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Doctoral Thesis

Children exposed to domestic violence: Assessment and psychopathology

Beatriz Olaya Guzmán

Thesis supervisor:
Dra. Lourdes Ezpeleta Ascaso

Programa de doctorat en Psicopatologia de nens, adolescents i adults
Unitat d'Epidemiologia i Diagnòstic en Psicopatologia del Desenvolupament
Departament de Psicologia Clínica i de la Salut
Facultad de Psicologia

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LIST OF CONTENTS

PRESENTATION

This thesis is a research in the project “Effects of Domestic Violence in children” (SEJ2005-01786) funded by the Ministry of Education and Science (Spain).

The general goal of this thesis is to study different relevant topics related with how exposure to Intimate Partner Violence (IPV) can affect children living with this stressor and how clinical psychologists could identify the effects and the related variables in the situation in order to improve the welfare of children. In spite of the great complexity of this issue, this study tries to address three fundamental questions: firstly, to study how the variables involved in IPV affect the child’s mental health; secondly, to provide mediation and moderation models of the parenting of the battered mother and the violent father; and finally, due to the paucity of protocols for assessing exposed children in our country, to propose an assessment schedule specifically designed for this population.

These research questions have been addressed through the development of scientific manuscripts which have been submitted to international journals. The idea that conducted the structure of this thesis is that developing scientific articles will allow greater diffusion of the results, both in scientific and professional fields.

First, general concepts about domestic violence (which is named henceforward as intimate partner violence in order to follow the trend of most of the scientific articles about the issue) and their effects on children are introduced. Afterwards, the paper *Protocolo de Evalución de niños y adolescentes víctimas de violencia doméstica* published in the Spanish journal Papeles del Psicólogo describes a proposal of a schedule to assess the main variables in the context of the exposure to intimate partner violence. These topics include characteristics of the violence, psychopathological effects on children, and mediator and moderator variables (individual, family and social characteristics). Then, the manuscript *Mental health needs of children exposed to Intimate Partner Violence who seek help from mental health services* presents clinical specific needs of children attending to outpatient mental health services who have been exposed to intimate partner violence. Next the manuscript *Characteristics of Intimate Partner Violence exposure predictive of psychopathology and functional impairment in children* addresses the question of the differential effects of the IPV characteristics (type of exposure, type of violence, abuse toward children, characteristics of aggressor) on the child’s psychopathology and

functioning. Lastly, the manuscript *Psychological abuse towards women and their child's functioning: The mediator and moderator role of the parenting of the father and mother* analyzes whether maternal parenting styles mediate in the effects of the IPV on the child's functioning, as well as whether the parenting of the father moderates these effects. To finish with, a discussion about the results, possible recommendations and implications, and a brief conclusion are presented.

ABSTRACT

Exposure to domestic violence is a current, complex concern with negative aftermath on the child's mental health. **Aim:** to answer the following questions about the effects that this exposure has on children's mental health: a) what should be assessed; b) what kind of psychopathology do outpatient exposed children have; c) which characteristics of the situation are more influential; and d) what is the role of parenting styles. **Method:** A retrospective cohort design was used; one cohort was formed by battered mothers attending to a special center for battered women and their children, and the other was formed by non-battered women and non-exposed children. Diagnostic interviews, self-reports and questionnaires were applied to mothers and children in order to assess child's functioning, psychopathology, individual and family variables. Logistic regression, ANOVAs, structural equation models, and generalized estimating equations were used for the statistical analysis. **Results:** An assessment schedule for children exposed to domestic violence is suggested. Outpatient children exposed to domestic violence had specific needs compared with non-exposed outpatients, regarding psychopathology, functional impairment, family and individual variables. Characteristics of the violence, as the type of violence against the mother or the child, the degree of involvement of the child, or the aggressor's characteristics, affected differentially on the child's psychopathology and functioning. Maternal parenting mediated the effects of psychological abuse against the mother on the child's wellbeing, whereas father's parenting did not moderate these effects. **Conclusions:** Efforts in order to detect and intervene in domestic violence situations should be made in order to improve the child's well-being.

1. INTRODUCTION

1.1. Domestic violence against women

The World Health Organization (WHO) defines the *violence* term as 'the intentional use of physical force or power, threatened or actual, against one-self, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, psychological harm, mal-development or deprivation' (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002). This definition of violence includes interpersonal violence, which is committed against other person. The WHO also describes that, inside the family, interpersonal violence may exist against the child, the partner or older people.

In the Pubmed database, domestic violence term appears as the unique thesaurus MeSH term (Medical Subject Heading), defined such as 'deliberate, often repetitive, physical abuse by one family member against other: marital partners, parents, children, siblings, or any other member of a household'. The accepted definition of Pudmed includes only one type of violence, the physical, and it is referred to any violent act which takes place within the family, both between siblings or members of the couple. Specifically, violence against women may be included within the wider concept of domestic violence. In Spain, the term of violence against women has received some names, including 'male violence' or 'gender violence'. Both terms refer to any type of violent act against the female intimate partner.

In the English literature, one of the most used terms for research is the **intimate partner violence** (IPV). The IPV includes any behavior within an intimate relationship (and therefore it includes the violence of the man against the female partner, such as wife, ex wife, girlfriend, ex girlfriend, or sporadic partner) which causes physical, psychological or sexual injury in the other person. Most of these acts include physical assault, psychological abuse, sexual coercion, and control behaviors such as isolating the other person from her family and social environment, controlling her movements, and restricting her access to information or help (Heise & Garcia-Moreno, 2002). Whereas some studies about IPV posit a similar prevalence of violence from the man toward woman and vice versa (Mirrlees-Black, 1999; Morse, 1995), other studies reject this asymmetry (Tjaden & Thoennes, 2000; Walby & Allen, 2004; Watson & Parsons,

2005). Most authors agree that the impact of the IPV is greater on women, both emotional and physical (Walby & Allen, 2004; Women's Aid & and the Child and Women Abuse Studies Unit, 2001) and women are more likely to suffer server or lethal abuse from their male partners (Campbell, Sharps, & Glass, 2001; Jaffe, Lemon, & Poisson, 2003; Walby & Allen, 2004; World Health Organization, 2002). Therefore, most IPV studies refer specifically to violence from the man towards the woman.

In some official reports, such as the II annual report of the Observatorio anual de violencia sobre la mujer (Delegación del gobierno para la violencia de género, 2009), it is specified that the IPV may appear in a wide range of social structures which are very common in our societies, such as marriage relationships, civil couples, second couples with children from past relationships, formal dating and informal dating inside the group of friends. The Centro Reina Sofía para el estudio de la violencia (2008) points out that the IPV might be present also in ex couples. Consequently, the IPV can be defined as the violence, physical, psychological or sexual, which is committed by a man against a woman with whom he holds or has held an intimate relationship for a long or short time. This wider definition of IPV allows to broaden the context of the violence from the family system to less structured contexts like sporadic dates.

The first step to develop a research area about IPV is providing an adequate operational definition. An operational definition of the violence helps the communication between professionals and provides to the community proper agents to decide what IPV is. There is still controversy and debate around the definition of IPV. One of the reasons is the subjective nature of the IPV. Each subject may judge what IPV is depending on several factors, such as the sex, culture or family socialization (Levendosky, Bogat, & von Eye, 2007).

Along the history, some efforts have been made in order to define the IPV taking into account some factors, like the nature of the act (form, severity, and frequency), the physical and psychological impact on the victim, the abuser's intentionality, or the buffering contextual influences. However, one of the problems for defining the violence based on many and different factors are the difficulty for an adequate operative definition. The use of a complex definition of the violence will depend on our aim as a clinicians or researchers. Therefore, due to the fact that the IPV definition involves a subjective judgment, obtaining a general consensus about the definition of IPV is not easy (Emery, 1989). Some authors such as Emery (1989) suggested that social agents should establish this definition.

1.1.1. Types of intimate partner violence

Psychological abuse may be characterized such as verbal and non verbal behaviors, committed with the intention of causing emotional harm or a threat to harm in the other person (Murphi & O'Leary, 1989; Straus, 1979) and they include a wide range of acts such as shouting, underestimation, jealousy, or social isolation (Hudson & McIntosh, 1981). Although psychological abuse is the most frequent type of abuse and with the worse consequences in the victim's mental health (Mechanic, Weaver, & Resick, 2008), most studies about IPV have focused mainly on the physical abuse. One of the reasons may be the difficulty for the definition of psychological abuse (Arias & Pape, 2001; Garbarino, Eckenrode, & Bolger, 1997).

Physical abuse (also known as physical aggression) is defined such as behavior with the intention of, or the perceived intention of causing pain or physical injury in the other person (Straus & Gelles, 1986). The aim of this behavior is, as minimum, causing temporally physical pain in the victim, and it includes acts such as slapping with an open hand or violent acts which lead to injuries requiring medical attendance or even the death. These violent behaviors can occur once or in a sporadic way, but in most of the relationships they are repetitive and chronic, and the frequency and severity may increase along the time. Some of these physical behaviors can be: slapping, pushing, scratching, punching, throwing objects, kicking, burning, inflicting beatings, attempted strangulations, using of weapons such as knives or clubs, etc.

Sexual abuse includes behaviors that correspond to legal definitions of rape, physical assault to the sexual parts of the victim's body, or uncomfortable sexual demands on woman (Marshall, 1992; Shepard & Campbell, 1992). It also includes behaviors of sexual nature carried out with the intention of causing physical, psychological and sexual degradation in the victim (Abraham, 1999). Some examples of these behaviors are demanding sex when the couple is not ready, keeping demanding sex when the victim feels uncomfortable, physical restraint in sexual acts, interfering with the birth control or insisting on unsafe sexual behaviors.

Two or more abuse types are common among IPV situations. The psychological abuse usually precedes, occurs at the same time or follows the physical and sexual abuse (Koss et al., 1994; Tolman, 1991; Walker, 1984), and women consider that the psychological abuse is more harmful than the physical (Follingstad, Rutledge, Berg, Hause, & Polek, 1990; Walker, 1984). In general samples, the prevalence of

psychological abuse can raise the 11.8% (Denham et al., 2007), whilst among women who attend centers to battered women, the prevalence can be around the 94.1% (Lewis et al., 2006). Elliot & Johnson (1995) found that, among women who consulted for routing visits in public health centers, 13% had suffered emotional abuse from their couples, 8% sexual abuse, 13% moderate physical abuse, and 4% assault with a weapon. Moreover, the authors also found that the emotional abuse was related to the presence of physical and sexual abuse and women who had been abused by their partners were more likely to seek help in primary health centers.

Women who are victims of IPV suffer from different physical and psychological problems. They report that their general health is poor or very poor, may have difficulties to walk, pain, memory loss, and dizziness (Ellsberg, Jansen, Heise, Watts, & García-Moreno, 2008), and they do a greater use of the health services (Campbell et al., 2002; Eberhard-Gran, Schei, & Eskild, 2007; Golding, 1996; Jones et al., 2006; McCaw, Golding, Farley, & Minkoff, 2007; Plichta & Abraham, 1996). Among the most common mental problems in abused women are depression and posttraumatic stress disorder (PTSD). The prevalence of PTSD can be 64% among battered women (Golding, 1999), a high proportion considering that the prevalence of PTSD in the general population would be between 1 and 12% (Mechanic et al., 2008). Similarly, 48% of abused women display depression, and this depression is usually chronic (Golding, 1999). Anxiety disorders, fears, suicide thoughts, and alcohol and drug abuse are other common mental problems in this type of population (Bonomi et al., 2006; Fischbach & Herbert, 1997; Loxton, Schofield, & Hussain, 2006; Patel et al., 2006; Plichta & Falik, 2001; Romito, Molzan Turan, & De Marchi, 2005).

1.1.2. Statistics of battered women

Over the last 50 years, both in Europe and the U.S. the perception of the IPV has gone from being a purely private matter to be an endemic social problem requiring efforts of scientific, political and clinical fields (Crowell & Burgess, 1996; National Research Council, 1993).

The number of women who are abused by their partners has varied from one study to other depending on what definition of violence has been taken into account. When violent assaults are taking into consideration, in countries like the U.S. the prevalence of IPV may be less than 1% (Rennison & Welchans, 2002), whereas when the specific violent behaviors are assessed with instruments like the Conflict Tactic

Scale (CTS; Straus, 1979), the prevalence raises to 12-20% (National Family Violence Survey, Straus & Gelles, 1990; National Longitudinal Couples Study, Caetano, Cunradi, Schafer, & Clark, 2000). In Spain, the prevalence of battered women in 2007 was 3.22 per 1000, and in 2008, 75 women were killed by the male violence (Centro Reina Sofía para el estudio de la violencia, 2008). Over the last years, legal reports about IPV have increased considerably. In Spain, agencies such as the Centro Reina Sofía para el estudio de la violencia suggests that, between 2003 and 2007, the incidence of women who were abused by their partners increased 26.7%, whereas the II annual report of the state observatory of the violence against women (Delegación del gobierno para la violencia de género, 2009), points out that, between 2007 and 2008, the number of reports from abused women amounted to 268.418. This increase may be partly explained by the growing awareness that currently exists about the necessity for legal reports about the IPV, and also by the common effort of public agencies to provide resources and access to this type of population. Although there has been an increase in the number of reports about IPV, reports from official agencies might be underestimated because many cases remain unreported. In Europe, official reports such as the Violent British (McVeigh et al., 2005), pointed out that, among the 6% of women who suffered abuse, only 21% of them had denounced. It is therefore possible that the number of women who suffer IPV from their male partners is greater than the official rates listed above.

1.2. Children and adolescents exposed to intimate partner violence

Although the IPV can occur in different forms of relationships, such as dating or casual encounters, the large proportion of abused women are aged between 21 and 40 years and are married or have stable relationships (Centro Reina Sofía para el estudio de la violencia, 2008). In most homes with IPV, children and adolescents are present and they may witness this violence, either directly (because they see, hear or are directly involved in this violence), or indirectly (because they live the consequences of the violence, as for example, the mother's psychopathology, or changes in the educational style of parents). Families suffering IPV have a greater number of children at home, especially preschoolers (Fantuzzo, Boruch, Beriama, Atkins, & Marcus, 1997). Fantuzzo and Mohr (1999), in their review of databases in the U.S., found that families with IPV were twice as likely to have children at home, compared to families without

IPV. Approximately, 10 million children are exposed to violence between their parents in countries like the U.S. (Straus & Gelles, 1990), and this data is similar in Europe (Kury, Obergefell-Fuchs, & Woessner, 2004). UNICEF informs about statistics of children exposed to IPV around the world, according the United Nations sources. In Spain, at least 118.000 children are exposed to violence between parents, while in countries such as the UK, the rates range from 240.000 to 963.000; in France, from 240.000 to 802.000; and in Germany, 22.000 (UNICEF, 2006).

Despite the high prevalence of children exposed to IPV, many cases remain in the anonymity and are not reported. Many of these children do not speak openly about the violent situation they are living at home, and they try to hide it for fear, shame or guilt (McAlister, 1999). Osofsky (1995) called these children the 'invisible victims'.

1.2.1. Taxonomy

Despite the fact that there has been a breakthrough in the study of children and adolescents exposed to IPV, there is still a lack of consensus on the terminology and definition of what IPV is. Holden (2003) postulates that the 'exposure' term is more acceptable than 'observed' or 'witnessed' because it includes different experiences and does not assume that the child actually observe directly the violence. Indeed, not all children who live at violent homes are witnesses of IPV. Often, these children are indirect witnesses because they suffer from the negative consequences.

Children are aware of the IPV presence more than mothers report. In this regard, in 75% of the cases children are present at home when an IPV incident occurs (Hutchison & Hirschel, 2001). Holden, Geffner, & Jouriles (1998) found that 78% of women who suffered IPV reported that their children were aware of the marital conflict for most of the time. Hilton (1992) posited that 55% of children living in a IPV situation observed directly violent assaults, while the 15% experienced immediate consequences (father's anger, police).

Holden (2003) suggests a proposal for the classification of exposure to IPV in 10 categories summarized in the following table.

Table 1. Proposal for Taxonomy of the different types of exposure to IPV

Type of Exposure	Definition	Examples
• Exposed prenatally	Real or imagined effects of IPV on the fetus	Injured fetus in the uterus; pregnant mother lives with terror; pregnant mother perceives that the IPV affects the fetus
• Intervenes	The child verbally or physical attempts to stop assault	Asks parents to stop; attempts to defend mother
• Victimized	The child is verbally or physically assaulted during an incident	The child is intentionally injured, accidentally hit by a thrown object, etc.
• Participates	The child is forced to participated in the assault	Coerced to participate; used as spy; joins in taunting mother
• Eyewitness	The child directly observes the assault	Watches assault or is present to hear verbal abuse
• Overhears	The child hears, though does not see, the assault	Hears yelling, threats, or breaking objects
• Observes the initial effects	The child sees some of the immediate consequences of the assault	The child sees bruises or injuries; police; ambulance; damaged property; intense emotions
• Experiences the aftermath	The child faces changes in his/her life as a consequence of the assault	Experiences maternal depression; change in parenting; separation from the father; relocation
• Hears about it	The child is told or overhears conversations about the assault	Learns of the assault from the mother, sibling, relative, or someone else
• Ostensibly unaware	The child does not know of the assault, according to the source	Assault occurs away from home or while the child is away; or occurs when mother believes the child is sleeping

Source: Holden (2003)

These types of exposure to IPV are not mutually exclusive and children may experience various forms of them. It is also possible that the type of exposure changes over time due to the dynamic characteristic of the violence and the fact that there may be an escalation of the violence which becomes increasingly serious and frequent.

The current trend in research is to consider the exposure to IPV as a form of abuse because witnessing an assault may terrify the children and alter significantly their socialization (McGee & Wolfe, 1991; Peled & Davis, 1995; Somer & Braunstein, 1999). Holden (2003) argues that the exposure to IPV is a form of child abuse as well, because it involves a psychological abusive situation. In fact, he proposes different psychological abuse the child may suffer in situations of IPV.

Table 2. The ways in which children exposed to IPV may be psychologically maltreated.

Types of psychological maltreatment	Definition	Examples
• Terrorized	Behavior that threatens or is likely to hurt a child or put a child or loved ones in dangerous situations	Threaten to hurt or abandon child; injury to the mother; abuse of pets
• Corrupted	Modeling, permitting, or encouraging antisocial or inappropriate behavior	Father models misogyny, verbal and physical aggression, substance abuse
• Spurned	Verbal or nonverbal acts that degrade or reject a child	Father calls the child names
• Denied emotional responsiveness	Ignoring child's attempts and needs to interact and showing no positive emotion to the child	Father uninvolved and mother may be unable to be affectionate with child
• Isolated	Confining or placing unreasonable limits on child or on contact with others	Father isolates family or child isolates self to avoid the batterer
• Neglect of mental health, medical, or educational needs	Failure to provide or refusal to allow necessary treatment for the child's needs or problems	Child's needs not met because father ignores and mother is overwhelmed

Source: Holden (2003)

In addition to the psychological abuse, children exposed to IPV are more likely to suffer physical and sexual abuse. Appel & Holden (1998), in their review of 30 studies, posited that between 30 and 60% of children of battered women also suffered physical abuse, while in non-clinical samples, the overlap between IPV and physical abuse towards children was 6%. Osofsky (1999) indicated that children exposed to IPV were fifteen times more likely to be at risk for physical abuse and neglect.

Despite the fact that there is paucity in the literature abuse sexual abuse toward children in the IPV context, some researches suggest that there is a risk of sexual abuse in exposed children. J. Smith et al. (J. Smith, Berthelsen, & O'Connor, 1997) found that, in a community sample, 4% of children had been exposed to IPV and also sexually abused. McCloskey et al. (McCloskey, Figuerdo, & Koss, 1995) pointed out that 10% of women who experienced IPV reported sexual abuse against their children.

1.2.2. Previous considerations

Currently, there is a consensus about the negative impact of the exposure to IPV on children and adolescents. In this sense, the literature agrees that children exposed to IPV have a greater number of difficulties ranging from the presence of psychopathology, both internalizing and externalizing, to negative problems such as low

self-esteem, poor social skills, academic problems, and health concerns (Edleson, 1999; Fantuzzo & Lindquist, 1989; Fantuzzo & Mohr, 1999; Margolin & Gordis, 2000; Wolak & Finkelhor, 1998).

However, some methodological limitations arise from the study of the effects of IPV on children and adolescents. One of these limitations is the fact that most studies used samples of children and women living in shelters (Kashani & Allan, 1998; Wolfe, Crooks, Lee, McIntyre-Smith, & Jaffe, 2003), which represents only a fraction of the whole population of children exposed to IPV. Using this type of samples may make difficult to generalize, first of all because they usually are characterized by more sever violence and therefore they are more affected (Edleson, 1999; McIntosh, 2003), and because lower socioeconomic status are over-represented (Kerig, 1998). On the other hand, living in shelters for battered women may affect additionally the welfare of children. This may make difficult to distinguish the negative effects of the exposure to IPV from the effects of living in a shelter (Holt, Buckley, & Whelan, 2008). It is important to use samples from other settings, such as clinic or community samples. Information reported exclusively from the abused mother and the definition of IPV are other methodological problems related to the study of the effects of IPV (Wolfe et al., 2003). Mothers who are abused by their partners usually report more problems than children do (Kitzmann, Gaylord, Holt, & Kenny, 2003), perhaps as consequences of their own stress (Hughes & Barad, 1983), or because exposed children minimize their problems as a method of defense or denial (Rossman & Rosenberg, 1992). When possible, it is important to provide information reported by the child in order to know his or her perception of the IPV as well as the exposure's effects. On the other hand, the studies about IPV should unify efforts and achieve a consensus about the definition of IPV in order to improve the comparability between studies.

Moreover, studies about the effects of IPV on children and adolescents should consider a developmental approach and variables that may modify the effect, such as the age and the gender of the child. School children or adolescents are more aware of themselves and what happens around in a more sophisticate way than younger children are. Therefore, they may be more conscious of how the abusive situation is affecting their mothers (Daniel, Wassell, & Gilligan, 1999). This greater awareness of the IPV situation leads the children to manage their emotional reacts and behaviors. Besides a different perception of the problems, adolescents may experience a different form of IPV than younger children. For example, adolescents are more likely to intervene in a

violent situation, attempting to defend their mother, and therefore, they are more likely to receive abuse from the father. Apart from individual factors, other variables may act as confounding factors in the study of IPV. Some of these factors may act as risk factors, and therefore they increase the negative effects of the IPV, or they may act as protective factors, buffering these effects. Among these factors, the socioeconomic status of the family is a well-known confounding variable, which increases spuriously the relation between the exposure to IPV and the negative consequences on the child.

1.2.3. Theories about the effect of intimate partner violence

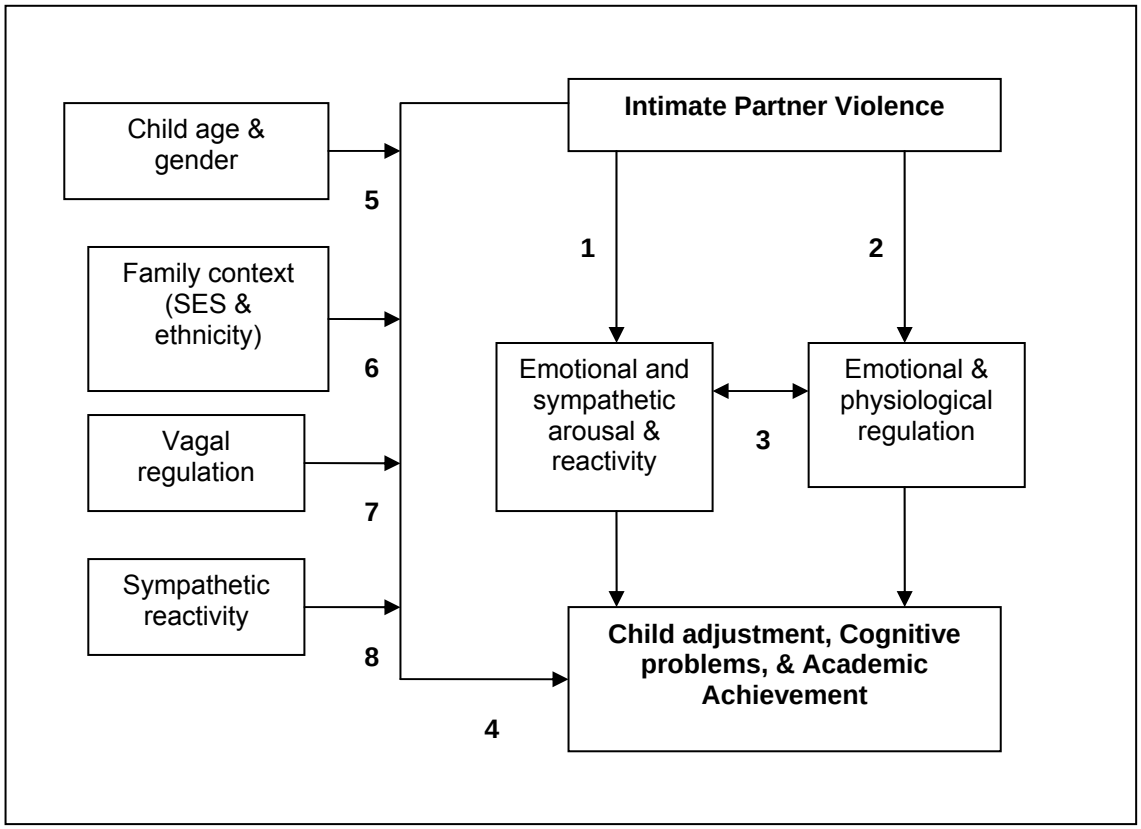
The social learning theory (Bandura, 1977) tries to explain the increase of aggression among children exposed to IPV. The violence present at home is learnt and rewarded in the child (Emery, 1989). The exposure to IPV requires a corrupted socialization by the father, who shows to the children that the use of the violence is an accepted way to solve problems (Holden, 2003). However, this social learning theory would not explain the association of the IPV and other common problems in children exposed to IPV, such as anxiety and depressive symptoms, or social competence problems (Fantuzzo et al., 1991; Graham-Berman & Levendosky, 1998; Hughes, 1988). For that reason, authors like Levendosky, Bogat and von Eye (2007) suggest other models more suitable for the explanation of why children exposed to IPV are affected by the violence. Firstly, they suggest the cognitive-contextual theory (Fosco, DeBoard, & Grych, 2007), which postulates that the appraisal of the children about the violent situation mediates the effects: the child interprets how the situation will affect him or her, why it happens, and if he or she may intervene or not. It is also important how the child appraises the threat for him or her (and therefore, the fear and the injury for him/her or other loved ones) and the tendency to self-blame for failing to protect the mother.

Secondly, the emotional security theory (Davies & Cummings, 1994) postulates that IPV threats the emotional security of the child in the familiar system, which causes regulating answers of the child in order to keep his or her security. The IPV impacts directly on the child's emotionality and on his/her regulation, which in turn may mediate in the appearance of adaptation problems (Davies & Cummings, 1998).

Currently, E. M. Cummings, El-Sheikh, Kouros and Buckhalt (2009), according with some studies (Erath, El-Sheikh, & Cummings, in press; E. El-Sheikh, Cummings,

Kouros, Emore-Staton, & Buckhalt, 2008; M. El-Sheikh, Kouros, Erath, Cummings, Keller, & Staton, in press) provide a bio-psycho-social model which tries to integrate mediate processes (variables affected by the IPV which also affect the child's outcomes) or moderate (variables which modifies the direct effect of the IPV on the child) (see figure 1). This model includes multiple paths through the IPV and the outcomes of the children may be related. In this model, emotional reactivity and regulation of the child appear as mediators (path 1 and 2), according with the emotional security theory of Davis and Cummings (1994) described above. Path 3 shows the interrelation between emotional regulation and reactivity. Path 4 shows the direct effect of the IPV on the child, and path 5, 6, 7, and 8 display the moderation effect of some variables, such as the child's gender an age, variables from the family context (e.g., socioeconomic status or parenting styles), and psychophysiological variables such as the vagal regulation and the sympathetic reactivity. In that sense, M. El-Sheikh et al. (M. El-Sheikh, Harger, & Whitson, 2001) found that the vagal regulation protected children exposed to IPV against externalizing and internalizing problems, whereas an excessive reactivity of the sympathetic nervous system is expected to enhance the negative effects of the IPV on children (M. El-Sheikh, 2005).

Figure 1. Bio-psycho-social model about the development of adjustment, cognitive, and academic problems in the context of intimate partner violence (adapted from E. M. Cummings et al., 2009).



1.2.4. Effects of the exposure to intimate partner violence on children and adolescents

The study of cases about children exposed to IPV appeared in the 70's and the first empirical works in the 80's. Being a eyewitnesses of violence in general affects the way in which a child perceives himself or herself and the world, his or her ideas about the significance and aims of his/her life, his/her expectancies about the future, and his/her moral development (Garbarino, Kostelny, & Dubrow, 1991; Ney, Fung, & Wickett, 1994). When studying the effects of exposure to IPV between parents, it is important to take into account a developmental approach. The effect of IPV depends on the children's capability to appraise and understand the violence, the way they answer and cope with it, and how they search external supports to obtain protection and support (Margolin & Gordis, 2000).

The exposure to IPV is related to an increase of the child's aggression (Graham-Berman & Levendosky, 1998; Holden & Ritchie, 1991; Rosenberg, 1986), externalizing problems (Graham-Berman & Levendosky, 1998; Jaffe, Wolfe, Wilson, & Zak, 1986; Kernic et al., 2003; McFarlane, Groff, O'Brien, & Watson, 2003) and behavioral problems (Jouriles, Murphy, & O'Leary, 1989; Kempton, Thomas, & Forehand, 1989). Apart from externalizing problems, being exposed to IPV increases the risk to internalizing problems in children (Davies & Cummings, 1994; Graham-Berman & Levendosky, 1998; Holden & Ritchie, 1991; Jaffe et al., 1986; Margolin, 1998; McFarlane et al., 2003; O'Keefe, 1994). Moreover, children exposed to IPV show a wide range of social and academic difficulties (Kitzmann et al., 2003). Kitzmann et al. (2003), in their review about the effects of IPV on children, found that the effect size for internalizing and externalizing problems was similar. They also posited out that exposed children who also were physically abused by their parents were affected in the same way than children who were only exposed to IPV. This suggests that the presence of IPV at home is enough to modify the normal development of the child (Kitzmann et al., 2003).

From a developmental framework, the way in which a child is affected by the violence will depend on his or her age; young children depend totally on their parents' care. These young children in IPV families may show poor weight gain, altered sleeping habits, irritability, and other stress signs such as regressive behaviors (Lundy & Grossman, 2005; Osofsky, 1999). The IPV might jeopardize the mother-child attachment, which would affect the child's well-being (Martin, 2002).

Preschool children exposed to IPV may show anxiety and fears (Jaffee, Wolfe, & Wilson, 1990), behavioral problems, social difficulties, posttraumatic stress symptoms, difficulties in the empathy development, and poor self-esteem (Huth-Bocks, Levendosky, & Semel, 2001; Rossman, 1998). Their limited ability to verbalize their emotions may be expressed through tantrums and aggression, cries, discouragement, and anxiety (Cunningham & Baker, 2004). The extreme fear they might suffer can result in somatic problems such as head and stomach-ache, asthma, insomnia, nightmares, sleepwalking, and enuresis (Martin, 2002).

School children (aged 6 to 12) have more cognitive resources to face and understand the violent situation, specifically how the violence affects the mother (Daniel et al., 1999). They are able to think about possible reasons for the violence, and try to predict and prevent the abuse. They might try to rationalize their father's

behaviors through the use of alcohol, the stress he suffers, or because they or their mothers did something that irritated him (Holt et al., 2008). If these erroneous beliefs are not detected promptly, the child may adopt in the future irrational ideas about their own aggressive behaviors (Cunningham & Baker, 2004). School children who are exposed to IPV in their homes show more problems in the school (Holden et al., 1998), depression, oppositionism, and aggressive behavior (McCloskey et al., 1995). The exposed children are described in school as aggressive, in a fifth part they have difficulties to obey the school rules, and show an erroneous learning (Lundy & Grossman, 2005).

Adolescents in violent homes may show an unsure and avoiding interaction style (Levendosky, Huth-Bocks, & Semel, 2002). They might try also to avoid the situation at home through inappropriate coping strategies, such as the use of alcohol or substances (Cunningham & Baker, 2004; Mullender et al., 2002). As they grow, other problems appear in the household. Adolescents exposed to IPV may become more active and try to prevent or intervene in the abusive situations, even with anger. This anger might be towards the abuser or the mother, who is perceived unable to protect or keep them off from the abusive environment (Hester, Pearson, & Harwin, 2000). Adolescents may adopt care roles for the mother and sibling, as well, leading them to a cost for their own well-being (Goldblatt, 2003).

Children who are exposed to IPV present greater proportion of posttraumatic stress disorder (Kitzmann et al., 2003). Most of the violent situations between parents can include threaten behaviours against the mother's life and even against the child's life (strangulations, beating, etc.). These traumatic events relate to disassociation, re-experiencing, and other posttraumatic symptoms (Kitzmann et al., 2003). Being exposed to a stressful event like the IPV generates in the child emotional des-regulation (Margolin & Gordis, 2000). According with some authors, the exposure to IPV may be related to the emerge of two type of emotional des-regulation; on the one hand, stress caused by the exposure to IPV can increase the negative feedback of the Hypothalamic-Pituitary-Adrenal (HPA) axis mechanisms, which leads to a decrease of the levels of basal cortisol. When this response is prolonged, the response for the preparation to 'fighting or flight' is also prolonged, which leads to the emergence of posttraumatic symptomatology. On the other hand, being chronically exposed to IPV may decrease the negative feedback, which would decrease also the response to the stress and it would

explain the emergence of depressive symptoms (Golier & Yehuda, 1998; Margolin & Gordis, 2000).

Literature has demonstrated widely the intergenerational transmission of the violence, suggesting that the exposure to IPV in the infancy leads to the use of the violence in the adulthood (Markowitz, 2001; S. M. Smith et al., 2000). The transmission of the violence may be present in 30% of cases of IPV in the childhood (Gelles & Cavanaugh, 2005). This transmission might be expressed in different ways: for example, adults who were exposed to IPV when they were children may be violent or be themselves victims of violence within the romantic relationship (Coohey, 2004; Guille, 2004; Margolin, Gordis, Medina, & Oliver, 2003). Young offenders are more likely to have been exposed to IPV in the childhood (Steinberg, 2000) and to be involved in violent crimes, substance abuse, delinquency and crime in the adulthood (Edleson, 1999; Osofsky, 1999). Exposed children learn that the violence is an effective method within a date. Holden (2003) called it as a '*bad socialization*'.

Children exposed to IPV are between 6 and 8 more likely to use health services compared with children who have not been exposed to IPV (Campbell & Lewandowski, 1997). McDonald et al (McDonald, Jouriles, Norwood, Shine Ware, & Ezell, 2000), in their study in a clinic sample, pointed out that, among children who attended to mental health centers for psychological problems, 48% were living in a family with IPV. Nevertheless, and despite the significant frequency of children exposed to IPV who attended mental health centers, the detection of the presence of the violence was not a systematic practice. In general, most children do not explain the violent situation they are living at home because they feel fear, shame or blame, and clinicians do not usually ask about it. Most exposed children may receive an inadequate treatment for mental problems caused by a situation that professionals do not know. Therefore, it is necessary for health centers and for mental health centers to be provided with valid and reliable schedules in order to assess the presence of IPV and its negative aftermaths in the child (McAlister, 1999).

1.2.5. Factors which influence the effect of intimate partner violence

Each child is unique and his or her reaction to the presence of IPV depends largely on his or her age, gender, personality, socioeconomic status, role in the family, the frequency, nature and duration of the violence, or his or her relation with the father,

siblings, peers or others (Hester et al., 2000; Kashani & Allan, 1998; Salcido Carter, Weithorn, & Behrman, 1999).

As discussed above, the child's age influences the impact of the exposure to IPV through his or her ability to understand and process their experiences and the way in which he or she express the stress caused by the violence. Although the effect of the exposure to IPV has been demonstrated in all developmental stages, the consequences in children from an early age are less known. It is sometimes assumed that preschool children are too young to be affected by the IPV, because they do not have sufficient cognitive resources to know and remember what happens at home. However, some studies have shown that younger children who are exposed to IPV display excessive irritability, immature behaviors, sleeping problems, emotional distress, fear of being alone, and regressions in evacuation behaviors and language (Osofsky, 1999). Kitzmann et al. (2003), in their meta-analysis, found that only preschool children showed greater negative affect as a response to the interparental conflict, and greater problems in the social competence. Notwithstanding, these authors concluded that, in general, the age of children is not a moderate variable in the effect of the exposure to IPV, suggesting that the IPV affects in the same way children of different ages. Despite these results, it is important to take into account a developmental framework, considering that the aftermath of the IPV may vary depending on the developmental stage of the child. For example, children from 6 to 12 years old who are exposed to IPV are more likely to have problems at school and with peers, while adolescents may show aggressive behavior and problems with the legal system (Osofsky, 1999).

Regarding the different effect of the exposure to IPV in the two genders, the results are contradictory; some studies posit that boys exposed to IPV have more externalizing problems than exposed girls (McIntosh, 2003), and they are more vulnerable to the impact of life events, including the presence of IPV (Jaffe et al., 1986). However, other studies suggest that girls exposed to IPV are more likely than boys to have internalizing and externalizing problems (J. G. Cummings, Pepler, & Moore, 1999; Holden & Ritchie, 1991; Sternberg, Lamb, & Dawud-Noursi, 1998). Some authors point out that this greater affectation in girls exposed to IPV is due to the fact that they are more sensitive than boys for affective situations and for the other's states, and in the case of IPV, for the mother's state (Zahn-Waxler, 1993) or because they identify with the mother, which leads them to a devaluated identity (Chodorow, 1991; Davis & Carlson, 1987). Finally, other works do not find significant differences among boys and

girls (Carlson, 1990; Fantuzzo et al., 1991; Grych, Jouriles, Swank, McDonald, & Norwood, 2000; O'Keefe, 1994). Indeed, some meta-analysis about gender differences in the effects of the exposure to IPV conclude that the child's gender does not modify this effect (Kitzmann et al., 2003; Sternberg, Baradaran, Abbott, Lamb, & Guterman, 2006; Wolfe et al., 2003). Therefore, studies about gender differences in the effects of the exposure to IPV tend to generate contradictory results, although there is a greater evidence for the absence of a significant difference between boys and girls. Stenberg et al. (2006) suggest that the mechanism to explain the risk for psychopathology is different for boys and girls, and this could explain the inconsistency of the results found so far.

1.2.6. Family and contextual variables

Literature agrees that the quality of the parenting style in IPV contexts is seriously damaged (Buchbinder, 2004; Levendosky & Graham-Bermann, 2001; McIntosh, 2002; Mullender et al., 2002). Being repeatedly abused by their partners impacts negatively the way mothers rear their children (Stephens, 1999) and the quality of the mother-child attachment (Levendosky, Huth-Bocks, Shapiro, & Semel, 2003). The stress they suffer due to the presence of IPV makes them emotionally distant with their children, and less predisposed to fill their needs (Holden, 2003). Most authors called it 'Fail to protect'. This term refers to the inability of the mother to stop the abusive situations against their children or to the inability to leave the home and get their children away from the violent situations (Farmer & Owen, 1995). However, this term may lead to blame the mother for the negative effects on the children. Consequently, it is important to use it with caution. Regarding father, fathers who abuse their wives usually use more physical punishment than abused mothers (Edleson, 1999; Holden et al., 1998). They are less involved in their children's care, are less consistent in their educational practices (Bancroft & Silverman, 2002), show anger toward their children (Holden et al., 1998), do not let them free expression or creativity (Margolin et al., 2003), and offer inadequate models of interpersonal relations and conflict solving (Bancroft & Silverman, 2002).

The IPV presence disrupts the general functioning of the family environment (Huth-Bocks et al., 2001; Salcido Carter et al., 1999; Ullman, 2003). Rossman (2000) adopted the term '*adversity package*' to describe the IPV situations, because the presence of violence from the man toward the woman is associated with the presence of

multiple stressors accumulated in the child's life. Families with IPV are more likely to experience greater levels of stress, poor socioeconomic status, and frequent relocations. Moreover, couples with IPV usually are young, with less educational sources, and greater problems of alcohol use (Fantuzzo et al., 1997; Jaffe, Hurley, & Wolfe, 1990; Spaccarelli, Sandler, & Roosa, 1994; Straus, Gelles, & Steinmetz, 1980).

It is important to note that not all children exposed to IPV show negative consequences (Grych et al., 2000; Hughes & Luke, 1998). Most of them still function adequately, and they do not suffer from psychological problems. The '*resilience*' concept is increasingly used in developmental psychopathology to name the child's ability for adapting to adverse situations. In IPV context, a safe attachment with the non-violent caregiver or with other significant caregiver (i.e. grandparents) has appeared as a protective factor against the trauma and stress (Graham-Bermann, DeVoe, Mattis, Lynch, & Thomas, 2006; Mullender et al., 2002). Studies agree that the positive role of the abused mother in the care and education of the child is crucial in helping to improve their welfare (Levendosky & Graham-Bermann, 1998; Mullender et al., 2002; Osofsky, 1999). The social support received by the child or the mother is another protective factor in IPV contexts (Kashani & Allan, 1998; Ullman, 2003). For example, an adult relative from outside the family system, such as grandparents, may act as a control and support agent for the child (Cox, Kotch, & Everson, 2003). In IPV contexts, the resilience is related also to the presence of positive relationships with peers and siblings, who can provide support and information of how to cope with the stress (Guille, 2004; Mullender et al., 2002). Finally, a good self-esteem helps the exposed child to cope with the violent situation in a more effective way (Guille, 2004).

Notwithstanding, no major problems do not necessarily mean that children exposed to IPV are not affected by the violence. Often, these children may be affected by sub-clinical symptoms or other problems that, though not serious, lead the child to a greater risk for later psychological problems (E. M. Cummings, 1998; Graham-Bermann, 1998). Exposed children may show inappropriate attitudes about the violence as a way to solve conflicts, either believing they are responsible for the violence between parents (Jaffe et al., 1990). Therefore, professionals who work with exposed children should consider what kind of characteristics of the child and the environment are buffering the impact of the exposure to IPV, and if there are other less severe problems that may cause later impairment.

1.3. Aims of the study

The empirical research presented in this thesis has been focused in three main areas:

1) Assessment of the effects of the exposure to IPV on children and adolescents.

2) Psychopathology in children and adolescents who are exposed to IPV.

3) Parenting styles of battered women and abuser men.

1.3.1. Assessment of the effects of intimate partner violence on children and adolescents

In order to address the problem of the exposure to IPV in children and adolescents, the first step is to have valid and reliable measures to obtain the best possible information. In this sense, it is important to use as far as possible instruments adapted to the Spanish population, and offer information from diverse sources. The assessment process should be guided by working hypothesis, and the choice of either measure will depend on our aim (e.g., diagnosis or therapy). IPV is, firstly, one of the variables to be assessed. It can be rated by the mother and the child. On the other hand, it is important to test how the violence is affecting the child's welfare, through the emergence of psychopathology or clinic symptoms, the child's functioning in different life areas, and through other factors such as self-esteem or social competence. It is also important to use instruments to assess other factors that are associated with the violent context and may be increasing the negative outcomes in the child, such as the educational styles of the parents, the maternal and paternal psychopathology, and social factors such as the social support of the child and the mother and the life events. Knowing this information will help to establish a complete history of each case, but also get information from variables likely to be modified in the therapeutic planning.

Therefore, the first question was: What kind of assessment instruments does exist currently in Spain to diagnose the effects of the exposure to IPV? In order to answer this question, the following paper was carried out:

Olaya, B., Tarragona, Mª.J., de la Osa, N., y Ezpeleta, L. (2008). Assessment schedule for children and adolescents exposed to Domestic Violence. *Papeles del Psicólogo, 29,* 123-135.

IN-RECS:0.236; RESH: 0.331

1.3.2. Psychopathology in children and adolescents exposed to intimate partner violence

The second raised question was whether, within a clinic setting, those children who attended to public mental health centers and was exposed to IPV had different mental health needs compared with children who also attended but were not exposed to IPV. In order to answer this question, the following manuscript was developed:

Olaya, B., Ezpeleta, L., de la Osa, N., Granero, R., y Doménech, J.M. (2009). *Special needs of children exposed to intimate partner violence who seek help from mental health services*. Manuscript submitted for publication.

Moreover, it was important to know what kind of the multiple characteristics influencing the violent situation were more related to psychological problems in children. The overall aim of the study was to simultaneously examine which characteristics of exposure to IPV were more predictive of psychopathology and functional impairment in children. Unlike previous studies that have analyzed partial IPV characteristics, the goal of this study was to determine which variables intervening in IPV events (degree of involvement of the child, characteristics of the violence to the mother and/or to the child and characteristics of the aggressor), are most closely associated with psychological problems in children.

Ezpeleta, L., Granero, R., de la Osa, N., Doménech, J.M., & Olaya, B. (2009). *Characteristics of intimate partner violence exposure predictive of psychopathology and functional impairment in children*. Manuscript submitted for publication.

1.3.3. Parenting styles in the intimate partner violence context

As discussed above, the exposure to IPV affects directly to the child's welfare, but also indirectly through the presence of inadequate parenting styles. As the 'Spillover Hypothesis' (Krisknakumar & Buehler, 2000) suggests, the hostility in one of the family system, such as the couple relation, may be translated to other family system, such as the father/mother-child interaction. The negative styles of the fathers and the mothers have, at the same time, a negative aftermath in the child's well-being. There are many studies that tried to answer how the negative parenting affects the exposed child through the use of mediate and moderate models. The mediate models use diverse

strategies to demonstrate how the IPV modifies the maternal or paternal style, and how this style also affects the child, increasing the psychopathology and impairment. On the other hand, moderate models try to demonstrate how the presence of a variable may enhance (risk factor) or buffer (protective factor) the negative outcomes in the exposed child.

In order to establish mediate and moderate models of parenting styles in IPV contexts, the following article was carried out:

Olaya, B., Ezpeleta, L., Granero, R., de la Osa, N (2009). *Psychological abuse towards women and their child's functioning: the mediator and moderator role of the parenting of the father and mother*. Manuscript submitted for publication.

2. ASSESSMENT OF THE EFFECTS OF INTIMATE PARTNER VIOLENCE ON CHILDREN AND ADOLESCENTS

2.1. Paper: Protocolo de evaluación de niños y adolescentes víctimas de violencia doméstica* [Assessment Schedule for children and adolescents exposed to domestic violence]

*An English version of the paper is provided in the annex

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PROTOCOLO DE EVALUACIÓN DE NIÑOS Y ADOLESCENTES VÍCTIMAS DE LA VIOLENCIA DOMÉSTICA

Beatriz Olaya[1,2], María Jesús Tarragona[2], Nuria de la Osa [1,2] y Lourdes Ezpeleta [1,2]
[1]*Unitat d'Epidemiologia i de Diagnòstic en Psicopatologia del Desenvolupament*
[2]*Departament de Psicologia Clínica i de la Salut*
Universitat Autònoma de Barcelona

Se sintetizan las áreas principales de evaluación psicológica en niños y adolescentes expuestos a violencia doméstica. Las características de la situación vivida (violencia doméstica), los efectos de la misma sobre la salud mental y el funcionamiento cotidiano de los niños y adolescentes y las variables mediadoras de carácter individual, familiar y social son objeto de atención en el proceso de evaluación. Se remarca la importancia de considerar a los niños expuestos a violencia doméstica en el proceso de evaluación y de intervención psicológica. Se proponen diferentes instrumentos apropiados para evaluar cada una de las variables intervinientes.
Palabras clave: *Violencia doméstica; Evaluación; Psicopatología; Variables mediadoras.*

The main psychological assessment areas in children and adolescents exposed to domestic violence are synthesized. Violence characteristics, their effects on children and adolescents' mental health and daily functioning as well as individual, familiar and social mediator variables are focused in the assessment process. The idea of considering children exposed to domestic violence in the assessment-intervention process is highlighted. Several instruments appropriated to assess each of the participant variables.
Key words: *Domestic Violence; Assessment; Psychopathology; Mediator variables.*

La violencia doméstica se refiere a un patrón de comportamientos agresivos y coercitivos que presentan los adultos hacia su compañero/a íntimo/a (Jouriles, McDonald, Norwood, y Ezell, 2001). Actualmente, este es uno de los problemas más importantes en nuestra sociedad. El Centro Reina Sofía para el estudio de la Violencia, (2007b) informa que la incidencia de mujeres maltratadas en España entre 2000 y 2004 aumentó en un 153.74%. De 0.66 casos de maltrato por cada mil mujeres en 1996 se ha pasado a 3.07 en 2004. Alrededor del 80% fueron maltratadas por su pareja en su domicilio. Las estadísticas disponibles no informan de cuántos niños en esos hogares han sido testigos de esa violencia. Por cada millón de mujeres, 4 fueron asesinadas por su pareja en 2006; en este caso las estadísticas indican que en al menos 10.14% de los asesinatos el agresor mató a su pareja en presencia de los hijos (Centro Reina Sofía para el estudio de la Violencia, 2007a). Se estima a la baja que alrededor de 3.3 millones de niños al año son testigos de la violencia física y verbal entre esposos (Farnós y Sanmartín, 2005). En población general de edad escolar entre un 20 y un 25% de los niños han visto a sus padres pegarse (McCloskey y Walker, 2000). Entre el 30 y el 60% de los casos en los que la mujer es maltratada, los niños también lo son (Edleson, 1999).

Correspondencia: Beatriz Olaya Guzmán. *Departament de Psicologia Clínica i de la Salut. Edifici B. Universitat Autònoma de Barcelona. 08193 Bellaterra (Barcelona). España.*
E-mail: Beatriz.Olaya@campus.uab.es

El estudio de las variables que intervienen en la determinación del impacto emocional y/o la psicopatología en niños y adolescentes víctimas de violencia doméstica, constituye un tema de gran interés en la práctica clínica profesional. Las dificultades para realizar este tipo de estudios son diversas. La privacidad y la intimidad en la que tiene lugar este tipo de violencia es un primer impedimento, al que se añade el sesgo y la distorsión que puede presentar la información que dan las personas afectadas, que pueden y suelen vivir la violencia intrafamiliar con secretismo, miedos y sentimientos de culpa y vergüenza que dificultan la obtención de indicadores precisos acerca de su prevalencia, características y consecuencias (Medina, 2002). La tercera dificultad es que en nuestro país no disponemos de instrumentos de medida adecuados, aptos para nuestro contexto y validados por la comunidad científica. Esto afecta tanto a instrumentos pensados para la detección de los casos como para la valoración del riesgo y la posibilidad de prevenir. Se ha estimado que más del 70% de los casos de violencia doméstica no son detectados (Siendones et al., 2002).

En este trabajo se ofrece un repertorio de instrumentos de evaluación que se pueden utilizar para entender y atender las necesidades de los niños y adolescentes víctimas de la violencia doméstica. Mientras la sociedad está tomando conciencia de la gravedad del problema de las mujeres maltratadas, la problemática de los niños, que también viven día a día el conflicto pero con menos recursos para afrontarlo, es un tema ignorado. La perspectiva de esta recopilación es ecológica; es

necesario evaluar las distintas variables que intervienen en el contexto de la violencia doméstica para poder comprender a las personas afectadas, y remarcar la necesidad de contar con la perspectiva del niño.

EVALUACIÓN DEL NIÑO EN SITUACIÓN DE VIOLENCIA DOMÉSTICA

Algunos autores defienden la conveniencia de no incluir la exposición a la Violencia Doméstica dentro de la categoría de maltrato porque aumentaría de manera dramática la información sobre abuso infantil y porque la definición que existe sobre ser testigo de violencia doméstica es aún hoy día demasiado ambigua (Edleson, 1999; Kerig y Fedorowicz, 1999; Magen, Conroy, Hess, Panciera, y Levi, 2001). Sin embargo, otros defienden su inclusión en el maltrato infantil, debido a su asociación con problemas psicológicos y conductuales en los niños (Wolfe, 1997). En los hogares de Estados Unidos donde hay violencia doméstica los niños sufren abuso o negligencia 15 veces más que la media nacional (Osofsky, 1995). La gravedad de la violencia parental predice la gravedad del maltrato que sufre el niño (Bowker, Arbitell, y McFerron, 1988). Hombres que abusan de sus esposas presentan mayor probabilidad de abusar también de sus hijos (Straus, 1993). Cuando el maltratador es el padre, el niño aprende que la violencia es un instrumento normalizado para la resolución de conflictos, facilitando la perpetuación del ciclo de violencia en la edad adulta; cuando se trata de la madre, aparecen dificultades en la vinculación y seguridad emocional del niño así como problemas de ansiedad, depresión y culpa (Kerig y Fedorowicz, 1999). Además, los niños que son testigos de la violencia de sus padres y a la vez sufren abuso presentan mayores proporciones de problemas de adaptación que los niños que no lo han sufrido.

Son cada vez más los estudios que demuestran los efectos negativos de la violencia doméstica en el desarrollo de los hijos, como por ejemplo la aparición de problemas interiorizados y exteriorizados, dificultades en las relaciones sociales, utilización de estrategias agresivas de solución de problemas (Magen, 1999) o disminución del rendimiento escolar y de la capacidad empática (Rossman, 1998).

El hecho de que la exposición a violencia doméstica aumente tanto el riesgo de ser víctima de abuso como el riesgo de presentar problemas psicológicos justifica que se planifique 1) un protocolo de evaluación que permita detectar precozmente cualquiera de estas situaciones para prevenir tempranamente ambos problemas, y 2) un protocolo de intervención en los niños expuestos a violencia de género que trate sus problemas específicos tanto en el ámbito de la salud mental como en el legal.

Cuando un niño está expuesto a violencia es necesario evaluar: 1) las características de la exposición; 2) los efectos de la exposición a violencia en su salud mental y en su funcionamiento cotidiano, y 3) los factores mediadores y protectores entre la exposición y las consecuencias, que pueden provenir tanto del propio niño (características individuales) como del ambiente familiar.

Evaluación de las características de la exposición

La detección del niño expuesto a violencia doméstica puede llegar por diversos caminos; el más común de ellos es que la madre haya hecho una consulta y revele la situación. El problema también puede salir a la luz porque otro profesional, como el pediatra o profesor lo haya detectado, o porque el propio niño lo verbalice. La información sobre la exposición la proporcionará en gran medida la madre. El Observatorio de la Salud de la Mujer de la Escuela Andaluza de Salud Pública (2005) ha realizado una excelente revisión de instrumentos para el cribado y el diagnóstico del abuso físico, psicológico y sexual y el patrón de violencia hacia la mujer. Sin embargo, cuando hay niños en el círculo de la violencia doméstica, existen algunas cuestiones específicas sobre la exposición que se deben conocer y evaluar desde su perspectiva. A pesar de la importancia de la información proporcionada por el niño, la mayoría de los estudios sobre maltrato infantil en general, y de exposición a violencia doméstica en particular, no lo incluyen en el proceso evaluativo. Con poca frecuencia las investigaciones estudian el contexto familiar desde los ojos del niño. Los modelos de Davies y Cummings (1994) subrayan su importancia ya que el significado y las implicaciones que el niño atribuye a la violencia influencian en cómo reacciona ante ella. La ley del silencio que socialmente se establece en relación a la violencia doméstica, la falta de instrumentos adecuados al nivel cognitivo de los niños y consideraciones éticas en relación al abordaje de este tema directamente con los menores suelen ser los motivos principales para no abordar el tema con ellos. A esto se suma que tanto los organismos que atienden a las mujeres víctimas de maltrato por su pareja y los servicios de protección al menor suelen dejar de lado la evaluación de la violencia doméstica en los niños, a pesar de que la presencia de esta circunstancia dificulta las intervenciones (Shepard y Raschick, 1999). El resultado es que los niños testigos de violencia doméstica se convierten, como señala Osofsky (1995), en las *víctimas invisibles*.

Existe un creciente reconocimiento de la necesidad de comprender como contribuyen a la adaptación psicológica del niño las características de la violencia, incluyendo el tipo, la severidad, la frecuencia, la cronicidad y la edad de inicio, la relación con el agresor, el número de éstos, o la concurrencia de diversos tipos de violencia (Kinard, 2004). Los distintos tipos de abuso y negligencia se han relacionado con diferentes tipos de dificultades (Manly, Cicchetti y Barnett, 1994). Pero la disponibilidad de sistemas de evaluación de violencia doméstica que

se centren tanto en la madre como en el niño y que evalúen directamente la violencia de género es escasa.

En EE.UU. comienzan a implantarse programas dirigidos a profesionales de protección al menor que incluyen la formación en la utilización de instrumentos de cribado para violencia doméstica. Los instrumentos de cribado deben de ser breves, incluir preguntas poco bruscas, ser fácilmente integrados en la práctica regular de los profesionales, permitir establecer un buen *rapport* con las madres, estar adaptados culturalmente al informador y ser útiles en la investigación. En general, los instrumentos de cribado de maltrato infantil presentan alta sensibilidad pero baja especificidad, aumentando la proporción de falsos positivos. Por ello, algunos autores apuntan que su utilización puede generar problemas, como actitudes punitivas hacia la familia, etiquetaje erróneo, estrés y tensión familiar, entre otros. Por otro lado, no detectar casos de maltrato infantil o de violencia de género aumentaría las consecuencias negativas, tanto para la madre como para el niño (Magen, et al. 2001). Hay que tener en cuenta que la información sobre posibles abusos o experiencias de violencia de género de los hijos puede verse afectada por la deseabilidad social, las expectativas irreales y las atribuciones erróneas de la madre (Stowman y Donohue, 2005), por lo que se hace necesario incluir en la construcción de los instrumentos escalas de deseabilidad social. El *Domestic Violence Questionnaire* (Task Force on Family Violence, 1993), que evalúa a través de la madre cuestiones como el tipo de exposición del niño y las acciones emprendidas por ella ante la violencia, es un ejemplo de cuestionario de cribado para profesionales de la salud. El *Child Abuse Potential Inventory* (Milner, 1986) es un autoinforme para padres validado en nuestro país (Arruabarrena y de Paúl, 1992) que detecta conductas indicativas de abuso hacia los hijos. El *Conflict Tactics Scale* (Straus, Hamby, Finkelhor, Moore, y Runyan, 1998) dispone de versiones para padres y para niños con el objetivo de detectar negligencia, abuso sexual, agresión psicológica, agresión física y métodos de disciplina no violenta. siendo muy utilizadas en investigación en Norteamérica.

Al intentar evaluar directamente al pequeño aparece la necesidad de adecuar el tipo de instrumento al periodo evolutivo, teniendo en cuenta sus capacidades cognitivas y lingüísticas. El *Violence Exposure Scale for Children* versión preescolar (Fox y Leavitt, 1995) está formada por dibujos que describen cada evento permitiendo que el niño o la niña de 4 a 10 años se identifiquen con el personaje de la historia. Se le pregunta al niño si ha sido testigo o víctima directa de alguna de las acciones de violencia física que se describen, recogiendo información sobre la frecuencia del evento, la persona que acompañaba al niño en ese instante y el lugar y el momento donde ocurrió. Dispone de una versión para padres. El *Children's Perception of Interparental Conflict Scale* (Grych, Seid, y Fincham, 1992) evalúa las percepciones que tienen los niños de 9 a 12 años sobre el conflicto marital (frecuencia, intensidad, tipo de resolución y satisfacción, y valoración del niño sobre el conflicto). El cuestionario *Juvenile Victimization Questionnaire* (Hamby, Finkelhor, Ormrod, y Turner, 2004), permite conocer la historia de victimización de niños a partir de 8 años (la versión de los cuidadores es para menores de 8 años). Sus autores consideran que la presencia de un tipo de maltrato o victimización aumenta el riesgo de padecer otro tipo de maltrato, lo que ellos denominan "polivictimización" (Finkelhor, Ormrod, Turner, y Hamby, 2005). Tiene dos formatos, uno de autoinforme y otro de entrevista, y permite detectar 34 actos ofensivos contra los niños (incluyendo maltrato y exposición a violencia doméstica). Una vez detectado el tipo de victimización vivida, se le preguntan al niño más detalles sobre lo sucedido, incluyendo frecuencia del evento, heridas sufridas, hospitalizaciones, y sobre la figura del perpetrador.

Uno de los sistemas de codificación más global para el estudio de la tipología de la violencia es el propuesto por Barnet, Manly y Cicchetti (1993) para profesionales de Servicios de Protección al Menor. Incluye frecuencia, cronicidad, número de perpetradores, periodo evolutivo en el que tuvo lugar el evento e historia de separaciones de los cuidadores principales. La propuesta de Barnet estaba pensada para el estudio de niños que han sufrido abuso. Sin embargo, hasta el momento ningún estudio ha utilizado esta medida con hijos de mujeres maltratadas. Un segundo sistema de codificar de forma dimensional las experiencia de abuso sufridas por los niños es el *Record of Maltreatment Experiences* (McGee, Wolfe, y Wilson, 1990), diseñado para obtener una evaluación global de la historia de victimización del niño. Evalúa la frecuencia y gravedad en tres momentos evolutivos. Presenta la posibilidad de evaluar la exposición al maltrato de la madre de manera independiente a otras formas de maltrato lo que lo hace apropiado para esos estudios. En nuestro país, la *Taxonomía de Violencia Doméstica* (Unitat d'Epidemiologia i de Diagnòstic, 2006) se ha diseñado específicamente para el estudio de las consecuencias de la violencia doméstica en la salud mental de los niños. Tiene en cuenta el número de agresores a los que ha estado expuesto y su relación con éste, características del agresor y edad actual, tipo de exposición, explicación sobre la agresión que da la madre al niño, tipología de violencia y gravedad, presencia de lesiones, atención requerida ante el episodio, frecuencia del maltrato, edad inicial y final del niño para la exposición a la violencia doméstica, último episodio vivido, escalada de violencia, rol de la madre ante la agresión y resolución del conflicto, y tipo de maltrato directo que recibe el niño. Una de las ventajas que ofrece es que el evaluador debe conjugar información relativa a la madre y al niño, así como incluir información sobre las características del agresor, la mayoría de las veces obvia-

do en las evaluaciones de la violencia de género. Permite sistematizar y consensuar la recogida de información por parte de los profesionales en relación al maltrato infantil y la exposición a violencia doméstica, incluyendo el tipo de maltrato menos evidente, el psicológico.

Evaluación de los efectos de la exposición a la violencia

Las condiciones asociadas a situaciones de maltrato, como la violencia de género, impiden el desarrollo normal a lo largo de la infancia y sitúan al niño a alto riesgo de desarrollar psicopatología (Cicchetti y Toth, 1997). Para conocer las consecuencias psicológicas de la violencia doméstica en los niños se hace necesaria la evaluación de su estado cognoscitivo, emocional y conductual (Osofsky, 1999). Las alteraciones que presente varían según la etapa evolutiva en la que se encuentra.

En preescolares, la exposición a violencia doméstica se asocia a irritabilidad excesiva, regresión en el lenguaje y control de esfínteres, problemas de sueño (insomnio, sonambulismo), ansiedad de separación, dificultades en el desarrollo normal de la autoconfianza y de posteriores conductas de exploración, relacionadas todas ellas con la autonomía (Osofsky, 1999). Los síntomas de Trastorno por Estrés Postraumático (TEPT), como reexperiencia repetida del evento traumático, evitación, y aumento del "arousal", también están presentes en niños pequeños. En la etapa preescolar se suele contar con la información de la madre o de otros adultos significativos. El *Child Behaviour Checklist* (CBCL1½-5 y TRF1½-5; Achenbach y Rescorla, 2001), contestado por la madre o por los profesores, permiten obtener un perfil sintomatológico general de los problemas conductuales y emocionales de los niños de estas edades. El cuestionario *Interactivo Gabi* (adaptación al español de *Dominic Interactive;* Valla, Bergeron, y Smolla, 2000) es un autoinforme de cribado de sintomatología psicopatológica para niños de 6 a 11 años. Se presenta en formato audiovisual con dibujos sobre un niño o una niña llamados Gabi. Cada ítem describe una situación que le sucede al personaje y el niño debe contestar si le sucede lo mismo a él. Se evalúan 8 escalas (fobias específicas, ansiedad de separación, ansiedad generalizada, depresión/ distimia, oposición, problemas de conducta, déficit de atención/hiperactividad y puntos fuertes/capacidades).

Los niños en edad escolar muestran síntomas de ansiedad, depresión, conducta agresiva y estrés postraumático, así como otros problemas asociados como dificultades para dormir, concentrarse y para afrontar las peculiaridades de su entorno. Sus actitudes, competencia social y su funcionamiento escolar se ven afectados y, a medida que crecen, tienen mayor riesgo de presentar fracaso escolar, cometer actos vandálicos y presentar psicopatología, incluyendo abuso de sustancias (Osofsky, 1999). Los adolescentes que son testigos de violencia doméstica presentan mayores índices de implicación en actos criminales (Fagan, 2003) y tienden a justificar el uso de la violencia en sus relaciones amorosas (Lichter y McCloskey, 2004). La entrevista diagnóstica estructurada realizada con la madre y con el niño por separado es la que proporcionará la información clínica más importante. Disponemos de dos protocolos adaptados al castellano. La *Diagnostic Interview for Children and Adolescents* (Reich, 2000; Entrevista Diagnóstica para Niños y Adolescentes; De la Osa, Ezpeleta, Doménech, Navarro, y Losilla, 1997; Ezpeleta et al., 1997) y la *Children's Inteview for Psychiatric Síndromes* (Weller, Weller, Rooney y Fridstad, 1999), adaptada por Molina, Zaldívar, Gómez, y Moreno (2006), que permiten realizar diagnósticos según criterios DSM-IV (APA, 2001). Ambas son apropiadas para niños de 8 a 18 años. Los cuestionarios dimensionales, como el *Child Behaviour Checklist* (CBCL 6-18) o el *Youth Self Report* (YSR 11-18) (Achenbach y Rescorla, 2001) son un buen complemento para evaluar dimensionalmente la psicopatología general.

En algunos casos es interesante utilizar instrumentos más específicos. El 20% de niños expuestos a violencia de género presentan el diagnóstico de TEPT, siendo mayor el riesgo cuando los niños son testigos directos de la violencia parental o sufren abuso ellos mismos (National Council of Juvenile and Family Court Judges, 1993). El *Trauma Symptom Checklist for Children and Young Children* (Briere, 1996), autoinforme para niños de 10 a 17 años, evalúa la sintomatología de TEPT y la psicopatología asociada ante un acontecimiento traumático, como ser testigo de maltrato hacia la madre. La versión para padres y cuidadores recoge esta información para niños de 3 a 12 años (Briere et al., 2001). Igualmente, obtener información sobre sintomatología depresiva y ansiosa puede ser útil para disponer de medidas de cambio en los programas de intervención que se lleven a cabo con los niños expuestos a violencia doméstica. El *Children's Depression Inventory* (Kovacs, 1992), adaptado por Del Barrio, Moreno y López (2000), es un auto-informe de 27 ítems para evaluar síntomas depresivos en niños de 8 a 17 años. En el caso de niños preescolares, es necesario utilizar cuestionarios para padres, como el *Preschool Children Depression Checklist* (Levi, Sogos, Mazzei, y Paolesse, 2001) para niños de 2 a 4 años. Sus 39 ítems evalúan tres dimensiones: falta de vitalidad, tendencia al aislamiento y agresividad. La *Escala Revisada de Ansiedad Manifiesta* (Reynolds y Richmond, 1978), adaptada por Sosa, Capafons y López (1990), es una medida de 53 ítems de niveles de ansiedad en niños de 6 a 19 años. Contiene tres escalas: ansiedad fisiológica, inquietud/hipersensibilidad y preocupaciones sociales.

El desarrollo cognitivo del niño que es testigo de violencia familiar también puede verse afectado. Se ha demostrado que existe una correlación negativa entre violencia doméstica y desarrollo cognitivo general. Koenen, Moffitt, Caspi, Taylor y Purcell (2003) hallaron que los niños expuestos a violencia do-

méstica presentaban puntuaciones de cociente intelectual 8 puntos por debajo de los niños no expuestos. No enumeramos la pruebas de desarrollo cognitivo que se podrían utilizar por ser suficientemente conocidas por los profesionales.

Los niños maltratados presentan déficit en el auto-concepto y baja autoestima (Bolger, 1997) que se asocian a problemas de adaptación, como ansiedad, depresión y problemas de conducta. Además, la autoestima media el impacto de la calidad de la relación madre-hijo en el funcionamiento del niño (Kim y Cicchetti, 2004). El *Cuestionario AC* (Martorell, Aloy, Gómez, y Silva, 1993) evalúa el auto-concepto de niños y adolescentes en diversos ambientes. Por su parte, la *Escala de Autoestima* (Rosenberg, 1965) permite evaluar la auto-imagen positiva y negativa en niños y adolescentes a través de 10 ítems. Este instrumento está adaptado a población española (Vázquez, Jiménez, y Vázquez, 2004).

La presencia de sintomatología psicopatológica en los hijos de mujeres maltratadas produce una serie de dificultades en diversas áreas de la vida cotidiana del niño. La *Child and Adolescent Functional Assessment Scale* (Hodges, 1995) y la *Preschool and Early Childhood Functional Assessment Scale* (Hodges, 1999) evalúan el nivel de funcionamiento de ocho áreas (ejecución de roles en casa, en el colegio y en la comunidad, cognición, conducta hacia los otros, humor y emociones, y uso de sustancias) en las diferentes etapas evolutivas. Las escalas deben ser completadas por clínicos conocedores del caso (Ezpeleta, Granero, de la Osa, Doménech, y Bonillo, 2006).

Evaluación de las variables mediadoras

Características individuales

En el proceso de evaluación de los efectos de la violencia doméstica en los niños no se puede olvidar la resistencia**,** o capacidad del niño para adaptarse correctamente a su entorno a pesar de la presencia de serias amenazas para su desarrollo. Como factores protectores cruciales ante la exposición a violencia cuenta tener un cuidador adulto, refugio comunitario y las características individuales del niño. Entre las características del niño que ayudan a desarrollar esta resistencia se encuentran la buena capacidad intelectual, la autoestima, los talentos individuales, las afiliaciones religiosas, tener una buena situación socioeconómica y una red social suficientemente cálida (Osofsky, 1999). Otras características del niño que pueden estar actuando como factores protectores ante acontecimientos adversos o bien verse afectados por ellos son las habilidades sociales. La *Batería de Socialización*, en sus dos versiones para padres y profesores de niños de 6 a 15 años (Silva y Martorell, 1983) y versión auto-informe para adolescentes de 11 a 19 años (Silva y Martorell, 1995), consta de 75 ítems divididos en cuatro escalas de aspectos sociales facilitadores (liderazgo, jovialidad, sensibilidad social y respeto-autocontrol) y tres escalas de aspectos perturbadores (agresividad-terquedad, apatía-retraimiento, ansiedad-timidez). También se obtiene una apreciación global del grado de adaptación social. La *Escala de Dificultad Interpersonal para Adolescentes* (Méndez, Inglés e Hidalgo, 2001) es un auto-informe que recoge en formato de rejilla la capacidad de los chicos para desenvolverse en 4 áreas de funcionamiento (amigos, familia, colegio, y comunidad) con diferentes estímulos-persona (compañeros, padres, profesores, grupo de personas, etc.). La *Escala de Comportamiento Asertivo* (Wood, Michelson y Flynn, 1978) clasifica a los niños como agresivos, inhibidos y asertivos. Consta de 27 ítems y ha sido adaptado con niños escolares de 6 a 12 años por De la Peña, Hernández y Rodríguez (2003).

Los niños expuestos a diversas situaciones abusivas, entre las que se encuentra el ser testigo de violencia doméstica, presentan estrategias de afrontamiento desadaptativas en edades posteriores (pensamiento ilusorio, evitación de problemas, retraimiento social y comportamiento auto-crítico) (Leitenberg, Gibson, y Novy, 2004) y tienden a utilizar en general estrategias caracterizadas por falta de compromiso en oposición a estrategias orientadas al problema (Ornduff, y Monahan, 1999). En situaciones escolares, estos niños utilizan estrategias agresivas con los compañeros y agresión verbal con profesores (Lisboa, Koller, y Ribas, 2002). La *Self-Report Coping Measure* (Causey y Dubow, 1992) es un auto-informe para niños de 9 a 12 años que evalúa estrategias de afrontamiento (búsqueda de apoyo social, solución de problemas y estrategias de evitación: distanciamiento, exteriorización, interiorización). Las *Escalas de Afrontamiento para Adolescentes* (Frydenberg y Lewis, 1996) evalúan tres tipos de estrategias: productivas (estrategias centradas en resolver problema a la vez que se mantiene físicamente bien y socialmente conectado), no productivas (estrategias de evitación) y orientadas a los otros (buscar ayuda en los demás).

Evaluación del contexto familiar y social

El estudio de las consecuencias de la violencia doméstica sobre los niños implica entender el problema de la violencia como algo más que un acontecimiento entre dos personas. A pesar del fuerte vínculo entre el hecho de testimoniar violencia doméstica y la aparición de problemas en los niños, el impacto de esta experiencia varía ampliamente (Lieberman, van Horn, y Ozer, 2005). Como ya se ha comentado, esto es así en función de características personales, tanto del niño como de la madre, pero también de la estructura y las características del entorno en el cual la violencia tiene lugar, así como de las características del acto violento en sí. Por tanto, conocer la situación familiar en su más amplio sentido, el entorno comunitario en el cual el niño se desarrolla y las particularidades del hecho violento pueden ayudar a conocer y mejorar la habilidad del niño para afrontar el problema o incrementar sus consecuencias negativas (Carter, Weithorn y Berhman, 1999). Dada la elevada y

contrastada asociación entre violencia domestica y maltrato infantil los factores de riesgo contextuales involucrados en este último deberían también ser objeto de evaluación.

La mejor manera de evaluar a la familia, según Cook (2005), parece ser la utilización de ítems que afecten directamente a pares de relaciones, así como tener una evaluación circular en la que cada miembro de la familia pueda evaluar a todos los demás; padres a hijos, éstos a hermanos y viceversa. La utilización de instrumentos con versiones paralelas para los distintos miembros de familia serían las técnicas de elección.

La pobreza, la pertenencia a familias monoparentales y el nivel educativo de los padres son factores que incrementan el riesgo de violencia doméstica (Carter et al., 1999). De otro lado, la dependencia económica, y la existencia de hijos pequeños explican, en parte, la convivencia prolongada de la víctima y el agresor (Echeburúa, Amor, y de Corral, 2002). La *Kemple Family Stress Inventory* (Korfmacher, 2000) es una breve escala de apreciación que evalúa el riesgo parental de tener dificultades con la educación de sus hijos basada en la presencia de diversas situaciones psicosociales, como la historia pasada de carencias o maltrato en los padres, historia de consumo, enfermedad mental o dificultades legales, funcionamiento emocional, embarazo indeseado, actitud hacia y percepción del niño, o nivel de estrés de los padres entre otras. Los datos sobre la validez sugieren que existe relación entre las puntuaciones del inventario y el incremento de las tasas de abuso, el potencial de abuso y las dificultades educativas. El instrumento debe ser utilizado, según sus propios autores, como parte de una batería más amplia.

Las consecuencias de la violencia pueden llevar a estos niños a vivir pérdidas y situaciones de cambio frecuentes e indeseadas, separación, muerte o encarcelamiento de sus padres, cambios de domicilio, de ciudad, de amigos, o penuria económica. La investigación reitera la evidencia de que los desenlaces evolutivos se predicen mejor por los factores de riesgo acumulados que por una simple condición patogénica (Sameroff, 2000). Es importante conocer cuántas y qué situaciones de cambio existen, así como las consecuencias percibidas por el niño como consecuencia de ellas. Los listados de acontecimientos vitales estresantes que incorporan la posibilidad de evaluar el impacto de los eventos en la vida del niño son una buena herramienta. El *Life Event Checklist* (Johnson y McCutcheon, 1980) es un ejemplo.

Las reacciones psicológicas al trauma de la violencia doméstica son más o menos intensas en función del apoyo social disponible y en especial de la percepción que del mismo tienen los niños (Osofsky, 1997). La presencia de una figura adulta competente y una fuerte relación con ella es el factor protector más importante en presencia de dificultades. Sin embargo, en este caso, los padres, que son por lo general el principal soporte de los niños a la hora de proporcionarles protección, seguridad y cuidados, pueden no estar en disposición de hacerlo cuando están expuestos o son víctimas de la violencia. Además del impacto directo de la violencia, estos niños viven el impacto indirecto, debido al estrés, la presencia de psicopatología materna o la poca comunicación que afecta la calidad de la disponibilidad emocional de las madres hacia sus hijos (Huth-Bocks, Levendosky, y Semel, 2001). Labrador, Rincón, De Luís y Fernández (2004) sitúan entre 55% y 84% la prevalencia del Trastorno por Estrés Postraumático en las mujeres víctimas de violencia doméstica, entre las cuales son comunes también los trastornos de ansiedad y depresión, así como el consumo de tranquilizantes o alcohol (Echeburúa, Amor y Corral, 2004) . La evaluación de la salud mental de las madres constituye, por tanto, un aspecto esencial de este proceso de evaluación. La exploración clínica debería contar con una entrevista diagnóstica estructurada que valore de manera extensa la presencia de psicopatología. La *Structured Clinical Interview (SCID)* (*SCID-I;* First, Spitzer, Gibbon, y Williams, 1997*; SCID-II;* First, Gibbon, Spitzer, Williams, y Smith, 1997) que cumpliría con estos objetivos, ha sido adaptada en nuestro país por Torrens, Serrano, Astals, Pérez y Martín (2004).

La *Escala de Gravedad de Síntomas del TEPT* (Echeburúa y Corral, 2002), o el *Inventario de Depresión de Beck* (Beck y Steer, 1993) serían también instrumentos adecuados para evaluar la presencia y gravedad de los trastornos más frecuentes. No se puede olvidar en el contexto de la violencia la evaluación de la peligrosidad del agresor. Es necesario conocer la situación de peligro potencial en que se encuentra la víctima. De Luis (2004) ha desarrollado la *Entrevista de Valoración de Peligrosidad,* que comprende preguntas sobre las características de la amenaza a través del perfil descriptivo del agresor, de su dinámica de agresiones, de la situación de la víctima y de sus recursos de afrontamiento.

Parte de las consecuencias estudiadas en las mujeres a causa de la violencia doméstica es el hecho de que pueden llegar a pensar que son incapaces de cuidar a sus hijos (Matud et al., 2004). Esa misma sensación pueden tener los hijos, que no lleguen a comprender porqué no son protegidos en sus propias casas. Por tanto, la percepción de los niños acerca de la "capacidad" de sus cuidadores para proporcionarles apoyo debería evaluarse también. La *Perceived Parental Support* (Stice, Barrera, y Chassin, 1993) es un auto-informe para adolescentes que mide la percepción del soporte recibido por los padres en cuanto a afecto, relación de compañerismo, ayuda, expresión de admiración e intimidad, y que se ha relacionado con la presencia de ansiedad y depresión ante situaciones de riesgo. Consta de sólo 6 ítems que se contestan por separado para ambas figuras parentales.

Las relaciones familiares son reconocidas como relevantes en el desarrollo de los niños. Dentro de este marco, las relaciones fraternales son las más perdurables en el tiempo y en todos los

contextos de relación. Tucker, McHale y Crouter (2001) informan que tanto los hermanos menores como los mayores son percibidos como fuentes de apoyo en el caso de tener que afrontar problemas familiares, especialmente en la adolescencia y en relación a la adaptación personal (Branje, Lieshout, van Aken, y Haselager, 2004). Este sería el caso de la violencia doméstica. El cuestionario *Relational Support Inventory* (Scholte, Cornelis, van Lieshout, y van Aken, 2001) aporta información de madre, padre, hermanos y amigo íntimo acerca de la calidad de la información, el respeto por la autonomía de los hijos, el apoyo emocional, la convergencia de objetivos y la aceptación de los hijos. Es aplicable de los 12 a los 18 años.

La violencia doméstica suele ocultarse tras pactos implícitos o explícitos de silencio. Los niños viven su situación como algo que debe ser mantenido en secreto y con vergüenza. La negación y la ocultación son una constante más que una excepción. Esto dificulta la posibilidad de poder expresar, compartir y buscar ayuda en los iguales. El estilo interpersonal de los perpetradores puede ser asimismo disfuncional e impedir la implicación de sus hijos en redes sociales más amplias. Conocer su capacidad de comunicar y de implicarse socialmente en redes más amplias que la familia es importante. En este caso, los amigos serían la esfera social más próxima al niño. Algunos estudios sobre niños maltratados informan de aislamiento y restricciones en el contacto social con otros niños (Lynch y Cicchetti, 1991) y, por tanto, de riesgo de que existan problemas con sus iguales. Auto-informes como el *Friendship Quality Questionnaire* (Parker y Asher, 1991), de 41 ítems, han sido utilizados en este campo y exploran las relaciones de amistad de los niños en relación a 6 dimensiones: cuidado, resolución de conflictos, traición, ayuda y consejo, compañerismo y diversión e intimidad.

La calidad de la relación madre-hijo es un mediador en la aparición de problemas de conducta de aquellos niños que testimonian violencia doméstica (Levendosky, Huth-Bocks, Shapiro, y Semel, 2003). Las madres que han experimentado violencia marital tienen más tendencia a ser impulsivas, utilizando estrategias más punitivas con sus hijos o exhibiendo hacia ellos mayor agresividad (Osofsky, 1998). Asimismo, los limitados estudios sobre el estilo educativo de los padres maltratadores muestran que son menos accesibles a sus hijos, menos implicados en conversaciones con ellos y menos afectuosos. Las prácticas parentales basadas en el calor y el respeto a la autonomía parecen ser las que ofrecen menos correlación con altos índices de mal funcionamiento (Barnes, Farrel, y Banerjee, 1994; Stice y Barrera, 1995). La escalas al uso más frecuente suelen incluir las dimensiones de calor emocional, hostilidad, respeto a la autonomía del sujeto y establecimiento de pautas o límites (Scholte et al., 2001). Entre ellas encontramos el *Parental Bonding Instrument* (Parker, Tupling, y Brown, 1979), que incluye escalas para valorar el cuidado, la sobreprotección y el autoritarismo; el *Parental Discipline Practice Scales* (Goodman et al., 1998) que evalúa las prácticas de disciplina de los padres diferenciando entre la disciplina no punitiva y el castigo físico; y el *EMBU* (*Inventory for Assessing Memories of Parental Rearing Behavior* ; Perris, Jacobson, Lindström, Knorring, y Perris, 1980), adaptado a población española por Castro, Toro, Van der Ende y Arrindell (1993). Este último evalúa por separado la percep-

TABLA 1
PROTOCOLO DE EVALUACIÓN DE VIOLENCIA DOMÉSTICA PARA NIÑOS Y ADOLESCENTES

VARIABLES	INSTRUMENTO	INFORMADOR	ÁREA EVALUADA
Exposición a Violencia Doméstica y Maltrato	*Domestic Violence Questionnaire* (Task Force on Family Violence, 1993)	Madre	Tipo de exposición a la Violencia y acciones emprendidas por la madre.
	**Child Abuse Potencial Inventory* (Milner, 1988)	Madre	Detección de conductas indicativas de abuso hacia hijos.
	Violence Exposure Scale for Children (Fox y Leavitt, 1995)	Niño 4-10 años	Exposición o victimización de actos de violencia física. Formato visual.
	Children's Percepction of Interparental Conflict Scale (Grynch et al., 1992)	Niño 9-12 años	Percepciones del niño sobre conflicto marital.
	Juvenile Victimization Questionnaire (Hamby et al., 2004)	Madre niños < 8 años Niño > 8 años	Historia de victimizaciones. Incluye maltrato y exposición a Violencia Doméstica.
	Record of Maltreatment Experiences (McGee, Wolfe, y Wilson, 1990)	Profesional	Profesional Historia de victimizaciones en tres estadios evolutivos. Incluye violencia hacia la madre.
	**Taxonomía de Violencia Doméstica* (UED, 2006).	Profesional	Características de Violencia Doméstica.
Efectos psicológicos	*Child Behavior Checklist 1$^{1/2}$ -5* (Achenbach y Rescorla, 2001)	Madre de niños de 1$^{1/2}$ a 5 años.	Perfil sintomatológico general de problemas conductuales y emocionales de niños
	Dominic Interactivo (Valla et al., 2000)	Niño 6-11 años	Tendencia en psicopatología.
	**Diagnostic Interview for Children and Adolescents* (Reich, 2000).	Cuidadores y niños 8-18 años	Diagnósticos DSM-IV (APA, 2001).
	Youth Self Report (Achenbach y Rescorla, 2001)	Adolescentes 11-18 años	Perfil sintomatológico general de problemas conductuales y emocionales.

TABLA 1
PROTOCOLO DE EVALUACIÓN DE VIOLENCIA DOMÉSTICA PARA NIÑOS Y ADOLESCENTES (continuación)

VARIABLES	INSTRUMENTO	INFORMADOR	ÁREA EVALUADA
• **TEPT**	*Trauma Symptom Checklist for Children and Young Children* (Briere, 1996).	Niños 10-17 años Cuidadores de niños 3-12 años	Síntomas de Estrés Post-traumático y psicopatología asociada.
• **Depresión**	**Children's Depression Inventory* (Kovacs, 1992) *Preschool Children Depression Checklist* (Levi et al., 2001)	Niños 8-17 años Madre niños 2-4 años	Sintomatología depresiva. Síntomas depresivos.
• **Ansiedad**	**Escala Revisada de Ansiedad Manifiesta* (Reynolds, y Richmond, 1978)	Niños 6-18 años.	Sintomatología ansiosa.
• **Desarrollo Cognitivo**	Escalas de Desarrollo y Nivel Cognitivo		
• **Auto-estima**	**Cuestionario AC* (Martorell et al., 1993) **Escala de Autoestima* (Rosenberg, 1965)	Niños y adolescentes Niños y adolescentes	Auto-concepto. Auto-estima.
Funcionamiento psicosocial	*Child and Adolescent Functional Assessment Scale* (Hodges, 1995) *Preschool and Early Childhood Functional Assessment Scale* (Hodges, 1999)	Clínico	Funcionamiento cotidiano en ocho áreas.
	**Batería de Socialización* (Silva y Martorell, 1983; 1995)	Cuidadores/profesores niños 6-15 años. Adolescentes 11-19a.	Aspectos sociales facilitadotes y perturbadores.
Habilidades Sociales	**Escala de Dificultad Interpersonal para Adolescentes* (Méndez et al., 2001)	Adolescentes	Capacidad social en cuatro áreas de funcionamiento.
	**Escala de Comportamiento Asertivo* (Word et al., 1978)	Niños 6-12 años	Conductas asertivas, inhibidas y agresivas.
Estrategias Afrontamiento	*Self-Report Coping Measure* (Causey y Dubow, 1992) *Escalas de Afrontamiento para Adolescentes* (Frydenberg y Lewis, 1996)	Niños 9-12 años Adolescentes	Estrategias de afrontamiento.
Contexto Familiar	*Kemple Family Stress Inventory* (Korfmacher, 2000)	Madre	Dificultades en la educación.
• **Apoyo familiar**	*Perceived Parental Support* (Stice et al., 1993)	Adolescentes	Apoyo recibido por los padres.
	Relational Support Inventory (Scholte et al., 2001)	Adolescentes 12-18 años	Apoyo y comunicación con padres, hermanos y amigos.
• **Estilos parentales**	*Parental Bonding Instrument* (Parker et al., 1979)	Madre	Cuidado, sobreprotección y autoritarismo.
	Parental Discipline Practice Scales (Goodman et al., 1998)	Madre	Prácticas de disciplina no punitivas y castigo.
	**EMBU Inventory for Assessing Memories of Parental Rearing Behavior* (Perris et al., 1983)	Adolescentes y padres niños < 12 años.	Estilo educativo.
• **Supervisión**	*Parental Monitoring Scale* (Goodman et al., 1998)	Madre o cuidadores	Supervisión y control del comportamiento del niño.
• **Expresión emocional**	*Camberwell Family Interview* (Rutter y Brown, 1966)	Madre	Afectividad positiva o negativa en las relaciones materno-filiales.
Contexto Social	*Friendship Quality Questionnaire* (Parker y Asher, 1991)	Niños	Relaciones de amistad.
Acontecimientos Vitales Estresantes	*Life Event Checklist* (Johnson y McCutcheon, 1980)	Niños	Acontecimientos estresantes a lo largo de la vida del niño.
Salud Mental materna	SCID-I y SCID-II (First et al., 1997) SCL-90-R (Derogatis, 1994)	Madre Madre	Diagnósticos eje I y II DSM-IV (APA, 2001). Síntomas psicopatológicos.

*Instrumento construido o adaptado en España.

ción del niño del estilo educativo de padre y madre en cuatro dimensiones: rechazo, sobreprotección, calor emocional y favorecimiento. Hay versiones similares para adolescentes y padres.

El grado de supervisión familiar se puede ver afectado cuando la madre se ve involucrada en situaciones de abuso. El bloqueo emocional, por un lado, y el consumo de tiempo en la búsqueda de recursos y soluciones, por otro, puede mermar su conocimiento acerca de las actividades y emociones de sus hijos. La *Parental Monitoring Scale* (Goodman et al., 1998) proporciona una medida sobre el grado en que los cuidadores principales controlan o supervisan el comportamiento del niño. La inclusión en los protocolos de evaluación de preguntas en relación a la apertura entre padres e hijos, como con qué fre-

cuencia hablan sobre sus planes en la escuela, o si hay secretos o complicidad entre ellos ofrece una medida de la calidad de la comunicación (Stattin y Kerr, 2000).

El concepto de "emoción expresada" se refiere a las actitudes y conductas afectivas, y se relaciona con la calidad del clima emocional entre un familiar y un miembro de la familia con un problema de salud mental. Las mujeres maltratadas viven bajo una situación de estrés continuado que puede incrementar el riesgo de que ellas maltraten también a sus hijos, ya sea de forma física o de manera psicológica. La forma en que se expresa la emoción de las relaciones materno-filiales puede incluir las críticas o quejas hacia una persona (afectividad negativa) (Cook y Kenny, 2004), o su contrario, aprobación y cumplidos hacia alguien (afectividad positiva). La hostilidad, la actitud crítica o la sobre-implicación emocional son los aspectos más estudiados por los diversos instrumentos de los que se dispone (Humbeeck et al., 2002). Entre los más utilizados y validados está la *Camberwell Family Interview* (Rutter y Brown, 1966), origen de las diversas escalas que se han derivado a posteriori.

La aceptación e incluso la expectativa que determinados grupos culturales y sociales pueden tener hacia el patrón dominante de los varones, así como la justificación de determinadas actitudes agresivas o dominantes hacia las mujeres puede dificultar el estudio de la violencia doméstica, minimizar sus efectos o negar su existencia. Conocer lo que se "tolera" o se justifica desde una determinada perspectiva es determinante de cara a poder intervenir. La actitud positiva hacia la dominancia masculina, favorecida por una cultura patriarcal, incrementa la aceptación y la frecuencia de abuso físico y del sometimiento incuestionable del hombre a la mujer. Los diferentes umbrales de tolerancia a la violencia pueden hacer que ciertas formas de abuso no sean consideradas como tal con lo que se perpetúan por falta de reconocimiento o denuncia pública. Una de las formas en que la violencia doméstica afecta a los niños y se convierte en violencia psicológica es el modelamiento de comportamientos violentos y misóginos considerándolos como normales y reproduciéndolos en la vida adulta. La *Abuse Attitude Form* (Faramarzi, Esmailzadeh, y Mosavi, 2005) contiene 10 ítems que miden la tolerancia de la mujer hacia determinadas conductas de la pareja que pueden estar en el origen de la violencia doméstica. Este instrumento, que carece de paralelo para los niños y no está en la actualidad adaptado al castellano, aborda un área de interés en la evaluación global de las posibles consecuencias de la violencia doméstica en el bienestar de los niños como lo es reproducir en un futuro conductas que han sufrido previamente.

RECOMENDACIONES PARA LA EVALUACIÓN

A lo largo de esta exposición se han nombrado distintos instrumentos de evaluación, algunos de los cuales no están adaptados en nuestro país. La Tabla 1 sintetiza la propuesta del protocolo de evaluación para niños víctimas de violencia doméstica diferenciando el informador y las áreas evaluadas. Una recomendación inmediata que se desprende de esta presentación es la necesidad de adaptar y/o crear instrumentos que sean adecuados para la evaluación psicológica de mujeres y niños de nuestro contexto. Hamby y Finkelhor (2000) han listado las recomendaciones para evaluar y desarrollar instrumentos para niños víctimas de diferentes tipos de abusos y agresiones (Tabla 2), que se presentan como colofón a la propuesta. Se ha comentado anteriormente que la exposición a violencia doméstica es un tipo de abuso (psicológico) que suele co-ocurrir con otros tipos de maltrato del niño (por ej. físico, otras formas de abuso psicológico y/o negligencia). En este sentido, las recomendaciones de estos autores son aplicables al evaluar a estos niños. Sintetizando, una parte de estas recomendaciones se refiere a la clasificación del acto agresivo, que circunscribiría el contenido de las preguntas que se deben hacer, otra parte tienen relación con cuestiones generales sobre la formulación de los contenidos en el caso de la evaluación infantil y, finalmente, hay unos consejos éticos. Algunas de las indicaciones son especialmente relevantes para la situación de

TABLA 2
RECOMENDACIONES PARA LA EVALUACIÓN Y DEL DESARROLLO DE INSTRUMENTOS PARA NIÑOS VÍCTIMAS DE DIFERENTES TIPOS DE ABUSOS Y AGRESIONES (HAMBY Y FINKELHOR, 2000)

- ✔ Situar la victimización del niño en las categorías convencionales de las actividades criminales
- ✔ Incluir la victimización no violenta
- ✔ Situar los datos entre las categorías de ofensas controladas por el sistema de protección del niño
- ✔ Ampliar el contexto de evaluación a cuestiones que van más allá de las actividades criminales
- ✔ Evaluar la victimización por parte de la familia y de otros perpetradores no extraños
- ✔ Incluir ofensas que son específicas de la situación de dependencia del niño
- ✔ Establecer métodos para comparar las victimizaciones jóvenes y a adultos
- ✔ Utilizar preguntas específicas sobre comportamientos frente a preguntas generales
- ✔ Utilizar un vocabulario sencillo
- ✔ Utilizar una gramática y sintaxis sencillas
- ✔ Recoger autoinformes del niño a partir de los 7 años
- ✔ Utilizar la información de los cuidadores en algunas circunstancias
- ✔ Proteger la privacidad durante la recogida de datos
- ✔ Utilizar tecnología audio-informatizada
- ✔ Recoger datos sobre incidentes ocurridos en un período de un año
- ✔ Atender a posibles diferencias étnicas, de clase o de género en los autoinformes
- ✔ Utilizar acontecimientos de la vida de los informadores para ayudar a limitar el recuerdo
- ✔ Usar conceptos de tiempo y número sencillos
- ✔ Ofrecer ítems de práctica
- ✔ Prepararse para ayudar al niño en peligro

violencia doméstica. Este es el caso de evaluar la victimización por parte de la familia que, a menos que se explicite, se infra-informará; de incluir las ofensas que son específicas de la situación de dependencia del niño, como lo son la negligencia o los abusos sexuales; la importancia de recoger auto-informes del niño a partir de los 7 años, habitualmente ignorados en la evaluación; y contar también con la información de la madre. Como señalan estos autores "muchas áreas de estudio han crecido considerablemente por el desarrollo de instrumentos de medida bien diseñados y fiables" (p.838). En el momento actual, el tema de la violencia doméstica y, específicamente sus efectos en los niños, necesita crecer en esta dirección.

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3. PSYCHOPATHOLOGY IN CHILDREN AND ADOLESCENTS EXPOSED TO INTIMATE PARTNER VIOLENCE

3.1. Manuscript: Mental health needs of children exposed to intimate partner violence who seek help from mental health services

Mental health needs of children exposed to intimate partner violence who seek help from mental health services

Abstract

The aim of this study is to examine whether children and adolescents who are exposed to interparental physical and environmental violence have specific needs when seeking mental health services, compared to those who are not exposed. The witnessing of intimate partner violence (IPV), psychopathology, functional impairment, and several individual and family variables were assessed in 520 children aged from 8 to 17 years who sought help from mental health centers. Results showed that living with violent parents at home increased the risk of post-traumatic stress disorder, dysthymia, self-harming behavior, and functional impairment. The mothers of exposed children overprotected their sons, punished their daughters and suffered more psychopathology. The gender of the child moderated the effects of IPV on parenting, parental discipline, life events, and health. Given the specific needs of exposed children, an attempt should be made to improve the capacity of mental health services to detect, assess, and treat these cases.

Key-words: children and adolescents, intimate partner violence, functional impairment, maternal psychopathology, mental health services, parental rearing, psychopathology, gender.

Mental health needs of children exposed to intimate partner violence who seek help from Mental Health Services

Intimate partner violence (IPV) can be defined as physical assault, sexual assault, psychological abuse, and battering of a woman by a male (Plichta, 2004); this may include environmental violence such as throwing or breaking objects. Approximately 15.5 million American children are exposed to IPV incidents annually (McDonald, Jouriles, Ramisetty-Mikler, Caetano, & Green, 2006). According to the United Nations secretary-general's study on violence against children (UNICEF, 2006), a minimum of 240,000 children in the UK are expected to have been exposed to IPV; in some other countries (e.g., Spain), an estimated of 118.000 children have been exposed to IPV and that this number is expected to increase to 275 million worldwide. Moreover, witnessing IPV negatively affects the child's social, emotional, and cognitive development (Edleson, Mbilinyi, Beeman, & Hagemeister, 2003) and it increases the risk of using health services between six to eight times more (Campbell & Lewandowski, 1997). Despite the high frequency of IPV and its negative effects on the child's life, detecting the presence of violence is not a systematic practice among mental health professionals. Specific detection and treatment of IPV's negative outcomes in the child's mental welfare are still undeveloped. A significant proportion of these children remains undetected and does not receive the correct treatment (McAlister, 1999). Assessing the specific needs of children exposed to IPV who seek help from mental health services may help professionals to encourage centers to develop adequate intervention protocols.

Children who have witnessed IPV have been reported to be psychologically maladjusted (Margolin, 1998) and have reported symptoms of anxiety and depression,

aggressive behavior, post-traumatic stress, concentration and sleeping problems, coping difficulties in different environments, and social competence (Osofsky, 1999) and self-esteem impairment (Bolger, 1997). Twenty percent of exposed children also suffer post-traumatic stress disorder (National Council of Juvenile and Family Court Judges, 1993). This symptomatology is associated with negative outcomes in some areas of the child's daily life (i.e., school, home, and social relations). Moreover, physical symptoms such as headache, enuresis, sleeping problems, vomiting, sickness, and diarrhea are frequent among exposed children (Campbell & Lewandowski, 1997). IPV comprises a major stressor associated with the presence of other life events, such as experiencing violence in secret, frequently moving home and city, and therefore, changing school and friends, separations, social and financial disadvantages, and even contact with the police and judicial system (J. Humphreys, 1993). Given the fact that the number of stressors is linearly and positively associated with high psychopathology and impairment risk (Appleyard, Egeland, van Dulmen, & Sroufe, 2005), detecting stressful situations is important to prevent negative outcomes. IPV not only have direct effects on the child's functioning, but it is also indirectly affected by family factors, such as maternal distress and parenting (Dehon, 2005). Abused women are at high risk of developing a wide range of psychiatric disorders (e.g., post-traumatic stress disorder, Golding, 1999) and anxiety and depressive disorders (Echeburúa, Amor, & de Corral, 2002) and that the presence of these disorders are generally linked to an increased prevalence of behavioral and emotional problems in children (Levendosky, Huth-Bocks, & Semel, 2002; Morrel, Dubowitz, Kerr, & Black, 2003). Similarly, exposed children may be affected by negative parenting. Mothers from violent homes are twice as likely to practice physical and verbal aggressive behavior toward their children (Hunter, Jain, Sadowski, & Sanhueza, 2000); they are more irritable, less involved in their children's education and

care and exhibit less emotional warmth (Margolin, Gordis, Medina, & Oliver, 2003). Abused women tended to overprotect their children (Smith, Berthelsen, & O'Connor, 1997) and they may practice inconsistent parenting styles (Holden & Ritchie, 1991). Both parents control their child's behavior less (Hartley, 2004), and are less involved in the child's activities (Margolin et al., 2003). However, the extent to which IPV affects the children depends on the gender of the child, although there are discrepancies across studies. Some meta-analyses show no significant gender differences in terms of the psychological effects of witnessing IPV (Kitzmann, Gaylord, Holt, & Kenny, 2003; Wolfe, Crooks, Lee, McIntyre-Smith, & Jaffe, 2003). Other studies have shown that gender differences in the impact of IVP was related to differences in which parents threat their daughter and son. For example, boys in comparison to girls are more likely to suffer aggression from their fathers in IPV contexts (O'Keefe, 1994). Furthermore, IPV is associated with high levels of both father and mother aggression toward their sons but not toward their daughters (Jouriles & LeCompte, 1991). Detecting differences in rearing styles according to the child's gender will allow professionals to adapt intervention programs to IPV situations.

The aim of the present study is to determine whether children and adolescents who witness IPV, exhibit different characteristics in clinical, psychological, contextual, and familiar variables when seeking help from mental health services. The relation between the child's gender and exposure to IPV will be explored in psychopathology, rearing styles, discipline, life events, and physical health. Given that mothers in the sample were mostly the victims of violence, the present study focused mainly on maternal psychopathology.

Method

Subjects

The sample included 520 children and adolescents aged from 8 to 17 years old and their parents, who were attending public mental health centers in the metropolitan area of Barcelona. Parents were invited to participate in the study by the clinicians between 1997 and 2005. Among the parents and children who were asked to collaborate with the study, 96.3% accepted to participate. 97.7% of participants who accepted to participate were Mediterranean European, 1% was Hispanic, and 1.3% pertained to other ethnicities. 41% of the participants had an Attention Deficit and Hyperactivity Disorder (ADHD) diagnosis, 48.6 % had Oppositional Defiant Disorder (ODD), 24.5% had major depression and 52.1% suffered from an anxiety disorder. The main diagnosis of children who rejected to participate in the study was 20.0% ADHD, 5% ODD, 25.0% Conduct Disorder, 5% Generalized Anxiety, 15% Anorexia Nervosa, 5% Tics, and the 25% other problems. Children who rejected to participate were significantly older than participants (mean age=14.47, SD=2.19 versus 13.24, SD=2.47; p=.031) and 65% were girls (Chi-score=14.47, p=.094). Children with mental retardation, general developmental disorder (i.e. Autism), or whose parents were no able to speak or read in Spanish were not invited to participated because the assessment instruments where not appropriate for these populations.

According to their answers to the following questions included in the Risk Factors Schedule (Unitat d'Epidemiologia i de Diagnòstic en Psicopatologia del Desenvolupament, 1997) *"Have you ever seen your parents push each other when they quarrel?", "Have you ever seen your parents hit each other during an argument?"* or *"Have you ever seen your parents break or throw objects during an argument?",* participants were classified in two groups: exposed (n=100) and non-exposed (n=420).

Table 1 shows participants' demographic characteristics. The exposed group presented a higher proportion of one-parent families ($p<0.001$) and a lower percentage of males ($p=0.03$). According to the parents' reports, in 95.5% of the cases the mother was the victim of violence and in 4.5% the victim was the father. According to the children's reports, of the family members who suffer from continuous violence by another family member, 47.5% were mothers, 6.6% were fathers, and the remaining were other relatives (grandparents, siblings, more than one, or other).

INSERT TABLE 1

Measures

Child and adolescent's psychopathology

The *DICA-IV* (Diagnostic Interview for Children and Adolescents; Reich, 2000. Adapted to Spanish population by Ezpeleta et al., 1997) was used to assess the psychological outcomes of children exposed to IPV. The instrument establishes the diagnosis based on DSM-IV criteria (American Psychiatric Association, 2001). There are different versions for parents (8 to 17 years old), children (8 to 12 years old), and adolescents (13 to 17 years old). Diagnoses were obtained by combining the information gathered from parents and children at symptom level: a symptom was presented when either parents or children reported it.

Child Behavior Checklist (CBCL; Achenbach & Rescorla, 2001). The questionnaire was used to assess dimensional psychopathology as a psychological outcome. Parents reported different emotional and behavioral problems in children and adolescents of between 6 and 18 years old. There are 113 items with three possible answers (0= never, 1= sometimes, 2= frequently). For the present study, the following scales were examined: *Anxious/depressed, withdrawn/depressed, somatic complaints,*

social problems, thought problems, attention problems, rule-breaking behavior, and *aggressive behavior*. Raw scores were used.

Child and adolescent's functioning

Child and Adolescent Functioning Assessment Scale (CAFAS; Hodges & Wong, 1996). The scale was used to address the child's adjustment. It assesses the extent to which children and adolescents' mental health affects their functioning in eight areas: *roles execution* (school/work, home and community), *behavior toward others*, *mood-emotions* (mood, autolysis behavior), *substance abuse*, and *cognition*. Using information obtained in the interview, the interviewer assessed the lowest level of functioning in each area during the evaluated period, taking into consideration the child's age, gender, and social class. In this study, total global score (based on the eight scales) and scores in each scale were used. The scales contain four levels of functioning (0, minimum; 10, mild; 20, moderate; and 30, severe). Due to the asymmetric distribution of frequencies in the scores on the scale, the four initial levels were grouped in two classes to facilitate statistical analysis (0=minimum/mild versus 1=moderate/severe). This instrument has good psychometric properties for a Spanish population (Ezpeleta, Granero, de la Osa, Doménech, & Bonillo, 2006).

Intimate Partner Violence and other familiar variables

Risk Factors Schedule (RFS; Unitat d'Epidemiologia i de Diagnòstic en Psicopatologia del Desenvolupament, 1997). This schedule is a structured interview based on the *Service Utilization and Risk Factors* (Goodman, Alegria, Hoven, Leaf, & Narrow, 1992; Goodman et al., 1998). The modified version presents acceptable levels of inter-rater reliability and concurrent validity (Ezpeleta, Granero, de la Osa, & Guillamón, 2000; Guillamón, 1999). The instrument was used to record the following dependent variables reported by children: *discipline* (Parental Discipline Practices

Scales; Goodman et al., 1998), *parental monitoring* (Parental Monitoring Scale; Goodman et al., 1998), *negative stressful life events* (Life Events Checklist; Johnson & McCutcheon, 1980), *physical quality of health* (0= excellent or good; 1= not too good or bad), and *exposure to IPV* as independent variable of the study (based on the Children's Perception of Interparental Conflict Scale; Grynch, Seid, & Finchman, 1992). Parents reported on the family history (based on the Family psychiatric screening instrument for epidemiological studies; Lish, Weissman, Adams, Hoven, & Bird, 1995).

Parenting styles

EMBU (Castro, Toro, Van der Ende, & Arrindell, 1993) was used to evaluate parental styles as dependent variable according to the information provided by the child. Versions for children (between 8 and 12 years old) and adolescents (from 13 years old) were used. The parenting of the mother and the father was assessed separately, and in this study, emotional warmth, rejection and overprotection scores were obtained. The answer is a likert-type with 4 options (from 1= no, never to 4= yes, always).

Maternal Psychopathology

SCL-90-R (Derogatis, 1983. Spanish adaptation by González de Rivera, de las Cuevas, Rodríguez, & Rodríguez, 2002) was used to measure maternal distress in the last week. Ninety self-report items assess the level of psychological distress and are combined in nine dimensions and three global indices (somatization, obsessive-compulsive disorder, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid thinking, psychoticism; Global Severity Index, Positive Symptom Distress Index, and Positive Symptom Total). The answer is a likert-type with 5 options (from 0= never to 4= very much). The higher is the score in each scale, the most severe is the disorder.

Individual characteristics

AC [Self-Concept] Questionnaire (Martorell, Aloy, Gómez, & Silva, 1993) assesses the self-concept of children and adolescents in different contexts. It has self-reported 38 items with four answer alternatives (ranking from 0= never or almost never to 3= always). The questionnaire is formed by two scales: negative self-concept (i.e. 'I am clumsy') and the positive self-concept /self-esteem (i.e. 'I am very popular among my friends').

Competence Questionnaire (Beiser, Lancee, Gotowiec, Sack, & Redshirt, 1993) was used to measure the perception of parents about the competence of their children. It is a 25 item scale with four option likert-type answers (ranging from 0= false to 3= frequently true). Items are clustered into two subscales: the *Instrumental Competence Perception* (i.e. 'He/she does their homework with no supervision) and the *Social Competence* (i.e. 'He/she has a lot of friends'). The internal consistency of both scales was good in this sample (social competence scale α= 0.83; instrumental competence scale α= 0.89).

Procedure

Ethical approval was obtained from the ethical committee of our institution. Written consent from parents and verbal assent from children and adolescents to participate in the study were obtained. Parents and children participated in a diagnostic interview simultaneously and in separate rooms, and were given risk factors schedules. The interviewers were clinical psychologists and psychology students who were all trained in using the diagnostic interview schedule (de la Osa, Ezpeleta, Doménech, Navarro, & Losilla, 1996). After collecting information from the diagnostic interview, the interviewers evaluated the children's psychosocial functioning with the CAFAS. Finally, the parents and children or adolescents answered the questionnaires.

Statistical analysis

Analyses were carried out through SPSS 15.0 for Windows. Logistic regressions (for binary outcomes) and analysis of variance (ANOVA, for quantitative outcomes) were used to explore the association between exposure to IPV and clinical, psychological, and family variables. All the regressions were adjusted according to the child's gender and age, and the family structure (i.e., one versus intact family member). Moreover, models for psychological disorders (as dependent variable) were also controlled by the presence of other comorbidities; the number of psychological disorders in the child was entered into the models for the impairment level and physical health. Due to the exploratory approach of analyses, significant results were considered for p-values ≤ 0.05.

The relation between the gender of the child and IPV was included into logistic models and ANOVA to examine whether gender was a moderator variable in the relationship between violence at home and psychopathology, rearing styles, discipline, life events and physical health. Interactions with p-values ≤ 0.10 (common bound in exploratory analyses) were retained in the models, and single effects were estimated for boys and girls; on the contrary (non-significant associations), IPV main effects were estimated jointly for both gender.

Results

The effects of IPV on child psychopathology

Table 2 shows the association between IPV and psychopathology. Regarding the diagnostic interview, children who had been exposed to IPV had a higher risk of developing dysthymic disorder and post-traumatic disorder, and had a higher number of DSM-IV diagnoses and symptoms, than the control children.

Regarding the CBCL, children who were exposed to IPV had significantly higher scores in the externalizing scale (mean of exposed children=19.45, SD=1.28; non-exposed= 15.83, SD= .95, p<.05) and the rule-braking behavior subscale (mean of exposed children= 6.25, SD=.52; non-exposed=4.36, SD=.39, p<.05).

INSERT TABLE 2

Impairment

Children who lived with violent parents reported more daily global impairment (based on the total score of the eight scales of the CAFAS; exposed children=61.02, SD=20.80; non-exposed=69.45, SD=27.87, p<.01), as well as more impairment in roles at home (based on the presence/absence of impairment at home; 44% of exposed children and 23.1% of non-exposed, OR= 2.17, 95% CI: 1.33 to 3.54) and autolysis (based on the presence/absence of autolytic behavior; 30% of exposed children and 16% of non-exposed, OR= 1.85, 95% CI: 1.04 to 3.29).

Maternal psychopathology

Mothers of exposed children obtained higher means for all the SCL-90-R subscales, except for the somatic score, than mothers of control children (the significant mean differences ranged from .15 for the phobic anxiety and .39 for the hostility). The mean difference between mothers of the two groups were also significantly different in the three indexes of the questionnaire: the Global Severity Index=.23 (95% CI:.09 to .37), the Positive Symptom Distress Index=.22 (95% CI:.09 to .34), and the Positive Symptom Total=5.88 (95% CI:1.07 to 10.69).

Rearing styles and discipline

Boys and girls who were exposed to IPV reported more rejection from mothers and fathers, and less emotional warmth from mothers (Table 3). Mothers who lived in these homes were more overprotective of their sons than those who lived in non-violent

homes. This effect was not observed in daughters. Fathers who were violent at home also physically punished their children (boys and girls) more frequently than non-violent fathers, while mothers from violent homes physically punished their daughters more frequently than non-exposed mothers. Fathers and mothers included in the exposed group controlled less their children's behavior.

INSERT TABLE 3

Life events

Children exposed to IPV obtained a higher number of life events than non-exposed children (exposed children=6.17 and non-exposed=3.36, $p<0.001$), and this difference was also higher in girls (mean number of life events among exposed girls=7.57, SD=2.90 and non-exposed girls=4.80, SD=3.72; $p<.001$) than in exposed boys (mean number of life events among exposed boys=5.51, SD=2.89 and non-exposed boys=4.12, SD=3.70; $p=.002$).

Individual variables

A relation between gender and the effect of IPV on the child's physical health was encountered: boys exposed to violence at home perceived more physical problems than non-exposed boys (based on the presence/absence of physical problems; 39.13% exposed boys and 17.67% non-exposed. OR=2.90, 95% CI: 1.4 to 5.9), but this effect was not found in girls (31.58% exposed girls and 29.59% non-exposed. OR=1.1, $p=0.70$).

Finally, social skills and self-esteem did not present significant mean differences between children who were exposed to IPV and those who were not exposed (for the scores of instrumental competence, mean of exposed children= 21.28, SD=9.16 and non-exposed=20.74, SD=13.61; for the score of social skills, exposed children=24.21, SD=7.60 and non-exposed=25.32, SD=10.94. Regarding the score of the negative self-

concept, mean of exposed children=32.77, SD= 10.68 and non-exposed=33.19, SD=15.12; for the score of positive self-concept, exposed children=17.99, SD=4.92 and non-exposed=18.05, SD=7.01).

Discussion

Although literature shows that children who witness physical and environmental violence among their parents seek mental health assistance frequently (Campbell & Lewandowski, 1997), there are few studies about their psychological impact. Results of the present study indicate that, of the children who attend consultation due to psychological problems, those exposed to IPV have different needs to those who are not exposed: they suffer from more frequent post-traumatic stress disorders, dysthymia and self-harm; display a higher number of symptoms, mental disorders, and functional impairment; their mothers suffer more psychopathology; abusive fathers physically punish and reject them more and take less care of them, mothers overprotect their sons and physically punish their daughters, and display a parenting style characterized by rejection and low emotional warmth; and girls suffer more stressful life events. Notwithstanding this profile, when a child is referred to a mental health service, the presence of an IPV situation is not assessed routinely (McAlister, 1999). In this study, a considerable percentage (20%) of children who did not consult the mental health service about IPV in particular was exposed to it. Similarly, McDonald et al. (McDonald, Jouriles, Norwood, Shine Ware, & Ezell, 2000) pointed out that among children referred to a child mental clinic for behavioral difficulties, 48% were living in a family with IPV. These results highlight the need to identify this situation and take note of the clinical profile of exposed children in order to design specific intervention schedules.

The type of violence assessed in the present study (throwing objects, hitting or pushing) may be related to the presence of severe stressful events that occur simultaneously (i.e. serious injuries to the mother or child abuse). This severe violence is more likely to be traumatic for children exposed to it, and it may be associated with dissociation, re-experiencing and other symptoms of post-traumatic stress disorder (Kitzmann et al., 2003). Exposed outpatients were more likely to break rules, which is consistent with the social learning theory of aggression (Bandura, 1977). Children and adolescents who see violence among their caregivers may use the violence as a way to resolve conflicts in contexts like the family or the school (Emery, 1989). Our findings point out that outpatient children who have been exposed to IPV have more risk of dysthymia, a disorder who is less severe than depression but longer in time. Furthermore, witnessing IPV affects the child's ability to regulate his/her emotions, which in turn increases irritability and helplessness (Margolin, 1998). This dys-regulation would enhance the responsiveness to stress, leading the child to high risk for posttraumatic stress disorder, or decrease this responsiveness, which in turn would be related to depression or dysthymia (Golier & Yehuda, 1998; Margolin & Gordis, 2000). The detection of internalizing and posttraumatic stress disorder is a priority since they are related to severe negative outcomes such as self-harming behaviors (Anderson, 1999; Mazza, 2000). In these circumstances, one could expect the psychosocial functioning of children exposed to IPV to be more affected than the non-exposed group, especially at home. The assessment of the adjustment of exposed children could help to adjust the "intensity" of intervention programs.

The present study found that children exposed to IPV were more likely to live a high number of life events in their lifespan than non-exposed children. Rossman (2000) postulated that families which suffer IPV are similar to an 'adversity package', in the

sense that multiple stressors can be accumulated in the life of children exposed to IPV: child abuse, parental psychopathology, unemployment, low socioeconomic status, homelessness, social isolation and involvement in crime (Golding, 1999). The present study also found that exposed girls reported that they have lived more life events than exposed boys. In this sense, literature shows differences in gender regarding the exposure to stressors during the childhood or adolescence. Adolescent girls report more stressors overall than boys (Rudolph & Hammen, 1999), mainly related to interpersonal conflict (Hankin, Mermelstein, & Roesch, 2007). Moreover, girls are more likely than boys to suffer stressors such sexual and physical abuse during the childhood (MacMillan et al., 1997) and the adolescence (Saewyc, Pettingell, & Magee, 2003).

In line with previous studies, physically abused mothers reported the high presence of psychopathology (Holtzworth-Munroe, Smutzler, & Sandin, 1997; Jarvis, Gordon, & Novaco, 2005) which have a negative impact in mother's positive parenting and the child's psychological well-being (Margolin, 1998). The present study highlights the negative impact of IPV on the parenting and their monitoring behavior. Mothers and fathers in violent families are more likely to reject their children and physically punish them. Others studies concluded that parents who live in violent homes use coactive disciplines and corporal punishment (Holt, Buckley, & Whelan, 2008; Osofsky, 1998). These results are in concordance with the 'spillover hypothesis', which postulates that the hostility which is present in one familiar system such as the partner relationship may affect negatively other familiar systems such as the parent-child interaction (Krisknakumar & Buehler, 2000). Although repetitive abusive situations undermine the mother-child relationship, it is important not to stereotype this relationship as damaged or negative. The violence mothers suffer is the responsible for undermining their ability and their predisposition to rear their children in a positive way. Yet, most authors

consider the mother-child dyad as a positive aspect which buffers the negative outcomes of the IPV (C. Humphreys, Mullender, Thiara, & Skamballis, 2006; McAlister, 1999) and therefore, inclusion of improvements of the mother-child relationship appears as a priority. Although little attention has been made to the father parenting, the present results follow the same line as other studies which indicated that abusive men are angrier with their children (Holden, Stein, Richie, Harris, & Jouriles, 1998) and they are more likely to use corporal punishment (Holden & Ritchie, 1991).

An important issue is the role of the child's gender in the IPV effects. Results show that gender does not modify the effect of witnessing IPV on any psychopathological profile, contrary to what other studies suggested (McIntosh, 2003; Stenrberg, Baradaran, Abbott, Lamb, & Guterman, 2006). Although the child's gender does not modify the effects of witnessing IPV on psychological variables, it has an important role in how parents are rearing them, the number of stressful life events which they have experienced or how children appraise their physical health. The fact that mothers overprotect their sons would be related to the fact that they try to protect their children from abusive situations (Smith, Berthelsen, & O'Connor, 1997) in a negative way characterized by restriction of the autonomy and independence of the child. On the other hand, girls who have been exposed to IPV perceive that their mothers punish them more frequently than boys. This difference between the mother's parenting depending on the child's gender may be due to an erroneous cognition of the abused mother. It may be possible that they perceive their sons more vulnerable to the negative outcomes of witnessing IPV (Kerig, 1996) and they try to compensate these negative effects with an overprotective style, while they may see their daughters as more conflictive. In fact, some studies pointed out that those adolescent girls who witness IPV are more likely to be aggressive and display externalizing problems (Buckley, Whelan, & Holt, 2006; J.

M. Cummings, Pepler, & Moore, 1999; Song, Singer, & McAnglin, 1998). Mothers, who are the parent who spend more time with their children, may use physical punish with their daughters as a strategy to deal with these behavioral problems.

Contrary to what literature suggests (Bolger, 1997; Margolin & Gordis, 2000; Osofsky, 1999), exposed children's social skills and self-esteem do not differ from children who are not exposed but have other psychological problems. Koldo, Blakely & Engleman (1996) pointed out in their revision that 5 out of 11 studies assessing social functioning did not find an important relationship between witnessing IPV and social skills problems.

In summary, children and adolescents exposed to IPV who seek help in mental health services are more likely to have different needs compared with those non-exposed to the violence. The first step for clinicians is identifying an IPV situation. One sector of this population remains hidden; most of these children do not talk openly about the situation and may feel shame, guilt or fear. Moreover, mental health professionals may treat them inappropriately because they are unaware of the cause for clinical symptoms. In order to respond properly to those children, mental health services must develop guidelines for screening and treating IPV (McAlister, 1999). Clinicians should consider individual and family or contextual characteristics before planning interventions. The first step must be the adequate detection of the IPV and its characteristics (chronicity, severity); the second step would be the assessment of psychopathology associated to this IPV situation, considering that posttraumatic stress disorder, dystymia and self-harmful behavior are common among these children; and finally, take into account that IPV is associated with other family and contextual variables which may be affecting the child's well-being and may moderate or mediate the effect of witnessing IPV at home. Adequate planning of resources for this subgroup

of children who seek help in primary mental health care centers will help to improve their correct identification, assessment and intervention and, finally, to improve their well-being.

A positive aspect of this work is that the report about exposure to IPV and rearing styles was obtained from children. Parents may refuse to report or hide the presence of IPV and they also tend to give socially desirable answers about their educational practices (Rivett, Howarth, & Harold, 2006). Other positive factors are the origin and size of the sample. The use of clinical samples, that is, families seeking help from mental health care centers, allowed us to eliminate clinical manifestations specifically associated with IPV. The considerable size of the sample guarantees good statistical accuracy in determining the effects of exposure and guarantees the result's internal validity. Among the limitations, it is necessary to bear in mind that the assessment of witnessing IPV is retrospective and based on the memory of the child and, consequently, it might be affected by recollection or subjectivity biases. Furthermore, the IPV assessment focuses only on physical and environmental aggression and does not include psychological abuse among parents which, although it is the most frequent type of abuse and comes before physical maltreatment, it is also the most difficult to detect.

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Table 1.

Demographic characteristics.

		Exposure to physical and environmental violence		
		Yes (N=100)	No (N=420)	TOTAL (N=520)
Sex*	*Male (%)*	44.7	56.5	54.3
Age	*Mean (SD)*	13.5 (2.6)	13.2 (2.5)	13.2 (2.5)
Ethnicity	*Caucasian (%)*	95.1	98.2	97.7
Socioeconomic status[1]	*High (%)*	1.0	2.3	2.0
	Mean-High (%)	12.0	11.4	11.5
	Mean (%)	20.0	14.4	15.4
	Mean-Low (%)	39.0	43.5	42.7
	Low (%)	28.0	28.5	28.4
Single-parent family*	*Yes (%)*	24.0	7.1	10.2

[1] Socioeconomic status based on Hollingshead's index (Hollingshead, 1975)

*Significant statistical difference ($p<0.05$).

Table 2.

Association between exposure to IPV and psychopathology

Diagnostic interview	Exposed to IPV N (%)	Non-exposed to IPV N (%)	Interaction IPV*gender p-values	OR (CI 95%)
Disruptive behavior disorders	66 (64.1)	279 (61.9)	.72	1.23 (0.76 to 2.00)
Substance abuse/dependence	9 (8.7)	19 (4.2)	.68	1.87 (0.73 to 4.78)
Anxiety disorder	60 (58.3)	230 (51.0)	.86	1.12 (0.71 to 1.77)
Post-traumatic stress dis.	7 (6.8)	6 (1.3)	.99	3.82 (1.11 to 13.14)*
Affective disorders	39 (37.9)	117 (25.9)	.91	1.34 (0.80 to 2.25)
Dysthymic disorder	18 (17.5)	34 (7.5)	.72	2.10 (1.09 to 4.06)*
Eating disorders	11 (10.7)	26 (5.8)	.99	1.54 (0.69 to 3.45)
Elimination disorders	8 (7.8)	27 (6.0)	.54	1.66 (0.68 to 4.06)
Diagnostic interview	Mean (SD)	Mean (SD)		Mean difference (CI 95%)
Total number of DSM-IV dis.	3.54 (2.00)	3.12 (2.87)	.59	.41 (.002 to .83)*
Externalized symptoms	16.68 (9.20)	14.93 (13.93)	.46	1.75 (-.18 to 3.68)
Internalized symptoms	16.19 (9.80)	13.75 (14.75)	.87	2.44 (.38 to 4.50)*
Total number of dis.	32.87 (13.40)	28.68 (20.49)	.70	4.19 (1.38 to 7.00)*

OR: Odd Ratio based on logistic regression; Mean differences: based on ANOVA;

CI: Confident Interval.

Results adjusted by age, gender, other comorbidities and single-parent family

*Significant ($p<.05$).

Table 3.

ANOVAs of parenting/discipline among exposed outpatients and non-exposed outpatients.

EMBU-N (rearing styles)		Exposed to IPV Mean (SD)	Non-exposed to IPV Mean (SD)	Interaction IPV*gender p-values	Mean differences (CI 95%)
Father rejection		18.98 (7.50)	16.78 (11.07)	.47	2.20 (.66 to 3.73)*
Mother Rejection		20.32 (7.10)	16.98 (10.25)	.78	3.35 (1.84 to 4.85)*
Father Emotional warmth		38.34 (14.20)	41.02 (20.90)	.63	-2.67 (-5.58 to .24)
Mother Emotional warmth		39.23 (12.3)	43.84 (17.42)	.98	-4.61 (-7.17 to -2.04)*
Father Over-protection		19.40 (6.60)	18.42 (9.43)	.26	.97 (-.35 to .30)
Mother Over-protection	boys	22.90 (10.10)	19.99 (10.66)	.01	2.92 (.80 to 5.04)*
	girls	21.26 (8.59)	22.16 (11.68)		.51 (-2.32 to 1.30)
Parental Discipline					
Father Physical punishment		1.38 (.60)	.04 (1.20)	.29	.18 (.07 to .30)*
Mother Physical punishment	boys	1.21 (.70)	1.19 (.08)	.01	.02 (-.12 to .16)
	girls	1.41 (.60)	1.15 (.08)		.26 (.13 to .39)*
Parental control		3.28 (.60)	3.43 (1.02)	.88	-.15 (-.29 to -.02)*

Results adjusted according to age, gender, and whether a single-parent family is concerned.

Results stratified by gender when interaction is significant.

CI: Confident Interval; *Significant (p<.05).

3.2. Manuscript: Characteristics of intimate partner violence exposure predictive of psychopathology and functional impairment in children

Characteristics of intimate partner violence exposure predictive of psychopathology and functional impairment in children

Abstract

Objective: To identify the characteristics of intimate partner violence (IPV) that predict psychopathology and functional impairment in children. **Methods:** Data was collected on 127 children between 4 and 16 years of age who had been exposed to IPV. They were assessed using categorical and dimensional measures of psychopathology and functional impairment, as well as with an instrument that takes into account the characteristics of exposure to IPV. Psychopathology and functioning were the dependent variables and characteristics of IPV, sex and age were the independent variables in the generalized estimating equations. **Results:** The most influential characteristics on child psychopathology were the child's degree of involvement in the violence and child abuse. The types of violence experienced by the child and by the mother were the most closely related to functional impairment. The characteristics of IPV were more differential of psychopathology than of functional impairment. **Conclusion:** The multiple intervening variables involved in IPV have a differential influence on psychopathology and functioning in children. In order to plan adequate care for children exposed to IPV, the situation must be assessed comprehensively using instruments that evaluate IPV as it relates to children.

Key words: children and adolescents at risk; intimate partner violence; functional impairment; psychopathology.

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Intimate partner violence (IPV) is defined as any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship [1, 2]. In this study, IPV refers to the violence inflicted by a male partner on the child's mother. As regards the child, exposure to IPV is considered a form of psychological maltreatment [3] that may be accompanied by other forms of maltreatment.

Nowadays, IPV is one of our most pressing social problems. The WHO multi-country study on women's health and domestic violence against women [4], carried out with 24.000 women of 10 countries, has shown the wide variations in the exposure between countries. The rate of ever-partnered women who had ever experienced physical or sexual violence by a male partner ranged from 13% in Japan to 61% in Peru, meanwhile acts of emotional abuse ranged from 20% in Samoa to 75% in Ethiopia. In Spain, The Queen Sofía Center for the Study of Violence [5] reports that the incidence of IPV in Spain increased 26.47% between 2003 and 2007. Out of every 1,000 women, 3.22 were victims of IPV in 2007. Out of every million women, four were murdered by their partners in 2006; in at least 10% of these murders, the aggressor killed his partner in front of the children [6]. Around 80% of the women were battered by their partners in their homes. Available statistics do not indicate how many children in these homes were witnesses to violence. However, data from another countries, as the U.S., have shown the magnitude of the problem evidencing that domestic violence households had a high proportion of children, especially younger than 5 years, and that between 6 and 27% were also involved in the incident [7].

Typically, research on IPV's effects on children has focused on certain aspects of the violence, in part because such situations are complex and also because there is a paucity of instruments that can be used to comprehensively assess the impact of IPV on children. Considering the overall situation of exposure to IPV, meta-analysis and mega-analysis confirm that children exposed to IPV exhibit more psychopathology than those who are not [8, 9, 10]. However, various converging characteristics of IPV may be considered in relation to their effects on children, e.g., the child's degree of involvement in the violence, the characteristics of the violence to the mother and/or to the child and the characteristics of the aggressor. A number of studies have partially addressed these topics.

One area of study has been the child's degree of involvement in or proximity to the violence and the consequent effects. In other words, does being a witness as well as a victim have worse repercussions than only being a witness? The literature shows divergent results about whether the risk of psychopathology increases in accordance with exposure to violence. Some data shows that being a direct victim of verbal or physical abuse is associated with behavioral and emotional problems, as well as with impaired general functioning [11, 12]. Witnessing violence is related to behavioral problems and low social competence [13, 14, 15]. However, other meta-analytic studies [8, 9] and individual studies [16] have found no significant discrepancies between witnesses and victims, suggesting that there are no differences in terms of effects according to differential exposure. Other reports [17, 18, 19] and meta-analysis [10] indicate that witnesses who were also victims exhibited more problems. Few studies have controlled for confounding factors; however, when the effects of IPV have been studied controlling for direct abuse experienced, IPV has remained a significant predictor of psychopathology [20, 21 22].

There is a paucity of literature on the differential influence on the child's mental state of the type of violence inflicted on the mother (psychological, physical or sexual) and other characteristics of the aggression, such as frequency, duration, injuries, legal processes, role of the mother or resolution of the event. Panuzio et al. [23] report that psychological aggression against the mother is a stronger predictor of behavioral problems in the child than physical aggression is. Spilsbury et al. [24] studied various characteristics of IPV and found that the high chronicity of violence, the child's victim status and the perceived threat to personal safety were related to different psychopathological outcomes. In addition, Bogat et al. [25] reported that the severity of violence moderated the relation between the mother's mental health and the number of trauma symptoms in children.

Obtaining access to the aggressor is a major challenge in IPV research [26]. Brookoff et al. [27] found that 92% of the assailants in IPV cases in their sample reported having used alcohol or other drugs on the day of the assault. In male abusers attending counseling, a history of childhood neglect, poor family cohesion and alcohol abuse were associated with the frequency of spousal physical abuse, while witnessing family violence was related to spousal psychological abuse. Other factors, such as unemployment, psychopathology, abnormal personality or lack of assertiveness in the marital relationship, have been studied by Guille et al. [28], who noted that, the various typologies described are relevant to because they may inform how different abusers' typologies relate to different parenting behaviors.

Appel and Holden [29] reported a 6% base rate co-occurrence of IPV and child physical abuse in 31 studies with representative community samples. Approximately 25% of children are physically involved in the situation [30]. In addition, children and women are often injured when they try to protect each other from the aggressor [31].

The overall aim of this study is to simultaneously examine which characteristics of exposure to IPV are more predictive of psychopathology and functional impairment in children. Unlike previous studies that have analyzed partial IPV characteristics, the goal of this study is to determine which variables intervening in IPV events (degree of involvement of the child, characteristics of the violence to the mother and/or to the child and characteristics of the aggressor), are most closely associated with psychological problems in children.

Method

Participants

All children between 4 and 16 years of age whose mothers sought outpatient help at a gender violence center serving an area on the outskirts of Barcelona (Spain) were invited to participate in the study. The gender violence center provides clinical psychological treatment, legal advice and welfare assistance to women suffering IPV. The inclusion criteria were as follows: the child's mother had to have been exposed to physical, sexual and/or psychological partner violence during the previous year according to cut-off scores in the Index of Spouse Abuse [32] for the Spanish population (6 for physical abuse and 14 for non-physical abuse- [33]; and the women had to have children in the age range of the study. Out of a total of 102 mothers, 87 agreed to participate. For the participating mothers, the mean ISA physical abuse score was 26.4 (SD= 19.2); their non-physical abuse score was 51.0 (SD= 21). There were no differences in the children's ethnicity (p=.070), sex (p=.944), age (p=.777), socioeconomic status (p=.133) or in mother's scores in the ISA (p=.115 and p=.817) between the families that agreed to participate and those that did not.

The mean age of the mothers was 36.4 years-old (SD=4.8), 92.9% were Spanish. The mean number of children per family was 1.47: 58% of families had only one child, 38% had 2 children and only 4% three children. A total of 127 children participated. The mean age of the children was 8.8 (SD = 3.4); 75 (59%) of them were boys. Socioeconomic status [34] was distributed as follows: 10.7% high, 18.0% mean-high; 23.8% mean, 25.4% mean-low; and 22.1% low. An 88.2% of the children were Caucasian, while 7.1% were Hispanic-American and 4.7% belonged to other ethnic groups. Sixty-two percent of the children lived with their mothers in a single-parent family and 33.1% lived with both mother and biological or adoptive father.

Measures

The *Index of Spouse Abuse* [32] evaluates the degree of physical and non-physical partner abuse as perceived by women. In this study, the presence of scores at or above the cut-off levels was used to screen for exposure to IPV.

The *Schedule for the Assessment of Intimate Partner Violence Exposure in Children (SAIPVEC* [35] assesses the characteristics of IPV as they may relate to children on the basis of a taxonomy described by Holden [3]. The taxonomy comprises the following areas: 1) *Degree of involvement of the child*: E.g., exposure during pregnancy; the child intervenes to try to stop the violence; the child is a victim; the child is forced/volunteers to participate in the aggression; the child overhears the violence; the child observes the consequences of the violence inflicted on the mother; the child experiences the consequences; the child is informed of the violence; the child is unaware of the violence; or the mother explains the aggression to the child; 2) *Characteristics of the violence to the mother*: type (physical, psychological, sexual); sequence; escalation; frequency; child's age at first and last episode; services required; injuries; legal processes; attitude of the mother toward the aggression; and resolution; 3)

Characteristics of the aggressor as reported by the victim: aggressive only at home; antisocial; dysphoric/borderline; substance abuser; impulsive; jealous; explosive; chauvinistic; psychopathic; 4) *Type of child abuse*: physical; sexual; physical neglect; terrorizing behavior; corruption/inadequate socialization; degrading/humiliating behavior; emotional unavailability; isolation.

Empirical profiles were created from SAIPVEC using the two-step cluster procedure. For the group of variables relating to the *child's degree of involvement* in the violence, the following clusters were selected as the best solution: 1) unaware-indirect exposure; 2) aware-indirect exposure; 3) involved-direct exposure. For the variables relating to the *characteristics of violence to the mother,* the following solution was chosen: 1) moderate physical/sexual violence; 2) psychological violence; 3) severe physical/sexual violence. The *characteristics of the aggressor* were grouped as: 1) psychopathic; 2) chauvinistic, psychological problems, abuse in childhood; and 3) impulsive, substance abuse, legal problems, dysphoric. Finally, the *characteristics of the violence to the child* were summarized as: 1) physical abuse, neglect, active psychological abuse; 2) corruption, inadequate socialization (only exposed to IPV); and 3) emotional deprivation. For simplicity of presentation the clusters will be identified by the first label.

Trained clinicians complete the schedule based on the rating descriptions provided for each item. The information must be obtained from significant persons with knowledge of the situation. Generally, these individuals are women and children. In this study, women were the main reporters. Children provided information for the sections *Child abuse* and *Degree of involvement of the child* when available. Special care was taken not to disclose situations of which the children were unaware. Internal consistency, assessed through Cronbach's alpha in one-dimensional Categorical

Principal Components Analyses (catPCA), ranged from moderate to very good: 0.61 for "degree of involvement of child", 0.89 for "characteristics of violence to the mother", 0.79 for "characteristics of the aggressor", and 0.67 for "type of child abuse". The concurrent validity of the clusters was tested by comparing the relationships of the cluster-profiles with other measures related with the content of the 4 areas of the SAIPVEC.

The current version of the *Diagnostic Interview for Children and Adolescents* [36], is a semi-structured diagnostic interview that covers the most frequent diagnostic categories according to DSM-IV [37], was used to assess psychopathology; it has been adapted and validated for the Spanish population and has been shown to offer satisfactory psychometric properties [38, 39]. There are three versions: one for children (8 to 12 years old), one for adolescents (13 to 17 years old) and one for parents. In the case of children under age 8, only the mothers were interviewed with the pre-school form of the interview [40]. The interviews should be administered by trained interviewers with knowledge of child psychopathology. The training procedure consisted of studying the interviews, simulating practice interviews, codifying recorded audio interviews and observing and codifying in-person interviews. Diagnoses were generated by combining the information from parents and children at the symptom level, i.e., a symptom was regarded as being present if either the parent or the child reported it.

The *Gabi Interactive* [41] is the Spanish version of the *Dominic Interactive*, a computerized DSM-IV-based cartoon questionnaire. It was used to assess self-reported psychopathology from ages 6 to 11. Raw scores in each scale were analyzed. Alpha internal consistency in the sample ranged from moderate to very good: specific phobia .65, separation anxiety .53, generalized anxiety .69, depression/dysthymia .85,

oppositional defiant .79, conduct disorder .67, ADHD .82, internalizing .89, externalizing .89.

The *Child Behavior Checklist*, in versions for pre-school (CBCL1½-5 [42] and school-age children (CBCL6-18 [43], was used to measure psychopathology dimensionally. The checklists contain 100 and 113 questions respectively, with three response options indicating various behavioral and emotional problems in children and adolescents. As both versions do not derive exactly the same scales, only common scales for pre-school and school questionnaires were used. In addition, since the number of items included in the empirical syndrome scales was not the same for the pre-school and school-age versions (consequently, neither was the range of total direct scores), the T-scores were analyzed. The self-reported version *Youth Self-Report (YSR* [43]) was completed by children between 11 and 18 years of age. The raw scores of the questionnaire were then analyzed.

The *Child and Adolescent Functioning Assessment Scale (CAFAS)* and the *Preschool and Early Childhood Functional Assessment Scale (PECFAS)* record the extent to which young people's mental health disorders are disruptive of their functioning in each of eight psychosocial areas, as reported by the children and their parents [44, 45]. The functional areas analyzed were: role performance at school, at home, in the community, behavior toward others, mood/emotion, self-harm, cognition and total score. Using the extensive information obtained during diagnostic interviews, the interviewers were required to rate the lowest level of functioning in each area, taking into account the child's age, sex and social class, as well as the norms for the community in which the child is living. Each scale is scored on four levels of impairment. For the purposes of this study, the *higher* (worse) of the two scores was used, based on the information provided by the parent or child. Due to the highly

asymmetric frequency distribution for each scale, the resulting score was dichotomized as (0) mild or no impairment (0 and 10), and (1) moderate and severe (20 and 30). The psychometric properties of the CAFAS have been extensively studied by its author [46] and in the Spanish population [47].

Procedure

The project was approved by the ethics review committee of our institution. After a complete description of the study was provided, written consent was obtained from the mothers and verbal consent was obtained from the children. A psychologist working with the mothers at the gender violence center invited them to participate in the study and to answer the ISA questionnaire. Afterwards, the psychologist completed the SAIPVEC. Trained interviewers with experience in clinical child psychology and assessment instruments conducted interviews with the mothers and their children both separately and simultaneously at the gender violence center and rated the CAFAS. Finally, the mothers and the children completed the questionnaires. The mothers were informed of the results of the child's assessment and referral to mental health services was indicated when necessary.

Statistical analysis

Analyses were conducted using SPSS 15.0.1 for Windows.

Although our research refers to a nested structure data (some siblings had the same parents), the specific level of hierarchy was extremely low (1.47 children per family in mean) and multi-level models (widely accepted for hierarchical structures) were not adequate due the influence of low levels of nesting in the robustness of the parameter estimation [48]. Therefore, to account for data dependency at the lower level and to prevent estimation bias, we included the random factor "family" into multiple mixed models through Generalized Estimating Equations (GEE procedure in SPSS

system). These models were adjusted with the binomial distribution and the logit link-function for binary criteria and with the normal distribution and the identity link-function for quantitative outcomes. To estimate the specific contribution of each cluster adjusted by the presence of the other groups, ENTER procedures were used including simultaneously the four variables that contained the inclusion of children into the empirical clusters. Given that some of the results may be affected by the age and sex of the participant, all the models were adjusted by age and sex. In addition, the analyses performed for specific DSM-IV disorders were also adjusted by the presence of other different comorbidities.

Results

Intimate partner violence characteristics predictive of DSM-IV diagnoses

Table 1 synthesizes the distribution of DSM-IV diagnoses in the total sample and stratified by age. Of all the exposed children, 3/4 had any DSM-IV diagnosis. The most frequent diagnoses were oppositional defiant disorder, specific phobia, attention-deficit/hyperactivity disorder (ADHD), stereotyped movement disorder, separation anxiety (SAD) and generalized anxiety disorder (GAD).

INSERT TABLE 1

Table 2 contains GEE models adjusted by sex, age and the presence of comorbidities to compare the presence of DSM-IV disorders between the empirical clusters. Since each broadband category of externalizing and internalizing problems includes a wide and heterogeneous group, we also identified what specific diagnoses were affected by the different types of exposure to domestic violence and what were the different degrees of affectation. In the case of statistical differences between groups, OR values have been included to describe the strength of association or non-independence

between the two categorical data sets (clusters and disorders).The degree of the child's involvement in the violence was associated with mood disorders, elimination disorders, GAD, specific phobias and stereotyped movement disorder (SMD); the type of violence to the mother was associated with anxiety disorders (SAD) and SMD; aggressor characteristics were not associated with diagnoses; and the type of violence to the child was associated with elimination disorders (Table 2).

In general, the distribution of psychopathology along the clusters was comparable, indicating that all typologies relate to the child's psychopathology in a similar way. However, there were a number of specific correlations between the characteristics of violence and the child's diagnosis. Table 2 indicates that mood disorders were more prevalent in unaware and involved children than in those who were aware but indirectly exposed; elimination disorders were associated with the child's victimhood (physical abuse or emotional deprivation); generalized anxiety was frequent in unaware and indirectly exposed children; specific phobias were linked with indirect exposure; SMD was associated with unawareness or lack of exposure, as well as with psychological violence to the mother.

The IPV characteristics accounted for between 7.6% and 30.5% of the variability (R^2) of the broad DSM-IV diagnostic categories among children and between 17.5% and 42.4% of the variability of individual categories.

INSERT TABLE 2

Intimate partner violence characteristics predictive of dimensional psychopathology

Table 3 includes GEE models adjusted by sex and age to compare mean scores between clusters for CBC, YSR and GABI scales. The mothers' CBCL reports show that the child's degree of exposure to violence was associated with anxiety-depression,

depression-withdrawal, internalizing and externalizing; the type of violence to the mother was not associated with any scale; the aggressor's characteristics were associated with anxiety/depression, depression-withdrawal and internalizing; and the type of violence to the child was associated with anxiety/depression (Table 3).

Table 3 shows how each IPV characteristic contributes to each CBCL factor. For example, anxiety/depression was associated with unawareness, psychopathic aggressor and with the child's emotional deprivation; depression-withdrawal with unawareness and psychopathic aggressor; internalizing was more prevalent in unaware children and psychopathic or impulsive aggressors; and externalizing was associated with indirect exposure and awareness. IPV characteristics accounted for between 0.3% and 9.1% of the variability of the CBCL narrow band scales and between 0.7% and 12.8% of the variability of the broad-band scales.

INSERT TABLE 3

Youth self-reports indicate that the child's degree of exposure to violence was associated with all factors except depression, thought disorder and attention; the type of violence to the mother were associated with somatic, rule-breaking, aggression, externalizing and total score; aggressor characteristics were associated with rule-breaking, aggression and total score; the type of violence to the child was associated with all factors except depression-withdrawal, thought and attention problems (Table 3).

Similarly to CBCL, Table 3 indicates the contribution of each IPV characteristic to each YSR factor. IPV characteristics accounted for between 1.9% and 39.2% of the variability of the YSR narrow-band scales and between 1.3% and 47.2% of the variability of the broad band scales. Based on the most significant factors, somatic complaints were highest in involved children, as well as when mothers were victims of psychological violence and children were victims of physical abuse and emotional

deprivation; rule-breaking had a higher mean among involved children, psychologically abused mothers, psychopathic or impulsive aggressors and emotionally deprived children; aggressive behavior was associated with involved children, psychologically abused mothers, psychopathic aggressors and emotionally deprived children; total score was associated with involved or aware children, moderate physical/sexual or psychological abuse to mothers, chauvinistic aggressors and children as corruption or emotional deprivation victims.

For children from 6 to 11 years the Gabi self-report showed that specific phobias were associated with severe physical violence to the mother; separation anxiety was associated with aggressor characteristics (chauvinistic); reduced child strength and capabilities were associated with psychologically abused mothers (see Table 3).

Intimate partner violence characteristics predictive of functional impairment

Table 4 includes GEE models adjusted by sex and age to compare impairment levels (prevalence of dysfunction areas and mean total score) between clusters. The CAFAS/PECFAS scores on functional impairment show that dysfunction at home was associated with physical violence to mothers and physical abuse of children; and mood/emotional impairment was associated with physical abuse of children. The type of IPV accounted for between 11.6% and 24% of the variability of functional impairment scores.

INSERT TABLE 4

Discussion

The multiple intervening variables in IPV have a differential influence on psychopathology and functioning in children. Overall, the IPV characteristics contributed significantly to children's difficulties, accounting for up to 46% of the

variability of psychopathology and up to 24% of functional impairment. Across different measures, the child's degree of involvement in the violence and child abuse were the IPV characteristic most frequently associated with psychological problems. Types of violence to mother and child abuse were related with functional impairment. The characteristics of IPV were more differential of psychopathology than of functional impairment. One noteworthy aspect of the results is that all the IPV characteristics were controlled for each other. This is the firs study in Spain about the effects of IPV in children.

It should be noted that exposed children had more extensive psychopathology and more dysfunction than did unexposed children. As a part of the overall study design, a control group of unexposed children was also evaluated. The exposed group, i.e., the focus of this paper, was significantly different than the control group in DICA any diagnosis ($p =. 001$) and total scores of CBCL, YSR and CAFAS/PECFAS ($p< .0005$). This suggests that the lack of significant differences in this study does not mean that the predictor variables do not affect psychopathology or functioning, but that they have similar effects.

In light of the foregoing, we observed that the pattern of influence of IPV characteristics varied according to disorder, method of assessment and informant. Therefore, while the combined mother-child information in the structured interviews and mothers' self-reports indicated that low awareness of the situation was most frequently associated with problems (specifically with higher depression, anxiety and SMD), children self-reported that direct exposure was the most relevant factor. Therefore, based on the combined and mothers' information, not knowing about violence or direct exposure to it are the factors most closely associated with child depression and anxiety. As regards ignoring violence, one might assume that, although

the children did not witness the violence, they experienced a dysfunctional environment without ever receiving an explanation of the situation; this could contribute to a lack of coping strategies. As regards direct exposure, one might assume that children's coping strategies were overwhelmed. These results highlight the necessity of providing children who experience IPV with an age-appropriate explanation of the situation so that they may cope more effectively. However, according to the children's self-reports, direct exposure to violence is the most relevant factor associated with psychopathology. Previous research has documented that a) models of aggressive behavior are associated with aggressive behavior in children [49, 50]; b) in general, there is a lack of agreement among reporters with respect to psychopathology [51]; and c) children report more externalizing problems than their parents do [52]. In light of these results, different reporters and different methods of assessment should be used to obtain a clearer picture of how IPV affects children. Further, the degree of child exposure was differentially related with psychopathology but not with functioning. Therefore, child proximity to violence may be associated with specific disorders or symptoms, although these symptoms have a similar effect on functioning.

Controlling for child knowledge of the violence and for child abuse, physical/sexual violence to the mother was a significant contributor to phobia, high YSR total scores and impairment at home, while psychological violence was associated with SMD, somatic complaints, low self-competence and externalizing problems. Severe physical violence was the most significant contributor to dysfunction at home. These results are in line with previous literature that has highlighted the importance of the impact of the severity of violence to the mother on the child's mental health [24, 25], together with the importance of psychological aggression. The relation between the mother's psychological abuse and the child's rule-breaking could be mediated, among

other things, by parenting style: it has been reported that battered women have a permissive parenting style [53] and lack parental control [54]; these characteristics are usually related to children's violation of minor norms. Regarding internalizing disorders, it is clear that violence is related to fear, feelings of insecurity and threats.

The results with respect to the characteristics of the aggressor should be interpreted cautiously. Although based on observable behaviors, these characteristics were rated based on information provided by the mothers. In the line of Holtzworth-Munroe [55], who found that "generally violent and antisocial" showed the most severe violence towards partner, psychopathic was the aggressor characteristic that made the greatest contribution to psychopathological outcomes in the child, particularly outcomes relating to interference in social relationships, violation of social norms and internalizing. Chauvinistic aggressors were associated with YSR higher total scores. Impulsive aggressors were mainly associated with internalizing and rule-breaking. Previous batterers' typologies had been associated with the outcome of the abuser or the characteristics of the violence to the woman. However, there are not previous reports of the association between batterers' typologies and the effects on children. Although tentative, these results indicate how important it is to include some way of assessing abusers' attitudes and behaviors in order to determine their relation to children's mental health. Numerous studies have documented the intergenerational continuity of violence: exposure to violence in childhood increases the risk of aggressive behavior in adulthood, including toward one's own children [56]. Although more rigorous research is needed [57], our findings highlight the need to detect and intervene with abused fathers, given the consequences of past abuse , not only for the partner, but also for the children.

The devastating effects of various types of maltreatment on children's mental health have been widely documented [10, 58, 59, 60]. When controlled for other intervening variables, emotional deprivation stands out in terms of its association with internalizing and externalizing psychopathology, while different types of active abuse (physical, neglect or psychological) and IPV exposure are associated with increased impairment at home. Given how difficult it is to detect emotional abuse, the specific association of emotional deprivation with child psychopathology underlines the importance of considering this factor in the context of IPV with a view to prevention and intervention.

Another important finding with respect to psychopathology is that YSR effectively identified the effects of IPV exposure (the highest R^2 values are found with these factors), highlighting the importance of considering how children are coping with the situation. According to the older children (YSR), all the IPV factors were predictive of rule-breaking, aggressive behavior and total score, i.e., all IPV characteristics disrupt children's behavior and emotions. Functional impairment was not correlated with the degree of child exposure, suggesting that other IPV characteristics are more explicative of daily functioning.

Among the strengths of this study are that various characteristics of IPV, empirically clustered, were considered together and controlled for the influence of each other. This enabled us to identify the specific importance of each factor in contributing to children's mental health. This study was carried out with a Spanish sample of non-sheltered women, generated through a community service program on gender violence that is more representative of IPV as it occurs in the general population. Finally, the study includes multiple informants (mother and child) and multiple assessment techniques (interview, self-reports and rating scales).

The results of this research should be interpreted in light of the various limitations. The use of a sample of mothers who seek help for themselves because of IPV may limit generalization of the results. Furthermore, information about the aggressors' behavior was obtained from the mothers, the abused women, and may be biased. Finally, due to the wide age range of the child participants, which was controlled in all the analysis, and to age-appropriate concerns, some questionnaires were completed by a limited number of children.

The results of this paper have several clinical implications. It provides profiles of how IPV associates with various disorders and functional impairments that can be used to design intervention plans for children exposed to violence at home, to indicate priority intervention areas and to identify target groups for prevention efforts. The results have also implications for future research and point out to the need of focusing on mechanisms by which the intervening characteristics of domestic violence impinge upon children. Mediation and moderation models could help to understand how these variables affect children.

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Table 1. DSM-IV Diagnostics in the Sample

% of Diagnostics	Total (N=127)	Age: 4-7 (N=58)	Age: 8-16 (N=69)
Any DSM-IV diagnosis	74.8	74.1	75.4
Attention deficit-hyperactivity disorder	23.6	19.0	27.5
Oppositional defiant disorder	29.1	24.1	33.3
Conduct disorder	6.3	5.2	7.2
Substance abuse-dependence	2.9	---	2.9
Major depression	11.8	5.2	17.4
Dysthymic disorder	7.1	6.9	7.2
Separation anxiety disorder	18.9	22.4	15.9
Generalized anxiety disorder	17.3	12.1	21.7
Specific phobia	26.0	22.4	29.0
Social phobia	7.9	8.6	7.2
Obsessive-compulsive disorder	7.1	3.5	10.1
Post-traumatic stress disorder	7.1	5.2	8.7
Eating disorder not specified	1.4	---	1.4
Enuresis	12.0	12.5	11.6
Encopresis	3.1	5.2	1.4
Tic disorders (chronic or transitory)	9.4	3.4	14.5
Stereotyped movement disorder	22.9	27.8	20.3

Table 2. Predictive Model of the Characteristics of Intimate partner violence on DSM-IV Diagnoses of the Child[1]

[1] Generalized Estimated Equations (GEE models) adjusted by sex, age and the presence of other comorbidities.

Independent variables (clusters).	A Degree of child involvement				B Characteristics violence to the mother				C Aggressor characteristics				D Violence to the child				
	% in each cluster			OR	% in each cluster			OR	% in each cluster			OR	% in each cluster			OR	
Dependent variable	C 1 N=48	C 2 N=41	C 3 N=37		C 1 N=55	C 2 N=28	C 3 N=41		C 1 N=37	C 2 N=53	C 3 N=37		C 1 N=24	C 2 N=47	C 3 N=55		R^2
Any DSM-IV diagnosis	75.6	72.5	75.6		77.7	75.2	73.7		67.1	71.3	87.5	2-1‡:3.1 3-1‡:3.8	76.9	73.3	74.7		.076
Behavior disorders	39.8	36.7	48.2		43.9	32.8	45.5		42.9	34.9	47.6		33.5	41.7	44.3		.117
Mood disorders	25.5	4.4	24.3	1-2*:8.3 3-2‡:4.9	22.7	14.5	15.7		18.7	13.1	24.7		33.9	13.5	15.5		.305
Anxiety disorders	46.1	47.2	52.8		57.5	43.0	42.3	1-2‡:2.1	50.1	43.2	55.6		50.5	41.4	55.3		.090
Elimination disorders	7.6	17.2	17.0	2-1‡:3.2	14.3	14.4	12.4		10.1	16.7	12.1		21.0	4.5	17.9	1-2*:7.4 3-2*:6.5	.196
Tics-Tourette disorders	10.0	10.7	7.5		10.1	14.6	5.8		8.3	9.0	11.2		8.0	10.2	9.6		.123
ADHD	26.4	15.9	32.4		23.9	31.7	19.2		26.2	18.3	30.3		21.0	19.7	34.0	3-2‡:2.9	.250
Oppositional Defiant Dis.	36.0	22.9	28.3		30.7	23.1	33.6		33.7	29.3	24.3		28.6	31.5	27.2		.230
Separation anxiety	13.3	23.6	19.9		27.8	10.4	18.6	1-2‡:4.1	26.1	18.2	12.5		26.5	11.7	18.6		.175
Generalized anxiety	30.9	15.4	4.5	1-3*: 15 1-2‡:4.3	22.5	13.4	14.9		22.2	12.7	16.0	1-2‡:3.9	21.3	9.7	19.8		.424
Specific phobia	26.8	35.4	11.3	2-3*:4.3	27.1	23.6	22.8		25.7	21.7	26.1		25.1	17.6	30.9		.188
Chronic-Transitory Tics	9.8	11.2	9.8		9.9	15.3	5.6		9.0	10.0	11.8		9.4	10.6	10.9		.237
Stereotyped Move. Dis.	32.8	11.1	32.5	3-2*:7.2 1-2*:5.4	15.9	43.5	17.1	2-3*:6.7 2-1*:7.1	18.2	33.0	25.2	2-1‡:2.9	33.9	17.4	25.2		.309

Models for substance abuse, conduct disorder, major depression, dysthymia, social phobia, obsessive-compulsive disorder, PTSD, enuresis, encopresis could not be estimated.

OR values were included only for significant comparisons between clusters.
Bold*: $p \leq .05$. ‡: $p \leq .10$. R^2: Nagelkerke coefficient; C: Cluster.
A: C1: unaware-indirect exposure; C2: aware-indirect exposure; C3: involved-direct exposure.
B: C1: moderate physical/sexual violence; C2: psychological violence; C3: severe physical/sexual violence.
C: C1: psychopathic; C2: chauvinistic, psychological problems, abuse in childhood; C3: impulsive, substance abuse, legal problems, dysphoric.
D: C1: physical abuse, neglect, active psychological abuse; C2: corruption, inadequate socialization; C3: emotional deprivation.

Table 3. Predictive Model of the Characteristics of IPV on Dimensional Psychopathology (CBCL, YSR, and GABI Scales)

Independent variables (clusters)	A Degree of child involvement				B Characteristics violence to the mother				C Aggressor characteristics				D Violence to the child				
	Mean score in each cluster				Mean score in each cluster				Mean score in each cluster				Mean score in each cluster				
Dependent Variables	C 1 N=48	C 2 N=41	C 3 N=37	p	C 1 N=55	C 2 N=28	C 3 N=41	p	C 1 N=37	C 2 N=53	C 3 N=37	p	C 1 N=24	C 2 N=47	C 3 N=55	p	R^2
CBCL (T-scores) N=106																	
Anxiety-depression	64.0	65.0	58.6	**1-3*** 2-3‡	63.5	60.5	64.9		65.9	58.9	67.0	**1-2*** 3-2‡	61.5	59.1	67.5	**3-2***	.087
Depression-withdrawal	62.9	59.7	56.9	**1-3***	60.3	59.8	61.0		65.4	57.7	60.0	**1-2***	59.8	58.4	63.2		.091
Somatic complaints	64.7	57.7	56.3	1-2‡	57.5	64.2	61.7		62.6	60.4	58.4		56.7	60.1	62.4		.026
Attention problems	59.3	58.8	56.7		60.2	57.6	57.6		57.2	58.5	60.1		59.7	55.8	60.6		.043
Aggressive behavior	62.9	66.4	60.4	2-3‡	65.5	57.9	64.9	1-2‡ 3-2‡	62.0	62.7	65.6		64.1	62.3	64.2		.003
Internalizing	67.8	65.4	58.5	**1-3***	63.1	64.1	68.2		68.9	60.9	67.6	**1-2***	61.2	62.1	69.3		.128
Externalizing	61.8	65.7	58.9	**2-3***	64.2	57.2	63.8	1-2‡ 3-2‡	62.0	61.1	64.4		62.0	61.3	63.5		.007
Total	65.0	65.9	59.9	1-3‡ 2-3‡	64.6	60.5	66.7		65.0	61.8	67.2		62.2	61.8	67.2		.028
YSR (Raw scores) N=25																	
Anxiety-depression	3.00	4.06	6.22	**3-1*** 3-2‡	5.33	4.64	3.71		5.51	5.02	3.15		3.33	3.73	6.61	**3-1*** **3-2***	.019
Depression-withdrawal	1.81	1.87	3.36		3.37	1.60	2.06		2.51	2.94	1.58		2.02	1.46	3.55	3-2‡	.087
Somatic complaints	2.68	2.14	4.20	**3-2*** 3-1‡	2.97	4.63	1.42	**2-3***	3.79	2.94	2.28		3.63	1.53	3.86	**3-2*** 2-1‡	.260
Social problems	2.40	3.48	4.06	**3-1***	4.39	3.22	2.33		4.41	2.56	2.96	1-2‡	3.23	2.46	4.25	**3-2***	.159
Thought problems	1.46	2.20	4.79	3-1‡	4.02	2.92	1.51		2.73	4.44	1.28	1-2‡	2.62	2.53	3.30		.019
Attention problems	4.57	5.73	6.83		5.14	7.08	4.91		5.43	5.71	5.99		6.04	4.24	6.85		.019
Rule breaking	2.69	3.72	7.19	**3-1*** **3-2*** 2-1‡	3.43	7.28	2.90	**2-1*** **2-3***	5.23	3.23	5.14	**1-2*** **3-2***	4.48	3.09	6.04	**3-2***	.390
Aggressive behavior	2.84	5.82	9.86	**3-1*** **3-2*** **2-1***	6.27	7.44	4.82	**2-3***	7.63	6.23	4.66	**1-3***	5.14	5.32	8.05	**3-1*** 3-2‡	.392
Internalizing	7.08	7.89	14.4	**3-1*** **3-2***	10.5	11.4	7.50		11.9	10.5	7.02		9.09	6.53	13.8	**3-2***	.013
Externalizing	5.53	9.54	17.1	**3-1*** **3-2*** **1-2***	9.70	14.7	7.72	**3-2*** 2-1‡	12.9	9.46	9.80		9.62	8.42	14.1	**3-1*** **3-2***	.472
Total	35.3	59.8	76.6	**3-1*** **3-2*** **2-1***	66.7	64.8	40.2	**1-3*** **2-3***	52.5	71.9	47.2	**2-1*** **2-3***	48.5	62.0	61.3	**2-1*** **3-1***	.466
GABI (Raw scores) N=45																	
Specific phobia	1.03	1.09	1.76		1.04	.69	1.90	**3-1*** 3-2‡	1.11	1.42	1.35		1.91	1.16	1.24		.227
Separation anxiety	3.44	3.26	3.47		3.95	2.80	3.02		2.49	4.27	2.88	**2-3*** **2-1***	3.76	3.49	3.22		.154
Generalized anxiety	6.27	6.06	6.61		6.28	5.28	6.71		5.26	7.18	6.09	2-1‡	6.43	6.66	6.04		.023
Depression/Dysthymia	3.97	4.28	4.20		4.52	3.09	3.77		3.38	4.69	4.10		4.17	4.97	4.50		.133
Oppositional defiant	1.95	1.32	1.70	1-2‡	1.52	1.33	1.90		1.61	1.51	2.15		2.70	1.85	1.25	1-3‡	.060
Conduct problems	.34	.45	.94		.86	.35	.35		.70	.61	.33		1.90	.39	.35	1-3‡	.019
ADHD	4.34	3.68	4.14		4.29	2.68	4.18		3.97	4.51	3.23		4.11	4.68	3.60		.066
Strengths-capacities	9.25	9.24	9.21		9.40	8.40	9.36	**3-2*** **1-2***	9.11	9.10	9.73		9.10	9.15	9.33		.066
Internalizing	14.7	14.7	16.0		15.8	11.9	15.4		12.2	17.6	14.4		16.3	16.3	14.0		.006
Externalizing	6.63	5.45	6.78		6.70	4.39	6.42		6.28	6.63	5.72		8.70	6.91	5.20		.080
Total	21.3	20.1	22.8		22.5	16.3	21.8		18.5	24.2	20.1		25.0	23.2	19.2		.012

p values: clusters with statistical differences in GEE models adjusted by sex and age. R^2: adjusted R-square coefficient. Bold*: $p \leq .05$.
‡: $p \leq .10$;

A: C1: unaware-indirect exposure; C2: aware-indirect exposure; C3: involved-direct exposure.
B: C1: moderate physical/sexual violence; C2: psychological violence; C3: severe physical/sexual violence.
C: C1: psychopathic; C2: chauvinistic, psychological problems, abuse in childhood; C3: impulsive, substance abuse, legal problems, dysphoric.
D: C1: physical abuse, neglect, active psychological abuse; C2: corruption, inadequate socialization; C3: emotional deprivation.

Table 4. Predictive Model of the Characteristics of Intimate partner violence on Functional Impairment (CAFAS)

Independent variables (clusters)	A Degree of child involvement				B Characteristics violence to the mother				C Aggressor characteristics				D Violence to the child				
	% in each cluster			OR	% in each cluster			OR	% in each cluster			OR	% in each cluster			OR	
Dependent variables	C 1 N=48	C 2 N=41	C 3 N=37		C 1 N=55	C 2 N=28	C 3 N=41		C 1 N=37	C 2 N=53	C 3 N=37		C 1 N=24	C 2 N=47	C 3 N=55		R^2
School	18.9	13.6	28.3		21.9	22.7	16.2		19.6	20.1	21.2		20.3	19.9	20.7		.116
Home	25.5	31.4	28.3		31.8	13.5	39.8	3-2*:6.1 1-2‡:3.9	32.3	25.4	27.5		37.7	32.2	15.2	1-3‡:3.4 2-3*:3.0	.186
Community	3.2	5.0	2.4		4.1	4.6	1.8		4.3	5.6	0.6		9.5	0	2.2		---
Behav. towards others	7.4	16.3	11.7		9.7	10.5	15.3		17.9	14.7	2.9	1-3‡ 7.5	12.9	9.0	13.6		.240
Mood emotion	49.3	39.1	35.5		42.4	40.2	41.3		44.3	46.4	33.2		56.8	29.0	38.0	1-2*:3.4	.128
Self-harm	6.9	6.9	0.4		6.5	3.6	3.6		8.1	5.9	0		14.1	0	1.9		---
Cognition	1.9	3.5	2.6		1.9	0	6.4		2.4	1.1	4.5		0	5.5	2.9		---
Mean Total score[1]	5.37	4.65	4.79		5.53	4.14	5.13		5.42	5.06	4.33		5.80	4.40	4.61		.093

[1]Means and mean differences between clusters in GEE models adjusted by sex and age.
OR: Odds ratio GEE analysis adjusted by sex-age; R^2: Nagelkerke's (logistic) and adjusted (multiple) R-square.
Bold*: $p \leq .05$. ‡: $p \leq .10$ --- The model could not be estimated because of low frequency. C: Cluster.

--- The model could not be estimated because of low frequency.

OR values were included only for significant comparisons between clusters.
A: C1: unaware-indirect exposure; C2: aware-indirect exposure; C3: involved-direct exposure.
B: C1: moderate physical/sexual violence; C2: psychological violence; C3: severe physical/sexual violence.
C: C1: psychopathic; C2: chauvinistic, psychological problems, abuse in childhood; C3: impulsive, substance abuse, legal problems, dysphoric.
D: C1: physical abuse, neglect, active psychological abuse; C2: corruption, inadequate socialization; C3: emotional deprivation

4. PARENTING STYLES IN THE INTIMATE PARTNER VIOLENCE CONTEXT

4.1. Manuscript: Psychological abuse towards women and their child's functioning: the mediator and moderator role of the parenting of the father and mother

Psychological abuse towards women and their child's functioning: the mediator and moderator role of the parenting of the father and mother

Abstract

The aim of this study is to assess the role of maternal and paternal parenting styles in the effect on the child's functioning after witnessing psychological abuse towards the mother. 138 children and adolescents exposed to psychological violence and 100 non-exposed children and adolescents participated in the study. Psychological violence, child's psychopathology and functioning, and the mother's and father's parenting were assessed. The mediator role of maternal parenting was analyzed with structural equation models, and the moderator role of the father's parenting was analyzed with multiple regression models. Maternal overprotection mediated the relation between psychological abuse and the child's functioning, and externalizing and internalizing problems. Maternal rejection was a mediator between the mother's exposure to psychological abuse and the child's externalizing and internalizing problems. Neither maternal emotional warmth nor the father's parenting style moderated the relationship between the mother's exposure to psychological abuse nor the child's functioning. Being a victim of psychological abuse is associated with negative maternal parenting, such as overprotection or rejection, which in turn is associated with the child's negative outcomes. It is important to target parenting styles in families living with psychological abuse.

Key words: psychological abuse, intimate partner violence, children, adolescents, parenting, externalizing and internalizing problems, functioning.

Psychological abuse towards women and their child's functioning: the mediate and moderate role of the parenting of the father and mother.

Introduction

Intimate Partner Violence (IPV) includes any action from the man towards the woman such as physical aggression, psychological abuse, sexual abuse, and any controlling behavior such as isolating the other person from her family and social environment, controlling her movements, and restricting her access to information or assistance (Heise & Garcia-Moreno, 2002). These forms of violence usually coexist in the same relationship (Alberdi & Matas, 2000).

Physical abuse has been the main focus of studies about IPV, because it is more visible and easier to quantify (Butterworth, 2004; Leserman et al., 1997; Lown & Vega, 2001), whereas psychological abuse is more difficult to define (Arias & Pape, 2001; Garbarino, Eckenrode, & Bolger, 1997). Psychological abuse from the man towards the woman can be defined as coactive or aversive actions with intent to cause emotional pain or the threat of pain in the other person (Murphi & O'Leary, 1989) and it includes behaviors such as disregard, jealousy, insults, underestimation, or social isolation (Hudson & McIntosh, 1981). Psychological abuse towards women is much more chronic than physical abuse and the two are typically associated (Lewis et al., 2006). Contrary to physical abuse, psychological abuse can occur unaccompanied by other abuses, and it can have the same or an even greater impact on the health of the victim than other types of abuse (Mechanic, Weaver, & Resick, 2008). In general samples, the prevalence of women suffering psychological abuse from their partners is around 11.8% (Denham et al., 2007). Among women who attend centers for maltreated women, the prevalence rises to 94.1% (Lewis et al., 2006).

Regarding children, the literature has also focused on the effects of exposure to IPV in general, with no distinction between the different types of violence. Approximately, 15.5 million children in America witness IPV annually (McDonald, Jouriles, Ramisetty-Mikler, Caetano, & Green, 2006). In the UK, 240,000 to 963,000 children are exposed to violence between their parents, whilst in Spain the number is around 118,000 (UNICEF, 2006). Some studies pointed out that exposure to psychological abuse between parents negatively affects the child's functioning and increases the risk of both internalizing and externalizing problems (Clarke et al., 2007; Levendosky & Graham-Bermann, 2001; Panuzio, Taft, Black, Koenen, & Murphy, 2007).

Psychological abuse from the father towards the mother may affect the child's well-being directly, but also through family variables, such as parenting styles. One possible explanation for this relation is the 'spillover hypothesis', which suggests that the conflict and hostility existing in one part of the family system, like marital interaction, may negatively influence the parent-child system. In this sense, Krisknakumar & Buehler (2000) found that marital conflict negatively affected parenting; this was especially evident in the fact that parents used harsher discipline and demonstrated less acceptance of their children (i.e. less emotional warmth). Most studies about parenting and IPV have focused on the role of the mother, and they suggest that there is a negative association between IPV and maternal parenting. Mothers who suffer IPV in general are twice as likely to be physically and verbally aggressive towards their children (Hunter, Jain, Sadowski, & Sanhueza, 2000), they are less affective (Margolin, Gordis, Medina, & Oliver, 2003), tend to be more impulsive (Osofsky, 1998), and evaluate their children's behaviour negatively, which increases the risk of physical punishment towards them. Apart from coercive styles, mothers who are

abused by their partners can overprotect their children as a way of dealing with the tension they are suffering in their home (Smith, Berthelsen, & O'Connor, 1997).

There is paucity in the literature about the parenting styles of fathers who are violent at home (Sullivan, Juras, Bybee, Nguyen, & Allen, 2000). Abuser fathers can negatively affect the children's well-being through exposure to violence, as well as through neglectful behavior and manipulation (Silverman & Bancroft, 1998). Moreover, violent men display negative parenting: they are rigid and authoritarian (Bancroft & Silverman, 2002), are not involved in their children's lives and neglect their needs (including those derived from abusive situations; Holden & Ritchie, 1991; Sterenberg et al., 1994), they use physical punishment and are not physically warm (Holden & Ritchie, 1991). However, other studies do not find significant differences between abuser and non-abuser men in the way they bring up their children (Baker, Perilla, & Norris, 2001; Fox & Benson, 2004). Negative parenting increases the likelihood of emotional and behavioral problems in the children. A hostile or overprotective style is associated with the development of behavioral problems in the child (Cunningham & Boyle, 2002; Overbeek, ten Have, Vollebergh, & de Graaf, 2007), whereas maternal rejection is related to both internalizing and externalizing problems (Crater, 2004; Cummings, Keller, & Davies, 2005; Doyle & Markiewicz, 2005).

There are no studies about psychological abuse and parenting. On the contrary, in the last few years some studies about the mediation role of parenting in marital discord have emerged. Most studies have focused on samples with marital discord or interparental hostility. However, there are few studies that focus specifically on IPV, and even less on psychological abuse. In this sense, one could consider psychological abuse as an extreme example of marital conflict or interparental hostility. In fact, marital conflict seems to be consistently associated with the presence of IPV (Jewkes,

Levin, & Penn-Kekana, 2002). Some studies state that both maternal rejection and intrusiveness are mediators in the effect of IPV or marital conflict on the child's well-being (Fauber, Forehand, Tomas, & Wierson, 1990; Gonzalez, Pitts, Hill, & Roosa, 2000; Krisknakumar & Buehler, 2000). Notwithstanding, there is some controversy in the results. Buehler & Gerard (2002) pointed out that, to date, some studies supported the mediator role of parenting in marital conflict models (Acock & Demo, 1999; Harold & Conger, 1997; Harrist & Ainslie, 1998; Mann & MacKenzie, 1996; Osborne & Fincham, 1996; Vanderwater & Lansford, 1998), whilst others demonstrated the absence of this mediation (Harold & Conger, 1997; Miller, Cowan, Cowan, Hetherington, & Clingempeel, 1993; Peterson & Zill, 1986). Buehler and Gerard suggested, as limitations of these studies, that only a few included preschooler children and they were only based on one aspect of the parenting style (rejection of the child) (Buehler & Gerard, 2002).

Given that the mediation of parenting in psychological abuse against women has not been studied yet, this study is centered on the psychological abuse of the man towards the woman. The study is based on a retrospective cohort design. It is considered that suffering psychological abuse affects the mother's parenting as is suggested in the 'spillover hypothesis', and this, in turn, influences the child's response. Besides, in this study it is also considered that abuser fathers may display negative parenting, and this negative parenting appears at the same time as the psychological abuse towards the mother and modifies the effect of the violence on the child. Therefore, it is expected that the parenting of mothers who suffer psychological abuse would mediate between psychological abuse and the psychopathology and functioning of the child. Specifically, it is expected that suffering psychological abuse from their partners would increase both maternal rejection and overprotection, and decrease emotional warmth, which in turn

would, in all cases, increase clinical symptoms in the children and deteriorate their global functioning. It is also expected that the parenting of abuser fathers would moderate the effect of the psychological abuse on the children. In this sense, it is expected that higher father rejection and overprotection and low emotional warmth would increase the negative effect of psychological abuse.

Method

Subjects

The current study is part of a wider project about the effects of exposure to IPV on children and adolescents, carried out from January 2006 to December 2008. Information was collected on two cohorts of mothers and children from 4 to 17 years old: one cohort was formed of 145 children exposed to IPV and the other cohort included 113 non-exposed children. Women who took part in the exposed cohort were recruited in a Gender Violence Center in the area of Barcelona. This center provides help and advice for women who suffer violence from their partner (e.g. legal, economical and employment advice, and psychological help). They were informed about the opportunity to participate in the study if: a) they had children aged 4 to 17 years old; b) the children had been exposed to IPV (physical, psychological and/or sexual) during at least the last year; c) they had adequate comprehension of Spanish, both spoken and written. The violence against the mother was perpetrated by her partner or ex-partner, who may or may not be the biological father of the child. In the non-exposed cohort, mothers and children who attended public health centers in the metropolitan area of Barcelona and met the criteria a) and c) were recruited. The Index of Spousal Abuse (ISA; Hudson & McIntosh, 1981), which assesses physical and non physical abuse in the last year, was administered to all the participant mothers, both exposed and non-exposed. Children were classified as exposed to psychological abuse if

the score in the non physical abuse subscale was 14 or higher (the cut-off point for the Spanish population; Observatorio de la Salud de la Mujer, 2009).

Table 1 lists the demographic characteristics of the sample. The ISA was obtained of 238 mothers (92.24%) from the initial sample. Among 138 women who suffered psychological abuse, 84.8% also suffered physical abuse (based on the ISA cut-off point of 6), whereas among the 117 women who suffered physical abuse, 100% also suffered psychological abuse. The group of children exposed to psychological abuse had a higher proportion of one-parent family ($p<.0001$) and medium/medium-low socio-economic status ($p<.0001$) (Hollingshead, 1975).

INSERT TABLE 1

Measures

Psychological abuse. The Index of Spouse Abuse (ISA; Hudson & McIntosh, 1981) is a self-report questionnaire on the perceived degree of abuse received from the partner. It is made up of 30 items clustered into two scales: physical and non physical abuse. The answer is Likert-type with 5 options (0= never to 5= very frequently). The non physical abuse scale is formed by 19 items about psychological abuse such as underestimation (i.e. belittles me), control over the woman's behaviors (i.e. is stingy in giving me enough money to run our home), jealous (i.e. is jealous and suspicious of my friends), insults (i.e. tells me I am ugly and unattractive), or isolation (i.e. does not want me to socialize with my female friends). The physical abuse scale, formed of 8 items, includes violent acts, both physical (i.e. slaps me around my face and head) and sexual (i.e. demands sex whether I want it or not). Both scales rate from 0 to 100. The cut-off point of the Spanish version is 14 for non physical abuse and 6 for the physical abuse, and its psychometric characteristics are good (Observatorio de la Salud de la Mujer, 2009).

Parenting styles. The parenting style of the father and the mother was assessed using the EMBU questionnaire (Castro, Toro, Van der Ende, & Arrindell, 1993). For this study, parents (reported by mothers of 4 to 17 year old children), children (from 8 to 12 years old), and adolescent versions (from 13 years old) were used. Rejection, emotional warmth and overprotection scales were also used. Due to the fact that the number of items on the scales in each version for children and adolescents were different, standardized scores were computed. Psychometric proprieties of the Spanish version are good (Castro et al., 1993). Standardized scores for the father and mother's scales were used separately. The mother's score in each subscale was obtained from the combined standardized scores of mothers and children. The scores for the father were obtained from the children's rates.

Children's functioning. This was assessed through the Children's Global Assessment Scale (CGAS; Shaffer et al., 1983), a one-dimensional scale rated by a clinician which synthesizes the child's functioning with a score from 1 (maximum impairment) to 100 (normal functioning). Scores higher than 70 indicate good functioning. Reliability and validity are adequate (Ezpeleta, Granero, & de la Osa, 1999).

Children's psychopathology. For the current study, the Child Behaviour Checklist (CBCL;Achenbach & Rescorla, 2001) was used to assess some emotional and behavioural problems rated by mothers. Preschool ($1^{1/2}$ to 5 years; Achenbach & Rescorla, 2000) and school versions (6 to 18 years; Achenbach & Rescorla, 2001) were used. The school version has 113 items and the preschool version has 100, both with 3 answer options (0= never, 1= sometimes, 2= frequently). For the study, standardized scores were used in the externalizing, internalizing, and total scales.

Procedure

Approval was obtained from the ethics committee of our institution. All mothers who were attending centers for battered women or health centers were invited to participate in the study if they met the inclusion criteria. A psychologist from the center for battered women invited mothers to participate, and for the non-exposed cohort, the pediatrician in the health centers was the person who invited them. In all cases, written consent from the mothers and verbal assent from the children were obtained. As part of a wider project which consisted of diagnostic interviews, trained interviewers (de la Osa, Ezpeleta, Doménech, Navarro, & Losilla, 1996) rated the child's functioning through CGAS. During the assessment process, mothers answered the ISA questionnaire about violence from their partners in the last year. The interviewers attended the evaluation in order to resolve any doubts. Finally, mothers and children completed the EMBU questionnaire, and mothers rated the CBCL.

Statistic Analysis

Mediation. Structural equation models were built using the EQS statistic program version 6.1 for Windows (Multivariate Software, 2007). The Baron and Kenny procedure (1986) was used in order to assess the meditator effect of the mother's parenting styles on aspects such as the psychological abuse and psychopathology of the child. The meditator significance was tested using the Kenny, Kashy, and Bolger (1998) method.

Once the presence of mediation was established, the partial or complete nature of the mediation was tested through the comparison of both models with the difference of Chi-score global indexes. The fit of the models was measured with the classic statistic Chi-score, the Comparative Fit Index (CFI; Bollen & Long, 1993) and the Root Mean Square Error of Approximation (RMSEA; Browne & Cudeck, 1993). In the

current study, it was considered that a fit was good if (Byrne, 2001): the Chi-score was not significant, the CFI coefficient was higher than .90 and the RMSEA was no higher than .08. Due to an important overlap between psychological and physical abuse, all models included physical abuse as a control variable. Models to assess the child's functioning also included the child's age and sex, the SES and one parent living at home as control variables, whereas models to assess CBCL scores included the child's sex, the SES and one parent at home.

Moderation. The SPSS program 15.0 for Windows was used to assess the moderate role of the father's parenting. This research refers to nested structure data (some siblings had the same parents), but due to the extremely low level of hierarchy (58% of families had only one child, 38% had 2 children and 4% three children: the mean number of children per family was 1.47), multi-level models did not allow a satisfactory adjustment (Hox, 2002). To account for data dependency at the lower data level and to prevent some estimation bias, the random factor "family" was included in multiple mixed models through Generalized Estimating Equations (GEE procedure in SPSS system). These models were adjusted with the Normal distribution and the Identity link-function for quantitative outcomes. As in the mediate models, all moderate models included physical abuse towards mothers as co-variables. The child's functioning models also included the child's age and sex, SES and one parent at home. It was considered that an interaction between psychological abuse and parenting was significant if $p \leq .05$. If interaction was significant, it was kept in the model and the effect of psychological abuse was estimated separately for low and high scores in the EMBU-N scales (25 and 75 percentiles of the same sample).

Results

Correlations

Table 2 shows the correlations between the study variables that were used to find out whether the mediate criteria had been met (the predictive variables should have been associated with the child's outcomes as well as with the mediate variables, and the mediate variables should have been associated with the child's outcomes). Psychological abuse towards mothers was correlated in a significant way with all the outcomes variables and mediate variables (except with the emotional warmth of the mother). Maternal rejection, overprotection and emotional warmth were significantly correlated with the child's psychopathology, and rejection and overprotection correlated with functioning. Both overprotection and rejection met criteria for mediation, but not in the case of emotional warmth.

Emotional warmth from the mother was negatively and significantly correlated with mother's rejection, and mother's overprotection and rejection were positively and significantly correlated. Even though overprotection and rejection were related in a significant way, they were considered as two different parenting styles and were analyzed separately.

INSERT TABLE 2

The mediate effect of the mother's rejection and overprotection

The mediate effect of each of the mother's parenting styles were analyzed separately (see Table 3). Maternal overprotection mediated in the effect of psychological abuse on the global functioning of the child in the predicted direction (abuse against the mother was positively associated with overprotection, and overprotection was associated negatively with the child's functioning). Regarding the child's psychopathology, in both global, internalizing and externalizing scores, maternal

rejection and overprotection were mediate variables in the predicted direction (psychological abuse increased rejection and overprotection, and maternal parenting increased the clinical symptoms of the child). In all cases, mediation was partial. Table 3 shows that mediate models were similar for internalizing and externalizing symptoms, although the z scores were slightly higher for externalizing symptoms, which suggests that the mediate model for externalizing problems is more robust than for internalizing problems.

INSERT TABLE 3

Mediate models with and without direct paths from psychological abuse to the responses were assessed in order to appraise possible models that would be more plausible. In all cases, there was a significant difference in the Chi-score tests. Therefore, models with a powerful prediction (R^2) and indexes that were a better fit were selected (see Table 3).

Once the mediate models for maternal rejection and overprotection were assessed, both parenting styles were analyzed jointly in the same model (see Figure 1). For global functioning, only overprotection partially mediated the effect of psychological abuse towards the mother. For internalizing symptoms, maternal rejection approched significance. Rejection showed the greatest z value, which suggests that maternal rejection is more powerful than overprotection for mediation in the internalizing symptomatology. For the externalizing symptoms, only rejection was a mediator variable. Finally, in the model for the total score in psychopathology, again rejection appeared as a mediator factor. Fit indexes of the models were moderate.

INSERT FIGURE 1

The moderate effect of father's parenting styles.

Regarding the scores of the EMBU questionnaire reported by children, psychological abuse against mother correlated positively with father's rejection (r=.24, p=.009) and negatively with emotional warmth (r=-.32, p=.001).

Interactions between psychological abuse and the parenting styles of the father (emotional warmth, rejection and overprotection) were not significant in the models neither for the child's functioning nor psychopathology. Due to the fact that maternal emotional warmth was not a mediator variable (it did not meet the criteria for mediator variables according to the Kenny et al. procedure), the possible moderate role was tested. Interaction between psychological abuse towards the mother and maternal emotional warmth were not significant in any model (child's functioning and psychopathology).

Discussion

The psychological abuse suffered by the mother affects the child's well-being directly, but also through the mediator role of maternal parenting. Hostility in partner interaction affects the interaction between the mother and the child. The fact that a mother undergoes psychological violence from the partner impacts negatively on her parenting (Stephens, 1999). The current results suggest that maternal overprotection is associated with a worse functioning of the children, whilst both overprotection and rejection are important for explaining clinical symptomatology. Many mothers who suffer psychological abuse from their partners may fear for the welfare of their children and may try to compensate the effects of hostility at home by employing an intrusive parenting style. When mothers overprotect, the autonomy of children is crippled and this leads to an increased risk of both internalizing (Lieb et al., 2000; Stein et al., 2000)

and externalizing problems (Bhatia et al., 1990; Holmbeck et al., 2002). On the other hand, women abused by their partners are often more likely to suffer a significant number of psychological problems as a result of the repeated abuse (Holtzworth-Munroe, Smutzler, & Sandin, 1997; Jarvis, Gordon, & Novaco, 2005). Abused mothers who also suffer emotional stress and depression are more emotionally distant with their children, are less available to them and may even be abusive (Holden, 2003).

The current results are consistent with other studies about the mediator role of maternal parenting in the effect of IPV in general, which suggested that the mediating effect is partial for both internalizing and externalizing problems (Benson, Buehler, & Gerard, 2008; Buehler & Gerard, 2002; Krishnakumar & Buehler, 2000). In Psychology, most variables mediate partially. These results also posit that exposure to psychological abuse toward the mother has a direct effect on the welfare of the children, either through an increase in arousal, or through an increase in the emotional insecurity of the child (Davies & Cummings, 1998). The likelihood of being a direct witness to situations of psychological violence and aggressive arguments between parents may occur in up to 75% of cases (Hutchison & Hirschel, 2001). It is also possible that the direct observation of these violent incidents increases the activation of the child, being responsible for the occurrence of psychological problems (Cummings, Goeke-Morey, Papp, & Dukewich, 2002; El-Sheikh & Reiter, 1996; Rieter & El-Sheikh, 1999). There are other variables related to parenting styles that have not been included, such as the inconsistency of parenting (Buehler & Gerard, 2002), the maternal psychopathology or the way the child perceives and interprets the violence. Future research on the models for the effect of psychological abuse should take into account these possible mediating variables. Unlike what was hypothesized, maternal emotional warmth is not a mediate or moderate variable in this study. Skopp et al. (Skopp, McDonald, Jouriles, &

Rosenfield, 2007), in contrast, found that the maternal warmth in IPV contexts protected girls but not boys against the presence of externalizing problems. Nevertheless, there are studies that suggest that mothers who suffer from violence from their partners struggle to maintain a positive relationship and therefore show the same emotional warmth towards their children as mothers who are not abused (Belsky, Youngblade, Rovine, & Volling, 1991; Brody, Pillegrini, & Sigel, 1986; Mahoney, Boggio, & Jouriles, 1996). Despite the fact that psychological abuse against the mother is related with more father's rejection and less emotional warm, the results of this study suggest that their parenting style does not modify the effect of the psychological abuse toward the mother on the welfare of the child. These results are consistent with other research that did not find a modifying role of the father's parenting (Frosch & Mangelsdorf, 2001). Another possible explanation for the fact that the father's parenting, or maternal emotional warmth, does not modify the effect of psychological abuse may be that boys and girls have been analyzed together. Gordis, Margolin, and John (1997) found that interaction between interparental aggression and hostility towards the child was only significant for the boys' behavior but not for the girls'. Besides, it must be remembered that in this study, children are the ones who are reporting the parenting style of the fathers or the mothers' partner. Sometimes, children who live in IPV situations may try to hide or deny the problems they are experiencing at home.

One of the limitations of the study is the fact that the assessment of both the child's psychopathology and parenting styles are assessed at the same time, which in turn decreases the likelihood of establishing causal conclusions. Indeed, the presence of psychopathology in the children may modify the way in which parents rear them (Pardini, 2008). Notwithstanding, it is important to note that mediating models in this study are consistent with the theoretical underpinning of the "spillover hypothesis".

Positive aspects of this study include, above all, the effect of the mother's and the father's parenting styles having been studied separately, which allows for the role of each parenting style in the model. In addition, both mediate and moderate models included possible confounding variables, including physical abuse, which in turn ensures that the mediator effect is specific for psychological abuse.

The current study posits that professionals who work with abused women who have children must also consider the child's psychopathology and the maternal parenting as elements to modify in the treatment program. In fact, the mother-child relationship is a positive aspect that other studies suggested as a buffering element for the negative effect of the IPV on the children (Humphreys, Mullender, Thiara, & Skamballis, 2006; McAlister, 1999). In that sense, it is important to help the mother to improve her child's acceptance and avoid overprotective behaviors, leading to an adequate development of the child's autonomy and security. Finally, these results demonstrate that the parenting of a mother who is psychologically abused by her partner is affected by this abuse, and therefore, it is not an individual factor pertaining to her. These results highlight the importance of not blaming abused mothers for the negative effect of their parenting on the children and helping them to improve their attachment and parenting.

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Table 1.

Socio-demographic characteristics of the sample.

		Exposure to psychological abuse		
		Yes (N=138)	No (N=100)	TOTAL (N=238)
Sex: male; (%)		84 (60.9)	54 (54.0)	138 (58.0)
Age (years); *Mean (SD)*		8.6 (3.5)	7.9 (2.8)	8.3 (3.2)
Ethnicity; *(%)*	*Caucasian (%)*	120 (97.0)	95 (95.0)	215 (90.3)
	Hispanic	12 (8.7)	5 (5.0)	17 (7.1)
	Others	6 (4.3)	0 (0.0)	6 (2.5)
*SES[1]; *(%)*	*High or Mean-high*	37 (27.6)	51 (52.6)	88 (38.1)
	Mean	65 (48.5)	42 (43.3)	107 (46.3)
	Low or Mean- Low	32 (23.9)	4 (4.1)	36 (15.6)
*Single-parent; *(%)*		78 (57.8)	4 (4.0)	82 (34.9)
Current caregiver (%)	*Biological mother*	138 (100)	99 (99.0)	237 (99.6)
	Biological father	125 (90.6)	96 (96.0)	221 (92.9)

[1] SES: Socioeconomic status based on Hollingshead's index

SD: standard deviation. *Significant statistical difference (p<.05).

Table 2.

Correlations between variables in the structured equation models.

	1	2	3	4	5	6	7	8	9	10	11	12
1. Psychological abuse	---											
2. Emotional warmth from the mother	-.11	---										
3. Rejection by the mother	.18*	-.34*	---									
4. Overprotection by the mother	.20*	.03	.50*	---								
5. Child's functioning (C-GAS)	-.50*	.12	-.28*	-.30*	---							
6. CBC total	.61*	-.21*	.43*	.39*	-.66*	--						
7. CBC internalizing	.55*	-.14*	.32*	.32*	-.61*	.88*	--					
8. CBC externalizing	.57*	-.27*	.43*	.38*	-.58*	.90*	.68*	--				
9. Child's age	.10	.00	.18*	.18*	-.24*	.05	.12+	-.04	--			
10. Child's sex	-.04	-.09	-.07	.01	-.17*	.02	.08	.04	.05	--		
11. Socioeconomic status (SES)	.28*	-.09	.04	.01	-.20*	.27*	.24*	.27*	.07	-.11	--	
12. One-parent at home	.53*	-.01	.12	.08	-.28*	.32*	.27*	.33*	.07	-.01	.09	--

*p<.05

Table 3.

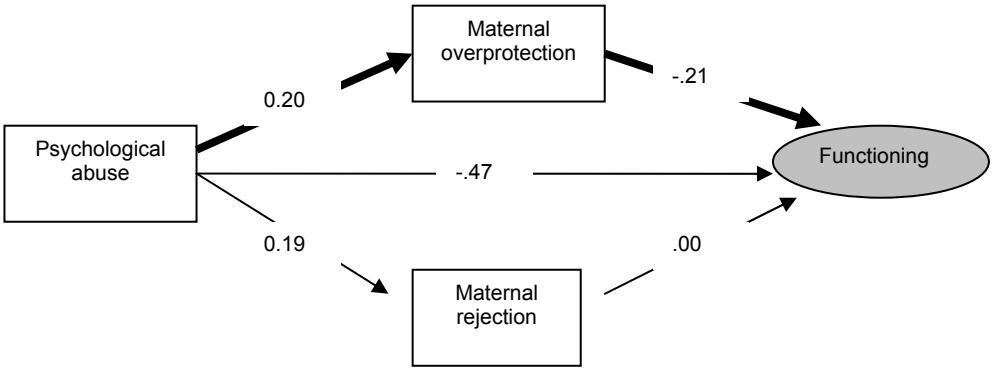
Mediating models for psychological abuse, the mother's parenting styles, and the child's functioning and psychopathology (standardized coefficients and fit indexes).

SEM for:	b_1	b_2	b_0	*z*	χ^2	$p(\chi^2)$	*CFI*	*RMSEA*	R^2
Child's global functioning									
Overprotection	.20*	-.20*	-.47*	**2.18**	14.02	.45	1.00	.00	.37
Rejection	.19*	-.10	-.50*	1.45	22.77	.06	.98	.06	.36
Internalizing symptoms									
Overprotection	.22*	.19*	.61*	**2.03**	2.72	.95	1.00	.00	.28
Rejection	.19*	.24*	62*	**2.05**	7.87	.45	1.00	.00	.31
Externalizing symptoms									
Overprotection	.22*	.27*	.53*	**2.51**	2.71	.95	1.00	.00	.33
Rejection	.20*	.34*	.55*	**2.35**	6.59	.58	1.00	.00	.37
Total symptoms									
Overprotection	.22*	.27*	.62*	**2.39**	2.83	.94	1.00	.00	.35
Rejection	.18*	.33*	.62*	**2.24**	7.92	.44	1.00	.00	.39

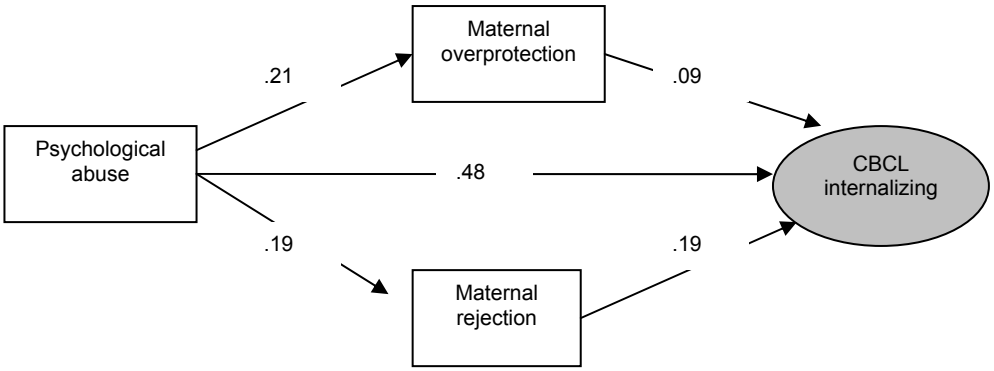
b_0= standardized path coefficients for the effect of IPV psychological on the child's response.
b_1= standardized path coefficients for the effect of IPV psychological on the mother's parenting.
b_2= standardized path coefficients for the effect of the mother's parenting on the child's response.
z= z scores for assessing mediation (significant mediation z ≥1.96)
R^2=Regression Coefficient of the model.
In bold, significant z scores.
All models include as co-variables physical abuse against the mother, child's sex and age, socio-economic status and one-parent living at home.
*p<.05

Figure 1.

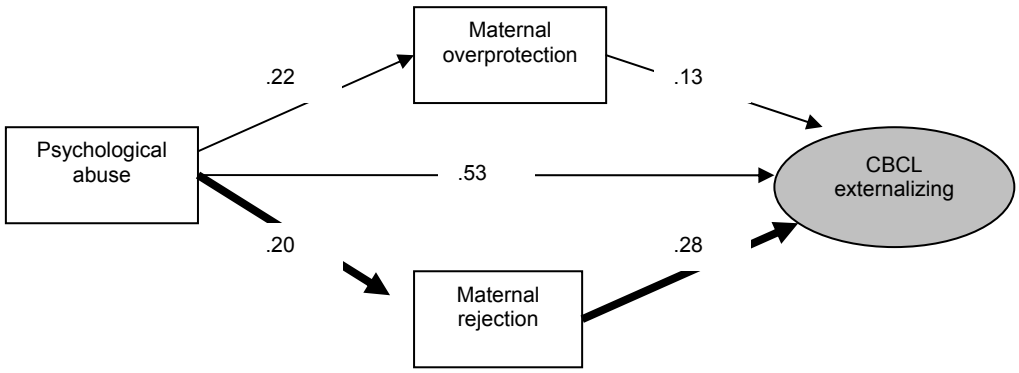
Joint mediation between overprotection and rejection by the mother in the effect of psychological abuse on the child's functioning, internalizing, externalizing, and total symptoms.*



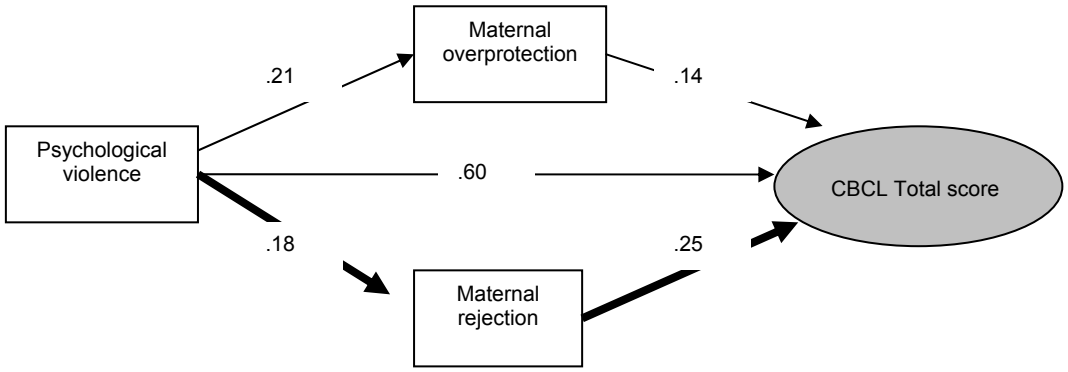
χ^2 = 89.78, p=.00, gl= 20; CFI=.0.85; RMSEA=.13; R^2=.39.
Mediation: Overprotection z=2.23; rejection z=.06.



χ^2 = 73.80, p=.00, gl=13; CFI=.84; RMSEA=.16; R^2=.30.
Mediation: Overprotection z=1.26; rejection z=1.87.



χ^2 =74.11, p=.00, gl=13; CFI=.85; RMSEA=.16; R^2=.36.
Mediation: Overprotection z=1.69; rejection z=2.24.



χ^2 = 74.23, p=.00, gl=13; CFI=.85; RMSEA=.16; R^2=.38.
Mediation: Overprotection z=1.78; rejection z=2.10.

*All models include as co-variables physical abuse against the mother, child's sex and age, socio-economic status and one-parent living at home.
Bold arrows indicate significant mediator paths (based in z scores).

5. DISCUSSION

The manuscripts and articles which have been exposed in this thesis highlight the importance of the exposure to IPV on the emotional and behavioral well-being of children and adolescents. The whole studies have answered the fields of research which were raised at the beginning.

5.1. Assessment of the effects of intimate partner violence on children and adolescents

Due to the fact that there is paucity in the number of assessment protocols specifically designed for children exposed to IPV in our country, the paper *Protocolo de evaluación de niños y adolescentes víctimas de violencia doméstica* tried to provide a proposal about an assessment schedule. The aim of these guidelines is to help both professionals from the mental health field and researchers who work with this type of population. Following the line of other authors, the first step in order to establish a framework in the field of the exposure to IPV is to create a consensus about the definition of exposure to IPV and dispose an assessment schedule to allow to obtain valid and reliable reports about the exposure and its effects (Graham-Bermann & Hughes, 2003; McAlister, 1999; Prinz & Feerick, 2003). This paper provides a summary of the variables which should be targeted in an IPV situation and available instruments to assess them. Instruments adapted in Spanish population are emphasized. First of all, the importance of assessing the exposure to IPV and its characteristics (such as the type of abuse against the mother, the time in which the child has been exposed to the violence, the severity of the IPV, the type of exposure, the characteristics of the aggressor, or the degree of exposure) are highlighted. Secondly, the importance of assessing several effects of the exposure is noted (including psychopathology such as depression, posttraumatic stress disorder or aggressive behavior, and the functioning of the child, which may be used to adapt the intensity and immediacy of the treatment). Apart from psychopathology, it is important to take into account other variables which may modify the effects of the IPV. Some of the child's variables, such as the self-esteem and the social competences, may modify the effects of the violence. Family variables such as maternal distress or parenting styles, and contextual variables such as

the social support of the child and the mother, might act as mediator and moderator factors. When possible, it is important to obtain reports from the mother, the child and other persons who could provide complementary information, such as teachers, psychologists or social workers. There is paucity about instruments adapted to Spanish population. Future researches should develop valid and reliable questionnaires and instruments to obtain a quality report of IPV situations. Moreover, research about the effectiveness of assessment schedules in mental health centers should be considered in the future.

5.2. Psychopathology in children and adolescents exposed to intimate partner violence

The second raised question was to establish whether children who are exposed to IPV at home and seek help from mental health centers have specific needs compared with those children who are non-exposed. The exposed children have a higher risk for several emotional and behavioral problems, and therefore, a higher risk for consulting public mental health centers. Notwithstanding, authors such as McAlister (1999) postulates that, in spite of the negative effects of the exposure to IPV on children, professionals from mental health may not know in most cases that these children are exposed to violence at home and that this violence explains mostly the clinic symptoms. The manuscript *Mental health needs of children exposed to intimate partner violence who seek help from mental health services* posits that these exposed children display important differences compared with other children who also attend for psychological problems. In particular, children who have been exposed to physical violence among their parents (pushing, slapping, throwing object, etc.) are more likely to have posttraumatic stress disorder, self-harm behavior, and dystimic disorder, which usually are less common even among clinic populations. The child is affected by the direct observation of this violence and its immediate aftermaths, which may produce symptoms of posttraumatic stress (Graham-Bermann & Hughes, 2003). The direct witness could also produce aggressive behaviors explained by the social learning theory (Bandura, 1977). Apart from direct effect, the child may be affected by the presence of other variables typically related to this violence, such as the psychopathology of the mother, stressful life events, or negative parenting styles from the violent father or the overwhelmed mother (Holden, Stein, Richie, Harris, & Jouriles, 1998; P. G. Jaffe, Poisson, & Cunningham, 2001; Levendosky & Graham-Bermann, 2001). Moreover,

exposure to IPV seems to affect equally the mental health and functioning of boys and girls, although the child's gender is important for the parenting of the battered women; battered mothers overprotect theirs sons and punish their daughters. Besides, exposed girls report more life events, and boys appraise their physical health in a negative way.

On the other hand, some meta-analysis about the effects of the IPV on children (Holt, Buckley, & Whelan, 2008; Kitzmann, Gaylord, Holt, & Kenny, 2003) posit that the effects on the mental health of children are heterogenic, ranging from internalizing problems, such as posttraumatic stress or depression, to externalizing problems, such as aggressive and defiant behaviors. One of the reasons for the several effects of the IPV on children may be the different characteristics of the violent situation. In general, the characteristics of the IPV are complex and heterogenic. The manuscritp *Characteristics of intimate partner violence exposure predictive of psychopathology and functional impairment in children* highlights that the diverse variables which take part in the IPV situations affect differentially on children who live at home. The IPV characteristics account for up to 46% of child's psychopathology and 24% for functioning impairment. In that sense, the characteristics more associated with the presence of psychological problems in children are the intervention degree of the child, and the direct abuse towards him or her, whereas the violent type towards the mother and the child's abuse were related to functioning impairment. It was shown that the pattern of affection depens on the disorder, the method of assessment and the reporter. When using combined information among mother and children from a diagnostic interview and the report from mothers from a dimensional questionnaire, children with a low awareness about the IPV situation were more likely to be affected by psychopathology, whereas using dimensional self-reports from the child, then direct exposure was more related to psychological problems (mainly externalizing symptoms). It is possible that unawareness children do not receive an explanation of the violence and they may not have adequate coping estrategies to deal with it. On the other hand, children directly exposed to the violence may have overwhelmed coping strategies and therefore, they appear as more affected. Moreover, direct exposed to IPV may be associated with learning aggressive patterns from the violent situation. Each type of violence towards the mother has a differential effect on the child, whereas psychopathic typology of aggressor was the great contributor for the child's psychopathology. The emotional deprivation of the child was related to psychopathology, and direct violence toward the child (physical, psychological, neglect) was important for impairment at home.

Therefore, some conclusions could be drawn: a) importance of taking into account different methods of assessment for the psychopathology (dimensional, categorial) and different reporters, including the child; b) importance of the involvement degree of the child in the violent incident; c) the importance of taking into account the types of violence against the mother (physical/sexual and psychological abuse) and the severity of the violence; d) considering the aggressor's characteristics; and finally e) considering also the possible abuse the child may be suffering in a IPV context. These characteristics may act as modifiers of the effect of the violence, e.g. increasing or buffering its effects.

5.3. Parenting styles in the intimate partner violence context

In line with the second field, the third question of research was to establish the importance of the parenting of battered women and aggressive men. The manuscript *Psychological abuse towards women and child's functioning: mediator and moderator role of the parenting of the father and mother* shows that the psychological abuse against the mother, which is the most frequent abuse among battered women who attend special centers for battered women, affects directly the child, but also through a modification in the way the mother rears them. Rejection and overprotection lead, in turn, children to be more likely to be affected by clinic symptoms and worse functioning. The results highlight that, although the mother who suffers psychological abuse from their partner display a negative parenting style with their children, this style is not an individual factor. This parenting is affected by the violent situation she suffers, in most cases in a chronic and repetitive way. First of all, these results should help to relief the blame of mothers from the negative effects of the violence on their children. Secondly, these results also highlight the importance of detecting and modifying the negative parenting in an IPV context. Regarding the violent father, the results are in line with other studies which did not find modifying role of their parenting (Baker, Perilla, & Norris, 2001; Fox & Benson, 2004; Frosch & Mangelsdorf, 2001). In situations of separations or divorces, which are common among cases of IPV, having a father who rears in an adequate way may help to improve the child's well-being. This would be possible in that situations in which it could be demonstrated that the father could offer an adequate environment for the normal development of the child. In most cases of IPV, the violent father is usually aggressive also with children and may mould aggressive behaviors (Holden, 2003). Professionals from mental health services and from justice

should assure that the father is able to provide a warm environment for the normalized growth of his children in that situations in which the shared custody is considered. On the other hand, there are several programs for the rehabilitation of aggressive men, although in Spain these programs are carried out in most cases in prisons, and therefore, focused mainly on extremely violent men. Public councils and agencies should be aware of the impact of the IPV on children and the need to develop programs for abuser men, in all levels.

5.4. Recommendations and Implications

The exposure to IPV has a negative impact on the mental health and the child's well-being. Due to the fact that children and adolescents exposed to IPV are more likely to attend mental health centers, public agencies should be aware of the importance of detecting and treating this vulnerable population. One example of possible measure is establishing guidelines for professionals who work with battered women and their children. First of all, these guidelines should provide detection and evaluation of the violence exposure, its negative aftermaths on children, characteristics of the IPV, and possible abuses towards the child. On the other hand, guidelines should provide intervention schedules taking into account the violence characteristics. These interventions should also be suitable for the child's adjustment and his or her personal and family characteristics. The therapeutic programs for exposed children should consider a developmental and multidisciplinary framework, including a closer collaboration between several professionals (psychologist, psychiatrics, physicians, social workers, lawyers, and teachers).

In some countries (e.g. the U.S.), there have been some efforts in order to develop intervention programs for children who witness IPV. These programs are originally from the 80's, when most interventions were mainly focused on women who were living in shelters. Along the 90's, interventions focused exclusively on the child, specifically focused on reducing psychopathology, whereas from the 2000 year professionals from mental health started to establish programs focused on clinical symptoms of the child considering an ecological framework. This perspective includes factors which may increase or buffer the negative outcomes of the exposure to IPV (Graham-Bermann & Hughes, 2003). Some examples are:

Advocacy and the Learning Club (Sullivan, Bybee, & Allen, 2002). This 16-week intervention focuses on battered women and their children. The mother is

provided with help and advice about dealing with possible difficulties in their children, goods, services, legal issues, employment, education, social support, child care, housing and transportation. It is based on community psychology and it has a feminist perspective, considering that the IPV disempowered battered women. That is, battered women do not have enough resources to use the community help. By extension, children are thought to be helped when their mothers receive more support. Moreover, children receive an educational program.

Project SUPPORT (Jouriles et al., 2001). It is a targeted, intensive program for children from 4 to 9 years old with a high degree of aggressiveness. This program is based on the social learning theory with the major premise being that parents should provide different models so that the children can learn adequate behaviors following violence exposure. The program, which lasts 8 months, includes weekly routine visits from the psychologist. The aim of the 60-90 minutes sessions is to provide parenting coaching to the mothers.

The Kids Club (Graham-Bermann, 2001). The aim of this program is to foster resilience of children who are exposed to IPV and enhancing their recovery from traumatic effects. It is a 10-week program for children from 5 to 13 years old and their mothers. The program is based on the idea that children can be traumatized by violence and may develop inappropriate beliefs about gender and the acceptance of the violence within the family. Children are helped to identify feelings and fears which are related to the IPV, to change social cognitions, and to develop adequate coping strategies and social competences. The program includes educational sessions with children and parenting coaching with mothers.

These intervention programs seem to be effective for children who are exposed to IPV and live in shelters for battered women (Graham-Bermann & Hughes, 2003). However, some authors argue that programs for exposed children should be targeted only in most server cases, whereas a generalized answer based on the community may be adequate in most cases (Edleson, 2004). Taking into account that only a part of women who suffer abuse from their partners seek help in shelters, it would be interesting to assess the effectiveness of these programs in other contexts, such as mental health centers or hospitals (Graham-Bermann & Hughes, 2003).

Graham-Bermann and Hughes (2003), in their revision about treatments for exposed children, provide some guidelines when considering treatments for this population. First of all, it is important to consider that children do not display the same

affectation degree. Children with higher affection should receive early and intensive interventions. Secondly, when planning an intervention, it is important to consider the child's developmental stage and cultural background. In that sense, preschool children would be beneficed by programs adapted to their cognitive abilities and focused mainly on mothers, whereas school children and adolescents would be beneficed by therapeutic groups with other children in similar conditions. Thirdly, it is important to keep in mind that most exposed children are well adapted. Detecting and addressing resilience factors should be considered in order to be included in the therapeutic program. Finally, assessment of the effectiveness of a therapeutic program for exposed children should be based on criteria such as: including comparison groups, a pre and post-intervention assessment and a reasonable follow-up, structured interventions, reports from several resources, comparative treatments (e.g., group intervention versus individual; including mother or not), addressing different intensities of the treatment based on the child's different need, and considering a theory and practical background.

The psychological problems of children exposed to IPV may be reduced directly by specific therapeutic programs, but also through relieving distress of the mother and helping her with the parenting. Besides, inclusion of the father in the therapeutic program for children could be difficult. Notwithstanding, programs for aggressive men should be developed. These programs should target wrong cognitions about the use of the violence and help them to use other non-violent strategies to solve problems. Considering the several typologies of abuser men and the severity of the violence, these programs should be available not only in the prison, but also in the community. The intervention characteristics for battered women and abuser men are described below.

Female victims of the violence are usually the targeted subjects in the therapeutic programs. The therapeutics aims of the treatment with battered women focus mainly on relieving the blame, improving the social relations of the woman, expressing the anger adequately, and treating psychopathology (Echeburúa & de Corral, 1999). Echeburúa, de Corral, Sarasua and Zubizarreta (1996) propose a cognitive-behavioral program for the IPV victims, including components such as: cognitive restructuration, problem solving and communication skills coaching, and stress inoculation. It is a weekly program which lasts between 10 and 12 weeks. The authors administrated the program in a sample of battered women who attended an out-patient health centre and did not live in shelters. The participant rate was high, and moreover, practically in all cases symptoms of PTSD, anxiety and depression were reduced, and their functioning

improved. The intervention was effective 12 months after the treatment (Echeburúa et al., 1996).

Despite the fact that most battered women decide to leave their aggressors, at least 50% of them do not (Echeburúa et al., 1996). Therefore, the therapy focused only on women is not sufficient and an integral treatment including the aggressor is needed. Regarding the therapy for aggressive men, Echeburúa and de Corral (1999) suggest that a justice perspective is not enough, since measures based on this perspective (such as criminal penalty, weekend arrests, etc.) may be insufficient or even counterproductive. Psychological treatment is expected to be the most suitable for these cases, as long as the aggressor is motivated for the change. Nonetheless, most violent men at home do not show motivation for the therapy. Echeburúa and Fernández-Montalvo (1997) applied a cognitive-behavioral therapy with abuser men which included components such as: recognizing the presence of the problem as a first and primordial step of the treatment; controlling some behaviors (e.g. jealousy, drinking, use of drugs); modification of cognitive bias; problem solving, social and communication skills coaching; coping with the anger; and controlling the impulse. Among men who participated in the therapy, the exit rate was 81% and 63% after 3 months. Notwithstanding, the authors posited that the non-acceptance or abandonment rate was almost 50%. As a guideline, therapies whit violent men against women should include individual cognitive-behavioral interventions, adapted to the characteristics of the aggressor and complemented with group sessions. The treatment should be lengthy (a minimum of 4 months), and include a sufficient follow-up period in order to guarantee the treatment exit (1 or 2 years) (Echeburúa & de Corral, 1999).

Redondo and Garrido (1999) propose some guidelines to consider when developing therapeutic programs for abusive men. Among these points, it is important to provide therapeutic programs when the violence is still less severe, which would prevent the violence. Therefore, justice networks should be activated in order to provide therapies as an alternative of criminal acts in case of mild IPV cases. Similarly to Echeburúa and Fernández-Montalvo (1997), these authors offer an approach about a cognitive-behavioral therapy for abusive men.

Some children exposed to IPV do not display psychological problems or psychosocial maladjustment. These children have several individual, familiar, or social characteristics which protect them against the adversity. Notwithstanding, assessment of sub-clinic symptoms should be addressed since some children may display clinic

symptoms although they may not meet criteria for a diagnosis. These symptoms may undermine the child's adjustment (E. M. Cummings, 1998; Graham-Bermann, 1998), and therefore, sub-clinic symptoms should be addressed and targeted. On the other hand, some exposed children may accept the violence as a way to solve problems (Jaffe, Hurley, & Wolfe, 1990). When they are adults, exposed children are more likely to be either aggressive or abused victims. Detecting and modifying these erroneous thoughts about the violence should be a part of the intervention for exposed children, which may help to prevent the generational perpetuation of the violence.

The child is a unit who is constantly connected with several functioning systems, such as the family, the school, or the general society. When approaching the IPV issue, a bio-psycho-social perspective should be kept, considering the participation of diverse people of the child context (e.g. clinicians, relatives, and friends). In that sense, and according to a more general perspective, the first step to eradicate the IPV in our society is increasing awareness of the violence against women as an important concern, their harmful aftermaths on the victims, and the need to detect IPV situations in order to report it to the justice agencies. In order to eradicate a complex concern as the violence against the women, public and private administrations should join forces. Currently, some efforts have been made by public agencies with the goal of preventing and eradicating the violence from the men toward the women. Some efforts are the development of prevention and sensitiveness programs. Examples of these programs are those focused on adolescent population or TV advertisement for battered women with the objective of being aware of the importance of reporting the abuse situation. In general, these prevention programs have several aims, such as to describe what the violence is, which sources are provided by public agencies to help battered women, to become aware of the importance of detecting and reporting the violence, etc. In Spain, departments for social issues in each autonomic community and the Ministry of Equality of the Spanish government have developed these types of prevention programs. Another example of efforts made from public agencies is the development of a Ministry of Equality among whose goals is struggling violence against women (http://www.migualdad.es/ss/Satellite?pagename=MinisterioIgualdad/Page/MIGU_home). For the future, prevention programs should be provided so that the prevalence of battered women decreases through a change in the misogyny ideas of the society.

5.5. Future direction for research

In spite of the fact that this thesis tried to answer some questions about the exposure to IPV, there are others which remain unanswered and should be considered in future researches.

According to E. M. Cummings et al. (2009), future researches should address thoroughly different explaining models for the effect of the IPV on children and adolescents, considering possible mediator and moderator variables. Taking into account mediator variables in the effect of IPV, models should consider child's individual characteristics (e.g. how the child appraises the violence, or his/her emotional reactivity and regulation) (Davies & Cummings, 1994). On the other hand, familiar variables, such as the parenting of the mother, maternal psychopathology, or parenting stress may also mediate in these models. Apart from mediator variables, other moderator factors should be considered, such as the child's gender and age, the characteristics of abuser men, the parenting of the violent father, or the socioeconomic status. Longitudinal studies should provide guarantees to establish causality relations between variables of the model. Yet, despite the fact that the parenting of the violent father seems to not modify the effect of the IPV, it may be possible that the modifier role of the father parenting would be different depending on the child's characteristics, such as the age and sex. It would be interesting to study whether the parenting of the violent father modifies the effect of the IPV on preschoolers, school children or adolescents and on boys and girls separately.

As described above, in Spain there is paucity in the number of assessment and intervention schedules for children and adolescents who suffer IPV at home. Regarding the implantation of assessment schedules, it would be necessary to establish a universal definition of what is exposure to IPV in order to facilitate communications in the IPV research field. Definition of exposure to IPV should consider wide aspects, such as the type of the violence, the intensity, and the type of exposure. Moreover, a common taxonomy of the exposure to IPV among the studies is needed; future research should consider also the assessment of validity and reliability of several reporters (child, mother, clinician, etc.); finally, it is necessary using valid and reliable measures, considering all the time the principle of parsimony.

Large-scale research is needed to determine some issues about intervention protocols: the earliest time for effective intervention, the optimal intensity, the

necessary skill levels of interveners, the best method (e.g. group therapy versus individual), and settings (e.g., shelter, clinic, in-home). Longitudinal studies are needed about both long and short interventions along the developmental stages, as well as prospective longitudinal studies about early interventions. Future research should consider, also, intervention programs which currently exist (e.g. interventions for battered women and abuser men, or prevention programs against the IPV). These studies should consider different providers and participants, include several reporters, and assess the effectiveness of different approaches (Prinz & Feeric, 2003).

To finish with, there is paucity of studies which have considered the separate effect of the three type of abuse (physical, psychological, and sexual) on children. Psychological abuse against women is complicated to be separated from the physical abuse because the last one could be considered as an emotional harm, as well. Even so, psychological abuse can appear alone (Tolman, 1991), and the prevalence is high among battered women (Mechanic, Weaver, & Resick, 2008). Therefore, studies about the differential effects of the three types of IPV on children and adolescents are needed.

6. CONCLUSIONS

The manuscripts described above allow to draw the next conclusions regarding the exposure to IPV in children and adolescents:

- Detecting the presence of IPV and its outcomes on children and designing intervention protocols appear as a priority. The assessment schedule should contain information about: characteristics of the exposure to IPV, its aftermaths on the child's mental health and functioning, as well as mediator and moderator variables, such as the child's age and gender, other individual characteristics (emphasizing the resilience), family characteristics (maternal psychopathology, parenting styles), and characteristics of the social context (social support networks).

- Outpatient children who are exposed to IPV show specific needs regarding psychopathology, functioning, individual and family characteristics. They suffer more frequently than non-exposed children posttraumatic stress disorder and dysthymia. They display more externalizing dimensional psychopathology (e.g. breaking rules). Moreover, their functioning is impaired, mainly at home, and they are more likely to harm themselves. IPV seems to affect equally on girls and boys, although the child's sex may modify other variables related to the violent context such as the way their mothers rear them, the number of life events they have lived and how they appraise their physical health. Mothers of outpatients who have been exposed to IPV suffer from greater psychopathology. Both mother and father involved in IPV context control less their child's behaviour, and are more likely to display negative parenting styles.

- The child's psychopathology and functioning may differ depending upon characteristics of the IPV. Child's degree of involvement and child abuse appear as important predictors of psychological problems in exposed children, whereas types of violence against mother and child abuse are important predictors for the child's functioning impairment. The pattern of influence of IPV characteristics depends also on the disorder and the method of assessment and informant; combined mother-child reports in interviews and mothers' reports show that low awareness of the child is related with greater problems, whereas when the child is the reporter, direct exposure to IPV relates to negative outcomes. The involvement degree of the child in the IPV is associated with specific mental disorders and symptoms, although this psychopathology

affects in a similar way to the child's functioning. Regarding the type of violence toward the mother, the physical/sexual violence and the psychological abuse relate to different psychopathology and problems in the child, as well as the severity of this violence. Characteristics of the aggressor also affect differentially the child's psychological problems, being the psychopathic type the greatest contributor. Finally, the type of abuse toward the children is related to child's psychopathology and impairment; emotional deprivation is associated with internalizing and externalizing problems whereas active abuse against the child is related to impairment at home.

- The presence of psychological violence against the mother increases overprotection and rejection, and these increase at the same time the child's internalizing and externalizing problems and maladjustment, whereas maternal emotional warmth neither mediates nor moderates the effect of the psychological abuse on their children. Regarding the violent father, although psychological abuse against the mother is significantly associated with more rejection and less emotional warmth, this does not modify the effect of the violence against the mother.

The studies described above posit that IPV constitutes a great, complex risk factor which undermines the child's mental health and it seems to be an 'adversity package', where several factors are associated to the violence and enhance their harmful aftermaths. Efforts in order to improve the detection and the treatment of the effects of the IPV and its characteristics appear as a priority and a great challenge for several agencies and fields (mental health, social work, schools, legal system, and public agencies).

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8. ANNEX

Running head: ASSESSMENT SCHEDULE FOR DOMESTIC VIOLENCE

Assessment schedule for children and adolescents victims of domestic violence

Beatriz Olaya [1,2] (*)

Maria Jesús Tarragona [2]

Nuria de la Osa [1,2]

Lourdes Ezpeleta [1,2]

[1]Unitat d'Epidemiologia i de Diagnòstic en Psicopatologia del Desenvolupament

[2]Departament de Psicologia Clínica i de la Salut

Universitat Autònoma de Barcelona

(*) Address:

Beatriz Olaya Guzmán

Departament de Psicologia Clínica i de la Salut. Edifici B

Universitat Autònoma de Barcelona

08193 Bellaterra (Barcelona). SPAIN

Phone: (34) 935 812 883; FAX: (34) 932 745 776;

E-mail: Beatriz.Olaya@campus.uab.es

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Summary

The main psychological assessment areas in children and adolescents exposed to domestic violence are synthesized. Violence characteristics, their effects on children and adolescents' mental health and daily functioning as well as individual, familiar and social mediator variables are focused in the assessment process. The idea of considering children exposed to domestic violence in the assessment-intervention process is highlighted. Several instruments appropriated to assess each of the participant variables are provided.

Se sintetizan las áreas principales de evaluación psicológica en niños y adolescentes expuestos a violencia doméstica. Las características de la situación vivida (violencia doméstica), los efectos de la misma sobre la salud mental y el funcionamiento cotidiano de los niños y adolescentes y las variables mediadoras de carácter individual, familiar y social son objeto de atención en el proceso de evaluación. Se remarca la importancia de considerar a los niños expuestos a violencia doméstica en el proceso de evaluación y de intervención psicológica. Se proponen diferentes instrumentos apropiados para evaluar cada una de las variables intervinientes.

Key words: Domestic Violence; Assessment; Psychopathology; Mediator variables.

Assessment schedule for children and adolescents victims of domestic violence

Domestic violence refers to a pattern of coercive and aggressive behaviours in adults against their partner (Jouriles, McDonald, Norwood, and Ezell, 2001). Currently, it is one of the most important problems in our society. The Centro Reina Sofía para el estudio de la Violencia, (2007b) points out that the incidence of battered women in Spain from 2000 to 2004 increased to 153.74%. In 1996, there were 0.66 abused cases per thousand of woman, and this number increased to 3.07 in 2004. About 80% had been battered by her partner at home. The available statistics do not report how many children are exposed to this violence at home. From every million of women, 4 were killed by their partner in 2006; in this case, the statistics indicate that, at least, in the 10.14% of murders, the perpetrator killed his partner when the child was present (Centro Reina Sofía para el estudio de la Violencia, 2007a). It is estimated to decline that around 3.3 million of children annually witness physical and verbal violence between parents (Farnós & Sanmartín, 2005). In general population of school age, between 20 and 25% of children have witnessed their parents battering (McCloskey & Walker, 2000). Between 30 and 60% of the cases in which the woman is abused, children are abused, as well (Edleson, 1999).

The study of the variables involved in determining the emotional impact and/or the psychopathology in children and adolescents exposed to domestic violence is a great concern in the professional clinic practice. Difficulties to develop this type of studies are various. The first difficulty to deal with is the privacy and intimacy in which the violence takes place, as well as the biased information reported by the affected victims, who may live the violence at home with secrecy, fear, and feelings of shame and blame. This obstructs the obtaining of accurate indicators about the prevalence, characteristics, and consequences of the violence (Medina, 2002). The third difficulty is that in Spain there is paucity in instruments to assess adequately the violence, adapted to the Spanish context and validated by the scientific community. This affects the number of instruments developed to detect violent cases as well as the assessment of the risk and the possibility to prevent. It was estimated that more than 70% of cases of domestic violence are not detected (Siendones et al., 2002).

This work offers a range of assessment instruments which may be used to understand and assist the needs of children and adolescents victims of domestic violence. Whereas the society improves its acknowledge about the severity of the problem of domestic violence, the children's issue, who also live day by day the conflict with less resources to deal with it, is an ignored field. This review use an ecological view; it is necessary to assess different variables

involved in the context of domestic violence in order to understand the affected victims, and to emphasize the need to take into account the child's perspective.

ASSESSMENT OF THE CHILD IN A CONTEXT OF DOMESTIC VIOLENCE

Some authors advocate the desirability of not including the exposure to domestic violence within the label of abuse. First, they argue that this would increase dramatically the rates of child abuse and second, the definition about being witnesses of domestic violence is still now too much ambiguous (Edleson, 1999; Kerig & Fedorowicz, 1999; Magen, Conroy, Hess, Panciera, & Levi, 2001). Notwithstanding, others advocate the inclusion of domestic violence within child maltreatment, due to its association with psychological and behavioural problems in children (Wolfe, 1997). In the American households with domestic violence, children suffer from abuse or neglectful 15 times more than the national mean (Osofsky, 1995). The severity of violence between parents predicts the severity of maltreatment against the child (Bowker, Arbitell, & McFerron, 1988). Men who abuse their wives are more likely to abuse also their children (Straus, 1993). When the perpetrator is the father, the child learn that violence is a normal strategy to solve conflicts, which leads to the perpetuation of the violent cycle in the adulthood; when the perpetrator is the mother, some difficulties in the attachment and the emotional security in the child appear, as well as other problems, such as anxiety symptoms, depression and blame (Kerig & Fedorowicz, 1999). Moreover, children who are exposed to domestic violence between parents and also suffer from abuse show greater levels of adaptation problems compared with children who do not suffer abuse.

There are an increased number of studies that show the negative aftermaths of the domestic violence in the child development, such as internalizing and externalizing problems, difficulties in the social relationships, use of aggressive strategies to solve problems (Magen, 1999) or a decrease in the school performance and in the empathic ability (Rossman, 1998).

The fact that exposure to domestic violence increases both the risk for being victim of abuse and the risk for showing psychological problems justifies the follow planning: 1) an assessment schedule to detect promptly any situation described above in order to prevent both problems, and 2) an intervention schedule focused on the children and adolescents exposed to domestic violence with the aim of treating specific problems both in the mental health and the legal field.

When a child is exposed to domestic violence it is necessary to assess: 1) the characteristics of the exposure; 2) the effects of the exposure to domestic violence on the mental health of the child and on his or her daily functioning; and 3) the mediating and buffering factors between the exposure and its consequences, which may be present in the child (individual characteristics) as well as in the family environment.

1. Assessment of the characteristics of the exposure

The detection of a child who are exposed to domestic violence may be reached by different ways; one of the most common way is when the mother goes to consultation and reveals the violent situation. The problem also can be known because a professional, such as the paediatrician or the teacher, has detected it, or because the child reported it. However, the mother is the person who mainly reports the information about exposure. The Observatorio de la Salud de la Mujer de la Escuela Andaluza de Salud Pública (2005) developed an excellent review of instruments to screen and diagnose physical, psychological, and sexual abuse and the violent pattern against women. However, when a child is living in a violent home, some specific questions about the exposure should be known and assessed from the child's perspective. Despite the importance of the information provided by the child, most studies about child maltreatment in general, and exposure to domestic violence in particular, do not include it in the assessment process. Studies hardly ever consider the family context through the perception of the child. The model of Davies and Cummings (1994) advocates the importance of the child's perception, because the significance and implications which a child attributes to the violence influence in how he or she reacts to it. The social silence about domestic violence, the paucity of adequate instruments for the cognitive level of the child and the ethic considerations about assessing the violence directly with the child are common reasons to avoid the assessment with the child. Moreover, both institutions for assisting abused women and for the child's welfare usually ignore the assessment of the exposure to domestic violence in children and adolescents, despite the fact that its presence disrupts the interventions (Shepard & Raschick, 1999). The result is that children exposed to domestic violence become, as called by Osofsky (1995), the *invisible victims*.

There is a growing recognition of the need to understand how the characteristics of the violence affect the psychological adaptation of the child, including the type, severity, frequency, chronicity, and the initial age, the relation with the aggressor, the number of aggressors, or the overlap between different types of violence (Kinard, 2004). The different

types of abuse and neglectful have been related to different types of difficulties in the child (Manly, Cicchetti, & Barnett, 1994). However, the availability of assessment protocols for the domestic violence focused both on mother and children and assessing directly the violence is poor.

In the U.S., some programs begin to be provided for professionals who work with the child protection, and they include trainning in the use of screening instruments for domestic violence. Screening instruments should be brief, include few sharp questions, be easily integrated into the regular practice of professionals, allow a good rapport with the mothers, be adapted culturally to the reporter and be helpful for the research. In general, screening instruments about child maltreatment show high sensibility but low specificity, leading an increase of false positives. Therefore, some authors point out that the use of them may cause some problems, such as punitive attitudes towards the family, wrong labels, or stress and tension within the family. However, if the child maltreatment or domestic violence is not detected, the negative consequences may increase, both for the mother and the child (Magen, et al. 2001).

It is important to bear in mind that the information about possible abuses or exposure to domestic violence might be affected by social desirability, unreal expectancies and erroneous attributions of the mother (Stowman & Donohue, 2005). Therefore, it would be necessary to include desirability social scales in the development of instruments. The *Domestic Violence Questionnaire* (Task Force on Family Violence, 1993) is an example of screening questionnaire for health professionals and it assesses through the mother questions such as the type of exposure of the child and the actions she made against the violence. The *Child Abuse Potential Inventory* (Milner, 1986) is a self-report for parents validated in Spanish population (Arruabarrena & de Paúl, 1992) to detect behaviours indicative of abuse towards the children. The *Conflict Tactics Scale* (Straus, Hamby, Finkelhor, Moore, & Runyan, 1998) includes versions for parents and children with the aim of detecting neglectful, sexual abuse, physical and psychological assault, and non violent disciplines. It is one of the most used instruments in the U.S.

One of the questions raised from the direct assessment of the child is the need to adequate the type of instrument to his or her developmental stage, considering the cognitive and linguistic abilities. The *Violence Exposure Scale for Children* preschool version (Fox & Leavitt, 1995) includes cartoons to describe each event, allowing the child from 4 to 10 years to identify himself or herself with the character of the story. The child is asked about if he or

she has been exposed or direct victim to some of the described physical violent acts, and it rates the frequency of the event, the person who was with the child when it happened and the moment and place where it took place. It also includes a parents' version. The *Children's Perception of Interparental Conflict Scale* (Grych, Seid, & Fincham, 1992) assesses the perception of children aged 9 to 12 about marital conflict (frequency, intensity, type of resolution and satisfaction, and the appraisal about the conflict). The *Juvenile Victimization Questionnaire* (Hamby, Finkelhor, Ormrod, & Turner, 2004), allows to know the victimisation story of children from 8 years (the caregiver's version is for children under 8). The authors consider that the presence of one type of maltreatment or victimization increases the risk for suffering other type of maltreatment, which they called 'poly-victimization' (Finkelhor, Ormrod, Turner, & Hamby, 2005). It has two formats, self-report and interview, and it allows to detect 34 offensive acts against children (including maltreatment and exposure to domestic violence). Once the victimization is detected, the child is asked about further details of what happened, such as the frequency of the events, injuries, hospitalizations, and information about the perpetrator.

One of the most global codification systems in the study of the taxonomy of the violence was proposed by Barnet, Manly, and Cicchetti (1993) provided for professionals of the Child Protective Services. It includes frequency, chronicity, number of perpetrators, developmental stage in which it took place, and story of separations from the main caregivers. The Barnet et al. proposal was initially thought for the study of abused children. However, until now no study has used this measure with children of battered women. A second system to codify dimensionally the experience of abuse in children is the *Record of Maltreatment Experiences* (McGee, Wolfe, & Wilson, 1990), designed to obtain a global assessment of the victimization story of the child. It assesses frequency and severity in three developmental stages. It allows us to assess the exposure to domestic violence independently from other maltreatment forms, which makes it appropriate for these studies. In Spain, the *Domestic Violence Schedule* (Unitat d'Epidemiologia i de Diagnòstic, 2006) was designed specifically for the study of the consequences of the exposure to domestic violence in the child's mental health. It takes into account the number of aggressors the child has been exposed to and their relation, the characteristics of the aggressor and his current age, type of exposure, the explanation the mother gives to the child about the violence, type of violence and severity, injuries against the mother, required assistance after a violent event, frequency of the maltreatment, age of the child in the beginning and the end of the violence, last experienced episode, violence escalation, maternal role in the assault and solve of the

conflict, and type of direct maltreatment against the child. One of the advantages of this schedule is that the evaluator should combine information about the mother and the child, as well as include information about the characteristics of the aggressor, who is usually ignored in the assessment of domestic violence. The schedule allows to obtain a summary and consensus about the collection of information by professionals regarding the child maltreatment and the exposure to domestic violence, including the psychological type, which is the less evident.

2. Assessment of the effects of exposure to domestic violence

Conditions typically associated with maltreatment, including domestic violence, disrupt the normal development along the childhood and lead the child in a great risk to develop psychopathology (Cicchetti & Toth, 1997). In order to know the psychological consequences of the domestic violence in the children, it is important to assess their cognitive, emotional, and behavioural state (Osofsky, 1999). The disruptions they have vary according to the developmental stage.

Among preschoolers, exposure to domestic violence is associated with excessive irritability, regression in the language and the sphincters control, sleeping problems (insomnia, sleepwalk), separation anxiety, difficulties in the normal development of the self-confidence and later exploration behaviours, related all them with the child's autonomy (Osofsky, 1999). Symptoms of posttraumatic stress disorder (PTSD), such as re-experiencing repeatedly the traumatic event, and an increase in the 'arousal', are also present in the youngest children. In the preschool stage, the information usually comes from the mother or other significant adults. The *Child Behaviour Checklist* (CBCL1½-5 and TRF1½-5; Achenbach & Rescorla, 2001a), rated by mothers or teachers, allows to obtain a general symptom profile for the emotional and behavioural problems in young children. The questionnaire *Interactive Gabi* (Spanish adaptation of *Dominic Interactive*; Valla, Bergeron, & Smolla, 2000) is a screening self-report of clinic symptoms for children from 6 to 11. It is based on an audiovisual format with cartoons about a boy or a girl named Gabi. Each item describes what happens to the character and the child should answer if the situation also happens to him or her. Eight scales are assessed (specific phobias, separation anxiety, generalized anxiety, depression/dystimia, defiance, conduct problems, attention deficit/hyperactivity, and abilities/strengths).

School children show anxiety symptoms, depression, aggressive behaviours, posttraumatic stress, and other related problems such as sleeping, concentrating problems and difficulties for coping with their peculiar environment. Their attitudes, social competence, and school functioning are also affected, and as they grow up, they are more likely to show school failure, commit vandalism, and display psychopathology, including substance abuse (Osofsky, 1999). Adolescents exposed to domestic violence are more likely to be involved in criminal acts (Fagan, 2003) and they tend to justify the use of violence within love relations (Lichter & McCloskey, 2004). Structured diagnostic interview with the mother and the child separately will provide the most relevant clinical information. There are two interviews adapted to Spanish population. The *Diagnostic Interview for Children and Adolescents* (Reich, 2000; Entrevista Diagnóstica para Niños y Adolescentes; De la Osa, Ezpeleta, Doménech, Navarro, & Losilla, 1997; Ezpeleta et al., 1997) and the *Children's Inteview for Psychiatric Syndromes* (Weller, Weller, Rooney, & Fridstad, 1999), adapted by Molina, Zaldívar, Gómez, and Moreno (2006), diagnose based on DSM-IV criteria (APA, 2001). Both are appropriate for children from 8 to 18. The dimensional questionnaires, such as the *Child Behaviour Checklist* (CBCL 6-18) or the *Youth Self Report* (YSR 11-18) (Achenbach & Rescorla, 2001b) are a good complement to assess dimensionally general psychopathology.

Sometimes, the use of more specific instruments is interesting. 20% of children exposed to domestic violence have the diagnostic of PTSD, and the risk is greater when the children are direct witnesses of the parental violence or are victims of abuse (National Council of Juvenile and Family Court Judges, 1993). The *Trauma Symptom Checklist for Children and Young Children* (Briere, 1996), is a self-report for children from 10 to 17, which assesses the symptoms of PTSD and the psychopathology associated to the traumatic event, such as being a witnesses of violence against the mother. The parents and caregivers version reports this information of children aged 3 to 12 (Briere et al., 2001). Likewise, collecting information about depressive and anxiety symptoms may be useful in order to have measures of the change in intervention programs with exposed children. The *Children's Depression Inventory* (Kovacs, 1992), adapted by Del Barrio, Moreno, and López (2000), is a 27 item self-report to assess depressive symptoms in children aged from 8 to 17. For preschool children, it is necessary to use questionnaires for parents, such as the *Preschool Children Depression Checklist* (Levi, Sogos, Mazzei, & Paolesse, 2001) for children from 2 to 14 years old. Its 39 items assess three dimensions: lack of vitality, trend to isolation and aggression. The *Manifest Anxiety Revised Scale* (Reynolds & Richmond, 1978), adapted by

Sosa, Capafons and López (1990), is a 53 item measure of the anxiety level in children from 6 to 19. It has three scales: physiological anxiety, inquietude/hyperactivity, and social concerns.

The cognitive development of the exposed child may be also affected. It has been demonstrated that there is a negative correlation between domestic violence and the general cognitive development. Koenen, Moffitt, Caspi, Taylor, and Purcell (2003) found that children exposed to domestic violence showed IQ scores 8 points lower than non exposed children. The instruments to assess the cognitive development are not listed due to they are well-known by professionals.

Abused children display a deficit in their self-concept and low self-esteem (Bolger, 1997) which is related to adaptation problems, such as anxiety, depression, and behavioural problems. Moreover, the self-esteem mediates the impact of the quality of the mother-child interaction on the child's functioning (Kim & Cicchetti, 2004). The questionnaire *AC* [Self-concept] (Martorell, Aloy, Gómez, & Silva, 1993) assesses the self-concept of children and adolescents in different environments. On the other hand, the *Self-esteem Scale* (Rosenberg, 1965) assesses the positive and negative self-image of children and adolescents with 10 items. This instrument is adapted to Spanish population (Vázquez, Jiménez, & Vázquez, 2004).

The presence of clinic symptomatology in children of battered women causes a number of difficulties in different areas of the daily life of the child. The *Child and Adolescent Functional Assessment Scale* (Hodges, 1995) and the *Preschool and Early Childhood Functional Assessment Scale* (Hodges, 1999) assess the functioning level in 8 areas (role performance at home, in the school and in the community, cognition, behaviour toward others, mood and emotions, and use of substances) in the diverse developmental stages. The scales must be completed by clinicians who have information about the case (Ezpeleta, Granero, de la Osa, Doménech, & Bonillo, 2006).

3. Assessment of the mediator variables

3.1. Individual characteristics

During the assessment process of the effects of exposure to domestic violence, the child's resilience should not be forgotten. The resilience can be defined as the ability of the child to adapt properly to his or her environment despite the serious threat against his or her development. Some of the crucial protective factors in the exposure to violence are having an adult caregiver, community guard, and the individual characteristics of the child. Among the

characteristics of the child which help to develop a resistance, are a good intellectual ability, the self-esteem, individual talents, religious affiliations, having a good socioeconomic situation and a sufficiently warmth social network (Osofsky, 1999). Social competences are other possible protective factors in the domestic violence context. The *Socialisation Schedule*, with versions for both parents and teachers of children from 6 to 15 (Silva & Martorell, 1983) and a self-report version for adolescents from 11 to 19 (Silva & Martorell, 1995), is formed by 75 items divided into four scales about social helping aspects (leadership, joviality, social sensitivity, and respect/self-control) and three scales about disturbing aspects (aggression-stubbornness, apathy-retreat, anxiety-shyness). It also assesses the global appreciation of the social adaptation degree. The *Interpersonal Difficulty Scale for Adolescents* (Méndez, Inglés, & Hidalgo, 2001) is a self-report to obtain in a grid format the ability of young to perform in 4 functioning areas (friends, family, school, and community) with different person-stimulus (peers, parents, teachers, group of persons, etc.). The *Assertive Behavior Scale* (Wood, Michelson, & Flynn, 1978) classifies children as aggressive, inhibited, and assertive. It has 27 items and it was adapted to school children from 6 to 12 by De la Peña, Hernández, and Rodríguez (2003).

Children who are exposed to different abusive situations, such as being witnesses of domestic violence, show wrong coping strategies in later stages (unrealistic thinking, problem avoidance, social retreat, and self-critic behaviour) (Leitenberg, Gibson, & Novy, 2004), and they tend to use aggressive strategies with peers and verbal aggression with teachers (Lisboa, Koller, & Ribas, 2002). The *Self-Report Coping Measure* (Causey & Dubow, 1992) is a self-report for children 9 to 12 years old which assesses coping strategies (seeking social support, solving problems, and avoiding strategies: distancing, externalizing an internalizing problems). The *Coping Scales for Adolescents* (Frydenberg & Lewis, 1996) assesses three type of coping: productive (oriented scales to solve problems while the adolescent keeps physically good and socially connected), no productive (avoiding strategies), and oriented to others (seek help in the others).

3.2. Assessment of the family and social context

The study of the consequences of domestic violence in children requires understanding the violence problem as more than a single event between two subjects. Despite the strong association between witnessing domestic violence and the emergence of problems in children, the impact of this event varies widely (Lieberman, van Horn, & Ozer, 2005). As discussed above, this depends on the personal characteristics of both the child and

the mother, and also on the characteristics of the violence. Therefore, knowing the family situation in the widest sense, the community environment in where the child is growing up, and the particularities of the violent act may lead both to detect and improve the ability of the child to cope with the problem or contrary, to increase the negative consequences (Carter, Weithorn, & Berhman, 1999). Due to the high and demonstrated association between domestic violence and child maltreatment, the contextual risk factors involved for the last should be addressed in the assessment.

According to Cook (2005), the best way to assess the family seems to be the use of items regarding pair relationships, and also through a circular evaluation in which each member of the family can assess other members; parents to children, children to siblings, and vice versa. The use of instruments with parallel versions for the different members of the family would be the techniques of choice.

Poverty, living in a single-parent family and the educational level of parents are factors which increase the risk for domestic violence (Carter et al., 1999). Besides, economic dependence and presence of young children explain, in part, the prolong coexistence between the victim and the aggressor (Echeburúa, Amor, & de Corral, 2002). The *Kemple Family Stress Inventory* (Korfmacher, 2000) is a brief appreciation scale to assess the parental risk for difficulties in the educational practices. It is based on the presence of different psychosocial situations, such as past story of believes or maltreatment of the parents, story of drugs and alcohol intake, mental disorders or legal difficulties, emotional functioning, unwanted pregnancy, perceptions and attitudes towards the child, and parenting stress. Data on its validity suggests that there is an association between the instrument scores and an increase in the rates of abuse, abuse risk, and educational difficulties. According to the authors, the instrument should be use as a part of a larger schedule.

The consequences of the violence may lead the children to live losses and frequent undesirable relocations, separations, death or incarceration of parents, changes of household, city and friends, or economical hardship. The literature reiterates the fact that developmental outcomes are better predicted by the accumulation of risk factors rather than a single status (Sameroff, 2000). It is important to know how many and what kind of changes exist, and the perceived outcomes by the child. A good election is the lists of stressful life events which incorporate the assessment of the impact on the child's life. One example is the *Life Event Checklist* (Johnson & McCutcheon, 1980).

Psychological reactions to the traumatic violence are more or less intense depending on the available social support and specially, on the perception of the child (Osofsky, 1997).

The presence of a competent adult and a strong relation with him or her is a greater protective factor in the adversity context. However, in the domestic violence case, parents, who are normally the main support to the child providing protection, security, and care, are less available when they are victims of violence. Besides the direct impact of the violence, exposed children live the indirect impact due to the maternal stress and psychopathology, or the poor communication with her which undermines the quality of the emotional availability of the mother (Huth-Bocks, Levendosky, & Semel, 2001). Labrador, Rincón, De Luís and Fernández (2004) posit out that the prevalence of PTSD among abused women is between 55 and the 84%, and they also suffer from anxiety and depressive disorders, tranquilizer and alcohol intake (Echeburúa, Amor, & de Corral, 2004). Therefore, the assessment of maternal mental health is an essential point in the assessment schedule. The clinical exploration should include a structured diagnostic interview to assess thoroughly the presence of psychopathology. The *Structured Clinical Interview (SCID)* (*SCID-I*; First, Spitzer, Gibbon, & Williams, 1997; *SCID-II;* First, Gibbon, Spitzer, Williams, & Smith, 1997) would be an adequate option, and it has been adapted to Spanish population by Torrens, Serrano, Astals, Pérez and Martín (2004). The *Severity Scale of PTSD Symptoms* (Echeburúa & de Corral, 2002), or the *Beck Depression Inventory* (Beck & Steer, 1993) would be also adequate instruments to assess the presence and severity of the most frequent disorders.

The assessment of the hazardousness of the aggressor should be considered in the violence context. It is necessary to know the potential danger in which a victim is living. De Luis (2004) developed the *Interview for the Assessment of the Hazardousness,* which includes questions about the characteristics of the threat through a descriptive profile of the aggressor, the aggressive dynamics, the victim's situation, and her coping sources.

Some of the studied consequences in abused women are the fact that they may think they are unable to look after their children (Matud et al., 2004). Children may also feel the same, and they may not understand why their mothers do not protect them in their homes. Therefore, the child perception about the 'capability' of their caregivers to provide support and care should be assessed. The *Perceived Parental Support* (Stice, Barrera, & Chassin, 1993) is a self-report for adolescents to rate the perception about the received support from their parents regarding the affect, partnership, help, admiration expression, and intimacy. It has been related to the presence of anxiety and depression in risk situations. It is formed only by 6 items answered separately for both parents.

The family relations are known as relevant for the child development. In this sense, the fraternal relations are more perdurable in the time and in all the contexts. Tucker,

McHale, and Crouter (2001) posited that both younger and older siblings are perceived as a support sources when a child has to face family difficulties, especially in adolescence and regarding the personal adaptation (Branje, Lieshout, van Aken, & Haselager, 2004). This would be the case of domestic violence. The questionnaire *Relational Support Inventory* (Scholte, Cornelis, van Lieshout, & van Aken, 2001) provides information about tmother, father, siblings, and close friends and the quality of the communication, respect for the child's autonomy, emotional support, convergence in the aims, and acceptance of the child. It is applicable to children from 12 to 18.

Domestic violence is usually hidden behind implicit or explicit pacts of silence. Children live the event with shame and as a something that must be secretly kept. The denial and concealment are a constant rather than an exception. This undermines the likelihood to express, share, and seek help. The interpersonal style of aggressors might be also dysfunctional and prevent the implication of the child in wider social nets. It is important to know the ability of the child to communicate and participate in wider social nets different from the family. In this case, friends would be the closer social net of the child. Some studies about child maltreatment report isolation and restriction to the social contact with other children (Lynch & Cicchetti, 1991) which leads to a high risk for difficulties with peers. The 41 item self-report *Friendship Quality Questionnaire* (Parker & Asher, 1991) has been used in this field. It explores the peer relationships in 6 dimensions: care, conflict resolutions, betrayal, help and advice, fun, companionship, and intimacy.

The quality of the mother-child relationship is a mediator in the presence of conduct problems in children who are exposed to domestic violence (Levendosky, Huth-Bocks, Shapiro, & Semel, 2003). Mothers who are abused by their partners are more likely to be impulsive, use more punitive strategies with the child and show more aggression towards them (Osofsky, 1998). Moreover, studies about the educational style of the aggressive father show that they are less accessible for their children, are less involved in conversations with them, and less affective. Parental practices based on emotional warmth and respect for the child's autonomy seem to be less correlated with high scores in maladjustment (Barnes, Farrel, & Banerjee, 1994; Stice & Barrera, 1995). The most frequent scales usually include dimensions about emotional warmth, hostility, respect for the autonomy of the child, and the establishment of patterns and limits (Scholte et al., 2001). Among these scales, there is the *Parental Bonding Instrument* (Parker, Tupling, & Brown, 1979), which includes scales to assess care, overprotection and authority; the *Parental Discipline Practice Scales* (Goodman

et al., 1998) assesses discipline practices of parents and it distinguishes between non punitive discipline and physical punishment; and the *EMBU* (*Inventory for Assessing Memories of Parental Rearing Behaviour;* Perris, Jacobson, Lindström, Knorring, & Perris, 1980), adapted to Spanish population by Castro, Toro, Van der Ende, and Arrindell (1993), assesses separately the child's perception about the parenting style of the mother and the father in four dimensions: rejection, overprotection, emotional warmth, and favouritism. There are similar versions for adolescents and parents.

The supervision degree of the family might be affected when the mother is involved in abusive situations. Her emotional blockade, on one hand, and the consumption of time to seek solutions and resources, on the other, may undermine her knowledge about the activities and feelings of her children. The *Parental Monitoring Scale* (Goodman et al., 1998) provides a measure about the degree in which the caregivers control and supervise the child's behaviours. The inclusion of assessment schedules regarding the openness among parents and children, the frequency they speak about the plans of the child in the school, or the presence of secrets or complicity among them provides a measure of the communication quality (Stattin & Kerr, 2000).

The concept of 'expressed emotion' refers to the affective attitudes and behaviours, and it is related to the quality of the emotional climate between one member and another with a mental health problem. Abused women live under a repeated stressful situation which may increase the risk of maltreatment to their children, either physically or psychologically. The way they express emotion in their relation with the child can include critics and complaints about the other person (negative affectivity) (Cook & Kenny, 2004), or contrary, include approval and compliment (positive affectivity). The hostility, the critic attitude or the emotional over-implication are the most studied aspects by the different available instruments (Humbeeck et al., 2002). *Camberwell Family Interview* (Rutter & Brown, 1966) is one of the most used instruments, and it is the origin of different scales subsequently developed.

Acceptance and expectancy of certain cultural and social groups about the predominant male pattern, as well as the justification of certain aggressive and dominate attitudes towards women, can undermine the study of domestic violence, minimize its effects, or deny its existence. It is important to know that what is tolerated or justified is determinant in order to intervene. Positive attitude towards the male dominance, encouraged by a patriarchal culture, increases the acceptance and the frequency of the physical abuse and the subjection from the man towards the women. Different tolerance threshold of the violence might cause that certain forms of abuse are not consider as an abuse, and therefore, the lack

of public recognition is maintained. One of the way in which the domestic violence affects children and becomes psychological violence is the modelling of violent and misogynous behaviours that are considered as normal and are reproduced later in adulthood. The *Abuse Attitude Form* (Faramarzi, Esmailzadeh, & Mosavi, 2005) has 10 items to assess the tolerance of the women about certain behaviours of the partner which may be the origin of domestic violence. This instrument, which does not provide a child version and is not adapted to Spain, addresses one of the interest areas of assessment in domestic violence, such as the possibility to reproduce in the future behaviours that they are suffering previously.

INSERT TABLE 1

GUIDELINES FOR THE ASSESSMENT

Throughout this review, different instruments have been list, some of them with no adaptation to Spanish population. Table 1 summarises the proposal for an assessment schedule of children exposed to domestic violence, considering the informant and the assessed areas. One immediate recommendation raised from this work is the need to adapt and/or develop adequate instruments for the psychological assessment of women and children in our context. Hamby and Finkelhor (2000) listed some guidelines to assess and develop instruments for children who are victims of different types of abuses and assaults (Table 2), as a complement for the proposal. As discussed above, domestic violence is a type of psychological abuse which may occur with other types of abuse against the child (for example, physical abuse, other forms of psychological abuse, and/or neglectful). In this regard, recommendations of these authors are applicable to exposed children. As a summary, one part of these recommendations refers to the classification of the aggressive event, which circumscribes the content of the questions that must be done, and other part refers to general questions about the formulation of the contents when assessing a child. Finally, they offer ethic advices. Some of the indications are especially relevant to the domestic violence situation. Some examples are: when assessing the victimization through the family is important to bear in mind that this information may be under-rated; it is important to include offensive related to the dependence of the child, such as neglectful or sexual abuse; it is important to collect self-reports of the child from 7 years old, which are usually ignored in the assessment process; and finally, consider the information provided by the mother.

As this authors posit, ‘many areas of study have grown considerably thanks to the development of assessment instruments which are well-designed and reliable’ (p. 838). At

present, the domestic violence issue and, specifically, its impact on children, need to grow in this direction.

Insert Table 2

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Table 1. Assessment Schedule for children and adolescents exposed to domestic violence.

Variables	Instrument	Informant	Assessed area
Exposure to domestic violence and maltreatment	*Domestic Violence Questionnaire* (Task Force on Family Violence, 1993)	Mother	Type of exposure to violence and actions the mother takes.
	**Child Abuse Potential Inventory* (Milner, 1988)	Mother	Screening of behaviours indicative of abuse towards the children.
	Violence Exposure Scale for Children (Fox y Leavitt, 1995)	Children 4-10	Exposure or victimisation of physical violence. Visual format.
	Children's Perception of Interparental Conflict Scale (Grynch et al., 1992)	Children 9-12	Perceptions of the child about marital conflict.
	Juvenile Victimisation Questionnaire (Hamby et al., 2004)	Mother of children < 8 Children > 8	Victimisation story. It includes maltreatment and exposure to domestic violence.
	Record of Maltreatment Experiences (McGee, Wolfe, and Wilson, 1990)	Professional	Victimisation story in three developmental stages. It includes violence against mother.
	**Domestic Violence Schedule* (UED, 2006).	Professional	Characteristics of the domestic violence.
Psychological effects	*Child Behaviour Checklist* $1^{1/2}$*-5* (Achenbach and Rescorla, 2001a)	Mother of children $1^{1/2}$ - 5.	General profile of symptomatology of behavioural and emotional problems.
	Dominic Interactivo (Valla et al., 2000)	Children 6-11	Trend in psychopathology.
	**Diagnostic Interview for Children and Adolescents* (Reich, 2000).	Caregivers and children 8-18	DSM-IV diagnosis (APA, 2001).
	Youth Self Report (Achenbach and Rescorla, 2001b)	Adolescents 11-18	General profile of symptomatology of behavioural and emotional problems.
• **PTSD**	*Trauma Symptom Checklist for Children and Young Children* (Briere, 1996).	Children 10-17 Caregivers of children 3-12	Stress posttraumatic symptoms and associated psychopathology.
• **Depression**	**Children's Depression Inventory* (Kovacs, 1992)	Children 8-17	Depressive symptomatology.
	Preschool Children Depression Checklist (Levi et al., 2001)	Mother of children 2-4.	Depressive symptoms.
• **Anxiety**	**Escala Revisada de Ansiedad Manifiesta* (Reynolds and Richmond, 1978)	Children 6-18.	Anxiety symtomatology.
• **Cognitive ability**	Escalas de Desarrollo y Nivel Cognitivo		
• **Self-esteem**	**Cuestionario AC* (Martorell et al., 1993)	Children & adolescents	Self-concept.
	**Escala de Autoestima* (Rosenberg, 1965)	Children & adolescents	Self-concept.
Psychosocial functioning	*Child and Adolescent Functional Assessment Scale* (Hodges, 1995)	Clinician	Daily functioning in eight areas.
	Preschool and Early Childhood Functional Assessment Scale (Hodges, 1999)		
	**Socialitation Schedule* (Silva and Martorell, 1983; 1995)	Caregivers/teachers of children 6-15. Adolescents 11-19.	Social aspects which are facilitator or disturbing.
Social Competence	**Interpersonal Difficulty Scale for Adolescents* (Méndez et al., 2001)	Adolescents	Social ability in four functioning areas.
	**Assertive Behaviour Scale* (Word et al., 1978)	Children 6-12	Assertive, inhibited, and aggressive behaviours.

Coping Strategies	*Self-Report Coping Measure* (Causey and Dubow, 1992) *Coping Scales for Adolescents* (Frydenberg and Lewis, 1996)	Children 9-12 Adolescents	Coping strategies.
Family context	*Kemple Family Stress Inventory* (Korfmacher, 2000)	Mother	Difficulties in the education.
• **Family support**	*Perceived Parental Support* (Stice et al., 1993)	Adolescents	Support provided from the parents.
	Relational Support Inventory (Scholte et al., 2001)	Adolescents 12-18	Support and communication with parents, siblings, and friends.
• **Parenting styles**	*Parental Bonding Instrument* (Parker et al., 1979)	Mother	Care, overprotection and authority.
	Parental Discipline Practice Scales (Goodman et al., 1998)	Mother	Non punitive and punishment discipline practices.
	**EMBU Inventory for Assessing Memories of Parental Rearing Behaviour* (Perris et al., 1983)	Adolescents and parents of children < 12.	Parenting styles.
• **Supervision**	*Parental Monitoring Scale* (Goodman et al., 1998)	Mother or caregivers	Supervision and control to the child's behaviour.
• **Expressed emotionality**	*Camberwell Family Interview* (Rutter and Brown, 1966),	Mother	Positive or negative affectivity in the mother-child relationships.
Social context	*Friendship Quality Questionnaire* (Parker and Asher, 1991)	Children	Frienships.
Stressful life events	*Life Event Checklist* (Johnson and McCutcheon, 1980)	Children	Stressful events along the child's life.
Maternal mental health	SCID-I and SCID-II (First et al., 1997)	Mother	DSM-IV diagnosis axis I and II (APA, 2001).
	SCL-90-R (Derogatis, 1994)	Madre	Psychopathological symptoms.

*Instrument developed or adapted in Spain.

Table 2. Guidelines for the Assessment and Development of Instruments for children who are victims of different types of abuses and assaults (Hamby and Finkelhor, 2000).

- To place the child's victimisation within the conventional categories of criminal actions.
- To include the non-violent victimisation.
- To place the victimisation among the categories of offenses which are controlled by the protection system of the child.
- To broaden the assessment context to issues which go beyond the criminal activities.
- To assess the victimisation through the family and other non estrange perpetrator.
- To include offenses which are specific to the dependence situation of the child.
- To establish methods in order to compare the victimisation of young and adults.
- To use specific questions about behaviours rather than general questions.
- To use an easy vocabulary.
- To use a comprehensive grammar and syntaxes.
- To collect self-reports from the child from 7 years old.
- To use the information provided by the caregivers when necessary.
- To protect the privacy along the assessment.
- To use audio-computered technology.
- To collect information about events which have occurred in a period of one year.
- To consider possible differences regarding the ethnic, class, and gender of the informants.
- To use life events of the informants in order to help to limit the memory.
- To use simple concepts of time and number.
- To offer items to practice.
- To be prepared to help the children who are at risk.