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The Effects of Exposure to Intimate Partner Violence on Children's Development

by Courtney A. Crittenden, M.S., Emily M. Wright, Ph.D., and Abigail A. Fagan, Ph.D.*

***Editor's Note:** Previous research indicates that intimate partner violence (IPV) increases the likelihood of negative outcomes for children exposed to it, including the use of violence, drug use, and poor mental health. Yet this work often overlooks potential complexities in how IPV exposure may affect children's development. For example, the impact of IPV may be felt immediately or develop over time; its effects may vary for boys and girls; and other life experiences may affect the extent to which exposure to IPV influences children's outcomes. This article summarizes the main findings of a research project examining the degree to which exposure to IPV affects youths' interpersonal violence, drug use, and internalizing (i.e., depression, anxiety, withdrawn, and somatic) symptoms, using data from a large and diverse group of adolescents from Chicago. Findings indicated that IPV exposure did result in some negative consequences for both boys and girls, but its impact was not as large as reported in other research and did not always vary by neighborhood as predicted. Overall, the results suggest that youth development is a complex process, and further research of the ways in which families and neighborhoods jointly influence children is needed in order to better understand this issue and develop policies and practices to foster healthy youth development.*

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INTRODUCTION

Millions of children and adolescents are exposed to intimate partner violence (IPV) between their parents each year (Finkelhor, Turner, Ormond, Hamby, & Kracke, 2009; Zinzow et al., 2009), and previous research has shown that exposure to IPV may increase the likelihood of children's violence (Fergusson & Horwood, 1998; Herrera & McCloskey, 2001), drug use (Dube & Anda, 2002; Fergusson & Horwood, 1998), and mental health problems (Graham-Bermann, DeVoe, Mattis, Lynch, & Thomas, 2006; Kitzmann, Gaylord, Holt, & Kenny, 2003). However, some studies have not shown a relationship between IPV and these outcomes. Few have identified the conditions under which or individuals for whom IPV exposure may be most detrimental. Researchers have called for more studies in order to better understand the consequences of youth exposure to violence. This article will focus on neighborhood contexts and individual gender to explore how exposure to IPV affects youth.

Research has demonstrated that neighborhoods are important contexts that may directly and indirectly affect children's development (Leventhal & Brooks-Gunn, 2000). In particular, neighborhoods characterized by structural factors such as high rates of poverty (i.e., concentrated disadvantage) increase the likelihood of crime, drug use, and other problem behaviors among youth (Peeples & Loeber, 1994). Disadvantaged communities are more likely to have lower levels of trust between residents and fewer informal social controls—that is, they are likely have low levels of collective efficacy. For example, residents may be unlikely to monitor youth activities and intervene when they see disorderly conduct. Thus, structural problems tend to exacerbate youth problems. However, social processes such as collective efficacy can help to reduce negative outcomes (Elliott et al., 1996; Simons, Gordon, Simons, Burt, Brody, & Cutrona, 2005; Xue, Leventhal, Brooks-Gunn, & Earls, 2005).

Although prior research has examined the effects of IPV exposure and neighborhood residence on a range of negative outcomes, few studies have assessed the combined impact of these experiences on children. Prior work has also failed to systematically investigate gender differences in the effects of exposure to partner violence or neighborhood characteristics. Moreover, the empirical evidence regarding gender differences is limited and mixed (Beyers, Bates, Pettit, & Dodge, 2003; Gottfredson, McNeil, & Gottfredson, 1991; Jacob, 2006; Karriker-Jaffe, Foshee, Ennett, & Suchindran, 2009; Kling, Ludwig, & Katz, 2005; Leventhal & Brooks-Gunn, 2003; Meier et al., 2008; Molnar, Cerda, Roberts, & Buka, 2008; Mrug & Windle, 2009; Simons, Johnson, Beaman, Conger, & Whitbeck, 1996). This oversight is somewhat surprising, given that gender differences in the rates of violence, mental health problems, and, to a lesser extent, substance use, can be significant. Additionally, while numerous studies have examined the deleterious effects of exposure to IPV on children's social and emotional development, findings must be viewed with some caution given methodological limitations of many studies.

Purpose of the Study

While prior work has suggested that exposure to intimate partner violence and neighborhood characteristics may influence youth development, some of this research has had methodological challenges which limit the impact of the findings, and

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very few studies have considered gender differences in these relationships or the ways in which the effects of IPV may be conditioned by neighborhood factors. This project, funded by the National Institute of Justice, seeks to increase our understanding of how both exposure to IPV and neighborhood characteristics lead to negative outcomes among youth. We highlight the major findings from the project here. Two research questions were examined using longitudinal data from the Project on Human Development in Chicago Neighborhoods (PHDCN), which involves a large and diverse number of youth and their families from across Chicago:

1. What are the direct effects of IPV exposure on youths' interpersonal violence, drug use, and internalizing symptoms (mental health)?
2. Does the effect of IPV exposure vary across neighborhoods? If so, is the relationship between IPV exposure and youth violence, drug use, and internalizing symptoms (mental health) conditioned by neighborhood characteristics?

Research Design

The data for this study were derived from interviews gathered from the Project on Human Development in Chicago Neighborhoods (PHDCN) (Earls, Brooks-Gunn, Raudenbush, & Sampson, 2002), a study conducted from 1994-2001 with the purpose of better understanding how families, schools, peers, and neighborhoods affect children's development.¹ Information from three linked datasets from the PHDCN were used in the current study, including: (1) surveys of adult residents in 79 Chicago neighborhoods, who reported on perceived levels of collective efficacy (i.e., the degree of informal social control and social cohesion between neighbors); (2) archival data from the U.S. Census data, used to measure neighborhood concentrated disadvantage (i.e., the percentage of residences in a neighborhood below the poverty line, receiving public assistance, of African-American race, unemployed, younger than 18 years old, and living under female headed households); and (3)

¹ A full description of the development, design, and implementation of the PHDCN can be found on the project's website: <http://www.icpsr.umich.edu/PHDCN>.

interviews with youth and their caregivers ($N = 2,344$), which were used to assess behavioral outcomes, IPV, and other psycho-social risk factors experienced by youth (e.g., low family SES, peer deviance, child physical abuse, etc.). The longitudinal sample was ethnically diverse, including 46% Hispanic, 36% African American, and 14% non-Latino Caucasian youth. Additionally, there were comparable numbers of boys ($n = 1,180$) and girls ($n = 1,164$) youths in the study.

The three outcomes examined in this study were youth violence (i.e., youth self-reported violent acts in past year, including: throwing objects at someone, hitting someone, hitting someone you live with, carrying a weapon, attacking with a weapon, being involved in a gang fight, and robbery), youth drug use (i.e., self-reported use of six drugs: alcohol, marijuana or hashish, cocaine, crack, inhalants, and hallucinogens), and youth internalizing symptoms (i.e., 31 items on the Child Behavior Checklist reported by parents or self-reported by youth measuring withdrawn, somatic, and depression/anxiety symptoms). Measures of both prevalence (yes/no) and incidence (number, count, or frequency) were assessed for each outcome.

The primary independent variables were exposure to severe levels of intimate partner violence (parents' self-reports of whether they had in the past year engaged in any of the following violent acts during an argument: kicked, bit, or hit their partner; hit or tried to hit their partner with something; beat their partner up; choked them; threatened them with a knife or a gun; or used a knife or fired a gun towards their partner), neighborhood concentrated disadvantage, and neighborhood collective efficacy. Control variables included in the analysis included gender, race/ethnicity, age, peer influences, parental influences, physical abuse, self-control, family socioeconomic status, and the youth's prior violence, substance use, and mental health problems, all of which were measured at the first wave of data collection.

Each research question was examined for the full sample ($N = 2,344$ youth at Wave 1 living in 79 neighborhoods in Chicago), and separately by gender ($N = 1,180$ males and 1,164 females). Both the short- and long-term effects of IPV exposure were examined using longitudinal data collected at three time points, when youth participants were aged 8-17 (Wave 1), 9-20 (Wave 2), and 12-22 (Wave 3). Data were analyzed using hierarchical linear modeling (HLM) to account for the multi-level nature (i.e., including both neighborhood- and individual-level characteristics) of the PHDCN dataset. Table 1 provides the descriptive statistics for the all variables used in the study.

Findings

Research Question 1: What are the direct effects of IPV exposure on youths' interpersonal violence, drug use, and mental health outcomes (internalizing symptoms)? Table 2 presents the overall results of the study. In regards to the first research question, controlling for other risk factors, youth exposed to severe IPV were no more likely to engage in violence (in

Table 1 Descriptive Statistics, Total Sample^a

	Mean	Standard Deviation	Min – Max
<i>Dependent Variables</i>			
<u>Wave 1 Outcomes</u>			
Violence	0.62	1.11	0 – 7
Any Violence ^b	0.33	0.47	0 – 1
Drug Use Frequency	0.55	1.85	0 – 23
Any Drug Use ^b	0.17	0.37	0 – 1
Internalizing Symptoms ^b	8.34	7.23	0 – 52
<u>Wave 2 Outcomes</u>			
Violence	0.66	1.27	0 – 9
Any Violence	0.32	0.47	0 – 1
Drug Use Frequency	1.02	2.58	0 – 22
Any Drug Use	0.25	0.44	0 – 1
Internalizing Symptoms	9.20	8.11	0 – 52
<u>Wave 3 Outcomes</u>			
Violence	0.59	1.21	0 – 10
Any Violence	0.29	0.46	0 – 1
Drug Use Frequency	1.99	3.47	0 – 23
Any Drug Use	0.45	0.50	0 – 1
Internalizing Symptoms	10.89	7.27	0 – 37
<i>Level-One Independent Variables</i>			
IPV exposure	0.21	0.41	0 – 1
Female	0.50	0.50	0 – 1
Age	11.99	2.43	7.77 – 16.9
African American	0.36	0.48	0 – 1
Hispanic	0.46	0.50	0 – 1
Caucasian	0.14	0.35	0 – 1
Family SES	0.06	1.00	-2.07 – 1.72
Child Abuse	0.68	0.47	0 – 1
Low Self Control	46.27	11.55	14 – 85
Parental Criminality	0.13	0.33	0 – 1
Parental Drug Use	0.15	0.36	0 – 1
Parental Depression	0.13	0.34	0 – 1
Parental Supervision	9.05	1.18	3 – 10
Parental Warmth	6.11	2.07	0 – 9
Peer Delinquency	14.75	3.20	7 – 28
Peer Drug Use	5.12	1.60	3 – 12
<i>Level-Two Independent Variables</i>			
Concentrated Disadvantage	-0.01	1.00	-1.59 – 2.42
Collective Efficacy	-0.00	0.22	-0.46 – 0.64

^aDescriptive statistics are based on 2,344 individuals within 79 neighborhood clusters.

^bUsed as control variables for prior problems in waves 2 and 3 analyses.

Youth exposed to severe IPV were no more likely to engage in violence (in either the short- or long-term) compared to those whose caregivers did not report engaging in severe IPV. IPV exposure increased the frequency, but not the prevalence, of drug use in both the short- and long-term.

either the short- or long-term) compared to those whose caregivers did not report engaging in severe IPV. IPV exposure increased the frequency, but not the prevalence, of drug use in both the short- and long-term, and it was associated with increased internalizing symptoms among youth victims only in

the short-term (Wave 1) only. Across all outcomes, only one significant gender difference in the strength of these relationships was demonstrated: IPV exposure was more strongly related to the frequency of drug use at Wave 1 for males compared to females.

Research Question 2: Does the effect of IPV exposure vary across neighborhoods? If so, is the relationship between IPV exposure and youth violence, drug use, and mental health (internalizing symptoms) conditioned by neighborhood characteristics? The findings demonstrated some support for the second research question and indicated that neighborhood characteristics sometimes conditioned the relationship between IPV exposure and youth outcomes. Specifically, the effect of IPV exposure on the number of violent acts reported by youth, as well as on the frequency and prevalence of their drug use, became weaker as neighborhood disadvantage increased. No gender differences in these relationships were demonstrated.

Summary and Interpretation of the Results

To summarize these results, the current study found that exposure to IPV increased the likelihood of negative consequences for youth only in some cases: it was not related to rates of violence, it increased adolescent drug use, and it increased internalizing symptoms in the short term only. These results indicated that the impact of IPV on youth was weaker than prior studies of family violence would suggest. Perhaps this was because the study represented a very rigorous test of this relationship by including numerous control variables and utilizing longitudinal data, both of which guard against mis-specifying and likely over-stating the impact of IPV. In fact, it is notable that some direct effects of IPV on outcomes were found at all, given the rigor of the tests.

Although we expected that the effects of IPV exposure would be exacerbated in disorganized neighborhoods due to the lack of resources, informal controls enacted by adults, and supportive networks for youth, the results consistently suggested otherwise. That is, the influence of IPV was felt less strongly in disadvantaged communities than in advantaged communities. It is possible that areas characterized by neighborhood disadvantage experience more violence between partners (Benson & Fox, 2004; Miles-Doan, 1998;

Table 2 Summary of Findings^a

	Total Sample						Males						Females						
	Violence		Drug Use		Internalizing Symptoms		Violence		Drug Use		Internalizing Symptoms		Violence		Drug Use		Internalizing Symptoms		
	Count	Any	Freq	Any	Count	Any	Count	Any	Freq	Any	Count	Any	Count	Any	Freq	Any	Count	Any	
IPV Exposure	ns	ns	(+)	ns	ns	(+)	ns	ns	(+)	ns	(+)	ns	ns	ns	ns	ns	ns	ns	(+)
<u>Cross-Level Interactions *</u>																			
Concentrated Disadvantage	(-)	ns	(-)	(-)	ns	ns	ns	ns	ns	(-)	ns	ns	ns	ns	ns	ns	ns	ns	ns
Collective Efficacy	ns	ns	ns	ns	ns	ns	ns	ns	ns	ns	ns	ns	ns	ns	ns	ns	(+)	ns	ns

^aTable summarizes any effect across waves

ns = not significant

(+) = positive relationship

(-) = negative relationship

* How IPV effects differ due to neighborhoods

Wright, 2011) and are more tolerant of deviance (Sampson & Bartusch, 1998; Sampson & Wilson, 1995). Thus, the negative effect of exposure to IPV could be weakened in such neighborhoods because violence between parents would not be seen as particularly problematic and possibly more “normal” in these neighborhoods. It may also be that within neighborhoods experiencing multiple risk factors (e.g., IPV and disadvantage), the effect of any *one* risk factor (such as exposure to parental IPV) is diluted.

CONCLUSIONS AND IMPLICATIONS

This NIJ-funded study is one of few methodologically rigorous studies exploring contextual and gender differences in the negative effects of exposure to IPV on children’s well-being and development. Clearly, more research is needed to examine these relationships, particularly given that some of these results were not consistent with prior theoretical or empirical research. The findings do underscore the fact that IPV and neighborhoods may affect youth in complex ways, and future research is needed to continue to identify the conditions under which and individuals for whom the negative effects of IPV are most likely to be demonstrated. Future research may wish to examine the effects of IPV exposure on additional outcomes of concern (e.g., dating violence, binge drinking, depression, etc.), ideally using longitudinal data that can identify the specific ways in which being exposed to parental violence leads to problematic outcomes among youth. Additional research may also wish to explore differences in the impact of IPV according to the nature or frequency of its occurrence, whether effects vary according to the race/ethnicity or age of the youth victim, and how other neighborhood characteristics may condition the effects of IPV.

While the current findings contribute to the extant literature on the effects of IPV exposure and overcome many of the methodological limitations of past research, this study had challenges of its own that must be noted. First, the analyses relied on self-reports of both IPV (from caregivers) and the outcomes assessed (from caregivers and youth participants). Although there is evidence that self-reports can produce valid measures of youth’s participation in substance use and other illegal activities (Bachman, Johnston, & O’Malley, 1996; Thornberry & Krohn, 2000), it is still possible that respondents may have under-reported the prevalence of problem behaviors so that their answers would be more socially desirable. Another limitation is that the measure of IPV exposure was restricted to the most serious forms of violence between caregivers; therefore, the results cannot be generalized to families experiencing less severe conflict. Third, we restricted the IPV measure to a dichotomous assessment of whether or not either parent was violent in the relationship. We did not assess the frequency of violence, and it is possible that outcomes would be different if the frequency, rather than the prevalence, of IPV was examined. Similarly, we did not examine the potential for differential effects of exposure to different forms of IPV (e.g., using a weapon

towards a partner versus slapping a partner). Given these limitations, future research may wish to assess the degree to which different forms of parental violence, as well as who perpetrates the violence, may impact youth differently. Fourth, we cannot ensure that all children whose parents reported IPV actually witnessed or knew about the events. Fifth, respondents in this study were primarily Hispanic and African-American adolescents from urban neighborhoods in just one city (Chicago); we cannot be sure that the results are generalizable to youth and families living in other geographical regions or from other racial/ethnic backgrounds.

Although additional research will help to increase our understanding of the ways in which exposure to parental violence and neighborhoods affect youth, the current findings have relevant implications for policy and practice. Given others' research demonstrating higher rates of IPV in neighborhoods characterized by concentrated disadvantage (Benson & Fox, 2004; Benson, Fox, DeMaris, & Van Wyk, 2003; Lauritsen & Schaum, 2004; Miles-Doan, 1998; Wright, 2011), it is important that prevention and treatment services target youth and adults living in these areas. This includes both primary prevention services that seek to reduce the occurrence of violence between caregivers and intervention services for families experiencing IPV (e.g., domestic violence shelters, "safe zones," access to counselors, access to safety officers, and access to safe places for children of violent families). In addition, training for police officers patrolling and responding to calls in disadvantaged areas would be useful to help ensure they respond appropriately to intimate partner violence and know how to refer families to local service providers.

Even though the prevalence of IPV may be greater in disadvantaged areas, our results suggest that its impact may be felt more strongly by youth living in higher-income neighborhoods. Thus services should not focus solely on disadvantaged areas but also target families and children living in more advantaged neighborhoods. Services should be directed at all youth living in homes in which IPV is present in order to help alleviate the immediate distress caused by victimization and to prevent the development of long-term problems. While interventions targeted to youth victims are needed, more universal interventions that take place in schools and/or community agencies can also be beneficial. Such services may include programs delivered in schools and in the community that enhance youth behavioral and emotional competence by, for example, providing them with skills to avoid drug use offers, cope with stress and anxiety, and recognize and respond appropriately to negative emotions.

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