

# Adults' Explanations for Intimate Partner Violence During Childhood and Associated Effects

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**Objectives:** Exposure to intimate partner violence (IPV) is known to challenge children's optimal development. This study sought to associate participants' beliefs about IPV held during childhood with their adjustment as adults, and to compare their beliefs from childhood to their beliefs in early adulthood. **Method:** A nationally representative sample of 703 Swedish young adults reported on their past and present beliefs about the causes of their parents' IPV. Standardized measures assessed their mental health (anxiety, depression, and traumatic stress symptoms) and the quality of their relationships as adults. **Results:** The most common explanations for IPV were that the perpetrator suffered from physical or mental illness, had relationship problems, or was distressed. Participants were less likely to blame themselves for IPV or to believe that the perpetrator was cruel when they were adults, compared to their reports of themselves as children. Women were more likely to attribute mental or physical illness as the cause of the perpetrator's IPV. Childhood beliefs that the perpetrator was debilitated (from mental illness or substance abuse) and cruel (took pleasure in violence and/or despised the child) were associated with greater mental health problems and poorer relationship quality in adulthood. **Conclusion:** Evaluation of children's harmful beliefs about IPV could be useful in adapting intervention services aimed at ameliorating negative personal causal attributions. © 2016 Wiley Periodicals, Inc. *J. Clin. Psychol.* 73:652–668, 2017.

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Intimate partner violence (IPV), defined as the presence of physical, sexual, or psychological abuse by a current or former partner, is a global phenomenon observed in a wide range of cultures (Abramsky et al. 2011). Estimates suggest that approximately 275 million children worldwide are exposed to IPV each year (UNICEF, 2006). Research from the United States and Europe consistently connects such exposure to problematic physical, psychological, emotional, and behavioral responses in childhood (e.g., El-Sheikh, Cummings, Kouros, Elmore-Staton, & Buckhalt, 2008; Graham-Bermann, Gruber, Girz, & Howell, 2009; Graham-Bermann, Castor, Miller, & Howell, 2012; Holmes 2013a,b; Kitzmann, Gaylord, Holt, & Kenney, 2003; Miranda, de la Osa, Granero, & Ezpeleta, 2011) with some consequences, such as depression and aggression in intimate relationships, lasting into adulthood (e.g., Cater, Andershed, & Andershed, 2014; Dube, Anda, Felitti, & Williamson, 2002; O'Leary, Tintle, & Bromet, 2014; Roberts, Gilman, Fitzmaurice, Decker, & Koenen, 2010; Russell, Springer, & Greenfield, 2010).

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Research on children exposed to IPV shows that after such exposure, many children report higher levels of threat and self-blame, which in turn are related to adjustment problems (Fosco, DeBoard, & Grych, 2007; Grych, Fincham, Jouriles, & McDonald, 2000; Miller, Howell, & Graham-Bermann, 2014).

In studies of general public opinion about the causes of IPV, adults typically identify substance use, relational/communication problems, and perpetrator mental health problems (Klein, Campbell, Solder, & Ghez, 1997; Worden & Carlson, 2005). Studies concerning beliefs about the causes of IPV with adult respondents, however, have not explicitly focused on adults who were exposed to IPV as children. As such, little is known about what those exposed to IPV as children believe caused violence in their family system. The present study documents adults' explanations for IPV held as a child and explanations held as an adult, and then associates those beliefs with adults' mental health and relationship quality.

### *Conceptualizations of IPV and IPV Perpetrators*

Researchers have suggested a variety of explanations for IPV perpetration, from social learning theory via the intergenerational transmission of violence, to mental illness, or to male-dominated societal structures and socialization practices that teach men and women gender-specific roles of superiority and subordination (Crane, Hawes, Devine, & Easton, 2014; Fritz, Slep, & O'Leary, 2012; Jasinski, 2001; Riggs, Caulfield, & Street, 2000). However, no one theory has yet found enough empirical support to provide consensus among researchers, partly because of the considerable variations found between perpetrators, family structures, and patterns of violence within relationships.

Given the heterogeneous profile of violent offenders, researchers have attempted to distinguish meaningful groups based on motivations for the abuse and demographic factors, personality, and mental health characteristics. Summarizing studies using rational deductive and empirical (cluster analysis) approaches, Holtzworth-Monroe and Stuart (1994) and others identified three basic subtypes of men who perpetrate IPV with categories that represent differences in the elements of personality, psychopathology, substance abuse, interpersonal attachment styles (dependency), and/or violence profiles (see also Hamberger & Phelan, 2006; Holtzworth-Monroe & Meehan, 2004; Holtzworth-Monroe, Meehan, Herron, Rehman, & Stuart, 2000; Lohr, Bonge, Witte, Hamberger, & Langhinrichsen-Rohling, 2005).

One category of abusers, labeled "Family Only," accounts for approximately 50% of abusive individuals who typically engage in the least severe and least frequent violence. They are less likely to hold a criminal record or to abuse substances but have more difficulty in processing problems and communicating in intimate relationships than other types of violent offenders. It is clear that these individuals resort to the use of physical force rather than negotiation to resolve conflicts with an intimate partner.

The second type (about 20%), labeled "Borderline Dysphoric," is characterized as having features of borderline personality, such as fearing abandonment, being jealous, emotionally volatile, and dependent. For this group, the violence is moderate with some partner injury, sexual assault, and arrest, but these abusers may present the highest risk of stalking, violence upon separation or suicide homicide.

The "Generally Violent-Antisocial" group (approximately 30%) is the most dangerous: This group has the highest number of arrests, the highest frequency and severity of violence, including concomitant sexual assault and child abuse, and is most likely to perpetrate violence and injure individuals outside of the home. This last category appears to be the most dangerous, frequent, and injurious to others, thus potentially having the greatest effect on children.

Beyond relationship problems, mental health, and personality issues, alcohol consumption has been associated with increased risk for all forms of interpersonal violence, including IPV (Foran & O'Leary, 2008; Klostermann & Fals-Stewart, 2006; O'Leary & Schumacher, 2003). Still, the extent to which there is a causal relationship between alcohol consumption and IPV remains unclear. Caetano, Schafer, and Cunradi (2001) suggest that heavy drinking and violence have common predictors, such as impulsivity, or that some people consciously use alcohol as an excuse for violent behavior. Children's assumptions about such connections and their

implications have, to date, gained little attention from researchers, yet as primary eyewitnesses to IPV in the home, they may have critical insight into the mechanisms through which IPV occurs.

### *Children's Explanations for IPV*

Attribution theory posits that explanations for why something has happened can serve to provide a sense of safety and security after unexpected and potentially traumatic events (Weiner, 1985). However, the converse is also true—that beliefs after stressful events can be negative and create uncertainty and a sense of helplessness (Kelley, 1973). Studies of adults' exposure to adverse events, such as IPV, have related negative explanations of events with greater behavioral and adjustment problems. For example, several studies have shown an interaction between traumatic events, negative attributions, and subsequent levels of distress (DePrince, Chu, & Pineda, 2011; Zinzow & Jackson, 2009).

While much research has examined the causes of IPV perpetration, less is known about children's understanding of the violence they witness in their home. Social cognitive models (Bandura, 1986; Crick & Dodge, 1994; Huesmann, 1997) theorize that behaviors are learned through the process of modeling and reinforcement from influential sources, such as parents. When children witness their parents use aggressive behaviors towards others, they may develop beliefs that the use of such aggression is a legitimate and effective means of achieving a desired outcome. These maladaptive beliefs about violence typically develop during the early childhood years and become more salient over time (Giles & Heyman, 2003).

Repeated exposure to violence may reinforce an internal set of beliefs, knowledge structures, and expectations about relationships that increase the likelihood of future aggressive behavior (Fosco et al., 2007). One qualitative study found many children believed marital conflict took place because the perpetrator lost control or was angry, while others said the victim provoked the perpetrator, or believed the perpetrator was unhappy, mean, or jealous (DeBoard-Lucas & Grych, 2011). Thus, studies of children's evaluations allude to a range of causes children might attribute to IPV, yet little empirical research exists in this domain. Further, there are no studies of attributions to IPV that employ sample of Swedish adults.

One study of preschoolers evaluated their attitudes and beliefs about violence and measured the extent to which young children held deleterious beliefs concerning the acceptability of violence in the family (Howell, Miller, & Graham-Bermann, 2012). They found that about half of the children exposed to IPV believed that most families have a lot of fighting and about 25% believed that they themselves were to blame, while another 25% felt that fighting was the only way to solve a problem. Although children may construct a number of maladaptive beliefs about their parents' violence, other research has focused on children's perceptions of threat and self-blame (Grych, 1998). That is, the extent to which children appraise situations as fearsome (threat) and blame themselves for the violence predicted poor child and adolescent adjustment (Ablow, Measelle, Cowan, & Cowan, 2009; Kim, Jackson, Conrad, & Hunter, 2008; McDonald & Grych, 2006; Miller et al., 2014).

Maladaptive beliefs about violence are linked to ongoing adjustment and relationship difficulties during adolescence and young adulthood. For example, children who witness IPV are more likely to engage in violence in dating relationships, to condone violence and view relationship aggression as justifiable and common (Kinsfogel & Grych, 2004; Sternberg, Baradaran, Abbott, Lamb & Guterman, 2006). Other studies have related maladaptive beliefs instilled by dysfunctional family members in childhood to depression, anxiety, and distress in adulthood (Garber & Hilsman, 1992; Kendall & Chansky, 1991; Rosen, Milich, & Harris, 2007).

In all, there is substantial evidence to suggest that children commonly hold maladaptive beliefs about IPV and that such beliefs are related to poor adjustment in both the short term and the long term. The majority of research to date, however, has been limited to beliefs about the *results* of conflict and has not examined *why* children think violence occurs. Further, to our knowledge, no research has examined how adults reported beliefs about violence might vary from childhood to adulthood.

### *Gender Differences in Perceptions of IPV*

Perceptions of violence are context-embedded, with the gender of the perpetrator, the victim, and the child potentially influencing how violence is perceived (Fosco et al., 2007; Grych 1998). Children may identify with either the aggressive parent (typically the male) or the victim of violence (typically the female) depending on their sex, thereby providing a partial explanation for gender differences in perceptions of IPV. While research findings are mixed, some studies suggest that boys are more attuned to physical aggression (Kinsfogel & Grych, 2004; Markowitz, 2001), whereas girls are more sensitive to threats involved in violence and more likely to blame themselves for the violence (Grych, 1998; Miller et al., 2014). Further, a study of school-aged children reported stereotyped gender roles in families with IPV, such that boys were more likely than girls to believe that the father holds all the power in the family, including the right to be violent (Graham-Bermann & Brescoll, 2000).

Simmons (2013) conducted a qualitative study of the perceptions of adult victims of violent crimes and found marked gender differences in the reports of their experiences. Half of the men (50%) ascribed positive outcomes to being exposed to a violent event compared to a much smaller percentage of the women (14%). For example, some male participants felt that the violence was an impetus to change their life for the better. Conversely, women (57%) were more likely than men (14%) to report that the event changed their life for the worse. Women were also more likely than men to describe the event as traumatic (100% women versus 21% of men) and scary (Simmons, 2013).

Empirical work has also illuminated gender differences in the short and long-term effects of IPV exposure in childhood. In the immediate aftermath of IPV, exposure appears to be especially potent for girls' depression, perhaps because of other sociocognitive risk factors, such as high levels of threat and self-blame (Kennedy, Bybee, Sullivan, & Greeson, 2009). Some studies find that after exposure to violence events in childhood women are less resilient than men as adults (Campbell-Sills, Forde, & Stein, 2009). For example, Afifi and colleagues (2009) evaluated data on adults exposed to IPV in childhood and found that women were significantly more likely to develop anxiety disorders, while men were more likely to develop disruptive behaviors and substance use problems. These findings suggest that research needs to further disentangle possible gender differences in childhood beliefs about IPV, with particular attention to the stability of such beliefs over time and possible gendered associations between childhood beliefs and later adjustment.

### *Current Study*

This study aims to determine what are the past and present explanations that young adults give as the cause of the IPV they witnessed in their family during childhood; whether there are gender differences in their beliefs concerning the causes of IPV; whether the explanations they recall as a child as the cause of IPV are different from the explanations as adults; whether their explanations are related to the amount of IPV to which they were exposed, and to explore which explanations are associated with mental health and relationship problems in adulthood.

Based on the literature, it is expected that participants' explanations will comprise a broad range of possible reasons for IPV and that

- childhood beliefs will be more egocentric and thus self-blaming than beliefs held as an adult.
- We hypothesize that explanations related to the parents' relationship/communication difficulties and mental health problems will be more prominent in adulthood than in childhood.
- We also expect gender differences in beliefs such that females will endorse feeling more threatened and blamed by IPV than will males.
- Violence that is ascribed to cruelty, such as sadism or being hateful, will be associated with greater adjustment and relationship problems in adulthood. More specifically, those who cite cruelty as an explanation for IPV will have greater anxiety, depression, traumatic stress, and aggression in their adult relationships than those without such ascriptions.

- Similarly, explanations related to the perpetrator's having a physical or mental illness, distress, or misusing drugs or alcohol will be related to greater adjustment problems and relationship aggression in adulthood, relative to those who did not endorse such explanations.
- Finally, there will be no significant contribution to adult mental health problems or relationship aggression when the violence in the home was believed to be caused by the perpetrator's having interpersonal communication problems.

## Method

### *Participants*

A large, nationally representative sample of 2,500 Swedish individuals reported on childhood experiences of abuse and neglect, as well as psychosocial functioning in young adulthood, known as the Retrospective Study of Young People's Experiences (RESUMÉ; Cater et al., 2014). The RESUMÉ included young adults aged 20 to 24 years (mean [ $M$ ] = 22.15 years, standard deviation [ $SD$ ] = 1.38). The present study comprises a subsample of those 703 young adults who had endorsed childhood exposure to IPV. This represents 28% of the larger sample. They reported a great variety of experiences with IPV during childhood, ranging from witnessing parental verbal conflict to witnessing threats or acts of parental violence using a knife, gun, or other weapon. More than half (57%) of this subset of participants was females.

### *Procedure*

Data collection occurred between March 2011 and December 2011 following approval by the regional ethical review board in Uppsala, Sweden. The recruiting, interviewing, and administration of the questionnaire were conducted by a Swedish survey and marketing company commissioned, and the 30 interviewers that were involved in the present study were uniformly trained on the present study protocols by the research team. Interviewers were selected based on previous experience in conducting interviews on sensitive topics (e.g., abuse, neglect, criminality) and were no younger than 30 years of age.

Study participants were randomly drawn from the Sweden national inhabitant register and contacted via telephone. Random selection was constrained to proportional draws based on gender and county of residence. Once informed of the background and purpose of the study, interested individuals selected a time and location to complete the survey. Most participants chose to be interviewed at home, in a public place, such as a library, or in the office of the company responsible for conducting the interviews.

Interviewers gathered basic demographic information about the participant via a brief, structured interview. Then the participant privately completed an electronically administered self-report questionnaire about their history of violence exposure, as well as their current psychosocial functioning and possible aggressive behaviors. The interviewer was nearby and available should the participant have any questions. Upon finishing the questionnaire, participants were debriefed by the interviewer and provided with mental health resources. Participants were compensated with a voucher that was valid at a variety of stores and attractions in Sweden.

### *Measures*

*Exposure to domestic violence.* Childhood exposure to intimate partner violence was measured using an adapted version of the Childhood Exposure to Domestic Violence Scale (Edleson, Shin, & Johnson Armendariz, 2008). This scale has been standardized and has demonstrated good internal reliability, with a coefficient alpha of ( $\alpha$ ) .78 (Edleson et al., 2008). The original scale was modified for the specific purposes of this large-scale survey. Three modifications were made: First, at the beginning of each question, "When you were a child" was added to cue participants to respond based on childhood exposure. Second, in questions 2–10, "mom's partner" was altered to "someone (one of your parents or someone else)" and the word "mother" was altered to "someone who took care of you (your other parent or someone else)."

Finally, the original follow-up-question was removed and included as a part of the main text of the items. As an example, the original question “How often has your mom’s partner threatened to use a knife, gun, or other object to hurt your mom?” Plus follow-up questions were altered in the present study to: “When you were a child, how often did someone (one of your parents or someone else) threaten to use a knife, gun or other object to hurt the person who took care of you (your other parent or someone else), and you saw or heard what happened and the consequences of that (e.g. someone got hurt, something broke, the police came)?” For each item, participants reported whether it occurred (1 = *never*, 2 = *sometimes*, 3 = *often*, 4 = *almost always*). In the present study, internal reliability for the scale was ( $\alpha$ ) .87.

*Beliefs as to why the violence occurred.* After completing the above questions regarding IPV in the family, respondents were asked, “When it happened, what did you think could be the cause of what you experienced?” Each question began with a stem that asked whether “the person or persons did so because . . .”. Response options (*yes/no*) were completed for each belief based on when the participant was a child. Next, the participants were asked to answer the same items for their current beliefs, as an adult. There were 12 items about possible beliefs: (a) the perpetrators had financial problems; (b) they were concerned or were very stressed about something; (c) they had a physical illness, disability, mental health problem, or were not feeling well; (d) they had alcohol or drug problems; (e) I deserved it, it was my fault; (f) they had problems in their own relationships; (g) they did it to be mean; (h) they did not like me or despised me; (i) they liked to do it, for pleasure or their own satisfaction; (j) they felt lonely; (k) to punish or threaten me; and (l) for some other reason.

*Symptoms of anxiety and depression.* Symptoms of anxiety and depression were assessed using the Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith, 1983), which is a questionnaire designed for nonclinical populations. HADS comprises 14 items, of which 7 measure anxiety and 7 measure depressive symptoms. For each item, participants report the extent to which they have experienced that symptom in the past week (0 = *not at all*, 1 = *not very often*, 2 = *quite often*, 3 = *very often indeed*). For the seven HADS items that measure anxiety, the internal reliability ( $\alpha$ ) was .79 and for the seven HADS items that measure depression, the internal reliability ( $\alpha$ ) was .69.

*Posttraumatic stress (PTS) symptoms.* The Revised Impact of Event Scale (IES-R; Weiss & Marmar, 1996; Weiss, 2007) was used to measure PTS symptoms. The IES-R comprises 22 questions designed to assess the presence and severity of PTS symptoms during the last 7 days. The questions were developed to correspond to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR; American Psychiatric Association [APA], 2000) criteria for posttraumatic stress disorder. As such, the scale does not include symptoms of negative cognition and mood identified as a symptom cluster in the most recent diagnostic manual, the DSM-5 (APA, 2013). The IES-R examines the symptom clusters of re-experiencing, avoidance, and arousal. Participants rate each item on how often the symptom was experienced, from 1 (*not at all*) to 5 (*extremely often*). Items were recoded as 0 (*not at all*) to 4 (*extremely often*). In the present study, the internal reliability ( $\alpha$ ) for the total scale was .96.

*Physical aggression.* To measure the respondents’ aggression, the Physical Aggression subscale from the The Buss–Perry Aggression Questionnaire (AQ; Buss & Perry, 1992) was used. The Physical Aggression subscale comprises nine items, such as “If somebody hits me, I hit back” and participants ranked each statement on a scale ranging from 1 (*extremely uncharacteristic of me*) to 7 (*extremely characteristic of me*). Internal reliability was  $\alpha = .81$  for the subscale.

*Relationship aggression.* To measure aggression within participants’ adult relationships the Romantic Relational Aggression subscale of the Self-Report of Aggression and Social Behavior Measure (SRASBM; Morales & Crick 1998; see also Murray-Close et al., 2010) was

used. This self-report subscale comprises five items about proactive and reactive functions of relationship aggression, such as “If my romantic partner makes me mad, I will flirt with another person in front of him/her”). The respondents ranked each statement on a scale ranging from 1 (*extremely uncharacteristic of me*) to 7 (*extremely characteristic of me*). In this study, internal reliability for the subscale was  $\alpha = .73$ .

### *Analysis Plan*

Descriptive statistics on adults' beliefs of IPV causes (in their childhood and now) were provided to gain important information about prevalence. Chi-square analyses were used to assess differences in adults' reported explanations for IPV in childhood versus their explanations in young adulthood. The magnitude of effects were determined using Phi, where the value of .1 is considered a small effect, .3 a medium effect, and .5 a large effect. Gender differences in explanations at both time points were analyzed using chi-square.

To ascertain what predicts the three mental health outcome scales (Traumatic Stress Symptoms, Anxiety, and Depression), separate hierarchical regression analyses were used and two models tested. In the first model, IPV and sex were entered. In the second model, IPV and sex were entered in the first step, and the 11 explanations held during childhood were entered in the second step. When predicting the outcomes of Physical Aggression, and Romantic Relationship Aggression, hierarchical regression analyses tested the same two models. In this way, the distinct contributions of violence and sex and explanations to mental health and aggression outcomes could be determined.

## Results

Participants' exposure to violence was relatively mild, as indicated by the Childhood Exposure to Domestic Violence Scale score ( $M = 13.69$ ,  $SD = 4.315$ , range = 11–40). Their scores on the adult mental health scales varied considerably but on average indicate mild to moderate levels of anxiety ( $M = 6.371$ ,  $SD = 4.107$ , range = 0–21), depression ( $M = 3.378$ ,  $SD = 2.865$ , range = 0–18), and traumatic stress symptoms ( $M = 16.149$ ,  $SD = 18.255$ , range = 0–88). The mean physical aggression score ( $M = 2.236$ ,  $SD = .9361$ , range = 1–6.67) indicates that the tendency to use physical aggression was somewhat characteristic of these participants. However, scores indicate infrequent use of interpersonal aggression in their own current romantic relationships ( $M = 1.654$ ,  $SD = .8366$ , range = 1–6.20).

### *Beliefs as a Child*

The most commonly reported belief held during childhood as to why IPV occurred was that the perpetrator had interpersonal relationship problems (56%; see Table 1). The second most common explanation was that the perpetrator was distressed or concerned about something (47%). Of the participants, 15% held childhood beliefs that the violence was due to the perpetrator's physical or mental illness or disability, and an equal percentage believed that it was due to the misuse of drugs and/or alcohol. While fewer participants thought the violence was due to financial problems or loneliness, others believed, as children, that the violence occurred because the parent despised them, the violence was their fault, the perpetrator did it to be mean, or took pleasure or satisfaction in being violent, or that the violence was done to threaten or punish them as a child.

### *Beliefs as an adult*

When citing reasons for IPV through the lens of childhood and adulthood, there is remarkable continuity in the belief that the perpetrator had his or her own relationship problems (63% reported as adults, as shown in Table 1). Still, a significant difference was found in every case when comparing explanations given as a child to explanations given as an adult. For example, adults were more likely to report that the perpetrator had relationship problems and/or experienced distress. They were more likely to assert beliefs as adults that the violence was

**Table 1**  
*Beliefs as a Child and as an Adult as to Why Perpetrator(s) was/were Violent and the Significance of Differences in these Beliefs*

Belief	As a child	As an adult	Chi-square	Effect size (Phi)
	%	%		
He/She/They had relationship problems	56	63	396.33***	.75
He/She/They were distressed	47	55	349.48***	.71
He/She/They had physical illness, disability or mental health problems and felt unwell	15	22	399.14***	.75
He/She/They had alcohol or drug problems	16	22	428.16***	.78
He/She/They despised me	6	1	80.42***	.34
He/She/They had financial problems	14	20	332.23***	.69
He/She/They did it to be mean	10	3	158.25***	.47
He/She/They were lonely	8	14	263.05***	.61
I Deserved it, it was my fault as a child	7	1	95.03***	.37
He/She/They took pleasure or satisfaction of it	4	2	110.73***	.40
He/She/They did it to punish or threaten me as a child	4	2	216.96***	.56
Other	9	8		

\*\*\*  $p < .000$ .  $N = 703$ , Bonferroni correction for 11 comparisons sets significance level at  $< .005$ .

due to the perpetrator’s mental or physical illness or disability or to the misuse of drugs and alcohol than their reported beliefs as children. They were also more likely to blame financial problems and the perpetrator being lonely when they were adults than when they were children. Conversely, as adults they were significantly less likely to deem themselves at fault or believe they were despised. However, explanations related to the cruelty of the perpetrator (being mean, for pleasure, and to punish or threaten the child) were also significantly diminished in adulthood.

*Gender Differences in Beliefs*

While the effects were small to moderate, there were significant differences in the extent to which males and females recalled endorsing particular explanations as children. Given 11 comparisons, a Bonferroni correction set the significance level at .005. Here, females were more likely to hold the belief that IPV was caused by physical or mental illness (chi-square = 22.957, degree of freedom [ $df$ ] = 1,  $p = .000$ ; Phi = .18). Of the participants, 8% of males and 21% of females believed this as a child. Females (8%) were more likely than males (3%) to explain as a child that violence took place because the perpetrator despised the child (chi-square = 7.994,  $df = 1$ ,  $p = .005$ ; Phi = .11). No gender differences that reached significance were found for IPV explanations as a child when the explanation was due to self-blame, money problems, stress, substance abuse, relationship problems, IPV done for pleasure, to punish the child, or for being lonely.

There was only one gender difference in the endorsement of explanations given as an adult. As with childhood explanations concerning the perpetrator’s mental or physical illness as the cause of IPV, significantly more females (30%) than males (12%) held those beliefs as adults (chi-square = 31.521,  $df = 1$ ,  $p = .000$ ; Phi = .212). Here, women were more than twice as likely to give this explanation than were men. There were no other gender differences in explanations as an adult that reached significance (at the  $p = .005$  level). Thus, it appears that men and women are more alike than different in their explanations for IPV during childhood.



### *Linking Childhood Beliefs to Adult Mental Health*

Three separate hierarchical regression analyses using two models were conducted to predict to traumatic stress symptoms, anxiety, and depression during adulthood. The first model tested the effects of IPV and sex on outcomes and the second model added the explanations given during childhood as predictors (see Tables 2 and 3). Both exposure to IPV and sex were significant contributors to traumatic stress symptoms in the first model and remained significant in the second model. Females had higher traumatic stress mean scores than did males (females  $M = .561$ ,  $SD = .752$ ; males  $M = .294$ ,  $SD = .506$ ),  $t(df\ 1,702) = 10.112$ ,  $p = .000$ . Childhood explanations that IPV was due to the perpetrator's mental or physical illness, use of alcohol or drugs, and cruelty (taking pleasure in violence) were also significant predictors. Together these variables accounted for 21.2% of the variance in traumatic stress symptoms with the explanations adding approximately 10% of variance in the second model.

Both IPV and sex significantly predicted anxiety scores in the first model (females  $M = 5.935$ ,  $SD = 4.052$ ; males  $M = 4.626$ ,  $SD = 3.397$ ),  $t(df\ 1,702) = 8.778$ ,  $p = .000$ . Physical or mental illness and use of alcohol or drugs by the perpetrator were additional predictors in Model 2. In all, 9% of the variance in anxiety was accounted for with these variables.

Only IPV significantly predicted depression in the first model. A number of childhood explanations were significant contributors to the variance in depression in Model 2. In this model, a lack of financial problems, physical and mental illness, and cruelty items (took pleasure in violence, was violent to punish me) added to the variance, although only 5% was accounted for with the variables in Model 2.

### *Linking Childhood Beliefs to Physical Aggression and Romantic Relationship Aggression*

Physical Aggression during adulthood was predicted by both IPV and sex with females reporting less physical aggression and those exposed to greater IPV showing more physical aggression as adults in both Models 1 and 2 (females  $M = 2.022$ ,  $SD = 0.813$ ; males  $M = 2.528$ ,  $SD = 1.013$ ),  $t(df\ 1,702) = 7.092$ ,  $p = .000$ . The only explanation that contributed significantly to variance in general adult physical aggression was the childhood belief that the perpetrator took pleasure in being violent. Sex, but not IPV, predicted to the extent of aggression in adult romantic relationships in Models 1 and 2. Here, women had higher aggressive in romantic relationships scores than did men (females  $M = 1.775$ ,  $SD = 0.922$ ; males  $M = 1.488$ ,  $SD = 0.671$ ),  $t(df\ 1,702) = -4.785$ ,  $p = .000$ . The childhood belief that IPV was due to the use of alcohol or drugs also predicted greater aggression in romantic relationships in adulthood.

## Discussion

This study offers important insight into the patterns of beliefs that young adults endorse during childhood and adulthood when attempting to make sense of the violence they witnessed in the home during their formative years. Specifically, more than half of participants (56% as a child, 63% as an adult) ascribed the violence to interpersonal issues between the adults in their home. These explanations are in concordance with the work of Holtzworth-Monroe and others who describe the most common type of abuser (approximately 50%) as having difficulty in processing problems and communicating in intimate relationships (Holtzworth-Monroe & Stuart, 1994).

The second most common explanation for IPV was that the perpetrator was distressed or concerned about finances (47% believed this as a child, 55% as an adult). This explanation relates to research on beliefs about the general acceptability of violence and violence against women. Specifically, research shows that adult perpetrators may hold gender-specific roles of superiority and subordination (Jasinski, 2001) and children in families with IPV may hold gender stereotypes and believe that violence is an appropriate way to resolve conflict (Graham-Bermann & Brescoll, 2000). Thus, the belief that IPV occurred because of distress or financial concerns may be related to a general normalization of the aggressor's actions.

Table 2  
Pearson Correlation Coefficients and Their Significance Between Beliefs as a Child and Adult Functioning

Variable	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
1. IPV	—														
2. PTSS SX <sup>a</sup>	.279***	—													
3. Anxiety <sup>d</sup>	.137***	.459***	—												
4. Depression <sup>a</sup>	.129***	.336***	.491***	—											
5. Aggression <sup>b</sup>	.132***	.178***	.091*	.093*	—										
6. Romantic aggression <sup>b</sup>	.033	.263***	.253***	.174***	.268***	—									
Explanations:															
7. Financial	.103**	.051	.073	-.059	.008	.053	—								
8. Distress	-.038	-.023	-.003	-.035	-.040	-.080*	.225***	—							
9. Illness	.150***	.291***	.106**	.150***	.015	.094*	.147***	.076	—						
10. Alcohol/drugs	.169***	.192***	.182***	.124**	.073	.087*	.152***	-.014	.194***	—					
11. My fault	.168***	.145***	.038	.094*	.006	.002	.103**	.075**	-.006	.037	—				
12. Relationship probs	-.044	-.069	-.055	-.048	-.024	.032	.023	-.016	.001	-.106**	-.069	—			
13. To be mean	.023***	.218***	.104**	.159***	.032	.085*	-.016	-.094*	.062	.006	.222***	.086*	—		
14. Despised me	.138***	.186***	.026	.113**	-.012	-.048	.010	.010	.017	.031	.501***	-.038	.386***	—	
15. Pleasure	.215***	.228***	.136***	.119**	.045	.100**	.056	-.087*	.110**	.106**	.100**	-.032	.363***	.255***	—
16. Lonely	.182***	.130**	.103**	.065	.004	.059	.204***	.139***	.184***	.122**	.162***	.060	.099**	.128**	.080*
17. To punish	.121**	.174***	.091*	.089*	.014	-.013	.020	-.022	.050	.087*	.369***	-.077*	.328***	.450***	.118**

Note. IPV = intimate partner violence; PTSS SX = Post Traumatic Stress Symptoms.

<sup>a</sup>For these measures, higher scores indicate poorer functioning.

<sup>b</sup>Higher scores indicate more aggression.

\* $p < .05$ . \*\* $p < .01$ . \*\*\* $p < .001$ . N = 703.

**Table 3**  
*Summary of Hierarchical Regression Using Recalled Childhood Explanations to Predict Mental Health and Relationship Qualities*

	PTSD symptoms		Anxiety		Depression		Aggression		Romantic aggression	
	$\beta$	<i>t</i>	$\beta$	<i>t</i>	$\beta$	<i>t</i>	$\beta$	<i>t</i>	$\beta$	<i>t</i>
Model 1	F = 43.126***		F = 21.030***		F = 6.005**		F = 37.100***		F = 10.505***	
IPV	.262***	.119**	.119***	.128**	.128**	.157***	.157***	.157***	.018	.018
Sex	.180***	.196***	.196***	.013	.013	-.281***	-.281***	-.281***	.168***	.168***
	R <sup>2</sup> = .110		R <sup>2</sup> = .057		R <sup>2</sup> = .017		R <sup>2</sup> = .096		R <sup>2</sup> = .029	
Model 2	F = 14.272***		F = 5.419***		F = 3.766***		F = 6.651***		F = 3.007***	
IPV	.162***	.062	.062	.082*	.082*	.150***	.150***	.150***	.025	.025
Sex	.116**	.163***	.163***	-.017	-.017	-.281***	-.281***	-.281***	.157***	.157***
Financial problems	-.021	-.041	-.041	-.091*	-.091*	.003	.003	.003	.030	.030
Distressed	-.014	.056	.056	-.023	-.023	.011	.011	.011	-.040	-.040
Physical/mental ill	.209***	.085*	.085*	.101**	.101**	.008	.008	.008	.063	.063
Alcohol or drugs	.101**	.093*	.093*	.078*	.078*	.009	.009	.009	.104**	.104**
My fault	.038	.034	.034	.005	.005	.071	.071	.071	.049	.049
Relationship probs	-.033	-.018	-.018	-.050	-.050	-.036	-.036	-.036	.025	.025
To be mean	.061	.084	.084	.069	.069	-.016	-.016	-.016	.031	.031
Despised me	.054	.022	.022	-.015	-.015	-.057	-.057	-.057	-.014	-.014
Took pleasure	.099**	.040	.040	.109**	.109**	.082*	.082*	.082*	.013	.013
Lonely	.019	-.001	-.001	-.000	-.000	-.010	-.010	-.010	.002	.002
Punish me	.044	.000	.000	.094*	.094*	.050	.050	.050	.042	.042
	R <sup>2</sup> = .212		R <sup>2</sup> = .093		R <sup>2</sup> = .046		R <sup>2</sup> = .111		R <sup>2</sup> = .054	

Note. IPV = interpersonal violence; PTSD = posttraumatic stress disorder.  
 \*p < .05. \*\*p < .01. \*\*\*p < .001. N = 703.

Less common, but still prevalent, is the belief that IPV was due to the perpetrator's being debilitated in some way (15% believed in childhood, 22% in adulthood), including physical or mental illness, disability, or the use of alcohol or drugs. Such findings may represent what Holtzworth-Monroe and colleagues (2004) described as "Borderline Dysphoric" abusers who have serious mental health problems and show the Axis I psychopathology described by Crane et al. (2014). They comprise approximately 20% of abusers. This focus on perpetrator characteristics is in line with the work of DeBoard-Lucas and Grych (2011), who found that about 30% of children blamed the violence on such aspects of the abuser. Further, while the literature on the disinhibiting function of alcohol in relation to IPV perpetration is strong and convincing (Caetano et al., 2001; Foran & O'Leary, 2008), it has not been shown to be the cause of IPV, as many of our respondents reported. Thus, this is the first study to explicitly link substance use with violence based on the reports of those who witnessed IPV in the home as children.

A smaller, but no less deleterious, belief was that the violence was due to the cruelty of the perpetrator, a belief held by 18% of the sample during childhood. This included beliefs that the perpetrator was intentionally mean to the child, despised, punished, or threatened the child and took pleasure in the violence. The "Generally Violent–Antisocial" group (approximately 30%) identified by Holtzworth-Monroe and colleagues (2004) is considered the most abusive and dangerous and most closely matches beliefs about cruelty identified in our sample. In this study, the respondent believed that he or she was purposefully blamed for the violence and hated. While many respondents were less likely to endorse these beliefs as adults (1%–3% vs. 4%–15% believed as a child), a small proportion continued to believe that they were responsible in some way. There were also significant gender differences, with women twice as likely to endorse this explanation as men, perhaps reflecting Grych's (1998) and Miller et al.'s (2014) findings that girls are more attuned to threat and self-blame in violent situations than are boys.

These findings also provide important insight into how some explanations for IPV remain stable over time. Most significantly, both childhood and adulthood explanations were predominated by the belief that relationship problems were at the root of IPV. This continuity in using relational distress to explain violence may provide insight into the intergenerational transmission of violence, because youth who believe that conflict in relationships is followed by IPV may be more likely to use such violence when relationship difficulties inevitably arise.

There were also important differences in how individuals explained violence as children and as adults. Notably, adults were more likely to see the perpetrator's health problems or substance use as the cause for violence, suggesting that as adults, participants were able to take into consideration individual struggles that may contribute to interpersonal conflict rather than emphasizing environmental or relationship-based explanations. Further, adults were less likely to blame themselves for the violence, which indicates that, at least for the participants in this study, the deleterious belief that children are at fault for parental violence diminished over time. While this is an important and positive shift, it remains concerning that upwards of 15% of childhood explanations and 3% of adult explanations placed the child at fault for IPV.

### *Association of Beliefs to Adult Functioning*

As hypothesized, childhood explanations for the violence concerning perpetrator debilitation or dysfunction were related to significantly more mental health problems in young adulthood. Having a parent with a physical or mental illness has been associated with more anxiety, depression, and traumatic stress in other studies of children exposed to IPV (Graham-Bermann et al., 2009). Research on substance use and misuse in families with IPV also shows evidence of associated adjustment problems children (Dube et al., 2002). Our findings associate childhood explanations regarding such debilitation with traumatic stress, depression and anxiety in adulthood. Thus, findings of the present study reinforce the work of other researchers suggesting that there are differences in mental health problems depending on perceived causes of violence, although these differences could also be consequences of factual variations in the nature of the violence they witnessed or the presence of other risk factors not identified here. Nevertheless, these findings emphasize the potential influential and long-term impact of not only witnessing IPV in Sweden but also the explanations that children hold for why such violent events transpire.

Even though beliefs related to cruelty as the cause for violence were reported to be significantly less common in adulthood than in childhood, participants' beliefs that the perpetrator used violence in a cruel or sadistic manner or to punish the child were still related to greater mental health problems and aggression in adulthood. Such findings suggest the long-term negative effects of finding personal fault in the actions of others. Studies of children exposed to IPV show that they may be blamed for the violence in their families and that this violence is related to negative outcomes during childhood, e.g., to greater internalizing and externalizing behavior problems (Ablow et al., 2009; Kim et al., 2008). The present study's findings suggest that such beliefs held during childhood may have longer term consequences.

Our results extend these findings by illustrating that those who held beliefs related to cruelty had the worst problems as adults in areas of adjustment (anxiety, traumatic stress) and in the use of aggression as adults. Yet again, these associations could be related to other risk factors not evaluated here. Interestingly, there was no significant association between the childhood beliefs that violence was related to the perpetrator's relationship problems and any of the mental health problems examined in this study. This explanation seemed to be more realistic or normative because those who perpetrate IPV most certainly do have problems in their relationships (e.g., seeking to control others, difficulty in communication, use of violence tactics) and with managing their behavior while under stress.

The role of gender is salient—women had higher mean traumatic stress and anxiety scores than did men. These findings reflect those of other studies that show more negative effects on women than men as a result of being exposed to violence. Recall that Simmons (2013) reported women were three times more likely to perceive violent crime as scary and five times more likely to perceive violence as traumatic than were men. In the present study, women were less likely to use physical aggression than were men. These findings are not surprising because a number of studies have shown males to be more physically aggressive and model physical aggression in families exposed to IPV and females to be more sensitive threats (Graham-Bermann & Brescoll, 2000; Kim et al., 2008; Kinsfogel & Grych, 2004; Markowitz, 2001; Miller et al., 2014).

However, the present study found females more likely to be aggressive in their own adult romantic relationships and that this was not predicted by their exposure to IPV in childhood but was associated with their reports of parents' alcohol or drug abuse. These results are contrary to those of Afifi and colleagues (2009), who reported males to be more aggressive in interpersonal relationships after family violence exposure. Yet the measure of relationship aggression in the present study comprised mild forms of aggression, whereas other studies measured severe physical assaults.

### *Limitations*

While this study offers novel information about both childhood and adulthood explanations for IPV, there are limitations that should be considered when interpreting results. These include the retrospective nature of the study and the sole use of self-report data, both of which may confer some bias in responses. Cognitive processes also come into play in retrospective self-report, where the most extreme examples often are better remembered. Studies have shown that when the behavior in question is rare or impactful, as is childhood exposure to IPV, then it is more memorable and more easily and accurately recalled (Brown, 2002; Schwarz & Oyserman, 2001). Still, what is recalled may not represent the true state of affairs, especially over a long time period.

Also at issue is the role that psychopathology plays in influencing both how memories are created in the first place and later recalled. Maughan and Rutter (1997) describe how traumatic early experiences may be remembered differently than later occurring events (given the limits of a child's cognitive abilities) and may be shaded by the respondent's present mental health, such that depressed or traumatized individuals may be less able to recall or may avoid recalling particular events. Thus, the recall of traumatic events may be underreported. When Hardt and Rutter (2004) tested the validity of studies of adults' retrospective reporting of adverse childhood events, including various types of family violence, they found substantial false negatives (not reporting adverse events when they had happened) and few false positives. Still, while subject

to certain biases, retrospective self-report studies have the advantage of collecting information about multiple events in a timely manner and in assuring participants' confidentiality and anonymity.

This study did not evaluate other forms of mental health problems, such as personality disorders or provide formal diagnoses. While the measure of childhood exposure to IPV employed was normed on studies of adolescents, and thus lacks evidence of validity for the young adult population, it proved to be reliable in the present study. Further, the measure of traumatic stress was limited to the self-report of trauma symptoms. We did not assess or control for child maltreatment or other potentially traumatic or distressing events that may have occurred. Thus, we cannot ascertain the extent to which current problems in functioning were related just to IPV, to IPV plus other events, or to events beyond IPV. In addition, all analyses were associational; therefore we cannot infer cause and effect from these data.

Finally, having a second reporter for purposes of comparison might have improved validity in our study. Yet some studies comparing parent's reports to children's reports of adverse childhood events show that parents minimize negative events when compared to their children's reports (Fisher, Bunn, Jacobs, Moran, & Bifulco, 2011; Tajima, Herrenkohl, Huang, & Whitney, 2004). Still, other forms of corroboration would have been ideal but unfortunately were not available for the present study. Thus, future studies would do well to include measures that allow for diagnoses and gather data from multiple sources over time.

### *Clinical Implications*

Strengths of this study include identifying the kinds of explanations children give for the IPV in their families and evaluating their mental health sequelae in adulthood. Our findings suggest that attention should be paid to the care that children receive when IPV is first acknowledged or reported. The mental health problems and aggression associated with these different beliefs might have serious consequences in terms of the child's future adjustment; therefore, it appears to be important for clinicians to distinguish whether the child's explanations for violence are related to the perpetrator's debilitation, cruelty, or relationship problems and stress.

### *Directions for Future Research*

Clearly, longitudinal studies are needed to develop causal inferences and to account for additional adverse events in the life of the child. It would be useful to include the current partner and possibly other informants to create a more complete understanding of the adult respondent's functioning and relationships. The use of videotaped observations that interviewers code for relational patterns might provide stronger evidence of relationship qualities rather than the paper and pencil measures employed here. Further, open-ended questions regarding the explanations participant's held for the violence would be useful to develop a more detailed and nuanced understanding of how the participant interpreted violence during childhood and adulthood. While the present study gives a unique view of the experiences of a large number of Swedish young adults, research comparing these results with samples from other countries is needed to evaluate the extent to which the childhood beliefs and explanations for IPV are culture-specific or may have universal qualities.

### Conclusion

Children are more likely to blame themselves for violence than are adults. Beliefs related to cruelty and debilitation were associated with more adjustment problems in adulthood. Thus, attention should be paid to children's early causal explanations.

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