MEDIATING FACTORS AFFECTING

PSYCHOSOCIAL WELLNESS FOR WOMEN

EXPOSED TO INTIMATE PARTNER VIOLENCE IN CHILDHOOD

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By

Billie Jo Heather Carter

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Head of the Department of Educational Psychology and Special Education
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ABSTRACT

The purpose of the study was to investigate the long-term implications of childhood exposure to physical intimate partner violence on women's social and psychological functioning in adulthood. To address one of the challenges associated with previous research in this area, the present study employed a multi-component conception of social and psychological well-being, referred to as psychosocial wellness. The present study also explored the influence of two key factors potentially mediating outcomes for women exposed to intimate partner violence in childhood: stage of development at the time of exposure and the experience of childhood physical abuse.

Participants included 262 female young adults from undergraduate university classes (Mean Age = 21 years), who completed the Conflict Tactic Scale - 2, the Satisfaction with Life Scale, the Social Avoidance and Distress Scale, and the Trauma Symptom Checklist. The findings indicated that females exposed to intimate partner violence demonstrated higher levels of trauma symptoms, t (-2.53), p = .012; and significantly lower scores on satisfaction with life t (-3.18), p = .002. Furthermore, females who had been both exposed and abused during childhood reported increased trauma symptoms, $F(1,1740.34) = 14.40, p = .000$, social avoidance and distress, $F(1,1740.34) = 14.40, p = .000$, and satisfaction with life, $F(1,426.05) = 8.40, p = .004$.

The findings of this study suggest that exposure to physical intimate partner violence in childhood has an impact on women's social and psychological functioning in adulthood. Furthermore, the results suggest that women's outcomes on internalized domains of functioning may be attributable to the co-occurrence of mediating factors.
such as childhood physical abuse. The strengths and limitations of the present study are outlined, followed by implications for future research and practice.
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CHAPTER 1: INTRODUCTION

1.1 Introduction

Violence against women by intimate male partners is evident in records dating back to the Roman Empire (Dobash & Dobash, 1979), yet sustained public concern for battered women has only emerged within the past three decades. From a historical perspective, innovative domestic violence services within Canada have developed dramatically in the past thirty years, with the first North American shelters for abused women opening their doors in the 1970s. However, it was only twenty years ago that the issue of domestic violence was first raised in the halls of Canada’s parliament by MP Margaret Mitchell to an echoing response of chorus calls, inappropriate comments, and laughter (Jaffe, Baker, & Cunningham, 2004). Since that introduction, the laughter has been silenced and replaced with a clear understanding from all levels of government, as well as the general public, that domestic violence represents a serious criminal and social problem across our nation.

In more recent years, there has been an increasing focus on the plight of children exposed to violence between adult intimate partners. Major conferences and publications within the past decade have documented the impact of domestic violence on children’s emotional, cognitive, and behavioral adjustment during different stages of development (e.g., Jaffe, Wolfe, & Wilson, 1990; Baker & Cunningham, 2005; Kashani & Allan, 1998). This emphasis on children’s issues was reflected in a speech from the throne by the Ontario government in May 2002, which included the following:
Every year, thousands of children see violence in their houses. These children are at risk and often continue a legacy of family violence themselves. Your government will continue to help children who are trapped in violent family situations. (Jaffe et al., 2004, p. 4)

While tremendous progress has been made on issues related to domestic violence within Canada over the past three decades, much remains to be accomplished, particularly with respect to the well-being of children who are exposed to violence between adult intimate partners. Each day children across Canada who have been exposed to violence come into contact with educators, social workers, shelter staff, public health officials, health care providers, and police officers. Consider the following illustration:

Twelve-year-old Charity has fallen asleep in school again. Her teacher sends her to the principal who asks if anything is wrong at home. Charity weighs her options. Sometimes she imagines living in another family. Her father is strict and all five children must follow the rules or they are punished. Even her mother sometimes breaks the rules and her father has to punish her, so she will learn to do better. Last night, Charity was too slow coming to the table for dinner. She was hit with a belt and sent to her room with nothing to eat. When her mother protested, her father turned on her. Charity later heard her mother crying in the next room and forced herself to stay awake as long as she could, to send her love to her through the wall. It wasn’t fair what happened to her mother and she blamed herself. She should have been quicker getting to the dinner table. Next time she will do better. She tells the principal she was up late finishing a school project. (adapted from Cunningham & Baker, 2004, p.54)

While often characterized as passive witnesses to woman abuse, children who live with violence are actively engaged in assessing their role in the violence (Cunningham & Baker, 2004). They are also engaged in worrying about consequences, problem-solving, and taking measures to protect themselves and others from the violence. As these children mature, their interpretations and means of coping with the violence change. The potential impact of the violence on their social and psychological
functioning may also be altered as they mature. By more fully understanding how children process these experiences, as well as the mediating factors that may influence their long-term outcomes, researchers may help to identify how harm is caused - or averted - for children living with adult intimate partner violence.

A common question in research exploring the impact of intimate partner violence on children has been whether boys and girls are affected in different ways or degrees as a result of exposure to woman abuse (Cunningham & Baker, 2004). While a multitude of studies have attempted to answer this question, there is currently no agreement as to whether there are reliable gender differences in children’s adaptation as a result of witnessing violence (Cummings, Pepler, & Moore, 1999). Many of the initial studies that explored the effects of woman abuse on children did not include gender as a variable in their research, and often attributed outcomes similarly across gender (e.g., Wolfe, Zak, Wilson, & Jaffe, 1986). In contrast, several studies that did include gender of the witnessing child as an important mediating factor found significant differences in child adjustment, with some studies reporting more negative outcomes for boys (e.g., Jaffe et al., 1990) and other studies indicating more negative outcomes for girls (e.g., Cummings, 1998a).

While previous research literature reveals inconsistent findings with respect to gender differences resulting from exposure to woman abuse, this could well be an artifact of how the topic was studied (Cunningham & Baker, 2004). In many of these previous studies (e.g., Kolbo, 1996; O’Keefe, 1994; Jaffe et al., 1990; Cummings 1998a), the authors were not explicit about their perspectives on gender differences in the development of identity and the resulting impact this had on the conceptualization of their research questions.
While comparing men and women on various psychological traits and behaviors has been a popular and often useful framework for studying gender and other constructs, it is now well understood that the sexes differ not only physically and biologically, but also psychologically, socially, economically, and politically (Rabinowitz & Martin, 2001). By constructing gender as an individual difference and negating the influence of larger developmental and ecological contexts, many researchers may have inadvertently oversimplified this complex issue.

Recent advances in developmental theory have informed the conceptualization of gender in violence and abuse research questions. Developmental theory hypothesizes that differences between boys and girls who have been exposed to intimate partner violence may be influenced by identification with their same-sex parent, and these resulting differences may also change with age (Carlson, 2000). Specifically, recent research has postulated that gender differences may play a significant role among older children and adolescents exposed to woman abuse, while differences among younger children may not be so apparent (Cunningham & Baker, 2004). Furthermore, an ecological approach to the conceptualization of gender has guided research by expanding the frame of analysis from individual differences to interpersonal, social, and cultural levels of explanation (Rabinowitz & Martin, 2001). Thus, gender effects can be viewed through multiple, embedded lenses of social and cultural contexts, providing a dynamic interplay of factors that constrain and reinforce the operation of gender in society. This approach recognizes that an individual’s gendered behaviors are socially constructed, structured by cultural norms, and supported through organizational systems that reward individuals for engaging in behaviors deemed culturally appropriate (Rabinowitz & Martin, 2001).
As delineated earlier, violence by an intimate partner is a gendered occurrence within Canadian society. Although men are usually the victims of non-intimate crimes, women and girls are much more likely than men to be the victims of violence in intimate relationships (White, Donat, & Bondurant, 2001). According to self-in-relation theory (Surrey, 1991), women's primary sense of self is organized and developed within the context of important relationships, beginning with their relationship to a primary caregiver. Under the best circumstances, girls learn to see themselves through relationship with their mothers, and learn that mutual empathy and connection with others promotes growth. Girls and women learn to organize their sense of identity, competence, and self-worth around their capacity for developing and sustaining healthy relationships (Surrey, 1991). Unfortunately, witnessing violence against their mothers at the hands of an intimate partner can seriously affect this developing sense of identity, competence, and self-worth and may impact females' social and psychological functioning into adulthood.

1.2 Statement of the Problem

Given this complex set of considerations, service providers face a significant challenge as they strive to assess, refer, and treat children exposed to intimate partner violence. While front-line workers must take into account the violence to which children have been exposed as well as other adversities that may be present in their lives, they also are also faced with the challenge of recognizing the unique strengths and protective factors within each child. This complex interplay of concerns faced by service providers has often not been matched by solid empirical research that considers the complexity of domestic violence and the resulting effects of exposure on children.
Recent research on the effects of exposure to woman abuse in childhood has begun to investigate the long-term consequences and resulting implications of such exposure on aspects of adult functioning. While the majority of research efforts have focused on externalizing problems in adulthood, such as violent behavior in the context of an intimate relationship, implications for internalized aspects of functioning as a result of exposure to woman abuse in childhood, such as social and psychological well-being, have been largely ignored. One of the main challenges faced by researchers investigating internalizing domains of functioning has been the lack of a common conceptualization of well-being.

Moreover, while many studies have sought to investigate the outcomes of children exposed to intimate partner violence, a variety of differential findings have emerged. Such variations can, in part, be attributed to unmeasured risk or protective factors that may affect the potential outcomes of children exposed to violence between adult intimate partners. For example, two mediating factors that seem to influence the short- and long-term harm experienced by children exposed to physical violence between adult partners include the child’s stage of development and the experience of physical abuse. While some studies have been conducted to explore the effects of these particular factors singularly, very few studies have investigated them collectively.

1.3 Purpose of the Study

Due to the limited research focused on internalized aspects of functioning for women exposed to violence between intimate partners in childhood, the purpose of the present study was to explore the social and psychological impact of such exposure into adulthood. Furthermore, as one of the main challenges facing researchers within this domain of inquiry has been the lack of a common conceptualization of well-being, an
important focus of the present study was to employ a recently proposed integrative model of well-being, referred to as psychosocial wellness (Lent, 2004). Moreover, in an effort to address gaps in previous research that have not considered the role of risk or protective factors in outcomes of children exposed to violence between adult intimate partners, the present study sought to explore the influence of the child’s stage of development and the experience of physical abuse as factors potentially mediating the social and psychological outcomes of women in adulthood. Finally, in an effort to expand the conceptualization of gender to include the influence of developmental and ecological approaches, and thereby avoid its conceptualization as an individual difference, the present study sought to explore the unique impact of childhood exposure to intimate partner violence on females alone.

In an effort to accomplish these intended objectives, the present study examined the relationship of exposure to intimate partner violence in childhood on psychosocial well-being in adulthood by comparing a group of women exposed to intimate partner violence in childhood with a group that was not exposed. Furthermore, the influence of key mediating factors such as developmental stage at the time of exposure and the experience of physical abuse on psychosocial wellness was considered among the group that was exposed to childhood intimate partner violence. Retrospective reports of exposure to intimate partner violence and experiences of childhood physical abuse were gathered through the Conflict Tactics Scale – 2 (Straus, Hamby, Boney-McCoy, & Sugarman, 1996). Self-report questionnaires assessing the social and psychological impact of such exposure were administered to convenience samples of female undergraduate students, and included the Social Avoidance and Distress Scale (Watson & Friend, 1969), the Trauma Symptom Checklist (Briere & Runtz, 1988), and the
Satisfaction with Life Scale (Diener, 1984). The statistical analyses, using Statistical Product and Service Solutions (SPSS) version 14 (SPSS, 2005), consisted of correlational analysis, t-tests, and a univariate analysis of variance (ANOVA).

1.4 Research Question and Hypotheses

The present study sought to address the following key question:

*How do age of exposure and the experience of childhood physical abuse mediate outcomes of psychosocial wellness for women exposed to intimate partner violence in childhood as measured by the Social Avoidance Scale, the Trauma Symptom Checklist, and the Satisfaction with Life Scale?*

It was hypothesized that:

1) Women who were not exposed to intimate partner violence in childhood would have significantly better outcomes on measures associated with psychosocial wellness than women who were exposed to intimate partner violence in childhood.

2) Women who were older (12 years and above) at the time of initial exposure to intimate partner violence would have significantly better outcomes on measures associated with psychosocial wellness than those who were eleven years of age or under.

3) Women exposed to intimate partner violence in childhood who did not experience physical abuse would have significantly better outcomes on measures associated with psychosocial wellness than those who experienced childhood physical abuse.

1.5 Significance

Although research on domestic violence has a thirty year history, there are still significant gaps in the research literature. The present study was designed to address key gaps within domestic violence inquiry in three particular areas. First, by operationalizing intimate partner violence as the experience of physical violence against women at the
hands an intimate partner, rather than collapsing bi-directional violence, it is hoped that the findings of the present study will make a significant contribution to the available "best evidence" in the research literature (Cunningham & Baker, 2004). Secondly, by employing initial testing of a recently proposed model of well-being, it is anticipated that the results of this study may generate future research endeavors designed to replicate and test the findings of the present study. Finally, it is hoped that the results of the present study will lead to further understanding of the effects of woman abuse on developing children. By more clearly understanding the potential long-term implications of childhood exposure to intimate partner violence on social and psychological functioning, more specific interventions can be designed for children based on their age and whether or not they have also experienced physical abuse themselves, thereby potentially decreasing the detrimental long-term effects of such exposure in childhood.
CHAPTER 2: LITERATURE REVIEW

This chapter contains a summary of literature highlighting the scope and impact of intimate partner violence in the lives of women. This is followed by an examination of important definitional issues pertaining to the study of intimate partner violence. The effects of childhood exposure to intimate partner violence are then considered, followed by an exploration of the long-term impact of childhood exposure to intimate partner violence on key internalizing domains of functioning in adulthood, including social and psychological well-being. In an effort to address one of the challenges associated with research in the area of internalizing domains of functioning, a recently proposed conception of well-being, referred to as psychosocial wellness, is then discussed. Finally, this is followed by a delineation of two critical mediating factors that may affect the social and psychological outcomes of those exposed to intimate partner violence in childhood: developmental stage at the time of exposure and the experience of childhood physical abuse.

2.1 The Scope and Impact of Intimate Partner Violence in Women’s Lives

In 1993, Health Canada commissioned a large-scale survey dedicated to women’s experiences of male violence. The Violence against Women Survey (Statistics Canada, 1993) involved telephone interviews with 12,300 women about their adult experiences of physical and sexual assault by men. Results of the survey indicated that 25% of Canadian women had experienced physical and sexual violence at the hands of their current or past intimate partners, including both marital and common-law unions.
Recently, another comprehensive survey estimated that at least 30% of all Canadian women suffer from some form of violence in an adult relationship during their lifespan (Jaffe & Geffner, 1998).

As stated in the Beijing Platform for Action adopted at the Fourth United Nations World Conference on Women in 1996:

Violence against women both violates and impairs or nullifies the enjoyment by women of their human rights and fundamental freedoms... Violence against women is a manifestation of the historically unequal power relations between men and women, which have led to domination over and discrimination against women by men, and to the prevention of women’s full advancement. (Platform for Action, 1996, p. 112)

It is not only the incidence of violence against women which limits women’s lives, but the fear of violence which affects their daily existence. Violence against women continues to be a significant problem in Canada with serious implications for health, justice, and social service services systems, as well as future generations of Canadians who are directly or indirectly affected by the impact of violence against women. Given the scope and impact of violence in the lives of women across Canada, research into the broad domain of domestic violence is of critical importance.

2.1.1 Intimate Partner Violence: Definitional Issues

In its broadest sociological sense, violence against women is an abuse of power that results in harm to women, including acts of physical and sexual assaults, as well as psychological and financial abuse (Statistics Canada, 1993). While acts of violence against women continue in Canadian society, researchers and practitioners work steadily to address issues raised by violence. One challenge facing researchers and practitioners in the area of violence against women has centered on definitional issues, particularly with respect to the directionality of the violence and the effects of collapsing exposure to
different forms of violence into one seemingly homogenous category. Each of these issues holds serious implications not only for the conclusions drawn from such research, but also the application of these conclusions when used to inform intervention for women and children who have experienced domestic violence.

2.1.1.1 Directionality

A variety of terms have been employed in the research and theoretical literature to describe violence against women, including family violence (Kashani & Allan, 1998), wife battering (Jaffe et al., 1990), woman abuse (Cunningham & Baker, 2004), and interparental violence (Rossman, Hughes, & Rosenberg, 2000). The variety of terms denoting violence against women stem, in part, from differing conceptual vantage points of what constitutes violence. Many studies within the domain of domestic violence have drawn on general population surveys and consequently report that violence is gender symmetrical or bi-directional in both frequency and severity (Walby & Allen, 2004; Rossman et al., 2000). These results are typically met with disbelief by advocates and those working in the field of domestic violence, who contend that women are overwhelmingly the victims of violence at the hands of an intimate partner (Cunningham & Baker, 2004).

Johnson (1995) postulates that these two vantage points – general population surveys and client lists at domestic violence support agencies – provide a view of two distinct, nearly non-overlapping phenomena. Johnson (1995) refers to the former as “common couple violence” and the latter as “patriarchal terrorism,” to denote both its severity and the gendered nature of this type of violence. As the name implies, the first category describes family settings in which there may be a great deal of conflict, but physical violence is relatively infrequent, less severe, and the use of violence is gender-balanced.
in both frequency and severity. The second category describes families where violence is frequent, severe, escalates in severity, is predominantly initiated by men, and is almost exclusively experienced by women. This type of violence is marked by a need to be in control and exert power over another, and tends to involve more severe acts of physical assault (Cunningham & Baker, 2004).

In a review of studies centered on children exposed to intimate partner violence, Cunningham and Baker (2004) found that 44% of empirical studies focused solely on male-to-female violence while 38% of researchers collapsed bi-directional violence between adult partners with male-to-female aggression. This lack of distinction regarding what constitutes violence and the directionality of the violence represents a significant shortcoming in previous research efforts. Utilizing such differential definitions of violence and thus, what constitutes childhood exposure to violence, has serious implications for the conclusions drawn from empirical research. For example, if researchers are utilizing different understandings of what constitutes domestic violence, research findings may be largely irrelevant or even misleading, when used in practice. More specifically, research may be oversimplifying a complex problem.

Furthermore, as a result of the differing definitions often employed by researchers and practitioners, using empirical research to inform intervention becomes a key problem (Cunningham & Baker, 2004). For example, the implications of combining children exposed to bi-directional violence between adults in the same group intervention with children exposed to male-to-female violence characterized by a pattern of power and control are yet to be explored and understood. As yet, based on the differing definitions of intimate partner violence employed in the research literature, it is
unclear whether interventions designed for one group of children should be different from interventions designed for the other.

2.1.1.2 Collapsing

Another concern within domestic violence research pertains to collapsing or combining exposure to different forms of violence into one seemingly homogenous group, rather than drawing a clear distinction about the type of violence being investigated. For example, many previous studies have not clarified the specific form of violence or abuse they have investigated (e.g., physical, psychological, sexual, verbal), or they have simply collapsed different forms of violence into the same investigation (e.g., Cummings, Davies, & Simpson, 1994; Hilton, 1992; Doumas, Margolin, & John, 1994). In a review of the literature, Cunningham and Baker (2004) found that 15% of reviewed studies collapsed physical and psychological abuse together. As a result of collapsing different forms of violence within the same inquiry, the unique impact of physical violence cannot be accurately discerned. Furthermore, the effects of physical violence could be confounded with those of psychological, sexual, or verbal abuse – each known to have their own profound impact on an individual’s adjustment (Cunningham & Baker, 2004).

2.1.1.3 Definitional Terms in the Present Study

In an effort to avoid the ambiguities found in previous research, the present study focused on physical violence experienced by a woman at the hands of a male intimate partner, whether a spousal, common-law, or otherwise intimate partner. Referred to as intimate partner violence or woman abuse, this type of violence has been defined as a pattern of male behavior characterized by power and control tactics against a woman that involves physical assault (Baker & Cunningham, 2005). Thus, the terms ‘intimate
partner violence’ and ‘woman abuse’ will be used interchangeably in the present study to refer to physical acts of violence perpetrated by males toward female intimate partners who are mothers (Jaffe & Geffner, 1998).

By establishing a clear definition and focus within the present study on male-to-female violence rather than bi-directional aggression between partners, it is anticipated that the results will contribute to practical and informed intervention for those working within the field of domestic violence, who contend that the overwhelming majority of their clients are women who have experienced physical violence at the hands of a male intimate partner (Cunningham & Baker, 2004).

Furthermore, while all forms of abuse including physical, psychological, sexual, and verbal abuse are equally important areas of study, the present study will focus on physical abuse, in an effort to discern the unique impact of exposure to physical violence during childhood and thereby attempt to avoid issues of confounding variables. By maintaining a distinct focus on the effects of exposure to physical violence, it is also anticipated that the results of the present study will contribute to the design of interventions for children that are based on sound empirical support.

Moreover, previous studies have illustrated that, apart from actually witnessing physical violence between adult partners, children may also have been exposed to the violence by overhearing an incident or experiencing its aftermath, including psychological and emotional disruption in the family (Holden, Geffner, & Jouriles, 1998). Therefore, the term ‘child exposure’ to woman abuse utilized within the present study will refer to seeing, hearing, being told about, or viewing the aftermath of a mother’s physical abuse by an intimate partner (Baker & Cunningham, 2005).
2.1.2 Childhood Exposure to Intimate Partner Violence

While increased attention has focused on the issue of intimate partner violence in Canadian society over the last three decades, the consequences of childhood exposure to intimate partner violence have not been considered until more recently (Jaffe et al., 1990), and thus these children have often been referred to as the “forgotten victims” (Jaffe & Geffner, 1998). Consider the following illustration:

Janie, who is six years old, is staying with her mother in a shelter for battered women. She has just thrown her drawing in the wastebasket. The children’s counsellor at the shelter retrieves the drawing and while smoothing it out, asks Janie to tell her about it. Janie says that it is a picture of a little girl drowning. The counsellor suggests that they try to save the girl by rowing a boat out and throwing her a rope or a buoy. Janie tells the counsellor that they can’t save her, because no one can see her. (adapted from Rossman & Rosenberg, 1998)

Although it is not known exactly how many incidents of intimate partner violence occur in the presence of children, it has been estimated that at least 120,000 Canadian children (10%) witness physical violence between adult partners in their home each year (Statistics Canada, 2004). Other research has suggested that between 13 to 42% of adults report having witnessed at least one incident of physical violence against their mothers by an intimate partner in childhood (Feerick & Haugaard, 1999).

Apart from directly observing physical violence between adult partners, children may also have been exposed to the violence by overhearing an incident or experiencing its aftermath, including psychological and emotional disruption in the family. Although many parents believe they have protected their children from the violence, between 80 to 90% of children have indicated the opposite during clinical interviews conducted by practitioners and researchers (Jaffe & Geffner, 1998; Jaffe et al., 1990).
While often referred to as witnesses – implying a passive role – recent research has shown that children who live with violence are actively engaged in assessing their role in the violence (Cunningham & Baker, 2004). They are also engaged in worrying about consequences, problem-solving, and taking measures to protect themselves and others from the violence. Thus, children from violent homes are most accurately and inclusively described as being ‘exposed to’ rather than ‘witnesses of’ intimate partner violence (Holden et al., 1998).

Recently, considerable research efforts have been directed at understanding the effects of childhood exposure to intimate partner violence (e.g., Baker & Cunningham, 2005; Kashani & Allan, 1998; Holden et al., 1998; Jaffe et al., 1990; Wolfe et al., 1986; Cummings et al., 1999). These research endeavors have suggested that being exposed to intimate partner violence has significant effects on a child’s development. In studies that compared groups of children exposed to intimate partner violence with those who were not, children exposed to intimate partner violence were found to exhibit more externalizing behavior problems which refer to behaviors that children act out, such as aggression, conduct disorder, impulsivity, hyperactivity, and bullying (Pepler, Catallo, & Moore, 2000; Feerick & Haugaard, 1999; Hilton, 1992; Fantuzzo, DePaola, Lambert, Martino, Andersen, & Sutton, 1991; O’Keefe, 1994). Other studies have shown that children of battered women also tend to exhibit internalizing problems which reflect the stresses that children endure, such as withdrawal, anxiety, depression, and fear of separation (Silvern, Karyl, Waelde, Hodges, Starek, Heidt, & Min, 1995; O’Keefe, 1994; Pepler et al., 2000). While these initial research efforts have yielded important findings, key questions about the specific effects of exposure to intimate partner
violence in childhood, particularly on internalizing domains of functioning, remain unanswered.

2.2 The Effects of Childhood Exposure to Intimate Partner Violence on Internalizing Domains of Functioning in Adulthood

While substantial research efforts have recently been directed at understanding the effects of exposure to intimate partner violence on developing children, much less is known about the potential long-term consequences of childhood exposure to woman abuse. Until the mid-1990s, few studies addressed the long-term repercussions of childhood exposure to intimate partner violence and the resulting implications on aspects of functioning in adulthood. Preliminary research has begun to explore the developmental trajectories of these children and their outcomes into adulthood and has shown that, while children’s negative reactions may be more pronounced immediately after they have witnessed violence, they can also display longer-term developmental and/or psychological problems (Statistics Canada, 2004; Jaffe & Geffner, 1998; Graham-Bermann, 1998; Feerick & Haugaard, 1999).

The majority of initial studies exploring the long-term effects associated with childhood exposure to woman abuse have focused on externalizing behaviors, particularly adult aggression in intimate relationships resulting from childhood exposure to physical violence between intimate partners. These studies have found that children exposed to intimate partner violence learn that violence is an appropriate way of solving conflicts, especially in the context of an intimate adult relationship (Jaffe & Geffner, 1998). Less research has focused on the long-term effects of exposure to woman abuse on social and psychological well-being during the adult years. In an overview of what is known about children’s exposure to intimate partner violence and indications of gaps in
extant research, Prinz and Feerick (2003) highlight the need for further research examining the impact of exposure to intimate partner violence on internalizing domains of behavior such as social and psychological functioning. Results from preliminary studies suggest that the effects of childhood exposure to intimate partner violence extend into adult life and significantly impact an individual’s social and psychological functioning.

2.2.1 Impact on Social Functioning

The effects of exposure to intimate partner violence can be seen in the earliest social relationships where children learn to resolve and to regulate emotions in social interactions with others. The development of social relationships in children is crucial to long-term adjustment outcomes, including friendship, social skills, and well-being (Graham-Bermann, 1998).

Preliminary research has shown that children who grow up in woman-abusive families have different sets of concerns and expectations for themselves and others, relative to children who have not been exposed to intimate partner violence. In one study, children exposed to intimate partner violence were more worried and concerned about the safety of their mothers and sisters, and more worried about the potential for harm by their father, than were children from non-violent families (Graham-Bermann, 1996). In another study, children of battered women were found to spend less time with their friends, were less likely to have a best friend, and had lower quality friendships than did children from non-violent families. Moreover, their worries about family members were generalized to others outside the home: children exposed to intimate partner violence were more worried about the safety of and potential harm to their

While prior studies have established a relationship between childhood exposure to intimate partner violence and affected social functioning, research also indicates the existence of longer-lasting implications into adulthood. A study by Feerick and Haugaard (1999) sought to investigate the long-term effects of witnessing marital violence in childhood on relationship functioning in a sample of 313 college women. Participants completed a questionnaire about experiences with violence in childhood and subsequent adult adjustment and relationship functioning. Nine percent of the women reported having witnessed some form of physical conflict between their parents as children. It was hypothesized that women who had been previously exposed to marital violence would demonstrate lower levels of relationship functioning as evidenced by high scores on the Social Avoidance and Distress Scale (Watson & Friend, 1969). The results indicated that witnessing violence between intimate partners in childhood was significantly associated with anxiety in social relationships, and thus increased social avoidance (Feerick & Haugaard, 1999).

2.2.2. Impact on Psychological Functioning

In addition to impacting social functioning, exposure to intimate partner violence in childhood has been found to effect psychological functioning. Children growing up in families marked by woman abuse have described this experience as living in a type of war zone (Rossman & Ho, 2000). Sometimes they feel they can predict the incidences of violence and sometimes the aggression is unexpected. This leaves them with a pervasive sense of danger and uncertainty.
Post-Traumatic Stress Disorder (PTSD; American Psychiatric Association, 2000) occurs when a person has experienced a traumatic event and reacts with intense fear, helplessness, or horror. Following exposure to such events, PTSD is further characterized by four main categories of symptoms: a) re-experiencing, b) avoidance, c) numbing, and d) hyperarousal. Frequently found patterns of symptoms of PTSD in children include regression to earlier developmental stages, nightmares, post-traumatic play in which children re-enact the trauma, daydreaming, and difficulties concentrating (Kilpatrick & Williams, 1998).

In a study designed to identify the range of trauma symptoms found in 64 children who were exposed to the physical and emotional abuse of their mother by an intimate partner, Graham-Bermann and Levendosky (1998) measured 17 posttraumatic symptoms in children which were experienced directly in conjunction with the violence. The results indicated that more than half of the children had symptoms of intrusive re-experiencing, and 42% experienced traumatic arousal symptoms. In total, 13% of the children qualified for a complete diagnosis of PTSD.

Given that more than half of the children in the previous study showed symptoms of intrusive re-experiencing, it appears that for many children, the devastating effects of exposure to intimate partner violence continue well beyond the time frame of the violent events themselves. Previous research has shown that some children exposed to intimate partner violence do not display significant improvement in either their trauma symptoms or behavior problems six months to a year later, even when they and their mothers have left the violent household (Rossman et al., 2000).

Further research has also evidenced a relationship between childhood exposure to intimate partner violence and the presence of trauma-related symptoms in adulthood. A
retrospective study by Silvern et al. (1995) explored whether or not exposure to woman abuse in childhood affected internalizing domains of adult adjustment such as depression, low self-esteem, and symptoms of post-traumatic stress. In a sample of 550 college students, nearly half of the participants indicated exposure to violence between intimate partners in childhood as reported on the Conflict Tactics Scale (Straus, 1979). In addition, to evaluate internalizing symptoms, subjects completed a series of self-report measures including the Beck Depression Inventory, the Trauma Symptom Checklist, and the Coopersmith Self-Esteem Inventory. Results of the investigation indicated a significant association between witnessing intimate partner violence in childhood and the presence of internalizing problems even years later in adulthood. In particular, childhood exposure to such violence was found to be significantly associated with trauma-related symptoms, such as re-experiencing the trauma, persistent avoidance of trauma-related stimuli, psychological numbing, and symptoms of increased arousal in adulthood (Silvern et al., 1995).

A study by Diamond and Muller (2004) investigated the association between witnessing violence against their mothers by an intimate partner in childhood and long-term psychological adjustment in adulthood amongst a sample of undergraduate students. The participants included 260 undergraduate students who had been exposed to physical or psychological violence against their mothers in childhood, as well as a control group. Participants completed a series of questionnaires designed to assess behavior and emotional problems, adult symptomology arising from traumatic experiences, and frequency of exposure to physical and psychological violence. The results indicated that participants who had witnessed physical violence against their mothers by an adult intimate partner in childhood had significantly more trauma-related
symptoms, such as sleep disturbances, feelings of social isolation, flashbacks, and somatic complaints than those who did not witness such violence (Diamond & Muller, 2004).

In summary, preliminary studies have suggested that the effects of exposure to intimate partner violence hold potential implications for social and psychological functioning into adulthood. Research has shown that exposure to woman abuse in childhood is associated with anxiety in social relationships, increased social avoidance, and trauma-related symptoms such as disturbed sleep patterns, flashbacks, and psychological numbing. While these initial research endeavors are promising, there is a need for increased research efforts focused on the long-term implications for internalized domains of functioning as a result of childhood exposure to woman abuse.

2.3 A Common Conceptualization of Well-Being

One of the major challenges impeding research in the area of childhood exposure to intimate partner violence and its resulting impact on internalized domains of behavior, such as social and psychological functioning, has been the lack of a common conceptualization of well-being. Some studies have simply employed the term “adjustment” (e.g., Silvern et al., 1995; Feerick & Haugaard, 1999) to refer to childhood outcomes on internalizing domains following exposure to intimate partner violence. Other studies have conceptualized internalizing aspects of functioning as “psychological adjustment” (e.g., Diamond & Muller, 2004; Fantuzzo et al., 1991), “subjective well-being” (e.g., Diener, Lucas, & Oishi, 2002) or “psychological well-being” (e.g., Callahan, Tolman, & Saunders, 2003).

While research on the broad domain of well-being extends back many years, it has recently re-emerged as a significant area of research. In the 1970s, social scientists
began to focus on the question of what leads people to evaluate their lives in positive terms, often defined as a sense of well-being (Diener, 1984). These researchers began to explore how and why people experience their lives in positive ways, even in the face of recent or past adversity, such as exposure to intimate partner violence.

2.3.1 Subjective and Psychological Well-Being

Throughout the past three decades, two more specific definitions of well-being have emerged in psychological literature: subjective well-being and psychological well-being. The idea of subjective well-being stems from the philosophical perspective of hedonism that views well-being as an experience of pleasant feelings (Lent, 2004). The scientific study of subjective well-being developed in part as a reaction to the overwhelming emphasis in psychology on negative states. Subjective well-being researchers maintain that social indicators alone do not define quality of life (Diener, Suh, Lucas, & Smith, 1999). Rather, they contend that people react differently to the same circumstances, and evaluate conditions based on their unique expectations, values, and previous experiences.

Another approach to the conceptualization of well-being stems from the philosophical perspective of eudaimonism and views well-being from a broader stance involving a diverse set of experiences and mechanisms through which people achieve psychological growth, make meaning, and seek purpose in their lives (Lent, 2004). Based on this eudaimonic view, Ryff (1989; 1995) has offered an alternative definition of well-being, drawing on the views of mental health, clinical, and lifespan developmental theorists. Rather than simply the attainment of happiness, Ryff (1995) characterizes well-being as the striving for perfection that represents the realization of one's true potential. From this stance, happiness is not the ultimate focus, but rather it is a by-product of a life that
is well-lived and is considered within the context of an individual’s life, not just in relation to their self-perceived satisfaction.

2.3.2 Psychosocial Wellness: A Unifying Perspective of Well-Being

In a review of empirical findings, Ryan and Deci (2001) concluded that well-being is probably best conceived as a multidimensional phenomenon that includes aspects of both subjective and psychological well-being. Lent (2004) has argued that subjective and psychological well-being appear to represent intricately related forms of well-being that can be brought together within a common conceptual framework. Consequently, he has proposed a multicomponent conception of well-being referred to as “psychosocial wellness” for use in future research. While “wellness” is intended to capture the notion of health as a dynamic state or process rather than a static endpoint, the term “psychosocial” acknowledges the importance of both intrapersonal and interpersonal functioning. There are four main aspects of the construct of psychosocial wellness, according to Lent’s (2004) model. These components include self-perceived global life satisfaction, which is a cognitive component that measures an individual’s subjective summation of their quality of life, as opposed to the actual condition (Callahan et al., 2003). The second aspect of psychosocial wellness encompasses an individual’s satisfaction in key domains of life including self, family, romantic relationships, income, friendships, school, and community (Diener et al., 1999). Respectively, the third and fourth facets of this model include low levels of social anxiety and avoidance, as well as low levels of psychological distress or symptoms (Lent, 2004).

Lent’s (2004) concept of psychosocial wellness establishes a unifying perspective of well-being and offers a viable starting point for research focused on the impact of intimate partner violence on internalized domains of functioning. By incorporating an
understanding of how and why people experience their lives in positive ways, even in the face of past adversity such as exposure to intimate partner violence, with an individual’s assessment of their social and psychological functioning, Lent’s (2004) model has the potential to assist researchers in assessing the impact of intimate partner violence on internalized domains of functioning. Furthermore, while results from preliminary studies suggest that the effects of childhood exposure to intimate partner violence significantly impact an individual’s social and psychological functioning, and that these implications can extend into adulthood, research has been limited to date. To address this gap in the literature, Lent’s model is particularly useful in research with adults who were exposed to intimate partner violence in childhood. By involving these adults in the process of providing a personal assessment of their satisfaction with their own lives, as well as in key domains of intrapersonal and interpersonal functioning, a richer understanding of the long-term impact of exposure to intimate partner violence in childhood can be ascertained by researchers. As a result, Lent’s conception of psychosocial wellness makes an important step in taking into account the complex set of considerations that individuals experience following exposure to intimate partner violence, including their own personal reactions to the event and its effect on their life satisfaction, as well as its impact on their intrapersonal and interpersonal functioning.

While some researchers have found significant relationships between childhood exposure to intimate partner violence and singular aspects of Lent’s (2004) proposed psychosocial wellness model, such as low self-efficacy (Silvern et al., 1995) and psychological distress (Feerick & Haugaard, 1999; Silvern, Karyl, & Landis, 1995; Diamond & Muller, 2004), no studies to date have explored such effects on all four domains of psychosocial wellness collectively. The present study sought to investigate
the relationship between exposure to intimate partner violence in childhood on psychosocial wellness in an effort to examine the long-term implications of such exposure on social and psychological functioning in adulthood. Such an understanding may hold important implications for intervention programs designed for children and adolescents exposed to intimate partner violence, as well as future research into the broad domain of well-being.

2.4 Exposure to Intimate Partner Violence and Mediating Factors

While many studies have sought to investigate the outcomes of children exposed to intimate partner violence, a variety of findings have surfaced, and notable differences have emerged - even between children from the same family (Rossman et al., 2000). Such variations can, in part, be attributed to unmeasured risk or protective factors that may affect the potential outcomes of children exposed to their mother’s abuse by an intimate partner. Many of these previous studies failed to consider properties of individuals or their environments that may have affected or otherwise protected development (Rossman & Rosenberg, 1998).

The notion of risk and protective factors stems from research in the area of resilience. Resilience refers to the ability of individuals to thrive despite exposure to adverse circumstances and significant risk (Masten, 2001), such as childhood exposure to intimate partner violence (Baker & Cunningham, 2005). Researchers studying resilience suggest that certain characteristics of the child or features of the family environment may mitigate or exacerbate adjustment difficulties. Consequently, the notion of resilience has resulted in a recent paradigm shift within domestic violence research that has focused on examining the mechanisms or characteristics of individual children and their families that may relate to and/or modify the global effects of exposure to intimate
partner violence. These features are commonly referred to as mediating factors (Moore & Pepler, 1998). Two mediating factors that seem to influence the short- and long-term harm experienced by children exposed to physical violence directed at their mothers include the child’s stage of development and the experience of childhood physical abuse.

2.4.1. Developmental Stage

Development is a continual and cumulative process (Kohlberg, 1966) referring to the process of physical maturation and learning as individuals grow and change throughout the various life stages such as infancy, middle childhood, adolescence, and young adulthood (Cunningham & Baker, 2004). As children develop, they mature physically, cognitively, socially, and emotionally. Experiences at each stage and the manner in which an individual adapts, copes, and integrates those experiences form the foundation for understanding, reacting to, and coping with later life experiences.

A key assumption of developmental theory is that younger children have fewer developmental capacities to regulate feelings and cognitively process and evaluate environmental information than older children (Cunningham & Baker, 2004). Consequently, it has been hypothesized that exposure to intimate partner violence may have differential impacts at differing stages of development, with younger children exhibiting increased vulnerability than older children (Carlson, 2000).

Consider the response of Regina, a nine year old girl in middle childhood (6 to 11 years old), who has been exposed to intimate partner violence:

What I heard was a lot of shouting and screaming and the shouting was mostly my dad because he did have...he’s got quite a loud voice and my mom was screaming and when she came downstairs the next day and she had a big bruise and it really hurt and she had some scratches as well. And I kept on asking her if she was okay and she wasn’t. (McGee, 2000, p.66)
For this young girl in the stage of middle childhood, exposure to intimate partner violence represents a confusing and frightening experience. She recalls her exposure to hearing the violence and abuse and expresses empathy with the pain her mother is experiencing as a result of her injuries. This child also expresses an awareness of the impact that the violence has had on her mother and that she is “not okay.”

In comparison to children in the stage of middle childhood, initial research has determined that adolescents (12 to 17 years old) living with violence differ from younger peers in that they are more active outside the home, have a broader range of coping strategies, and have greater skills in expressing their opinions (Cunningham & Baker, 2004). As a result of this increased sense of self, as well as autonomy from the family and increased peer group influence (Carlson, 2000), it has been hypothesized that adolescents exposed to intimate partner violence may be more likely to prematurely pursue independence from the family. Adolescents exposed to intimate partner violence may also develop problems in their peer relationships such as isolation, avoidance, and risk-taking, leading to difficulty establishing healthy relationships (Goldblatt, 2003). Finally, it has been postulated that adolescents may tend to prematurely adopt caretaking roles for their mothers and siblings as a result of intimate partner violence (Cunningham & Baker, 2004).

In contrast to Regina, the young girl in the stage of middle childhood who was quoted previously, the following statement by a 13 year old girl emphasizes her focus on caring for and protecting her siblings in the face of intimate partner violence. She expresses feeling angry at the amount of responsibility she has for her age, as well as regret about her actions towards her siblings:
I tried to protect my little sisters. I would try to keep them with me. I would bring them into my bed when the abuse was happening. Other times I’d try to get them out of the house. I used to get angry ‘cause I had so much responsibility. Once I actually hit my sister and then I felt so, so bad. I wanted to think it was ok ‘cause I got it [hit] but I knew it wasn’t [okay]. But I’d let them sleep with me and take them places to keep them safe. I feel like I’ve already had my kids and been a Mom. I’m not sure I want to do it again. (Cunningham & Baker, 2004, p. 100)

Despite the hypothesis proposed in the developmental literature that exposure to intimate partner violence has differential impacts at different stages of development, with younger children exhibiting increased vulnerability, the majority of previous studies have not considered the child’s age at the time of exposure as an important mediating variable. For the most part, previous research has tended to group vastly different developmental ages together. For example, in O’Keefe’s study (1994), which investigated the link between exposure to marital violence and child behavior problems, children between 7 to 13 years of age were included in the sample as if representing a homogeneous developmental group. Similarly, research conducted by Wolfe et al. (1986), which investigated the relationship between exposure to intimate partner violence and social competence, health problems, and emotional difficulties, included samples of children between the ages of 4 to 13 years old.

The few studies that have included age of exposure as a potential mediating variable on outcomes for children exposed to intimate partner violence found significant differences. In one study that focused on the effects of exposure to intimate partner violence within a specific developmental category, it was found that infants showed distress reactions when exposed to background anger, such as adults yelling and arguing. Furthermore, 20-month old toddlers showed increased amounts of aggression with their playmates after they had been exposed to loud and angry arguing between adults.
In a preliminary research endeavor exploring the impact of exposure to intimate partner violence at differing developmental stages, Jaffe et al. (1990) found that younger children demonstrated increased vulnerability when compared to older children due to their more dependent developmental stage and lack of social supports. Despite these promising findings, further research is needed in an effort to address this gap in the research literature. As a result, the present study sought to investigate the mediating effects of developmental stage – whether middle childhood or adolescence – on outcomes in adulthood following exposure to intimate partner violence.

2.4.2 Childhood Physical Abuse

While being exposed to intimate partner violence is a significant risk factor, it rarely happens in isolation from other stressors in a child’s life (Jaffe & Geffner, 1998). In many circumstances, children may personally experience physical violence themselves aside from witnessing their mother’s victimization. The most conservative estimates suggest an overlap of at least 30% between woman abuse and physical child abuse, and some studies have estimated an overlap of up to 70% (Jaffe & Geffner, 1998). Consider the experience of Sabrina, a ten year old girl:

Most people if they get drunk, they laugh and be funny and joke, but he didn’t. He would like beat Mummy up. And he keeps smacking me round the head. Mummy tells him not to because she says ‘you’ll give her brain damage’, that can happen, and he kept on doing it. He didn’t listen to Mummy. (McGee, 2000, p.52)

The definition of child abuse varies among criminal justice, health, social service professionals, and researchers. Despite variations in definitions of child abuse, categories of maltreatment have been established and include physical abuse, sexual abuse, neglect, emotional abuse, and witnessing intimate partner violence (Statistics
Canada, 2004). While there are no comprehensive national data sources for each of these types of abuse, there have been increasing efforts to quantify the nature and extent of certain forms of child maltreatment in Canada. The present study sought to focus on the distinct experience of childhood physical abuse in an effort to discern the unique impact of experiencing such physical abuse during childhood and its mediating effects on adult outcomes related to exposure to intimate partner violence. By maintaining a clear focus on experiences of childhood physical abuse and attempting to avoid the influence of confounding variables, it is also anticipated that the results of the present study will contribute to the design of interventions for children that are based on sound empirical support.

While childhood physical abuse has been shown to be a major risk factor with its own outcomes on development, such as physical injury and impaired cognitive functioning (Fantuzzo et al., 1991), more recent research has begun to explore the cumulative risk of several factors leading to negative outcomes. Preliminary research has shown that a combination of two or more psychosocial stressors may multiply children’s risk of adjustment problems (Cummings, 1998a). Studies have found that children who witness physical violence against their mothers and have also been the victim of physical abuse themselves show significantly more problems than children who only witness violence or children with neither experience (Kolbo, 1996).

Similarly, research focused on young adults has suggested that both witnessing violence between adult partners and experiencing physical abuse in childhood are significant predictors of maladjustment in adulthood, as well as becoming either a perpetrator or victim of violence. Further research suggests that when both experiences are present - exposure to violence between adult intimate partners and experiencing
physical abuse - the probability of subsequent violence in adulthood is increased (Feerick & Haugaard, 1999; O'Keefe, 1994). Results from a study conducted by Feerick and Haugaard (1999) indicated that the effects of exposure to intimate partner violence depend on the presence of other risk factors, such as childhood physical abuse. In addition, they found an additive effect whereby witnessing violence between adult partners combined with experiencing abuse led to increased levels of distress in adulthood. Cummings (1998b) also found significant interactions between exposure to marital violence and childhood abuse on aspects of adult functioning. Similarly, Silvern et al. (1995) found that the relationship of exposure to violence in childhood and increased internalizing problems, such as depression and low self-esteem in adulthood, were associated with the co-occurrence of child abuse. These findings were replicated by Diamond and Muller (2004), who found greater incidences of internalizing problems amongst young adults who had both witnessed their mother's victimization and experienced childhood physical abuse.

From these preliminary investigations it is clear that, while being exposed to intimate partner violence is a significant risk factor, it rarely happens in isolation from other stressors in a child’s life. Studies have shown that experiencing physical abuse in addition to being exposed to intimate partner violence can have a cumulative effect on children’s short-term outcomes. Furthermore, previous research has suggested that these cumulative effects can have long-term effects into adulthood on both externalizing and internalizing domains of functioning.

In summary, previous research has underlined the importance of examining the influence of key mediating factors related to childhood exposure to intimate partner violence. Two key mediating factors that seem to influence the short-and long-term
harm experienced by children exposed to woman abuse include the child’s developmental stage and the experience of physical abuse. While some studies have explored the effects of these particular factors singularly, very few studies have investigated them collectively. Furthermore, previous research has not explored the influence of these mediating factors on outcomes of psychosocial wellness, as proposed in Lent’s (2004) model.

2.5 Summary

In this chapter, the primary purpose was to review issues related to the scope and impact of intimate partner violence in the lives of women and girls. Estimates contend that at least 30% of all Canadian women suffer from some form of violence in an adult relationship during their lifespan (Jaffe & Geffner, 1998) and that 10% of Canadian children witness this violence directed against their mothers (Statistics Canada, 2004). While a growing awareness about the unique needs of abused women and their children has sparked a tremendous amount of research attention, studies within the broad domain of domestic violence have been plagued by differing conceptualizations of what constitutes intimate partner violence, resulting in conflicting approaches to studying and defining the directionality of the violence between intimate partners. Methodological issues such as collapsing or combining exposure to different forms of violence into one seemingly homogeneous group have also held serious implications for the conclusions drawn from previous empirical research, as well as the applications of these conclusions when used to inform intervention. These issues were reviewed as the present study sought to avoid these ambiguities by clearly focusing on physical violence experienced by a woman at the hands of a male intimate partner.
More recent research attention has begun to focus on the consequences of childhood exposure to intimate partner violence and has established significant effects on both externalizing and internalizing domains of behavior. However, key gaps in the research literature indicate that much less is known about the potential long-term consequences of childhood exposure to woman abuse, particularly on internalizing domains of functioning, such as social and psychological well-being. In an overview of what is known about children’s exposure to intimate partner violence and indications of gaps in extant research, researchers (Prinz & Feerick, 2003) highlight the need for further studies examining the impact of exposure to intimate partner violence on internalizing domains of behavior such as social and psychological functioning. One of the major challenges impeding research exploring the impact of exposure to intimate partner violence on internalizing domains has been the varied approach to defining and conceptualizing these domains of functioning. In an effort to address these gaps and challenges reflected in the research literature, the present study incorporated a recently proposed model of well-being, referred to as psychosocial wellness (Lent, 2004).

Finally, while preliminary studies have sought to investigate the long-term outcomes of children exposed to intimate partner violence, a variety of findings have surfaced, and notable differences have emerged (Rossman et al., 2000). Such variations can, in part, be attributed to unmeasured risk or protective factors that may affect the potential outcomes of children exposed to their mother’s abuse by an intimate partner. Thus, two critical mediating factors that may affect the long-term social and psychological outcomes of those exposed to intimate partner violence in childhood were outlined in the present review: developmental stage at the time of exposure and the experience of childhood physical abuse.
CHAPTER 3: METHODOLOGY

3.1 Method and Design

This section describes the methodology that was conducted in the present study. The relationship between exposure to intimate partner violence in childhood and psychosocial wellness in young adulthood was examined using a non-experimental survey research design.

3.2 Ethical Considerations

Ethics approval to conduct the study was obtained from the University of Saskatchewan Research Ethics Board (Appendix A). There were no aspects of this study that involved any risk to the participants or involved the deception of participants. The researcher worked with voluntary and informed participants and obtained written consent from all participants. Confidentiality was insured and data were reported in aggregate form. All data were secured in a locked facility and will be stored for a minimum of five years, in accordance with University of Saskatchewan regulations.

3.3 Participants

Approximately 262 young adult females between the ages of 17 to 36 years of age from undergraduate programs in a western Canadian university were asked to participate in the study. Participation involved completing a series of questionnaires presented in counterbalanced order. The participants were informed that participation was voluntary and that they were required to be 17 years of age or older in order to participate in the study, as well as have English as their first language.
3.4 Materials and Procedures

Data for this study were generated by administering six self-report measures. Professors were contacted via telephone and electronic mail to arrange for class time to administer the questionnaires. Potential participants were provided with information about the study and the voluntary nature of participating was emphasized. Participants were asked to sign two consent forms that provided information about the study: one consent form remained with the participant and the second consent form was kept in a place separate from the completed questionnaires in order to ensure anonymity (Appendix B). Once individuals consented to learn more about the study, the researcher provided detailed information about participation requirements and invited those interested in participating to complete the series of questionnaires.

After participants signed consent forms, the questionnaires were distributed by the researcher. In order to avoid difficulties ensuing from possible order effects, such as response bias, the order of presentation of the questionnaires was counterbalanced. Participants randomly received a package of materials, including the Family Information Questionnaire (Appendix C), the Conflict Tactics Scale - 2 (Straus et al., 1996) for exposure to intimate partner violence (Appendix D), the Conflict Tactics Scale - 2 (Straus et al., 1996) for physical child abuse experiences (Appendix E), the Trauma Symptom Checklist (Briere & Runtz, 1988) (Appendix F), the Social Avoidance and Distress Scale (Watson & Friend, 1969) (Appendix G), and the Satisfaction with Life Scale (Diener, 1984) (Appendix H). The instructions for task completion were included in the written materials; however, the researcher also briefly reviewed the instructions and clarified any questions from the participants. The average administration time ranged from 10 – 25 minutes. Participants were informed that the completed thesis
would be available for loan from the Department of Educational Psychology and Special Education, University of Saskatchewan, in the spring of 2006.

3.4.1 Measures of Participant Characteristics

To assess the demographic characteristics of the group of participants, one questionnaire was administered.

3.4.1.1 The Family Information Questionnaire

The purpose of the Family Information Questionnaire was to establish the degree of correspondence between the target population (female young adults exposed to intimate partner violence in childhood) and the group of participants studied. In addition, previous research has used the term “adversity package” to describe the multiple stressors which cluster together in the lives of many young people who have been exposed to intimate partner violence. Elements of this adversity package include poverty, child maltreatment, and a family history of parental substance abuse, and/or mental illness (Cunningham & Baker, 2004). These multiple stressors both elevate the risk for negative outcomes and potentially obscure the relationship between exposure to intimate partner violence and those negative outcomes. Thus, in order to avoid confounding the results of the present study, information was gathered pertaining to the age of the participants, marital status, parents’ marital status, parents’ occupational status, as well as family history regarding depression, alcoholism, drug abuse, psychiatric hospitalization, and suicide.

3.4.2 Measures of Independent Variables

Two questionnaires were administered in the present study to assess the independent variables of exposure to intimate partner violence in childhood, as well as experiences of physical abuse in childhood.
3.4.2.1 Exposure to Intimate Partner Violence

The Conflict Tactics Scale - 2 (Straus et al., 1996) is an updated revision of the Conflict Tactics Scale (Straus, 1979), which is a standardized measure frequently used by researchers of domestic violence to quantify the nature and extent of violence in the home (Wolfe et al., 1986; Fantuzzo et al., 1991; Kolbo, 1996). The original version of the CTS (1979) was designed to obtain data on violence between parents of adolescents or adults by asking them to respond with respect to the behavior of their parents towards one another. The revised instrument (CTS-2, 1996) yields scores across five subscales: physical assault, psychological aggression, negotiation, injury, and sexual coercion. The Physical Assault Scale of the CTS-2 (1996) was used in this study to assess exposure to physical intimate partner violence in childhood. Items vary from minor to severe acts of physical assault including: throwing objects, slapping, pushing, grabbing, pushing another person into a wall or other object, kicking, biting, or choking. Participants responded to the question, “How often did this happen?” on a 7-point scale with the following anchor points: 1 = once, 2 = twice, 3 = 3-5 times, 4 = 6-10 times, 5 = 11-20 times, 6 = more than 20 times, 0 = this has never happened. The instructions directed participants to focus on the period when they were between 6 to 17 years old. Participants were also instructed to respond to the questions based on the behavior of their father or step-father towards their mother. In cases of parental divorce or loss, participants were instructed to focus their responses on the behavior of adults in their home with whom they had lived for over three years between the ages of 6 to 17 years old. The number for each of the twelve items was then summed, with the resulting total score reflecting the overall exposure to physical intimate partner violence in childhood. For the purposes of this study, exposure to physical intimate partner violence was
operationalized as a frequency greater than zero on the male-to-female items of the CTS-2 (1996).

Preliminary studies investigating the reliability of the CTS-2 Physical Assault Scale indicate good internal consistency ($\alpha = .86$) with the other subscales ranging from .79 to .95 (Straus et al., 1996). To investigate discriminant validity and ensure that the test is not correlated with irrelevant variables, Straus et al. (1996) identified two pairs of scales on the CTS-2 that, in principle, should not be correlated: negotiation and injury. The results indicated non-significant correlations on those two scales, and were interpreted by Straus et al. (1996) as evidence of discriminant validity.

While the information gathered on the CTS-2 (Straus et al., 1996) employed retrospective reports of exposure to intimate partner violence, previous research has demonstrated the necessity and value of employing such retrospective reports of exposure to violence and child abuse (Silvern et al., 1995). Research about methodology demonstrates that while under-reporting of child sexual abuse is frequent amongst retrospective reports (Brewin, Andrews, & Gotlib, 1993), information affirming physical abuse and other negative childhood events are typically valid (Silvern et al., 1995; O'Keefe, 1994).

3.4.2.2 Childhood Physical Abuse

Based on Straus's suggestion (Straus, 1979; Straus et al., 1996), as well as prior studies (e.g. Silvern et al., 1995; Callahan et al., 2003), the CTS (1979) can also be modified to allow adult child witnesses of physical intimate partner violence to indicate the amount of physical abuse they experienced personally. In the present study, the index of childhood physical abuse was based on CTS (1979) responses about parental behavior toward the participant. Participants were categorized on this dimension based
on their responses to the twelve items of the CTS Violence Scale. Each of the twelve items presented two statements that obtained data on the behavior of both parents toward the child, totalling 24 responses. A positive response to any of the first ten statements on the index with a frequency above 3-5 times or a positive response to any one of the remaining fourteen statements was defined as a participant’s self-report of a childhood experience of physical abuse.

The internal consistency reliability of the CTS Violence Scale has been reported to be strong \( r = .88 \) (Straus, 1979). The coefficient of reliability for the CTS Violence Scale concerning parental behavior towards a child was reported as moderate \( \hat{\alpha} = .62 \). Straus (1979) also provides evidence of concurrent, content, and construct validity for the Violence Scale of the CTS (1979).

3.4.3. Measures of Dependent Variables

Three questionnaires were administered in the present study to assess the dependent variables of satisfaction with life, social avoidance and distress, and trauma symptomology.

3.4.3.1 Satisfaction with Life

Self-perceived and domain satisfaction were measured by the Satisfaction with Life Scale (Diener, 1984) which assesses satisfaction in seven different domains of life (self, family life, romantic relationship[s], family income, friendships, school, and neighborhood/community). These domains were measured using the same question (“How satisfied are you with _____ these days?”) across response sets. Participants responded on a 7-point Likert-type scale with the following anchor points: 1 = completely satisfied, 4 = neutral, and 7 = completely dissatisfied. To determine discriminant validity, scores on the Satisfaction with Life Scale were correlated with the
Marlowe-Crowne scale of social desirability \((r = .02)\), indicating that it is not evoking a social desirability response set (Diener, Emmons, Larsen, & Griffin, 1985). In studies correlating the Satisfaction with Life Scale to other measures of well-being among university student populations, moderate to strong correlations were found, ranging from .50 to .75 (Diener et al., 1985).

### 3.4.3.2 Social Avoidance and Distress

The Social Avoidance and Distress Scale (SAD) is a 28-item self-report inventory that measures social avoidance and distress in social situations on a reverse-scored true-false format (Watson & Friend, 1969). The SAD Scale has been used in many studies to identify subjects with varying degrees of social anxiety, as well as to examine the cognitive, emotional, and behavioral correlates of social anxiousness (Feerick & Haugaard, 1999; Leary, 1988). Evidence of construct and criterion validity has been reported as strong (Watson & Friend, 1969).

### 3.4.3.3 Trauma Symptomology

The Trauma Symptom Checklist (TSC-33; Briere & Runtz, 1988) is a 33-item self-report questionnaire that evaluates adult symptomology arising from traumatic experiences in childhood. The TSC-33 was designed to assess the impact of traumatic events, including childhood abuse, on later adult functioning (Briere & Runtz, 1989). It consists of five subscales (anxiety, depression, dissociation, sexual abuse trauma, and sleep disturbance) and a total score. Response categories vary from 0 (never) to 3 (very often), so that the total can range from 0 to 99. The TSC-33 has also demonstrated solid predictive validity with regard to traumatic experiences, such as childhood physical abuse (Diamond & Muller, 2004). The scale has been significantly positively associated with retrospective reports of childhood physical abuse (Silvern et al., 1995).
3.5 Data Cleaning and Verification

Following data collection, the researcher verified the data by randomly selecting ten questionnaires and visually checking every item entered. No errors were found. The researcher also verified the data by visually inspecting each item as it was entered for analysis. A frequency analysis was also conducted to examine the minimum and maximum value for each variable and to ensure that it was within the appropriate range of the data. Any variables that were not within the appropriate range of the data were corrected. Furthermore, a missing values analysis was also conducted using Statistical Package for the Social Sciences (SPSS, 2005). Two cases were deleted as the majority of the data responses were missing. Cases with random patterns of missing values were replaced with mean values, or where appropriate, a random pattern was used to replace missing values which provided a reasonable alternative, as the sample size was fairly large and the number of missing values was comparatively small (Tabachnick & Fidell, 2001).

3.6 Exclusionary Criteria

Information was collected from all participants, but due to the focus of the current study, individuals who reported being exposed to intimate partner violence or physical abuse in other developmental stages such as under the age of six years old or over the age of seventeen years old, were not included in the analyses.

Furthermore, exposure to intimate partner violence or experiences of abuse within both age categories (6 to 11 years old and 12 to 17 years old) was not included in the present analysis. Therefore, if participants indicated they had been exposed to intimate partner violence during middle childhood and adolescence, their responses were coded as the time of first exposure to intimate partner violence and consequently, they were
included in the category of middle childhood. The same criterion was established for experiences of physical abuse – participants were categorized based on their developmental stage at the time of initial experience of abuse.

3.7 Data Analysis

Both descriptive and inferential statistical procedures were completed for this study using SPSS Version 14.0 (2005). Descriptive statistics, including means and standard deviations, were used to facilitate statistical interpretations. Pearson Product Moment Correlation Coefficients were calculated in order to identify any statistically significant relationships existing among satisfaction with life, trauma symptomology, and social avoidance and distress. Independent t-tests and univariate analyses of variance (ANOVAs) were employed to determine whether there were group differences occurring more frequently than would be attributable to chance. For all hypotheses, inferential statistical tests were set with an alpha probability of .05 to ensure reasonable guarantee against Type I errors, as well as consistency in producing power statistics for all the tests.
CHAPTER 4: RESULTS

This section presents the results of data analysis regarding the relationship between psychosocial wellness, as operationalized by participants' scores on the Satisfaction with Life Scale (Diener, 1984), the Social Avoidance and Distress Scale (Watson & Friend, 1969), as well as the Trauma Symptom Checklist (Briere & Runtz, 1988), and exposure to intimate partner violence in childhood, as operationalized by participants' scores on the Conflict Tactics Scale – 2 (Straus et al., 1996). Secondly, this chapter presents the results of the data analysis regarding the impact of developmental stage at the time of exposure to physical intimate partner violence and the experience of physical abuse on outcomes of psychosocial wellness.

Three primary hypotheses were investigated:

1) Women who were not exposed to intimate partner violence were anticipated to have significantly better outcomes on measures associated with psychosocial wellness than those who were exposed to intimate partner violence.

2) Women who were exposed to intimate partner violence but did not experience physical abuse were anticipated to have significantly better outcomes on measures associated with psychosocial wellness than those who experienced child abuse.

3) Women who were older (12 to 17 years old) at the time of initial exposure to intimate partner violence were predicted to have significantly better outcomes on measures associated with psychosocial wellness than those who were under younger (6 to 11 years old) at the time of exposure.
4.1 Sample and Subsample Descriptive Statistics

The present sample (N = 262) consisted of females from a university setting ranging in age from 17 to 36 years old (M = 21; SD = 4.3). The majority of participants in the sample were single (N = 226 or 86.3%) while the remainder of the sample were either married (N = 18; 6.9%), living common-law (N = 14; 5.3%), or divorced (N = 2; 0.8%).

4.1.1 Family Demographics

With respect to family demographics, the majority of participants indicated that their parents were married (N = 208; 79.4%), divorced (N = 32; 12.2%), or separated (N = 8; 3.1%). When reporting the level of education completed by their parents, 32.4% of the sample (N = 85) indicated that their mother had completed grade twelve, while 20.6% (N = 54) reported their mother had completed technical school, and 30.9% (N = 81) said their mother had completed a university degree or graduate education. In contrast, 25.2% of the sample (N = 66) reported their father had completed high school while 19.1% (N = 50) indicated their father had completed technical school and 25.6% (N = 67) said their father had completed a university degree or graduate education. In terms of their parents’ gross yearly income, 36.3% of the sample (N = 95) reported their mother’s annual income was above $30,000 and 60.7% of the sample (N = 159) indicated their father’s annual income was above $30,000.

4.1.2. Family History

With respect to family history, 32.1% of the sample (N = 84) indicated a family history of depression while 13.7% (N = 36) reported that at least one relative had been hospitalized in a psychiatric facility at one point in time. When asked to indicate whether a family relative had committed suicide, 10.3% of the sample (N = 27) responded
affirmatively; 13.0% of the sample (N = 34) reported that at least one relative had a history of drug abuse, and 41.2% (N = 108) indicated a family history of alcoholism.

4.1.3. Exposure to Intimate Partner Violence

Two hundred and seventeen of the total respondents (82.8%) indicated no exposure to physical intimate partner violence in childhood. Of the remaining 45 respondents (17.2%) who indicated exposure to physical intimate partner violence, 33 reported exposure during middle childhood while 12 participants reported exposure to physical intimate partner violence during adolescence (See Table 4.1). One hundred and thirty-seven participants reported no experience of physical abuse in childhood. Of the remaining 125 participants, 74 indicated experiencing physical child abuse during middle childhood while 51 reported experiencing physical child abuse during adolescence.

Table 4.1 Sample Descriptive Statistics

<table>
<thead>
<tr>
<th>Value Label</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exposure to IPV</td>
<td></td>
</tr>
<tr>
<td>No Exposure</td>
<td>217</td>
</tr>
<tr>
<td>Exposure in Middle Childhood</td>
<td>33</td>
</tr>
<tr>
<td>Exposure in Adolescence</td>
<td>12</td>
</tr>
<tr>
<td>Experience of Physical Abuse</td>
<td></td>
</tr>
<tr>
<td>No Physical Abuse</td>
<td>137</td>
</tr>
<tr>
<td>Abuse in Middle Childhood</td>
<td>74</td>
</tr>
<tr>
<td>Abuse in Adolescence</td>
<td>51</td>
</tr>
</tbody>
</table>

In order to further examine group differences on psychosocial wellness, the sample was divided into nine subsamples, which are shown in Table 4.2. These subsamples
were derived based upon an initial plan to conduct multivariate analysis of variance (MANOVA). However, as Table 4.2 illustrates, the sample sizes in many of the subsample cells were insufficient to proceed with multivariate analyses. However, the range in means and standard deviations across subsamples on each of the dependent variables provides descriptive information concerning responses across measures of psychosocial wellness for each of the subsamples.

Table 4.2 Sample Descriptive Statistics on Psychosocial Wellness Categories

<table>
<thead>
<tr>
<th>Subsample</th>
<th>N</th>
<th>SAD</th>
<th>TSC</th>
<th>SWL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>M (SD)</td>
<td>M (SD)</td>
<td>M (SD)</td>
</tr>
<tr>
<td>NoE*/NoA*</td>
<td>123</td>
<td>5.34</td>
<td>15.20</td>
<td>22.13</td>
</tr>
<tr>
<td>E&lt;12/NoA*</td>
<td>10</td>
<td>5.50</td>
<td>15.00</td>
<td>29.10</td>
</tr>
<tr>
<td>E&gt;12/NoA*</td>
<td>3</td>
<td>4.75</td>
<td>15.75</td>
<td>26.25</td>
</tr>
<tr>
<td>NoE/A&lt;12*</td>
<td>53</td>
<td>6.88</td>
<td>20.96</td>
<td>24.01</td>
</tr>
<tr>
<td>E&lt;12/A&lt;12</td>
<td>18</td>
<td>7.33</td>
<td>23.38</td>
<td>24.16</td>
</tr>
<tr>
<td>E&gt;12/A&lt;12</td>
<td>3</td>
<td>9.00</td>
<td>28.33</td>
<td>21.66</td>
</tr>
<tr>
<td>NoE/A&gt;12</td>
<td>41</td>
<td>7.07</td>
<td>22.41</td>
<td>23.34</td>
</tr>
<tr>
<td>E&lt;12/A&gt;12</td>
<td>5</td>
<td>12.00</td>
<td>28.20</td>
<td>29.00</td>
</tr>
<tr>
<td>E&gt;12/A&gt;12</td>
<td>5</td>
<td>6.00</td>
<td>32.20</td>
<td>30.80</td>
</tr>
</tbody>
</table>

* E = Exposure to physical intimate partner violence; A = Experience of physical abuse; E<12 = Exposure to intimate partner violence under 12 years of age; E>12 = Exposure to intimate partner violence over 12 years of age; A<12 = Experience of physical abuse under 12 years of age; A>12 = Experience of physical abuse over 12 years of age.
4.2 Internal Consistency Reliabilities of Measures

Cronbach’s alpha, an internal consistency reliability estimate, was examined for this study. Reliability estimates calculated using Cronbach’s alpha with a criterion of .80 were considered moderate to strong within the present analysis.

4.2.1 Trauma Symptom Checklist

Previous studies using the 33-item Trauma Symptom Checklist (TSC; Briere & Runtz, 1988) have provided evidence of strong reliability (Diamond & Muller, 2004; Briere & Runtz, 1988; Silvern et al., 1995; Callahan et al., 2003). For example, Diamond and Muller (2004) report an extremely high internal consistency value of $\alpha = .99$ for the full scale. Response sets range from 0 to 3 on the TSC, resulting in a possible total score ranging from 0 to 99. Higher scores indicate increased trauma symptoms. Reliability analyses of the full scale in the present study yielded a Cronbach’s alpha of .90 across the full sample, with a mean of 18.78 ($SD = 11.49$). Reliability analyses of the non-exposed subsample yielded a Cronbach’s alpha of .93 with a mean of 22.68 ($SD = 14.67$). Reliability analyses of the exposed subsample yielded a Cronbach’s alpha of .89 with a mean of 17.97 ($SD = 10.57$). Table 4.3 provides a summary of the reliability coefficients, means, and standard deviations.

4.2.2 Social Avoidance and Distress Scale

Previous studies using the 28-item self-report Social Avoidance and Distress Scale (Watson & Friend, 1969) have reported evidence of strong reliability (Leary, 1988; Feerick & Haugaard, 1999; Watson & Friend, 1969). For example, Leary (1988) reports a high internal consistency value of $\alpha = .87$ for the full scale. Inter-item reliability (Cronbach’s Alpha or KR-20) of the 28 items has been reported at approximately .90 on
both true-false and Likert versions of the scale (Watson & Friend, 1969; Leary, 1988). Factor analyses have obtained separate avoidance and anxiety factors, and have shown that both subscales have adequate alpha coefficients (\( \alpha > .80 \)) and they correlate moderately with one another (Leary, 1988). Response sets range from 0 to 1 with a possible total score ranging from 0 to 28. Higher scores are indicative of increased social avoidance and distress. Reliability analyses of the Social Avoidance and Distress Scale in the present study yielded a Cronbach’s alpha of .91 across the full sample with a mean of 6.24 (\( SD = 6.12 \)). Reliability analyses across the non-exposed subsample yielded a Cronbach’s alpha of .91 and a mean of 6.07 (\( SD = 5.97 \)). Reliability analyses across the exposed subsample yielded a Cronbach’s alpha of .93 and a mean of 7.18 (\( SD = 6.95 \)). A summary of the reliability estimates are included in Table 4.3.

4.2.3 Satisfaction with Life Scale

This seven item scale (Diener, 1984) is designed to provide a measure of global life satisfaction and has been found to have moderate reliability coefficients in previous studies (\( \alpha = .76 \)) (Callahan et al., 2003; Diener, 1984). Response sets ranged from 1 to 7 with a possible total score ranging from 7 to 49. Lower scores are indicative of increased satisfaction with life across domains. Reliability analyses of the Satisfaction with Life Scale in the present study yielded a Cronbach’s alpha of .75 across the full sample and a mean of 23.46 (\( SD = 7.27 \)). Reliability analyses of the non-exposed subsample yielded a Cronbach’s alpha of .74 and a mean of 22.82 (\( SD = 6.97 \)). Reliability analyses of the exposed subsample yielded a Cronbach’s alpha of .76 and a mean of 26.55 (\( SD = 7.95 \)). Table 4.3 provides a summary of the reliability estimates.
Table 4.3 *Internal Reliability Estimates of Measures*

<table>
<thead>
<tr>
<th>Scale</th>
<th>N items</th>
<th>n</th>
<th>(\hat{\alpha})</th>
<th>(M (SD))</th>
</tr>
</thead>
<tbody>
<tr>
<td>TSC</td>
<td>33</td>
<td>262</td>
<td>.90</td>
<td>18.78 (11.49)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exposed</td>
<td>45</td>
<td></td>
<td>.93</td>
<td>22.68 (14.67)</td>
</tr>
<tr>
<td>Not Exposed</td>
<td>217</td>
<td></td>
<td>.89</td>
<td>17.97 (10.57)</td>
</tr>
<tr>
<td>SAD</td>
<td>28</td>
<td>262</td>
<td>.91</td>
<td>6.24 (6.12)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exposed</td>
<td>45</td>
<td></td>
<td>.93</td>
<td>7.17 (6.95)</td>
</tr>
<tr>
<td>Not Exposed</td>
<td>217</td>
<td></td>
<td>.91</td>
<td>6.07 (5.97)</td>
</tr>
<tr>
<td>SWL</td>
<td>7</td>
<td>262</td>
<td>.75</td>
<td>23.46 (7.27)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exposed</td>
<td>45</td>
<td></td>
<td>.76</td>
<td>26.55 (7.95)</td>
</tr>
<tr>
<td>Not Exposed</td>
<td>217</td>
<td></td>
<td>.74</td>
<td>22.82 (6.97)</td>
</tr>
</tbody>
</table>

4.3 Correlation Analysis on Measures of Psychosocial Wellness

The investigation of the relationship between exposure to intimate partner violence and psychosocial wellness was of primary interest in this study. Psychosocial wellness was operationalized and measured by outcomes on the Satisfaction with Life Scale, the Trauma Symptom Checklist, and the Social Avoidance and Distress Scale.

Correlation coefficients were calculated for the sample in order to identify statistically significant relationships existing among satisfaction with life, trauma symptomology, and social avoidance and distress. Table 4.4 presents the results of the correlational analyses. While the correlation between satisfaction with life and social avoidance was significant and positive,
It was fairly low and accounts for only 12.6% of the variance between satisfaction with life and social avoidance. A similar pattern was found between satisfaction with life and trauma symptomology \((r = .432, p = .01)\), and trauma symptomology and social avoidance \((r = .386, p = .01)\).

Table 4.4 *Pearson Product Moment Correlations for Psychosocial Wellness*

<table>
<thead>
<tr>
<th></th>
<th>SWL</th>
<th>SAD</th>
<th>TSC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Satisfaction with Life</td>
<td>-</td>
<td>.355*</td>
<td>.432*</td>
</tr>
<tr>
<td>Social Avoidance</td>
<td>.355*</td>
<td>-</td>
<td>.386*</td>
</tr>
<tr>
<td>Trauma Symptoms</td>
<td>.432*</td>
<td>.386*</td>
<td>-</td>
</tr>
</tbody>
</table>

*Correlation is significant at the 0.01 level (2-tailed)*

4.4 Independent T-test

Three independent t-tests were conducted in the present study to investigate whether there were statistically significant differences on outcomes of psychosocial wellness across subsamples that were exposed to intimate partner violence and those who were not exposed to intimate partner violence. Furthermore, six independent t-tests were conducted to investigate whether age of exposure to intimate partner violence and age of childhood physical abuse produced statistically different outcomes on measures associated with psychosocial wellness. In order to protect against Type I error, Bonferroni adjustments were made to the alpha level (Tabachnik & Fidell, 2001), dividing it by the number of t-tests \((\alpha/3 \text{ and } \alpha/6)\).

4.4.1 T-test Exposure to Intimate Partner Violence and Psychosocial Wellness

Exposure to intimate partner violence was a demographic variable used to describe the level of exposure to intimate partner violence within subsamples. Exposure to
intimate partner violence was operationalized as a frequency greater than zero on the total score of the Physical Assault Subscale of the Conflicts Tactic Scale – 2 (Straus et al., 1996). Three independent t-tests were conducted to evaluate the effect of exposure to physical intimate partner violence on each of the dependent variables associated with psychosocial wellness. With respect to trauma symptomology, the difference between the mean scores of the exposed (22.68) and non-exposed subsamples (17.97) was significant with the exposed subsample demonstrating higher levels of trauma symptoms, $t (-2.53), p = .012$. No significant differences were found between the exposed and non-exposed subsamples on the dependant variable of social avoidance and distress. This finding did not support the assumption that the two subsamples would have significantly different scores on social avoidance and distress. However, significant differences were found between the two subsamples with respect to satisfaction with life, $t (-3.18), p = .002$. The non-exposed subsample (22.82) reported significantly lower scores on the Satisfaction with Life Scale than the exposed subsample (26.55), indicating that the non-exposed subsample reported increased satisfaction with life.

Table 4.5 presents the results of the independent t-tests.
Table 4.5 Comparison of Means for Psychosocial Wellness

<table>
<thead>
<tr>
<th>Source</th>
<th>M (SD)</th>
<th>df</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>TSC</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exposed</td>
<td>22.68 (14.67)</td>
<td>260</td>
<td>-2.53</td>
<td>.012*</td>
</tr>
<tr>
<td>Non-Exposed</td>
<td>17.97 (10.57)</td>
<td>260</td>
<td>-2.53</td>
<td>.012*</td>
</tr>
<tr>
<td>SAD</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exposed</td>
<td>7.17 (6.95)</td>
<td>260</td>
<td>-1.13</td>
<td>.260</td>
</tr>
<tr>
<td>Non-Exposed</td>
<td>6.04 (5.93)</td>
<td>260</td>
<td>-1.13</td>
<td>.260</td>
</tr>
<tr>
<td>SWL</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exposed</td>
<td>26.55 (7.95)</td>
<td>260</td>
<td>-3.18</td>
<td>.002*</td>
</tr>
<tr>
<td>Non-Exposed</td>
<td>22.82 (6.97)</td>
<td>260</td>
<td>-3.18</td>
<td>.002*</td>
</tr>
</tbody>
</table>

* Note: p< .05/3 = .016

4.4.2 T-test Age of Exposure to Intimate Partner Violence and Age of Childhood

Physical Abuse on Psychosocial Wellness

Six independent t-tests were conducted to evaluate the effect of exposure to intimate partner violence and physical abuse at differing developmental stages on each of the dependent variables associated with psychosocial wellness. Two developmental categories were considered within the present study: middle childhood (6 to 11 years old) and adolescence (12 to 17 years old). With respect to exposure to intimate partner violence at each of the developmental stages, no significant differences were found on mean scores of trauma symptomology between the subsample exposed in middle childhood (21.57) and the subsample exposed in adolescence (25.75). No significant differences were found between those same subsamples on scores of social avoidance and distress. As predicted, the subsample exposed in middle childhood reported higher
scores of social avoidance and distress (7.48) than the subsample exposed in adolescence (6.33), but they were not statistically significant. Finally, the subsample exposed in middle childhood (26.39) did not display statistically different scores on satisfaction with life than the subsample exposed in adolescence (27.00), although the pattern of scores was in the anticipated direction. Table 4.6 presents the results of the independent t-tests.

With respect to experiences of physical abuse at each of the developmental stages, no significant differences were found between the subsample exposed in middle childhood (21.85) and those exposed in adolescence (23.94) on self-reported trauma symptomology. Similarly, no significant differences were reported between the samples on social avoidance and distress, as well as satisfaction with life. These findings did not support the assumption that those exposed or abused in adolescence would have significantly better scores on measures associated with psychosocial wellness. The results of the independent t-tests for age of experience of physical abuse are presented in Table 4.6.
### Table 4.6 Comparison of Means for Developmental Stage on Psychosocial Wellness

<table>
<thead>
<tr>
<th>Source</th>
<th>M (SD)</th>
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<td>0.759</td>
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<tr>
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<td>Abused &gt; 12</td>
<td>24.62 (7.18)</td>
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Note: \( p < .05/6 = .008 \)

#### 4.5 Univariate Analysis of Variance

Three ANOVAs were conducted to investigate the relationship between exposure to intimate partner violence and the experience of childhood physical abuse on measures of
psychosocial wellness. Similar to the t-tests, a conservative $\alpha$ level was used to protect against Type I error.

4.5.1 ANOVA Exposure to Intimate Partner Violence and Experience of Physical Abuse on Psychosocial Wellness

Three $2 \times 2$ (exposure to intimate partner violence x experience of physical abuse) univariate ANOVAs were used to investigate the effects of exposure to intimate partner violence and experience of physical abuse on psychosocial wellness as operationalized by scores on the Trauma Symptom Checklist, the Social Avoidance and Distress Scale, and the Satisfaction With Life Scale.

For the dependent variable of trauma symptomology, the mean for the Non-Exposed/Non-Abused subsample (15.95) was lower than the Non-Exposed/Abused subsample (22.12) indicating less trauma symptoms for the Non-Exposed/Non-Abused subsample. The mean for the Exposed/Non-Abused subsample (18.40) was lower than the Exposed/Abused subsample (26.12) indicating higher trauma symptoms for the Exposed/Abused subsample. Table 4.7 illustrates the results of the ANOVA $F$-test. The main effect of experience of physical abuse was significant, $F(1, 1740.34) = 14.40, p = .000, \eta^2 = .053$. The main effect for exposure to intimate partner violence and experience of physical abuse was approaching significance $F(1, 373.99) = 3.09, p = .080, \eta^2 = .012$. The observed power of the statistical tests were quite low (.001 - .053) which suggests that increased sample sizes may have produced different statistical outcomes by producing more powerful statistical tests and more effectively illustrating a significant effect for exposure to intimate partner violence and experience of physical abuse.

For the dependent variable of social avoidance and distress, the mean for the
Non-Exposed/Non-Abused subsample (5.61) was lower than the Non-Exposed/Abused subsample (6.92) indicating less social avoidance and distress for the Non-Exposed/Non-Abused subsample. The mean for the Exposed/Non-Abused subsample (5.05) was lower than the Exposed/Abused subsample (8.88) indicating increased social avoidance and distress for the Exposed/Abused subsample. Table 4.7 illustrates the results of the ANOVA F-test. The main effect of experience of physical abuse was significant, $F(1, 1740.34) = 14.40, p = .000, \eta^2 = .053$. The main effect for exposure to intimate partner violence and experience of physical abuse was not significant. The observed power of the statistical tests were low (.002 - .025), indicating that an increased sample size may have resulted in different statistical outcomes by producing a more powerful test that may have illustrated significant outcomes.

For the dependent variable of satisfaction with life, the mean for the Non-Exposed/Non-Abused subsample (22.14) was lower than the Non-Exposed/Abused subsample (24.21) indicating greater satisfaction with life for the Non-Exposed/Non-Abused subsample. The mean for the Exposed/Non-Abused subsample (27.15) was higher than the Exposed/Abused subsample (26.08) indicating a greater satisfaction with life for the Exposed/Abused subsample. These findings did not support the assumption that those exposed or abused would have significantly lower self-reports of satisfaction with life. Table 4.7 illustrates the results of the ANOVA F-test. The main effect of exposure to intimate partner violence was significant, $F(1, 426.05) = 8.40, p = .004, \eta^2 = .032$. The main effect for exposure to intimate partner violence and experience of physical abuse was not significant; however, it is important to note that the observed power for the statistical tests were quite low (.001 - .032) and an increased sample size may have resulted in more powerful analyses that more clearly illustrated
significant differences between exposure to intimate partner violence and experiences of physical abuse in childhood on satisfaction with life.

Table 4.7 Analysis of Variance for Exposure to IPV and Physical Abuse on Psychosocial Wellness

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<tr>
<th>DV Source</th>
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<td>IPV x Abuse</td>
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<td>.006*</td>
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* Note: \(p < .05/06 = .008\)
CHAPTER 5: DISCUSSION

This chapter includes a summary of the present study and a discussion of the findings, including limitations of the current study. Recommendations for further research and implications for practice and intervention are also addressed.

5.1 Summary of the Research Study

The impetus for this study follows from the scarcity of research investigating the long-term implications of childhood exposure to physical intimate partner violence on internal aspects of functioning. To date, the majority of studies focusing on childhood exposure to domestic violence have centered on the relationship between childhood exposure to such violence and adult experiences of intimate relationship violence. Broader symptoms related to internalizing domains, such as social and psychological functioning, have generally been ignored in retrospective studies of childhood exposure to violence between adult partners.

Due to the exploratory, non-experimental design of the study, a significant strength associated with this research is the generation of potential fruitful areas of inquiry. The present study represents a preliminary investigation of the impact of exposure to intimate partner violence in childhood on internalizing domains of functioning, including social and psychological functioning, amongst women in adulthood. Furthermore, as one of the main challenges facing researchers within this domain of inquiry has been the lack of a common conceptualization of well-being, an important contribution of the present study was to employ a recently proposed model of
psychosocial wellness (Lent, 2004). Moreover, in an effort to address gaps in previous research that have not considered the role of mediating factors in outcomes of children exposed to intimate partner violence, the present study explored two key mediating factors: developmental stage at the initial time of exposure to intimate partner violence and the experience of physical abuse on outcomes of psychosocial wellness.

5.2 Discussion of Research Findings

The current study sought to address how exposure to childhood physical abuse and age at the time of exposure may mediate outcomes on psychosocial wellness for women who were exposed to intimate partner violence during their developmental years.

5.2.1 Exposure to Intimate Partner Violence and Psychosocial Wellness Outcomes

On the basis of relevant theory and previous research conducted within the field, it was hypothesized that women who were not exposed to intimate partner violence would have significantly better outcomes on measures associated with psychosocial wellness than those who were exposed to intimate partner violence. The results indicated that there were some statistically significant differences on measures related to psychosocial wellness between women who had been exposed to physical intimate partner violence during their developmental years and those who had not. As anticipated, women who were not exposed to physical intimate partner violence in childhood reported higher satisfaction with life than their exposed counterparts. Women who were exposed to intimate partner violence also displayed higher levels of trauma-related symptoms in adulthood compared to women who were not exposed. Finally, contrary to expectation, there were no significant differences between women exposed to intimate partner violence in childhood and those who were not exposed with respect to social avoidance and distress. This finding contrasts previous research that found significant differences
on social avoidance and distress when women who were exposed to intimate partner violence were compared with those who had not been exposed to intimate partner violence (Feerick & Haugaard, 1999). One possible explanation for this finding is that previous studies investigated the impact of exposure to intimate partner violence on singular aspects of adult functioning whereas the present study sought to investigate several aspects of adult functioning, including life satisfaction, social avoidance, and trauma symptomology.

5.2.2 Effects of Childhood Physical Abuse on Psychosocial Wellness Outcomes

The present study hypothesized that women exposed to intimate partner violence who did not experience physical abuse would have significantly better outcomes on measures associated with psychosocial wellness than those who experienced physical abuse. The findings of the present study supported this hypothesis. There were significant differences on psychosocial wellness between women who were both exposed to intimate partner violence and experienced physical abuse in childhood versus those who were either exposed to intimate partner violence or physical abuse alone. With respect to trauma symptomology, women who were not exposed to intimate partner violence or physically abused reported low trauma-like symptoms. Similarly, as anticipated, women who were both exposed and abused during their childhood (6 to 17 years of age) displayed the highest frequency of trauma-like symptoms.

Similar findings were reported for social avoidance and distress. The average scores for women who were not exposed nor abused during their developmental years evidenced lower levels of social avoidance and distress than women who were not exposed but were abused. Furthermore, women who were both exposed to intimate partner violence in childhood and abused reported higher levels of social avoidance and
distress than those women who were exposed to intimate partner violence alone, but did not experience physical abuse. This supports previous research that a combination of two or more psychosocial stressors may multiply children’s risk of adjustment problems (Cummings, 1998a; Kolbo, 1996; Diamond & Muller, 2004), as well as longer-term outcomes in adulthood (Feerick & Haugaard, 1999; O’Keefe, 1994).

In terms of life satisfaction, there were also significant differences among the groups. Women who were neither exposed to intimate partner violence nor abused reported greater life satisfaction than their counterparts who were abused in childhood. Interestingly, women who were both exposed to intimate partner violence and abused in childhood reported greater satisfaction with life than those who were exposed but not abused. Although this finding was not anticipated, it may suggest important implications about the nature of life satisfaction. Well-being theorists indicate that life satisfaction may change with the conditions in people’s lives (Diener, et al., 2002). Given that the present sample was a predominantly young adult university population, recent changes in their life conditions (e.g., living arrangements, active pursuit of academic goals) may have affected their perceptions of life satisfaction. This potential effect on self-reports of life satisfaction may have been more pronounced among those women who were both exposed to intimate partner violence and experienced physical abuse while living at home than those with a singular experience of either exposure or abuse. As a result of recent changes in their living conditions or the pursuit of their academic goals, it is possible that female young adults who were both exposed and abused during their developmental years would report greater life satisfaction than those with a singular experience of victimization such as either exposure or abuse (Diener et al., 2002).
5.2.3 Influence of Developmental Stage at Time of Exposure or Abuse on Psychosocial Wellness

The present study also hypothesized that women who were older (12 years and above) at the time of initial exposure to intimate partner violence would have significantly better outcomes on measures associated with psychosocial wellness than those who were under eleven years of age at the time of initial exposure. Contrary to the predicted results, there were no significant differences on psychosocial wellness amongst groups based on the developmental period at the time of exposure and/or the experience of physical abuse. However, for social avoidance and distress, and satisfaction with life, the pattern of responses was in the anticipated direction. As predicted, women who were initially exposed to intimate partner violence during middle childhood reported increased social avoidance and distress compared to women who were initially exposed to intimate partner violence during adolescence. This trend supports the premise of developmental theory (Cunningham & Baker, 2004) which hypothesizes that children in the stage of middle childhood (6 to 11 years old) are more vulnerable to the impact of exposure to intimate partner violence than those in adolescence because they have fewer developmental capacities to regulate feelings and cognitively process and evaluate environmental information than older children. As there were no studies reported in the literature that investigated the effects of exposure to intimate partner violence across different stages of development, the results of this study suggest that initial exposure to intimate partner violence during a younger developmental stage, such as middle childhood versus adolescence, may lead to increased social avoidance and distress in adulthood.
Overall, these results suggest that many of the effects of exposure to physical intimate partner violence may be attributable to the co-occurrence of other risk factors, including physical abuse in childhood and developmental stage. In support of a cumulative risk approach to the impact of traumatic experiences during childhood on adult functioning (Cummings 1998a), these findings suggest the importance of examining the combined effects of different risk factors.

5.3 Limitations of Current Research

The preceding findings notwithstanding, the present findings must be tempered in light of a number of limitations inherent in the current research study.

5.3.1 Generalizability

The data in the present study were based on a sample of undergraduate students taken from a western Canadian university and between the ages of 17 and 36 years. As such, generalizability to other ages and populations is limited due to the developmental and contextual factors that impact individuals. While some aspects of the conclusions may be applied to similar populations and locales, it is important to note that limited information was gathered about the context in which participants were raised, as well as cultural background, which provide further limitations to generalizability. The inclusion of other age groups and/or longitudinal studies, rather than a cross-sectional study, as well as other contexts besides the university setting could have broadened the scope of generalizability.

It is also difficult to compare the results of the present study across other studies as this study focused on specific forms of abuse – namely, exposure to physical intimate partner violence and the experience of childhood physical abuse. As such, this study did
not consider exposure to verbal, emotional, or sexual intimate partner violence nor did it consider experiences of verbal, emotional, or sexual childhood abuse.

5.3.2 Potential Confounding Factors

Another potential limitation of the present study is the possibility of confounding factors. Although the current study attempted to include factors that had not been controlled for in previous studies, such as age at the time of initial exposure and the experience of childhood physical abuse, other potentially traumatizing experiences were not controlled for in the present study. For example, experiences of community violence or violence at the hands of an adult intimate partner may have influenced participants’ self-reports of trauma-like symptoms, social avoidance and distress, and life satisfaction.

Another challenge faced by the current research study involved the focus on physical intimate partner violence alone. While other forms of abuse were not included in the present analysis in an effort to minimize the influence of confounding variables, it is acknowledged that women are often exposed to multiple types of violence in their daily lives including physical, psychological, sexual, and/or verbal abuse. The complexity of dividing abuse into distinct categories such as physical, psychological, sexual, and/or verbal remains a challenge that researchers within this domain of inquiry should strive to address.

5.3.3 Variables Measured

This study focused solely on two developmental categories: middle childhood and adolescence. Participants indicating exposure to intimate partner violence or physical abuse in early childhood or later young adulthood were not included in the present analyses. This constraint was established to control for potentially confounding variables such as memory with respect to the recall of experiences in early childhood (e.g., prior
to six years of age) (Brewin et al., 1993) and current exposure to intimate partner violence or abuse. Furthermore, the present study did not include analysis of exposure to intimate partner violence or experiences of abuse within both age categories of middle childhood and adolescence. Rather, participants who indicated they had been exposed or abused during both developmental categories were categorized according to the time of their initial exposure or experience of abuse.

While the results of this study suggest the importance of considering the impact of developmental stage at the time of exposure or abuse on outcomes of psychosocial wellness, future studies should consider two recommendations. First, the implications of exposure to intimate partner violence and/or experiences of physical abuse in other developmental stages should be considered beyond just middle childhood and adolescence. And secondly, the implications of being exposed and abused during both developmental categories of middle childhood and adolescence should be explored in an effort to understand the resulting outcomes on psychosocial wellness.

5.3.4 Research Design

Due to the exploratory nature of this study, the research design included a convenience sample of female undergraduate students from a western Canadian university who volunteered to participate in the study. Although random sampling and an experimental design may have strengthened the generalizability of the research findings, that particular research methodology was not feasible within the confines of the present study.

Furthermore, the initial intention for the present study was to conduct a multivariate analysis of variance. However, because the sample sizes in many of the subsample cells were insufficient to meet the assumptions of a balanced design (Tabachnik & Fidell,
2001), t-tests and ANOVAs were performed. Future studies should strive for larger sample sizes in an effort to meet the assumptions of balanced subsample cells associated with multivariate analysis of variance and therefore potentially enhance the statistical power of the results of the investigation.

5.3.5 Questionnaires

Another issue mitigating the interpretation of these findings lies in the limitation of the measures employed in the current study. This study used self-reported measures of exposure to intimate partner violence, experiences of physical childhood abuse, social avoidance and distress, trauma symptoms, and satisfaction with life. As is the nature of self-report measures, the data are a reflection of the respondents’ perceptions to the items requested and cannot always be interpreted as actual fact. Considerations of the implications of self-reported data are necessary in the interpretation of the results.

Although it could be argued that reports of exposure to intimate partner violence should have been corroborated by parental reports, parents have been found to greatly underestimate the amount of violence to which their children are actually exposed (Edleson, 2001). In addition, it may be that the subjective experience of exposure to intimate partner violence is more essential to predicting the impact on one’s own life than information from other sources (Feerick & Haugaard, 1999).

In addition, exposure to intimate partner violence and physical abuse were assessed with a retrospective self-report questionnaire, which could have been influenced by recall bias. However, studies have suggested that participants’ recall of specific childhood experiences such as exposure to intimate partner violence and experiences of abuse are relatively accurate (Brewin et al., 1993). Despite this finding, the use of retrospective data does limit the ability of researchers to determine causality.
Another area of limitation with respect to the questionnaires utilized for the present research study includes the underlying cultural and gender-based assumptions associated with these scales. For example, the Social Avoidance and Distress Scale (Watson & Friend, 1969) includes statements that may be interpreted differently based on an individual’s gender or their cultural origin.

5.4 Implications for Future Research and Practice

The results of the current study hold several key implications for future research and practice, as well as intervention.

5.4.1 Implications for Future Research

Despite the limitations of the present study, the findings of this investigation contribute to the relatively small empirical knowledge base of the impact of childhood exposure to physical intimate partner violence on women in adulthood. In particular, the results of this study contribute to understanding the influence of such exposure on internalized domains such as social and psychological functioning. The results of this study also suggest the importance of further investigations that stem from clear conceptual frameworks of the nature of intimate partner violence and the resulting definitions that are utilized in empirical research. Furthermore, this study points to the importance of examining mediating factors that potentially affect an individual’s outcomes on internalized aspects of functioning such as psychological and social well-being.

Six recommendations for future study include: (1) larger sample sizes to ensure multivariate normality, as well as balanced or proportional designs to ensure the robustness of the statistical method and any resultant significant findings; (2) exploration of the implications of being exposed to intimate partner violence in both age categories.
of middle childhood and adolescence; (3) exploration of exposure to intimate partner violence and physical abuse in age categories beyond middle childhood and adolescence, such as infancy and preschool years; (4) continued investigation of Lent’s (2004) model of psychosocial wellness, with additional consideration given to the effects of exposure to intimate partner violence on physical aspects of health and well-being; (5) exploration of exposure to intimate partner violence and experiences of physical abuse on outcomes amongst men; and (6) continued study of the impact of different forms of violence and abuse including physical, sexual, emotional, and verbal on women’s social and psychological functioning. In all cases, it is recommended that clear distinctions are made regarding what constitutes intimate partner violence and the directionality of the violence (Johnson, 1995).

Furthermore, future studies based on a naturalistic research design hold potential in elaborating on the understanding of key mediating variables for children and adolescents exposed to intimate partner violence. For example, a factor that has been gaining recent consideration in the research literature is the role of hope in the counselling process (Jevne, 2005). While practitioners have commented for years on the role of hope in the counselling process with women and children affected by intimate partner violence, little, if any research has been directed to understanding the experience of hope in the counselling process as well as resulting outcomes (Edey, Jevne, & Westra, 1998). By gaining further understanding of the role of hope in supporting victims of intimate partner violence, practical applications could be developed to support these women and children through the counselling process, leading to enhanced outcomes, as well as spurring further research into primary and secondary prevention efforts in the area of intimate partner violence.
5.4.2 Implications for Practice and Intervention

While the results of this study are preliminary in nature, they underscore the need for the consideration of multiple issues in developing effective interventions with children, youth, and young adults who have been exposed to physical intimate partner violence. This study demonstrated significant differences on important aspects of internalizing domains of functioning in women as a result of exposure to intimate partner violence. In particular, women exposed to intimate partner violence during their developmental years were still reporting significant trauma-like symptoms in adulthood, as well as decreased satisfaction with their lives as a whole. These findings suggest that interpersonal functioning may be an important focus of intervention efforts for children and youth exposed to intimate partner violence. In particular, these findings hold implications for group approaches to intervention offered for children exposed to intimate partner violence. Typically, these interventions involve a series of semi-structured group sessions that are intended to assist children and adolescents in processing their experiences of witnessing woman abuse in a supportive environment (Sudermann, Marshall, & Loosely, 2000). Common themes or goals in these approaches include offering children and adolescents opportunities to talk about their experiences of witnessing intimate partner violence and improving self-esteem. The results of the current study underscore the value of informing children about the possible effects of exposure to woman abuse on their social and psychological functioning, such as increased trauma-like symptoms, including sleep disturbances and somatic complaints, as well as imparting coping skills to children and adolescents who have been exposed to woman abuse. Moreover, as participants in the current study commonly reported symptoms such as loneliness, isolation, and challenges in getting along with others as a
result of exposure to intimate partner violence, the results of the present study suggest
the value of group interventions for children and adolescents that allow opportunities for
socialization and social support.

Furthermore, women who had experienced more than one form of victimization
during their developmental years, such as exposure to intimate partner violence and
physical abuse, tended to report increased symptoms of trauma, social avoidance and
distress, and lower overall satisfaction with life than women who had neither experience,
or who were either exposed or abused. Hence, experiences of multiple victimization
should be considered when designing interventions for children and youth. In particular,
practitioners may consider offering a variety of intervention programs – some
specifically designed for children and adolescents who have been exposed to woman
abuse, as well as programs for children and adolescents who have been exposed to
intimate partner violence and were also victimized themselves.

Finally, the findings of this study provide preliminary support for the premise that
exposure to intimate partner violence during an early developmental stage potentially
leads to poorer outcomes of psychosocial wellness in adulthood than those exposed
during adolescence. This finding holds two important implications for practice. First, the
results of this study suggest the importance of designing interventions that are age­
appropriate and that do not combine children and adolescents from differing
developmental stages into one homogenous therapy group. The intervention needs of
children exposed to intimate partner violence in middle childhood (6 to 11 years of age)
are quite different from the needs of adolescents exposed to intimate partner violence.
As developmental theory suggests, younger children are more prone to self-blame and
somatic complaints as a result of exposure to woman abuse (Cunningham & Baker,
as such, interventions designed specifically for their age-appropriate reactions to woman abuse would be of great benefit. Interventions designed for adolescents should focus on aspects that are of primary concern during this developmental stage including peer relationships, tendencies towards care-taking of younger siblings, safety-planning, and issues related to premature departure from the home (Cunningham & Baker, 2004).

A second implication for practice as a result of this finding is the important role of prevention and early intervention with respect to exposure to intimate partner violence and childhood abuse. One conclusion that is almost inevitably reached by those involved in the field of domestic violence is that intimate partner violence is a problem better prevented before it occurs than addressed after the damage is done (Jaffe, et al., 2004). By addressing systemic issues related to violence against women within Canadian society, through education, advocacy programs, and supportive services, occurrences of intimate partner violence may be prevented for many women, children, and adolescents across our nation.

5.5 Conclusion

In conclusion, this study has provided some insight into the complex nature of exposure to intimate partner violence during children's developmental years. While attempts to clearly define and research the construct of exposure to intimate partner violence persist in posing challenges for researchers, continued investigation into the impact of such exposure on a child's development remains important. Previous research has begun to establish a clear link between exposure to intimate partner violence in childhood and resulting effects on externalizing domains of functioning. Importantly, the current study identifies some of the potential long-term impact of such exposure on internal aspects of functioning, such as psychological and social well-being. Further
research into the domain of childhood exposure to intimate partner violence is critical to ending the systemic cycle of violence and its effects in our modern-day society.

Over the past thirty years, tremendous gains have been made across Canada in addressing the issues related to domestic violence. People involved in government, research, education, health, and support services across the nation have begun to work together to raise awareness of the deleterious impact of violence against women and its impact on the children who are exposed to such violence each day in our country. Although it has become increasingly clear that the impact of such exposure is complex and unique for each child, central themes of fear, anxiety, depression, and anger resound, leading to withdrawal from school and community participation – the very institutions designed to support our children. Communities and the individuals they are comprised of can no longer be passive bystanders to this harm (Jaffe et al., 2004). The present research represents the dreams of one individual who hopes for better understanding, broader education, a more sensitive community response, and genuine collaboration in ending domestic violence in Canada. The children of this country and others around the world deserve no less.
References


Appendix A: Ethics Approval

NAME: Stephanie Martin (Billie Jo Carter)
Educational Psychology and Special Education

DATE: August 4, 2005

The University of Saskatchewan Behavioural Research Ethics Board has reviewed the Application for Ethics Approval for your research study "Mediating Factors Affecting Psychosocial Wellness amongst Young adults Exposed to Intimate Partner Violence in Childhood" (05-176).

1. Your study has been APPROVED subject to the following minor modifications:
   a. The consent form should specify that participants can refuse to answer individual questions.
   b. The consent form should also indicate that the participants may contact the researcher if they feel distressed (you should be prepared to make an appropriate referral or take whatever other action appears necessary).

2. Any significant changes to your proposed method, or your consent and recruitment procedures should be reported to the Chair for Research Ethics Board consideration in advance of its implementation.

3. The term of this approval is for 5 years.

4. This approval is valid for one year. A status report form must be submitted annually to the Chair of the Research Ethics Board in order to extend approval. This certificate will automatically be invalidated if a status report form is not received within one month of the anniversary date. Please refer to the website for further instructions http://www.usask.ca/research/behavioural.shtml

I wish you a successful and informative study.

Dr. Valerie Thompson, Chair
University of Saskatchewan
Behavioural Research Ethics Board

VT/cc

Office of Research Services, University of Saskatchewan
Room 1607, 110 Gymnasium Place, Box 5000 RPO University, Saskatoon SK S7N 4J8 CANADA
Telephone: (306) 966-8576 Facsimile: (306) 966-8597
http://www.usask.ca/research
Appendix B: Consent Form

You are invited to participate in a study entitled “Mediating Factors Affecting Psychosocial Wellness amongst Young Adults Exposed to Intimate Partner Violence in Childhood.” Please read this form carefully, and feel free to ask any questions you might have.

Researcher: Bille Jo Carter
Supervisor: Dr. Stephanie Martin

Telephone Number: 966-7653
Telephone Number: 966-5259

Institutional Affiliation: Department of Educational Psychology, University of Saskatchewan

The purpose of the study is to determine the long-term effects of exposure to intimate partner violence – physical violence experienced by a woman at the hands of an intimate partner - on the psychosocial wellness of young adults. Further, it is the intention of this study to determine if the age of exposure to intimate partner violence in childhood, as well as gender, and the joint experience of physical child abuse, affects long-term outcomes on psychosocial wellness.

Individuals choosing to participate in this study will be required to sign this consent form. A copy of such will be provided for your own records. Participants will then be asked to respond to a given set of six self-report measures. The first questionnaire will assess demographic information such as age, gender and family history. The second questionnaire will assess exposure to intimate partner violence in childhood, as well as experiences of childhood physical abuse. The final three questionnaires will assess psychosocial wellness. Specific instructions as to how to correctly respond to each measure are provided on the questionnaire form. You are free to refuse to answer any of the individual questions related to the questionnaires. It is expected that completion of these measures will take approximately 30 – 45 minutes.

There are no direct personal benefits to participating in this study. It is hoped that the findings of this study will benefit the wider community, particularly childhood victims of intimate partner violence, although these benefits are in no way guaranteed.

A potential risk or side affect of participation in this study may involve the revisiting of sensitive and painful memories regarding exposure to intimate partner violence in childhood, as well as the experience of childhood physical abuse. In addition, there may be a potential risk to those participants who may have not realized that they were exposed to intimate partner violence in childhood, but as a result of completing these questionnaires, recognize they may have been. If issues of a sensitive nature arise as a result of participating in this study, support and counselling services are available at Student Counselling Services on the University of Saskatchewan campus (telephone number: 966 – 4920) as well as Family Service Saskatoon (telephone number: 244 – 0127). Participants may also contact the researcher (telephone number: 966 – 7653) in case of distress or if further information is required or if questions arise.
Your identity will be kept in complete confidence. Other than this consent form, which will be stored separately from the set of self-report measures, you will not be asked to place your name or any other specific identifying information on any other material used during the course of this study. The results of all measures will be strictly anonymous. Study results and all related materials will be safeguarded and stored by Dr. Stephanie Martin in a secure location at the University of Saskatchewan for a minimum of five years upon the completion of this study as per university policy.

The findings from this study will be reported as a final written thesis. Although the data from this study may be published and presented at conferences, the data will be reported in aggregate form, so that it will not be possible to identify individuals. Moreover, the consent forms will be stored separately from the self-report questionnaires, so that it will not be possible to associate a name with any given set of responses. Please do not put your name or other identifying information on the questionnaires. Given that participant names will not in any way be associated with the self-report measures, information regarding individual scores on any of the measures will not be available. However, for those individuals interested in the overall results of this study, information will be made available through Dr. Stephanie Martin. Further, the completed thesis will also be available for loan at the General Office of the Department of Educational Psychology and Special Education in the spring of 2006.

Participation in this study is strictly voluntary. You may withdraw from the study for any reason, at any time, without penalty of any sort. Withdrawal from the study shall not in any way affect academic status or access to services that the university provides. If you withdraw from the study at any time, any data that you have contributed will be destroyed.

If you have any questions concerning this study, please feel free to ask at any point; you are also free to contact the researcher if you have questions at a later time. This study has been approved by the University of Saskatchewan Behavioural Sciences Research Ethics Board on August 4th, 2005. Any questions regarding your rights as a participant may be addressed to that committee through the Office of Research Services (966-2084). Out of town participants may call collect.

I have read and understood the description provided above; I have been provided with an opportunity to ask questions and my questions have been satisfactorily answered. I consent to participate in the study described above and understand that I may withdraw this consent at any time. A copy of this consent form has been given to me for my records.

Participant Signature ___________________ Date ____________

Researcher Signature ___________________
Appendix C: Family Information Questionnaire

AGE: ____

GENDER: Male ____ Female ____

MARITAL STATUS: Single ____ Married ____ Common-Law ____
Divorced ____ Separated ____

PARENTS' MARITAL STATUS: Single ____ Married ____ Common-Law ____
Divorced ____ Separated ____

FATHER'S EDUCATIONAL STATUS:
Below grade 12 ____ Completed grade 12 ____ Technical School ____
University Degree ____ Masters Degree ____ PHD ____

MOTHER'S EDUCATIONAL STATUS:
Below grade 12 ____ Completed grade 12 ____ Technical School ____
University Degree ____ Masters Degree ____ PHD ____

PARENT'S INCOME:
Is your father's income:
Less than $10,000 per year? ____
$10,000 - $15,000 per year? ____
$15,000 - $20,000 per year? ____
$20,000 - $30,000 per year? ____
More than $30,000 per year? ____

Is your mother's income:
Less than $10,000 per year? ____
$10,000 - $15,000 per year? ____
$15,000 - $20,000 per year? ____
$20,000 - $30,000 per year? ____
More than $30,000 per year? ____

FAMILY HISTORY:
Do you have a family history of any of the following, and if so, please indicate which relative (for example, maternal grandmother):

Depression ____ relative: ______
Alcoholism ____ relative: ______
Drug Abuse ____ relative: ______
Suicide ____ relative: ______
Psychiatric Hospitalization ____ relative: ______
Appendix D: Conflict Tactics Scale – 2  
(Straus, et al., 1996)

No matter how well people get along, there are times when they disagree, get annoyed with the other person, want different things from each other, or just have spats or fights because they are in a bad mood, are tired, or for some other reason. Couples also have many different ways of trying to settle their differences. This is a list of things that might happen when two people in an intimate relationship have differences. Please circle how many times you saw or heard each of these things happen from the time you were 6 – 17 years old. Your responses should focus on your primary caregivers. In cases of parental divorce or loss, however, focus your answers on the behavior of adults in your home who you have lived with for over three years between the ages of 6 – 17 years old.

<table>
<thead>
<tr>
<th>How often did this happen?</th>
<th>0 = this has never happened</th>
<th>1 = once</th>
<th>2 = twice</th>
<th>3 = 3-5 times</th>
<th>4 = 6-10 times</th>
<th>5 = 11-20 times</th>
<th>6 = more than 20 times</th>
</tr>
</thead>
<tbody>
<tr>
<td>My father/step-father threw something at my mother that could hurt</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>My father/step-father twisted my mother’s arm or hair</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>My father/step-father pushed or shoved my mother</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>My father/step-father grabbed my mother</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>My father/step-father slapped my mother</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>My father/step-father used a knife or a gun on my mother</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>My father/step-father punched or hit my mother with something that could hurt</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>My father/step-father choked my mother</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>My father/step-father slammed my mother against a wall</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>My father/step-father beat up my mother</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>My father/step-father burned or scalded my mother on purpose</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
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<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

If you circled 1-6 for any of the above items, please check the age category at which it occurred:

__________ 6-11 years of age ___________ 12 – 17 years of age

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Appendix E: Childhood Experiences of Physical Abuse

Please circle how many times each of these things happened to you during the time you were between 6-17 years old. Your responses should focus on your primary caregivers. In cases of parental divorce or loss, however, focus your answers on the behavior of adults in your home who you have lived with for over three years.

<table>
<thead>
<tr>
<th>How often did this happen?</th>
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</tr>
</thead>
<tbody>
<tr>
<td>My father threw something at me that could hurt</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>My mother threw something at me that could hurt</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>My father twisted my arm or hair</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>My mother twisted my arm or hair</td>
<td>0</td>
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<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>My father pushed or shoved me</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
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<td>0</td>
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<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>My father grabbed me</td>
<td>0</td>
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<td>2</td>
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<td>My father used a knife or a gun on me</td>
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<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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</tr>
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<td>My father beat me up</td>
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<td>4</td>
<td>5</td>
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<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>My father burned or scalded me on purpose</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
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<tr>
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<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>My mother kicked me</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

If you circled 1-6 for any of the above items, please check the age category at which it occurred:

_____ 6-11 years of age       ____ 12 – 17 years of age
Appendix F: Trauma Symptom Checklist  
(Briere & Runtz, 1988)

How often have you experienced each of the following in the last two months?

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Occasionally</th>
<th>Fairly Often</th>
<th>Very Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Insomnia (trouble getting to sleep)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Restless sleep</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Nightmares</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Waking up early in the morning and can't get back to sleep</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Weight Loss (without dieting)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling isolated from others</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Loneliness</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Low sex drive</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Sadness</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>10. “Flashbacks” (sudden, vivid, distracting memories)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>11. “Spacing out” (going away in your mind)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>12. Headaches</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>13. Stomach problems</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>14. Uncontrollable crying</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>15. Anxiety attacks</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>16. Trouble controlling temper</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>17. Trouble getting along with others</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>18. Dizziness</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>19. Passing out</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
Appendix F Cont’d: Trauma Symptom Checklist

How often have you experienced each of the following in the last two months?

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Occasionally</th>
<th>Fairly Often</th>
<th>Very</th>
</tr>
</thead>
<tbody>
<tr>
<td>20. Desire to physically hurt yourself</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>21. Desire to physically hurt others</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>22. Sexual problems</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>23. Sexual overactivity</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>24. Fear of men</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>25. Fear of women</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>26. Unnecessary or over-frequent washing</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>27. Feelings of inferiority</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>28. Feelings of guilt</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>29. Feeling that things are “unreal”</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>30. Memory problems</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>31. Feeling that you are not always in your body</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>32. Feeling tense all the time</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>33. Having trouble breathing</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
Appendix G: Social Avoidance and Distress Scale  
(Watson & Friend, 1969)

Please read through the following statements and indicate to which extent they are “true” or “false” of you. If you feel the statement is true of you most of the time, then circle 1, but if it is not true of you most of the time, then circle 0.

<table>
<thead>
<tr>
<th>Statement</th>
<th>FALSE</th>
<th>TRUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I feel relaxed even in unfamiliar social situations.</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>2. I try to avoid situations which force me to be very sociable.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. It is easy for me to relax when I am with strangers.</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>4. I have no particular desire to avoid people.</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>5. I often find social settings upsetting.</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>6. I usually feel calm and comfortable at social occasions.</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>7. I am usually at ease when talking to someone of the opposite sex.</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>8. I try to avoid talking to people unless I know them well.</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>9. If the chance comes to meet new people, I often take it.</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>10. I often feel nervous or tense in casual get-togethers in which both sexes are present.</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>11. I am usually nervous with people unless I know them well.</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>12. I usually feel relaxed when I am with a group of people.</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>13. I often want to get away from people.</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>14. I usually feel uncomfortable when I am in a group of people I don’t know.</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>15. I usually feel relaxed when I meet someone for the first time.</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>
### Appendix G Cont’d: Social Avoidance and Distress Scale

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>16. Being introduced to people makes me tense and nervous.</td>
<td>FALSE</td>
</tr>
<tr>
<td>17. Even though a room is full of strangers, I may enter it anyway.</td>
<td>FALSE</td>
</tr>
<tr>
<td>18. I would avoid walking up and joining a large group of people.</td>
<td>FALSE</td>
</tr>
<tr>
<td>19. When my superiors want to talk with me, I talk willingly.</td>
<td>FALSE</td>
</tr>
<tr>
<td>20. I often feel on edge when I am with a group of people.</td>
<td>FALSE</td>
</tr>
<tr>
<td>21. I tend to withdraw from people.</td>
<td>FALSE</td>
</tr>
<tr>
<td>22. I don’t mind talking to people at parties or social gatherings.</td>
<td>FALSE</td>
</tr>
<tr>
<td>23. I am seldom at ease in a large group of people.</td>
<td>FALSE</td>
</tr>
<tr>
<td>24. I often think up excuses in order to avoid social engagements.</td>
<td>FALSE</td>
</tr>
<tr>
<td>25. I sometimes take responsibility for introducing people to each other.</td>
<td>FALSE</td>
</tr>
<tr>
<td>26. I try to avoid formal social occasions.</td>
<td>FALSE</td>
</tr>
<tr>
<td>27. I usually go to whatever social engagements I have.</td>
<td>FALSE</td>
</tr>
<tr>
<td>28. I find it easy to relax with other people.</td>
<td>FALSE</td>
</tr>
</tbody>
</table>
Appendix H: Satisfaction with Life Scale
(Diener, 1984)

Please respond to the following questions by circling a number between 1 – 7, based on the following anchor points: 1 = completely satisfied, 4 = neutral and 7 = completely dissatisfied.

How satisfied are you with your self these days?

1 2 3 4 5 6 7

How satisfied are you with your family life these days?

1 2 3 4 5 6 7

How satisfied are you with your romantic relationship[s] these days?

1 2 3 4 5 6 7

How satisfied are you with your income these days?

1 2 3 4 5 6 7

How satisfied are you with your friendships these days?

1 2 3 4 5 6 7

How satisfied are you with school these days?

1 2 3 4 5 6 7

How satisfied are you with your neighborhood/community these days?

1 2 3 4 5 6 7