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## Children's Exposure to Intimate Partner Violence: Should Sexual Coercion be Considered?

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### Abstract

**Objective**—This study examined whether male-perpetrated sexual intimate partner violence (IPV) directed at a child's mother is associated with children's adjustment problems, and if sexual IPV increases risk for children's adjustment problems over and above the risk associated with physical IPV alone.

**Method**—Participants were a community sample of 539 mothers and their children (7 to 10 years). Mothers and children reported on children's externalizing and internalizing problems. Mothers reported on recent male-perpetrated physical and sexual IPV and on their own psychological distress (depressive symptoms, relationship dissatisfaction). Four groups were formed on the basis of mothers' reports of IPV: 1) non-violent, 2) physical-only, 3) sexual-only, 4) sexual + physical.

**Results**—Children in the physical-only, sexual-only, and sexual + physical groups exhibited greater levels of externalizing problems than children in the non-violent group. Levels of externalizing problems among children in the physical-only and sexual-only groups did not differ.

**Conclusions**—Including sexual IPV in the conceptualization of children's exposure to IPV may offer a more comprehensive understanding of how children are affected by IPV.

### Keywords

intimate partner violence; sexual coercion; sexual violence; children's exposure to violence; children's adjustment problems

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Exposure to parental intimate partner violence (IPV) during childhood is a significant global public health problem. Worldwide, between 133 and 275 million children are exposed to IPV (UNICEF, 2006). In the United States alone, over 15 million children are estimated to live in households in which at least one incident of IPV occurred in the previous year (McDonald, Jouriles, Ramisetty-Mikler, Caetano, & Greene, 2006). Meta-analytic reviews consistently conclude that children's exposure to IPV increases risk for a variety of childhood behavioral and emotional problems (Evans, Davies, & DiLillo, 2008; Kitzmann, Gaylord, Holt, & Kenny, 2003). In short, a large body of research substantiates children's

exposure to IPV as highly prevalent and as a potent risk factor for children's mental health problems.

In the scientific literature on children's exposure to IPV, "IPV" has typically referred to physical aggression, such as pushing, slapping, and hitting with a fist. In fact, the study of IPV in general has historically focused on physical forms of violence (Woodin, Sotskova, & O'Leary, 2013). As a result, much of what is known about children's exposure to IPV is specific to physical IPV (Evans et al., 2008; Kitzmann et al., 2003). Although this knowledge is important, it may not permit a truly comprehensive understanding of children's exposure to IPV. There is widespread agreement that the construct of IPV extends beyond physical aggression, and several different forms of IPV are recognized (physical, psychological, and sexual). The influence of psychological IPV on children has received some empirical attention (e.g., Jouriles, Norwood, McDonald, Vincent, & Mahoney, 1996), and investigators sometimes operationalize IPV to include both physical and psychological aggression (e.g., El-Sheikh, Cummings, Kouros, Elmore-Staton, & Buckhalt, 2008). However, the potential influence of sexual IPV on child development is almost completely absent from the empirical literature.

Sexual violence often is conceptualized to include the use of physical force to obtain sex, as well as acts of coercion intended to reduce a person's resistance to having sex, such as emotional manipulation and insistence on sex (Follingstad & Rogers, 2013). Some have argued that the omission of sexual violence from efforts to estimate IPV prevalence has resulted in incorrect conclusions about IPV (Hamby, 2014; White, Smith, Koss, & Figueredo, 2000). Others have argued that sexual coercion is "one of the major driving forces behind IPV" (Tanha, Beck, Figueredo, & Raghavan, 2010; p. 1838), implying that omitting it ignores a key feature of IPV itself. With respect to IPV and child behavior, it might be theorized that a partner's sexual coercion increases mothers' psychological distress (e.g., depressive symptoms, relationship dissatisfaction), which in turn leads to children's problems. This is consistent with findings that victims of sexual coercion often experience psychological distress (Campbell, Dworkin, & Cabral, 2009; Edwards et al., 2009) and with research linking maternal psychological distress with children's adjustment problems in the context of IPV (Holmes, 2013; Levendosky & Graham-Bermann, 2001). Mothers' experience of sexual IPV relates to children's adjustment difficulties in samples of women seeking help for IPV (Spiller, Jouriles, McDonald, & Skopp, 2012; Symes, Maddoux, McFarlane, Nava, & Gilroy, 2014), but it is not clear if such findings apply to families in which physical IPV is absent, or families in which the sexual IPV is likely to be characterized by acts of coercion, as opposed to physical force.

The primary purpose of this study is to test the following two hypotheses: (1) sexual violence directed at a child's mother by a male partner is positively associated with children's externalizing and internalizing problems, and this relation emerges whether physical IPV is present or not, and (2) sexual IPV by the mother's partner potentiates the risk for children's externalizing and internalizing problems, over and above the risk associated with children's exposure to the partner's physical IPV only. In addition, because mothers' psychological distress (depressive symptoms, relationship dissatisfaction) might be a vehicle through which sexual IPV leads to children's adjustment problems, we also

evaluate associations between the partner's sexual IPV perpetration and the mothers' psychological distress.

## Method

### Participants

Families were recruited as part of a larger study on IPV and child adjustment. The larger study included a domestic violence shelter sample and a community sample drawn from a large urban area in Texas, US. The community sample forms the basis for the present study. Families in the community sample were recruited from randomly drawn lists of phone numbers within the census tracts in which the shelter families had lived prior to shelter entry. Families were recruited by inviting the mothers to participate in a phone screening for a longitudinal study on families and family conflict. To be eligible, mothers had to have a biological child between the ages of 7 and 10 years who had not been previously diagnosed with mental retardation or developmental delay. Additionally, the mother and child had to speak English well enough to complete an interview conducted in English, and the mother had to be in an intimate relationship with a male partner for at least 5 of the 6 months prior to screening.

Mothers of families who were eligible upon screening were invited to participate. They were informed that participation involved several half-day assessment sessions conducted at our research offices over the course of a year (for which they would receive financial compensation), and children participating in the study would be asked questions about their behaviors, emotions, and family interactions. If a family had more than one eligible child, the oldest was invited to participate.

Eligibility screenings located 1,099 eligible families, 539 (49%) of whom completed assessments. This participation rate is comparable to other attempts at actively recruiting families for laboratory-based studies (e.g., Fosco & Grych, 2008). Children (277 male, 262 female) on average were 8.5 years old ( $SD = 1.16$ ) and predominantly White (49.5%). However, other races and ethnicities were represented, including Black (26.3%), Hispanic (14.3%), and multi-racial or "Other" (9.8%). On average, mothers were 36.2 years old ( $SD = 6.45$ ), with 14.5 ( $SD = 2.96$ ) years of education. For 91.3% of the families, the mother and partner were married, 8.2% were cohabiting but unmarried, and 0.5% were unmarried and not living together; the average length of the intimate relationship was 13.3 years ( $SD = 6.42$ ). In 78.7% of the families, the partner was the biological father of the participating child. Median monthly family income was \$3,900. Although we did not attempt to recruit a sample representative of the larger geographic area from which the sample was drawn, our sample was comparable to the surrounding county on key demographic variables, such as race (e.g., 49.5% White and 26.3% Black for the present sample; 53.5% White and 22.3% Black for the county) and median family income (\$50,000 for the present sample; \$54,000 for the county) (U.S. Census Bureau, 2010).

## Assessment Procedures

The university Institutional Review Board approved all procedures. Mothers and children completed assessments separately at university research offices. Measures were read aloud to participants to help ensure that all questions were understood. Only the measures used in the present study are described below.

## Measures

**Physical IPV**—Mothers reported the frequency of her partner's physical IPV perpetration in the past six months on the 12-item physical assault subscale of the Revised Conflict Tactic Scales (CTS2; Straus, Hamby, Boney-McCoy, & Sugarman, 1996). The response scale was modified to a 10-point scale ranging from 0 = *Not in the past 6 months*, to 9 = *Every day*. The items include a range of physically aggressive acts, including those deemed by the scale authors as minor (e.g., pushed or shoved, slapped) and severe (e.g., beat up, choked).

**Sexual IPV**—Mothers reported on their partner's acts of sexual IPV perpetration in the past six months using a modified version of the sexual coercion subscale of the CTS2 (Straus et al., 1996). Scale items were modified by combining questions about different types of sex (oral, anal, vaginal) into single questions, and the response scale was modified to reflect a 10-point scale ranging from 0 = *Not in the past 6 months*, to 9 = *Every day*. This resulted in a 3-item scale: *How often in the past six months did... A partner insist on oral, anal, or vaginal sex when you did not want to, but did not use physical force; A partner use threats to make you have oral, anal, or vaginal sex; A partner use force (like hitting, holding down, or using a weapon) to make you have oral, anal, or vaginal sex.*

**Children's internalizing problems**—Children completed the Revised Children's Manifest Anxiety Scale (RCMAS; Reynolds & Richmond, 1978). This 28-item measure asks children to indicate whether each item is true of them or not (0 = *No*, 1 = *Yes*). Sample items include: *You worry a lot of the time*; and *You get nervous when things do not go the right way for you*. Coefficient alpha in the present sample was .86. Mothers completed the Child Behavior Checklist internalizing scale (CBCL; Achenbach, 1991). Mothers reported the extent to which each item was true of their child in the past 6 months using a 3-point scale (0 = *Not true*, 1 = *Sometimes or somewhat true*, 2 = *Very true or often true*). Sample items include *Complains of loneliness*; and *Unhappy, sad, or depressed*. Coefficient alpha in the present sample was .83. CBCL T-scores were used in analyses.

**Children's externalizing problems**—Children completed the Children's Disruptive Behavior Scale (CDBS; McDonald & Jouriles, 1999), a 9-item measure with a 3-point response scale (0 = *Never*, 1 = *Sometimes*, 2 = *Often*). Higher scores reflect greater externalizing problems. Sample items include: *Do people think you break other people's things on purpose?* and *Do people think that you don't do what you are told or don't follow the rules?* Coefficient alpha in the present sample was .75. Mothers completed the CBCL externalizing scale. As with the internalizing scale, mothers reported how true each item was of their child during the past six months. Sample items include: *Temper tantrums or hot temper* and *Gets into many fights*. Coefficient alpha in the current sample was .88.

**Maternal depressive symptoms**—Mothers completed the Center for Epidemiologic Studies Depression Scale (CES-D; Radloff, 1977). This 20-item measure asks about the frequency of depressive symptoms during the past week on a scale ranging from 0 = *Rarely or none of the time (less than 1 day)* to 3 = *Most or all of the time (5–7 days)*. Sample items include: *I felt that I could not shake off the blues, even with the help of my family or friends* and *My sleep was restless*. Coefficient alpha in the current sample was .86.

**Maternal relationship satisfaction**—Mothers completed the 6-item Quality of Marriage Index (QMI; Norton, 1983), indicating their agreement with 5 items rated on a 7-point scale (1 = *Very strongly disagree*, 7 = *Very strongly agree*). Sample items include: *We have a good relationship*; and *My relationship with my partner is very stable*. The 6<sup>th</sup> item asks respondents to rate their happiness in their relationship with their partner on a 10-point scale (1 = *Very unhappy*, 5 = *Happy*, 10 = *Perfectly happy*). Items were summed to create an index of relationship quality (with scores ranging from 6 to 45), with higher scores reflecting greater relationship satisfaction. Coefficient alpha in the current sample was .95.

## Results

### Descriptive Data on Victimization and the Formation of Groups

As is common in research on IPV in community samples, mothers' reports of their partner's physical and sexual IPV perpetration were highly positively skewed: skewness = 9.38 and 3.40, respectively. Twelve percent (67/539) of mothers reported that their partner perpetrated physical IPV toward them during the 6-month period prior to the assessment. Of those, 75% (50/67) reported acts of minor physical IPV only. Eighteen percent (96/539) of mothers reported that their partner perpetrated sexual IPV toward them during the 6-month period prior to the assessment. Of those, 94% (90/96) reported only that their partner had insisted on having sex when the woman did not want to. Given the distribution of the partner-perpetrated IPV scores, families were classified into one of four mutually-exclusive groups: 1) non-violent (neither physical IPV nor sexual IPV reported;  $n = 404$ ), 2) physical-only (only physical IPV reported;  $n = 39$ ), 3) sexual-only (only sexual IPV reported;  $n = 68$ ), and 4) sexual + physical (both physical and sexual IPV reported;  $n = 28$ ).

Results of ANOVAs indicated no group differences in mothers' education, family income, child age, or child sex,  $ps > .20$ . Table 1 displays the means and standard deviations for study variables across the four groups. Results of separate omnibus MANOVAs testing for group differences on children's externalizing and internalizing problems (mother and child reports as the dependent variables in each analysis) indicated group differences for both externalizing, Wilk's  $\Lambda = .95$ ,  $F(6, 1068) = 4.47$ ,  $p < .001$ ,  $\eta^2 = .02$ , and internalizing, Wilk's  $\Lambda = .97$ ,  $F(6, 1068) = 2.01$ ,  $p = .02$ ,  $\eta^2 = .01$ , problems.

### Hypothesis Tests

**Sexual IPV and children's adjustment problems**—To test the hypothesis that the partner's perpetration of sexual IPV is positively associated with child adjustment problems, we first conducted contrasts to examine whether externalizing problems in the sexual-only group and the sexual + physical group were greater than in the non-violent group.

Multivariate results indicated greater externalizing problems in the sexual-only group than in the non-violent group, Wilk's  $\Lambda = .98$ ,  $F(2, 534) = 4.81$ ,  $p = .009$ ,  $\eta^2 = .02$ . Follow-up univariate contrasts revealed that this result emerged for both mothers' reports,  $p = .006$ ,  $\eta^2 = .01$ , and children's reports,  $p = .049$ ,  $\eta^2 = .01$ , of externalizing problems. Similarly, there were greater externalizing problems in the sexual + physical group than in the non-violent group, Wilk's  $\Lambda = .98$ ,  $F(2, 534) = 4.60$ ,  $p = .010$ ,  $\eta^2 = .01$ , and this result emerged for both mothers' reports,  $p = .010$ ,  $\eta^2 = .01$ , and children's reports,  $p = .036$ ,  $\eta^2 = .03$ . For internalizing problems, no differences were detected between the non-violent group and either the sexual-only group, Wilk's  $\Lambda = 1.00$ ,  $F(2, 534) = 1.24$ ,  $p = .289$ ,  $\eta^2 = .01$ , or the sexual + physical group Wilk's  $\Lambda = .99$ ,  $F(2, 534) = 2.08$ ,  $p = .276$ ,  $\eta^2 = .01$ .

We also evaluated whether children in the physical-only group differed from those in the non-violent group and found greater externalizing problems among children in the physical-only group, Wilk's  $\Lambda = .98$ ,  $F(2, 534) = 6.41$ ,  $p = .002$ ,  $\eta^2 = .02$ . Follow-up univariate contrasts indicated greater externalizing problems in the physical-only group than the non-violent group according to both mothers' reports,  $p = .047$ ,  $\eta^2 = .01$ , and children's reports,  $p = .001$ ,  $\eta^2 = .02$ . In addition, children in the physical-only group had greater internalizing problems than children in the non-violent group, Wilk's  $\Lambda = .98$ ,  $F(2, 534) = 4.80$ ,  $p = .009$ ,  $\eta^2 = .02$ , according to children's,  $p = .005$ ,  $\eta^2 = .01$ , but not mothers',  $p = .142$ ,  $\eta^2 < .01$ , reports. We followed this with a test of whether the sexual-only and physical-only groups differed on child problems, and they did not for either externalizing problems, Wilk's  $\Lambda = 1.00$ ,  $F(2, 534) = 1.20$ ,  $p = .302$ ,  $\eta^2 < .01$ , or internalizing problems, Wilk's  $\Lambda = .99$ ,  $F(2, 534) = 2.87$ ,  $p = .058$ ,  $\eta^2 = .01$ .

**Sexual + physical IPV and children's adjustment problems**—To test our second hypothesis, that the partner's perpetration of sexual IPV predicts children's adjustment problems over and above the effects of partner physical IPV alone, we conducted multivariate contrasts to examine whether children's problems were greater in the sexual + physical group than in the sexual-only group and the physical-only group. This pattern of differences did not emerge for either externalizing problems, Wilk's  $\Lambda = 1.00$ ,  $F(2, 534) = 0.27$ ,  $p = .760$ ,  $\eta^2 < .01$ , or internalizing problems, Wilk's  $\Lambda = 1.00$ ,  $F(2, 534) = 0.47$ ,  $p = .623$ ,  $\eta^2 < .01$ .

### Additional Exploratory Analyses

**Child sex**—In an analysis to examine whether child sex moderated our findings from Hypotheses 1 and 2, results of omnibus MANOVAs indicated no moderating effect for either externalizing problems, Wilk's  $\Lambda = .98$ ,  $F(6, 1060) = 1.40$ ,  $p = .212$ ,  $\eta^2 = .01$ , or internalizing problems, Wilk's  $\Lambda = .99$ ,  $F(6, 1060) = 2.01$ ,  $p = .223$ ,  $\eta^2 = .01$ .

**IPV and mothers' psychological distress**—Results of an omnibus ANOVA indicated differences among the four groups on mothers' depressive symptoms,  $F(3, 535) = 7.49$ ,  $p < .001$ ,  $\eta^2 = .04$ , and relationship dissatisfaction,  $F(3, 535) = 12.83$ ,  $p < .001$ ,  $\eta^2 = .07$ . Follow-up analyses focused on contrasts of the three violent groups against the non-violent group. Mothers in the sexual + physical group,  $p < .001$ ,  $\eta^2 = .03$ , and the physical-only group,  $p = .003$ ,  $\eta^2 = .02$ , reported greater depressive symptomatology than mothers in the non-violent



group. Mothers in the sexual-only group did not differ from mothers in the non-violent group,  $p = .155$ ,  $\eta^2 < .01$ . For relationship dissatisfaction, mothers in the three violent groups reported poorer relationship adjustment than mothers in the non-violent group, sexual-only,  $p = .015$ ,  $\eta^2 = .01$ ; physical-only,  $p = .007$ ,  $\eta^2 = .01$ ; sexual + physical,  $p < .001$ ,  $\eta^2 = .05$ .

We next examined whether the partner's sexual IPV perpetration was associated with child externalizing problems, over and above relationship dissatisfaction. Including relationship dissatisfaction as a covariate, an omnibus MANCOVA indicated group differences on children's externalizing problems, Wilk's  $\Lambda = .96$ ,  $F(6, 1066) = 3.53$ ,  $p = .002$ ,  $\eta^2 = .02$ . Multivariate results indicated that children in the sexual-only group had greater externalizing problems than children in the non-violent group, Wilk's  $\Lambda = .99$ ,  $F(2, 533) = 3.99$ ,  $p = .019$ ,  $\eta^2 = .02$ . Follow-up univariate contrasts revealed that this result emerged for both mothers' reports  $p = .017$ ,  $\eta^2 = .01$ , and children's reports,  $p = .05$ ,  $\eta^2 = .01$ . Similarly, children in the sexual + physical group had greater externalizing problems than those in the non-violent group, Wilk's  $\Lambda = .99$ ,  $F(2, 533) = 2.95$ ,  $p = .05$ ,  $\eta^2 = .01$ . Follow-up univariate contrasts indicated that this result emerged for children's reports,  $p = .045$ ,  $\eta^2 = .01$ , but not mothers' reports,  $p = .082$ ,  $\eta^2 = .01$ .

## Discussion

Mothers' reports of their male intimate partners' perpetration of sexual IPV were positively associated with children's externalizing problems. This association emerged whether physical IPV was present or not, and for mothers' as well as children's reports of externalizing problems. Furthermore, the levels of externalizing problems among children exposed to recent male-perpetrated sexual IPV were similar to those of children exposed to male-perpetrated physical IPV: approximately 1/3 SD above the mean of the non-violent group. It is noteworthy that almost all women (94%) who reported their partner to have engaged in sexual IPV reported acts of sexual coercion (e.g., partner insistence on sex) rather than threats or the use of physical force. This implies that sexual IPV does not have to be physically forceful to have an adverse impact on children's adjustment. Contrary to our expectations, reports of partners' sexual IPV perpetration did not relate to children's internalizing problems. Nor did it increase risk for children's problems when physical IPV was also present.

At a general level, the present results are consistent with those of other studies (Spiller et al., 2012; Symes et al., 2014) that have linked mothers' sexual victimization with their children's adjustment problems. However, the present research failed to replicate certain specific results reported in these other studies (e.g., the link between mothers' experience of sexual IPV and children's internalizing problems), which employed help-seeking samples. Women seeking help because of IPV are likely to differ in a number of ways from women recruited from the general community (Johnson, 1995), including the levels and types of partner-perpetrated sexual and physical IPV, and the presence of other family stressors. It seems plausible that such differences may influence the magnitude of associations between IPV and children's problems. In addition, the scientific study of the association between sexual IPV and children's adjustment problems is just beginning, and some contradictory results are expected as findings accumulate.

We return to the question posed by the title of this paper: In research on children's exposure to IPV, should the conceptualization of IPV be broadened to include sexually violent and coercive acts? There is no simple answer to this question. Sexual violence is widely recognized as a form of IPV, and sexual coercion is widely acknowledged to be an act of sexual violence. Our results suggest that children whose mothers reported recent experiences of sexual IPV perpetrated by their male intimate partner have elevated levels of externalizing problems—levels comparable to those of children whose mothers reported experiencing recent physical IPV. In short, both sexual and physical IPV perpetrated by the mother's partner appear to relate similarly to children's externalizing problems. If one focuses on the word *exposure*, it might be argued that children are less likely to witness sexual coercion than physical or psychological IPV. However, this is untested. Moreover, living in a family in which IPV has occurred, even if children do not directly witness it, constitutes a form of exposure, albeit indirect (Jouriles, McDonald, Norwood, & Ezell, 2001). Some have noted that broadening the conceptualization of IPV carries the risk of trivializing it, by including acts that could be construed as not truly violent (Hamby, 2014; Muehlenhard & Kimes, 1999), and it is possible that this concern may apply in the case of broadening the conceptualization of IPV to include sexual coercion, especially since the definition of sexual coercion is not always clear. Interestingly, when sexual coercion is included in the definition of IPV, the prevalence of children exposed to IPV doubles in the present sample. Specifically, in 12.4% (67/539) of our sample, the mother reported her partner to have perpetrated physical IPV. The prevalence male-perpetrated physical IPV reported by their female partners varies from study to study, but our figure is comparable to data from at least one national survey on the number of women reporting physical IPV in the past year (Straus & Gelles, 1990). Yet, an additional 12.6% (68/539) of mothers in our sample reported recent sexual IPV in the absence of recent physical IPV.

Mothers' reports of partners' sexual IPV perpetration were also positively associated with their relationship dissatisfaction. It is possible that the experience of recent sexual coercion increases maternal psychological distress, which might adversely affect children's adjustment, for example, by altering mothers' parenting. However, it is also possible that relationship dissatisfaction increases the likelihood of experiencing sexual coercion. The cross-sectional nature of the present research, unfortunately, limits the conclusions that can be drawn about the temporal sequencing of these variables.

Several limitations of the study should be acknowledged. Again, the data are cross-sectional. Thus, in addition to the limitation noted above regarding temporal sequencing, other unmeasured variables common to male-perpetrated sexual IPV and children's externalizing problems may be responsible for some of the documented associations. This might include the fathers' potential genetic influence on children's externalizing problems, as well as parenting processes in the family. Second, data on partners' sexual IPV perpetration were collected on a 3-item, mother-report measure. This is arguably an incomplete assessment of the phenomenon, and may have restricted our ability to detect it. Third, the sample was recruited from the general community, and approximately half of the eligible families declined to participate. The extent to which our findings generalize to other samples, particularly help-seeking samples where the levels of IPV are likely to be higher, is not clear.



In conclusion, this research underscores the potential importance of including sexual coercion in the conceptualization of IPV when considering children's exposure to IPV. Although this research was conducted with community families, mental health professionals should be sensitive to sexual IPV when assessing children's exposure to violence. Replication is necessary to evaluate the robustness and generalizability of our findings, and additional research is needed to explicate the pathways by which men's sexual IPV perpetration might increase the likelihood of children's externalizing problems.

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**Table 1**

Means and Standard Deviations of Study Variables Across the Four Groups

	Non-Violent (n = 404)	Sexual-Only (n = 68)	Physical-Only (n = 39)	Sexual+Physical (n = 28)
<i>Children's adjustment problems</i>				
CBCL externalizing (Mother report)	54.39 (10.02)	57.90 (9.15)	57.64 (8.13)	59.29 (8.85)
CDBS externalizing (Child report)	2.79 (2.78)	3.53 (3.10)	4.38 (3.13)	3.96 (3.10)
CBCL internalizing (Mother report)	54.52 (9.29)	56.40 (8.44)	56.77 (7.99)	58.07 (9.75)
RCMAS internalizing (Child report)	12.15 (6.24)	12.12 (5.87)	15.10 (6.30)	12.89 (6.20)
Maternal depressive symptoms (CES-D)	10.33 (7.03)	11.69 (7.34)	13.94 (7.02)	15.79 (10.54)
Maternal relationship satisfaction (QMI)	38.98 (7.27)	36.50 (8.36)	35.44 (8.35)	30.64 (11.34)

*Note.* CBCL scores are T-scores; all other scores are raw scores.

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