

The Impact of Exposure to Domestic Violence on Mental Health and Well-Being of Children in Lusaka District Zambia

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ABSTRACT:- Domestic violence (DV) is major risk to the development of children. It is even a more serious concern among developing nations faced with other factors such as poverty. Current evidence suggests children's outcomes are severely affected. However, this is unclear for developing nations as findings are based on research conducted in the west with different contextual factors. We explore the association between DV and mental health and wellbeing among children. 530 randomly selected children (345 females, 185 males, mean age = 15.9) and 320 parents/caregivers of children self-reported to have been exposed to DV participated in the study. Three instruments; questionnaires assessing mental health and wellbeing and a Child Behavior checklist (CBCL, 4-18years) were used. Data was analyzed using SPSS. Findings are that domestic violence negatively affects mental health and wellbeing of children victims. Further, mental health mediates the relationship between DV and wellbeing as a special mechanism is set in motion once a child is exposed to DV. The results demonstrate that DV is a negative background on child outcomes, hence the need to pay special attention to these issues especially among developing nations. This implies that attention must be given to children's mental health to achieve their full potential and avoid poor psychological development. In terms of intervention, there is need to focus on protecting mental status of Victims as a resilience measure.

Key words: Domestic violence, Mental health, Wellbeing, Impact

I. INTRODUCTION

Domestic violence (DV) has devastated society affecting millions of children worldwide and children in Zambia are not an exception. Conservatively 275 million children worldwide are exposed to violence⁴. 15.5 million children in the US live in families in which partner violence occurs and seven million in families with severe partner violence⁵. One (1) in every five (5) children has experienced severe maltreatment and is almost 3 times more likely to witness family violence in the UK⁶. Figures indicate that during 2013-14, there were 198,966 children suspected of being harmed or at risk of abuse and/or neglect representing an increase of 11.4% from the 272,980 reports of the previous year in Australia⁷.

Although little data is available and great variation in how psychological violence is measured across African countries, existing evidence suggests high prevalence of violence perpetrated against women and children⁸. Empirical evidence on DV is limited and confined to a small number of population-based or special-population studies in Sub Saharan Africa⁹ which does not indicate it does not exist but lack of research on the subject matter.

⁴UNICEF (2012). Women in Transition, Region Monitoring Report, No. 6. Florence: UNICEF International Child Development Centre⁴

⁵Graham-Bermann, S. A. and Seng, J. (2005). Violence Exposure and Traumatic Stress Symptoms as Additional Predictors of Health Problems in High-Risk Children. *Journal of Pediatrics*, 146(3): 309-10

⁶Radford et al (2011). Child abuse and neglect in the UK today. London, NSPCC.

⁷Austrian Institute of Health and Welfare. (2015). Child protection Australia 2013-14. Canberra: AIHW. Retrieved from >www.aihw.gov.au/publicationdetail/id=60129550762>

⁸Pallitto et al (2013). Intimate partner violence, abortion and unintended pregnancy: results from WHO Multi-Country study on women's health and Domestic violence. *International Journal of Gynecology & Obstetrics*, 120(1), 3-9.

⁹Jewkes, R, Penn-Kekana, L, Levin, J, Ratsaka, M, Schreiber, M. (2001). Prevalence of emotional, physical and sexual abuse of women in three South African provinces. *South African Medical Journal*, 91: 421-8.

In Zambia, 35% of cases reported to the police involve children exposed to violence. Statistics have shown a pervasive increase of violence against children (32% in 2011; 31% in 2010; 31% in 2009)¹⁰ which is not a complete reflection of the problem considering unreported cases. Statistics for 10-years (2005-15) indicate an average of 25% across forms of violence reported in Lusaka District which happens to be highest in DV terms against children. Zambia with 45% of the population consisting of younger people is at risk.

This study measures the impact of DV on children victims in Lusaka District by examining the relationship between mental health and wellbeing of victims once exposed to DV. We assume that mental health is more affected than wellbeing which assumption is important for developing an understanding of the mechanism that takes place once a child is exposed to DV and can be used for intervention.

Exploring the impact of DV on child outcomes for people living under complex cultural and social factors shall immensely contribute to the building of the knowledge base. This is true because existing studies on DV concerning children have mostly been conducted in developed nations, the relevance of which, while important remain limited in a sense. Human kinds are not natural kinds as research findings connect people's attempts to make sense of their lives which cannot be captured in other settings except theirs¹¹. The value of this study lies both in its engagement with the family as a whole through interviews with children and their guardians. Results shall help enhance policy formulation and intervention based on informed research.

For the sake of this study, DV is defined as exposure to, experiencing and witnessing of emotional, psychological, physical, sexual abuse of a child below 17 years. The word "domestic violence" refers to relationships involved rather than the place of occurrence. It encompasses psychological, physical and sexual aggression involving or witnessed by children. Exposure (experiencing) broadly includes emotional and physical experience, either directly or indirectly that may affect the child's self-worth¹².

II. EFFECTS OF DOMESTIC VIOLENCE ON MENTAL HEALTH AND WELL-BEING

Impact of DV is not predictable and children may exhibit a range of behavior problems¹³. Mental health effects are related to observable acts while wellbeing refers to social functioning. Experts argue that DV puts children in a "state of alertness" but however create a state of perpetual fearfulness that is tragically maladaptive. Children may suffer "loss of control" which may affect initiative; personality style, self-esteem and impulse control¹⁴. Children are associated with hopelessness and powerlessness¹⁵. Victims may find it hard to "understand" the violence but also not willing to "talk" about it¹⁶ especially when it happens within the family.

Depression affects mental health status of victims as children develop depressive moods¹⁷. Children may see or hear violent incidents which gets "imprinted" on all of a child's senses in such a powerful way; visual impressions, sounds, smells, tastes and skin sensations all associated with traumatic events and appear to be absorbed (engrossed) into the memory of the child vividly¹⁸.

DV impacts children's well-being and could have lasting implications. Social relations and networks such as friendships create an entry into wider social society for human beings and play a critical role in childhood and beyond. Difficulties in making and sustaining social relationships can leave children vulnerable to social exclusion¹⁹. Thus, an impaired ability to forge good quality friendship with peers and others result in not experiencing good social interaction²⁰.

¹⁰Zambia Police National Crime Statistics. Police Headquarters, Victim Support Unit, National Co-ordinate's office. (2009-13).

¹¹Glynis, M., Breakwell, Jonathan, A. Smith and Daniel, B. Wright. (2012). Research Methods in Psychology. (4th edition). London: Sage Publications.

¹²Trocme, N., and Wolfe, D. (2001). Child maltreatment in Canada: Canadian incidence study of reported child abuse and neglect. Clearing House on Family Violence Health Canada.

¹³Holden, G.W. (2003). Children exposed to domestic violence and child abuse: Terminology and taxonomy. Clinical child and family psychology.

¹⁴Pryor, J., and Rodgers, B. (2001). Children in changing families: life after parental separation. Blackwell Publishing.

¹⁵Cunningham, A.J and Baker, L.L (2004). What about me! Seeking to understand a child's view of violence in the family. Centre for children and families in the Justice system, 309-16; Webster et al, 2007

¹⁶Mullender, A. (2004). Tackling Domestic Violence: providing support for children who have witnessed domestic violence. London: Home Office.

¹⁷Widom, C. S (2000). Childhood Victimization: Early Adversity, Later psychopathology. National Institute of Justice Journal, 2000. National Institute of Justice Journal, 242,3-9; Scott,S., Knapp, M., Henderson, J., and Maughan, B. (2001). Financial cost of social exclusion: follow up study of antisocial children into adulthood. British Medical Journal, 323 (7306), 191. Wekerle & Pittman, 2001

¹⁸Manohon, 1993

¹⁹Ridge, T (2009). Living with poverty: a review of the literature on children's and families experiences of poverty; Ridge, T and Millar, J. (2001). Families, poverty, work and care: review of the literature on lone parents and low income couple families with children: a report of research carried out by the centre for analysis of social policy at the University of Bath on behalf of the Department for Work and Pensions.

²⁰Howe, D. (2005). Child abuse and neglect: attachment, development and intervention. Palgrave Macmillan.

Social networks are the victim's best support and provide something else that creates a buffer²¹. DV inhibits free interaction which has been attributed to fear and shame victims develop²². Victims may be afraid and increase on holding back²³.

DV could lead to difficulties in sustaining peer-relationships²⁴ and failure to build peer relations. Children develop an inability to regulate emotions and greater tendency towards violence²⁵. They may be lacking in social competence which significantly is associated with great immaturity and inadequacy²⁶. They could be impulsive and lacking in social skills and possess different attitudes²⁷.

III. METHODS

Correlational design was used to examine relationship of variables that do not readily lend themselves to experimental manipulation. Correlation design allows for qualitative than quantitative methods hence achieve in depth findings and more exploration of issues obtained in a contextual manner.

Research Questions

The following questions were asked:-

1. What impact does DV have on child outcomes-mental health and wellbeing among children exposed to DV?
2. Which variable, mental health and wellbeing is impacted more than the other?
3. Is there a special relationship that exists between mental health & well being once a victim experiences DV?

Study Hypothesis

We hypothesized as follows;

1. DV exposure affects child outcomes-mental health and wellbeing once children are exposed to DV.
2. Mental health is highly impacted than is wellbeing hence distorting a victim's wellbeing.

Study Rationale

DV violates rights of children and undermines their development. It can create intergenerational violence hence a dysfunctional society. It affects families and societies as children are tomorrow's future. However, impact of exposure to DV has not been fully explored among developing nations hence the need to replicate findings in the actual context with all necessary realities to generate relevant potential policy.

Study settings

Lusaka district is home to over 2.5 million people of diverse cultural background most of which live in shanty townships with limited social amenities and unemployed. Rampant use of alcohol and drugs has negatively affected the family. High poverty exists coupled with orphaned and out of school children as a result of HIV/AIDS, families are child headed, factors all of which contribute to the higher occurrence of violence hence appropriate for our study.

Sample and Procedure

530 randomly selected children aged eleven (11) to seventeen (17) with and without exposure to DV drawn from ten schools, five (05) primary and (05) five secondary schools and 320 parents/care givers participated in the study. Individual schools were visited and once permission and consent was granted by parents, actual administration took place lasting up to about forty-five (45) minutes per instrument. Appointment was made to administer instrument to parents.

Sample characteristics

Of the 530 child participants (mean age 15.9), 35% (185) were Male while 65% were (345) Female. Only grades six (6) and seven (7) were allowed to participate for primary school assumed had adequate language skills but left open for high school. 54% (286) were from primary and 46% (244) from high school. Of

²¹Houghton, M. E., Hilton, N. Z., Harris, G. T., Rice, R. E., and Eke, A. W. (2008). An in-depth actuarial assessment for wife assault recidivism: The Domestic Violence Risk Appraisal Guide. *Law and Human behavior*, 32(2), 150-163.

²²Hoglund & Nicholas, 1995

²³McGee, C. (2000). *Childhood experiences of domestic violence*. Jessica Kingsley Publishers.

²⁴Sronfe, Egeland & Carlson, 1999

²⁵Gelles, R. J., and Cavanaugh, M. M. (2005). Violence, abuse and neglect in families and intimate relationships. *Families and change: coping with stressful events and transitions*, 129-154; Goddard & Bedi. (2010)..... and child abuse: a child-centered perspective. *Child abuse review*, 19(1), 5-20.

²⁶Jouriles, Murphy & O'Leary, 1989

²⁷Reyes et al, 2008

320 parents, 43% (135) were for children not exposed to DV while 57% (185) for children exposed. Participants were selected from within and outside the peripheries of the district.

Ethical considerations

DV is a sensitive and traumatic experience hence informed consent was obtained from parents and children before commencement of the study. Further oral consent was obtained during administration with full withdrawal rights at any given time fully explained. Client confidentiality was assured while victimization was avoided by adhering to ethical procedures.

Study materials

Three (3) instruments were used to conduct the study;- two self-report questionnaires for child participants measuring mental health and wellbeing modeled and modified using the Symptom Checklist (SCI) 90-R scale and the Child Behavior Checklist (CBCL) administered to parents. Reliability test (SPSS 22.0) was found to be of good internal consistency ($\alpha = 0.78$). The instruments were a 3-point Likert-type scale ranging from not true to very true, with higher scores indicating a lower state. Participants were instructed to respond to questions on the basis of true experience to obtain unbiased information.

Data Analysis

Data was analyzed using SPSS(22.0). Correlation and Regression analysis determined the relationship between independent (DV) and dependent variables while regression indicated differences. An independent sample t-test determined differences among variables.

III. RESULTS

Sample Characteristics on Exposure to DV

Chart 1: Exposure and Non-exposure to DV (N=530)

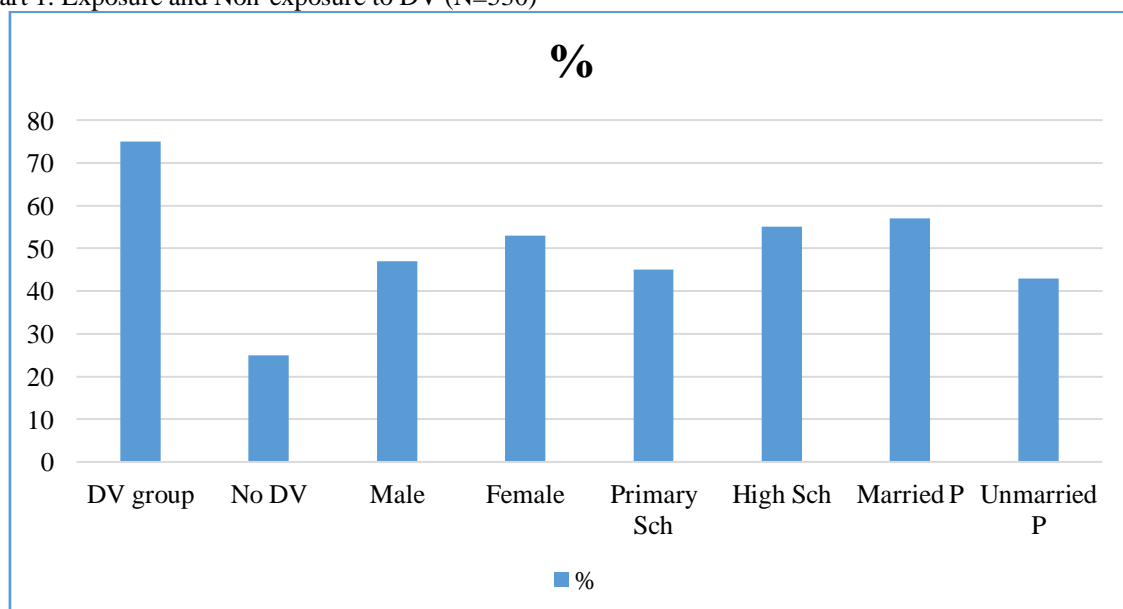


Chart 1 represents sample characteristics for children participants. 75% were exposed while 25% were not exposed. The normal curve for both groups reveals normal distribution without extremes, though DV group was negatively skewed while No DV group was positive.

Table 1: 95% Confidence Interval-DV and No DV

	Mean	SE	95% C.I
Mentalhealth			
DV	21.9	.42706	21.9699-22.8147
No DV	10.6391	.42645	9.7955-11.4827
Wellbeing			
DV	21.3083	.45670	20.4840-22.1325
No DV	7.6917	.35079	6.9978-8.3856

Table 1, Confidence interval showed means fall within the upper and lower bound for all variables hence the confidence of results and therefore could be generalized to the population. Smaller SEM's gave assurance that only minor errors could be associated with the findings. Thus results could be attributed to the population assuming the null hypothesis to be true.

EFFECTS OF DV ON MENTAL HEALTH

Table 2: Correlation Analysis-DV and Mentalhealth (N=395)

DV	Mentalhealth
r-value	-.157
Sig.	.002

Table 2 indicates that a relationship exist between DV and mental health among participants with experience of DV ($r = -0.16$; $p < 0.002$).

Table 3. Correlation Analysis-No DV and Mentalhealth (N=136)

No DV	Mentalhealth
r-value	-.002
Sig.	.980

In Table 3 the result showed no correlation exist between DV and mental health among children with no DV experience due to lack of exposure ($r = -0.0$; $p < 0.980$), thus, no co-variance.

Table 4: Correlation Analysis-Mentalhealth and Wellbeing (N=396)

DV	Mentalhealth & Wellbeing
r-value	.146
Sig.	.004

In Table 4 we establish if a relationship exists between mental health and wellbeing once exposed to DV. The result established correlation ($r = 0.15$; $p < 0.004$) meaning that once mental health is affected the effect is extended to an individual's wellbeing.

Chart 3: Comparison of means between DV and No DV-mental health

Chart 3 shows Means for DV and No DV groups of mental health. The result indicated wide differences between the two groups. DV group had a larger mean (21.9) as opposed to No DV group (10.5). The difference can be attributed to different experiences between the groups, with DV group having been exposed to DV and none for No DV group.

Table 5: ANOVA-DV and Mentalhealth (N=395)

R-value	df	F	sig.	SEM
.610	529	312.905	.000	5.51118

In Table 5 we establish the direction and magnitude of the relationship between DV and mental health. Results showed correlation R-value (0.61) and therefore a relationship exist among participants with DV experience (p -value < 0.001 ; F -value = 312.905).

Table 6: Regression analysis-DV and Mentalhealth (N=395)

B	t	Sig.	95% C.I
DV	5.085	.000	4.520-5.560 (SE=.287)

Note: values enclosed in parenthesis represent standard error

In Table 6 we established predictive value of DV on mental health once an individual is exposed to DV. The regression coefficient was 5.09, thus, as DV increased by a unit, mentalhealth also increased by 5.09. Confidence level of the population coefficient was between 4.520 and 5.650; t -value 17.689 with an associated

probability of 0.001. The regression coefficient was unlikely to have arisen by sampling error and we conclude that exposure to DV has a predictive value on one's mental health status.

Table 7: ANOVA-DV and Mental health (N=136)

R-value	df	F	sig.	SEM
.043	134	.245	.621	4.94137

In Table 7 we establish magnitude and direction of the relationship between none exposure to DV and mental health of participants with No DV experience. The R-value was (0.04; p-value 0.621, F-value = 0.245). This meant no relationship exists between the two.

Table 8: Regression Analysis for No DV and MentalHealth (N=136)

	B	t	Sig.	95% C.I
DV	-.480	-.043	6.527	.621
				-2.397-1.437 (SE=.969)

Note: values enclosed in parenthesis represent standard error

In Table 8 we found out if none exposure to DV predict low mental health among participants in the No DV group. A regression coefficient of -0.48 was obtained (population coefficient between -2.397 and 1.437; t-value 6.527; associated p-value of 0.001.), thus, as DV increased by 1 unit, mental health increased by -0.48. The result meant there was no effect of DV on the mental health among participants without DV experience.

EFFECTS OF DOMESTIC VIOLENCE ON WELLBEING

Table 9: Correlation Analysis-DV and Wellbeing (N= 395)

DV	Wellbeing
r-value	.717
sig.	.000

In table 9 we established if a relationship existed between experiencing DV and Wellbeing. A positive and strong ($r = 0.72$, $p < 0.001$) relationship was obtained thus significant co-variance.

Table 10: Correlation Analysis No DV and Wellbeing (N=136)

No DV	Wellbeing
r-value	.031
sig.	.720

Table 10 was meant to establish if a relationship existed between none exposure to DV and Wellbeing. A negative and none significant ($r = -0.03$, $p < 0.720$) relationship was obtained, thus no significant relationship exists.

Table 11: Correlation Analysis Wellbeing and Mentalhealth for DV (N=395)

DV	Mental Health & Wellbeing
r-value	.242
sig.	.005

In table 11, the objective was to establish if Wellbeing has an effect on mental health once participants experience DV. A positive correlation ($r = 0.242$), with a p-value of (< 0.005) was established hence a relationship exists. This means that once wellbeing is exposed to DV it equally affects ones mental health status as well.

Chart 4: Comparison of Means on wellbeing, DV and No DV

Chart 4 shows means for DV and No DV groups on wellbeing. The result indicates variation of means between the two conditions. DV group had a bigger mean and its SD varied from the mean, while No DV group had a smaller mean and the SD is not varied. The difference implies the different experiences between the two groups.

Table 12: ANOVA-DV and Wellbeing (N=395)

R-value	df	F	sig.	SEM
.717	526	555.769	.000	5.32320

In Table 12 above we established magnitude and direction of the relationship between DV and wellbeing among participants with exposure to DV. The R-value was 0.72 (p-value of 0.001; F-value = 555.769) hence a strong relationship was established. The result confirms the relationship between exposure to DV and wellbeing.

Table 13: Regression Analysis-DV and Wellbeing (N=395)

	B	t	Sig.	95% C.I	
DV	6.552	.717	23.575	.000	6.006-7.09 (SE=.278)

Note: values enclosed in parenthesis represent standard error

Table 13 established if exposure to DV would predict wellbeing and by what margin. Regression coefficient was 6.55 (population coefficient between 6.006 and 7.098; t-value 23.573, associated probability 0.001), as DV exposure increased by 1 unit, wellbeing also increased by 6.55. Thus the regression was unlikely to have arisen by sampling error meaning DV experience predicts poor wellbeing. The result could be attributed to the population mean at 95%.

Table 14: ANOVA-No DV and Wellbeing (N=136)

R-value	df	sig.	SEM	
.031	135	.130	.720	4.05973

In Table 14 we established if a relationship exists between none exposure to DV and wellbeing. The R-value was 0.03 (p-value 0.720, F-value = 0.130). In this case, no relationship was established between DV and wellbeing among participants with no exposure to DV.

Table 15: Regression Analysis-DV and Wellbeing (N=136)

	B	t	Sig.	95% C.I	
DV	6.552	.287	.360	.000	1.288-1.861 (SE=.796)

Note: values enclosed in parenthesis represent standard error

IV. RESULTS FROM THE CBCL-PARENTS/GUARDIANS VIEW.

Descriptive indices for 8 behavior problem domains and the 3 broadband scores are presented in table 16 below and indicate variation of results between the two groups, DV and No DV. Exposure to violence in the DV group is assumed responsible for the state of affairs for the noted difference both of Means and the SD. The results further indicated that total problems were more for the DV group than was the case in No DV group.

Table 16: Scale t-test: Low Risk: No DV (n=135) High-Risk DV (n=185)

Scales	t-value	df	p-value	No DV	Means DV group
Withdrawn	-.053	318	.002	4.755	5.816
Somatic Complaints	-.794	312	.000	1.664	2.286
Anxious/Depressed	-3.732	318	.000	1.000	1.414
Social Problems	-1.459	317	.006	2.625	4.309
Thought Problems	-1.459	317	.040	1.727	3.301
Attention Problems	-.314	318	.003	0.445	1.015
Delinquent Behavior	-3.704	316	.000	2.527	5.323

Aggressive Behavior	-2.151	318	.002	9.881	10.983
Internalizing	1.505	314	.003	5.125	7.722
Externalizing	2.734	316	.007	7.637	15.000

Independent t-test were conducted to assess differences between normative and control sample. Normative sample consisted of children deemed low risk in the sense that they were not exposed to DV. Results indicated statistically significant higher mean scores for the control group in all domains as well as internalizing and externalizing broadband scores. In this case, the null hypothesis that no real difference exist between the two groups was rejected and assumed that equal variances were not the same. This was as reported by the parents/guardians.

Table 17: Scale Correlations- Responses for Parents of children exposed to DV (N= 185)

Scale	Thought	Attention	Delinquent	Aggressive
<u>Withdrawn</u>				
r-value	.564	.602	.536	.536
p-value	.001	.001	.001	.001
<u>Somatic Complaints</u>				
r-value	.567	.731	.585	.524
p-value	.001	.001	.001	.001
<u>Anxious Depressed</u>				
r-value	.587	.495	.715	.688
p-value	.001	.001	.001	.001
<u>Social Problems</u>				
r-value	1.0	.558	.511	.650
p-value	.001	.001	.001	.001
<u>Thought Problems</u>				
r-value	-	.558	.511	.650
p-value	.001	.001	.001	.001
<u>Attention Problems</u>				
r-value	.558	-	.501	.499
p-value	.001	.001	.001	.001
<u>Delinquent Behavior</u>				
r-value	.511	.501	-	.608
p-value	.001	.001	.001	.001
<u>Aggressive Behavior</u>				
r-value	.650	.499	.608	-
p-value	.001	.001	.001	.001
<u>Internalizing</u>				
r-value	.684	.728	.710	.790
p-value	.001	.001	.001	.001
<u>Externalizing</u>				
r-value	.741	.680	.803	.827
p-value	.001	.001	.001	.001

Table 18: Scale Correlations- Responses for Parents of children exposed to DV (n= 185)

Scale	Internalizing	Externalizing
<u>Withdrawn</u>		
r-value	.722	.656
p-value	.001	.001
<u>Somatic Complaints</u>		
r-value	.644	.741
p-value	.001	.001
<u>Anxious Depressed</u>		
r-value	.725	.801
p-value	.001	.001
<u>Social Problems</u>		
r-value	.684	.741
p-value	.001	.001

<u>Thought Problems</u>		
r-value	.684	.741
p-value	.001	.001
<u>Attention Problems</u>		
r-value	.728	.741
p-value	.001	.001
<u>Delinquent Behavior</u>		
r-value	.710	.608
p-value	.001	.001
<u>Aggressive Behavior</u>		
r-value	.790	.803
p-value	.001	.001
<u>Internalizing</u>		
r-value	-	.827
p-value	-	.001
<u>Externalizing</u>		
r-value	.851	-
p-value	.001	-

Tables 17 and 18 above are correlations conducted on parental views of 185 children exposed to DV. Results indicate co-variance of scales for children exposed to DV in all the 8 domains as well as the 2 broad-based domains on the children's profile. This meant that children exposed to DV had suffered impact on their behavior-emotional aspects and confirms that children exposed to DV have their mental health and wellbeing affected.

Table 19: Partial Correlations-DV group (n =185)

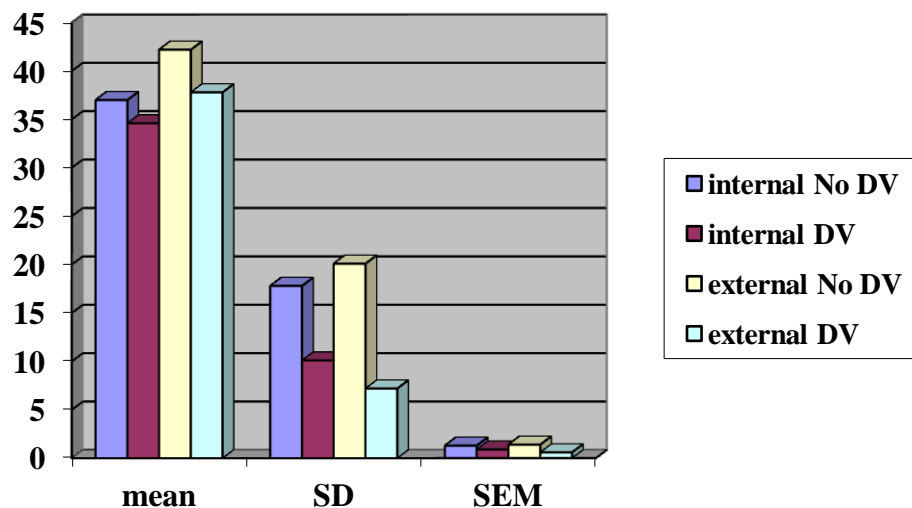
Scale	Internalizing-Externalizing Behavior
Aggressive Behavior	
r-value	.575
p-value	.001
df	311

A partial correlation comparison between internalizing and externalizing behavior indicated there was co-variance between scales for children exposed to DV.

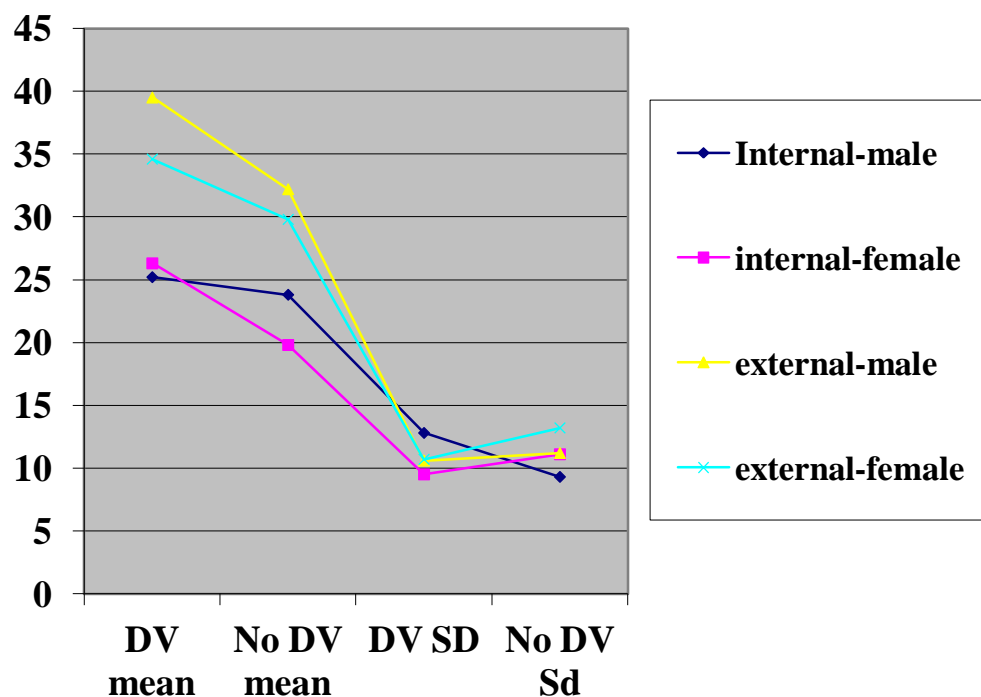
Table 20: Group Statistics-Participant's Gender (n= 185)

Scale	n	Mean	SD	SEM
Internalizing				
Male	149	33.919	15.891	1.301
Female	167	38.419	13.819	1.069
Externalizing				
Male	150	42.046	17.874	1.459
Female	168	38.940	14.363	1.108

Analysis by gender in table 20, i.e., boys and girl's differences was reported significant and indicated that boys had more externalizing behavior problems while girls had internalizing problems as shown above in table 20.

Table 21: Groups Differences-No DV and DV groups (N = 320)

Subsequent analysis on the basis of the DV class in table 21 revealed a significant effect on the externalizing behavior problem score with non-significant trend evident on the internalizing behavior problem scale score as shown above for the two groups, with the DV group scoring highest.

Table 22: Maternal Reports of Means and SD by Group & Gender (N = 320)

Analysis between externalized and internalized behavior reveal significant interaction effect as reported by parents. There were fewer problems for girls on externalizing behavior while boys were significantly impacted. On the other hand, girls had more behavior problems (internalized problems) while boys had less. Analysis between gender and the DV grouping reveal significant interaction. Children in the DV group were found to have more externalizing (but not internalizing) behavior problems than children in the No DV group (See Table 22 above).

Table 23: Independent Sample t-test-Gender (N = 320)

	t-value	p-value	df	Standard Error Difference	95% C.I
Internalizing	3.265	0.001	314	1.671	2.184-8.715
Externalizing	1.716	0.000	316	1.832	-.455-6.667

Table 24: Independent Sample t-test-No DV and DV groups (N = 320)

	t-value	p-value	df	Standard Error Difference	95% C.I
Internalizing	1.505	0.003	314	1.587	-.734-5.512
Externalizing	2.734	0.007	316	1.618	1.236-7.613

The t-test conducted on both gender and the DV grouping above in tables 23 and 24 reveal significant differences in the two categories. Gender analysis showed that there were significant differences between boys and girls on internalizing and externalizing behavior problems while it was also the same for DV and No DV group. This meant marked differences between boys and girls in both No DV and DV groups and the same applied to the scale on internalizing and externalizing scales on gender.

V. DISCUSSION

DV impacts children's mental health & well-being and could have lasting implications. We investigated impact of DV on mental health & wellbeing of children exposed to DV. Participants were tested on anxiety, fear, sadness, aggression, and depression regarded as indicators for mental health; and for well-being, variables dependent on cognitive/social functioning/interpersonal skills were measured.

Results showed differences between none and exposure to DV with the DV group showing effects. There was correlation between exposure to DV and mental health (table 3; $r = -0.1$, $p < 0.002$). Thus, participants with DV experience had a corresponding increase of the impact of DV on mental health status, indicating an affect. On the other hand, results for participants not exposed to DV (table 4) showed no co-variance ($r = -0.0$, $p < 0.980$) on mental health in contrast to children that had experienced DV.

Regression analysis indicated a regression (tables 5 & 6; $R = 0.61$) with necessary associated probability (0.001) between DV and mental health meaning that with one unit of DV experience/exposure a victim's mental health was impacted by 0.61. DV experience therefore predicts negative mental health.

To consolidate findings, regression analysis for participants not exposed to DV group was conducted (tables 7 & 8) which showed no relationship between DV and mental health, ($r = 0.04$, $p < 0.001$). This means that without an experience of/exposure to DV, there is no effect on mental health, a result consistent with previous findings²⁸. Thus, children exposed to DV exhibit more than normal anxiety, low self-esteem, anger and temperament and depression problems than those that had not experienced violence.

For well-being Means (Chart 4) between DV and No DV groups were different, with the DV group having a bigger mean (21.7347) while for No DV was less (7.6985). In the same vein, the S.D for DV group (4.67633) was widely varied from the mean while for No DV groups (4.04662) were closer. Thus, the difference could be attributed to different experiences between the two groups, with DV group clearly way above the population norm. The correlation among participants with exposure to DV showed a relationship ($r = 0.72$) with the necessary associated significance (p-value; 0.001, table 9) implying co-variance between DV and wellbeing in the DV group. Correlation analysis conducted for participants without exposure to DV (table 10) designated a result indicating no correlation ($r = -0.03$, $p < 0.720$) implying no relationship between DV and wellbeing among participants not exposed to DV.

ANOVA in the DV group indicated a strong correlation (R-value = 0.72) with an associated p-value of (< 0.001 , table 12). Regression coefficient was 6.55 (table 13) implying that as DV increased by 1 unit, well-being also increased by 6.55. Further Regression analysis on well-being among participants without DV exposure (tables 14 and 15) showed that there was no correlation (0.03) and significance (0.720) while regression coefficient was (0.287). Thus, a child with no experience of DV does not also suffer significant negative impact on their well-being.

On the other hand further analysis of parents/guardians reports of their children's exposure to DV was conducted. A Child Behavior Checklist for Ages 6-18 (CBCL/6-18) which possess DSM-Oriented Scales constructed through expert clinical judgment to match selected categories for behavioral/emotional problems as

²⁸Harper, F. W., and Arias, I. (2004). The role of shame in predicting adult anger and depressive symptoms among victims of child psychological maltreatment. *Journal of Family Violence*, 19(6), 359-367.

described in the DSM-IV was used to that effect. In this case we examined psychometric properties for all six DSM-Oriented Scales (i.e., Affective, Anxiety, Somatic, Attention-Deficit/Hyperactive, Oppositional and Conduct Scales) in a sample of the parents to the children (N =320).

The results showed (tables 24 & 25) marked differences in reports of the parents between children exposed to DV and those that had not been. Correlation of scales for children exposed to DV (tables 17, 18 & 19) suggested similarities of experiences. This was further supported by the results (tables 21 & 22) suggesting that there were differences between the two groups. To consolidate the findings, when tested on the basis of gender, in both participants exposed to DV and without DV, indications were that males were more affected on externalized behavior while females were affected on internalized behavior.

The findings support views of the children exposed to DV and provide strong evidence that children once exposed suffer behavioral and emotional problems unlike colleagues without such experience. These results confirm findings obtained in previous studies. In addition, they further confirm that early childhood experiences have a significant impact on children and that marked differences exist between children exposed and those not to negative life events.

The implication is that negative life experiences are detrimental to child development notwithstanding one's location hence need to avoid such events. Findings of this study are critical to comprehending the development of children especially that CBCL present the most widely used parent-report measure in child psychopathology and for assessing a range of problems²⁹. Within clinical settings, results demonstrate remarkable utility and could be used to discriminate between children with behavioral and emotional problems. They may be used to diagnose and treat internalizing or externalizing behavioral problems of children³⁰. The results provide useful associations with both narrower child problems and broad based ones such internalizing and externalizing ones. The results are important for practitioners and parents in determining the problem a child may be faced with.

Having better mental health cannot be over emphasized because better cognition, social relations and networks create an entry into wider social society for human beings. Social relations play a critical role as assets in childhood and beyond. In a similar way, difficulties in making and sustaining social relationships can leave children vulnerable to social exclusion³¹.

As demonstrated in the findings, understanding the mechanism of the impact of DV on children's development is an important way to assess development of children as it also affects children's ability to develop social networks. Thus, an impaired ability to forge good quality friendship with peers and others can result in poor social interaction which increases risk of poor wellbeing³².

The result suggest that the impact of experiencing DV is pervasive, beyond mere physical harm and could lead to emotional disturbance which in turn affect mental health of the victims. Essentially, traumatic events have a tendency to intrude into children's mind and victims may struggle by avoiding circumstances that remind them of the incident. It is clear in this experiment that participants that experienced DV had been negatively impacted on their mental health unlike colleagues that did not. In this respect, the results suggest that victims of DV experience low mental health hence poor Well-being. It has also been established that a special mechanism is set in motion affecting mental health which in turn affects a child's well being hence detrimental to child growth and development. This basically leads to the development of malformed child personalities which are the forerunners of ill balanced, partially integrated and poor adjusted adult personalities.

REFERENCES

- [1]. Manohon, Cynthia. (1993). Children and trauma. A parent's guide to helping children heal. New York; Macmillan.
- [2]. Achenbach, T. M., &Rescorla, L. A. (2001). ASEBA preschool forms & profiles. *University of Vermont, Research Center for Children, Youth and Families, Burlington, VT.*
- [3]. Australian Institute of Health and Welfare. (2015). Child protection Australia 2013-14.
- [4]. Cunningham, AJ and LL Baker. (2004). *What about Me! Seeking to Understand a Child's View of Violence in the Family.* Centre for Children & Families in the Justice System, 309-316.
- [5]. Glynis, M. Breakwell; Jonathan, A. Smith and Daniel, B. Wright. (2012). *Research Methods in Psychology.* (4th edition). London; Sage Publications

²⁹Achenbach, T. M and Rescorla, L. A. (2001). ASEBA preschool forms and profiles. University of Vermont, Research center for Youth and families, Burlington, VT.

³⁰Seligman, L. D., Ollendick, T.H., Langley, A. K., and Baldacci, H. B. (2004). The utility of measures of child and adolescent anxiety: a meta-analytic review of the revised children's manifest anxiety scale, the state-trait anxiety inventory for children, and the child behavior checklist. *Journal of Clinical Child and Adolescent psychologist*, 60, 687-696.

³²Howe, 2005

- [6]. Graham-Bermann, SA, and Seng, J. 2005. Violence Exposure and Traumatic Stress Symptoms as Additional Predictors of Health Problems in High-Risk Children. *Journal of Pediatrics*. 146(3):309-10.
- [7]. Gelles, R. J., & Cavanaugh, M. M. (2005). Violence, abuse and neglect in families and intimate relationships. *Families & change: Coping with stressful events and transitions*, 129-154.
- [8]. Goddard, C., & Bedi, G. (2010). Intimate partner violence and child abuse: a child-centered perspective. *Child abuse review*, 19(1), 5-20.
- [9]. Holden, G. W. (2003). Children exposed to domestic violence and child abuse: Terminology and taxonomy. *Clinical child and family psychology*.
- [10]. Howe, D. (2005). *Child abuse and neglect: Attachment, development and intervention*. Palgrave Macmillan.
- [11]. Houghton M. E., Hilton, N. Z., Harris, G. T., Rice, R. E., & Eke, A. W. (2008). An in-depth actuarial assessment for wife assault recidivism: The Domestic Violence Risk Appraisal Guide. *Law and human behavior*, 32(2), 150-163.
- [12]. Jewkes R, Penn-Kekana L, Levin J, Ratsaka M, Schreiber M. (2001). Prevalence of emotional, physical, and sexual abuse of women in three South African provinces. *South African Medical Journal*, 91:421-8.
- [13]. Mullender, A. (2004). *Tackling Domestic Violence: providing support for children who have witnessed domestic violence*. London: Home Office.
- [14]. McGee, C. (2000). *Childhood experiences of domestic violence*. Jessica Kingsley Publishers.
- [15]. Pallitto, C. C., García-Moreno, C., Jansen, H. A., Heise, L., Ellsberg, M., & Watts, C. (2013). Intimate partner violence, abortion, and unintended pregnancy: results from the WHO Multi-Country Study on Women's Health and Domestic Violence. *International Journal of Gynecology & Obstetrics*, 120(1), 3-9.
- [16]. Pynoos, R. S., & Nader, K. (1990). Children's exposure to violence and traumatic death. *Psychiatric Annals*, 20(6), 334-344.
- [17]. Ridge, T. (2009). Living with poverty: a review of the literature on children's and families' experiences of poverty.
- [18]. Ridge, T & Millar, J. (2001). Families, poverty, work and care: a review of the literature on lone parents and low-income couple families with children: a report of research carried out by the Centre for the Analysis of Social Policy at the University of Bath on behalf of the Department for Work and Pensions.
- [19]. Radford, L, et al (2011). Child abuse and neglect in the UK today. London, NSPCC.
- [20]. Scott, S., Knapp, M., Henderson, J., & Maughan, B. (2001). Financial cost of social exclusion: follow up study of antisocial children into adulthood. *Bmj*, 323(7306), 191.
- [21]. Seligman, L. D., Ollendick, T. H., Langley, A. K., & Baldacci, H. B. (2004). The utility of measures of child and adolescent anxiety: a meta-analytic review of the revised children's manifest anxiety scale, the state-trait anxiety inventory for children, and the child behavior checklist. *Journal of Clinical Child and Adolescent Psychology*, 33, 557-565.