Behavior problems in children of battered women

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BEHAVIOR PROBLEMS IN CHILDREN OF BATTERED WOMEN

by
Stacey Monahan

A Thesis
Submitted in partial fulfillment of the requirements of the
Master of Arts in Mental Health Counseling and Applied Psychology Degree
of
The Graduate School
at
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Approved by

Date Approved 9/13/06
The purpose of this study was to address this question: Is there a relationship between the trauma symptoms of mothers and the behavior problems of their children in the context of domestic violence? Mothers’ trauma symptoms significantly correlated with their children’s behavior problems in these children between the ages of 3 to 10 years. Pearson correlations revealed that the mothers’ defensive avoidance scale scores significantly correlated with their children’s anxious/depressed and internalizing scale scores, mothers’ depression and impaired self-reference scale scores significantly correlated with their children’s withdrawn and internalizing scale scores, and mothers’ dysfunctional sexual behavior and tension reduction behavior scale scores significantly correlated with their children’s withdrawn scale scores. Implications for treating women and children of domestic violence are discussed.
Acknowledgements

I would like to thank my thesis advisor Dr. Linda Jeffrey for her expertise and encouragement. I am also grateful to Dr. Eleanor Gaer and Dr. John Frisone for giving their time and energy to help me with this project. Finally, I thank my family and friends for their love and support.
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CHAPTER I

Introduction

Domestic Violence (DV) also called interparental conflict, intimate partner violence (IPV) or marital conflict, affects more than the partners involved. Data from misdemeanor DV incidents were analyzed in five major U.S. cities (Fantuzzo, Boruch, Beriama, Atkins, & Marcus, 1997). In that study they found that the DV group had on average more children than the general population in all five cities. As a result of findings like these, effects of witnessing DV have been investigated. One group of researchers (Jaffee, Moffitt, Caspi, Taylor, & Arseneault, 2002) conducted a study with a sample of 1,116 five year-old twins. Independent of genetic influences on behavior, an environment of DV was found to cause children's externalizing and internalizing problems. In addition to the risk of emotional and behavior problems, children who witness DV have been found to be at risk for also being physically abused. Finally, the author's review of the literature suggests that these children are indirectly affected by the mothers' stress of being battered.

Some researchers have found that a significant percentage of child witnesses do not display negative effects. For example, in a study of 228 children between the ages of 8 and 14 years, Grych et al. (2000) found that one third did not exhibit any behavior problems. However, this leaves two-thirds of innocent children to suffer the effects of being exposed to DV. Some evidence suggests that regardless of the level of conflict, exposure has negative effects on children. For example, Jouriles,
Norwood, McDonald, Vincent, and Mahoney (1996) examined the relationship between different forms of marital aggression and behavior problems in children whose parents were seeking marital therapy. The Conduct Disorder and Personality Disorder subscales of the Behavior Problem Checklist (BPC; Quay & Peterson, 1979) were administered to 55 children between the ages of 5 and 12 years. After accounting for physical marital violence, they found that insults, threats, and violence toward objects during marital disputes contributed to children's behavior problems. Jouriles et al. (1996) repeated this study with a sample whose parents had higher levels of violence. In these 199 children living in a shelter, similar results were found. These findings suggest that whereas threats and insults may be less severe in themselves, the higher frequency of them can be as devastating as physical violence. Thus, they are associated with behavior problems in children.

Relationships have been established between witnessing DV and externalizing behaviors, particularly aggression. For example, Marcus, Lindahl and Malik (2001) examined the association between interparental conflict, children's social cognitions, and child aggression in 115 children 7 to 13 years of age. Using The Normative Beliefs About Aggression Scale (NOBAGS; Huesmann & Guerra, 1997), they found that higher levels of interparental conflict were associated with higher levels of aggressogenic cognitions. Aggressogenic cognitions are defined by Marcus et al. (2001) as an endorsement of physically and verbally aggressive strategies to solve interpersonal problems and acceptance of the legitimacy of verbal and physical aggression. Furthermore, using the CBCL, The Children's Action Tendency Scale (CATS; Deluty, 1979) and the CBCL Teacher Rating Form (CBCL-TRF;
aggression was related to endorsing beliefs about retaliation and to having aggressive responses to hypothetical problems. This sample is limited with regard to age, so it is uncertain that these results will generalize to older children. In addition, it is unclear if problems associated with urban living, such as community violence may account for the findings. Similar results were found by Katz and Low (2004) in 130 middle class preschool children. Using the CBCL and the Rapid MACRO (R-MACRO; Gottman, 1983) peer interaction coding system, DV was a significant predictor of peer noncompliance. In particular, peer skill deficits in these children included high levels of noncompliance and bossiness with best friends. Although this study showed similar results using a different SES, again, this sample was limited with regard to age. Therefore, it is uncertain whether these results would generalize to older children. Kinsfogel and Grych (2004) addressed this limitation using a sample with a wide range of family income and a different age range, 14 to 20 year old adolescents. They examined the impact of parental conflict on the dating behavior of 391 adolescents using the Conflict in Relationships Scale (CIR; Wolfe, Reitzel-Jaffe, Gough, & Wekerle, 1994). They found that boys who witnessed higher levels of aggressive interparental conflict were more likely to have difficulty controlling anger and perceive aggression as justifiable in a romantic relationship. Furthermore, this belief predicted reports of greater hostile and abusive behavior toward their dating partners. This group of studies found similar results in children of different ages and backgrounds. Taken together, it appears that children who witness DV are likely to suffer externalizing behaviors like aggression in a number of different types of relationships.
Researchers have investigated the association between witnessing DV and internalizing behaviors, specifically anxiety. DV, and other variables related to this, were tested to see if they predicted Post-Traumatic Stress Disorder (PTSD) level (Kilpatrick, Kym and Williams, 1998). In this study of 6 to 12 year olds, 20 child witnesses were compared to 15 non-witnesses. The mean score on the Child Post-Traumatic Stress Reaction Index (PTSRI; Frederick, 1985) for child witnesses was 36.7 with all but one of them having PTSD. The mean score for the non-witnesses was 8.6 with none of them meeting the criteria for the diagnosis. Furthermore, there were no statistically significant correlations between the level of PTSD and factors such as the child’s age, gender, frequency of violence or intensity of violence. The sample was limited with regard to size. Thus, it is unclear whether such a high PTSD rate would generalize to all children who witness DV. In addition, the sample was limited with regard to age and income. Therefore, it is uncertain whether these results will generalize to younger children or low-income children.

McCloskey and Walker (2000) expanded this research by including a larger sample that is low income. They examined posttraumatic stress in 337 children between the ages of 6 and 12 years, using the 12-item inventory derived from the criteria in the Diagnostic Statistical Manual (DSM-III-R; American Psychiatric Association, 1987), the Child Assessment Schedule (CAS; Hodges & Saunders, 1990), and the CBCL. Although approximately half were suffering from symptoms of posttraumatic stress, 19% of the children who witnessed the abuse of their mothers had PTSD. In addition, they found that the children with PTSD were more likely to show elevated symptoms of phobias, separation anxiety, oppositional disorder, and
depression. Although a smaller percentage of PTSD was found, this study used a larger sample and showed that trauma symptoms were common. However, again, it is unclear whether these results would generalize to a different age group.

Levendosky, Huth-Bocks, Semel and Shapiro (2002) extended this study with younger children, ages 3 to 5, to examine the effects of DV in 62 children. Results showed that preschool children who witness DV can suffer from symptoms of PTSD. Although few of them met the criteria for the diagnosis of PTSD, trauma symptoms were common. Specifically, these children had symptoms of hyperarousal and re-experiencing of the trauma. The results from this group of studies show that witnessing DV can be traumatic for preschool children as well as for children between ages 6 to 12. Whereas a diagnosis of PTSD is not very common, symptoms can be expected.

Most findings indicate a risk of both externalizing and internalizing behaviors for children who witness DV. Johnson et al. (2002) tracked mental health and behavior problems over two years in six year-old children. Using the CBCL and the Trauma Symptom Checklist for Children (TSCC; Briere, 1996), moderate to high levels of witnessed violence were both significantly associated with four mental health problems at age eight. These included depression, anger, anxiety, and aggression. This study was limited with regard to age, thus it is unclear whether these results will generalize to children who are older. In addition, these children were high-risk so it is unclear if problems such as having a teenage mother may account for the findings. These results were replicated with four year-olds in a longitudinal study of 682 children. Researchers discovered that after two years, using the CBCL, it was

5
found that exposure to family violence within this time period, predicted reported
problem behaviors at age six (Litrownik, Newton, Hunter, English, & Everson, 2003).
In particular, the family violence predicted aggressive problem behaviors as well as
anxious and depressed problems. Similar to the previous study, these children were
also young. They were also high-risk so, again it is not known whether and to what
degree other factors contribute to the behavior problems.

Other studies have examined cognitive and social deficits in addition to the
behavior problems, in children who are exposed to IPV. Lemney et al. (2001) wanted
to see if exposure to IPV will correlate with increased problems in 83 children.
Results from the CBCL indicated that the total behavioral problems for these 4 to 11
year-olds were significantly higher than the norm. This study was replicated by
others (Kernic et al., 2003) who explored the same relationship, but with older
children between the ages of 2 to 17 years. They found that, in 143 children exposed
to maternal IPV, they were 40% more likely to have a total behavioral problem score
within the borderline to clinical range than CBCL normative children. Taken
together, these findings indicate that at risk and shelter children are likely to
experience dysfunction in many areas of their development. It is unclear if this is true
for children who are not high risk.

Children who witness DV have been found to also be at risk for being abused.
Appel and Holden (1998) evaluated 31 studies on the co-occurrence of spouse abuse
and physical child abuse. From their review, they estimated that in the United States,
children who witness IPV have a 40% chance of also being abused. The effects of
both witnessing DV and being abused have been investigated. For example, a study
compared direct victims of violence, adolescents who were both direct victims and
witnessed IPV, and nonabused adolescents. Using The Kiddie-Schedule for Affective
Disorders and Schizophrenia (K-SADS-E; Orvaschel, Puig-Antich, Chambers,
Abrizi, & Johnson, 1982), the Conners Teacher Rating Scale (Conners, 1969), and the
PTSD module from the Structured Clinical Interview for the DSM-III-R non-patient
edition (SCID-NP; Spitzer, Williams, Gibbon, & First, 1990), psychological
functioning was assessed in 185 adolescents who were between 12 to 18 years of age.
Adolescents with co-occurrence had significantly higher rates of depression, Conduct
Disorder (CD), and Oppositional Defiant Disorder (ODD) when compared to non-
abused adolescents. Additionally, they found that compared to adolescents who were
abused only, those with co-occurrence were five times more likely to be depressed,
four times more likely to have ODD, and 375.9 times more likely to receive a lifetime
diagnosis of PTSD (Pelcovitz, Kaplan, DeRosa, Mandel & Salzinger, 2000). These
findings show that the co-occurrence of these incidents, are very detrimental to
adolescents. Furthermore, the higher rates of pathology compared to those abused
only shows the additive problems that are related to witnessing DV.

Literature findings regarding the parenting of battered women have not been
consistent. In a sample of 184 mothers, Coohey (2004) found that being battered
does not cause a woman to abuse her own children. These findings are recent and
need to be replicated. Nonetheless, associations have been found between being
wanted to see if witnessing aggression in the family affects children's beliefs about
close relationships. In 31/2 to 7 year olds, 23 children from DV agencies were
compared with 23 children from the community. Children were assessed with the MacArthur Story Stem Battery (MSSB; Bretherton & Oppenheim, 1990). They found that the child witnesses portrayed mothers in their stories as less nurturing, affectionate, and authoritative. This sample was limited in that the children were very young in age. Others (Levendosky & Graham-Bermann, 2000) addressed this limitation by examining this relationship in an older group, 7 to 12 years of age. 120 children were observed using the Family Interaction Global Coding System (Hetherington, 1992). It was found that battering impacted the parenting of the women. Specifically, higher levels of physical abuse predicted lower levels of maternal warmth. In addition, these women had low levels of authority with their children which then predicted antisocial behavior. The findings from these two studies suggest that being battered interferes with the ability to nurture one’s children.

Particularly, the relationship between PTSD in these mothers and children’s functioning has been investigated. Rossman, Bingham, and Emde (1997) examined adaptive functioning in children aged 4 to 9 years. Among these 30 children who witnessed parental violence, mothers PTSD symptoms were significantly related to internalizing behavior problems and lower social competence. This sample was limited with regard to size. Therefore it is unclear whether these results would generalize to all battered mothers. Chemtob and Carlson (2004) examined 50 battered women and found that the total score of the Parenting Scale (Arnold, Leary, Wolff, & Acker, 1993), and more specifically, the Reactivity subscale were significantly higher in those with PTSD. Thus, these mothers would be more impulsive toward their children. Further, using the State-Trait Anger Expression
Inventory (STAS; Spielberger, 1985), mothers with PTSD had higher levels of anger. Moreover, mothers with PTSD tended to underestimate the distress of their children. For example, 91% of the mothers with PTSD had not received counseling for their children whereas 92% of these mothers obtained help for themselves. These two studies used small samples. Therefore, the generalizability of these findings is uncertain. Taken together, these group of studies regarding the parenting of battered women suggest the indirect effects of DV on children through the stress that the mother experiences. More research is needed in this area.

Overall, the findings regarding witnessing DV show that the effects are manifested in different ways. Although some children are found not to display any clinical levels of pathology, this does not mean they are not affected in other ways. Further, just because children do not show evidence of dysfunction, does not mean they will not have difficulties when they are older. Regarding findings on internalizing symptoms, children tend to exhibit anxiety problems. It appears that witnessing parental conflict is traumatizing, as some of them qualify for a diagnosis of PTSD. These children become overly sensitive to conflict, for their emotional and physical safety is threatened. Thus, research needs to be more focused on the anxiety of the child to replicate these results. As for externalizing symptoms, children appear to be at risk for aggression. They tend to have high levels of aggressogenic cognitions, which guide their behavior in handling conflict with peers, and also with dating partners. Further research is needed on treating aggressogenic cognitions in young children to prevent the consequences of acting out on these beliefs.
Research linking DV exposure and multiple problem behaviors has been more consistent. Whereas researchers have found that the comorbidity of externalizing and internalizing symptoms is likely, other difficulties are of additional concern. These include social problems and attention difficulties. A limitation is that many of these children suffering from multiple dysfunction are from high-risk families. Further research is needed in children who witness DV but who are not high risk. Additionally, children are also at risk for being physically abused, which results in a higher incidence of pathology. Finally, children are at a disadvantage due to the mother’s stress of being battered. It appears that being battered may decrease maternal parenting effectiveness. Larger studies with a focus on the mothers’ PTSD are needed to replicate these results. Families of DV seem to be unstable in many ways. The environment that DV creates clearly affects the development of these children who are exposed.

This present analysis is focused on the post-traumatic stress that DV may create in the women. Physical abuse and emotional abuse are the two most known forms of trauma that a battered women experiences. However other types of trauma are threats, sexual abuse, and substance abuse. A woman being pushed, kicked, slapped, punched or choked are examples of physical abuse. Further when a partner pulls her hair, grabs her, physically keeps her from leaving, or destroys property, this is also physical abuse. She is emotionally abused when she is called demeaning names, money is withheld from her, not being allowed to work, daily activities are controlled, is harassed at work, or is stalked. Similarly threats involve the batterer threatening to hurt or kill her, a family member, or the family pet. In addition, a
batterer making a suicide attempt or threatening to do so falls under threats. The next form of abuse is being forced to have unwanted sex or being forced to have sex after being physically or emotionally abused. Last, abusive incidents may occur when the batterer is drunk or high. It follows that the abuse may become more severe, as his judgment is impaired.

Whereas many couples find themselves in one of the above situations at some point in their relationship, DV involves a never ending cycle of violence. This cycle gives the batterer power and control and involves three stages: tension building or minor battering, acute battering incident, and honeymoon period (Walker, 1979). Although most victims of DV are female, they can be male. For simplicity, the female will be referred to as the victim. During the tension building stage, there is nitpicking, isolation, drinking, threats, and criticism from the batterer. Her response is to try to calm him, be nurturing, stays away from family and friends, agrees, withdraws, and has a feeling of walking on eggshells. In the next stage, acute battering incident, the batterer may hit, choke, shove, humiliate, or rape her. She responds with trying to protect herself, calling the police, trying to reason with him, leaving or fighting back. The third stage is the honeymoon period where he says that he is sorry, sends flowers, declares his love, or cries. She agrees to stay, stops legal proceedings, sets up counseling appointments for him, and feels hopeful. This cycle repeats because the batterer and battered are in denial during every stage.

It is not uncommon for battered women to be diagnosed with PTSD because of the reaction to trauma that is experienced. According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; 2003), the three categories of
post-traumatic stress symptoms are re-experiencing, avoidance and numbing, and arousal. Re-experiencing symptoms include distressing recollections and dreams of the trauma, flashbacks or reliving the event, being emotionally upset and having physiological reactivity when reminded of the trauma. Avoidance involves ignoring thoughts, feelings, and particular conversation topics that may be reminders of the trauma. Similarly, numbing symptoms include losing interest in activities and socializing, feeling emotionally numb, and feeling hopeless about the future. Lastly, arousal symptoms include having sleep problems, feeling irritable and angry, not being able to concentrate, and feeling jumpy and on guard.

Interest in this study focused on whether the mothers’ post-traumatic stress relates to their children’s behavior problems. In previous studies, children who witness DV have often been found to exhibit behavior problems. For example, Lemney et al. (2001) found in a sample of 4 to 11 year-olds that the total behavioral problems were much higher than the norm, and Kernic et al. (2003) found in 2 to 17 year-olds that they were 40% more likely than the norm to have borderline to clinical levels of behavior problems. Studies on women’s post-traumatic stress are limited. Nonetheless, Rossman et al. (1997) found in 30 children 4 to 9 years of age that mother’s PTSD symptoms related to internalizing behavior problems and lower social competence. It was also a goal to determine which particular symptoms of the mothers’ post-traumatic stress relate to children’s difficulties. To examine the effects of DV, mothers and children were assessed prior to receiving treatment. Relationships were investigated between the scores on the mothers’ trauma measures and the scores on the children’s behavior measures. Thus, the hypothesis is that
children of mothers with high Trauma Symptom Inventory (TSI; Briere, 1995) scores will have elevated CBCL scores.
CHAPTER II

Method

Participants

This study was a secondary analysis of existing data drawn from the Peace: A Learned Solution (PALS) Project. This project was funded by a grant from the N.J. Division of Youth and Family Services. Participants consisted of 71 3 to 10 year old children and their mothers. The participants were voluntary outpatient clients of a battered women’s shelter in New Jersey who were given the choice to participate. The TSI and the CBCL were both completed by the mothers prior to entering treatment.

Measures

Mothers’ trauma. The 100 item Trauma Symptom Inventory (TSI; Briere, 1995) was used to assess the mothers’ posttraumatic stress. The ten categories of symptoms include anxious arousal, depression, anger/irritability, intrusive experiences, defensive avoidance, dissociation, sexual concerns, dysfunctional sexual behavior, impaired self-reference, and tension reduction behavior.

Children’s behavior problems. The 118-item Child Behavior Checklist (CBCL; Achenbach, 1991) was used to assess a wide range of problems that the child may have displayed. The thirteen categories were withdrawn, somatic complaints, anxious/depressed, social problems, thought problems, attention problems, delinquent
behavior, aggressive behavior, sex problems, other problems, internalizing, externalizing and total.

Analyses

Pearson correlations were computed to examine the relationships between the mothers’ trauma symptoms and the children’s behavior problems. Alpha was set at .05 and .01.
The relationship between the mothers’ pre-treatment trauma symptoms and their children’s pre-treatment behavior problems was examined. The sample for this investigation included 71 mother-child pairs who completed the pre-treatment measures.

Table 1. Significant correlations between the mothers’ pre-treatment trauma symptoms as measured by the TSI and their children’s pre-treatment behavior problems on the CBCL.

<table>
<thead>
<tr>
<th>CBCL WITHDRAWN</th>
<th>TSI DEPRESSION</th>
<th>TSI DEFENSIVE AVOIDANCE</th>
<th>TSI DYSFUNCTIONAL SEXUAL BEHAVIOR</th>
<th>TSI IMPAIRED SELF-REFERENCE</th>
<th>TSI TENSION REDUCTION BEHAVIOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>.404**</td>
<td></td>
<td>.297*</td>
<td>.347**</td>
<td>.275*</td>
<td></td>
</tr>
<tr>
<td>CBCL ANXIOUS/DEPRESSED</td>
<td>.245*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CBCL INTERNALIZING</td>
<td>277*</td>
<td>.276*</td>
<td>.275*</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Indicates statistical significance at .05, **=.01

As Table 1 shows, there were statistically significant correlations between some of the mothers’ trauma symptoms and their children’s behavior problems. It should be emphasized that there were 156 total comparisons as shown on Table 2. Therefore, the probability of finding at least one significant correlation between the mothers’ TSI scales and the children’s CBCL scores approaches 1.0. Further, although statistically significant these correlations are not high, ranging from .245 to

16
.404. It is possible that the eight significant relationships are due to chance. However, the stronger relationships are consistent with previous findings by Rossman et al. (1997) who showed that mothers’ PTSD symptoms predicted internalizing symptoms. Where we do find correlations, it makes sense clinically so it is a real possibility that the high correlations reflect true relationships. These findings suggest that in the above instances, the children of mothers with high TSI scores will have elevated CBCL scores. The mother’s scale scores that correlated with the children’s symptom scale scores at a significance level of at least .05 included:

**TSI Depression**

The mothers’ depression scale scores significantly correlated with their children’s withdrawn and internalizing scale scores ($r=.404, p<.01; r=.277, p<.05$).

**TSI Defensive Avoidance**

The mothers’ defensive avoidance scale scores significantly correlated with their children’s anxious/depressed and internalizing scale scores ($r=.245, p<.05; r=.276, p<.05$).

**TSI Dysfunctional Sexual Behavior**

The mothers’ dysfunctional sexual behavior scale scores significantly correlated with their children’s withdrawn scale scores ($r=.297, p<.05$).

**TSI Impaired Self-Reference**

The mothers’ impaired self-reference scale scores significantly correlated with their children’s withdrawn scale scores ($r=.347, p<.01; r=.275, p<.05$).

**TSI Tension Reduction Behavior**

The mothers’ tension reduction behavior scale scores significantly correlated with their children’s withdrawn and internalizing scale scores ($r=.347, p<.01; r=.275, p<.05$).
The mothers’ tension reduction behavior scale scores significantly correlated with their children’s withdrawn scale scores ($r = .275$, $p < .05$).

**Table 2.** Non-significant correlations between the mothers’ pre-treatment trauma symptoms as measured by the TSI and their children’s pre-treatment behavior problems on the CBCL.

<table>
<thead>
<tr>
<th>TSI ANX. AROUSAL</th>
<th>TSI DPRESSION</th>
<th>TSI ANG. IRRITABILITY</th>
<th>TSI INTRU. EXP.'S</th>
<th>TSI DEFNSV. AVOIDANCE</th>
<th>TSI DISSO CIATN</th>
<th>TSI SEX. CONCERTNS</th>
<th>TSI DYSF. SEX. BEH</th>
<th>TSI IMPAIR. SELF -REF.</th>
<th>TSI TENSN. REDCT. BEH.</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBCL WITHDRAWN</td>
<td>.218</td>
<td>.199</td>
<td>.079</td>
<td>.217</td>
<td>.205</td>
<td>.238</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CBCL SOMATIC CMPLNTS</td>
<td>.007</td>
<td>.173</td>
<td>.004</td>
<td>.174</td>
<td>.195</td>
<td>.122</td>
<td>.180</td>
<td>.012</td>
<td>.190</td>
</tr>
<tr>
<td>CBCL ANXIOUS/DEP.</td>
<td>.163</td>
<td>.143</td>
<td>-.026</td>
<td>.166</td>
<td>.144</td>
<td>.132</td>
<td>.109</td>
<td>.180</td>
<td>.037</td>
</tr>
<tr>
<td>CBCL SOCIAL PROBS</td>
<td>.050</td>
<td>.119</td>
<td>-.183</td>
<td>.155</td>
<td>.118</td>
<td>.016</td>
<td>.085</td>
<td>-.066</td>
<td>.139</td>
</tr>
<tr>
<td>CBCL THOUGHT PROBS</td>
<td>-.061</td>
<td>.033</td>
<td>-.030</td>
<td>-.035</td>
<td>.114</td>
<td>.093</td>
<td>.103</td>
<td>-.068</td>
<td>.017</td>
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<tr>
<td>CBCL ATTNPROBS</td>
<td>.026</td>
<td>.040</td>
<td>-.082</td>
<td>.084</td>
<td>.053</td>
<td>-.077</td>
<td>-.190</td>
<td>-.207</td>
<td>-.013</td>
</tr>
<tr>
<td>CBCL DELINQ. BEH.</td>
<td>.072</td>
<td>-.027</td>
<td>-.151</td>
<td>.060</td>
<td>.088</td>
<td>.042</td>
<td>-.057</td>
<td>-.089</td>
<td>.109</td>
</tr>
<tr>
<td>CBCL AGGRESS. BEH.</td>
<td>.103</td>
<td>-.023</td>
<td>-.200</td>
<td>.073</td>
<td>.025</td>
<td>-.019</td>
<td>-.026</td>
<td>-.100</td>
<td>.141</td>
</tr>
<tr>
<td>CBCL SEX. PROBS</td>
<td>.134</td>
<td>-.033</td>
<td>-.163</td>
<td>.199</td>
<td>.202</td>
<td>.101</td>
<td>-.142</td>
<td>-.064</td>
<td>.051</td>
</tr>
<tr>
<td>CBCL OTHER PROBS</td>
<td>.128</td>
<td>.085</td>
<td>-.153</td>
<td>.218</td>
<td>.164</td>
<td>.025</td>
<td>-.062</td>
<td>.023</td>
<td>.086</td>
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<tr>
<td>CBCL INTERNALIZING</td>
<td>.158</td>
<td>.029</td>
<td>.179</td>
<td>.182</td>
<td>.207</td>
<td>.172</td>
<td></td>
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<tr>
<td>CBCL EXTERNALIZING</td>
<td>.103</td>
<td>-.024</td>
<td>.199</td>
<td>.076</td>
<td>.044</td>
<td>-.006</td>
<td>.010</td>
<td>-.103</td>
<td>.142</td>
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<tr>
<td>CBCL TOTAL</td>
<td>.124</td>
<td>.117</td>
<td>-.164</td>
<td>.167</td>
<td>.177</td>
<td>.062</td>
<td>-.032</td>
<td>.187</td>
<td>.004</td>
</tr>
</tbody>
</table>

As Table 2 shows, there is no evidence of any statistically significant associations between the mother’s pre-treatment anxious arousal, anger/irritability,
intrusive experiences, dissociation and sexual concerns and the children’s pre-
treatment behavior problems listed above.
CHAPTER IV

Discussion

The present analysis adds to the DV literature by providing information on how mothers’ trauma symptoms relate to their children’s behavior problems. The outcomes of witnessing DV have been determined in previous research. However, the relationship between the mothers’ post-traumatic stress and these outcomes has not been established. Interest in this study focused on whether mothers’ PTSD symptoms relate to children’s behavior problems. The results support findings by Rossman et al, (1997) that mothers’ PTSD symptoms were significantly related to children’s internalizing symptoms. However, the results did not support findings by Rossman et al, (1997) that mothers’ PTSD significantly related to children’s social problems.

Internalizing refers to being anxious and depressed, withdrawn, and having somatic complaints. These symptoms are sometimes hard to recognize because they do not involve ‘acting out’. However, internalizing symptoms are very distressing to the children and should be addressed. For example, anxious and depressed children may feel lonely, unloved, worthless or guilty. In addition, they may be perfectionistic, nervous, fearful, self-conscious, suspicious of others, sad, or worrisome. Similarly withdrawn children may be secretive, shy, or under-active. Also they may stare, sulk, not talk or would rather be alone. Lastly, somatic complaints that children experience are being dizzy, tired, nauseous, and having aches
or headaches. Further, they may have problems with their eyes, skin, stomach, or with vomiting (Achenbach, 1991).

Whereas the children’s internalizing problems did not significantly correlate with the mothers’ symptoms of re-experiencing or hyperarousal, they did relate to the mothers’ numbing and avoidance symptoms. These include depression and defensive avoidance. In addition, the children’s difficulties also related to the mothers’ self-dysfunction. Mothers’ impaired self-reference, dysfunctional sexual behavior, and tension reduction behavior are all symptoms of self-dysfunction (Briere, 1995).

It is easy to understand how a battered woman becomes depressed. For example, being criticized often may lead her to view herself as worthless. Second, many batterers keep their partners from seeing family or friends. This lack of access to a support system may contribute to her sadness or loneliness. Next, chronic emotional pain may lead her to feel hopeless. As a result, she may have thoughts about death and dying. Lastly, she has received distorted messages about herself, others and the world. Thus, she may seclude or isolate herself and may become less nurturing. The results from this study show that a mother’s depression relates to her child having internalizing symptoms. Grych et al. (2002) and Levendosky and Graham-Bermann (2000) found similar results that battered women are less nurturing. It appears that this serious mood disturbance from being emotionally abused, may affect children in significant ways. These symptoms include the child being anxious, depressed, having somatic complaints and particularly being withdrawn.

Impaired self-reference refers to having problems in discriminating one’s issues from those of others (Briere, 1995). In other words, she has learned that what
she wants and needs does not matter. Second, she may be confused about her identity. For example she may view herself as a mother or wife only and not her own person. Next, she may not understand her own behavior at times. Being traumatized makes her unable to think clearly. Therefore, this extreme stress results in her doing things that she would not do otherwise. Last, she may have less self-knowledge and less self-confidence than others. Not receiving positive reinforcement from the batterer leaves the woman lacking in this area of self-esteem. The results of this current analysis show that mothers’ impaired self-reference relates to children’s internalizing symptoms. This shows how the lack of the mother’s assertiveness due to the batterer’s power, can impact the child similarly to the way her depression does.

A battered woman uses ‘defensive avoidance’ to deal with her emotional pain and anxiety symptoms. It is not unconscious like dissociation, but rather it is intentional. In addition to avoiding her own memories of the abuse, she will avoid all instances that might possibly remind her of the abuse. The reason why she is in such a state of avoidance is because with every reminder of the abuse comes emotional pain. Examples of what she may feel are hurt, uncomfortable, resentful, trapped, incompetent, lonely, guilt, troubled, fear, used, anxiety, victimized, ashamed, defeat, uneasy, embarrassed, inadequate, regret, or vulnerable. The results of this study show that defensive avoidance in the mothers relates to children’s internalizing symptoms. In particular, this defensive avoidance relates to children’s depressed and anxious symptoms. It is not clear how this relationship exists. Although, the author suggests that an avoidance of her own feelings leads her to avoid the feelings of her children. This emotional neglect from the mother results in her children feeling lonely, fearful
and sad. Similarly, Chemtob and Carlson (2004) found battered women with PTSD to underestimate the distress of their children.

Dysfunctional sexual behavior is when the battered woman is flirtatious or seductive with men in inappropriate ways (Briere, 1995). It is not clear as to why these behaviors occur in battered women. She is emotionally neglected and abused which involves the batterer withholding affection and telling her that she is unattractive, or a horrible wife. Therefore, one of the reasons may be to combat loneliness. Another reason is that the batterer has raped or pressured her to commit sexual acts that she is uncomfortable with. This sexual abuse may lead to dysfunctional behavior with other men. Taken together, witnessing sexual inappropriateness of either parent is uncomfortable for children. Therefore, dysfunctional sexual behavior may lead a child to withdraw such as wanting to be alone.

Being shoved, slapped, burned, grabbed, choked, threatened, or receiving any other abuse creates an environment of tension. This trauma may contribute to tension reduction behavior. For example, she may hurt herself using self-mutilation or even attempting suicide. Further, she may also act out on others such as her children. Chemtob and Carlson (2004) found high levels of impulsiveness and high reactivity in battered women with PTSD. It follows that if this aggression is used against the children, they may avoid her and be withdrawn.

Overall, the results of this study show that mothers’ depression, defensive avoidance, and impaired self-reference relate to their children’s internalizing symptoms. Internalizing refers to children’s anxious and depressed symptoms, being
withdrawn, and having somatic complaints. In particular, mothers’ depression, dysfunctional sexual behavior, impaired self-reference and tension reduction behavior relate to children being withdrawn. Last, the mothers’ defensive avoidance relates to their children’s anxious and depressed symptoms.

This analysis has limitations. Because this is correlational data, causation cannot be determined. The mother may be influencing the child or vice-versa. For example, a mother may be depressed because her child is having difficulties. Second, there are other incidents that are likely to co-occur in families of DV. Some examples are alcoholism, drug addiction, incest and physical child abuse (Appel & Holden, 1998). Since they were not controlled for, it is uncertain whether the correlations were all due to the mothers’ post-traumatic stress. Third, children’s behavior problems were assessed by mother reports only. Additional reports by the teacher or another source may have been helpful. Last, these findings are true for children 3 to 10 years of age. Whether they would generalize to younger or older children is uncertain.
CHAPTER V

Conclusion

In conclusion, mothers’ PTSD symptoms relate to children’s internalizing symptoms, a finding consistent with the study by Rossman et al, (1997). The particular mothers’ symptoms that relate to the children’s difficulties were depression, defensive-avoidance, dysfunctional sexual behavior, impaired self-reference and tension reduction behavior. Understanding how a mother’s particular symptomatology relates to a child’s difficulties will improve interventions that help these victims recover from the trauma of DV. Therefore, in addition to treating a child directly, he or she will benefit by their mother receiving PTSD treatment. Therapy should include a focus on their mother’s numbing/avoidance and self-dysfunction symptoms.

Regarding depression, treatment should focus on eliminating guilt. For example, she may feel guilty about marrying or partnering with the batterer, causing the abuse, or the effects that it had on the children. This guilt contributes directly to shame, depression, and social isolation. Therefore therapy can involve her analyzing the guilt and developing appropriate boundaries of personal responsibility. Similarly, negative self-talk such as self-put downs and regret phrases such as ‘should have’ and ‘could have’ can be monitored. Negative self-talk statements are shocks that "recharge neutral memories and images of abuse and abuser with negative energy"
(Kubany, McCaig, & Laconsay, 2003, p. 25). The sadness may slowly go away if she stops speaking to herself in this manner when thinking about the abuse or the abuser.

When treating defensive avoidance it is necessary for a woman to reprocess her memories of past abuse. When thinking about the past abuse, the negative feelings can be so painful, that she does not want to think about it. If the avoidance is not treated, this emotional reasoning may keep her living in fear for years after the abuse has ended.

Dysfunctional sexual behavior, impaired self-reference, and tension reduction behavior are all symptoms of self-dysfunction. Thus, treating these problems involves empowerment. Training should include learning how to identify subtle forms of verbal aggression, respond to verbal aggression, and effectively communicate her needs. Finally, treatment can also include stress reduction and increasing access to her support system.
References


Abuse & Neglect, 22(4), 319-330.


