners directly involved in violent episodes suffered from the consequences; however, current research has provided evidence to the

contrary. Children who are exposed to IPV suffer effects similar to those of women who experience IPV. There are profound long-term effects for children who experience IPV (Bragg, 2003; Stiles, 2002), many of which manifest as externalizing or internalizing problem behaviors (APA, 2001). Externalizing problem behaviors are blatant acting-out behaviors such as aggression, bullying, lying, antisocial behaviors, excessive anger, and delinquency (APA, 2001; Edleson, 1999a; Reynolds & Sattler, 2002; Stiles, 2002). These behaviors are represented by disorders in the Diagnostic and Statistical Manual of Mental Disorders, 4<sup>th</sup> edition, Text Revision (DSM-IV-TR, 2000) such as conduct disorder, attention-deficit/hyperactivity disorder, and oppositional defiant disorder. Internalizing problem behaviors consist of social withdrawal, suicidal ideation, anxiety, depression, fearfulness, fatigue, and low self-esteem (APA, 2001; Edleson, 1999b; Reynolds & Sattler, 2002; Stiles, 2002). Internalizing disorders are more challenging to identify as they are less disruptive than externalizing behaviors (Reynolds & Sattler, 2002). These behaviors are represented by disorders in the DSM-IV-TR (2000) such as generalized anxiety disorder, posttraumatic stress disorder, and mood disorders such as major depressive disorder and dysthymic disorder.

Henning and colleagues' (1997) study of over 1,400 college-aged young adults revealed that IPV is frequently experienced by children. Fourteen percent of participants had witnessed a violent physical altercation, on at least one occasion, between their parents prior to 16 years of age. Furthermore, a mere 20% of these participants reported that physical altercations between their parents occurred in a singular, isolated event. This leaves 80% who reported experiencing multiple physical altercations between their parents prior to 16 years of age. Of this 80%, approximately 38% of participants reported between two and five physical altercations and 42% reported in excess of six acts of physical altercations between their parents. Men reported more

externalizing behaviors while women reported more internalizing behaviors and higher global severity index scores. Men and women who visually witnessed IPV had higher internalizing, externalizing, and total behavior problem scores than men and women who were aware of IPV but did not visually witness the violence.

Lemmey and colleagues' (2001) study of 83 children (4-18 years of age) who had experienced IPV revealed that the older children (12-18 years of age) in the sample did not demonstrate more or fewer externalizing or internalizing behavior problems than did a comparable national sample. However, younger children (4-11 years of age) who had experienced IPV did demonstrate more externalizing and internalizing behavioral problems compared to a national sample. Specifically, over one-third of young boys and nearly one-half of young girls in the IPV group possessed total behavior problem scores on the Child Behavior Checklist (CBCL; Achenbach, 1990) in the clinical referral range. Mothers endorsed that their children displayed common behavior problems such as nightmares, nervous movements, sulking, and somatic complaints such as headaches, nausea, dizziness, and eye twitches. Additionally, the severity of physical violence the mother experienced corresponded to their children's level of internalizing problems such as anxiety, depression, withdrawal, and somatic complaints.

Gleason's (1995) study of 47 children and adolescents (7 months-16 years of age) residing in a domestic violence shelter revealed that they displayed more pathology than a normative sample. Mothers who completed the Connors Parent Rating Scale (CPRS; Connors, 1970) and teachers who completed the Connors Teacher Rating Scale (CTRS; Connors, 1969) reported that these children displayed more pathology than a normative sample, with the exception that mothers did not endorse the impulsive/hyperactive scale. Mothers additionally reported that their children were less advanced with regards to developmental attainments in

areas such as communication, motor skills, and total adaptive behavior compared to normative samples via the Vineland Adaptive Behavior Scales (VABS; Sparrow, Balla, & Cicchetti, 1984). Furthermore, mothers also reported that their children demonstrated externalizing problem behaviors in areas such as conduct, learning, socialization, and hyperactivity and internalizing problem behaviors in areas such as anxiety and psychosomatic complaints.

Fergusson and Horwood's (1998) longitudinal study of over 1,000 18-year-old participants revealed that nearly 40% had been exposed to IPV at least once during their lifetime. According to criteria placed forth in the Diagnostic and Statistical Manual of Mental Disorders, 4<sup>th</sup> edition (DSM-IV, 1994), children exposed to the highest frequency of IPV were between 1.9 and 6.1 times more likely to suffer from mental health problems (conduct disorder, anxiety disorder, and major depression), substance abuse (nicotine dependence, alcohol abuse/dependence, cannabis abuse/dependence, and other substance abuse/dependence), and criminal activity (3 or more violent and property offenses) than children not exposed to IPV. Furthermore, when male partners initiated violence against female partners, children were significantly more likely to have attempted suicide, but were not significantly more likely to have attempted suicide if females initiated violence against males. Surprisingly, no differences were found between the rates of male and female initiated violence. Fergusson and Horwood stated that male and female partners engaged in similar amounts of IPV, however, the authors did not differentiate between hostile aggression and instrumental aggression or the frequency or severity of violence initiated by each gender.

Chemtob and Carlson's (2004) study of 50 children (7-17 years of age) who had experienced IPV revealed that children were exposed to verbal abuse (80%) and/or physical abuse (46%) inflicted upon their mothers by her intimate partner at least monthly. Additionally,

both mothers and children reported that children tried to intervene 56% of the time in order to protect their mothers from abuse. Mothers reported that they believed their children had experienced physical effects (56%), psychological effects (88%), and emotional effects (96%) as a result of the violence. While mothers sought psychiatric services for themselves 92% of the time, only 32% of mothers sought psychiatric services for their children, despite their reports of the effects of violence upon their child's mental health. Additionally, 50% of mothers and 40% of children in the study met diagnostic criteria for posttraumatic stress disorder (PTSD). Furthermore, mothers with PTSD were more likely to underestimate the effects of IPV upon their children compared to mothers without PTSD.

Lehmann's (1997) study of 84 children (9-15 years of age) revealed that 58% and 42% of children had experienced an average of 59 and 75 (respectively) IPV events. Utilization of the Children's Impact of Traumatic Events Scale – Family Violence Form (Wolfe & Lehmann, 1992) determined that nearly 60% of children in the study met criteria for posttraumatic stress disorder. Children who met criteria for PTSD tended to be younger and endorsed higher levels of anger, dissociation, depression, and anxiety regarding future assaults which left them feeling terrorized, helpless, and threatened.

Kilpatrick and Williams's (1998) study of 20 children (6-12 years of age) who had been exposed to IPV and 15 children (6-12 years of age) who had not been exposed to IPV, revealed that children who experienced IPV had mean scores of 36.7 ( $SD = 6.5$ ) on the Child Post-traumatic Stress Reaction Index (PTSRI; Frederick, 1985) compared to non-experiencing children who had mean scores of 8.6 ( $SD = 3.0$ ) on the PTRSI. Nineteen of the 20 children exposed to IPV met criteria for PTSD while none of the non-exposed children met criteria.

Stiles (2002) examined the effects of IPV upon children from a developmental perspective. She stated that 50% of infants display increased levels of crying, eating, and sleeping problems due to IPV exposure. Preschool children were more likely to develop problems such as psychosomatic headaches, pain, and regressive behaviors including enuresis, thumb sucking, whining, crying, clinging, and insomnia than their non-exposed counterparts. School-aged children suffered from psychosomatic headaches and pain, poorer academic achievement, fewer friends, less involvement in activities, and lower self-esteem. Lastly, adolescents displayed increased tension with members of their family and specifically within the parent-child dyad.

#### *Summary of Behavioral Problems Displayed by Children*

As the aforementioned research indicated, children exposed to IPV are dramatically impacted by its consequences. They are more likely to display hyperactivity, impulsivity, conduct disorder, posttraumatic stress disorder, anger, dissociation, learning and socialization difficulties, anxiety disorder, major depressive disorder, withdrawal, and somatic complaints. They also attained fewer developmental milestones, used/abused substances more frequently, and engaged in higher levels of criminal activity (Chemtob & Carlson, 2004; Fergusson & Horwood, 1998; Gleason, 1995; Lehman, 1997; Lemmey et al., 2001; Ornduff & Monahan, 1999) compared to normative samples.

#### *Children's Resiliency to Intimate Partner Violence*

There are two basic components to resiliency: (a) an individual must be exposed to an adverse life circumstance (i.e., poverty) or adverse life event (i.e., exposure to violence or another trauma) that threatens the growth of typical development, and (b) the individual achieves typical developmental milestones, relative to their community and culture, despite this adversity

(Goldstein & Brooks, 2006; Masten & Coatsworth, 1998; O'Dougherty Wright & Masten, 2006).

In order to be considered resilient, both these components must be present. Consequently, if an individual is not faced with an adverse event, then they would not be considered to be resilient, even if they have achieved typical development, as nothing threatened to interrupt their development (Daniel, 2006; Masten, 2001).

Hence, resiliency refers to an individual's ability to positively adapt to her or his environment despite serious adversity (Goldstein & Brooks, 2006; Masten, 2001). This positive adaptation may be present in any number of arenas such as social, academic, emotional, and behavioral. The research question posed by the majority of studies is to uncover why some children are able to cope effectively, and even thrive, in the face of major adversities, while other children are unable to successfully cope, and may develop severe emotional and behavioral problems (Collishaw et al., 2007; Jaffe et al., 2007; Luthar, 1991; Luthar & Zigler, 1991; Werner, 1995).

Currently, the majority of research in the field of psychology adopts a deficits-based approach which focuses on identifying pathology (Cowen & Kilmer, 2002; Hoge, Austin, & Pollack, 2007). This approach leaves those who conduct research from a strength-based perspective at a loss (Early, 2001; Gleason, 1995) since factors that promote positive adaptation to trauma have been relatively unexplored (Ornduff & Monahan, 1999). The literature has already shown that children exposed to IPV are at an increased risk for pathology (Graham-Bermann & Hughes, 2003), what researchers should now strive to uncover is how that risk may be minimized. Conversely, the field of resiliency targets children who do not display psychopathology, but who would be expected to subsequent to trauma, and then assesses the lack of psychopathology in these children. Essentially, resiliency research has progressed from a

deficits-based model to a strength-based model (Goldstein & Brooks, 2006; Luthar & Zigler, 1991). Because of this positive approach, resilience is gaining in popularity as a manner of study to investigate high-risk children and developing positive approaches to intervention strategies (Daniel, 2006). Identifying strengths of children and families who are exposed to IPV provides a solid basis upon which to develop possible intervention strategies (Early, 2001). Several factors examined in the literature appear to impact children's resiliency in response to IPV. Previous studies have examined child gender, chronological age of child, frequency, severity, intensity, and time elapsed since last exposure, proximity to violence, and a mother's ability to "buffer" her child from the effects of IPV.

Though resiliency research is gaining in popularity, there are drawbacks and limitations to utilizing this strengths-based approach. A general limitation of research in this field is a scarcity of longitudinal or comparison studies regarding resiliency. Few studies possess the extensive resources necessary to collect longitudinal data from participants. While more economical, there are still additional financial and personnel commitments required to collect comparison group data. Hence, the data available from cross-sectional studies inherently do not provide information regarding increases or decreases in participant behaviors over time or allow for the comparison of participant behaviors to the behaviors of the general population. While many cross-sectional studies face this challenge; resiliency studies have the additional burden of comparing strengths-based research findings to deficits-based research findings.

#### *Factors that Influence Children's Resiliency to Intimate Partner Violence*

All individuals respond differently to stressful situations and environments, and children who are exposed to IPV are no exception (Bragg, 2003; McAlister Groves, 1999). Resiliency "refers to a dynamic process encompassing positive adaptation within the context of significant

adversity (Luthar, Cicchetti, & Becker, 2000, p. 543).” While some children display adverse behaviors related to their exposure to IPV, still others remain unaffected and appear to display no dire effects (Bragg, 2003; Stiles, 2002). The explanation regarding such different outcomes when exposed to similar violent events may be accounted for by individual and contextual factors that promote resiliency in children. In order to fully comprehend these factors, it is essential to conduct studies examining factors to identify protective influences (Graham-Bermann & Hughes, 2003; Ornduff & Monahan, 1999; Prinz & Feerick, 2003).

Child gender is important to consider when examining the effects of exposure to IPV upon long-term outcome and adjustment (Kerig, 1998). Several studies have indicated that male and female children exposed to IPV demonstrate different long-term outcomes while additional studies have found no evidence of a relation between child gender and adjustment. Male children exposed to IPV have been found to display more “externalizing” behaviors (Bragg, 2003; Kerig, 1998) which may manifest in increased difficulties with peers, autonomy, and self control compared to female counterparts (Edleson, 1999a; Edleson, 1999b; Stiles, 2002). Henning and colleagues (1997) found that men exposed to IPV as children reported more externalizing symptoms on the Young Adult Self Report (YASR; Achenbach, 1990; Achenbach, Howell, McConaughy, & Stanger, 1995) whereas female children exposed to IPV have been found to display more “internalizing” behaviors (Bragg, 2003; Kerig, 1998). Henning et al. (1997) found that women exposed to IPV as children reported more internalizing symptoms on the YASR and more global symptoms on the Brief Symptom Inventory (BSI; Derogatis, 1993). Lemmey et al. (2001) provides additional support for gender differences with their findings that young girls exposed to IPV exhibited more total behavior problems in the referral range than young boys on the CBCL (45.0% versus 34.8%, respectively). Interestingly, Henning et al. (1997) additionally

found that male and female children who witnessed IPV toward the same-sex parent reported more internalizing and externalizing behavior problems and greater psychological impairment than male and female children who witnessed IPV directed toward the opposite-sex parent. Since women are primarily the victims of IPV, it seems logical that female children, who identify with their same-sex parent, experience more global psychological symptoms than males. Alternatively, Gleason (1995) did not find any gender differences of statistical significance on the CPRS, the CTRS, or the VABS. Furthermore, Fergusson and Horwood's (1998) study revealed that male and female children exposed to IPV did not differ in terms of mental health, substance abuse/dependence, and criminal offending. Lastly, studies conducted by Lehmann (1997) and Kilpatrick and Williams (1998) both found that gender did not related to whether or not children met criteria for PTSD.

Chronological age during exposure to IPV may relate to children's cognitive ability to process violent events (Bragg, 2003; Edleson, 1999a; McAlister Groves, 1999). Younger children tend to display higher levels of maladaptive behaviors than older children who possess more advanced cognitive abilities that allow them to process violent events (Bragg, 2003). Lemmey and colleagues' (2001) found that younger children (4-11 years of age) displayed significantly more total behavior problems than older children (12-18 years of age) on the CBCL. Alternatively, Gleason (1995) did not find any age statistically significant differences (7 months-5 years of age versus 6-16 years of age,  $M = 4.9$  years) on the CPRS, CTRS, or the VABS. Furthermore, Lehmann (1997) and Kilpatrick and Williams (1998) both found that chronological age was not associated with whether or not children met criteria for PTSD.

The frequency, severity, intensity, and time elapsed since last exposure to violence has been shown to correlate with increased problems in multiple areas of functioning (Bragg, 2003;

McAlister Groves, 1999; Sox, 2004). Elapsed time since exposure to violence has been correlated with the severity of children's internalizing and externalizing behavior problems such that a greater amount of time since the last exposure to violence was related to less severe difficulties (Edleson, 1999a). Additionally, children display the most anxiety and fear directly following exposure to IPV with these emotions dissipating as the amount of time since the violent event increases (Bragg, 2003). Furthermore, children who are exposed to frequent and acute IPV may internalize the abuse as their responsibility (Bragg, 2003). Lemmey and colleagues' (2001) findings revealed that children whose mothers experienced more severe levels of physical violence presented with increased levels of internalizing problem behaviors on the CBCL. Henning and colleagues (1997) also found that exposure to severe IPV that required police intervention was related to internalizing symptoms on the YASR, was marginally related to global severity symptoms on the BSI, and was not related to externalizing symptoms on the YASR. Furthermore, Ferguson and Horwood (1998) found that children exposed to increased amounts of IPV were at risk for more adjustment problems. Lastly, Lehmann (1997) found that children with PTSD were exposed to longer durations of violence and more frequent violence and had mothers with multiple abusive partners compared to children without PTSD. Alternatively, Kilpatrick and Williams's (1998) study found that frequency, intensity, and severity of IPV did not influence children's PTSD group membership.

Child proximity and type of exposure to violent events (e.g., being in the same room during violence, hearing violence while elsewhere in the home, experiencing the aftermath of violence) may also influence children's resiliency in response to IPV (McAlister Groves, 1999). Children may fare differently depending upon the type of violence (verbal, physical, sexual) and the intensity, frequency, and severity of the violence to which they were exposed (Graham-

Bermann & Hughes, 2003). Henning et al. (1997) found that girls who were exposed to (but did not witness) IPV reported more symptoms on the global severity index of the BSI and more internalizing problem behaviors on the YASR while males who were exposed to (but did not witness) IPV reported more externalizing problem behaviors on the YASR. Regardless of gender, boys and girls who actually witnessed violence (compared to being exposed) had similar outcomes on the BSI and YASR. Kilpatrick and Williams (1998) found that witness status alone differentiated PTSD group membership and accounted for 85% of variance among groups.

Most importantly, the strength of a child's relationship with adults in the home and community who are emotionally able to protect the child minimizes their experiences with IPV (Edleson, 1999a; Luthar et al., 2000; McAlister Groves, 1999; Stiles, 2002; Sox, 2004). Particularly important is the mental health status of the child's mother and her ability to serve as a "buffer" to violence, which may contribute to the resiliency of her child(ren). Mothers who suffer from psychopathology due to IPV, and the daily stress of avoiding or minimizing this violence, may not be emotionally available for their children (Bragg, 2003; Graham-Bermann & Hughes, 2003). Chemtob and Carlson (2004) found that mothers with PTSD were more likely to be depressed, express anger, have higher levels of dissociation, and have higher total and reactivity scores on the Parenting Scale (Arnold, Leary, Wolff, & Acker, 1993) than mothers without PTSD. Additionally, while 96% of mothers tried to protect their children from being physically abused, mothers with PTSD were less likely to seek mental health services for their children than mothers without PTSD; indicating that mothers with greater psychopathology may not be able to identify their child's mental health needs, resulting in decreased resiliency to the effects of IPV. Henning and colleagues (1997) found that parental caring and warmth decreased due to IPV which consequently had an effect upon their child's internalizing, externalizing, and

total problem behaviors on the CBCL. Parenting practices may also mediate children's resiliency (Graham-Bermann & Hughes, 2003), which may be particularly important in providing consistent structure for children residing in shelters who have experienced the additional stress of separation from peers, adults, and academic supports (Ornduff & Monahan, 1999). Alternatively, Kilpatrick and Williams (1998) found that maternal emotional well-being did not account for children's PTSD group membership.

Hence, it is important to realize that although children appear resilient in some environments, they may not be resilient in other arenas (Luthar et al., 2000). Resiliency in children appears to be more continuous than dichotomous, with some children demonstrating strengths in some areas and weaknesses in still others (Bragg, 2003). Conflicting findings in studies indicate that more research needs to be conducted to identify factors that promote resiliency in children exposed to IPV. Researchers are just beginning to identify and address resiliency issues that may have important implications for working with women, children, and families who have been exposed to IPV (Graham-Bermann & Hughes, 2003).

#### *Statement of the Problem*

Individual and contextual factors that promote resiliency in children who are exposed to IPV are important to consider when developing and implementing interventions for children's internalizing, externalizing, and total behavior problems. Current research has explored and demonstrated that there are psychological and behavioral consequences for children who have been exposed to IPV. However, there are contradictions and deficits in the literature regarding protective factors that may influence to what extent children display these psychological and behavioral difficulties. This research study explored potential factors that promote resiliency in children who are exposed to IPV. The primary objective of this study was to examine the

influence of IPV, maternal mental health, child proximity to IPV, family support, and the parent-child relationship upon resiliency in children, with resiliency being defined as non-clinical total behavior problems on the CBCL and the presence of an elevated strength quotient scale score on the Behavior and Emotional Rating Scale (BERS; Epstein & Sharma, 1998).

### Hypotheses and Research Questions

*Hypothesis 1: Maternal Psychopathology.* Maternal psychopathology as indicated by the BSI will be related to child resiliency as indicated by the CBCL and the BERS. It is hypothesized that children whose mothers report lower levels of psychopathology will display decreased behavior problems as measured by the CBCL Total score and increased adaptive functioning as measured by the BERS Total score (Bragg, 2003; Chemtob & Carlson, 2004; Graham-Bermann & Hughes, 2003).

*Hypothesis 2: Maternal Severity of IPV.* Maternal report of severity of IPV as indicated by the Revised Conflict Tactics Scale (CTS2; Straus et al., 1996) will be related to child resiliency as indicated by the CBCL and the BERS. It is hypothesized that children whose mothers report lower levels of IPV will display decreased behavior problems as measured by the CBCL Total score and increased adaptive functioning as measured by the BERS Total score (Bragg, 2003; Ferguson & Horwood, 1998; Henning et al., 1997; Lehman, 1997; Lemmey et al., 2001; McAlister Groves, 1999; Sox, 2004).

*Hypothesis 3: Child Proximity to Violence.* Child proximity to violence as indicated by the O'Leary-Porter Scale (OPS; Porter & O'Leary, 1980) will be related to child resiliency as indicated by the CBCL and BERS. It is hypothesized that children exposed to lower levels of IPV will display decreased behavior problems as measured by the CBCL Total score and

increased adaptive functioning as measured by the BERS Total score (Graham-Bermann & Hughes, 2003; Henning et al., 1997; Kilpatrick & Williams, 1998; McAlister Groves, 1999).

*Hypothesis 4: Family Support.* Family support as indicated by the Family Support Scale (FSS; Dunst, Jenkins, & Trivette, 1984) will be related to child resiliency as indicated by the CBCL and BERS. It is hypothesized that children with higher levels of family support from external sources will display decreased behavior problems as measured by the CBCL Total score and increased adaptive functioning as measured by the BERS Total score (Ornduff & Monahan, 1999).

*Hypothesis 5: Parent Child Relationship.* Maternal report of satisfaction toward parenting as indicated by the Parent Child Relationship Inventory (PCRI; Gerard, 1994) will be related to child resiliency as indicated by the CBCL and BERS. It is hypothesized that children whose mothers report increased parental satisfaction will display decreased total behavior problems as measured by the CBCL Total score and increased adaptive functioning as measured by the BERS Total score (Edleson, 1999a; Henning et al., 1997; Luthar et al., 2000; McAlister Groves, 1999; Stiles, 2002; Sox, 2004).

*Research Question 1: Resiliency and the CBCL.* How do maternal psychopathology, severity of IPV, child proximity to IPV, family support, and parental satisfaction relate to total behavior problems, as indicated by the CBCL, displayed by children exposed to IPV?

*Research Question 2: Resiliency and the BERS.* How do maternal psychopathology, severity of IPV, child proximity to IPV, family support, and parental satisfaction relate to the strength quotient, as indicated by the BERS, displayed by children exposed to IPV?

## Methods

### *Participants*

Fifty-five women who had experienced IPV were recruited via domestic violence emergency shelters and domestic violence support groups located throughout Colorado, Maryland, Pennsylvania, South Carolina, and West Virginia. These mothers completed questionnaires for 68 children who had also experienced IPV. Inclusionary criteria for participation in this study included: a) a child(ren) 1.5 to 13 years of age residing with their mother, b) the mother spoke English fluently, c) the mother was the primary target of violence, d) the perpetrator of violence was the intimate partner of the mother, and e) the mother was at least 18 years of age at the time of consent. Exclusionary criteria for participating in this study included: a) a child with a developmental disorder, b) the child was the significant target of violence, and c) there is no known Child Protective Service investigation regarding the child. A power analysis, utilizing methods advocated by Cohen (1988) was conducted and, using a power criterion of .80, it was determined that a sample of 65 children was adequate to detect a medium effect size in this project.

### *Procedure*

The Institutional Review Board at West Virginia University reviewed and approved the study protocol and informed consent forms. Recruitment occurred between September 2006 and April 2007. The primary investigator first met with the staff members of participating shelters to explain the nature of the study and discuss the surveys to be administered. The study was then explained to participants by investigators, consent was read to participants and obtained prior to completing the questionnaires, and participants were provided with a copy of their consent form. Assistance was provided by investigators if necessary to complete the questionnaires. To ensure

confidentiality, all participants were assigned an identification number and questionnaires were provided with a sealed envelope to ensure privacy of responses.

Participants were informed they may withdraw from the study at any time without penalty. Following study protocol, participants were debriefed regarding the expectations of the study and provided with a list of area resources and the primary investigator's contact information should they require services due to psychological distress as a result of participation. Participants were compensated \$15.00 for participating in this research project and completing measures for one child. If there were additional children in the family who had been exposed to IPV, the mothers were compensated an additional \$5.00 for completing measures for each additional child. Measures were presented in the following order: Demographics Form, Parent Child Relationship Inventory, Behavior and Emotional Rating Scale, Child Behavior Checklist, The Revised Conflict Tactics Scale, O'Leary-Porter Scale, Family Support Scale, and the Brief Symptom Inventory and were completed by participants in approximately 85-100 minutes.

### *Measures*

*Demographic Form (Hollingshead, Unpublished Manuscript)*. (Appendix A). Maternal caregivers completed a 24-item demographic measure. Information gathered included: maternal age, paternal age, child age, child gender, sibling ages and genders, maternal educational attainment, paternal educational attainment, maternal ethnicity, paternal ethnicity, child ethnicity, maternal relationship status, maternal employment, paternal employment, and family income. Socioeconomic status was assessed using a Two-Factor Hollingshead Index.

*Parent Child Relationship Inventory (PCRI; Gerard, 1994)*. (Appendix B). Maternal caregivers completed the Parent Child Relationship Inventory, which is a 78-item measure designed to assess a parent's attitude toward parenting and their children ranging from 3-15 years

of age. Seven narrow-band dimensions included: parental support, satisfaction with parenting, involvement with child, communication, limit setting, autonomy, and role orientation. The PCRI has internal consistencies above .70 for all scales, a median value of .82 for all scales, and good predictive validity (Gerard, 1994). Items are rated on a four-point Likert scale: 1 = Strongly Agree, 2 = Agree, 3 = Disagree, and 4 = Strongly Disagree.

*Behavior and Emotional Rating Scale (BERS; Epstein & Sharma, 1998).* (Appendix C).

Maternal caregivers completed the Behavior and Emotional Rating Scale, which is a 52-item measure designed to assess the strengths of children ranging from 5-18 years of age. There is one broad-band dimension: total score. Five narrow-band dimensions included: interpersonal strengths, family involvement, intrapersonal strengths, school functioning, and affective strengths. Correlation coefficients range between .83 and .98 and two-week test-retest reliability correlations range from .85 to .99 (Epstein & Sharma, 1998). Items are rated on a four-point Likert scale: 0 = Not At All Like The Child, 1 = Not Much Like The Child, 2 = Like The Child, and 3 = Very Much Like The Child. Elevated scores indicate increased levels of functioning.

*Child Behavior Checklist (1 ½ - 5, Achenbach & Rescorla, 2000; 6-18, Achenbach, 2001).* (Appendix D and Appendix E). Maternal caregivers completed the Child Behavior Checklist, which is an approximately 100-item (118-items for 6-18 year olds, 99-items for 1½ - 5 year olds) measure designed to assess children's social, behavioral, and emotional problems within the previous six months. Three broad-band dimensions included: internalizing behaviors, externalizing behaviors, and total problem behaviors. Eight narrow-band dimensions included: anxious/depressed, withdrawn/depressed, somatic complaints, social problems, thought problems, attention problems, rule-breaking behavior, and aggressive behavior. Internal consistency ranges from .56 to .92 and one-week test-retest reliability correlations range from .63

to .97 (Achenbach, 1990). Items are rated on a three-point Likert scale: 0 = Not True, 1 = Somewhat or Sometimes True, and 2 = Very True or Often True. Elevated scores indicate increased total problem behaviors and borderline clinical (*T*-scores of 65-69) and clinical (*T*-scores of 70 or more) ranges for each subscale. For the present study, the total behavior problems score was utilized during analyses.

*The Revised Conflict Tactics Scale (CTS2; Straus et al., 1996).* (Appendix F). Maternal caregivers completed The Revised Conflict Tactics Scale, which is a 78-item measure designed to assess the amount and severity of violence in a relationship. Ten subscales included: female and male negotiation, female and male sexual violence, female and male psychological violence, female and male injury, and female and male physical violence. Internal consistency ranges from .79 to .95 and the CTS2 is a widely used and validated instrument (Straus, Hamby, Boney-McCoy, & Sugarman, 1996). Mothers reported the frequency of whether they or their partners have demonstrated certain violent behaviors within the previous year using a seven-point Likert scale: 1 = Once In The Past Year, 2 = Twice In The Past Year, 3 = 3-5 Times In The Past Year, 4 = 6-10 Times In The Past Year, 5 = 11-20 Times In The Past Year, 6 = More Than 20 Times In The Past Year, 7 = Not In The Past Year, But It Did Happen Before, and 0 = This Has Never Happened. Elevated scores indicate increased levels of IPV.

*O'Leary-Porter Scale (OPS; Porter & O'Leary, 1980).* (Appendix G). Maternal caregivers completed the O'Leary-Porter Scale, which is a 10-item measure designed to assess how often children are exposed to verbal or physical IPV. In addition to assess verbal and physical IPV, the OPS also assesses areas such as financial discussions, child manipulation of parents, child discipline disagreements, gender roles of family members, and partner affection. Items are summed to create one broad-band score of interparental conflict. This total score

encompasses areas in addition to verbal and physical IPV exposure. The OPS has an internal consistency of .86, a two-week test-retest reliability of .96, and good predictive validity (Porter & O'Leary, 1980). Items are rated on a five-point Likert scale: Never, Rarely, Occasionally, Often, and Very Often. Total scores range from 0 - 40 with scores in excess of 20 indicating a physically abusive relationship. For the present study, scores for exposure to verbal IPV, physical IPV, and overall IPV were utilized during analyses.

*Family Support Scale (FSS; Dunst, Jenkins, & Trivette, 1984).* (Appendix H). Maternal caregivers completed the Family Support Scale which is an 18-item measure designed to assess the extent of social support that families have found helpful in raising their child over the previous 3-6 months. Six narrow-band dimensions included: informal kinship, immediate family, social organization, formal kinship, specialized professional services, and generic professional services. The FSS has internal consistency of .77, one-month test-retest reliability that ranges from .75 to .91, and good predictive validity (Dunst et al., 1984). Items are rated on a five-point Likert scale: 1 = Not At All Helpful, 2 = Sometimes Helpful, 3 = Generally Helpful, 4 = Very Helpful, and 5 = Extremely Helpful. Elevated scores indicate increased access to resources. For the present study, the six subscales were combined to equal a total scale score, which was utilized during analyses.

*Brief Symptom Inventory (Derogatis, 1993).* (Appendix I). Maternal caregivers completed the Brief Symptom Inventory which is a 53-item measure designed to assess psychological symptoms over the previous 7 days. Three broad-band dimensions included: general severity, positive symptoms, and global severity index. Nine narrow-band dimensions included: somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism. The BSI has internal reliability

that ranges from .71 to .85 and test-retest reliability that ranges from .68 to .91 (Derogatis & Melisaratos, 1983). Items are rated on a five-point Likert scale: 0 = Not At All, 1 = A Little Bit, 2 = Moderately, 3 = Quite A Bit, and 4 = Extremely. Elevated scores indicating increased problem behaviors, and borderline clinical (*T*-scores of 60-62) and clinical (*T*-scores in excess of 62) ranges for each scale.

## Results

### *Preliminary Analyses*

In total, data collected for 68 children as reported by 55 mothers were included in data analysis. To combat missing data, study personnel reviewed assessments prior to compensating participants. If missing data existed, participants were asked if the item was intentionally left blank. Missing data were minimal with the majority of participants omitting no items. The maximum amount of data missing for participants was 10%. If the mother omitted more than 10% of responses on any given measure, data for that measure alone was not considered in further analyses. One participant met this criterion (50% missing on the Parent-Child Relationship Inventory) and that one measure was not included in analysis. Missing data points for the Parent Child Relationship Inventory, Behavior and Emotional Rating Scale, Child Behavior Checklist, The Revised Conflict Tactics Scale, O'Leary-Porter Scale, Family Support Scale, and the Brief Symptom Inventory were replaced with overall means for individual items on that measure. Data were initially screened for the presence of outliers and problems of skew or kurtosis. These explorations did not indicate that outliers, skew, or kurtosis were present or affected the distribution of participants' responses.

### *Descriptive Statistics*

Demographic characteristics of this sample are presented in Table 1. The analyses presented in this document are based upon a sample of 55 women who participated in this research project. Participants were recruited from 12 domestic violence shelters or domestic violence support groups located throughout Colorado, Maryland, Pennsylvania, South Carolina, and West Virginia. The majority of women in this study were Caucasian, followed by African-American, and American Indian. Women in this study ranged from 19.75 to 51.5 years of age ( $M = 36.13$ ,  $SD = 7.15$ ). Most women reported that they were single, followed by divorced, separated, married, and cohabitating. The majority of women reported having completed specialized training or partially fulfilling college requirements and family incomes under \$20,000 per year. Assessment measures were completed by mothers for 68 children (39 female and 29 male). The majority of children were Caucasian, followed by African-American, and multiple-ethnicities. Children in this study ranged from 1.5 to 13.75 years of age ( $M = 8.67$ ,  $SD = 3.17$ ). Overall means and standard deviations for assessment measures gathered from recruitment sites in this study are presented in Table 2.

### *Major Analyses*

*Hypothesis 1: Maternal psychopathology as indicated by the BSI will be related to child resiliency as indicated by the CBCL and the BERS.*

Pearson's correlation coefficient was utilized to determine if maternal psychopathology was related to child resiliency. Bivariate correlational analysis indicated a positive correlation between maternal psychopathology (BSI Global Severity) and child behavior problems (CBCL Total), indicating that higher maternal psychopathology was related to higher behavior problems,  $r(66) = .511$ ,  $p = .000$ . Analyses also indicated a negative correlation between maternal

psychopathology (BSI Global Severity) and child adaptive functioning (BERS Total), indicating that higher maternal psychopathology was related to lower adaptive functioning,  $r(63) = -.393, p = .001$ .

*Hypothesis 2: Maternal report of severity of IPV as indicated by the CTS2 will be related to child resiliency as indicated by the CBCL and the BERS.*

Pearson's correlation coefficient was utilized to determine if maternal severity of IPV was related to child resiliency. Bivariate correlational analyses indicated a significant correlation between paternal (male-to-female) severity of IPV (CTS2 Subscales) and child behavior problems (CBCL Total), indicating that higher negotiation scores were related to lower behavior problems, (see Table 3). Two nearly significant results were found: (a) paternal severity of IPV (female-to-male injury) and child adaptive functioning (BERS Total), and (b) maternal severity of IPV (male-to-female injury) and child adaptive functioning (BERS Total). All other bivariate correlations between CTS2 subscales and child resiliency measures (CBCL Total and BERS Total) also were not significant (all  $p$ 's  $> .05$ ).

*Hypothesis 3: Child proximity to IPV as indicated by the OPS will be related to child resiliency as indicated by the CBCL and the BERS.*

Pearson's correlation coefficient was utilized to determine if child proximity to IPV was related to child resiliency. Bivariate correlational analysis indicated a significant correlation between child proximity to IPV (OPS Total) and child behavior problems (CBCL Total), indicating that closer proximity to IPV (lower scores indicate closer proximity to IPV) was related to an increase in behavior problems (see Table 4). Analyses also indicated a significant correlation between proximity to physical IPV and child behavior problems, indicating that closer proximity to physical IPV was related to an increase in behavior problems. Furthermore,

significant correlations were present between proximity to physical IPV and child adaptive functioning, as well as proximity to verbal IPV and child adaptive functioning, indicating that closer proximity to verbal and physical IPV were related to a decrease in adaptive functioning. All other correlations between child proximity to IPV and measures of child resiliency were not significant (all  $p$ 's > .05).

*Hypothesis 4: Family support as indicated by the FSS will be related to child resiliency as indicated by the CBCL and BERS.*

Pearson's correlation coefficient was utilized to determine if family support was related to child resiliency. Bivariate correlation analyses indicated significant correlations between child behavior problems (CBCL Total) and informal family support (FSS) and immediate family support (FSS), indicating that higher levels of informal and immediate family support were related to lower levels of behavior problems (see Table 5). Analyses also demonstrated a significant correlation between informal family support and child adaptive functioning (BERS Total), indicating that higher levels of informal family support were related to lower levels of adaptive functioning.

*Hypothesis 5: Maternal report of the parent-child relationship as indicated by the PCRI will be related to child resiliency as indicated by the CBCL and the BERS.*

Pearson's correlation coefficient was utilized to determine if the quality and strength of the parent-child relationship was related to child resiliency. Bivariate correlational analysis indicated significant correlations between the parent-child relationship (PCRI Subscales) and child behavior problems (CBCL Total). Results demonstrated that lower levels of child behavior problems were related to higher levels of parental support, communication, and limit setting. In contrast, higher levels of parental involvement and autonomy were related to lower levels of

behavior problems (i.e., less child resilience) (see Table 6). Analyses also indicated significant correlations between the parent-child relationship (PCRI Subscales) and child adaptive functioning (BERS Total). Results demonstrated that higher levels of parental support, parental satisfaction, communication, and limit setting were related to lower levels of adaptive functioning. Alternatively, higher levels of parental involvement and autonomy were related to lower levels of adaptive functioning.

*Research Question 1: How do maternal psychopathology, maternal severity of IPV, child proximity to IPV, family support, and the parent-child relationship relate to behavior problems, as indicated by the CBCL, displayed by children exposed to IPV?*

A multiple linear regression analysis was conducted to examine the effects of maternal psychopathology, maternal severity of IPV, child proximity to IPV, family support, and the parent-child relationship on child behavior problems. Factors that were significantly correlated with child behavior problems as measured by the CBCL Total score were entered into a multiple regression analysis. The independent variables (maternal psychopathology, parental limit setting, parental support, and child proximity to IPV overall) together accounted for 47.0% (adjusted  $R^2$ ) of the variance in child behavior problems in this model as measured by the CBCL Total score the model and was significant,  $F(4, 58) = 14.72$ ,  $p = .000$  (see Table 7).

*Research Question 2: How do maternal psychopathology, maternal severity of IPV, child proximity to IPV, family support, and the parent-child relationship relate to adaptive functioning, as indicated by the BERS, displayed by children exposed to IPV?*

A multiple linear regression analysis was conducted to examine the effects of maternal psychopathology, maternal severity of IPV, child proximity to IPV, family support, and the parent-child relationship on child adaptive functioning. Factors that were significantly correlated

with child adaptive functioning as measured by the BERS Total score were entered into a multiple regression analysis. The independent variables (maternal psychopathology, parental support, parental communication, parental involvement, child proximity to verbal, physical, and overall IPV) together accounted for 52.7% (adjusted  $R^2$ ) of the variance in child adaptive functioning in this model as measured by the BERS Total score and the model was significant,  $F(7, 56) = 11.04, p = .000$  (see Table 8).

### *Exploratory Analyses*

#### *Child Behavior Checklist and Behavioral and Emotional Ratings Scale*

This study replicated Epstein's (1997) findings which indicated that the CBCL Total score and the BERS Subscale scores were negatively correlated. For this study, results indicated that interpersonal strength, family involvement, intrapersonal strength, school functioning, affective strength, and total scores were all negatively correlated with CBCL Total score (see Table 9). The data show that lower levels of behavior problems were related to higher levels of adaptive functioning.

#### *Child Gender and Age*

Independent samples t-tests did not reveal any significant differences between female and male children on any of the dependent variables in this study (all  $p$ 's > .05). With respect to child age, Pearson's correlation coefficient was utilized to determine if child age was related to proximity to IPV, parent-child relationship, severity of IPV, maternal psychopathology, family support, problem behaviors, and adaptive functioning. A bivariate correlational analysis indicated significant correlations between child age and proximity to physical IPV and proximity to verbal IPV but a non-significant correlation to proximity to overall IPV (see Table 10). These findings indicate decreases in child age were related to closer proximity to physical and verbal

IPV but not to overall IPV. Analyses also indicated a significant correlation between child age and school functioning (BERS) but no significant relationship between age and adaptive functioning. In other words, increases in child age were related to increases in academic performance, but not overall adaptive functioning. No significant correlations were revealed between child age and the following variables: behavior problems, parent-child relationship, severity of IPV, maternal psychopathology, and family support.

#### *Child Ethnicity*

An independent samples t-test was conducted on the means of the BERS Total score to determine if the number of children in the household was related to proximity to IPV, parent-child relationship, severity of IPV, maternal psychopathology, family support, problem behaviors, and adaptive functioning. Results indicated a significant difference between white children and non-white children exposed to IPV,  $t(63) = -2.20, p = .032$  (see Table 11), indicating that white children experienced lower adaptive functioning compared to non-white children. Analyses conducted on the means of the CTS2 female-to-male physical IPV subscale revealed a significant difference between white children and non-white children,  $t(66) = -2.76, p = .008$ , indicating that mothers of white children demonstrated less physical violence towards their partners compared to mothers of non-white children. Additional analyses conducted on the means of the FSS specialized services subscale revealed a significant difference between white children and non-white children,  $t(66) = -2.10, p = .039$ , indicating that white children were less likely to receive specialized support services compared to non-white children. No significant differences were revealed between child ethnicity and the following variables: proximity to IPV, behavior problems, parent-child relationship, and maternal psychopathology.

*Number of Children in Household*

Pearson's correlation coefficients were utilized to determine if the number of children in the household was related to proximity to IPV, parent-child relationship, severity of IPV, maternal psychopathology, family support, problem behaviors, and adaptive functioning. Bivariate correlational analysis indicated significant correlations between number of children in the household and female-to-male injury (CTS2) due to IPV and female-to-male sexual (CTS2) IPV (see Table 12), indicating that higher levels of children in the household was related to lower levels of female-to-male injury due to IPV and sexual IPV. Furthermore, analyses indicated a significant correlation between number of children in the household and behavior problems (CBCL Total) signifying that higher levels of children in the household was related to lower levels of behavior problems. No significant correlations were revealed between the number of children in the household and the following variables: adaptive functioning, proximity to violence, parent-child relationship, maternal psychopathology, and family support.

*Socioeconomic States (SES)*

Pearson's correlation coefficient was utilized to determine if socioeconomic status was related to proximity to IPV, parent-child relationship, severity of IPV, maternal psychopathology, family support, problem behaviors, and adaptive functioning. Bivariate correlational analysis indicated significant correlations between socioeconomic status and behavior problems (CBCL Total) and adaptive functioning (BERS Total) denoting that higher levels of socioeconomic status were related to lower levels of behavior problems and higher levels of adaptive functioning (see Table 13). Analyses also indicated a significant correlation between socioeconomic status and parental satisfaction (PCRI) and parental involvement (PCRI) indicating that higher levels of socioeconomic status were related to higher levels of parental

satisfaction and lower levels of parental involvement. No significant correlations were revealed between socioeconomic status and the following variables: proximity to IPV, severity of IPV, maternal psychopathology, and family support.

#### *Maternal Education*

Pearson's correlation coefficient was utilized to determine if maternal education was related to proximity to IPV, parent-child relationship, severity of IPV, maternal psychopathology, family support, problem behaviors, and adaptive functioning. Bivariate correlational analysis indicated significant correlations between maternal education and behavior problems (CBCL Total) but a non-significant relation with adaptive functioning (BERS Total), indicating that higher levels of maternal education were related to lower levels of behavior problems but were not related to adaptive functioning (see Table 14). Additional analyses indicated significant correlations between maternal education and child proximity to verbal IPV (OPS) and child proximity to overall IPV (OPS) but a non-significant correlation to child proximity to physical IPV (OPS). These results demonstrate that higher levels of maternal education were related to closer child proximity to verbal IPV and overall IPV but were not related to child proximity to physical IPV. Furthermore, analyses indicated significant correlations between maternal education and parental satisfaction, parental communication, parental involvement, and parental role orientation. These results denote that higher levels of maternal education were related to higher levels of parental satisfaction and communication and lower levels of parental involvement and role orientation. Moreover, significant correlations were found between maternal education and male-to-female injury (CTS2) due to IPV, physical (CTS2) IPV, and sexual (CTS2) IPV, indicating that higher levels of maternal education were related to lower levels of male-to-female injury, physical, and sexual IPV. No significant

correlations were found between maternal education and parental support, limit setting, or autonomy.

### *Maternal Age*

Pearson's correlation coefficient was utilized to determine if maternal age was related to proximity to IPV, parent-child relationship, severity of IPV, maternal psychopathology, family support, problem behaviors, and adaptive functioning. Bivariate correlational analysis indicated significant correlations between maternal age and behavior problems (CBCL Total) and adaptive functioning (BERS Total), indicating that increases in maternal age were related to decreases in behavior problems and increases in adaptive functioning (see Table 15). Further analyses revealed significant correlations between maternal age and child proximity to physical (CTS2) IPV, but a non-significant correlation to overall (CTS2) IPV. Lastly, a significant correlation was revealed between maternal age and parental involvement (PCRI), denoting that an increase in maternal age was related to a decrease in parental involvement. No significant correlations were revealed between maternal age and the following variables: severity of IPV, maternal psychopathology, and family support.

### Discussion

Within the realm of IPV research, child resiliency is still an emerging field. Previously, IPV studies centered exclusively on the effects of male physical violence inflicted upon females. The discipline then expanded to examine the effects of additional forms of male initiated IPV (sexual, psychological, emotional, and financial) upon females. However, the effects of experiencing IPV upon children have remained relatively unexplored (Trocki & Caetano, 2003). Recently, IPV researchers have begun to examine the detrimental effects of experiencing IPV on children. This study sought to continue to investigate the effects of IPV on children from a

resiliency perspective. Results garnered from this project support previous findings regarding child exposure to IPV and also advance the child resiliency literature.

### *Maternal Psychopathology*

As hypothesized, maternal psychopathology was significantly correlated with both measures of child resiliency. Higher levels of maternal psychopathology were related to higher levels of child behavior problems and lower levels of child adaptive functioning. These relations were anticipated as women who experience IPV have been shown to demonstrate not merely physical suffering, but also mental health maladjustment, subsequent to these traumas (Bragg, 2003; Chemtob & Carlson, 2004; Graham-Bermann & Hughes, 2003). These mental health concerns may influence their interpersonal and social performance (APA, 2001; Bragg, 2003) and impact their ability to meet their children's needs (Salcido Carter et al., 1999). Indeed, Chemtob (2004) found that 92% of mothers who had experienced IPV required psychiatric services at some point in time and that half of mothers met criteria for PTSD. Furthermore, Kilpatrick (1997) postulated that maternal accounts of children's behavioral and emotional maladjustment may be related more to the mother's mental state than to the child's actual ability to self-regulate. Mental health problems may encumber mothers from accurately evaluating her and her children's environment and her ability to exert necessary changes (AMA, 1992) to improve her child's functioning. Increased levels of psychopathology necessitate that women allocate their cognitive and psychological resources towards managing their own symptoms. Thereby, women are forced to apportion fewer resources to their children, resulting in lower child resiliency in the form of increased behavior problems (Jarvis & Novaco, 2006) and decreased adaptive functioning. Alternatively, maternal mental health may serve as a protective factor for children. Mothers in this study who demonstrated increased levels of mental health

had children with decreased behavior problems and increased adaptive functioning. Therefore, addressing the mental health needs of women who have experienced IPV may consequently improve their children's resiliency to IPV.

#### *Severity of Intimate Partner Violence*

Contrary to the hypothesis, maternal (male-to-female) severity of IPV was non-significantly correlated to either measure of child resiliency. However, paternal (male-to-female) negotiation demonstrated a significant correlation to child behavior problems. Components of this construct include male partners demonstrating to their female partners: care after a disagreement, their perspective of a disagreement, that the couple could solve a problem, suggesting a compromise, and trying their partner's compromise (Straus et al., 1995), which may constitute male attempts to repair the relationship following IPV episodes. Conversely, other forms of male-to-female IPV were non-significantly correlated to either measure of resiliency. While this was unexpected, previous studies have also found no relation between the severity of IPV and child adjustment in later life (Henning, 1997). Non-significant findings may be attributed to inadequate assessment measurements for the proposed research question. The CTS2 assesses multiple forms of violence over the previous year and lifetime exposure utilizing a Likert-scale. Two points on that scale, "Not in the past year, but it did happen before" and "This has never happened" are both scored as zero. Hence, whilst the CTS2 measures IPV over the previous year, it is not necessarily an accurate indicator of IPV over the course of a lifetime. Therefore, while maternal reports of IPV during the last year may be accurate, the scoring procedure may have resulted in lower scores regarding overall IPV exposure. Interestingly, male partners who negotiated with their female partners had children who demonstrated decreased behavior problems, perhaps because these children had also learned to negotiate when

confronted with aversive situations, thereby increasing their resiliency. Cummings and colleagues (2002) research supports this and has shown that parents conflict resolution tactics has an important influence upon children's adjustment to exposure to marital conflict. Furthermore, Fergusson's (1998) study found that male and female partners initiated IPV towards their partners in equal amounts and that IPV was correlated in partners. Similar results were also present in this study in that IPV in male and female partners was again correlated. Bidirectional violence in these relationships may have influenced results as children who experience one parent initiating IPV against another parent may be different from children who experience both parents initiating IPV toward each other.

#### *Child Proximity to Intimate Partner Violence*

The hypothesis regarding child proximity to IPV and child resiliency was partially supported. Analyses demonstrated a significant relation between child proximity to physical and overall IPV, but not verbal IPV, and child behavior problems as measured by the CBCL Total score. Additionally, analyses indicated a significant relation between child proximity to physical and verbal IPV, but not overall IPV, to child adaptive functioning as measured by the BERS Total score. Interestingly, both measures of resiliency indicated that behavior problems and adaptive functioning were significantly correlated with child proximity to physical IPV. Chemtob's (2004) study found that 32% of maternal participants reported experiencing physical abuse daily and that 84% of children had witnessed the physical abuse of their mothers. Furthermore, 56% of mothers reported daily verbal abuse and that 92% of children had witnessed the verbal abuse their mothers received from their fathers. While verbal abuse occurs more frequently in IPV than physical abuse, physical abuse produces more extreme consequences due to the intensity of its nature which often results in bodily injury. Research has

repeatedly demonstrated that children who do not visually witness IPV are still affected by its repercussions. While children may not be directly exposed to IPV, they are usually aware of IPV (Holden, 2003; Ornduff, 1999) and are able to accurately describe these experiences to others based on what they have merely overheard during the event (Edleson, 1999a; Holden, 2003). Furthermore, children who do not visually witness IPV often experience other consequences of IPV such as police involvement and maternal injuries resulting in Emergency Department services (Edleson, 1999a). Hence, while verbal IPV may occur at slightly higher rates in the presence of children, physical IPV that transpires behind closed doors may impact children more significantly. Additionally, this study assessed children's proximity to IPV, but not their awareness of IPV, which may have provided differing results.

#### *Family Support Systems*

Contrary to the hypothesis, family support was not significantly related to either measure of child resiliency. However, significant relations existed between two components of the FSS, informal family support and immediate family support, and child behavior problems (CBCL Total). These findings indicate that women who were able to access support networks that included their partner, their partner's parents, friends, their partner's friends, their children, the parents of other children, and church members had children who displayed fewer behavioral problems. Additionally, a significant relation was found between the FSS informal support and adaptive functioning (BERS Total), indicating that mothers who were able to access support networks that included their friends, their partner's friends, their children, the parents of other children, and church members had children who displayed increased adaptive functioning. This finding suggests that women who had extensive and supportive networks of friends and family also had children who displayed fewer behavior problems and increased adaptive functioning.

While overall family support may not have been correlated with child resiliency, certain components of family support, specifically extended family and friends, were related to child resiliency. It may be that these adult role models fulfilled functions for these children that were left empty by mothers coping with their own IPV experiences; hence, providing a supportive environment that may not have been present or further enhancing an already supportive environment. These results support Jaffe and colleagues (2007) findings that children who had meaningful relationships with adults in the community had increased levels of resiliency.

#### *Parent-Child Relationship*

As hypothesized, a significant relation was found between the parent-child relationship and both measures of child resiliency. This finding was expected as children's relationships with their caregivers have been found to increase resiliency (Jaffe et al., 2007; Masten & Coatsworth, 1998). For example, Collishaw and colleague's (2007) study revealed that adults who were abused as children reported increased resiliency if they had at least one caring parent. Significant correlations in this study indicated that increases in levels of parental support (emotional and social support a parent receives), communication (parent-child communication, empathy towards child), and limit setting (effectiveness of parental discipline) were related to decreases in behavior problems and increases in adaptive functioning. Significant correlations indicated that increases in parental involvement (parental involvement in child activities) and autonomy (parental commitment to child independence) were related to increases in behavior problems and decreases in adaptive functioning. Findings also indicated that an increase in satisfaction with parenting (enjoyment and fulfillment in parental role) was related to an increase in adaptive functioning but was not related to behavior problems. Results indicate that parents who have increased levels of emotional and social support, effective communication patterns with their

children, and effective discipline practices have children with decreased levels of behavior problems and increased levels of adaptive functioning. Results also suggest the possibility that parents who were over-involved in child activities or who granted their children too much independence had children with increased levels of behavior problems and decreased levels of adaptive functioning. Findings suggest that increases in enjoyment and fulfillment as a parent were related to increases in adaptive functioning but were not related to child behavior problems. Parents serve as the primary social educator for their children who observe and learn from their parents how to act and respond accordingly in social situations. It may be that children whose parents receive emotional and social support, practice effective communication strategies, and fairly and effectively discipline their child have children who emulate their example and seek out support systems, demonstrate pertinent communication skills, and possess self-regulatory abilities, all of which increase their resiliency to IPV.

#### *Behavior Problems, Adaptive Functioning, and Resiliency*

The most highly correlated variables that predicted behavior problems in children exposed to IPV were maternal psychopathology, parental limit setting, parental support, and child proximity to overall IPV. These variables were further analyzed to determine which variable contributed the most toward behavior problems. Results indicated that the most significant predictor of behavior problems was maternal psychopathology. This was followed by parental limit setting and parental support. Overall exposure to IPV did not account for unique variance individually. The most highly correlated variables that predicted adaptive functioning in children exposed to IPV were maternal psychopathology, parental support, communication, involvement, and child proximity to verbal, physical, and overall IPV. These variables were further analyzed to determine which variable contributed the most toward adaptive functioning.

Results indicated that communication was the most significant predictor of adaptive functioning followed by maternal psychopathology, child proximity to physical IPV, and parental support. Parental involvement and child proximity to verbal and overall IPV did not account for unique variance individually. These results are important because they indicate which variables are most likely to impact child resiliency, allowing for programs to be designed that target these high risk factors and, thereby maximize a child's ability to be resilient.

### *Exploratory Analyses*

In this study, resiliency was measured utilizing the CBCL Total score and the BERS Subscale scores as previously demonstrated in the literature (Epstein, 1997). Prior findings were replicated and revealed that the CBCL Total score and BERS Subscale scores were negatively correlated, indicating that a decrease in the CBCL Total score was related to an increase in BERS Subscale scores. This is important as resiliency can be constructed as both the absence of behavior problems and the presence of adaptive functioning despite exposure to traumatic circumstances. Collectively, these two assessments appear accurate predictors for child resiliency as they measure both components. It is important to assess both constructs as resiliency is not a dichotomous variable. Children are not either resilient or not resilient, but rather demonstrate strengths in some areas and deficits in other areas, which may also change over time. In order to ascertain a more global perspective on child resiliency, it is therefore important to understand how the child is faring both positively and negatively.

### *Child Gender*

Independent samples t-test conducted on the gender of child participants did not reveal any significant differences between female and male children in this study. Previous studies reported conflicting results; some indicated that male and female children exposed to IPV

demonstrated different long-term outcomes while others found no evidence of a relation between child gender and adjustment to IPV. Male children exposed to IPV have been found to display more “externalizing” behaviors (Bragg, 2003; Edleson, 1999a; Edleson, 1999b; Henning et al., 1997; Kerig, 1998; Stiles, 2002) while female children exposed to IPV have been found to display more “internalizing” behaviors (Bragg, 2003; Henning et al., 1997; Kerig, 1998). Alternatively, Gleason (1995) did not find any gender differences of statistical significance on the CPRS, CTRS, or VABS (Gleason, 1995), mental health, substance abuse/dependence, or criminal offending (Fergusson & Horwood, 1998), or PTSD (Kilpatrick & Williams, 1998; Lehmann, 1997).

### *Child Age*

Pearson’s correlation coefficient conducted on child age revealed several significant differences in this study. This study found that child age was related to proximity to physical IPV and verbal IPV and school functioning. Child proximity and type of exposure to violent events (e.g., being in the same room during violence, hearing violence while elsewhere in the home, experiencing the aftermath of violence) may also influence children’s resiliency to IPV (McAlister Groves, 1999). Henning et al. (1997) found that, regardless of gender, males and females who actually witnessed violence (compared to being exposed) had similar outcomes on the BSI and YASR. Kilpatrick and Williams (1998) found that witness status alone differentiated PTSD group membership and accounted for 85% of variance among groups. Previous studies support the finding that younger children displayed more behavior problems, maladaptive behaviors, psychological trauma than older children due to their decreased cognitive processing abilities (Bragg, 2003; Edleson, 1999a; Lemmey et al., 2001; McAlister Groves, 1999) which may influence their understanding of IPV events.

*Child Ethnicity*

An independent samples t-test conducted on the means of the BERS Total score revealed that white children experienced lower adaptive functioning than non-white children. The mothers of white children also demonstrated less physical IPV towards their partners than the mothers of non-white children and white children were less likely to receive specialized support services compared to non-white children. These results indicate that mothers of non-white children reciprocate their partner's IPV at higher rates than mothers of white children and mothers of non-white children are more likely to access support services than mothers of white children. These findings provide evidence that white children may witness more unidirectional IPV between caregivers and are less resilient than non-white children who may witness more bidirectional IPV between caregivers. Furthermore, non-white children whose mothers accessed support services fared better than white children whose mothers did not access support services as often.

*Exploratory Analyses*

Pearson's correlation coefficients were conducted on a variety of demographic variables including number of children in the household, socioeconomic status, maternal education, and maternal age. Number of children in the household was significantly correlated to behavior problems but was not correlated to adaptive functioning. This suggests that as the number of children in the household increases, parents may be forced to allocate fewer resources (emotionally and financially) to each child, consequently resulting in increased behavior problems. Socioeconomic status was negatively correlated with behavior problems and positively correlated with adaptive functioning. This finding suggests that families with higher socioeconomic status, who have access to more financial resources, have children with fewer behavior problems and increased adaptive functioning compared to families with lower

socioeconomic status. Maternal education was negatively correlated to male-to-female injury due to IPV, male-to-female physical IPV, and male-to-female sexual IPV. This finding suggests that mothers with higher levels of education may experience less IPV compared to mothers with lower levels of education. Lastly, maternal age was negatively correlated with behavior problems and positively correlated with adaptive functioning. This finding suggests that older mothers had children with fewer behavior problems and less behavior problems.

### Limitations

Several limitations were observed throughout the course of this research project. To begin, this study did not assess overlapping violence, such as IPV directed toward the mother concurrent with physical, psychological, emotional, or sexual violence directed towards the child. Edleson's (1999c) review of the literature found that IPV and child abuse frequently coincide. Due to the sensitive nature of the participants enrolled in this study, subsequent child abuse that may have occurred within these homes was not explored. However, it is important to note that merely because it was not explored does not mean that it was not present.

Second, a number of assessments utilized in this study (i.e., O'Leary-Porter Scale, The Revised Conflict Tactics Scale, and the Family Support Scale) demonstrated scale and or metric issues that may have influenced analyses. These measures and future research studies that utilize them would be greatly enhanced by their further development. Furthermore, the women in this study reported contradictory information regarding the amount of time since their last IPV experience on the demographics form and on the CTS2. This may be accounted for by the narrow definitions that currently constitute IPV. The demographics form could have been enhanced by including the various forms of IPV and assessing when each of these types of IPV last occurred. The OPS assesses multiple components of parenting such as discipline practices,

personal complaints, and affection between partners. While these items assess meaningful relationship components, they do not necessarily assess IPV per se. Hence, utilizing the OPS Total score may not have been the best measurement of child proximity to IPV. Additionally, utilizing one item to assess physical IPV and one item to assess verbal IPV exposure may not be an accurate indication of the child's experiences with IPV overall.

Third, there were several important areas that may affect children's resiliency that this study was unable to assess. Information gathered from multiple sources regarding children's resiliency would have provided a more global view of their behavior problems and adaptive functioning in a multitude of environments. Direct measures of school functioning would have provided more information regarding children's strengths and problem areas. In particular, reports gathered from children's school teachers could have revealed a more comprehensive view of children's academic attainment, peer relationships, and maladaptive or adaptive behaviors. Childcare workers at the domestic violence shelters or support groups could have provided additional information regarding the children in those settings. The IPV field also would benefit from more thorough investigations into the father's relationships with their children (Edleson, 1999c). Paternal reports of child behaviors, the father-child relationship, and IPV within their relationship would have provided a more complete evaluation than maternal report alone. Additionally, child self-report would have provided researchers with the child's perspective regarding their behaviors, peer and parent relationships, and functioning in multiple settings. Furthermore, behavioral observations on the parent-child relationship and children's behaviors across multiple environments would have provided objective data to supplement multiple informant reports. The literature also suggests that maternal report, a common method to gather child data, may actually skew data (Edleson, 1999b) as parents often mistakenly believe

their children do not witness IPV episodes (Edleson, 1999a; Edleson, 1999b; Holden, 2003; Margolin & Gordis, 2004). Hence, maternal reports may underestimate children's exposure to IPV. Finally, this study could have benefited from the inclusion of measures that evaluate the family's exposure to additional stressors, such as residence in deprived neighborhoods or exposure to school violence.

Fourth, no qualitative data were gathered regarding the women's and children's experience of IPV. Although quantitative information was gathered regarding families' experiences and responses to IPV, each mother and child has different IPV experiences. Qualitative data could have provided a more personal account of information that was pertinent to the family along with gathering information regarding the accuracy of children's perceptions of events they witnessed or overheard.

Fifth, the age of child participants at the time of the first and last exposure to IPV was not assessed in this study. For this project, ages of child participants were determined based upon the date their mothers completed study measures. One criterion for participation in this study was that IPV must have occurred within the last year. For example, some children in this study may have been exposed to IPV one year ago while other children may have been exposed to IPV within 24-hours of their mothers completing questionnaires. Hence, the amount of time since exposure to IPV and duration of exposure to IPV is inconsistent across participants. Previous research has demonstrated that the amount of time since exposure to IPV has been correlated with the severity of children's internalizing and externalizing behavior problems, anxiety and fear, and PTSD (Bragg, 2003; Edleson, 1999a; Lehmann, 1997).

Sixth, due to time, budget, and personnel constraints, this study was designed to be cross-sectional. Data available from cross-sectional studies inherently do not provide information

regarding increases or decreases in participant behaviors over time or allow for the comparison of participant behaviors to the behaviors of the general population. The results and implications of the findings derived from this project would have been more convincing if they were the result of a longitudinal or comparison study.

Lastly, there is a high chance of Type 1 Error occurring in this project. Due to the large number of correlations conducted in this study; the probability exists that some results may have occurred by chance and should have, in actuality, been rejected. As this is one of the first studies examining child resiliency following IPV exposure and there are a number of methodological limitations inherent in the design, results should be considered tentative until replicated.

#### Implications

The purpose of this study was to understand how IPV affects children so that more effective treatments can be developed and detrimental long-term effects reduced. This study examined a population that was recently involved in IPV. Instead of focusing solely on child psychopathology, this study included an evaluation of positive factors that can be defined as resiliency. Identifying the specific areas that most impact resiliency allows for researchers to focus on these components when developing prevention and treatment programs, thereby increasing children's resiliency to IPV. The information garnered from this study may be important in designing and implementing treatment programs for women and children affected by IPV (Edleson, 1999a; Goldstein & Brooks, 2006). Findings show that establishing independent programs for women and children affected by IPV along with coordinated mother-child programs may enhance children's resiliency to IPV. These programs should be available within a variety of settings such as shelters, support groups, outreach services, therapy sessions, personal residences, and schools. This research may help inform public policy regarding the

impact of how funds could be allocated and dispensed, encouraging effective, evidence-based treatments for children affected by IPV.

In the current study, mothers with lower levels of mental health had children who displayed higher levels of behavior problems and lower levels of adaptive functioning. IPV programs have traditionally centered on addressing women's immediate needs such as safety, health concerns, housing, and employment needs (Graham-Bermann, 2003) and do not necessarily address mental health needs. Designing programs that specifically address mothers' mental health needs may have positive effects upon children's functioning. Additionally, mothers in this study who were able access family, friends, and community resources had children who displayed fewer behavior problems and increased adaptive functioning. Educating mothers about community programs created for families experiencing IPV will strengthen their ties with the community, provide mothers with support networks, and target children in need of additional services.

Increased child proximity to verbal, physical, and overall IPV was related to increased behavior problems and decreased adaptive functioning. Many community organizations have designed outreach programs to target women affected by IPV, however not all of these programs offer services for children while the mother receives treatment (Salcido Carter et al., 1999). Programs must also be designed that address children's issues, at levels that are developmentally appropriate, which may improve children's resiliency to IPV. Many programs for children who have experienced IPV are based upon IPV programs for women (Salcido Carter et al., 1999) and do not account for children's different perceptions of the trauma. The current investigation also suggests that programs should be designed to educate maternal and paternal caregivers about the effects of experiencing not only physical, but also verbal, IPV upon their children as many

individuals who engage in verbal IPV do not understand the long-term consequences of these behaviors upon their children.

The quality of the parent-child relationship has also been shown to impact children's behavior problems and adaptive functioning. Implementing parent training programs that specifically focus on support, communication, limit setting, parental involvement, and autonomy may strengthen the quality of the parent-child relationship as well as decrease children's behavior problems and increase their adaptive functioning. These programs should instruct mothers on the use of non-physical methods, such as time-out, to discipline their child's inappropriate behaviors when necessary. Additionally, children should be taught effective resolution management techniques to resolve conflicts such as communication skills versus physical methods.

There are a range of evidence-based programs, generally referred to as behavioral parent training, which address the communication and limit setting variables found in this study to be associated with resilience. These programs include, but are not limited to, *Helping the Noncompliant Child* (McMahon & Forehand, 2005), *Parent-Child Interaction Therapy* (Hembree-Kigin and McNeil, 1995), *The Incredible Years* (Webster-Stratton, 1992), and *The Oregon Model of Parent Management Training* (Patterson & Chamberlain, 1988). In general, behavioral parenting training programs involve two phases: (a) one improving communication and the parent-child relationship, and (b) one addressing appropriate limit setting and discipline. These two phases parallel the parenting issues found in this study to most relate to both child behavior problems and children's adaptive functioning. The effectiveness of programs developed to support women and children exposed to IPV have not been evaluated (Statham, 2004). Evaluating interventions implemented in community programs, domestic violence shelters, and

domestic violence support groups will provide additional information regarding their efficacy and allow for modifications based on these appraisals that will further maximize both women's and children's resiliency to IPV.

#### *Future Clinical Directions*

Future directions when working with this population include the identification of women and children who are experiencing IPV earlier and providing effective interventions and treatments. This can be accomplished through several venues such as assessing for IPV at well baby check-ups, routine maternal and paternal doctor's visits, Emergency Department admissions, social work appointments, and intake sessions with psychologists/psychiatrists. Often, women must seek services for physical injuries or psychological impairment resulting from IPV. However, health care professionals usually do not ask questions regarding IPV out of trepidation that they may offend a patient/client. Health care professionals should include IPV questions as a component of their standard intake form, be sensitive to how they phrase these inquiries, and approach this topic without hesitation or judgment (AMA, 1992). Additionally, health care providers should be trained to identify signs and symptoms of IPV in women and children, as not all individuals who experience IPV will be forthcoming with their experiences. Mental health care specialists such as psychologists and psychiatrists should receive specialized training regarding the impact of IPV and consider these implications when diagnosing and treating patients/clients. Furthermore, inquiring about IPV once does not assure that IPV may not occur in the future. Family circumstances change and patients should be asked routinely if they have experienced IPV. Screening women and children in a multitude of locations would be beneficial in assessing not only the psychological impact of IPV but the medical effects of IPV

on women and children. Lastly, health care providers must be prepared to provide specialized resources to women and children affected by IPV.

Educational programs regarding the impact of all forms of IPV upon women, children, and families should be sponsored on local and national levels. Additionally, resources for individuals who have experienced IPV should be prominently displayed in public location along with emergency and non-emergency contact information. The primary objective should be to address the needs of everyone affected by IPV and to provide education and support regarding the destructive implications of IPV upon individuals and families.

#### *Future Research Directions*

Males who inflict IPV upon their female partners are not often included in IPV research. The field would benefit greatly by gathering data regarding their perspectives on IPV and its impact upon women and children. These data would be beneficial not only in designing education and intervention programs for men but also in designing treatment programs for women and children. Additionally, males also experience IPV from female partners and this area of IPV research is insufficiently investigated.

This study examined women and children who had experienced IPV within the last year. Yet, it would be helpful to have more information about women and children currently experiencing IPV. This is a more difficult population to access and families who are actively experiencing IPV have not been adequately researched. Women and children currently experiencing IPV may have a different clinical presentation than the participants in this study who have left violent partners. Many participants commented that their responses would have been different if they had completed the assessments while still involved with their violent partner. While these data may accurately represent women and children recently removed from

IPV, it may not be generalizable for women and children still immersed in IPV. Future research should explore ways to access this sensitive population.

While this study included sufficient participants to yield results with a medium effect size, the project would have been further enhanced through recruitment of a larger sample. Increased sample size would have increased power and allowed study findings to be more generalizable. Unfortunately, this particular population is often difficult to access as domestic violence shelters and support groups are kept confidential in order to protect the women and children from violent partners. In fact, conducting this study required that domestic violence shelters and support groups across five states be accessed. Future studies would benefit from larger sample sizes and may consider collaborating with other researchers in the field to access this population.

Finally, longitudinal research should be conducted regarding child resiliency to IPV. Current studies are cross-sectional in design due to the transient nature of the population or involve a retrospective college-aged sample. Identifying children who have experienced IPV and assessing their resiliency over time will provide the field with valuable information. Future studies should investigate how children with IPV who are identified early and receive interventions fare compared to children who are identified later and experience greater violence.

In summary, this research study revealed valuable information regarding children's resiliency to IPV. However, this study is just the beginning of exploration in this field and much valuable information is still to be learned. This project investigated a multitude of factors that may impact a child's ability to adapt following exposure to trauma and offered suggestions regarding how to improve children's functioning. Findings revealed that although children are exposed to adverse trauma most are able to adapt and develop appropriately. Furthermore, it

identified a variety of resources that decreased their risk of developing behavior problems and increased their adaptive functioning (Masten & Coatsworth, 1998). Once these factors are more thoroughly identified and explored in future research, the main objectives will be to create environments that foster resiliency in children (O'Dougherty Wright & Masten, 2006) and utilize this information to direct prevention and intervention programs (Collishaw et al., 2007) and foster nurturing home environments.

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Table 1.

*Demographic data regarding participants included in the sample based upon maternal self-report.*

Recruitment Location	n	Percent	
Colorado			
Colorado Springs	2	2.9	
Maryland			
Cumberland	6	8.8	
Pennsylvania			
Washington	5	7.4	
Washington	7	10.3	
South Carolina			
Columbia	13	19.1	
West Virginia			
Weirton	1	1.5	
New Martinsville	2	2.9	
Fairmont	4	5.9	
Wheeling	5	7.4	
Elkins	6	8.8	
Charleston	8	11.8	
Lewisburg	9	13.2	
<i>Total</i>	<i>55</i>	<i>100.00</i>	
<b>Number of Families</b>	<b>n</b>	<b>Percent</b>	
One child in study	45	81.81	
Two children in study	8	14.55	
Three children in study	1	1.82	
Four children in study	1	1.82	
<i>Total</i>	<i>55</i>	<i>100.00</i>	
<b>Child Gender</b>	<b>n</b>	<b>Percent</b>	
Female	39	57.4	
Male	29	42.6	
<i>Total</i>	<i>68</i>	<i>100.00</i>	
<b>Age of Participants</b>	<b>n</b>	<b>Mean (SD)</b>	<b>Range</b>
Mother (years)	55	36.13 (7.15)	19.75-51.5
Father (years)	48	38.56 (9.06)	22.75-67.08
Target Child (years)	68	8.67 (3.17)	1.5-13.75

<u>Number of Child Participants</u>	<u>n</u>	<u>Percent</u>
0-4 years	8	11.75
4-6 years	8	11.75
6-8 years	10	14.70
8-10 years	16	23.60
10-12 years	17	25.00
12-14 years	9	13.20
<i>Total</i>	55	100.00
<u>Ethnicity: Mother</u>	<u>n</u>	<u>Percent</u>
American Indian or Alaska Native	2	3.6
Black or African American	11	20.0
White	42	76.4
<i>Total</i>	55	100.0
<u>Ethnicity: Father</u>	<u>n</u>	<u>Percent</u>
Black or African American	13	23.6
Hispanic or Latino	1	1.8
White	41	74.5
<i>Total</i>	55	100.0
<u>Ethnicity: Target Child</u>	<u>n</u>	<u>Percent</u>
Black or African American	11	16.2
White	46	67.6
Other Race (Multi-ethnic)	11	16.2
<i>Total</i>	68	100.0
<u>Parental Marital Status</u>	<u>n</u>	<u>Percent</u>
Cohabiting (Not married)	3	5.45
Divorced	14	25.45
Married	6	10.91
Separated	13	23.64
Single	18	32.73
Missing	1	1.82
<i>Total</i>	55	100.00
<u>Family Income</u>	<u>n</u>	<u>Percent</u>
\$10,000 or less	11	20.0
\$10,001 - \$20,000	10	18.2
\$20,001 - \$30,000	5	9.1
\$30,001 - \$50,000	4	7.3
\$50,001 - \$90,000	6	10.9
Missing	19	34.5
<i>Total</i>	55	100.00

<u>Family SES</u>	<u>n</u>	<u>Percent</u>
Category 1	13	23.6
Category 2	20	36.4
Category 3	3	5.5
Category 4	14	25.5
Category 5	3	5.5
Missing	2	3.6
<i>Total</i>	55	<i>100.00</i>

<u>Education: Mother</u>	<u>n</u>	<u>Percent</u>
Junior High School or less	2	3.64
Partial High School	7	12.73
High School Graduate or GED	13	23.64
Partial College or Specialized Training	24	43.64
College Graduate	6	10.90
Graduate or Professional Degree	3	5.45
<i>Total</i>	55	<i>100.00</i>

<u>Education: Father</u>	<u>n</u>	<u>Percent</u>
Less than 7 <sup>th</sup> grade	1	2.0
Junior High School or less	1	2.0
Partial High School	7	13.0
High School Graduate or GED	22	40.0
Partial College or Specialized Training	18	33.0
College Graduate	3	5.0
Graduate or Professional Degree	1	2.0
Missing	1	2.0
<i>Total</i>	55	<i>100.00</i>

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Table 2.

*Means and standard deviations of assessment measures.*

	Mean (SD)
<b>O'Leary-Porter Scale</b>	
Physical	2.18 (1.26)
Verbal	1.59 (1.46)
Total	18.72 (9.07)
<b>Child Behavior Checklist</b>	
Internalizing	56.61 (13.65)
Externalizing	56.06 (12.79)
Total	55.30 (14.61)
<b>Parent-Child Relationship Inventory</b>	
Support	47.14 (10.07)
Satisfaction	37.14 (4.12)
Involvement	22.31 (3.35)
Communication	42.06 (8.19)
Limit Setting	47.57 (4.70)
Autonomy	50.95 (8.00)
Role Orientation	35.75 (9.11)
<b>The Revised Conflict Tactics Scale</b>	
Female-to-Male Injury	5.75 (12.04)
Male-to-Female Injury	29.26 (37.71)
Female-to-Male Physical	24.50 (43.06)
Male-to-Female Physical	83.28 (94.28)
Female-to-Male Psychological	49.31 (47.37)
Male-to-Female Psychological	90.99 (62.56)
Female-to-Male Sex	6.87 (15.71)
Male-to-Female Sex	43.38 (50.05)
Female-to-Male Negotiation	74.35 (40.15)
Male-to-Female Negotiation	39.56 (32.77)
<b>Behavioral and Emotional Ratings Scale</b>	
Interpersonal Strength	9.46 (3.64)
Family Involvement	9.63 (3.44)
Intrapersonal Strength	10.05 (3.54)
School Functioning	9.38 (4.09)
Affective Strength	10.09 (2.89)
Total	113.15 (29.86)

Brief Symptom Inventory	
Global Severity Index	65.03 (12.16)
Family Support Scale	
Informal	13.45 (6.55)
Social	5.34 (4.37)
Formal	7.09 (3.80)
Immediate	4.39 (2.43)
Specialized	6.64 (4.29)
Generic	4.19 (3.12)
Total	41.10 (17.77)

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Table 3.

*Correlations between The Revised Conflict Tactics Scale (CTS2) and the Child Behavior Checklist (CBCL) Total score and the Behavioral and Emotional Rating Scale (BERS) Total score.*

	CBCL Total ( $n = 66$ )	BERS Total ( $n = 65$ )
Female-to-male Injury	-.166	.218
Male-to-female Injury	.190	-.230
Female-to-male Physical	-.022	.094
Male-to-female Physical	.077	-.187
Female-to-male Psychological	.049	-.014
Male-to-female Psychological	.051	-.096
Female-to-male Sex	-.012	.138
Male-to-female Sex	.021	-.188
Female-to-male Negotiation	-.054	.083
Male-to-female Negotiation	-.316*	.211

\*  $p < .05$ .

Table 4.

*Correlations between The O'Leary-Porter Scale (OPS) Subscales and the Child Behavior Checklist (CBCL) Total score and the Behavioral and Emotional Rating Scale (BERS) Total score.*

	CBCL Total ( $n = 64$ )	BERS Total ( $n = 65$ )
Physical IPV	-.260*	.378**
Verbal IPV	-.197	.248*
Total IPV	-.282*	.114

\*  $p < .05$ . \*\*  $p < .01$ .

Table 5.

*Correlations between The Family Support Scale (FSS) Subscales and the Child Behavior Checklist (CBCL) Total score and the Behavioral and Emotional Rating Scale (BERS) Total score.*

	CBCL Total ( $n = 66$ )	BERS Total ( $n = 65$ )
Informal	-.254*	.305*
Social	-.199	.154
Formal	-.038	.071
Immediate	-.273*	.122
Specialized	.147	.049
Generic	.000	-.080
Total	-.152	.177

\*  $p < .05$ .

Table 6.

*Correlations between The Parent-Child Relationship Inventory (PCRI) Subscales and the Child Behavior Checklist (CBCL) Total score and the Behavioral and Emotional Rating Scale (BERS) Total score.*

	CBCL Total ( $n = 63$ )	BERS Total ( $n = 64$ )
Support	-.578**	.466**
Satisfaction	-.242	.271*
Involvement	.286*	-.451**
Communication	-.309*	.558**
Limit Setting	-.435**	.367**
Autonomy	.405**	-.308*
Role Orientation	.024	.104

\*  $p < .05$ . \*\*  $p < .01$ .

Table 7.

*Summary of a linear regression analysis for variables predicting children's behavior problems on the Child Behavior Checklist (CBCL) Total score (n = 62).*

	CBCL Total		
	<i>B</i>	<i>SE B</i>	$\beta$
BSI Global Severity Index	.364	.134	.326
PCRI Support	-.383	.165	-.279
PCRI Limit Setting	-1.052	.291	-.355
OPS Total Score	-.113	.148	-.075

*Note:* BSI = Brief Symptom Inventory, PCRI = Parent-Child Relationship Inventory, OPS = O'Leary-Porter Scale.

Table 8.

*Summary of a linear regression analysis for variables predicting children's adaptive functioning on the Behavioral and Emotional Ratings Scale (BERS) Total score (n = 63).*

	BERS Total		
	<i>B</i>	<i>SE B</i>	$\beta$
BSI Global Severity Index	-.146	.288	-.060
PCRI Support	.822	.337	.273
OLS Total Score	-1.525	.579	-.456
PCRI Communication	1.407	.355	.376
PCRI Involvement	-1.113	1.040	-.110
OPS Physical	10.396	3.002	.436
OPS Verbal	4.708	3.365	.225

*Note:* BSI = Brief Symptom Inventory, PCRI = Parent-Child Relationship Inventory, OPS = O'Leary-Porter Scale.

Table 9.

*Epstein (1997) and Foley (2007) correlations between the Child Behavior Checklist (CBCL) Total score and Behavioral and Emotional Ratings Scale Subscale scores.*

	Epstein, 1997 CBCL Total	Foley, 2007 CBCL Total
Interpersonal Strength	$r = -.60$	$r = -.49^{**}$
Family Involvement	$r = -.42$	$r = -.50^{**}$
Intrapersonal Strength	$r = -.27$	$r = -.55^{**}$
School Functioning	$r = -.51$	$r = -.44^{**}$
Affective Strength	$r = -.33$	$r = -.27^*$
Total Score	$r = -.61$	$r = -.55^{**}$

\*  $p < .05$ . \*\*  $p < .01$ .

Table 10.

*Correlations between child age and the following variables: The O'Leary-Porter Scale, Child Behavior Checklist, Parent-Child Relationship Inventory, The Revised Conflict Tactics Scale, Behavioral and Emotional Ratings Scale, Brief Symptom Inventory, and the Family Support Scale.*

	Child Age
<b>O'Leary-Porter Scale (n = 66)</b>	
Physical	.300*
Verbal	.275*
Total	.173
<b>Child Behavior Checklist (n = 66)</b>	
Internalizing	-.083
Externalizing	-.061
Total	-.151
<b>Parent-Child Relationship Inventory (n = 65)</b>	
Support	-.028
Satisfaction	-.114
Involvement	-.169
Communication	-.007
Limit Setting	.020
Autonomy	.243
Role Orientation	.044
<b>The Revised Conflict Tactics Scale (n = 66)</b>	
Female-to-Male Injury	.006
Male-to-Female Injury	-.135
Female-to-Male Physical	.064
Male-to-Female Physical	-.104
Female-to-Male Psychological	.076
Male-to-Female Psychological	.043
Female-to-Male Sex	-.168
Male-to-Female Sex	-.103
Female-to-Male Negotiation	.055
Male-to-Female Negotiation	.015
<b>Behavioral and Emotional Ratings Scale (n = 65)</b>	
Interpersonal Strength	.148
Family Involvement	.140
Intrapersonal Strength	.110
School Functioning	.427**
Affective Strength	.078
Total	.197

Brief Symptom Inventory ( $n = 68$ )	
Global Severity Index	-.096
Family Support Scale ( $n = 68$ )	
Informal	.017
Social	.054
Formal	.075
Immediate	.086
Specialized	.104
Generic	-.162
Total	.044

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\*  $p < .05$ . \*\*  $p < .01$ .

Table 11.

*T-tests examining differences between white and non-white children on the following dependent variables: The Revised Conflict Tactics Scale, the Behavioral and Emotional Rating Scale, and the Family Support Scale.*

	White Children		Non-white Children		<i>t</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	
<b>O'Leary-Porter Scale</b>					
Physical	2.22	1.38	2.10	1.00	0.378
Verbal	1.58	1.47	1.62	1.47	-0.106
Total	19.38	9.47	17.31	8.20	0.859
<b>Child Behavior Checklist</b>					
Internalizing	57.96	13.38	53.71	14.12	1.179
Externalizing	56.11	13.13	55.95	12.32	0.047
Total	56.38	14.26	53.00	15.44	0.873
<b>Parent-Child Relationship Inventory</b>					
Support	45.76	8.85	50.25	12.06	-1.685
Satisfaction	37.04	4.23	37.35	3.96	-0.274
Involvement	22.16	2.70	22.65	4.56	-0.546
Communication	41.69	7.67	42.90	9.42	-0.547
Limit Setting	47.42	4.86	47.90	4.41	-0.376
Autonomy	50.60	7.22	51.75	9.71	-0.532
Role Orientation	34.91	9.52	37.65	8.04	-1.120
<b>The Revised Conflict Tactics Scale</b>					
Female-to-Male Injury	2.13	6.08	13.32	17.17	-3.956**
Male-to-Female Injury	32.50	41.65	22.50	27.38	1.023
Female-to-Male Physical	15.02	31.65	44.32	56.22	-2.750**
Male-to-Female Physical	90.07	101.93	69.09	77.60	0.853
Female-to-Male Psychological	43.89	43.61	60.64	53.72	-1.373
Male-to-Female Psychological	100.33	65.75	71.45	51.32	1.810
Female-to-Male Sex	3.20	7.84	14.55	23.76	-2.942**
Male-to-Female Sex	50.15	55.25	29.23	33.75	1.633
Female-to-Male Negotiation	76.50	39.89	69.86	41.26	0.635
Male-to-Female Negotiation	36.91	28.08	45.09	41.10	-0.962

Behavioral and Emotional Ratings Scale					
Interpersonal Strength	8.69	3.44	11.20	3.53	-2.692**
Family Involvement	9.00	3.47	11.05	2.98	-2.290*
Intrapersonal Strength	9.38	3.49	11.55	3.25	-2.366*
School Functioning	9.07	4.08	10.10	4.13	-0.940
Affective Strength	9.73	2.94	10.90	2.65	-1.519
Total	107.89	30.61	125.01	24.91	-2.196*
Brief Symptom Inventory					
Global Severity Index	65.72	11.24	63.59	14.07	.672
Family Support Scale					
Informal	12.07	6.48	15.03	6.57	-1.379
Social	5.39	4.59	5.23	3.99	0.144
Formal	6.87	4.10	7.55	3.14	-0.683
Immediate	4.37	2.70	4.44	1.77	-0.118
Specialized	5.90	3.88	8.18	4.78	-2.104*
Generic	4.59	3.15	3.36	2.95	1.527
Total	39.82	18.67	43.79	15.78	-0.861

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\*  $p < .05$ . \*\*  $p < .01$ .

Table 12.

*Correlations between the number of children in the family and the following variables: The O'Leary-Porter Scale, Child Behavior Checklist, Parent-Child Relationship Inventory, The Revised Conflict Tactics Scale, Behavioral and Emotional Ratings Scale, Brief Symptom Inventory, and the Family Support Scale..*

	Number of Children in Family
<b>O'Leary-Porter Scale (n = 66)</b>	
Physical	.122
Verbal	-.054
Total	-.015
<b>Child Behavior Checklist (n = 66)</b>	
Internalizing	.262*
Externalizing	.302*
Total	.262*
<b>Parent-Child Relationship Inventory (n = 65)</b>	
Support	-.100
Satisfaction	.000
Involvement	-.047
Communication	-.030
Limit Setting	-.012
Autonomy	.187
Role Orientation	.003
<b>The Revised Conflict Tactics Scale (n = 68)</b>	
Male-to-Female Injury	-.112
Female-to-Male Injury	-.265*
Female-to-Male Physical	-.230
Male-to-Female Physical	-.110
Female-to-Male Psychological	-.098
Male-to-Female Psychological	-.018
Female-to-Male Sex	-.244*
Male-to-Female Sex	-.118
Female-to-Male Negotiation	.013
Male-to-Female Negotiation	-.203
<b>Behavioral and Emotional Ratings Scale (n = 65)</b>	
Interpersonal Strength	-.160
Family Involvement	-.079
Intrapersonal Strength	-.122
School Functioning	-.083
Affective Strength	-.150
Total	-.100

Brief Symptom Inventory ( $n = 68$ )	
Global Severity Index	.061
Family Support Scale ( $n = 68$ )	
Informal	.017
Social	-.022
Formal	.077
Immediate	-.011
Specialized	.192
Generic	-.026
Total	.058

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\*  $p < .05$ .

Table 13.

*Correlations between socioeconomic status and the following variables: The O'Leary-Porter Scale, Child Behavior Checklist, Parent-Child Relationship Inventory, The Revised Conflict Tactics Scale, Behavioral and Emotional Ratings Scale, Brief Symptom Inventory, and the Family Support Scale.*

	SES Status
<b>O'Leary-Porter Scale (n = 64)</b>	
Physical	.084
Verbal	-.220
Total	-.143
<b>Child Behavior Checklist (n = 64)</b>	
Internalizing	-.295*
Externalizing	-.286*
Total	-.337**
<b>Parent-Child Relationship Inventory (n = 63)</b>	
Support	.195
Satisfaction	.314*
Involvement	-.364**
Communication	.101
Limit Setting	.033
Autonomy	-.045
Role Orientation	-.187
<b>The Revised Conflict Tactics Scale (n = 66)</b>	
Female-to-Male Injury	.091
Male-to-Female Injury	-.191
Female-to-Male Physical	-.016
Male-to-Female Physical	-.164
Female-to-Male Psychological	-.002
Male-to-Female Psychological	.056
Female-to-Male Sex	-.032
Male-to-Female Sex	-.131
Female-to-Male Negotiation	.208
Male-to-Female Negotiation	.182
<b>Behavioral and Emotional Ratings Scale (n = 64)</b>	
Interpersonal Strength	.256*
Family Involvement	.356**
Intrapersonal Strength	.282*
School Functioning	.224
Affective Strength	.200
Total	.293*

Brief Symptom Inventory ( $n = 66$ )	
Global Severity Index	-.177
Family Support Scale ( $n = 68$ )	
Informal	-.101
Social	-.077
Formal	-.009
Immediate	.016
Specialized	-.018
Generic	-.193
Total	-.094

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\*  $p < .05$ . \*\*  $p < .01$ .

Table 14.

*Correlations between maternal education and the following variables: The O'Leary-Porter Scale, Child Behavior Checklist, Parent-Child Relationship Inventory, The Revised Conflict Tactics Scale, Behavioral and Emotional Ratings Scale, Brief Symptom Inventory, and the Family Support Scale.*

	Maternal Education
<b>O'Leary-Porter Scale (n = 66)</b>	
Physical	-.155
Verbal	-.372**
Total	-.277*
<b>Child Behavior Checklist (n = 66)</b>	
Internalizing	-.272*
Externalizing	-.193
Total	-.263*
<b>Parent-Child Relationship Inventory (n = 65)</b>	
Support	.047
Satisfaction	.350**
Involvement	-.298*
Communication	.320**
Limit Setting	.055
Autonomy	-.173
Role Orientation	-.337**
<b>The Revised Conflict Tactics Scale (n = 68)</b>	
Female-to-Male Injury	-.094
Male-to-Female Injury	-.374**
Female-to-Male Physical	-.209
Male-to-Female Physical	-.328**
Female-to-Male Psychological	-.059
Male-to-Female Psychological	-.059
Female-to-Male Sex	-.078
Male-to-Female Sex	-.295*
Female-to-Male Negotiation	.131
Male-to-Female Negotiation	.155
<b>Behavioral and Emotional Ratings Scale (n = 65)</b>	
Interpersonal Strength	.113
Family Involvement	.264*
Intrapersonal Strength	.269*
School Functioning	.151
Affective Strength	.168
Total	.218

Brief Symptom Inventory ( $n = 68$ )	
Global Severity Index	-.257*
Family Support Scale ( $n = 68$ )	
Informal	-.060
Social	-.119
Formal	-.037
Immediate	.130
Specialized	-.041
Generic	-.115
Total	-.072

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\*  $p < .05$ . \*\*  $p < .01$ .

Table 15.

*Correlations between maternal age and the following variables: The O'Leary-Porter Scale, Child Behavior Checklist, Parent-Child Relationship Inventory, The Revised Conflict Tactics Scale, Behavioral and Emotional Ratings Scale, Brief Symptom Inventory, and the Family Support Scale.*

	Maternal Age
O'Leary-Porter Scale ( <i>n</i> = 66)	
Physical	.373**
Verbal	.135
Total	.167
Child Behavior Checklist ( <i>n</i> = 66)	
Internalizing	-.274*
Externalizing	-.297*
Total	-.318**
Parent-Child Relationship Inventory ( <i>n</i> = 65)	
Support	.021
Satisfaction	.085
Involvement	-.293*
Communication	.033
Limit Setting	.184
Autonomy	.040
Role Orientation	-.001
The Revised Conflict Tactics Scale ( <i>n</i> = 68)	
Female-to-Male Injury	-.109
Male-to-Female Injury	-.170
Female-to-Male Physical	-.060
Male-to-Female Physical	-.154
Female-to-Male Psychological	.001
Male-to-Female Psychological	-.035
Female-to-Male Sex	-.141
Male-to-Female Sex	-.120
Female-to-Male Negotiation	.023
Male-to-Female Negotiation	.163
Behavioral and Emotional Ratings Scale ( <i>n</i> = 65)	
Interpersonal Strength	.235
Family Involvement	.220
Intrapersonal Strength	.164
School Functioning	.330**
Affective Strength	.220
Total	.267*

Brief Symptom Inventory ( $n = 68$ )	
Global Severity Index	-.178
Family Support Scale ( $n = 68$ )	
Informal	-.174
Social	-.099
Formal	-.103
Immediate	-.060
Specialized	-.191
Generic	-.191
Total	-.199

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\*  $p < .05$ . \*\*  $p < .01$ .

## ***DEMOGRAPHICS FORM***

Please complete the following pages based upon your family. We realize that all families are unique and that caregivers may not necessarily be biologically related. If there is any confusion as to how to best answer the questions with regards to your family structure, please do not hesitate to ask and I will assist to the best of my abilities.

**Family Composition:**

1. Mother's date of birth:
2. Father's date of birth:
3. Child's date of birth:                      Gender: male / female                      Grade in school:
4. Child's date of birth:                      Gender: male / female                      Grade in school:
5. Child's date of birth:                      Gender: male / female                      Grade in school:
6. Child's date of birth:                      Gender: male / female                      Grade in school:
7. Child's date of birth:                      Gender: male / female                      Grade in school:
8. Other:    Gender: male / female
9. Other:    Gender: male / female
10. Other:    Gender: male / female

**11. Marital Status (select one):**

- a. Cohabiting / Living with Partner (not married)
- b. Divorced
- c. Married
- d. Remarried after divorce
- e. Remarried after widowed
- f. Separated
- g. Single

**12. Is your current partner your children's biological father?                      Yes / No**

**13. If no, please select your current partner's relationship to your children.**

- |           |            |             |         |                 |       |
|-----------|------------|-------------|---------|-----------------|-------|
| a. Child: | Biological | Step-father | Adopted | No relationship | Other |
| b. Child: | Biological | Step-father | Adopted | No relationship | Other |
| c. Child: | Biological | Step-father | Adopted | No relationship | Other |
| d. Child: | Biological | Step-father | Adopted | No relationship | Other |
| e. Child: | Biological | Step-father | Adopted | No relationship | Other |

14. How many years and months have you been involved with your current partner: \_\_\_\_\_
15. How long has it been since your partner was physically violent with you: \_\_\_\_\_
16. How long has it been since your partner was violent in another way with you: \_\_\_\_\_

**Please write in your occupation and choose the matching number from this packet.**

17. Your occupation \_\_\_\_\_ Occupation Number: \_\_\_\_\_
18. Your partner's occupation \_\_\_\_\_ Occupation Number: \_\_\_\_\_
19. What was your families' income within the last year: \_\_\_\_\_
20. Please circle your highest level of education completed.
- a. less than 7<sup>th</sup> grade
  - b. junior high school
  - c. partial high school
  - d. high school graduate/GED
  - e. partial college or specialized training
  - f. college graduate
  - g. graduate or professional degree
21. Please circle your partner's highest level of education completed.
- a. less than 7<sup>th</sup> grade
  - b. junior high school
  - c. partial high school
  - d. high school graduate/GED
  - e. partial college or specialized training
  - f. college graduate
  - g. graduate or professional degree
22. Your racial background (please select one)
- a. American Indian or Alaska Native
  - b. Asian
  - c. Black or African American
  - d. Native Hawaiian or Other Pacific Islander
  - e. White
  - f. Hispanic or Latino
  - g. Some Other Race \_\_\_\_\_
23. Your partner's racial background (please select one)
- a. American Indian or Alaska Native
  - b. Asian
  - c. Black or African American
  - d. Native Hawaiian or Other Pacific Islander
  - e. White
  - f. Hispanic or Latino
  - g. Some Other Race \_\_\_\_\_

24. Your child's racial background (please select one)
- a. American Indian or Alaska Native
  - b. Asian
  - c. Black or African American
  - d. Native Hawaiian or Other Pacific Islander
  - e. White
  - f. Hispanic or Latino
  - g. Some Other Race \_\_\_\_\_

### **Occupation List**

- 1 = Farm laborers, service workers, receiving welfare.  
Examples: dishwashers, maids, teamsters, ushers.  
Those not currently employed for wages and not receiving welfare or unemployment.  
Examples: housewives or househusband.
- 2 = Unskilled workers.  
Example: bartenders, cooks, dry cleaning operators.
- 3 = Machine operators and semiskilled workers.  
Examples: guards, painters, health aides, child care workers.
- 4 = Smallest business owners, skilled manual labor workers, craftsmen, tenant farmers.  
Examples: carpenters, bakers, electricians.
- 5 = Clerical and sales workers, very small business owners.  
Examples: bank tellers, bookkeepers, cashiers.
- 6 = Technicians, semiprofessionals, smaller business owners.  
Examples: secretaries, draftsmen, teacher's aides.
- 7 = Small business owners, managers, professionals with Bachelor's level training.  
Examples: social workers, real estate agents, elementary school teachers.
- 8 = Administrators, professionals, proprietors of medium-sized businesses, lesser commissioned officers.  
Examples: accountants, registered nurses, computer systems analysts, secondary school teachers.
- 9 = Higher executives, proprietors of large businesses or farms, professionals with advanced degrees, commissioned officers or Major or above in military service.