Effects of Direct and Indirect Violence on Youth Who Recently Entered the Child Welfare System – An Exploratory Study

Catherine Gallahue

Chaminade University

A Clinical Research Project

Submitted to the Graduate Faculty of

The Hawaii School of Professional Psychology

at Chaminade University

In Partial Fulfillment

of the Requirements for the Degree of

Doctor of Psychology

Clinical Psychology

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Abstract

Although family violence has been linked with a variety of adverse outcomes among youth who experience it, data on how physical abuse (PA) and intimate partner violence (IPV) contribute to children's externalizing and internalizing behaviors in the proximal aftermath of exposure are not conclusive. This study compared the internalizing and externalizing symptoms of children who have been exposed to intimate partner violence to children who have experienced physical abuse. The effects of gender, age, and resiliency on the relationship between familial violence exposure and internalizing and externalizing symptoms were explored. Data were drawn from the archives of the Family Strengthening Center (FSC) of Family Programs Hawaii, a community mental health clinic that provides services to culturally, socially, and economically diverse children and their families. The Behavior Assessment System for Children, Third Edition (BASC-3), Parent Rating Scales were used to assess internalizing and externalizing behavior problems and resiliency. Maltreatment history was gathered from Child Welfare Services (CWS) records. ANOVAs were used to compare externalizing and internalizing problems of children exposed to direct or indirect violence. Mean scores did not differ across maltreatment groups. The majority of children in both groups did not obtain scores in the clinically significant range on both externalizing and internalizing measures. There was a moderate to strong negative correlation between resiliency and internalizing and externalizing symptoms. Age and gender did not have significant impacts on the emotional and behavioral symptoms of children exposed to IPV. Physically abused girls obtained significantly higher internalizing scores than physically abused boys. Additional efforts are needed to examine the more immediate psychological effects of

maltreatment and age and gender differences to guide service and treatment decisions and prevent long-term harm.

Keywords: child maltreatment, childhood trauma, domestic violence, intimate partner violence, physical abuse, exposure to direct and indirect violence, externalizing, internalizing

Dedication

To my family,

for always believing in me, inspiring me, and encouraging me to aim high in order to achieve great things and reach my full potential.

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Chapter I

Each year, many of children are exposed to family violence or victimized by maltreatment around the world and in the United States (U.S.). In the United States, an estimated 26% of children between birth and age 17 are directly or indirectly exposed to some form of intra-familial violence during their lifetime (Hamby, Finkelhor, Turner, & Omrod, 2011).

Many forms of family violence are considered to be child maltreatment. Child maltreatment is defined by federal and state laws. It includes physical, sexual, and emotional abuse, as well as physical, supervisory, and educational neglect. At present, no national legislation defines children's exposure to intimate partner violence (IPV) as child maltreatment (Ravi & Casolaro, 2018). However, some states have begun incorporating children's exposure to IPV into existing definitions of child abuse and neglect (Lawson, 2014; Nixon, Tutty, Weaver-Dunlop, & Walsh, 2007).

Extensive research has established child maltreatment as a severe environmental hazard that has the potential to exert pervasive and deleterious effects on a wide range of developmental domains and adulthood functioning (Cicchetti & Valentino, 2006). The consequences of child maltreatment can wary widely. Physical injuries and, in some cases, death are some of the most harmful ramifications. In the majority of cases, however, the short- and long-term impact of the exposure causes more severe psychological scars than physical ones.

Recently, increased attention has focused on children who are not the direct targets of violence in the home but who are potentially harmed by witnessing its occurrence. Intimate partner violence (IPV), a form of domestic violence, and children's exposure to this violence

have been shown to be a social problem that affects every segment of the population. Although IPV cuts across the economic spectrum, the literature suggests that families from lower socioeconomic backgrounds are more likely to be affected (e.g., Buckner, Bearslee, & Bassuk, 2004). Children's witnessing of IPV can be visual, auditory, or inferred, whereby the child perceives the outcome of the violence (e.g., physical injuries or property damage). Each year, 1 in 15 children is exposed to IPV, and 90% of exposed children are eyewitnesses to the violence (Hamby, Finkelhor, Turner, & Omrod, 2011). Children who witness IPV may endure significant emotional difficulties and experience developmental delays or problems that have been found to be similar to those of children who have been directly abused.

Although IPV has been found to be prevalent and associated with significant mental health impairment, the potential harm done by children's witnessing of IPV continues to be frequently overlooked by law enforcement, families, and other community members at the time of a violent incident. Many cases of exposure continue to go unnoticed and unreported. When cases are reported and investigated, services are not reliably initiated. There are several explanations for this finding (e.g., overworked state child protection agencies; limited knowledge of child reactions; lack of instruments to reliably assess children's exposure to IPV).

To date, there is a strong research base that suggests that children exposed to direct (i.e., physical abuse) and indirect (i.e., exposure to IPV) forms of child maltreatment may suffer deleterious long-term consequences. Various studies have provided evidence that the experience of violence can lead to lasting psychological and physical harm. Children who are exposed to violence are more likely than non-maltreated children to experience anxiety, depression, and attachment problems, and they tend to exhibit higher levels of anger, aggression, and conduct problems. Other consequences of violence exposure include health-related problems, academic

and cognitive deficits, delinquency, and involvement in the child welfare and juvenile justice systems.

Many studies that have looked at the effects of childhood exposure to violence, whether direct or indirect, have focused on children's risk for developing internalizing and externalizing symptoms (VanZomeren-Dohm, Xu, Thibodeau, & Cicchetti, 2015). Externalizing refers to a broad range of behaviors that are overt and manifest externally. Externalizing behaviors are often seen as disruptive. Temper tantrums, arguing, defiance, non-compliance, impulsivity, and aggression are examples of externalizing behaviors (Keil & Price, 2006). Externalizing behaviors are often associated with violations of societal norms and/or the basic rights of others. Externalizing behaviors put children at risk for the development of conduct disorders and delinquency. Internalizing refers to behaviors that are more covert and inwardly experienced. Examples of internalizing problems are symptoms of depression and anxiety, as well as withdrawal and somatization (Gresham & Kern, 2004). Internalizing behavior problems can be difficult to detect and might not become apparent until they cause clinically significant distress or impairment.

Most recent studies have explored the long-term or distal impact of exposure to violence on the behavioral and psychological functioning of youth. The immediate or proximal effects of different types of exposure to violence remain somewhat elusive and tend to vary (e.g., Manly, Kim, Rogosch, & Cicchetti, 2001; Nolin & Ethier, 2007). Furthermore, the impact of a child's age and gender, as well as his or her level of resiliency, on the immediate consequences of maltreatment is not completely clear. Difficulties in fully elucidating the proximal and distal effects of the different types of maltreatment may be due to the heterogenous and diverse nature

of maltreatment experiences, contexts of abuse, and potential moderating and mediating factors (Putnam, 2006).

Children and adolescents who enter the child welfare system (particularly those who are removed from their biological family and placed in the custody of resource caregivers) often present with complex physical, psychological, developmental, and interpersonal challenges. As a result, they are designated as children with special health care needs. However, because proximal effects of child maltreatment remain unclear, there continue to be obstacles to providing effective and comprehensive health care to these youth. Lack of appropriate care in the proximal aftermath of child maltreatment can potentially increase a child's risk for developing negative long-term outcomes. Therefore, getting a clear sense of the short-term effects of abuse seems of the utmost importance.

In an effort to help fill this gap, the present study aims to explore whether children exposed to direct versus indirect violence exhibit similar or different proximal symptom patterns. Variables of interest are children's internalizing and externalizing behaviors. The study sample is comprised of Hawaiian children who were involved with Child Welfare Services (CWS) at the time their symptoms were assessed. Children's age and gender, as well as their level of resiliency, are considered to be potential moderating variables.

Rationale of the Study

Despite the significance and magnitude of the problem of IPV and child physical abuse, research shedding light on children's emotional and behavioral presentation in the proximal aftermath of family violence exposure remains inconclusive. While some maltreatment subtypes have been linked to specific negative distal effects, proximal or short-term outcomes are less clear and often relative to youth from non-violent families. When comparing maltreated children

to their non-maltreated peers, important differences in the characteristics or socioeconomic status of the youths' families and their broader social context may confound the results.

In order to address current limitations of the literature, more information on the effects of different types of maltreatment on children from diverse backgrounds is needed. Identification of the range of consequences of familial violence exposure and the factors that affect these consequences could help identify children who are prone to developing negative reactions. It could also aid caseworkers in better tailoring responses and services for exposed children who end up on their caseloads.

Furthermore, additional data on children's reactions at different points in time following exposure are needed to obtain a better understanding of possible sleeper effects. A critical time that seems to be understudied at this time is the period during which children and their families are actively involved with CWS secondary to maltreatment. At that time, children's psychological wellbeing is often assessed by professionals in order to determine family service needs. A clear understanding of children's typical presentations during this time will prevent them from slipping through the cracks.

To help fill the aforementioned gaps, the current study compared the symptom profiles of physically abused or IPV-exposed Hawaiian children from low socioeconomic backgrounds whose families were actively involved with CWS at the time of their assessment. By utilizing a unique sample, clearly delineating the different maltreatment types, and taking into consideration age, gender, and level of resiliency, this study adds to the current literature. The study is considered exploratory due to its limited sample size.

Review of the Literature

Definitions

The key federal legislation addressing child abuse and neglect is the Child Abuse and Prevention Treatment Act (CAPTA; Child Welfare Information Gateway, 2019a). It was first signed into law in 1974 (P.L. 93-247) and was most recently amended in 2018 (P.L. 115-424; GovTrack.us, 2019). The Child Abuse and Prevention Treatment Act, amended by the CAPTA Reauthorization Act of 2010, defines child abuse and neglect as

> any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act which present an imminent risk of serious harm. (CAPTA Reauthorization Act, 2010, § 5101, Note § 3)

Nearly all states provide additional civil definitions of child abuse and neglect that recognize specific subtypes of abuse (i.e., physical abuse, emotional abuse, and sexual abuse; medical, educational, physical, and emotional neglect; Child Welfare Information Gateway, 2019b). To date, there is no national legislation that regards children's exposure to IPV as abuse. However, some states have begun to incorporate children's exposure to IPV into their existing definitions of child maltreatment.

Physical abuse. Physical abuse is broadly defined as any action that results in a non-accidental physical injury to a child (Child Welfare Information Gateway, 2019). Physical abuse can include hitting, kicking, shoving, biting, or burning (Child Welfare Information Gateway, 2019). In approximately 38 of the 50 states, including Hawaii, the definition of physical abuse also encompasses acts that place a child's health or welfare at risk of harm (Child Welfare Information Gateway, 2019).

Intimate partner violence. Definitions of domestic violence or IPV and a child's witnessing of violence vary widely. Domestic violence has been defined as a systematic pattern of abusive behaviors that are used to gain or maintain control and power over another person in a relationship (Office of Violence Against Women, U.S. Department of Justice, 2017). The Centers for Disease Control's (CDC) National Center for Injury Prevention and Control delineates four main types of intimate partner violence: (a) physical violence, (b) sexual violence, (c) psychological/emotional violence, and (d) threats of physical or sexual violence (CDC, 2019). Physical harm is defined as the intentional use of physical force against a household member and may include shoving, shaking, choking, hitting, punching, or kicking (CDC, 2019). Psychological or emotional violence traumatizes a victim through acts, threats of acts, or coercive tactics (CDC, 2019). Psychological violence may include controlling behaviors that limit an individual's access to family, friends, finances, information, and/or services (CDC, 2019). Sexual violence can include forced intercourse or other sexual coercion. A victim of IPV may be exposed to different types of intimate partner violence at once or over time. IPV is associated with several risk and protective factors (Niolon et al., 2017). IPV varies in intensity and frequency. Niolon and colleagues (2017) report that it occurs on a continuum, ranging from a single episode that might or might not have a lasting impact on the victim of the violence to chronic and severe episodes that persist over a period of years (Niolon et al., 2017).

Children's exposure to intimate partner violence. Different terms have been used to describe children with a history of IPV exposure. Initially, exposed children were referred to as "witnesses." More recently, children have been described as "exposed." Terms seem to have shifted when definitions of what constitutes children's IPV exposure changed. Early definitions were often narrow, including only the witnessing of physical violence between caretakers.

Current definitions tend to be broader and more inclusive, acknowledging that children may be exposed to any of the aforementioned types of domestic violence to varying degrees. The current consensus appears to be that children's exposure to IPV constitutes a continuum (Holt, Buckley, & Whelan, 2008) that ranges from witnessing a violent act or intervening in it to observing its after-effects. However, to date, no standardized definition of children's exposure to IPV has emerged (Mohr, Lutz, Fantuzzo, & Perry, 2000). Children are typically considered to have been exposed to IPV if they were within sight of or could hear the violent act (Edleson et al., 2006).

Child Welfare and IPV: From Past to Present

Historically, child maltreatment and domestic violence were regarded as two distinct social problems (Findlater & Kelly, 1999). Each was assumed to have its own causes, effects, interventions, and policy contexts (Fleck-Henderson, 2000). Domestic violence was mainly regarded as a woman's issue. Thus, the child welfare system did not routinely respond to domestic violence situations. When child welfare service systems became involved, it was most often because children sustained physical injuries during an incident of domestic violence. In these instances, state child welfare agencies tended to define children's exposure to intimate partner violence as child abuse by commission or neglect by omission (De Bellis et al., 2002). Being the primary caretakers, mothers were often charged with "failure to protect" the child. This made it extremely difficult for child welfare and domestic violence agencies to collaborate in working to protect mothers and children (Aron & Olson, 1997).

Since a plethora of research on the negative effects of children's exposure to domestic violence has surfaced, the aforementioned assumptions have shifted somewhat. Several child welfare jurisdictions across the U.S. have begun to establish cross-system protocols and partnerships with domestic violence agencies to ensure coordinated responses and provide

targeted services to families experiencing intrafamilial violence (Toussaint, 2006). There are now a number of successful programs that address different aspects of IPV and its impact on child welfare. However, due to overworked systems and limited resources, CWS divisions can often only respond to the most severe cases (Edleson, 2004). Many families in which IPV occurs are substantiated for child maltreatment only after other risk factors, such as substance abuse by parents, are found to exist (Edleson, 2004).

Child Maltreatment and IPV: Prevalence and Demographic Characteristics

Child maltreatment in the United States. The United States Department of Health and Human Services (USDHHS) reported that during Federal Fiscal Year (FFY) 2017, an estimated 674,000 children were abused and neglected (USDHHS, 2019). This results in a rate of 9.1 victims per 1,000 children in the general population. The majority of child maltreatment victims (85.6%) suffered from a single type of maltreatment. According to the Child and Family Services Review Aggregate Report (USDDHS, 2018), during Fiscal Year 2015–2016, neglect (~63%) and substance abuse by parents (~42%) were the most commonly cited reasons for CWS case openings. Approximately 20% of cases were opened for reasons of physical abuse and 19% for domestic violence in the child's home (USDDHS, 2018). Boys and girls appear to be similarly affected (i.e., 51% of documented victims were female, and 48.6% were male). National statistics indicate that many children exposed to childhood maltreatment experience other additional adverse childhood experiences. For example, during FFY 2017, 50.8 % of victims came from families with a drug abusing caregiver, 23.8% came from homes with domestic violence problems, and 3% came from homes that lacked the financial funds to meet minimum living standards and needs (USDHHS, 2019).

Child maltreatment in Hawaii. During FFY 2017, there were 4.2 victims of child abuse

and neglect per 1,000 children (1,297 total victims of child maltreatment) in the state of Hawaii. Pacific Islander children had the highest rate of victimization (9 out of 1,000). White children and those identifying as "Multiple Race" were victimized at a rate of 5.5 out of 1,000 children. Hispanic children had the lowest victimization rate. The majority of substantiated cases were for "Other" types of maltreatment (89.5%), followed by neglect (13%) and physical abuse (8.7%; USDHHS, 2019). The National Child Abuse and Neglect Data System (NCANDS)—a voluntary data collection system that gathers information from all 50 U.S. states, the District of Columbia, and Puerto Rico about reports of child abuse and neglect—defines the "other" maltreatment category as any type of maltreatment coded by states that does not fit the NCANDS coding system (USDHHS, 2019). In the state of Hawaii, the "other" category contains cases of "threatened abuse" and "threatened neglect," which refer to any reasonably foreseeable substantial risk of harm to a child (HRS 587A-4, 2018). A child's exposure to IPV may be coded under the threatened harm or psychological abuse category.

Domestic violence. In the U.S., nearly 4.8 million acts of physical or sexual violence are perpetrated against women, and 2.9 million physically violent acts are perpetrated against men annually (Tjaden & Thoennes, 1998). The United States Bureau of Justice estimates that between 2001–2005, nonfatal IPV affected 1 in 320 households (Catalano, 2006). Although it is assumed that many of these incidents occur in the presence of children, it has been challenging to determine exact exposure incidence and prevalence rates. Estimates vary according to the definitions used and study methods employed. Many estimates are extrapolated from national surveys that were not specifically devised to measure children's exposure. Furthermore, estimates are often limited to cases reported to CWS or based on retrospective reports of adults, which may not be representative of all cases or could be subject to recall bias (Hardt & Rutter,

2004). Thus, reported prevalence rates likely underestimate the extent of children's exposure to IPV.

Two of the earliest and most widely cited past-year estimates of children's IPV exposure are based on data from the National Family Violence Survey (NFVS). Utilizing survey data from 1975, Carlson (1984) estimated that 3.3 million U.S. children between the ages of 3 and 17 may be at risk of witnessing IPV between caretakers annually. Relying on results from the 1985 survey, Straus (1992) estimated that as many as 10 million teens may be exposed to parental violence each year. Straus obtained this estimate by utilizing retrospective reports provided by adults about their adolescent years.

The Developmental Victimization Survey, which includes a single item on witnessing IPV, produced a 1-year incidence rate of 1 in 3 children (Finkelhor, Omrod, Turner, & Hamby, 2005). More recent studies show similar variations in estimates. For example, a study based on the National Survey of Children's Exposure to Violence (NatSCEV) found that 6.1% of sampled children were exposed to IPV within the past year (Finkelhor, Turner, Shattuck, & Hamby, 2013). Hamby, Finkelhor, Turner, and Omrod (2011) reported that in 2008, approximately 1 in 9 youths, which equates to 11.1%, were exposed to some form of IPV between caretakers. McDonald, Jouriles, Ramisetty-Mikler, Caetano, and Green (2006) estimated that nearly 15.5 million children in the United States live in two-parent households in which IPV occurred within the previous year. Finkelhor et al. (2013) reported that children 10 years and older had witnessed more past-year violence than younger children. Hamby et al. (2011) noted that the majority of children (~90%) are eyewitnesses to the violence.

Reflecting a longer period of possible exposure, lifetime exposure estimates are higher than past-year exposure estimates. Finkelhor et al. (2013) found that approximately 25% of

children had witnessed a parent assault another parent or caretaker in their lifetime. Using data from nearly 8,700 adult members of a health plan who completed a survey about adverse childhood experiences, Dong et al. (2004) reported a childhood domestic violence exposure prevalence rate of 24%. Similarly, another retrospective study examining the transition from the child welfare system into the juvenile justice system among 10,850 maltreated children and adolescents reported that 20% of children in the sample had been exposed to domestic violence (Vidal et al., 2017). Other sources indicate that as many as 3–18 million children are exposed to IPV in some form during their lifetime (Tajima, Herrenkohl, Moylan, & Derr, 2011).

Effects of Family Violence: Theoretical Underpinnings

Various theories that attempt to explain the relationship between the witnessing or experiencing of violence and the development of emotional or behavioral problems in children have been proposed (Jaffe, Hurley, & Wolfe, 1990).

Operant conditioning models involving positive and negative reinforcement contingencies (Patterson, 1982), as well as social or observational learning models (Bandura, 1973), maintain that children learn social behaviors by observing and imitating others (Schwartz, Dodge, Pettit, & Bates, 1997). Children's behaviors are thought to be reinforced via the consequences they bring about.

Attachment theory assumes that an abusive home environment and unpredictable parent–child relationships result in a disturbance of the child's basic trust, which may lead to an inability to self-regulate behaviors and emotions (Rieder & Cicchetti, 1989) and poor self-esteem (Okun, Parker, & Levendosky, 1994).

Transactional-bioecological or ecological models consider the relative contributions of risk and protective factors in children's developmental outcomes (Belsky, 1993; Cicchetti &

Lynch, 1993). These models take into account the ontogenic development of the child, as well as his or her broader social environment (i.e., microsystem, exosystem, macrosystem). A child's interrelated and mutually embedded micro-, exo-, and macrosystems are thought to have an impact on the potential effects of violence exposure (i.e., increased resilience or adversity; Cicchetti & Lynch, 1993).

From a developmental psychopathology perspective (Sroufe & Rutter, 1984), the effects of exposure to direct or indirect intrafamilial violence are thought to depend on a child's level of functioning, the timing and frequency of the exposure, and the child's way of responding or adaptation to the violence.

Intimate Partner Violence

Overview. The impact of IPV on youth has been the focus of many researchers and clinicians over the past several decades. The first case studies on the topic emerged in the 1970s, and the first empirical studies were conducted in the mid-1980s. Since then, researchers have elucidated various deleterious effects associated with children's exposure to IPV. The research indicates that even when children are not the direct target of intrafamilial violence, they can be severely harmed by its occurrence (McLean & Bocinski, 2017). Some researchers have remarked that IPV may be most toxic violence children can experience in their family of origin (Groves, 2001). The National District Attorneys Association (NDAA) has noted that IPV is a serious and pervasive criminal and public health issue, with devastating consequences for both the victim and society (The City Auditor, 2017). The population-level health consequences of exposure and the related social and economic costs of such exposure are immense (McLean & Bocinski, 2017; Carlson, Voith, Brown, & Holmes, 2019). Exposed individuals may experience negative effects from the cradle to the grave. Due to the significant negative impact of IPV on children, families,

and the social environment, it is increasingly being recognized as a form of childhood maltreatment (MacMillan, Wathen, & Varcoe, 2013; Dubowitz, 2014).

Children's witnessing of IPV has been linked with significant elevations on indices of concurrent and prospective adjustment problems. For example, IPV has been associated with sleep disturbances (NCTSN, 2019a); poor emotional regulation and impulse control (e.g., Putnam, 2006); language lag, difficulty concentrating, poor academic performance, and lower cognitive functioning (e.g., Wolak & Finkelhor, 1998; Hurley & Jaffe, 1990; Crozier & Barth, 2005); peer difficulties; and low self-esteem and confidence. Furthermore, it has been associated with significant internalizing problems, such as mood (i.e., major depression) and anxiety disorders (i.e., generalized anxiety disorder, panic disorder, and posttraumatic stress disorder), as well as substance use and personality disorders (Jaffe, Wilson, & Wolfe, 1990; NCTSN, 2019a).

The majority of the research that has been completed has explored the impact of children's witnessing of IPV on their emotional and behavioral adjustment by measuring levels of internalizing and externalizing symptoms. According to Sternberg, Baradaran, Abbott, Lamb, and Guterman, (2006), IPV-exposed children are almost twice as likely than non-exposed children to exhibit externalizing and internalizing problems. The distinction between externalizing and internalizing was first made by Achenbach and Edelbrock (1978). Externalizing behaviors are exhibited overtly and are often considered socially negative and disruptive. Children who display persistent patterns of externalizing behaviors are at an increased risk for peer difficulties, academic underachievement, high school dropout, substance abuse, conduct problems, and persistent antisocial behaviors, as well as the perpetration of interpersonal violence later in life. Internalizing behaviors, in contrast, are typically characterized by quiet, internal distress. As a result, internalizing disorders may go unnoticed or be viewed as less

problematic by individuals whom the affected child comes into contact with (e.g., parents, caregivers, or teachers; Tandon, Cardeli, & Luby, 2009). If untreated, internalizing problems may place a child at risk for substance use, academic underachievement, school dropout, and self-harming behaviors.

The majority of the research on the effects of IPV, to date, has utilized standardized parent and/or self-report measures to determine children's psychological and adjustment problems at various time points after exposure to a domestic violence incident. Some studies have explored children's immediate reactions, while others have focused on the short- and long-term effects. Most researchers have compared children exposed to IPV with children not so exposed or with those exposed to other types of maltreatment. Although many studies have found an association between children's IPV exposure and problems in one or more domains of functioning, results have varied. Furthermore, not all studies have found empirical support for the aforementioned associations.

Immediate effects. Research on the immediate effects of IPV exposure on children's behavioral, emotional, cognitive, and physiological functioning appears limited. Some qualitative and analogue studies have been conducted. Carlson (2000) hypothesized that this gap in the literature may, in part, be due to children's limited ability to accurately report their immediate reactions to family violence.

Children tend to respond to angry inter-adult conflict with heightened distress, fear, and aggression (Cummings & Davies, 1994). Often, distress manifests behaviorally. Behavioral manifestations may include increased irritability and regressed behavior around language and toileting (Osofsky, 1999), as well as emotional distress, sleep disturbances, and/or fear of being alone (Lundy & Grossman, 2005). Children may "cry, express anger; freeze; become distressed;

ask to leave the room; describe discomfort, anxiety, or concern; or report anger, sadness, fear, guilt, shame or worry" (Cummings et al., 1998, p.55). Socolar (2000) added that children may attempt to avoid the danger or to protect their mother. Other immediate reactions that have been associated with IPV exposure include generalized anxiety, difficulty concentrating, high activity levels, distress at separation from parents, as well as intense worry about the safety of the self- and/or a parent (NCTSN, 2019a).

Short- and long-term effects. Short-and long-term term effects of exposure to IPV are difficult to tease apart. Post-exposure time frames explored by researchers significantly vary across studies and no clear definition on what constitutes short- versus long-term effects exists.

To date, researchers have found no single pattern of short-term responses to IPV. Studies utilizing longitudinal designs have shed some light on children's long-term responses. The effects of children's exposure to IPV may manifest in multiple ways across the lifespan and encompass various domains of a child's functioning (Carlson, 2000). IPV may impact children's emotional, behavioral, cognitive, social, and/or physical wellbeing (Kolbo, Blakely, & Engleman, 1996).

Behavioral or externalizing problems are some of the most well-established consequences of IPV exposure. Behavioral problems that have been associated with IPV include impulsivity (Widom, 1997); temper tantrums and aggression (Cunningham & Baker, 2004; Sternberg, Lamb, Guterman, & Abbott, 2006); higher levels of emotional expressivity and hostile reactivity (Ehrensaft & Cohen, 2012); regressed behaviors (Hughes, Graham-Bermann, & Gruber, 2001); disobedience, noncompliance, and oppositionality; bullying and aggression toward peers (Baldry, 2003; Bauer et al., 2006); school absenteeism (Kiesel, Piescher, & Edleson, 2016) and

school suspensions (Kernic et al., 2002); cruelty to animals (Currie, 2005); as well as substance use, delinquency, anti-social behavior, and violent crime (Edleson, 1999b).

Exposed children have been shown to exhibit more school-related problems, as well as increased problems with peers and teachers, than their non-exposed counterparts (Jaffe, Wilson, & Wolfe, 1990). Adamson and Thompson (1998) reported that IPV-exposed youth are more likely to use aggression to resolve conflict.

Common socioemotional effects of IPV exposure on children include internalizing problems, such as depressive symptoms, anxiety, and worry (Sternberg et al., 1993); emotional withdrawal (Margolin & Vickerman, 2007); low self-esteem (Carlson, 2000); as well as deficits in prosocial behavior (Lundy & Grossman, 2005). Various studies have found that exposed children have difficulty managing and regulating their emotions (Rigterink, Fainsilber Katz, & Hessler, 2010), which may impact their ability to effectively engage interpersonally.

Cognitive difficulties include attention difficulties and learning problems. Some studies comparing exposed to non-exposed children indicate that IPV exposure may also be associated with lower academic achievement and higher risk for impairments in speech and language (Artz et al., 2014).

Physical problems may include difficulty sleeping (Lemmey, McFarlane, Willson, & Malecha, 2001); poor motor skills (Fantuzzo & Mohr, 1999); enuresis (Martin, 2002); and psychosomatic symptoms, such as gastrointestinal issues and headaches (Martin, 2002).

A variety of long-term effects of IPV have been proposed. Studies have longitudinally linked IPV exposure with post-traumatic stress disorder (PTSD), anxiety, low self-esteem, depression, drug and alcohol abuse, delinquency and criminal behaviors, as well as problems in romantic relationships. Some of these effects might first appear during childhood or adolescence

and then worsen over time. Socolar (2000) mentioned that the longitudinal effects of children's IPV exposure may depend on the gender and age of the child at the time of exposure; the chronicity, intensity, and severity of the exposure; as well as the child's perception of his or her role in the violence.

Children exposed to IPV during the preschool and school-age years have been found to exhibit significant adjustment problems during adolescence. A meta-analysis of 74 studies that longitudinally examined the impact of IPV on children's behavioral adjustment found IPV to be linked with children's internalizing, externalizing, and total adjustment problems (Vu, Jouriles, McDonald, & Rosenfield, 2016). Kernic et al. (2003) found that children exposed to IPV were 40% more likely to have a higher subclinical total behavioral problems score on the Child Behavior Checklist when compared to their non-exposed peers. Lamers-Winkelman (2004) reported that 40–45% of children in their IPV-exposed sample exhibited high levels of trauma symptoms and behavioral and emotional problems. Kimball (2016) found exposed children to be at risk for later internalizing behaviors, such as depression, anxiety, attachment disorders, and PTSD. Graham-Bermann and Levendosky (1998) found that most children exposed to the physical abuse of their mother by their father had intrusive, reexperiencing symptoms; 40% had hyperarousal symptoms; and more than 10% met the full criteria for PTSD. Adolescents from violent families have also been found to exhibit lower levels of self-esteem and higher levels of depression and delinquency. Herrera and McCloskey (2001) found that exposure to IPV in childhood predicted referrals to juvenile court during adolescence. A study on juvenile offenders concluded that all offenders in the study had a history of childhood abuse (physical, psychological, or sexual; Pomeroy, Green, & Kiam, 2001). Other research has found that children with a history of IPV exposure are more likely to exhibit cruelty toward animals than

children from non-violent families (Currie, 2005. In line with social learning theory (Bandura, 1973), some research findings have provided evidence that children with a history of exposure to IPV are more likely to be abusive; experience higher levels of dating violence; and/or express views that justify the use of violence as adults (Lichter & McCloskey, 2004). Other researchers have questioned this connection. For example, Mullender and Morley (1994) note that many studies which provide support for a cycle of violence theory lack control groups and rely on non-representative samples. Some researchers have proposed that the process of intergenerational transmission of violence is more complex than learning theory predicts. Bevan and Higgins (2002) suggest that other types of child maltreatment, such as neglect, may play a more significant role in predicting whether or not children will grow up and continue the cycle of violence by being engaging in abusive behaviors.

As previously mentioned, not all studies indicated that there is an association between IPV exposure and children's adjustment problems. Outcomes seem to vary significantly. For example, Grych, Jouriles, Swank, McDonald, and Norwood (2000) found that while some children exhibit multiple symptoms (30%; both internalizing and externalizing problems), others experience internalizing problems alone (18%), externalizing problems alone (21%), or no adjustment problems at all (31%). McCloskey, Figueredo, and Koss (1995) also found low agreement on symptoms of child psychopathology following exposure to various displays of family aggression. Inconsistencies in the literature have been explained by methodological variations, such as recruitment methods (e.g., recruitment from domestic violence shelters versus communities), sample composition (e.g., low socioeconomic status [SES] versus average SES; single-exposed versus multiple-exposed), and timing of assessment (e.g., time since exposure to violence). Moderating factors have also been considered as possible explanations for diverse

findings. Several factors have been proposed to moderate children's responses to exposure (e.g., age, sex, social support, and other types of maltreatment; Carlson, 2000). Edleson (2004) noteed that consequences of IPV exposure may vary depending on the chronicity and severity of the violence exposure, degree of violence exposure (e.g., seeing the violence versus hearing the violence versus experiencing its after-effects), other stressors to which a child might be exposed (e.g., other types of maltreatment; parental substance use; parental separation), the harm the exposure produces for the child, and the protective factors a child may draw on. Due to their greater dependency, younger children are more likely than older children to witness IPV as well as more likely to suffer negative outcomes. It has been theorized that the latter may be due to their limited ability to cope with and understand the violence (Graham-Bermann, 2002). Time since last exposure might also play a role. Some researchers have argued that symptoms are most prevalent in the immediate aftermath of an event, whereas others have proposed a sleeper effect (Holmes, 2013).

Physical Abuse

Overview. Physical abuse is one of the most common forms of child maltreatment. The impact of physical abuse on a child's life can be significant and far-reaching. Kempe, Silverman, Steele, Droegemueller, and Silver (2013) were the first to describe the symptoms of "the battered child syndrome." Since then, the widespread prevalence of child physical abuse, as well as adverse effects associated with it, have been increasingly elucidated and recognized. Various studies have found that physically abused children may develop various psychological problems, including internalizing symptoms, such as anxiety and depression (Cougle, Timpano, Sachs-Ericsson, Keough, & Riccardi, 2010; Libby, Orton, Novins, Beals, & Manson, 2005), and externalizing symptoms, such as aggression and violence (Maas, Herrenkohl, & Sousa, 2008;

Stouthamer-Loeber, Loeber, Homish, & Wei, 2001). Links between physical abuse and difficulties developing and maintaining friendships, trusting authority figures, low self-worth (NCTSN, 2019b), and delinquency (Smith & Thornberry, 1995) have also been established.

Short- and long-term effects. As with IPV exposure, the short- and long-term effects of physical abuse on children are difficult to tease apart. Physically maltreated children exhibit cognitive deficits (e.g., lower general intellectual functioning and academic achievement scores); maladaptive social-emotional behaviors that contribute to interpersonal difficulties (e.g., poor emotion processing; aggressive responses to conflict; Teisl & Cicchetti, 2008); externalizing difficulties (e.g., aggression, impulsivity, rule-breaking, disruptive and delinquent behaviors, conduct problems; Cohen, Brown, & Smailes, 2001); and internalizing problems (e.g., hopelessness, low self-worth, depression, anxiety; Moylan et al., 2010). Childhood physical abuse has also been linked with an increased risk for bullying perpetration and victimization (Shields, Ryan, & Cicchetti, 2001), substance abuse (Dembo et al., 1987), delinquency (Lansford et al., 2007), suicidal behavior (Salzinger, Rosario, Feldman, & Ng-Mak, 2007), and high school dropout (Lansford et al., 2007; Widom, 2000). Effects seem to vary based on the child's age at the time of exposure, as well as the intensity and chronicity of exposure. Various other factors have been proposed to impact the effects of physical abuse on children's physiological, psychological, and interpersonal functioning.

Moderating Factors

Age. Various researchers have proposed that children's responses to family violence may vary with age (e.g., Cunningham & Baker, 2004) due to (1) developmental differences in emotion-processing and cognitive capacities; and (2) the unique maturational and social challenges faced by children in each developmental stage (Margolin & Gordis, 2000). Some

researchers have added that early and repeated exposure may lead to more severe problems due disruption of the chain of development (Fantuzzo et al., 1991). However, not all studies have provided evidence to support the aforementioned hypotheses and, to date, no clear developmental response patterns have emerged.

Exploring the effects of different types of family violence on children in different developmental stages, Sternberg, Lamb, Guterman, and Abbott (2006) found that younger children were more susceptible to the effects of family violence than adolescents. However, not all children who experienced problems in childhood continued to exhibit problems during their teenage years. Meltzer et al. (2009) also found that younger children tended to exhibit more severe behavior problems than older children. Emery (2011) suggested that the effects of exposure to IPV may lessen as the age of the child at time of exposure increases. Meta-analyses by Kitzmann, Gaylord, Holt, and Kenny (2003) and Evans, Davies, and Dilillo (2008) which examined the effects of IPV on various domains of childhood functioning did not find evidence for age differences. Wolfe, Crooks, Lee, McIntyre-Smith, & Jaffe (2003) proposed that conclusions concerning the moderating effect of age on exposure to IPV and behavioral outcomes may be difficult to determine due to methodological differences between studies.

Infants and toddlers. As previously mentioned, findings suggest that younger children may be most affected by intrafamilial violence exposure because they are more dependent on parents for all aspects of their care (Huth-Bocks, Levendosky, & Semel, 2001). Holt et al. (2008) summarized that following violence exposure, infants and toddlers may exhibit sleep disturbances, increased irritability and emotional distress (Lundy & Grossman, 2005), regressed behavior around language and toilet-training (Osofsky, 1999), and separation anxiety.

Preschool age children. Preschoolers exposed to family violence may display disturbances in emotion regulation as well as cognitive and social functioning. For example, both Huth-Bocks at al. (2001) and Rossman (1998) found that IPV-exposed preschoolers had more behavioral and social problems; higher levels of depression, anxiety, and post-traumatic distress; as well as poorer self-esteem and greater difficulty developing empathy than their peers from nonviolent homes.

School-age children. IPV-exposed school-age children may exhibit increased externalizing behavior problems (e.g., Emery, 2011; Bauer et al., 2006). A study by Lundy and Grossman (2005) that sampled 4,636 children who had been exposed to IPV found that one-third of school-age children were described as aggressive and one-fifth as having difficulties following school rules. However, although various studies have linked IPV exposure to externalizing behavior problems in school-age children (e.g., Bauer et al., 2006; Hughes, Parkinson, & Vargo, 1989; Litrownik, Newton, Hunter, English, & Everson, 2003; McFarlane, Groff, O'Brien, & Watson, 2003), some researchers found no such relationship (e.g., Ybarra, Wilkens, & Lieberman, 2007).

Adolescents. Exposure to intra-familial violence, whether direct or indirect, has been associated with increased internalizing and externalizing behaviors in adolescents (Moylan et al., 2010; Mahoney, Donnelly, Boxer, & Lewis, 2003; Lansford, Deater-Deckard, Dodge, Bates, & Pettit, 2004). Davies and Lindsay (2004) reported internalizing symptoms may be more prevalent in adolescent girls than boys.

Gender. Studies focusing on gender as a possible moderator of the relationship between familial violence exposure and child adjustment problems have generated mixed results. Several studies suggest that exposure to IPV and physical abuse affect males and females differently

(e.g., Keyes et al., 2012; Kerig, 1996; Edleson, 1999b; Yates, Dodds, Sroufe, & Egeland, 2003; Hughes, 1988), with these differences reflected in both the nature and the extent of the presenting problem. For example, according to Kerig (1996), boys tend to exhibit more frequent problems. Edleson (1999a) added that they tend to exhibit ones that are categorized as externally oriented (e.g., aggression and hostility). In contrast, girls have been found to show evidence of more internally oriented problems (e.g., somatic complaints and depressive symptoms). However, Edleson (2004) noted that there are also findings that indicate that as girls get older, they may exhibit more aggressive behaviors than boys.

Although the view that girls tend to display more internalizing behaviors while boys tend to show greater externalizing behaviors has been supported with empirical evidence (Graham-Bermann & Hughes, 2003), not all studies have found support for differential symptom patterns when comparing similarly exposed girls to boys (Kitzmann et al., 2003; Graham-Bermann & Levendosky, 1998). For example, meta-analyses by Wolfe, Crooks, Lee, McIntyre-Smith, and Jaffe (2003) and Kitzmann, et al. (2003) found no gender differences in externalizing symptoms secondary to IPV exposure. A study by Holmes, Voith, and Gromoske (2015) reported that while boys and girls may exhibit comparable levels of externalizing symptoms (i.e., aggression) following IPV exposure, boys may be at greater risk for developing negative cross-domain effects.

To explain the inconsistent findings, some researchers have suggested that gender differences may change with age. Based on previous research, Evans et al. (2008) hypothesize that during childhood, boys may be more likely to exhibit externalizing symptoms than girls, but during adolescence, this pattern may switch to boys exhibiting more feelings of sadness and girls displaying more feelings of anger. Theories providing a basis for this suggestion seem to be

sparse, however. Other researchers have argued that gender differences may be due to variations in exposure or differences in recruitment methods and sample composition (Evans et al., 2008).

Resilience. As outlined above, children who experience violence in their families are at an increased risk for a wide range of problems. However, not all children exposed to familial violence are affected in the same way. Outcomes tend to vary widely. While some children experience debilitating and adverse effects secondary to familial violence exposure, many children exposed to trauma show no greater problems than their non-exposed peers. A growing body of research has examined factors that may contribute to children's positive adaptation in the face of adversity (e.g., Levendosky, Huth-Bocks, & Semel, 2002; Collishaw et al., 2007; Wright, Turanovic, O'Neal, Morse, & Booth, 2019). In this literature, children who achieve positive developmental outcomes are often referred to as resilient. Resilience has been defined as "a good outcome in spite of high risk, sustained competence under stress, and recovery from trauma" (McGloin & Widom, 2001, p. 1022). Research has reported resilience rates from 31% to 65% (Grych et al., 2000). According to Masten (2001), a child is resilient if he or she experienced a circumstance or event that had the potential to be developmentally disruptive and nevertheless adapted successfully. There are various definitions of successful adaptation, including appropriate developmental mastery and absence of psychopathology (Martinez-Torteya, Bogat, Von Eye, & Levendosky, 2009). Multiple definitions have also been used to define adversity or risk. Individual risk models explore the contribution of individual risk factors (e.g., exposure to IPV; physical abuse) to the development of negative outcomes. Cumulative risk models assert that maladaptation results from multiple adverse events or experiences (Rutter, 1979).

Factors that have been found to lessen the effects of witnessing or experiencing violence and/or promote positive adaptation have been examined at the levels of the individual (e.g.,

child's level of self-esteem and independence; child's interpretation of the violence), family (e.g., parenting quality; parental mental health), and social environment (e.g., quality of peer relationships; supportiveness of school environment; Hunter, 2012; Masten & Coatsworth, 1998). Afifi and Macmillan (2011) identify a supportive and stable family environment, as well as personality traits that support social skills to be the three most well-established protective factors.

Individual-level protective factors. Individual-level protective factors include gender (some research suggests that females are more resilient than males; e.g., McGloin & Widom, 2001); personality traits (e.g., high self-esteem, external attributions of blame, and internal attribution of success); and other personal characteristics (e.g., coping ability; life satisfaction, relationship capabilities; Afifi & MacMillan, 2011). Children's perception of the conflict as less threatening, as well as low levels of self-blame, has also been associated with more positive adaptation following violence exposure (Grych & Fincham, 1990). While there is some evidence that cognitive ability or intellectual functioning may serve as a protective factor (Masten & Tellegen, 2012), not all studies exploring individual-level protective factors have been able to back this finding (Afifi & Macmillan, 2011). For example, Jaffee and Gallop (2007) found that boys but not girls with above average intelligence were more likely to be resilient to maltreatment. Some authors have noted that children's successful adaptation due to strong individual level protective factors may decrease as environmental stress increases. Jaffee and Gallop (2007) reported that individual level protective factors distinguished resilient from non-resilient children in low-stress environments but not in high stress environments.

Family-level protective factors. Family-level protective factors include maternal warmth; absence of maternal depression; positive parenting (Martinez-Torteya et al., 2009); supportive

familial relationships at time of abuse (Afifi & Macmillan, 2011; Collishaw et al., 2007; Jaffee & Gallop, 2007); as well as positive changes in family structure (e.g., effective family intervention; removal to foster care; cessation of visitation).

Social-level protective factors. Social-level protective factors include supportive relationships with peers and non-family members, such as family friends, teachers, coaches, or school counselors (Flores, Cicchetti, & Rogosch, 2005; Jaffee & Gallop, 2007).

Risk Factors. Risk factors are environmental variables that increase a child's likelihood of poor physical, psychological, behavioral, and social outcomes following exposure to familial violence (Gewirtz & Edleson, 2007). Low socioeconomic status has been associated with a relatively high prevalence of risk factors for maladaptation (e.g., McLoyd, 1998). Positive adaptation has been associated with lower levels of risk (Leech, Larkby, Day, & Day, 2006). Various factors at the individual, family, and social level have been found to increase a child's risk for negative outcomes following intrafamilial violence exposure. These include: premature birth; lower intellectual functioning; parental separation or divorce; parental mental illness and substance use; parental incarceration; socioeconomic disadvantage; minority status; poverty and homelessness; social isolation; and living in dangerous neighborhoods (Jaffee & Maikovich-Fong, 2011; Gewirtz & Edleson, 2007; Herzog & Schmahl, 2018). There seems to be an agreement amongst most researchers that risks of a chronic, rather than acute, nature are more likely to exert detrimental long-term effects (Garmezy & Masten, 1994; Martinez-Torteya et al., 2009). As risk factors often co-occur in time, it can be difficult to determine the unique effects of each factor (Gewirtz & Edleson, 2007).

Purpose of the Study

While children often face adversity throughout their formative years and may experience situations of community violence or threatened harm by others (such as bullying), witnessing violence in the family home is a different type of stressor that can have significant deleterious and long-term effects on child development and adult functioning. Understanding the specific short-term effects of exposure to the most common and severe forms of maltreatment at different developmental stages on each gender seems of the utmost importance in providing adequate services and preventing long-term harm.

While a growing number of studies have explored the effects of IPV and other types of childhood maltreatment, taking into account the high rates of co-occurring subtypes, findings of subtype differences continue to be ambiguous. Maltreatment subtype effects have also been smaller in studies comparing maltreated samples than in studies that compare maltreated children to non-maltreated peers. Furthermore, while many studies have explored the long-term (distal) effects of physical abuse and exposure to IPV by utilizing longitudinal designs, there appears to be only limited information on the short-term (proximal) consequences of—and potentially differential symptoms following—direct and indirect exposure to violence at different ages in males and females. Thus, the objectives of the current study are: (a) to assess and compare levels of internalizing and externalizing symptoms of children exposed to direct versus indirect maltreatment; (b) to explore the impact of resiliency on internalizing and externalizing scores of children in the different maltreatment groups; and (c) to determine whether there are age and gender differences in the outcomes.

Research Questions and Hypotheses

RQ1. Do children exposed to IPV exhibit levels of internalizing and externalizing problems similar to those of physically abused children?

SQ1. Are mean Externalizing Symptoms Index (EPI) and Internalizing Symptoms Index (IPI) scores significantly different across maltreatment groups?

- H_0: Mean EPI and IPI scores will not differ to a statistically significant degree across maltreatment groups.
- H_1: Mean IPI scores will differ to a statistically significant degree across maltreatment groups, with children in the IPV group obtaining significantly higher scores than children in the physical abuse group.
- H_2: Mean EPI scores will differ to a statistically significant degree across maltreatment groups, with children in the physical abuse group obtaining significantly higher scores than children in the IPV group.

SQ2. What proportion of physically abused and IPV-exposed children score in the average, at-risk, and clinically significant ranges on the BASC-3 Externalizing Symptoms Index (EPI) and Internalizing Symptoms Index (IPI)?

- H_0: The majority of children exposed to either direct or indirect violence will obtain EPI and IPI scores that fall in the average range.
- H_1: The majority of children exposed to either direct or indirect violence will obtain EPI and IPI scores that fall minimally within the at-risk range.

SQ3. Are the proportions of children scoring in the average, at-risk, and clinically significant ranges on the BASC-3 Externalizing Symptoms Index (EPI) and Internalizing Symptoms Index (IPI) different across maltreatment groups?

- H_0: The proportion of children who obtain average, at-risk, and clinically significant scores on the BASC-3 EPI and IPI will not be significantly different across maltreatment groups.
- H_1: The proportion of children who obtain BASC-3 EPI scores in the average, at-risk, and clinically significant ranges will be statistically significantly different across maltreatment groups, with higher proportions of physically abused children scoring in the clinically significant range than IPV-exposed children.
- H_2: The proportion of children who obtain BASC-3 IPI scores in the average, at-risk, and clinically significant ranges will be statistically significantly different across maltreatment groups, with higher proportions of IPV-exposed children scoring in the clinically significant range than physically abused children.

RQ2. Do children exposed to IPV or physical abuse exhibit higher or lower levels of internalizing and externalizing symptoms than the normative mean T-score of 50?

- H_0: Mean IPI and EPI scores will not significantly differ from the normative mean.
- H_1: Mean IPI and EPI scores will be statistically significantly higher than the normative mean.

RQ3. Do children's levels of *resiliency* impact their scores on measures of externalizing and internalizing?

- H_0: There will be no significant correlations between resiliency and mean EPI and IPI scores of both groups.

- H_1: There will be a statistically significant negative correlation between BASC-3 resiliency and BASC-3 EPI and IPI scores of both groups.

RQ4. Does the *gender* of children exposed to (1) IPV or (2) physical abuse impact their scores on the BASC-3 IPI and EPI?

- H_0: Females and males in both maltreatment groups will not obtain statistically significant scores on the BASC-3 IPI and EPI.
- H_1: Females in both maltreatment groups will obtain statistically significantly higher scores on the BASC-3 IPI than males.
- H_2: Females scores on the BASC-3 EPI will be statistically significantly lower than those of males.

RQ5. Does the *age* of children exposed to (1) IPV or (2) physical abuse impact their scores on the BASC-3 Internalizing and Externalizing Symptoms Indexes?

- H_0: Age will not significantly impact children's IPI and EPI scores.
- H_1: Age will statistically significantly impact children's EPI and IPI scores.

Significance of the Study

In hopes to effectively respond to the problems associated with child maltreatment, the World Health Organization's (WHO) 2006 report on the prevention of child maltreatment recommends the expansion of scientific evidence for the magnitude, consequences, and preventability of child maltreatment (WHO, 2006). This study can help shed light on children's short-term reactions to direct and indirect family violence, on which advocacy, education, and public policy can be advanced with urgency and authority. Furthermore, the study may provide a baseline understanding of the immediate adverse effects of direct and indirect exposure to violence in male and female children of different ages, which may be used to stimulate additional

research in this important area, moving the field toward a more systematic understanding of the effects of various types of violence on the child. This understanding may aid agencies (including education, mental health, family services, and the justice system) working to protect children from maltreatment to make more informed decisions about the likelihood of harm. In addition, it may serve to assist in developing improved screening measures and treatment recommendations aimed at preventing the well-established adverse long-term effects of both types of abuse.

Chapter II

Methods

Participants

Data for the present study were obtained from the archived files of the Family Strengthening Center (FSC) of Family Programs Hawaii (FPH). The FSC is a Hawaiian non-profit community mental health center that provides services to culturally, socially, and economically diverse Hawaiian children and their families. The FSC currently conducts all psychological evaluations for Hawaii's child welfare service system.

Approval to use archived assessment data for research purposes was obtained from (a) parents/legal caretakers of children as part of the FSC's consent process that precedes screening and comprehensive psychological assessment procedures for which children are referred (a copy of the consent form can be found in Appendix C); and (b) from the director of the FSC (a copy of the approval letter can be found in Appendix B).

Records of all children between the ages of 3–18 who underwent psychological screening or comprehensive psychological testing with the FSC between January 2016 and January 2019 were reviewed for inclusion in the study.

Children are usually referred to the FSC for a mental health screening or comprehensive psychological evaluation by CWS as part of their family service plan. Referrals for psychological evaluations are typically initiated within the first 6 months of a case opening. Thus, most children included in the study were assessed for mental health concerns within close temporal proximity to their most recent exposure to family violence.

Archival data were reviewed for the following variables of interest: child's age at time of assessment; child's gender; child's history of maltreatment (e.g., physical abuse or witnessing

domestic violence); level of externalizing symptoms (as assessed by the BASC-3 Parent Rating Scales); level of internalizing symptoms (as assessed by the BASC-3 Parent Rating Scales); child's history of exposure to significant stressors within the past year (e.g., losses of family members; accidents; injuries; illnesses; or natural disasters); relation of the BASC-3 rater to the child (e.g., parent versus relative resource caregiver versus non-relative resource caregiver); history of substance use of child's parent/s; history of mental health problems in child's parent/s; history of incarceration of child's parent/s; separation of child's parents; and child's history of homelessness. Details regarding the frequency and intensity of the children's exposure could not be obtained. In addition, the age of first exposure could not be obtained.

The final sample was comprised of children that met the following inclusion criteria: children who were (a) between ages 3–17 at the time of assessment; (b) exposed to one or more incidents of either physical abuse or IPV; and (c) had a BASC-3 Parent Rating Scale (i.e., BASC-3 PRS-P, PRS-C, PRS-A) completed as part of their assessment. Children (a) whose files clearly indicated that they were exposed to other types of maltreatment (i.e., sexual abuse) or more than one type of maltreatment under review (i.e., physical abuse and domestic violence exposure); (b) experienced other traumatic events within the past year (i.e., the loss of a family member; severe accident; illnesses); or (c) whose BASC-3 PRS validity scale score fell in the extreme caution range on any of the three validity scales (i.e., F-Index; Response Pattern; Consistency) were omitted from the final sample. Children whose files only contained BASC-3 self-report measures were also not included in the final sample. Lastly, children whose file contained two or more completed BASC-3 PRS were included in the study, but only the primary caretakers' (i.e., person spending the most time with the child) responses were recorded in the study's data sheet.

Measures

Maltreatment history/maltreatment type. Archived clinical interview data obtained from the children's parent/s or legal guardian/s, as well as CWS case files that were provided as part of the referral, were reviewed to explore maltreatment history and code maltreatment type (i.e., direct exposure = history of physical abuse; indirect exposure = history of witnessing domestic violence between parents). Previous research has supported the use of case file data and demonstrated the level of rigor that can be achieved in studies that utilize such records (Green et al., 2015). Case file records indicate whether or not allegations of child maltreatment were confirmed by professionals trained to apply state laws and regulations (DePanfilis, 2006). Furthermore, case file records are less likely to be impacted by the social desirability bias present in self-reports of parenting behaviors (MacMillan, Jamieson, & Walsh, 2003). Lastly, case file records are less likely to be affected by the omission, misremembering, and/or forgetting of information related to child maltreatment, all of which may further impact the reliability of parent and child self-reports.

A child was coded as having been exposed to indirect violence (IPV between caretakers) if (a) CWS referral records indicated that he/she resided with their parent/s or caretaker/s who reported a history of multiple occurrences of IPV but (b) did not indicate that he/she experienced any type of direct abuse. IPV itself was broadly versus narrowly defined (i.e., psychological, physical, or sexual IPV versus physical IPV only; Jouriles, McDonald, Norwood, & Ezell, 2001). A child was coded as having been exposed to direct violence if (a) CWS records substantiated (i.e., an investigation disposition that concludes the allegations of maltreatment or risk of maltreatment are supported or founded by state law or policy) the abuse and (b) did not indicate the presence of significant IPV between parents. Maltreatment type categories were mutually

exclusive. Maltreatment type was coded as a dichotomous variable (1 = physical abuse; 2 = IPV exposure).

Child emotional and behavior problems. Child emotional and behavioral problems were assessed via the Behavior Assessment System for Children, 3rd Edition (BASC-3), Parent Rating Scales (PRS). Children's scores on the Internalizing Problems Index (IPI) and Externalizing Problems Index (EPI) were the primary variables of interest. Sample BASC-3 PRS Internalizing and Externalizing Problems Index items can be found in Appendices D and E, respectively. Internalizing and externalizing symptoms were reported and coded as T-score values with a mean of 50 and a standard deviation of 10.

The BASC-3 is a multi-method, multi-dimensional system for assessing the behavioral and psychological functioning of children and young adults age 2–25. Although the BASC-3 is a relatively new measure (published in 2015), and research on psychometric properties of the current version is limited, data released in the measures' manual (Reynolds & Kamphaus, 2015) and in earlier versions (i.e., BASC-2; Reynolds, Kamphaus, & Vannest, 2011) indicate good internal consistency and test-retest reliability.

Resilience. A child's resilience was assessed via the Behavior Assessment System for Children, 3rd Edition (BASC-3), Parent Rating Scales (PRS). The BASC-3 PRS includes a Resiliency Scale, which assesses a child's ability to access both internal and external support systems to alleviate stress and overcome adversity. Resiliency was reported and coded in T-score values with a mean of 50 and a standard deviation of 10.

Vulnerability. Information related to vulnerability factors was obtained from child assessment and CWS referral records. Variables of interest included number and type of significant life events experienced by the child other than direct or indirect exposure to violence in the family

home, history of homelessness, parental substance use, parental separation/divorce, incarceration of parent, and/or mental health diagnosis in parent. Each vulnerability factor was coded in a dichotomous fashion (0 = not exposed to vulnerability factor; 1 = exposed to vulnerability factor) if the information could be located in a child's case file. It should be noted that information regarding whether or not children had a history of exposure to the aforementioned vulnerability factors could not be reliably determined for every case, and thus, this information was not included in this study's analyses.

Demographics. Demographic variables of primary interest were obtained via assessment and CWS referral records and included the child's gender as well as the child's age and placement at the time of assessment (i.e., with parents/relative caregiver/resource caregiver). Age was coded as a continuous variable in exact years and months. Gender was coded as a dichotomous variable (1 = male, 2 = female). Placement at the time of assessment was coded as "1" with "parent," "2" with "relative caregiver," or "3" with "non-relative resource caregiver." Other demographic information (e.g., child race and ethnicity, SES) could not be reliably obtained. However, as the FSC completes all mental health screenings and psychological assessments for Hawaii's child welfare service system, it is likely that children in the current sample closely resemble child victims described in the 2017 Child Maltreatment Report released by the U.S. Department of Health and Human Services (USDDHS, 2019).

Procedures

Parent/s or legal caretaker/s were administered the BASC-3 PRS as part of a routine mental health screening or comprehensive psychological assessment, for which they were referred to the Family Strengthening Center at Family Programs Hawaii by the Department of Human Services, Child Welfare Services Branch. An overview of assessments typically

administered to children/adolescents or adults referred to the FSC can be found in Appendices F and G, respectively. No measures were administered to participants for the sole purpose of this study, and the primary researcher did not have face-to-face interactions with participants at any time.

Data required to explore hypotheses of the present study were obtained from the cloud-based archives of the FSC. All data under review for inclusion/exclusion were stored in a password-protected data file on a password-protected computer in the principal investigator's office. Approval to access archival data was obtained from the Family Strengthening Center at Family Programs Hawaii. Approval to use archival data for research purposes was obtained from potential participants during the routine informed consent process of the FSC's assessment procedures. Participants with missing data and those who did not meet the inclusion criteria were omitted from the study and deleted from the data sheet. Cases included in the study were assigned a random identification number that was generated with the help of Excel's random number generator. Once cases were assigned, an identification number and a list connecting each participant to his or her ID was printed and stored in a locked filing cabinet at the FSC office, and all identifying information was removed from the original data sheet. The SPSS file used for data analysis did not contain any identifying information and will be permanently destroyed 3 years past the publication of study findings (should publication be sought) or no later than January 2022.

Data Analysis

The BASC-3 PRS scores on the Internalizing Problems Composite (IPI) and Externalizing Problems Composite (EPI) scale T-scores comprised the outcome variables of

interest. Outcomes of interest were compared based on maltreatment type. Child age, gender, and level of resiliency were included as other variables of interest.

To determine the proportions of children from each maltreatment group scoring in the average, at-risk, and clinically significant ranges on the BASC-3 EPI and IPI and to determine whether there were significant differences in proportions between groups, chi-square analyses were conducted. To determine whether children in the sample groups obtained scores on the BASC-3 EPI and IPI that were statistically significantly higher than the BASC-3's mean T-score of 50, one-sample t-tests were run. ANOVAs were utilized to explore whether mean BASC-3 EPI and IPI scores differed across maltreatment groups. To explore the relationship between resiliency and levels of emotional and behavioral problems, Pearson product-moment correlations were run. Lastly, the impact of gender was explored via independent sample t-tests and the impact of age via Pearson product-moment correlations.

Data were first checked for normality and outliers. Normality was judged based on skewness and kurtosis values (Kim, 2013). Kim's (2013) recommendations regarding skewness and kurtosis cut-off values for small samples ($n < 50$) were used. Specifically, if absolute z-scores for either skewness or kurtosis were larger than 1.96, which corresponds with an alpha level of .05, the null hypothesis was rejected, and it was concluded that the sample was not normally distributed (Kim, 2013). All dependent variables fell within the cut-off value. Boxplots were checked for univariate outliers on dependent variables and addressed on a case-by-case basis.

Chapter III

Results

Sample Characteristics

The records of 139 children who were referred to the FSC for a mental health screening or comprehensive psychological evaluation were reviewed for inclusion in the study. The final sample consisted of 46 children (N=46). The age of the children ranged from 3 years, 3 months to 17 years, 3 months. The mean age of the children was 9.39 years (SD=3.62). Approximately 61% of the children had been exposed to IPV (*n* = 28; Group 1 = Indirect Violence Group), and 39% experienced physical abuse (*n* = 18; Group 2 = Direct Violence Group). The majority of the children were female (58.7%). Group 1 was comprised of 11 males and 17 females, and Group 2 was comprised of 8 males and 10 females. As additional demographic information could not be reliably collected for all cases included in the study, it is not reported here. It should be noted that a large proportion of children in the sample had a history of exposure to parental separation or divorce and/or parental substance use in addition to the identified maltreatment type. Furthermore, most children came from a low socioeconomic background and some had a history of homelessness.

Measure Characteristics

The Mean Externalizing Problems Index score of the children in the sample was 58.20 (SD = 13.76). The mean Internalizing Problems Index was 50.59 (SD = 10.81). The mean Resiliency scale score of children in the sample was 42.58 (SD = 9.26). Table 1 portrays the sample means, standard deviations, and ranges for all BASC-3 scales used in the statistical analyses. The possible range for each scale is included for reference purposes.

Table 1

Sample Means, Standard Deviations, and Ranges for BASC-3 Externalizing, Internalizing, and Resiliency Scales

Variable	Mean (SD)	Possible Range	Sample Range
BASC-3 EPI	58.20 (13.76)	10–120	36–84
BASC-3 IPI	50.59 (10.81)	10–120	35–80
BASC-3 Resiliency	42.58 (9.26)	24–78	21–62

Note. BASC-3 = Behavior Assessment System for Children, 3rd Edition; IPI = Internalizing Problems Index; EPI = Externalizing Problems Index; RES = Resiliency; Means, Standard Deviations, and Ranges are reported as T-Score points.

Tests of Hypotheses

Primary aim. The primary aim of this study was to compare the internalizing and externalizing symptoms of children with a history of exposure to IPV to the internalizing and externalizing symptoms of children with a history of experiencing physical abuse.

Research question 1. Do children exposed to IPV exhibit levels of internalizing and externalizing problems similar to those of physically abused children?

R1, SQ 1, H1. Mean IPI scores will differ to a statistically significant degree across maltreatment groups, with children in the IPV group obtaining significantly higher scores than children in the physical abuse group.

A one-way analysis of variance (ANOVA) was conducted to examine whether children who experienced different types of maltreatment differed with respect to their levels of internalizing symptoms (as determined by their BASC-3 IPI score). Children in Group 1 obtained a mean IPI score of 51.39 (SD = 10.84). Children in Group 2 obtained a mean IPI score of 49.33 (SD = 10.95). Although the mean IPI scores of Group 1 were higher than those of Group 2, differences between the two maltreatment groups were not statistically significant, $F(1,44) = .392$, $p = .534$. Findings indicate that IPV-exposed and physically abused children exhibit similar levels of internalizing problems. As mean IPI scores did not differ across

maltreatment groups, the hypothesis that children in the IPV group will obtain significantly higher IPI scores than children in the physical abuse group (H_1) was rejected. Table 2 provides an overview of means and standard deviations of IPI scores by maltreatment type.

Table 2

Means and Standard Deviations of Internalizing Problems Index Scores by Maltreatment Group

Maltreatment Group	*n*	*Mean*	*SD*
Physical Abuse	18	49.33	10.95
IPV Exposure	28	51.39	10.84
Total	46	50.59	10.81

R1, SQ1, H2. Mean EPI scores will differ to a statistically significant degree across maltreatment groups, with children in the physical abuse group obtaining significantly higher scores than children in the IPV group.

A one-way analysis of variance (ANOVA) was also conducted to examine whether children in the two maltreatment groups differed with respect to their levels of externalizing symptoms (as determined by their BASC-3 EPI score). Children in Group 1 obtained a mean EPI score of 59.21 (SD = 15.89), while children in Group 2 obtained a mean EPI score of 56.61 (SD = 9.81). As there was heterogeneity of variances, as assessed by Levene's test of homogeneity of variances (p = .014), Welch's F is reported. Although the mean EPI scores of Group 1 were higher than those of Group 2, differences were, again, not statistically significant, Welch's $F(1, 43.962) = .472$, $p = .496$. Results indicate that IPV-exposed and physically abused children exhibit similar levels of externalizing in the proximal aftermath of violence exposures. As there were no differences in the mean EPI scores across maltreatment groups, the hypothesis that children in the physical abuse group would obtain higher EPI scores than children in the IPV group (H_1) was rejected. Table 3 provides an overview of the EPI means and standard deviations by maltreatment type.

Table 3

Means and Standard Deviations of Externalizing Problems Index Scores by Maltreatment Group

Maltreatment Group	*n*	*Mean*	*SD*
Physical Abuse	18	56.61	9.81
IPV Exposure	28	59.21	15.89
Total	46	58.65	14.60

R1, SQ2, H1. The majority of children in Group 1 and Group 2 will obtain EPI and IPI scores that fall minimally within the at-risk range.

Based on the established cut-off scores for the two BASC-3 outcome variables of interest, children in both maltreatment groups were classified into two groups: a clinical group that included children scoring in the at-risk or clinically significant range and a non-clinical group that included children scoring below the at-risk range (i.e., in the average range). Table 4 shows the numbers and percentages of children scoring in the clinical and non-clinical range on the BASC-3 IPI and EPI for each maltreatment group. The majority of children in both maltreatment groups obtained IPI scores that fell in the average range (T-scores=<59; Intimate Partner Violence = 82.1%, Physical Abuse = 72.2%). Externalizing symptoms (as assessed by the BASC-3 EPI) were somewhat more prevalent, with 50% of physically abused children and 57.1% of children exposed to IPV obtaining T-scores larger than 60. Although at least half of the children in each maltreatment group exhibited clinically relevant externalizing problems, internalizing problems tended to fall in the average range. Based on the aforementioned finding, the hypothesis that the majority of children in both maltreatment groups would obtain IPI and EPI scores that fall minimally in the at-risk range was rejected (H_1).

Table 4

Numbers and Proportions of Children in Each Maltreatment Group Obtaining Average, At-Risk, and Clinically Significant Scores on BASC-3 Internalizing and Externalizing Symptoms Indexes

	Group 1 (IPV) N=28	Group 2 (PA) N=18
Internalizing Problems Index (IPI) Score Classification		
Non-Clinical	23 (82.1%)	13 (72.2%)
Clinical	5 (17.9%)	5 (27.8%)
Externalizing Problems Index (EPI) Score Classification		
Non-Clinical	12 (42.9%)	9 (50.0%)
Clinical	16 (57.1%)	9 (50.0%)

Note. Group 1 = Intimate Partner Violence; Group 2 = Physical Abuse

R1, SQ3, H1. The proportion of children who obtain BASC-3 EPI scores in the average, at-risk, and clinically significant ranges will be statistically significantly different across maltreatment groups, with higher proportions of physically abused children scoring in the clinically significant range than IPV-exposed children.

R1, SQ3, H2. The proportion of children who obtain BASC-3 IPI scores in the average, at-risk, and clinically significant ranges will be statistically significantly different across maltreatment groups, with higher proportions of IPV-exposed children scoring in the clinically significant range than physically abused children.

Two-way contingency table analyses showed that proportions of children who obtained BASC-3 EPI and IPI scores in the average, at-risk, and clinically significant ranges did not differ significantly across maltreatment groups (Fisher-Freeman-Halton, $p = .25$ and $p = .30$, respectively; Freeman-Halton, 1951). Results indicate that IPV-exposed and physically abused children exhibit comparable adjustments following violence exposure. Based on the aforementioned findings, the hypothesis that the proportions of children who obtain average, at-risk, and clinically significant scores on the BASC-3 EPI and IPI are significantly different

across maltreatment groups is rejected. Table 5 provides an overview of the numbers and percentages of children falling in the different score classification categories of the BASC-3. Information is provided for the IPI and EPI scores of both maltreatment groups.

Table 5

Numbers and Percentages of Children in Each Maltreatment Group Obtaining Average, At-Risk, and Clinically Significant Scores on BASC-3 Internalizing and Externalizing Symptoms Indexes

	Group 1(IPV) N=28	Group 2 (PA) N=18
	Internalizing Problems Index (IPI) Scores	
Average	23 (82.1%)	13 (72.2%)
At-Risk	3 (10.7%)	5 (27.8%)
Clinically Significant Scores	2 (7.1%)	0 (0.0%)
	Externalizing Problems Index (EPI) Scores	
Average	12 (42.9.0%)	9 (50.0%)
At-Risk	7 (25.0%)	7 (38.9%)
Clinically Significant	9 (32.1%)	2 (11.1%)

Research question 2. Do mean IPI and EPI scores of children in both maltreatment groups differ to a statistically significant degree from the BASC-3 normative mean T-score of 50?

RQ2, H1. Mean IPI and EPI scores of both groups will be statistically significantly higher than the normative mean T-score of 50.

One-sample t-tests were run to determine if the mean IPI and EPI score of children in Group 1 and Group 2 differed from the normative average (T=50).

Regarding internalizing symptoms, the mean IPI score of children in Group 1 (M = 51.39, SD = 10.84) was slightly higher than the BASC-3 normative average but not to a statistically significant degree, $t(27) = .680$, $p = .502$. The mean IPI score of children in Group 2

(M = 49.33, SD = 10.95) was slightly lower than that of the BASC-3 normative average but, again, not to a statistically significant degree, t(17) = -.258, p = .799.

Children in both Group 1 and Group 2 obtained mean EPI scores that were statistically significantly higher than the normative mean of 50. Specifically, the mean EPI score (M = 56.61, SD = 9.81) of physically abused children was statistically significantly higher by 6.61, 95% CI [11.49 to1.74], t(17) = 2.861, p = .011, d = .67. The mean EPI score of IPV-exposed children (M = 59.21, SD = 15.89) was statistically significantly higher by 9.214, 95% CI [15.37 to 3.05], t(27) = 3.069, p = .005, d=.58. A summary of the results of all one-sample t-tests can be found in Table 6. As only the mean EPI scores of children in both groups differed significantly from the BASC-3 normative average, the hypothesis that mean EPI and IPI scores of children in both groups would be significantly higher than the normative mean T-score of 50 (H_1) could only be partially accepted.

Table 6

Results of One-Sample T-Tests (Test Value = 50) and Descriptive Statistics for BASC-3 IPI and BASC-3 EPI by Maltreatment Type

	Mean (SD)	95% CI for Mean Difference	t	df
Group 1				
BASC-3 IPI	51.39 (10.84)	-2.81, 5.60	.680	27
BASC-3 EPI	59.21 (15.89)	3.05, 15.37	3.069*	27
Group 2				
BASC-3 IPI	49.33 (10.95)	-6.11,4.78	-.258	17
BASC-3 EPI	56.61 (9.81)	1.74, 11.49	2.861*	17

Note. *p<.05; PI = Internalizing Problems index; EPI = Externalizing Problems Index; IPV = Intimate Partner Violence; PA = Physical Abuse

Secondary aim. The secondary aim of this study was to examine whether age, gender, and level of resiliency (as measured by the BASC-3) impact children's level of internalizing and externalizing symptoms.

Research question 3. Does children's level of *resiliency* impact their scores on measures of externalizing and internalizing?

RQ3, H1. There will be a statistically significant negative correlation between BASC-3 resiliency scores and BASC-3 EPI and IPI scores of both groups.

Pearson product-moment correlations were run to assess the relationship between BASC-3 Resiliency scale scores and BASC-3 EPI and IPI scores for both Group 1 and Group 2. One IPV case was excluded from Group 1 due to a missing Resiliency scale score, leaving 27 cases in the final IPV sample.

There were statistically significant, moderate to strong negative correlations between the children's resiliency scores and their scores on internalizing and externalizing measures for both groups (Table 7). Specifically, for children in Group 1, there was a statistically significant, strong, negative correlation between resiliency and externalizing, $r(25) = -.731$, $p < .01$, with resiliency explaining 53% of the variation in externalizing problems scores, and a statistically significant, strong, negative correlation between resiliency and internalizing, $r(25) = -.585$, $p < .01$, with resiliency explaining 34% of the variation in internalizing scores. For Group 2, there was a statistically significant, moderate, negative correlation between BASC-3 Resiliency scale scores and BASC-3 EPI scores, $r(16) = -.471$, $p < .05$, with resiliency explaining 22% of the variation in externalizing symptoms, and a statistically significant, strong, negative correlation between resiliency and IPI scores, $r(16) = -.538$, $p < .05$, with resiliency explaining 29% of the variation in internalizing symptoms. An overview of correlations between resiliency scale scores and EPI and IPI scores for each group is provided in Table 6. Results indicate that high levels of resiliency are associated with lower levels of internalizing and externalizing symptoms. Based on

the aforementioned findings, the hypothesis that there will be a statistically significant negative correlation between resiliency and internalizing and resiliency and externalizing (H_1) is accepted.

Table 7

Correlations Between BASC-3 Resiliency and BASC-3 IPI and EPI Scores by Maltreatment Type

	Group 1		Group 2	
	IPI	EPI	IPI	EPI
Resiliency	-.585*	.-.731*	-.538*	-.471*

Note. *p<.05; Group 1 = Children Exposed to Intimate Partner Violence; Group 2 = Physically Abused Children; IPI = Internalizing Problems Index; EPI = Externalizing Problems Index

Research question 4. Does the *gender* of children exposed to IPV or physical abuse impact their scores on the BASC-3 IPI and EPI?

RQ4, H1. Females in both maltreatment groups will obtain statistically significantly higher scores on the BASC-3 IPI than males.

RQ4, H2. Females scores on the BASC-3 EPI will be statistically significantly lower than those of males in both groups.

Independent-samples t-tests were run to determine if there were differences in the EPI and IPI scores of males and females in Groups 1 and 2. There was one outlier in Group 2's IPI scores. Analyses were run with and without the outlier to determine the impact of the outlier on the results of the independent samples t-test. The significance of the independent-samples t-test seemed to be unaffected by the removal of the outlier. Thus, the outlier was retained in the data set.

In Group 1, there were no statistically significant differences between the mean EPI scores of males (M=61.45, SD = 17.79) and females (M = 57.76, SD = 14.91), M = 3.69, 95% CI [-9.10, 16.48], t(26) = .593, p = .558, as well as between the mean IPI scores of males (M =

49.27, SD = 9.58) and females (M = 52.76, SD = 11.66), M = -3.49, 95% CI [-12.17, 5.18], t(26) = -.827, p = .416.

In Group 2, there were no statistically significant differences between males (M = 53.88, SD = 10.06) and females (M = 58.80, SD = 9.53) on measures of externalizing (BASC-3 EPI), M = -4.93, 95% CI [-14.75, 4.90], t(16) = -1.063, p = .788. However, physically abused females (M = 53.90, SD = 10.98) scored statistically significantly higher than males (M = 43.63, SD = 8.314) on measures of internalizing (BASC-3 IPI), M = -10.28, 95% CI [-20.23, -.32], t(16) = -2.19, p = .04. An overview of results for Group 1 and Group 2 can be found in Table 8. Results indicate that physically abused males and females differ regarding internalizing symptoms, with females obtaining significantly higher scores. IPV-exposed males and females did not differ regarding internalizing or externalizing symptoms. Based on the findings, the hypothesis that female scores on measures of externalizing will be significantly lower than those of males was rejected (H_2). The hypothesis that female scores on measures of internalizing will be significantly higher than those of males was accepted for physically abused children.

Table 8

Results of Independent-Samples T-Tests and Descriptive Statistics for BASC-3 IPI and BASC-3 EPI for Each Maltreatment Group by Gender

	Sex				95% CI for Mean Difference		
	Male		Female			t	df
	M	SD	M	SD			
Group 1 - IPV							
BASC-3 EPI	61.45	17.79	57.76	14.91	-9.10, 16.48	.59	26
BASC-3 IPI	49.27	9.58	52.76	11.66	-12.17, 5.18	-.83	26
Group 2 - PA							
BASC-3 EPI	53.88	10.06	58.80	9.53	-14.75, 4.90	-1.10	16
BASC-3 IPI	43.63	8.31	53.90	10.98	-20.23, -.32	-2.19*	16

Note. *p<.05; PI = Internalizing Problems Index; EPI = Externalizing Problems Index; IPV = Intimate Partner Violence; PA = Physical Abuse

Research question 5. Does the *age* of children exposed to IPV or physical abuse impact their scores on the BASC-3 EPI and IPI?

RQ5, H1. Age will have a statistically significant impact on the children's EPI and IPI scores.

Pearson product-moment correlations were run to assess the relationship between the children's age and their EPI and IPI scores for both maltreatment groups. No statistically significant differences were found. Thus, the hypothesis that age will significantly impact the children's EPI and IPI scores was rejected (H_1). An overview of correlations between age and IPI and EPI scores for both groups is provided in Table 8.

Regarding age effects, some general trends can be observed. Specifically, when both groups were combined, school-age children seemed to exhibit lower levels of internalizing and externalizing symptoms than adolescents and pre-school age children (Figures 1 and 2). However, differences did not reach statistical significance.

Table 9

Correlation Between Age and BASC-3 IPI and EPI Score by Maltreatment Type

	Group 1		Group 2	
	IPI	EPI	IPI	EPI
Age	.825	.629	.422	.675

Note. *p<.05; Group 1 = Children Exposed to Intimate Partner Violence; Group 2 = Physically Abused Children; IPI = Internalizing Problems Index; EPI = Externalizing Problems Index

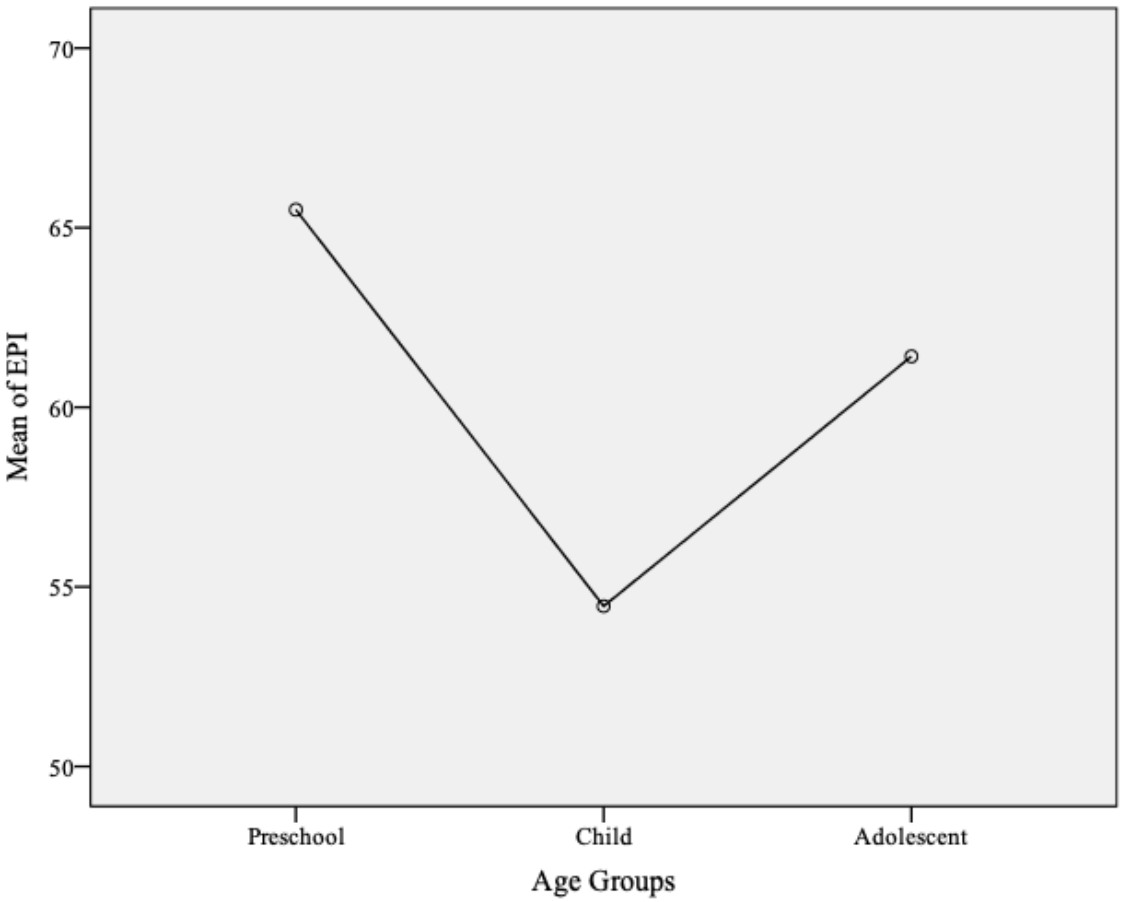

Figure 1. Mean Externalizing Problems Index (EPI) scores by age group

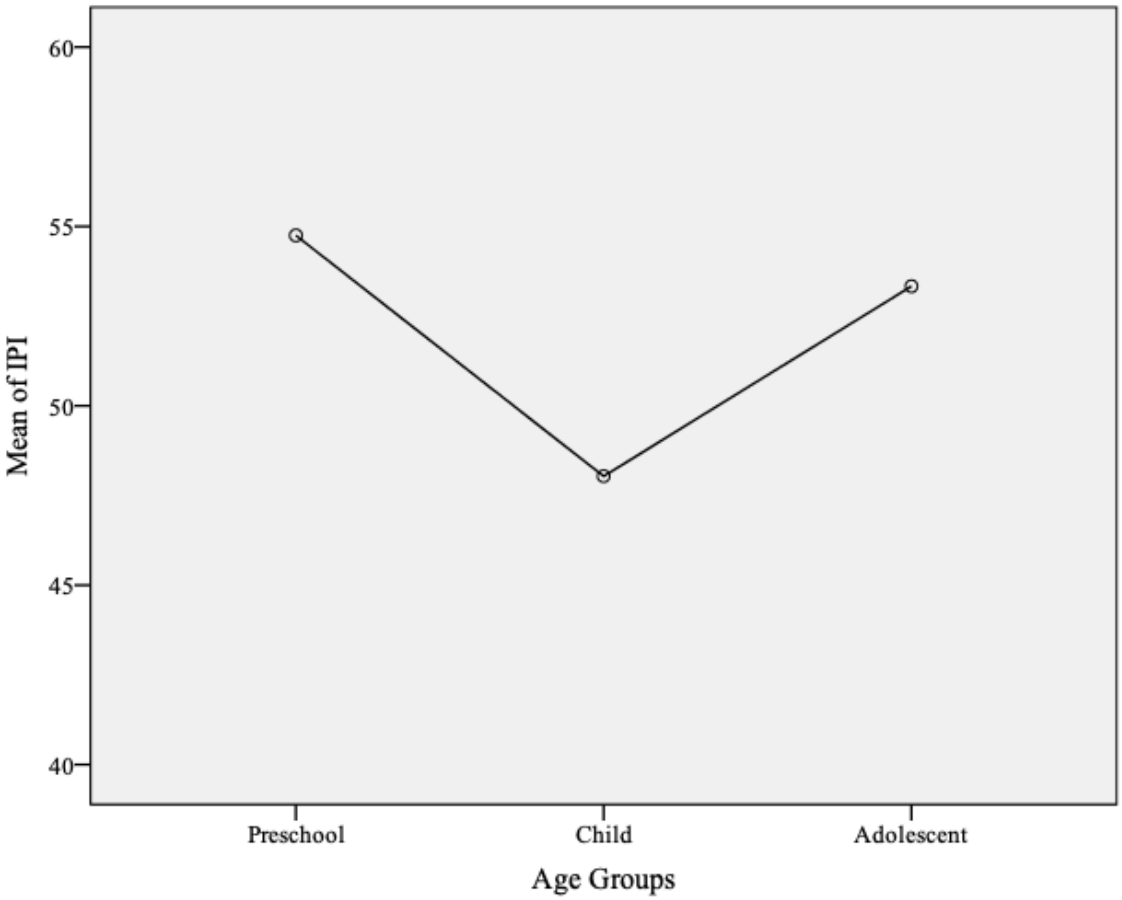

Figure 2. Mean Internalizing Problems Index (IPI) scores by age group

Chapter IV

Discussion

The present study examined the proximal effects of physical abuse and exposure to IPV on children's emotional and behavioral adjustment by analyzing archival data collected by the FSC of FPH as part of mental health screenings and comprehensive psychological evaluations, for which the children were referred by CWS. Records of 139 children were reviewed for inclusion in the study. Cases with a substantiated history of either physical abuse or exposure to IPV who met all inclusion criteria and none of the exclusion criteria were retained in the final sample. Groups were compared based on BASC-3 PRS Internalizing and Externalizing scores. Age, gender, and level of resiliency (as assessed by the BASC-3 PRS) were hypothesized to impact associations between maltreatment type and internalizing and externalizing problem behaviors. The study built on prior research by utilizing a sample of physically abused or IPV-exposed Hawaii children whose families were still actively involved with CWS at the time internalizing and externalizing symptoms were assessed.

The final sample consisted of 46 cases that were divided by maltreatment group. Maltreatment groups were mutually exclusive. Approximately 61% of the cases had a history of exposure to IPV (Group 1 = indirect violence group), and 39% experienced physical abuse (Group 2 = direct violence group). The majority of children were female (58.7%), which corresponds with national and regional child maltreatment prevalence rates (USDHHS, 2019).

The primary aim of this study was to compare externalizing and internalizing symptoms of children with a history of exposure to IPV to those of children with a history of experiencing physical abuse. Based on previous studies, it was hypothesized that children in both groups would exhibit clinically relevant elevations, minimally in the at-risk range, on both internalizing

and externalizing measures. Children in the physical abuse group were expected to obtain statistically significantly higher scores on measures of externalizing than children in the IPV group, and children in the IPV group were expected to obtain statistically significantly higher scores on measures of internalizing than children in the physical abuse group. The study found no differences between groups on internalizing and externalizing measures. Furthermore, although at least half of the children in both groups obtained higher than average externalizing scores, the mean group scores did not reach clinically significant levels. Regarding internalizing, the majority of children in both groups obtained scores in the average range. The current results are in contrast to studies suggesting that children experience significant behavioral and emotional problems in the proximal aftermath of exposure to family violence (Ravi & Casolaro, 2018). Furthermore, the results are surprising when the present study's sample characteristics are considered. Families of children in the sample were actively involved with CWS at the time internalizing and externalizing symptoms were assessed. CWS agencies tend to respond only to children at greatest risk, especially when it comes to IPV exposure. Often, IPV cases are substantiated for maltreatment only after other risk factors are found to exist. Furthermore, children referred to CWS tend to come from families with low socioeconomic status, low social support, and relatively high rates of caregiver mental health, drug, and alcohol problems (Thompson & Wiley, 2009)—factors that have been associated with a heightened risk for negative outcomes. Several researchers have found empirical evidence that children recruited from places such as battered women's shelters or child welfare services caseloads are more likely to display adjustment problems than children recruited from non-clinical community settings. This elevated risk for negative outcomes was attributed to the additional stress associated with living in a shelter or being involved with CWS and a higher likelihood of more severe and

chronic violence exposure (Vu et al., 2016; Margolin, 1998). Given the clinical nature of the sample and referral source, the majority of children would be expected to exhibit clinically relevant elevations on, minimally one, if not both measures of adjustment. Null findings might be explained by various factors. Some authors have proposed the theory of a "sleeper effect." For example, Vu et al. (2016), exploring longitudinal associations between children's exposure to IPV and adjustment problems, found that the strength of the association between violence exposure and adjustment problems changes over time. According to the researchers, contrary to what might be expected, the greater the time lag between IPV exposure and measurement of adjustment problems, the stronger the association. In support of this theory, Holmes (2013) found that the effects of IPV exposure between birth and age 3 were delayed until children reached school age. Holmes (2013) concluded that an initial assessment of symptoms directly following exposure to IPV may not be able to identify behavior problems, especially in young children. The author explained this finding via a possible "sleeper effect." In Vu, Jouriles, McDonald, and Rosenfield (2016), the "sleeper effect" is described as an effect that is weak or undetectable early on but strengthens and unfolds over time. According to Vu et al. (2016), sleeper effects are based on the theory that exposure to direct or indirect violence sets in motion a negative chain of events that takes time to evolve and unravel. Based on this theory, children's symptoms might not yet have been detectable at the time of assessment. Other researchers have argued that the majority of children do not develop negative psychosocial outcomes following familial violence exposure because of a "steeling effect," such that children in high-stress environments eventually develop some degree of immunity (Rutter, 2012). Resiliency might also play a role. The term "resilient" has been used to describe children who exhibit positive outcomes despite significant risk for developing problems (Kaufman, Cook, Arny, Jones, &

Pittinsky, 1994). Various factors have been associated with children's resiliency. Resiliency research is in line with the present study's finding that children with higher levels of resilience exhibited significantly lower levels of both internalizing and externalizing symptoms.

The secondary aim of this study was to examine whether age, gender, and level of resiliency (as measured by the BASC-3) would have an impact on children's level of internalizing and externalizing symptoms. As mentioned above, there were statistically significant, moderate to strong negative correlations between children's resiliency scores and their scores on internalizing and externalizing measures for both groups. Various other studies have reported similar results. Studies have discussed the positive impact of individual, family, and social resilience factors (e.g., maternal warmth, children's cognitive capacities, positive influential figures in a child's life). It is unclear which conditions promoted resilience in the current sample. Future studies might want to explore which factors contribute to resiliency for children who grow up in familial and social environments that place children at an increased risk for negative behavioral and emotional problems.

Regarding gender, the present study did not find significant differences between IPV-exposed males and females on measures of externalizing or internalizing problems. However, physically abused females scored significantly higher than physically abused males on measures of internalizing. Findings are in contrast with studies that have found that boys tend to exhibit higher scores on measures of externalizing than girls.

Studies exploring children's capacity for successful adaptation and development following exposure to a variety of stressors suggest that gender and age may interact to moderate children's risk of developing negative outcomes. Furthermore, some gender differences may become apparent when more specific emotional (e.g., symptoms of depression, anxiety),

behavioral (e.g., elevated levels of aggression), and cognitive reactions (e.g., difficulties with attention and concentration) are assessed, rather than broadband adjustment problems (e.g., externalizing and internalizing).

Considering the developmental changes children undergo over time, it was hypothesized that exposure to direct or indirect family violence would impact children in distinctive ways at different ages. Pearson product-moment correlations were run to assess the relationship between children's age and their EPI and IPI scores for both maltreatment groups. No statistically significant differences were found. This finding partially converged with Renner and Boel-Studt (2017), who examined the relationship between three types of family violence victimization (e.g., exposure to physical IPV; exposure to physical abuse; and exposure to physical abuse of a sibling) and internalizing and externalizing behaviors. While the researchers found age effects while examining the relationship between different types of intra-familial violence exposure and externalizing, there were no significant differences when it comes to internalizing.

It is possible that the present study's small sample size limited its ability to detect age effects. When children were divided into three age groups, some general trends could be observed. Specifically, school-age children tended to exhibit lower levels of internalizing and externalizing symptoms than adolescents and preschool age children. However, differences did not reach statistical significance.

Clinical Implications

The present study has several important clinical implications. Large numbers of children around the world and in the U.S. are exposed to IPV and physical abuse each year. Exposed children have been found to be at risk for several adjustment problems in the short and long term. Exposed children may first be recognized by schools and community settings, battered women's

programs, the child welfare service system during investigations of reports of maltreatment, or the legal system in civil or criminal court. Until fairly recently, these systems viewed IPV as a problem of adults. Not surprisingly, efforts to address the issue were geared toward adults. However, since evidence has begun to mount that IPV not only impacts adults but also the children exposed to it, it has become clear that agencies need to screen and provide services to both children and their families. However, identification and screening have continued to be difficult as professionals working for community agencies have had limited guidance and few tools to effectively assess the impact of familial violence on exposed children. In order to develop effective screening tools, it is critical to have a clear understanding of children's behavioral and emotional presentation in the proximal aftermath of exposure to direct or indirect family violence.

The present study's finding that children exposed to IPV or physical abuse may not exhibit concerning levels of emotional distress or behavioral problems in the proximal aftermath of exposure to direct or indirect violence is significant and has important implications for individuals and agencies working to protect children. It suggests that violence-exposed children may not exhibit concerning psychosocial problems while they are actively involved with child welfare services. As a result, they may not be referred for and receive interventions aimed at preventing long-term harm. This is concerning as previous literature has documented that exposure to IPV, just like physical abuse, can exert devastating long-term effects.

Therefore, early intervention, despite seemingly low initial distress, seems of utmost importance. The distal effects of child maltreatment may be mitigated with appropriate early supports and interventions. As this study suggests that resiliency impacts the relationship between direct and indirect violence exposure and internalizing and externalizing problems, a

key target for early intervention may be the fostering of resilience and strengthening of protective factors. Support for children should be provided in the context of their developmental needs, environment, and culture.

Limitations

The present study adds to the literature on the effects of childhood maltreatment by exploring the behavioral and emotional adjustment of a diverse group of Hawaiian children involved with CWS after having witnessed IPV or experienced physical abuse. However, several limitations warrant consideration. First, families in the study sample were involved with CWS at the time of their assessment. Family violence is unevenly distributed across social categories. Persons who are younger, nonwhite, and of lower in socioeconomic standing are more likely to use physical means to punish their children and/or engage in violence toward their spouses (Rodriguez, Lasch, Chandra, & Lee, 2001; Cunradi, Caetano, & Schafer, 2002; Capaldi, Knoble, Shortt, & Kim, 2012). Thus, the findings of the present study cannot be generalized to other populations.

Second, there are measurement limitations. For example, all outcome variables of interest, except maltreatment substantiation, were reported by children's caretakers. This may have produced biased results. Kazdin and Bass (1988) report that parental judgments of children's behaviors are influenced by various factors, such as marital stressors, mental health concerns, expectations regarding appropriate child behavior, self-esteem, and perceived social support. Kroes (2006) added that the accuracy of judgments for behavioral problems in children is further dependent upon the personality of the informant and the context in which the behavior occurred.

Third, analyses were based on a relatively small convenience sample of clinically referred children. Limited sample sizes are a common issue in studies of child maltreatment. However, this precludes the possibility of addressing more nuanced research questions and may result in limited power to detect significant associations. It also limits statistical test selection.

Fourth, there was no non-clinical control group. Furthermore, this study's operationalization of children's exposure to IPV included merely residing in a household in which IPV was reported to have occurred. Different ways to operationalize or define children's exposure may lead to different results. The studies reliance on CWS reports to assess children's maltreatment history and determine maltreatment type presents another limitation. Although CWS records have been deemed a relatively reliable source of information regarding a child's maltreatment history as allegations of abuse are investigated by professionals trained to apply state laws and regulations, they may not capture the complex nature of a child's maltreatment history. Child welfare statistics suggest that childhood maltreatment that is identified, reported, investigated, and confirmed represents only a small percentage of the abuse children experience. Therefore, many incidents of childhood maltreatment may not be reflected in CWS data. In addition, CWS reports may not indicate the frequency and intensity at which a child was exposed to various maltreatment types. Furthermore, CWS records may not provide information regarding the timing of a child's first and last exposure to maltreatment. The aforementioned shortcomings made it impossible to disentangle the effects of single versus chronic exposure and to reliably assess the effects of direct and indirect violence exposure on a child's behavioral and emotional functioning.

Lack of data on specific sample characteristics presents an additional limitation. IPV has been shown to be most prevalent in families from low socioeconomic backgrounds. Low

socioeconomic status has been associated with several risk factors that may disrupt children's healthy development. Rossman (2001) adopted the term "adversity package" to describe the various stressors that may accumulate and exert additive negative effects on the cognitive, physiological, psychological, and interpersonal functioning of youth exposed to IPV and other forms of intrafamilial violence. Examples of these factors include parental psychopathology and substance use, unemployment and financial hardship, homelessness, and involvement in crime. The presence of these factors in a child's life may heighten his or her risk for adverse outcomes. If these factors are unmeasured, they may render the exact relationship between IPV/physical abuse exposure and negative outcomes indistinct.

Although the present study explored the effects of children's level of resiliency on externalizing and internalizing symptoms, it did not assess specific factors that might increase (e.g., parental psychopathology and/or substance use; parental separation; or divorce) or decrease (e.g., maternal warmth; supportive school environment) a child's risk for adverse outcomes.

Lastly, the study's cross-sectional design is a limitation. Data gleaned from cross-sectional studies are insufficient when trying to disentangle the ordering of exposure to adverse experiences and presumed effects. Furthermore, it does not allow for the evaluation of the role of contextual factors that may correlate with exposure and negative outcomes.

Future Directions

While the present study sheds some light on the possible proximal effects of exposure to IPV and physical abuse in a sample of Hawaiian children involved with CWS, further research on this topic is needed.

As this study's sample size was limited, it was impossible to detect subtle differences between the two maltreatment groups, especially when considering the effects of age and gender

on the association between maltreatment type and internalizing and externalizing problems. A larger sample might allow for a more detailed exploration of the moderating effects of age and gender on outcomes in the different groups.

Furthermore, as this study was based on data gathered from children's caretakers while they were actively involved with CWS, it is possible that symptoms were not accurately reported. To address this methodological issue, future studies should consider collecting information regarding children's externalizing and internalizing symptoms from multiple sources at various points in time throughout a family's CWS involvement. A multi-informant, longitudinal approach to assessment might shed light on the development of children's adjustment problems over time.

Although the current study focused on some of the key problems that have been linked with exposure to IPV and physical abuse (i.e., internalizing and externalizing problems), other important symptom areas should be explored in a similar sample at a similar point in time (i.e., symptoms of PTSD, depression, anxiety, anger, aggression, bullying, etc.). Exploration of the more nuanced effects of exposure to IPV and physical abuse might shed additional light on children's proximal reactions to family violence and could help elucidate potential age and gender differences.

In addition to exploring a broader scope of possible proximal outcomes that might be associated with IPV exposure, future studies should continue to bring to light the various contextual factors that might be associated with an increased risk of developing negative outcomes secondary to IPV exposure (e.g., low socioeconomic status; maternal depression; parental substance abuse) (Fantuzzo, Boruch, Beriama, Atkins, & Marcus, 1997; Fantuzzo & Lindquist, 1989). Additionally, further delineating the dose response effects may help to identify

patterns that may aid in intervention and prevention efforts for those at the highest risk of deleterious outcomes.

To date, there is limited agreement regarding the definition of children's exposure to IPV. Some studies classify children as having been exposed to IPV if they are merely aware of violent acts between caretakers (e.g., hearing the violence or witnessing its after-effects). Other studies define exposure as children's direct witnessing of the violent event (e.g., seeing the violence). There are also differences in the frequency of children's violence exposure as well as the types of domestic violence they may witness (e.g., physical, psychological, or sexual; male versus female perpetrated; uni-directional versus bi-directional). As varying levels of proximity to incidents of IPV and differences in type and chronicity of exposure may lead to diverse outcomes, it is important that future studies explore these nuances and go beyond the simple dichotomization of an experience as complex and multifaceted as IPV exposure.

Further research is also needed on the differential effects of IPV exposure on girls and boys in different developmental stages. In these studies, the timing of first and last exposure should be taken into consideration as some studies have proposed that early exposure may lead to more severe outcomes. As the literature base on children's reactions secondary to IPV exposure expands, empirical information can be used to guide clinical work and assist in developing more effective screening and intervention strategies.

In general, research suggests that children exposed to physical abuse or IPV are at significant risk for various adjustment difficulties that can occur in the proximal and/or distal aftermath of violent events. However, there is still some uncertainty when it comes to age and gender differences in children's more immediate responses.

Although exposure to violence in the home has been associated with several problems with behavioral and emotional adaptation over time, a substantial proportion of exposed children do not go on to develop clinically significant adjustment problems or psychopathology. This finding suggests that some factors may mitigate the negative effects of children's exposure to IPV. Although various individual and contextual factors have been identified, additional research is needed to identify the interaction of multiple factors that might contribute to adaptive outcomes, especially in children who are exposed to multiple adverse life experiences in addition to IPV.

Conclusion

In summary, the present study's findings indicate that children exposed to IPV or physical abuse may not exhibit clinically significant behavioral or emotional adjustment problems in the proximal aftermath of violence exposure. Considering that various longitudinal studies have consistently associated childhood exposure to IPV and physical abuse with significant, deleterious, long-term effects, the aforementioned finding has important clinical implications. Even though children may seem well adjusted when they first come in contact with CWS, there exists a need for intervention. In order to meet children's needs and provide effective interventions, children at risk for long-term harm need to be reliably screened and identified. However, effective screening and identification are only possible if service providers have a clear understanding of children's typical presentations in the proximal aftermath of violence exposure. At present, further research shedding light on the effects of exposure to IPV, as well as potential risks and protective factors, is needed to reliably protect those children at the greatest risk of harm.

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Appendix A

Copy of Institutional Review Board (IRB) Certification Letter

ARGOSY UNIVERSITY

July 30, 2017

Catherine Gallahue
801 Kakala Street Unit 16C7
Kapolei, HA 96707

cat.gallahue@gmail.com

Dear Ms. Gallahue,

Your application, "The Effects of Direct and Indirect Violence on Children and Adolescents Involved with the Child Welfare System: An Exploratory Study of Differential Symptom Expression," is fully certified by the Institutional Review Board as of 7-27-2017.

Please note that research must be conducted according to this application that was certified by the IRB. Your proposal should have been revised to be consistent with your application. Please note that you also need to abide by any requirements specified in your letter of permission. Any changes you make to your study need to be reported to and certified by the IRB.

Any adverse events or reactions need to be reported to the IRB immediately.

Your full application is certified for one year from 7-27-2017. Please be aware that if your study is not likely to be completed one year from 7-27-2017, you will need to file a **Continuing Review for IRB or Continuing Certification of Compliance** form with the IRB at least two months before that date to obtain recertification. If your proposal is not recertified within the year specified (365 days), your IRB certification expires and you must immediately cease data collection.

When you have completed your research you will also need to inform the IRB of this in writing and complete the required forms. You may use the **Project Completion Report** form for this purpose. Records must be retained for at least three years.

Good Luck with your research!

Please be careful not to lose this letter.

If you have questions please feel free to contact me.

Sincerely,

Robert M. Anderson Jr., Ph.D., Co-Chair
Institutional Review Board

cc: Dr. Steven Choy

Appendix B

Institutional Approval Letter from Family Strengthening Center

FAMILY PROGRAMS HAWAII
FAMILY STRENGTHENING CENTER
In Affiliation with the Hawaii School of Professional Psychology at Argosy University

250 Vineyard Street
Honolulu, Hawaii 96813
Telephone: 808.223.8483

May 1, 2017

Dear Catherine Gallahue,

This letter is to grant you permission to use the archival data from our Center in your research. Our archival date were all initially collected in an ethical manner with all of our clients giving their consent to use their information void of any personal identifying information for research purposes. All data will be stripped of all identifying information before completing any analysis of the data and any publication will not identify any individual record data.

If you need any additional information, please feel free to contact me.

Sincerely yours,

Steven J. Choy, Ph.D.
Clinical Psychologist, Hawaii Licensed, PSY179
Director, Family Strengthening Center at Family Programs Hawaii

Appendix C

Family Strengthening Center Informed Consent Form

FAMILY STRENGTHENING CENTER
In Affiliation with the Hawaii School of Professional Psychology at Argosy University

Consent for Mental Health Evaluation and/or Treatment

Name:
Date of Birth:
Address:

Phone:

1. **Consent to Evaluate/Treat:** I voluntarily consent that I will participate in a mental health (e.g. psychological) evaluation and/or treatment by staff from the Family Strengthening Center at Family Programs Hawaii. I understand that following the evaluation and/or treatment, complete and accurate information will be provided concerning each of the following areas:
   a. The benefits of the proposed treatment
   b. Alternative treatment modes and services
   c. The manner in which treatment will be administered
   d. Probable consequences of not receiving treatment
   e. The possible usage of the psychological evaluation

   The evaluation or treatment will be conducted by a licensed clinical psychologist, and/or psychology intern, post-doctoral psychology fellow, graduate psychology or marriage and family therapist practicum students under the direct supervision of a licensed clinical psychologist.

2. **Benefits to Evaluation/Treatment:** Evaluation and treatment may be administered with psychological interviews, psychological assessment or testing, psychotherapy, as well as expectations regarding the length and frequency of treatment. It may be beneficial to me as well as the referring professional, to understand the nature and cause of any difficulties affecting my daily functioning, so that appropriate recommendations and treatments may be offered. Uses of this evaluation include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and rehabilitation planning. Possible benefits to treatment include improved cognitive or academic performance, health status, quality of life, and awareness of strengths and limitations.

3. **Research:** I acknowledge that information obtained through the comprehensive psychological evaluation may be utilized for research and outcome quality purposes. I understand that my name and any personal identifying information will not be connected to the data used for these purposes or in any findings published.

4. **Charges:** Fees are based on the length or type of the evaluation or treatment, which are determined by the nature of the service. I will be responsible for any charges not covered by contract or insurance, including co-payments and deductibles. Fees are available to me upon request. If you have been referred by an agency that has a contract with the Family Strengthening Center at Family Programs Hawaii, you will not be charged any fees for the treatment or evaluation.

5. **Confidentiality, Harm, and Inquiry:** Information from my evaluation and/or treatment is contained in a confidential health record at the Family Strengthening Center at Family Programs Hawaii, and I consent to disclosure for use by the Family Strengthening Center at Family Programs Hawaii for the purpose of continuity of my child's care. Per Hawaii law, information provided will be kept confidential and can only be released to others outside of the Family Strengthening Center at Family Programs Hawaii with a signed consent for disclosure of Protected Health Information with the following exceptions: 1) if I am deemed to present a danger to myself or others; 2) if concerns about possible abuse or neglect arise; or 3) if a court order is issued to obtain records.

6. **Right to Withdraw Consent:** I have the right to withdraw my consent for evaluation and/or treatment of myself at any time by providing a written request to the treating clinician.

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment of myself. I understand that I have the right to ask questions of my service provider about the above information at any time.

_____ _____
Signature of Client **Date**

_____ _____
Signature of witness **Date**

ADULT FORM

Appendix D

Sample BASC-3 Internalizing Problems Index Questions

Anxiety
Is fearful.
Is easily stressed.
Has panic attacks.
Is nervous.
Appears tense.
Worries about what parents think.
Says, "It's all my fault."
Says, "I'm not very good at this."

Depression
Cries easily.
Is sad.
Is irritable.
Seems lonely.
Says, "I can't do anything right."
Says, "Nobody likes me."
Changes moods quickly.
Says, "I want to die," or "I wish I were dead."

Somatization
Is afraid of getting sick.
Has headaches.
Gets sick.
Complains of stomach pain.
Complains of physical problems.
Says, "I think I'm sick."
Complains of being sick when nothing is wrong.
Vomits.

Appendix E

Sample BASC-3 Externalizing Problems Index Questions

Aggression
Argues when denied own way.
Annoys others on purpose.
Threatens to hurt others.
Hits other children.
Loses temper too easily.
Teases others.
Gets back at others.
Throws or breaks things when angry.

Conduct Problems
Gets into trouble.
Sneaks around.
Uses others' things without permission.
Breaks the rules.
Lies.
Hurts others on purpose.
Disobeys.
Steals.

Hyperactivity
Is overly active.
Has trouble keeping hands or feet to self.
Has trouble staying seated.
Has poor self-control.
Acts without thinking.
Cannot wait to take turn.
Is in constant motion.
Interrupts parents when they are talking on the phone.

Appendix F

Overview of Assessments that may be Administered to Children/Adolescents Referred to FSC

FAMILY STRENGTHENING CENTER
In Affiliation with the Hawaii School of Professional Psychology at Argosy University

PSYCHOLOGICAL TEST SELECTION FOR CHILD MALTREATMENT CASES
CHILDREN AND ADOLESCENT CLIENTS

Client's Name: _____ **Date of Evaluation:** _____

CATEGORY AND PSYCHOLOGICAL TESTS	AGES	READING LEVEL	SCORING METHOD
Review of all Documents and Collateral Data	ALL	-	-
Clinical Interview, Observations and Mental Status Examination	ALL	-	-

COGNITIVE AND LEARNING ASSESSMENT	AGES	READING LEVEL	SCORING METHOD
☐ Stanford-Binet Intelligence Scale-Fifth Edition (SB-5) ☐ Abbreviated (IQ >75 and no significant difference between Routing Tests) ☐ Full (Abbreviated IQ<75 or significant difference between Routing Tests)	2+	-	C
☐ Wechsler Abbreviated Scale of Intelligence-II (WASI-II)	6+	-	H
☐ Wechsler Intelligence Scale for Children-5 (WISC-5)	6 TO 16		H
☐ Comprehensive Test of Non-Verbal Intelligence-2 (CTONI-2)	6+	-	H
☐ Wide Range Achievement Test-4	4+	-	H
☐ Others: List -			

NEUROPSYCHOLOGICAL ASSESSMENT	AGES	READING LEVEL	SCORING METHOD
☐ Repeatable Battery for the Assessment of Neuropsychological Status Update (RBANS® Update)	12+	-	H
☐ Wisconsin Card Sorting Test (WCST)	6.5+	-	H
☐ Wechsler Memory Scale - Fourth Edition (WMS-IV)	6+	-	H
☐ Others: List -			

BEHAVIORAL ASSESSMENT	AGES	READING LEVEL	SCORING METHOD
☐ Behavioral Assessment System for Children, 3rd Edition (BASC-3)	5+ (SELF) AND CAREGIVER	4TH	H/C
☐ Eyberg Child Behavior Inventory (ECBI)	CAREGIVER	11TH	H
☐ Burks Behavior Rating Scale, Second Edition (BBRS-2)	6 TO 18	4TH	H
☐ Conners Comprehensive Rating Scale (CCRS)	13 TO 17	9TH	H
☐ Others: List -			

Appendix G

Overview of Assessments that May be Administered to Adults Referred to FSC

FAMILY STRENGTHENING CENTER
In Affiliation with the Hawaii School of Professional Psychology at Argosy University

PSYCHOLOGICAL TEST SELECTION FOR CHILD MALTREATMENT CASES-ADULTS

Client's Name: _____ **Date of Evaluation:** _____

CATEGORY AND PSYCHOLOGICAL TESTS	AGES	READING LEVEL	SCORING METHOD
Review of all Documents and Collateral Data	ALL	-	-
Clinical Interview, Observations and Mental Status Examination	ALL	-	-

COGNITIVE AND LEARNING ASSESSMENT	AGES	READING LEVEL	SCORING METHOD
☐ Stanford-Binet Intelligence Scale-Fifth Edition (SB-5) ☐ Abbreviated (IQ >75 and no significant difference between Routing Tests) ☐ Full (Abbreviated IQ,75 or significant difference between Routing Tests)	2+	-	C
☐ Wechsler Abbreviated Scale of Intelligence-II (WASI-II)	6+	-	H
☐ Wechsler Adult Intelligence Scale-IV (WAIS-IV)	16+		H
☐ Comprehensive Test of Non-Verbal Intelligence-2 (CTONI-2)	6+	-	H
☐ Wide Range Achievement Test-4	4+	-	H
☐ Others: List -			

NEUROPSYCHOLOGICAL ASSESSMENT	AGES	READING LEVEL	SCORING METHOD
☐ Repeatable Battery for the Assessment of Neuropsychological Status Update (RBANS® Update)	12+	-	H
☐ Wisconsin Card Sorting Test (WCST)	6.5+	-	H
☐ Wechsler Memory Scale - Fourth Edition (WMS-IV)	6+	-	H
☐ Others: List -			

EMOTIONAL ASSESSMENT	AGES	READING LEVEL	SCORING METHOD
☐ Beck Depression Inventory-II (BDI-II)	13+	5TH	H
☐ Beck Anxiety Inventory (BAI)	18+	3RD	H
☐ Suicide Probability Inventory (SPS)	14+	4TH	C
☐ Firestone Assessment of Self-Destructive Thoughts (FAST)	18+	-	H
☐ Firestone Assessment of Violent Thoughts (FAVT)	18+	-	H
☐ State Trait Anger Expression Inventory-2 (STAXI-2)	16 TO 63	-	H
☐ Others: List -			

RELATIONSHIP ASSESSMENT	AGES	READING LEVEL	SCORING METHOD
☐ Marital Satisfaction Inventory-2 (MSI-2)	18+	6TH	H
☐ Incomplete Sentences (Marital)	18+	-	H
☐ Others: List -			