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Tesis doctoral

Experiencias maternas de violencia: Psicopatología y deterioro funcional en niñas, niños y adolescentes

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RESUMEN

La violencia contra las mujeres constituye una violación a los derechos humanos, un grave problema social y sanitario, que afecta no sólo la salud mental de las mujeres, sino que también el bienestar de sus hijas/os. **Objetivo**: estudiar la asociación entre la historia de violencia de las madres y los problemas de salud mental de sus hijas/os; y extender el conocimiento sobre el rol de factores individuales, familiares y contextuales en esta asociación. **Método**: los participantes fueron niñas, niños y adolescentes, y sus figuras parentales, consultantes de servicios primarios de salud mental. Se utilizaron entrevistas diagnósticas y otros instrumentos de evaluación para valorar y medir el funcionamiento de las/os niñas/os, la psicopatología, variables individuales, familiares y contextuales. Los análisis estadísticos fueron realizados a través de modelos de regresión múltiple, binominal-negativa y logística, así como de ecuaciones estructurales. **Resultados**: las niñas y los niños, cuyas madres han sufrido abuso en la infancia, violencia en la pareja o ambas experiencias de violencia, independientemente de la edad, mostraron serios problemas de conducta. Las/os niñas/os que han estado expuestas/os a violencia en la pareja y, también, han sufrido castigo físico por parte de sus padres/madres presentaron mayores problemas interiorizados. El castigo físico contra las/os niñas/os, los problemas de salud mental materna -malestar psicológico general y síntomas depresivos-, y la exposición de las/os niñas/os a eventos vitales estresantes mediaron la relación entre la historia materna de violencia y los problemas psicopatológicos de sus hijas/os. **Conclusiones**: los presentes hallazgos sugieren posibles objetivos de evaluación e intervención para familias que acuden a servicios de salud mental. Fortalecer los esfuerzos en la prevención de la violencia aparece como prioritario para mejorar la salud mental de las madres y sus hijas/os.

ABSTRACT

Violence against women constitutes a violation of human rights, a serious social and health problem that affects not only women's mental health, but also their own children's well-being. **Aim**: to study the association between mothers' history of violence and their offspring's mental health problems; and to extend the knowledge on the role of individual, family and contextual factors in this association. **Method**: participants were children and adolescents, and their parents, who accessed to mental health services. Diagnostic interviews and other instruments were used to assess children's functioning and psychopathology, individual, familiar and contextual variables. Statistical analyses were carried out through hierarchical multiple, negative-binomial and logistic regressions, as well as Structural Equation Models. **Results**: Girls and boys, whose mothers experienced childhood abuse, intimate partner violence or both violent experiences, regardless their age, showed serious conduct problems. Offspring who were exposed to intimate partner violence and also suffered physical punishment by parents showed higher internalizing problems. Physical punishment against children, mothers' mental health problems -global psychological distress and depressive symptoms-, and children's exposure to negative life events mediated the relationship between mothers' history of violence and their offspring's psychopathology. **Conclusions**: Current findings point out potential targets of assessment and intervention for families seeking help in mental health services. Strengthening our efforts to prevent violence appears as a priority for improving both mothers' and their offspring's mental health.

1. INTRODUCCIÓN

1.1 Violencia contra las mujeres a lo largo del ciclo vital

1.1.1 Comprendiendo el contexto general

La violencia que sufren las mujeres y las niñas, constituye probablemente la violación a los derechos humanos más habitual y que afecta a un mayor número de personas. Es una violación especialmente grave de los derechos humanos, debido a que atenta contra muchos derechos a la vez (Amnistía Internacional, 2004), por ello, se han establecido normas vinculantes que imponen a los Estados la obligación de prevenir, erradicar y castigar estos actos de violencia (ONU, 2006).

La declaración sobre la Eliminación de la violencia contra la mujer (Asamblea General Naciones Unidas, 1993) define ésta como "*todo acto de violencia basado en la pertenencia al sexo femenino que tenga o pueda tener como resultado un daño o sufrimiento físico, sexual o sicológico para la mujer, así como las amenazas de tales actos, la coacción o la privación arbitraria de la libertad, tanto si se producen en la vida pública como en la vida privada*". En su artículo 2, esta declaración establece como violencia contra la mujer actos como: la violencia física, sexual y psicológica ocurridas en la familia o en la comunidad en general, incluyendo los malos tratos, el abuso sexual de las niñas en el hogar y la violación por el marido. El Comité para la Eliminación de la Discriminación contra la Mujer (recomendación general nº 19) ha reconocido la violencia contra la mujer como una forma de discriminación, en tanto menoscaba o anula el goce de sus derechos humanos y libertades fundamentales, como son el derecho: a la vida, a no ser sometido a tratos crueles, inhumanos o degradantes, a la libertad y a la seguridad personales, a igualdad en la familia y al más alto nivel posible de salud física y mental, entre otros. En este marco, la violencia contra las mujeres ha sido definida como una forma de violencia de género, toda vez que es violencia dirigida contra las mujeres por el hecho de ser mujeres o que afecta a las mujeres desproporcionadamente.

Las estadísticas internacionales y nacionales evidencian con claridad que la violencia en la pareja (VP) y la violencia sexual afectan a una amplia proporción de la población, destacando que mayoritaria y *desproporcionadamente* la mujer (y la niña, en el caso de las agresiones sexuales) es quien sufre estas formas de violencia y el hombre es quien la ejerce (WHO, 2010; Echeburúa y Redondo, 2010). La Organización Mundial de la Salud, de manera sistemática, ha

mostrado que un elevado porcentaje de mujeres en el mundo ha sido golpeada, obligada a mantener relaciones sexuales o sometida a algún otro tipo de abusos a lo largo de su vida (Krug, Dahlberg, Mercy, Zwi, y Lozano, 2002; WHO, 2005, 2009, 2010). Ha visibilizado además, el grave impacto que estos actos tienen en la salud de las mujeres y, también, en la de aquellos pertenecientes a su entorno más cercano, consiguiendo posicionar la violencia contra la mujer como un problema prioritario de salud pública.

En la actualidad, no cabe duda de que la violencia contra las mujeres es un fenómeno pervasivo y común tanto en los países desarrollados como en vías de desarrollo (WHO, 2010). Progresivamente, en las distintas sociedades se ha ido derribando el mito de que el hogar es un lugar seguro para la mujer. Estudios realizados en diferentes países demuestran que las mujeres tienen mayores riesgos de sufrir violencia en el contexto de sus relaciones íntimas que en otro lugar (WHO, 2005). Así, a través de las culturas, la experiencia más común para las mujeres es la violencia que sufren por parte de sus parejas o ex-parejas (Krug y cols., 2002; ONU, 2006). Los costos sociales derivados de este tipo de violencia son amplios y profundos, pero a la vez difíciles de cuantificar (International Center for Research on Women, 2009). Organismos gubernamentales y no gubernamentales han reconocido que la violencia física, sexual o psicológica que han sufrido las mujeres se asocia con una gran variedad de problemas de salud física y mental, una pérdida de sus ingresos, la afectación de su capacidad productiva y el consecuente empobrecimiento de sus familias, comunidades y sociedades (Krug y cols., 2002; AI, 2009). La violencia que sufre la mujer en la pareja tiene repercusiones devastadoras para ella, pero además puede tener un efecto traumático para quienes la presencian, particularmente las niñas y los niños, afectando el bienestar, la salud y la educación de éstos (International Center for Research on Women, 2009; WHO, 2005).

La evidencia científica consistentemente muestra que las experiencias de violencia sufridas en la infancia y/o en la relación de pareja pueden generar un profundo, variado y duradero daño psicológico en las mujeres. Especialmente relevantes para la investigación clínica son los repetidos hallazgos acerca de los efectos que la victimización temprana (p.e: maltrato infantil) tienen en una subsecuente victimización (p.e: violencia en la pareja), así como en la perpetración de actos violentos (p.e: maltrato hacia las/os hijas/os), y la resultante acumulación de efectos negativos (White, Koss, y Kazdin, 2010a).

1.1.2 Abuso infantil

En la literatura científica, diversos términos son utilizados para referirse a la violencia que sufren las niñas y los niños, tales como: *abuso infantil*, *maltrato infantil* o *exposición a violencia*. En 1999, la *WHO Consultation on Child Abuse Prevention* definió el abuso o maltrato infantil como todas las formas de violencia física y emocional, malos tratos, abuso sexual, negligencia, explotación comercial o de otro tipo, resultando en un daño real o potencial para la salud, desarrollo o dignidad del niño/a en el contexto de una relación de responsabilidad, confianza o poder (Runyan, Wattam, Ikeda, Hassan, y Ramiro, 2002).

Esta definición conceptual cubre un amplio espectro de actos abusivos, incluyendo las cuatro categorías de maltrato reconocidas: 1) abuso físico, 2) abuso sexual, 3) abuso emocional y psicológico, y 4) negligencia. Cada categoría ha desarrollado su propia tipología y marco de referencia, revelando ciertas similitudes, pero también importantes diferencias. Si bien, se han establecido ciertos criterios recomendables para la definición operacional de cada una de ellas (WHO & International Society for Prevention of Child Abuse and Neglect, 2006), tras décadas de debate aún no existe un consenso sobre qué constituye (o no) maltrato infantil y cómo debería ser definido.

El problema de construir una definición operacional efectiva y universal del maltrato infantil ha sido reconocido por numerosos expertos. Dentro de los factores asociados a ello, Cicchetti y Lynch (1995) y Ciccheti y Toth (2005) destacan: falta de consenso social acerca de qué prácticas parentales son inaceptables o peligrosas; falta de acuerdo sobre si la intención parental debería ser o no considerada para determinar la ocurrencia de un acto de maltrato; incertidumbre sobre si se debe definir el maltrato basado en el comportamiento adulto, los efectos en las niñas y los niños o una combinación de ambas; confusión respecto de si definiciones similares deberían ser utilizadas para propósitos científicos, legales y clínicos. Este último aspecto, ha sido un constante motivo de desacuerdos, debido a que científicos, legisladores y clínicos usan la definición de maltrato que mejor se adapte a sus particulares necesidades.

Cuando se estudian los efectos a largo plazo del abuso infantil, un tema de especial preocupación para los investigadores se refiere a los métodos de evaluación. La mayoría de los estudios en esta área usan medidas de auto-informe y retrospectivas, las cuales tienen limitaciones referidas al posible sesgo del informante, eventuales distorsiones mnémicas y una probable subestimación de la incidencia del abuso. No obstante, la evidencia disponible indica que cuando el abuso o negligencia son informados retrospectivamente como eventos que han

ocurrido, es probable que estos informes positivos sean correctos (Hard y Rutter, 2004). Junto con ello, reconociendo las limitaciones antes listadas, White, Koss y Kazdin, (2010b) señalan que el auto-informe inherentemente no limita la evaluación de la violencia interpersonal y, claramente, en muchos casos es el único camino para obtener información; por otra parte, indican que la evaluación retrospectiva tiene un lugar importante en la investigación y no es invariablemente *defectuosa* o *viciada*.

1.1.3 Estadísticas sobre abuso infantil

Durante la década de los noventa, diversos estudios en población española documentaron que la incidencia del abuso infantil variaba desde un promedio nacional de .44/^{000} (Saldaña, Jimenez, y Oliva, 1995) a 5.09/^{000} (Ingles, 1995) a 15/^{000} (Moreno, Jimenez, Oliva, Palacios, y Saldaña, 1995) en diferentes áreas del país. De Paúl, Milner, y Múgica (1995), en un estudio con población universitaria del País Vasco, encontraron que un 96.4% de las mujeres informaron haber sufrido comportamientos físicamente abusivos en su infancia y un 16.7% alguna forma de secuela física del abuso.

Específicamente, sobre el abuso sexual infantil el único estudio que se ha realizado a nivel nacional (López, Hernández, y Carpintero, 1995) informó que un 22.5% de las mujeres españolas, entre 18 y 60 años, informaron haber sufrido abuso sexual en su infancia. Por su parte, De Paúl y cols. (1995) encontraron que un 14.8% de las participantes de su estudio informaron este tipo de abusos.

Investigaciones recientes realizadas en Catalunya, con población universitaria, han encontrado que entre un 3.8% y un 5.3% de las mujeres informaron abuso físico en su infancia, mientras que entre 14.3% y un 19% manifestaron haber sufrido abusos sexuales (Pereda y Forns, 2007; Villarroel, 2008).

En la actualidad, datos del Centro Reina Sofía (2007) indican que el año 2005 la prevalencia del maltrato infantil fue de .84/^{000}, observándose entre 2001 y 2005 un aumento en la incidencia del 146.29%, en tanto la prevalencia se incrementó un 133.33% durante dicho período. En todos los años analizados (2001-2005), se ha observado que la prevalencia es superior en las niñas (p.e: el 2005 fue de 1.09 vs .60 en los niños) y esta diferencia se ha incrementado cada año. Así, en el caso de las niñas, se registra un aumento en la incidencia del 183.13%, mientras que la prevalencia incrementó un 165.85%.

Los datos revisados reflejan que el maltrato infantil en general y el que se ejerce contra las niñas en particular, ha sido y es un extendido problema en la sociedad española.

1.1.4 Violencia en la pareja

Términos como *violencia doméstica*, *violencia familiar, violencia conyugal*, *abuso conyugal, violencia de pareja, violencia interparental* y *terrorismo íntimo,* son usados para designar la violencia que ocurre en una relación de pareja adulta. La ausencia de un lenguaje unificado, refleja las divergencias existentes respecto de la comprensión y la conceptualización de esta problemática.

La Organización Mundial de la Salud, define la VP como cualquier comportamiento dentro de una relación íntima que cause daño físico, psicológico o sexual a aquellos en la relación. Estos comportamientos incluyen actos de agresión física (p.e: bofetadas, golpes, patadas), abuso psicológico (p.e: intimidación, constante desprecio y humillación), coerción sexual y comportamientos controladores (p.e: aislar a la persona de su familia y amigos, controlar sus movimientos, restringir el acceso a información o asistencia). Esta definición incluye actuales y anteriores cónyuges y parejas (Heise y García-Moreno, 2002).

Generalmente co-existen diferentes tipos de abuso en una misma relación de pareja (Koss, Goodman, Browne, Fitzgerald, Keita y Russo, 1994; McCloskey, Figueredo y Koss, 1995). Si bien, el abuso físico es la manifestación más visible de VP, a menudo está precedido por o acompañado de abuso psicológico (Koss y cols., 1994; Pico-Alfonso, 2005) y, en algunos casos, también de otras formas más extremas de abuso, como violencia sexual (McCloskey y cols., 1995; Pico-Alfonso, 2005; Pico-Alfonso y cols., 2006).

La VP se refiere a un proceso que puede ocurrir antes, durante y después de que se establezca una relación formal entre dos personas y, a su vez, puede suceder dentro o fuera del espacio físico y social delimitado por los territorios doméstico, familiar, conyugal o del género (Cantera, 2004). Es, asimismo, una conducta continuada en el tiempo, por lo que la cronicidad es una de sus características distintivas (Echeburúa y Redondo, 2010). Aunque algunas investigaciones sugieren una simetría en la prevalencia de VP perpetrada por hombres y mujeres (Archer, 2000, 2006; Fergusson, Boden y Horwood, 2008; Straus, 2009), otros estudios contradicen la existencia de tal similitud (Arias y Corso, 2005; Tjaden y Thoennes, 2000a; Walby y Allen, 2004). Más aún, los hallazgos sobre la simetría del sexo hacen referencia principalmente a formas menos graves de violencia física en la pareja y mayoritariamente se aplican a países occidentales de altos ingresos (Archer, 2006). La evidencia es ampliamente concordante respecto de que la violencia física en la pareja tiene consecuencias más severas para las mujeres. En comparación con los hombres, las mujeres tienen mayor probabilidad de sufrir lesiones graves o letales, registran una mayor utilización de servicios médicos, uso de

salas de urgencias, hospitalización, visitas a servicios de salud mental y requieren más tiempo libre del trabajo, del cuidado de las hijas/os o del hogar a causa de las lesiones (Arias y Corso, 2005; Archer, 2000, 2006; Straus, 2009). Estos hallazgos permiten comprender el hecho de que la mayoría de los estudios examinen la violencia ejercida por el hombre contra la mujer.

En España, el uso de conceptos como *violencia de género*, *violencia sexista*, *violencia machista* o *violencia masculina*, focalizan el análisis en las raíces socio-culturales de esta problemática, visibilizando las desigualdades de género y la dominancia masculina que imperan en la sociedad (Roca y Masip, 2011). Los estereotipos sociales y la relativa aceptación social de las conductas de maltrato contra las mujeres han contribuido a mantener creencias erróneas y, consiguientemente, a minimizar las reales dimensiones de este fenómeno (Echeburúa y Corral, 2009; Echeburúa y Redondo, 2010).

1.1.5 Estadísticas sobre violencia en la pareja

El gobierno de España, a través del Instituto de la Mujer, ha aplicado tres macroencuestas en población general sobre la violencia contra las mujeres. Los datos indican que el porcentaje de mujeres "técnicamente" clasificadas como "maltratadas" fue 12.4 (año 1999), 11.1 (año 2002) y 9.6 (año 2006). En los mismos años, se registran datos sobre mujeres "autoclasificadas" como "maltratadas", observándose porcentajes menores en comparación con el primer grupo: 4.2, 4.0 y 3.6, respectivamente. En los tres años y en las dos clasificaciones analizadas, los más altos porcentaje de mujeres victimizadas se encuentran en el rango etáreo correspondiente a 45-64 años (Instituto de la Mujer, 2006).

El Centro Reina Sofía para el Estudio de la Violencia (2007) informó que en el año 2007 la prevalencia de mujeres maltratadas por su pareja fue $3.22/^{000}$, observándose entre el 2003 y el 2007 un incremento en la incidencia del 26.47%, en tanto la prevalencia aumentó un 15.83%. De acuerdo a datos del Ministerio de Sanidad, Política Social e Igualdad (2011a), entre 2003 y 2009 el promedio mensual de mujeres asesinadas por sus parejas o ex-parejas fue de 5.6. En el mismo periodo, mensualmente los tribunales de justicia recibieron un promedio de 11.221 denuncias por violencia contra mujeres ejercida por la pareja o ex-pareja. Y, en el año 2010, los juzgados registraron un total de 134.105 denuncias de este tipo (Ministerio de Sanidad, Política Social e Igualdad, 2011b).

Recientemente, el Instituto de la Mujer (2012) informó que en el año 2011 hubo 61 mujeres muertas por violencia de género, siendo el agresor su pareja o ex-pareja. 43 de estas

mujeres asesinadas tenían entre 21 y 50 años. Del total de las víctimas mortales, el 26.23% había terminado con su pareja o estaba en fase de ruptura.

Una actual revisión en la materia que incluye los indicadores proporcionados por organismos gubernamentales, así como publicaciones científicas recientes, indica que en España aproximadamente un 10% de las mujeres en la población general reporta violencia ejercida por la pareja durante el último año, mientras que un 25% de las mujeres atendidas en servicios de salud manifiesta haber sufrido alguna experiencia de este tipo a lo largo de su vida (Ezpeleta y Bayarri, 2010).

1.1.6 Consecuencias de la violencia en la salud mental de las mujeres

El nocivo impacto que el abuso infantil y la VP tienen en la salud mental de las mujeres ha sido bien documentado (Kendall-Tackett, 2002; Coker, Williams, Follingstad y Jordan, 2010). Los estudios han mostrado que no existe un perfil psicopatológico uniforme en quienes han sufrido abuso en la infancia (Rodriguez, Vande Kemp, y Foy, 1998) y los efectos asociados a éste pueden variar dependiendo de múltiples factores (Beitchman y cols., 1992; Zielinski y Bradshaw, 2006). Similarmente, la violencia en la pareja se ha asociado a una heterogeneidad de resultados negativos en las mujeres (Heise y García-Moreno, 2002), incluyendo diferentes alteraciones psíquicas (Echeburúa y Redondo, 2010) y problemas en el funcionamiento cognitivo, social, emocional y comportamental (Tjaden y Thoennes, 2000b).

Numerosas investigaciones han informado que las mujeres con historia de abuso infantil, así como aquellas que han experimentado VP, tienen un elevado riesgo de presentar Trastorno por Estrés Post-traumático (TEPT) o algunos de sus síntomas (Kendall-Tackett, 2002; Golding, 1999; Rodríguez y cols., 1998) y depresión (Campbell, Sullivan, y Davidson, 1995; Golding, 1999; Wise, Zierler, Krieger, y Harlow, 2001). En estas poblaciones, también se ha encontrado la presencia de sentimientos de culpa, miedo, desconfianza, rabia, baja autoestima y otras manifestaciones clínicas como trastornos de ansiedad, pensamientos y comportamientos suicidas, dependencia a alcohol y otras drogas (Jumper, 1995; McCauley y cols., 1995; McCauley y cols., 1997; Pico-Alfonso y cols., 2006; Silverman, Reinherz, y Giaconia, 1996; Springer, Sheridan, Kuo, y Carnes, 2007). A nivel teórico, Herman (1992) ha propuesto la existencia de un trastorno de estrés post-traumático complejo, el cual se focaliza en los aspectos traumatizantes de la violencia y explicaría la presencia de síntomas adicionales al TEPT (disociación, somatización, ansiedad y depresión, entre otros), particularmente en mujeres que han experimentado situaciones de violencia repetida y prolongada.

Una importante secuela a largo plazo del abuso infantil es la ocurrencia de una subsecuente victimización en la vida adulta. Diversos estudios han mostrado que el riesgo de sufrir VP es mayor cuando las mujeres tienen una historia de abuso en la infancia (Desai, Arias, Thompson y Basile, 2002; Fergusson y cols., 2008; Whitfield, Anda, Dube, y Felitti, 2003) y los efectos psicológicos de la re-victimización son más severos (McGuigan, y Middlemiss, 2005, Weisbart y cols., 2008). Por ello, se ha recomendado que la investigación sobre el impacto de la violencia utilice una perspectiva comprensiva que examine la ocurrencia de diferentes experiencias de victimización a lo largo del ciclo vital (White y cols., 2010b). Esta aproximación ha sido sustentada clínica, empírica y teóricamente (Banyard, Williams y Siegel, 2001; Becker, Stuewig y McCloskey, 2010), constituyendo un potencial aporte para ampliar nuestros conocimientos sobre la violencia y sus dañinos efectos.

1.2 Hijas e hijos de mujeres que han sufrido violencia

1.2.1 Exposición a violencia en la pareja

No existe una definición estandarizada sobre el concepto de exposición a VP. Inicialmente los estudios describían a las niñas y los niños como "*testigos*" u "*observadores*" de tal violencia. Sin embargo, más recientemente los investigadores han comenzado a utilizar el término "exposición", el cual sería más inclusivo al no requerir que las niñas y los niños observen directamente la violencia (Holden, 2003). Pese a la falta de consenso, la mayoría de los investigadores concuerdan en que la exposición acontece cuando la niña o el niño ve, escucha o está directamente involucrada en la violencia (p.e: intenta intervenir), o experimenta las consecuencias de ataques físicos o sexuales que ocurren entre sus cuidadores (Evans y cols., 2008). Estudios indican que un alto porcentaje de niñas/os está presente cuando sus madres sufren violencia en la pareja, por ejemplo, McGee (2000) encontró que un 71% de las/os niñas/os había observado directamente ataques físicos contra sus madres, mientras que un 10% habían sido testigos de la violación de éstas.

A nivel global, se estima que aproximadamente 275 millones de niñas y niños están expuestos a violencia en el hogar. Sin embargo, esta es una cifra conservadora, basada en los limitados datos existentes (UNICEF, 2006). En la literatura, se observa que las estadísticas varían ampliamente entre los diversos estudios, dificultando conocer con precisión la magnitud de este fenómeno. La mayoría de las investigaciones provienen de Estados Unidos, en donde se estima que cada año entre 3 y 17.8 millones de niñas/os son o están expuestos a violencia en la familia (Evans, Davies, y DiLillo, 2008). Según la *National Survey of Children Exposed to*

Violence (Finkelhor, Turner, Ormrod, y Hamby, 2009), aproximadamente .64/000 niñas/os en este país han sido testigos de dicha violencia.

En cuanto a la realidad de España, no hay estadísticas disponibles acerca del número de niñas/os expuestas/os a VP. Los únicos datos publicados corresponden al informe de la Secretaria de Naciones Unidas (UNICEF, 2006), el cual estima que en el territorio español cada año aproximadamente 188.000 niñas/os son testigos de esta violencia.

Consecuentemente, el Observatorio Estatal de Violencia sobre la Mujer, en el año 2009, acordó por una unanimidad la conformación del *Grupo de Trabajo de Investigación sobre la infancia víctima de la violencia de género.* Su objetivo es contribuir a la visibilización de la infancia como víctima directa de la violencia de género. Esta entidad, ante la mencionada falta de estadísticas, ha realizado una estimación de la prevalencia, deducida de los datos referidos a las mujeres afectadas. De este modo, considerando que el año 2006 se estimó que más de un millón y medio de mujeres en España sufrían VP y que en el 40%-80% de los casos las/os hijas/os eran testigos de la violencia, se estima que alrededor de 700.000 niñas y niños en el país han sido expuestas/os a violencia en la pareja (Ministerio de Sanidad, Política Social e Igualdad, 2011b).

1.2.2 Efectos de las experiencias maternas de violencia en hijas e hijos

A pesar de la extensa evidencia que existe sobre las consecuencias que tiene el abuso infantil en el funcionamiento adulto, los conocimientos acerca de sus efectos intergeneracionales son limitados. Tal como destacan Collishaw, Dunn, O'Connor, y Golding, (2007), pocos estudios se han focalizado en evaluar los resultados psicológicos de hijas/os de mujeres que han sufrido este tipo de violencia. Los hallazgos existentes muestran que las/os hijas/os de mujeres maltratadas en su infancia tienen un significativo riesgo de presentar diversos problemas psicopatológicos, incluyendo un elevado malestar psicológico general, hiperactividad, problemas comportamentales, interpersonales y emocionales (Dubowitz y cols., 2001; Roberts, O'Connor, Dunn, y Golding, 2004; Thompson, 2007), así como incrementados problemas de ajuste psicológico y un peor pronóstico a través del tiempo (Collishaw y cols., 2007).

En las últimas tres décadas, la investigación sobre la exposición de las/os niñas/os a VP y los efectos relacionados ha tenido un crecimiento exponencial (Holt, Buckley, y Whelan, 2008). Desde el primer estudio empírico publicado en la década de los 80 hasta la actualidad, un importante cúmulo de investigaciones ha documentado los adversos efectos que esta violencia tiene en el bienestar de las/os niñas/os (Evans y cols., 2008). En recientes revisiones, un amplio

rango de resultados negativos ha sido sistematizado, los que involucran problemas en diferentes áreas, como son: académica/cognitiva, emocional, comportamental y social (Evans y cols., 2008; Holt y cols., 2008; Kitzmann, Gaylord, Holt, y Kenny, 2003; Sternberg, Baradaran, Abbot, Lamb, y Guterman, 2006; Wolfe, Crooks, Lee, McIntyre-Smith, y Jaffe, 2003; Chan y Wai-Keung, 2009). Existe un acuerdo acerca de que la exposición a violencia constituye un factor de riesgo general para problemas en la infancia (Margolin, 2005). Sin embargo, no se ha alcanzado un consenso respecto de la variabilidad de las repercusiones asociadas, existiendo hallazgos inconsistentes e incluso contradictorios. La mayoría de las investigaciones examinan la relación directa entre la exposición a VP y los resultados de las/os niñas/os y poco se conoce acerca de los procesos que explican esa relación (Wolfe y cols., 2003). Por otro lado, debido a que la mayoría de la evidencia disponible se basa en la información de las madres, actualmente los investigadores enfatizan la relevancia de explorar directamente la experiencia y percepción de las niñas y los niños sobre la violencia (Buckley, Whelan, y Holt, 2006; Holt y cols., 2008).

Junto con lo anterior, en la actualidad existe un creciente interés por estudiar el impacto que las experiencias de violencia sufridas por las madres, a lo largo de la vida, tienen no sólo en la salud mental de éstas, sino también en la de sus hijas/os (Dubowitz y cols., 2001; Koverola y cols., 2005; Morrel, Dubowitz, Kerr, y Black, 2003). Más aún, una incipiente línea de investigación ha examinado el potencial efecto acumulativo que múltiples experiencias maternas de violencia podrían tener en la siguiente generación (Dubowitz y cols., 2001). Fundamentado en el modelo teórico de riesgo acumulativo, propuesto por Rutter (1979), el cual plantea que la prevalencia de problemas clínicos se incrementa a medida que aumenta el número de factores de riesgo, Dubowitz y cols. (2001) sugieren que una mayor exposición a violencia experimentada por las madres (p.e: abuso en la infancia y luego violencia en la pareja) se asociaría con peores resultados psicopatológicos en las/os hijas/os.

Expertos en el área del maltrato infantil y en la exposición de las/os niñas/os a violencia, han indicado que la investigación requiere trascender la mera documentación de efectos bivariados y examinar cuidadosamente: 1) los mecanismos que explican esas asociaciones (mediadores); y 2) las variables que ayudan a reducir o aumentar esos efectos (moderadores) (Banyard, Williams, y Siegel, 2003; Briggs, Thompson, Ostrowski, y Lekwauwa, 2010; Margolin, 2005; Wolfe y cols., 2003).

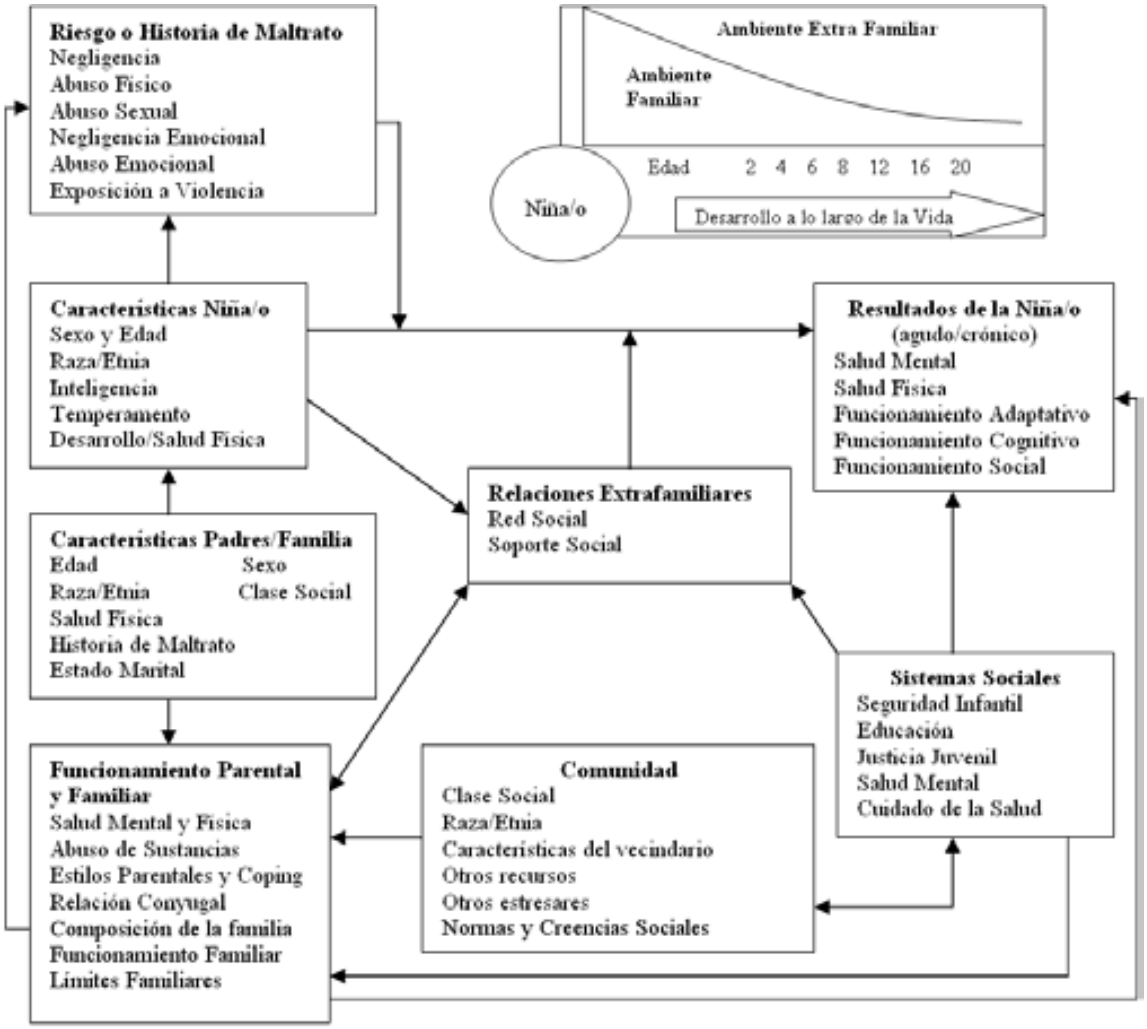
1.2.3 Psicopatología del desarrollo: una mirada comprensiva e integral

Diversos investigadores destacan la necesidad de estudiar el impacto de la violencia en las niñas y los niños teniendo en cuenta su contexto de desarrollo (Holt y cols., 2008; Margolin, 2005; Sternberg y cols., 2006; Wolfe y cols., 2003). Al respecto, la psicopatología del desarrollo constituye un relevante marco teórico para intentar comprender la heterogeneidad y la complejidad de los efectos intergeneracionales del abuso infantil y, también, de la exposición a VP. Esta perspectiva postula que el desarrollo adaptativo o mal-adaptativo es el resultado de la interrelación entre factores individuales, la etapa del desarrollo y factores externos del ambiente (Cicchetti, 1993; Rutter y Sroufe, 2000). Circunstancias inusuales, como los tipos de violencia mencionados, alterarían el logro de tareas del desarrollo específicas de una etapa e incrementarían el riesgo de subsecuentes fallas en tareas del desarrollo posteriores (Cicchetti, 1993; Ciccheti y Toth, 1995). El abuso infantil (así como los hogares violentos) ejemplifican un tóxico ambiente relacional que claramente excede las experiencias normativas de cuidado y poseen un considerable riesgo de mal-adaptación a través de diversos dominios biológicos y psicológicos del desarrollo (Cicchetti, 2002, Cicchetti y Toth, 2005). Esto, puede (o no) tener graves implicaciones para el funcionamiento a lo largo del ciclo vital. Así, las madres con historia de abuso infantil pueden presentar diferentes problemas en la vida adulta (p.e: problemas en la parentalidad y salud mental), los que a su vez llevarían a problemas psicopatológicos en sus hijas/os. Por su parte, la gran variabilidad de problemas comportamentales y emocionales asociados a la exposición a violencia pueden representar los esfuerzos de las/os niñas/os para adaptarse a una situación mal-adaptativa (Wolfe y cols., 2003).

Este marco plantea la importancia de una aproximación multidimensional, entendiendo que el impacto de la violencia es un fenómeno que está determinado por una serie de factores y que raramente existe una ruta o trayectoria causal directa que lleve a un particular resultado. Por ello (Wolfe y cols., 2003), subrayan la necesidad de comprender los diferentes mecanismos a través de los cuales la violencia ejerce su impacto y, asimismo, el efecto de potenciales moderadores.

La línea de investigación desarrollada por Longitudinal Studies of Child Abuse and Neglect (LONGSCAN) ilustra un integrativo modelo ecológico y del desarrollo que busca comprender tanto la etiología como las consecuencias del maltrato infantil y otros potenciales eventos traumáticos (Runyan y cols., 1998) (ver figura 1).

Figura 1: Modelo conceptual ecológico y del desarrollo (fuente: Runyan y cols., 1998).



1.2.4 Factores que influencian el efecto de la violencia

1.2.4.1 Sexo y edad

En la literatura sobre la exposición a violencia en la infancia, un importante foco de interés ha sido examinar si los efectos de ésta pueden manifestarse diferencialmente dependiendo de factores individuales como son el sexo y la edad. Al respecto, diferentes revisiones revelan que los hallazgos son inconclusos (Evans y cols., 2008; Kitzmann y cols., 2003; Wolfe y cols., 2003; Sternberg y cols., 2006).

La investigación ha sugerido que la violencia tiene efectos diferentes para las niñas y los niños. Las niñas exhibirían más problemas interiorizados (p.e: depresión, ansiedad, quejas somáticas), mientras que los niños tenderían a mostrar más problemas exteriorizados (p.e: hostilidad y agresión). Los resultados de Evans y cols. (2008) sustentan la hipótesis de diferencias de sexo, informando en los niños mayores problemas exteriorizados. No obstante,

otros investigadores no confirman estos hallazgos, sugiriendo que las niñas y los niños son igualmente afectados por esta violencia (Bayarri, Ezpeleta y Granero, 2011; Kitzmann y cols., 2003; Sternberg y cols., 2006; Wolfe y cols., 2003).

Por otro lado, se ha planteado que la edad tiene una influencia en el impacto de la violencia, particularmente con respecto a las habilidades evolutivas de las/os niñas/os para comprender y procesar sus experiencias, así como a la manera en que el malestar es manifestado. Al respecto, Holt y cols. (2008) realizan una rigurosa sistematización de los efectos diferenciales que puede tener la violencia en cada etapa del desarrollo. Sin embargo, la evidencia indica que no existe un claro patrón de síntomas. En este sentido, Evans y cols. (2008), Kitzmann y cols. (2003) y Wolfe y cols. (2003), informan que la edad no tiene un efecto moderador, mientras que Sternberg y cols. (2006) informan que la edad influencia los efectos de la violencia en los problemas exteriorizados.

1.2.4.2 Psicopatología parental

Varios factores contextuales y familiares han sido identificados como variables que pueden moderar o mediar la relación entre la historia materna de violencia (abuso infantil o VP) y los problemas psicopatológicos de las/os niñas/os. Entre ellos, la salud mental materna ha concitado especial interés.

Algunos estudios muestran que los problemas de salud mental de las madres moderan o modifican los efectos que tiene la violencia en el funcionamiento de las/os niñas/os (Levendosky y Graham-Bermann, 2000a; Levendosky, Huth-Bocks, y Semel, 2002). Estos investigadores informan que niñas/os y adolescentes expuestas/os a VP tienen una mayor probabilidad de presentar síntomas de trauma y depresión cuando sus madres manifiestan dicha sintomatología.

Otras investigaciones han examinado el rol mediador de la salud mental materna, informando hallazgos discordantes. Por una parte, ciertos estudios indican que la violencia experimentada por las madres afecta el bienestar de las/os hijas/os a través de diferentes problemas maternos de salud mental, tales como malestar psicológico general (Owen, Thompson, Shafer, Jaackson y Kaslow, 2009; Street, King, King, y Riggs, 2003), depresión (Dehon, 2005; Koverola y cols., 2005; Morrel y cols., 2003), síntomas ansiosos y afectivos (Collishaw y cols., 2007; Roberts y cols., 2004). Sin embargo, otros hallazgos no proveen soporte empírico al rol mediador de la salud mental materna en general (McCloskey y cols., 1995) y a la depresión en particular (Roberts y cols., 2004; Thompson, 2007).

La salud mental de los padres también es un factor que puede influenciar significativamente los problemas psicológicos de las niñas/os. En hogares donde hay violencia en la pareja, se ha encontrado que los padres tienen una alta probabilidad de presentar problemas psicopatológicos, incluyendo incrementados niveles de rabia y problemas de abuso de sustancias (Eckhardt, Samper, y Murphy, 2008), problemas de alcoholismo y conductas criminales (Fergusson y Horwood, 1998). Al respecto, se ha encontrado un alta comorbilidad entre alcoholismo y VP, con un porcentaje de hombres que ejercen violencia bajo la influencia del alcohol en el rango de 48% a 87% (Lipsky, Caetano, Field y Larkin, 2004). La literatura ha demostrado, por ejemplo, una importante asociación entre alcoholismo parental y psicopatología de las/os niñas/os (West y Prinz, 1987). No obstante, hay escasa evidencia disponible respecto de la psicopatología paterna y su rol mediador o moderador en las relaciones aquí estudiadas.

1.2.4.3 Castigo físico hacia niñas y niños

Las experiencias traumáticas pueden generar un perjudicial impacto en las capacidades parentales. El abuso en la infancia se ha vinculado con distintos problemas en la parentalidad de las supervivientes, como son una visión negativa de sí mismas como madres (Banyard, 1997) y de sus propias hijas/os (Gara, Allen, Herzog, y Woolfolk, 2000) y un mayor uso de castigo físico o comportamientos abusivos hacia las/os niñas/os (Banyard, 1997; Cicchetti y Lynch, 1995; DiLillo y Damashek, 2003; Pears, y Capaldi, 2001). Similarmente, la evidencia sugiere que la VP afecta negativamente las habilidades de las madres para mantener una adecuada parentalidad, manifestando comportamientos hipervigilantes y sobreprotectores (Levendosky y Graham-Bermann, 2000b), incrementada rabia y reducida disponibilidad emocional (Levendosky, Lynch, y Graham-Bermann, 2000) y menor calor parental (McCloskey y cols., 1995). Además, una elevada co-ocurrencia entre la VP y el maltrato hacia las/os hijas/os ha sido extensamente documentada (Appel y Holden, 1998; Edleson, 1999; Osofsky, 2003). No obstante, los efectos moderadores o mediadores de los problemas en la parentalidad y, particularmente, del castigo físico hacia las niñas y los niños constituyen otro foco de discrepancias.

Si bien, numerosos estudios sugieren que el castigo físico parental modifica el efecto que tiene la VP sobre los problemas psicopatológicos de las/os niñas/os (Kaslow y Thompson, 2008; Sternberg y cols., 2006; Wolfe y cols., 2003), otros hallazgos contradicen esta evidencia (Kitzmann y cols. 2003). Al respecto, se sugiere que las/os niñas/os que han estado expuestas/os

a VP y, además, sufrieron castigo físico no difieren significativamente de aquellas/os que sólo estuvieron expuestas/os.

Investigaciones con madres que sufrieron abuso en la infancia aportan evidencia referida al papel mediador que desempeña la parentalidad. Estos hallazgos sostienen que la hostilidad y la baja confianza materna contribuyen a explicar los problemas psicológicos de las/os hijas/os (Collishaw y cols., 2007; Roberts y cols., 2004).

En el área de la VP, algunos investigadores han propuesto que el castigo físico hacia las/os niñas/os sería uno de los mecanismos que explica el impacto negativo que tiene la violencia sobre el bienestar de éstas/os (Jouriles, Barling, y O'Leary, 1987; Levendosky y Graham-Bermann, 2001). Los resultados muestran que la violencia en la pareja se asocia con el castigo físico y éste se asocia con los resultados negativos de las/os niñas/os (Salzinger y cols., 2002).

Paralelamente a lo mencionado, la literatura señala que la historia de abuso en la infancia, aunque es un factor significativo, no determina, ni tampoco se relaciona de manera inevitable o irreversible con un comportamiento abusivo hacia las/os hijas/os (Wolfe, 2010). En la misma línea, algunos estudios destacan que la VP no necesariamente daña las capacidades parentales de las madres, quienes pueden intentar desplegar conductas compensatorias al contexto de violencia (Casanueva, Martin, Runyan, Barth, y Bradley, 2008; Levendosky, Lynch, y Graham-Bermann, 2000; Letourneau, Fedick, y Willms, 2007).

Por último, en este tipo de poblaciones, escasos estudios han examinado el comportamiento parental de los padres. Considerando que alteraciones en la relación padre-hija/o pueden perturbar el desarrollo esperado, recientes publicaciones han enfatizado la necesidad de futuras investigaciones en esta área (Guille, 2004; Salisbury, Henning, y Holdford, 2009).

2. OBJETIVOS DEL ESTUDIO

La presente tesis intenta contribuir a extender los conocimientos existentes sobre el impacto que la violencia sufrida por las madres, durante la infancia y/o la vida adulta, puede tener en la salud mental de sus hijas e hijos. Desde una aproximación comprensiva, las investigaciones empíricas presentadas en esta tesis han incluido dos principales focos de análisis:

1. Asociación entre la historia materna de violencia y los problemas de salud mental de niñas, niños y adolescentes.

2. Factores individuales, familiares y contextuales que pueden influenciar los resultados psicológicos de niñas, niños y adolescentes.

En una muestra de niñas/os y adolescentes consultantes de servicios públicos de salud mental en Barcelona, se plantearon los siguientes objetivos: 1) Examinar los efectos independientes de las experiencias maternas de abuso infantil y VP sobre la psicopatología y el deterioro funcional de las/os niñas/os; 2) Examinar el potencial rol moderador y mediador de factores individuales y familiares; 3) Explorar el potencial efecto acumulativo de las experiencias maternas de abuso infantil y VP sobre la psicopatología y el funcionamiento de las/os niñas/os; 4) Examinar el rol mediador de la salud mental materna en la relación entre las experiencias maternas de abuso infantil, VP y la psicopatología de las/os hijas/os; 5) Explorar el rol moderador del sexo en los modelos de mediación propuestos.

Los primeros tres objetivos de la tesis fueron desarrollados en el artículo "*Maternal Experiences of Childhood Abuse and Intimate Partner Violence: Psychopathology and Functional Impairment in Clinical Children and Adolescents".* Esta investigación, en primer lugar, examinó si la experiencia materna de abuso infantil y la exposición a VP afectan los resultados de las/os hijas/os, incluyendo problemas de comportamiento y emocionales, así como diagnósticos DSM-IV y deterioro en el funcionamiento habitual. La segunda pregunta de investigación fue si la asociación entre el abuso infantil de las madres, la violencia en la pareja y los resultados de sus hijas/os es modificada (moderada) por el sexo y la edad de éstas/os. Así también, el papel moderador y mediador de la psicopatología parental y el castigo físico hacia las/os niñas/os fue analizado. En tercer lugar, se exploró si la experiencia materna de haber

sufrido una victimización en la infancia y luego una re-victimización en la adultez se asocia con peores resultados en sus hijas e hijos.

Los otros dos objetivos de la tesis se abordaron en el artículo "*Maternal Childhood Abuse, Intimate Partner Violence and Child Psychopathology: The Mediator Role of Mothers' Mental Health"*. En este estudio diferentes problemas de salud mental de las madres, tales como malestar psicológico general, ansiedad, hostilidad y depresión, fueron examinados como posibles mecanismos que explicarían la relación entre la historia materna de violencia y los problemas clínicamente significativos de sus hijas/os. La siguiente pregunta abordada fue si los modelos de mediación propuestos operan diferencialmente para las niñas y los niños.

De acuerdo a la revisión de la literatura, los objetivos planteados en esta tesis no han sido investigados en población española. Es una de los pocas investigaciones en el área que introduce la valoración del deterioro funcional de las/os niñas/os, y, responde a la necesidad de extender las investigaciones en población clínica (McDonald, Jouriles, Norwood, Shinn, y Ezell (2000), posibilitando identificar factores claves para la evaluación y la intervención.

3. MÉTODO

3.1 Participantes

Esta tesis forma parte de un proyecto más amplio sobre factores de riesgo y protección para problemas psicopatológicos en la infancia y adolescencia. Las investigaciones que se presentan incluyeron niñas, niños y adolescentes, de 7 a 18 años de edad, y sus madres/padres, consultantes de servicios primarios de salud mental, pertenecientes a la red de salud pública del área de Barcelona. Los resultados aportados en esta tesis corresponden a dos muestras de 547 y 327 participantes (en el primer y segundo artículo, respectivamente), quienes habían completado todas las medidas requeridas para los análisis. Los criterios de exclusión fueron retraso mental o trastornos severos del desarrollo. Los participantes fueron clasificados en cuatro grupos, según la exposición de la madre a experiencias de violencia en la infancia y/o VP durante la adultez: No Exposición, Exposición a Abuso Infantil, Exposición a VP, Exposición a Abuso Infantil y VP.

En cada uno de los artículos realizados se encuentra una descripción detallada de las muestras utilizadas.

3.2 Instrumentos

Protocolo de Factores de Riesgo (UED, 1997). Es una entrevista estructurada basada en la entrevista sobre Utilización de Servicios y Factores de Riesgo (Goodman y cols., 1998). Posee adecuadas propiedades psicométricas, con aceptable fiabilidad entre entrevistadores y validez concurrente (Guillamón, 1999). Consta de un exhaustivo compendio de factores y situaciones que pueden influir en los trastornos mentales de niñas/os y adolescentes. Existen protocolos para madres/padres e hijas/os. En los estudios presentados diferentes apartados fueron utilizados: *información de las madres sobre abuso infantil* (de tipo psicológico, físico y/o sexual); *información de las/os niñas/os sobre exposición a violencia en la pareja*, específicamente una pregunta sobre si las/os niñas/os han visto o escuchado a sus padres golpearse durante una discusión fue utilizada (ítem adaptado de Child´s Perception of Interparental Conflict Scale; Grych, Seid, y Finchman, 1992); *castigo físico hacia las/os niñas/os* fue definido como presente si el padre, la madre o la niña/o respondieron afirmativamente sobre la ocurrencia de: a)

palmadas/nalgadas o bofetadas; b) golpes con un cinturón u otro objeto (Parental Discipline Practices Scales; Grych y cols., 1992). Además, se utilizaron ítems de screening sobre la *presencia de trastornos mentales en los padres* (Family Psychiatric History Screen for Epidemiologic Studies; Lish, Weissman, Adams, Hoven y Bird, 1995).

Diagnostic Interview for Children and Adolescents (DICA-IV), (Reich, Leacock, y Shanfeld, 1997). Es una entrevista semi-estructurada que evalúa la presencia de las categorías diagnósticas más frecuentes en niñas, niños y adolescentes, según los criterios del DSM-IV (American Psychiatric Association, 1994). Ha sido adaptada y validada a población española, con satisfactorias propiedades psicométricas (Ezpeleta, de la Osa, Doménech, Navarro y Losilla, 1997; de la Osa, Ezpeleta, Domènech, Navarro, y Losilla, 1996). Existen 3 versiones: para niñas/os, adolescentes y madres/padres. Los diagnósticos se obtienen combinando la información de madres/padres e hijas/os, considerando un síntoma presente si algún informante lo reporta.

Child Behavior Checklist (CBCL), (Achenbach y Rescorla, 2001). Es un inventario informado por las madres/padres que evalúa una amplía variedad de problemas emocionales y de comportamiento en niñas/os y adolescentes entre 6 y 18 años. La adaptación a población española y sus satisfactorias propiedades psicométricas han sido bien documentadas (Sardinero, Pedreira, y Muñiz, 1997). Consta de 113 ítems con una escala de respuesta de 3 opciones (0-Nunca, 1-A veces, 2-Siempre).

Child and Adolescent Functioning Assessment Scale (CAFAS), (Hodges, 1997). Es una medida dimensional del nivel de deterioro funcional de niñas/os y adolescentes. En población española presenta adecuadas propiedades psicométricas (Ezpeleta, Granero, de la Osa, Doménech, y Bonillo, 2006). Consta de 8 escalas que evalúan el funcionamiento en las siguientes áreas: colegio, hogar, comunidad, comportamiento hacia otros, humor/emociones, comportamiento autolesivo, uso de sustancias y cognición. Cada escala se puntúa en 4 niveles (0-Nulo, 10-Leve; 20-Moderado, 30-Severo). La suma de las escalas permite obtener una puntuación total. En los artículos presentados se incluyeron las puntuaciones que indican el nivel más alto de deterioro, según la información de madres/padres e hijas/os. Para el análisis el nivel de deterioro fue dicotomizado en mínimo-leve (0-10) y moderado-grave (30-40).

Symptom Checklist 90 items-Revised (SCL-90-R), (Derogatis, 1983). Es un cuestionario multidimensional y auto-administrado que evalúa diferentes problemas psicopatológicos y niveles de malestar psiquiátrico. Su adaptación a la población española posee propiedades psicométricas satisfactorias (Robles, Andreu y Peña, 2002). Consta de 90 ítems combinados en

9 dimensiones sintomáticas. Los participantes responden cada ítem en una escala de 5 puntos, desde 0 (nunca) a 4 (mucho).

3.3 Procedimiento

El estudio fue aprobado por el comité de ética de la Universidad Autónoma de Barcelona. Después de obtener el consentimiento escrito de las figuras parentales y el asentimiento de las/os niñas/os y adolescentes, se realizaron las entrevistas diagnósticas y se aplicó el protocolo de factores de riesgo. Diferentes entrevistadores, especialistas en psicología clínica y psicopatología del desarrollo, entrenados previamente en el uso de todos los instrumentos, efectuaron por separado y simultáneamente las entrevistas a las figuras parentales, niñas/os y adolescentes. Después de la entrevista diagnóstica, los entrevistadores evaluaron el funcionamiento psicosocial de las/os niñas/os con el CAFAS. El CBCL y el SCL-90-R fueron entregados a madres/padres para que los cumplimentaran. Una vez terminada la evaluación, los investigadores entregaron un completo informe a los clínicos de los centros.

3.4 Análisis estadístico

Para el análisis de los datos se utilizaron los programas SPSS, versión 15.0.1 para Windows, PASW17.0.1 y EQS6.1.

Para evaluar el efecto de la historia materna de violencia sobre la psicopatología y el deterioro funcional de las/os niñas/os se utilizaron modelos de regresión controlando diversas co-variables. En un primer paso del modelo, se incorporaron las variables de ajuste: sexo y edad de las/os niñas/os, psicopatología del padre y la madre, presencia de castigo físico hacia las/os niñas/os y de otros posibles trastornos comórbidos. En un segundo paso del modelo, se introdujeron las experiencias maternas de abuso en la infancia y VP. En un tercer paso, los términos de interacción entre dichas experiencias maternas y las potenciales variables moderadoras fueron introducidos en el modelo.

Se utilizó el modelo de Regresión Logística para analizar las variables binarias (diagnósticos DSM-IV) y la regresión lineal múltiple para las variables de tipo cuantitativas (puntuaciones CBCL, puntuación total del CAFAS). Las variables de recuento, tales como: número de trastornos psicopatológicos, número de síntomas interiorizados, número de síntomas exteriorizados y número de síntomas totales, se analizaron con el modelo de regresión binomial negativa.

La capacidad predictiva global de los modelos se valoró a través de la R^2 de Nagelkerke en la regresión logística y con R^2 ajustada en los modelos de regresión múltiple y la regresión binomial negativa. La contribución particular (o efecto principal) de las experiencias maternas de violencia se valoró mediante el cambio en la R^2.

El potencial efecto acumulativo de las diferentes experiencias maternas de violencia (no exposición a violencia, "sólo" abuso infantil, "sólo" VP, abuso infantil y VP) fue valorado a través de las tendencias lineal y cuadrática, utilizando modelos de regresión y análisis de la variancia con contrastes polinómicos.

Para evaluar el rol mediador de las variables propuestas, diferentes modelos de ecuaciones estructurales fueron construidos siguiendo el procedimiento descrito por Baron y Kenny (Baron y Kenny, 1986). La significación de cada ruta o *pathway* fue valorada según el método indicado por Kenny, Kashy, y Bolger (1998). Todos los modelos de ecuaciones estructurales incluyeron como co-variables el sexo y la edad de las/os niñas/os, con el objetivo de controlar el efecto de ambas variables en los *pathways*. El buen ajuste del modelo fue evaluado a través de varios índices: test del chi cuadrado (c^2), Comparative Fit Index (CFI) y Root Mean Squared Error of Approximation (RMSEA) (Byrne, 2001). El rol moderador del sexo en los modelos mediacionales analizados fue evaluado a través de modelos de regresión múltiple.

4. RESUMEN DE LOS RESULTADOS Y DISCUSIÓN

4.1 Principales hallazgos de las investigaciones

En su conjunto, los artículos incluidos en esta tesis, así como el manuscrito presentado en el apartado de anexo, han respondido a los dos focos de investigación propuestos inicialmente. Cada uno de estos trabajos, destaca la relevancia de las experiencias maternas de violencia en los problemas psicopatológicos de las niñas/os y adolescentes. Asimismo, evidencian la compleja interrelación entre diferentes factores implicados en esta asociación.

Respecto a los efectos de la historia materna de violencia sobre los problemas psicológicos de las/os niñas/os (primer objetivo de la tesis), los resultados del artículo *"Maternal Experiences of childhood abuse and intimate partner violence: psychopathology and functional impairment in clinical children and adolescents"* confirman que cada una de estas experiencias afectan significativa y negativamente el bienestar de las/os niñas/os y adolescentes. Este estudio muestra que el abuso infantil sufrido por la madre se asoció con trastornos disruptivos en las/os hijas/os, mientras que la violencia en la pareja fue relacionada con problemas de comportamiento exteriorizados. Estos resultados son consistentes con hallazgos anteriores sobre problemas de salud mental en hijas/os de mujeres con historia de maltrato infantil (Collishaw y cols.., 2007; Dubowitz y cols., 2001; Koverola y cols., 2005; Morrel y cols., 2003; Roberts y cols., 2004) y expuestas/os a VP (Evans y cols., 2008; Kitzmann y cols., 2003; Wolfe y cols., 2003).

No obstante lo anterior, en comparación con la gran variedad de problemas psicopatológicos asociados a la historia materna de violencia, especialmente a la VP (Evans y cols., 2008; Kitzmann y cols., 2003; Wolfe y cols., 2003), en la presente investigación se encontraron pocos resultados significativos. Una hipótesis que explicaría esta diferencia es que en nuestra investigación fueron incluidas como co-variables una serie de factores individuales y familiares (sexo y edad de las/os niñas/os, psicopatología materna y paterna, y castigo físico hacia las/os niñas/os). Al respecto, Kitzmann y cols. (2003), en un meta-análisis de 118 estudios, destacan que la mayoría de las investigaciones sobre los efectos de la exposición a VP no controlan estadísticamente posibles variables de confusión y que aquellas que sí lo hacen informan menos efectos significativos. Al respecto, diversos investigadores reconocen que la violencia puede impactar diferencialmente el funcionamiento de las/os niñas/os dependiendo de

factores individuales y contextuales (Wolfe y cols., 2003). Consecuentemente, los hallazgos de los estudios varían según la extensión en que los investigadores controlan distintas co-variables (Kitzmann y cols., 2003).

En cuanto a la pregunta sobre si otros factores moderan o median la asociación entre el abuso infantil de las madres, la exposición a VP y los problemas psicológicos de las/os niñas/os (segundo objetivo de la tesis), los hallazgos son variados según el factor específico analizado.Los resultados que se incluyen en el primer artículo, indican que el sexo y la edad de las/os niñas/os no tienen un rol moderador en las relaciones examinadas. De este modo, el abuso infantil de las madres afecta similarmente a niñas y niños, independientemente de la edad, aumentando el riesgo de presentar trastornos disruptivos. Por su parte, las/os niñas/os y adolescentes de ambos sexos presentan el mismo riesgo de sufrir problemas de comportamiento exteriorizados cuando han sido expuestas/os a VP. Estos resultados son concordantes con estudios previos que no confirman un efecto moderador del sexo (Kitzmann y cols., 2003; Sternberg y cols., 2006; Wolfe y cols., 2003) y la edad (Evans y cols.., 2008, Kitzmann y cols., 2003; Wolfe y cols., 2003).

Otro resultado relevante indica que el castigo físico hacia las/os niñas/os modifica los efectos de la exposición a VP sobre los problemas de comportamiento interiorizados. Las/os niñas/os que estuvieron expuestas/os a violencia física entre sus padres y, además, sufrieron castigo físico por parte de éstos, presentan aumentados problemas interiorizados. Por el contrario, la exposición a VP no se asocia a este tipo de problemas cuando el castigo físico parental es informado como ausente. Estos resultados destacan la importancia de considerar la significativa co-ocurrencia entre VP y castigo físico parental (Appel y Holden, 1998; Edleson, 1999; Osofsky, 2003). Y, a su vez, sugieren que cuando ambos tipos de violencia están presentes aumenta el riesgo de que las/os niñas/os manifiesten excesivo temor, miedo, comportamientos de retraimiento e inhibición (McCloskey y cols., 1995; Sternberg y cols., 2006).

Los resultados también aportan evidencias sobre el rol mediador del castigo físico parental en la relación entre la exposición a VP y los problemas de comportamiento exteriorizados. El castigo físico que sufren las/os niñas/os expuestas/os a VP contribuye en parte a explicar sus problemas de agresión y sus conductas antisociales. Esto sugiere que la VP puede afectar las capacidades parentales de las madres/padres, desplegando comportamientos abusivos hacia sus hijas/os (Holt y cols., 2008). Como consecuencia de ello, las/os niñas/os pueden desarrollar modelos representacionales de interacciones familiares agresivas, los cuales pueden ser generalizados a otras interacciones (Cicchetti & Lynch, 1995). Cabe destacar que los efectos mediadores del castigo físico fueron parciales, es decir la exposición a VP mantuvo

efectos directos sobre los problemas exteriorizados. Al respecto, dos explicaciones son delineadas. Por una parte, estos resultados concuerdan con estudios previos que indican que la exposición a VP afecta directamente los problemas de conducta de las/os niñas/os, independiente de otros factores familiares (McDonald y cols., 2000; Fergursson y Horwood, 1998). Una explicación alternativa es que otros factores ambientales o genéticos - no incluidos en este estudio - podrían explicar los problemas psicológicos de las/os niñas/os expuestas/os a VP (Fergursson y Horwood, 1998; McCloskey y cols., 1995).

La siguiente pregunta fue si la experiencia materna de haber sufrido abuso en la infancia y, posteriormente, VP en la adultez, se asocia con peores resultados en sus hijas/os (tercer objetivo de las tesis). Los hallazgos encontrados sugieren que la doble experiencia de victimización materna (abuso infantil y VP), constituye un riesgo significativo, particularmente, para el desarrollo de trastornos disruptivos en las/os hijas/os. Esto coincide con y provee evidencia a la hipótesis de un efecto acumulativo (Dubowitz y cols., 2001), es decir cada experiencia de violencia que han sufrido las madres se añadiría a una "carga general", conduciendo a resultados negativos en las/os niñas/os.

El segundo artículo, *Maternal Childhood Abuse, Intimate Partner Violence and Child Psychopathology: The Mediator Role of Mothers' Mental Health"* aporta evidencia sobre diferentes problemas de salud mental que pueden presentar las madres que han sufrido violencia y cómo estos problemas podrían explicar los problemas psicológicos de sus hijas/os (cuarto objetivo de la tesis). Los resultados obtenidos indican que las madres que han sufrido abuso infantil o VP manifiestan diversa sintomatología psiquiátrica y ésta puede afectar negativamente el bienestar de sus hijas/os, lo cual es consistente con estudios previos (Collishaw y cols., 2007; Levendosky y cols., 2001; Owen y cols., Street y cols., 2003). Los modelos de mediación analizados indican que el malestar psicológico general y los síntomas depresivos de las madres fueron importantes mecanismos a través de los cuales las experiencias maternas de abuso infantil y la exposición a VP influencian los problemas de comportamiento exteriorizados de sus hijas/os. En particular, los hallazgos destacan los síntomas depresivos maternos como un factor clave, en tanto fue la única variable que medió completamente las relaciones analizadas, cuando otros problemas maternos de salud mental (ansiedad y hostilidad) fueron conjuntamente examinados como mediadores. Estos resultados son consistentes con investigaciones anteriores (English y cols., 2003; Graham-Bermann, DeVoe, Mattis, Lynch, y Thomas, 2006; Graham-Bermann, Gruber, Howell y Girz, 2009; Lang Gartstein, Rodgers, y Lebeck, 2010), los cuales indican que en este tipo de poblaciones la depresión materna es un importante predictor de los problemas

psicológicos de las/os niñas/os. En mujeres con historia de violencia, una alta prevalencia de depresión ha sido documentada (Kendall-Tackett, 2002; Golding, 1999; Graham-Bermann y cols., 2009). Las madres depresivas pueden presentar importantes dificultades en la interacción con sus hijas/os, incluyendo menor disponibilidad emocional e incrementados afectos negativos hacia éstas/os (Cummings y Davies, 1994). Harnish, Dodge, y Valente (1995) sugieren que la interacción negativa entre madres depresivas y sus hijas/os se asocia con aumentados problemas de comportamiento exteriorizados, debido a que las/os niñas/os aprenden a responder negativamente durante una interacción o desarrollan pobres habilidades de interacción social.

Junto con lo anterior, a nivel bivariado, se encontró una asociación significativa entre la VP y el deterioro funcional de las/os niñas/os. Así también, todos los modelos de mediación indican que los problemas exteriorizados de las/os niñas/os afectan globalmente su funcionamiento habitual.

Los hallazgos referidos al rol moderador del sexo en los modelos de mediación analizados (quinto objetivo de la tesis), sugieren que la relación entre la historia materna de violencia, la salud mental de las madres y los problemas de comportamientos exteriorizados, es similar para niñas y niños. Estos resultados son coherentes con aquellos que indican que las niñas y los niños que viven en hogares violentos presentan similares problemas psicológicos (Kitzmann y cols., 2003; Sternberg y cols., 2006; Wolfe y cols., 2003). Asimismo, son concordantes con los aportes de otros trabajos que sugieren que la psicopatología materna puede afectar negativamente a las/os jóvenes, independientemente de su sexo (McCauley y cols., 2005)

El manuscrito "*Multiple Mediators of the relationships among Maternal Childhood Abuse, Intimate Partner Violence and Offspring Psychopathology"*, utiliza una perspectiva integrativa para examinar simultáneamente si la depresión materna, la parentalidad materna y parterna, el castigo físico y la exposición de las/os niñas/os a eventos vitales negativos explican los efectos de la historia materna de violencia sobre la psicopatología de sus hijas/os. Además, examina si la VP media la relación entre el abuso infantil de la madre y dichos factores familiares y contextuales. Los resultados obtenidos indican que la depresión materna explica los problemas exteriorizados y totales de las/os hijas/os de mujeres que han sufrido abuso infantil, VP y violencia acumulada (abuso infantil y VP). Los eventos vitales negativos constituye un importante mecanismo a través del cual el abuso infantil de la madre afecta los problemas totales de sus hijas/os, así como también explica la relación entre la violencia acumulada y los problemas exteriorizados y totales. Por otro lado, los modelos de múltiples mediadores muestran cómo el abuso infantil materno se asocia con VP y ésta con el castigo físico y la

exposición de las niñas/os a eventos vitales negativos, los cuales a su vez afectan los problemas de comportamiento de las/os niñas/os.

Los hallazgos de esta investigación destacan que los efectos del abuso infantil de la madre y/o la exposición a VP, dependen de diversos factores de riesgo, más que afectar directamente el bienestar de las/os niñas/os. Sustentan, además, la necesidad de una mirada comprensiva acerca de las consecuencias asociadas a estos tipos de violencia, enfatizando la relevancia de analizar el rol mediador de variables relacionadas con el contexto donde las niñas y los niños crecen. Así también, muestran la compleja interconexión entre diferentes formas de violencia y sus dañinos efectos para las mujeres y sus hijas/os, y la necesidad de extender nuestros conocimientos en esta materia.

Los resultados incluidos en este manuscrito confirman que la depresión materna es un mecanismo prominente mediante el cual las experiencias maternas de violencia ejercen un perjudicial efecto en las capacidades de las/os niñas/os para manejar la agresión (problemas exteriorizados) (Dehon, 2005; Morrel y cols., 2003) y, también, alteran otros aspectos del funcionamiento cognitivo y social (problemas totales) de éstas/os. El sufrir violencia puede llevar a sentimientos de pérdida de control y subsecuentes sentimientos de desesperación y depresión (Carlson y Dalenberg, 2000). Así, quienes han estado expuestas/os a eventos dolorosos pueden aprender que sus intentos por protegerse del daño son inútiles y, entonces, pueden detener sus esfuerzos por ayudarse a sí mismas/os. En las mujeres, los sentimientos de falta de poder, la experiencia de abuso y un disminuido soporte social contribuyen a sus síntomas depresivos (Campbell y cols., 1995). Cuando la violencia afecta el estado emocional de las madres, particularmente manifestando síntomas depresivos, esto afecta cómo ellas perciben y reaccionan ante los problemas de comportamiento de sus hijas/os (Morrel y cols., 2003). Recientes investigaciones han mostrado que la ausencia de depresión materna es un significativo predictor de adaptación y resiliencia en niñas/os que viven en familias violentas (Graham-Bermann y cols., 2009; Martinez-Torteya, Bogat, von Eye, y Levendosky, 2009). Al respecto, se postula que las madres depresivas pueden desplegar un modelo disfuncional de respuesta al estrés y que la falta de disponibilidad emocional puede llevar a sus hijas/os a esperar rechazo y sentir desesperanza (Martinez-Torteya y cols., 2009).

Cabe destacar que el castigo físico hacia las/os niñas/os media específicamente los efectos de la exposición a VP sobre los problemas exteriorizados. Las/os niñas/os que viven en hogares violentos y, además, son físicamente maltratadas/os, pueden experimentar continua hostilidad entre los miembros de su familia, pueden tener pocas oportunidades para interacciones pro-

sociales en la familia y pueden crecer vinculadas/os a un cuidador que directamente modela relaciones abusivas (Herrenkohl, Sousa, Tajima, Herrenkohl, y Moylan, 2008). En familias violentas, la VP es más probable que incremente la agresión física hacia las/os niñas/os, en lugar de generar *per se* pobres resultados en éstas/os (Salzinger y cols., 2002). Es comprensible que, para las/os niñas/os, ser repetidamente sujeto de agresión puede resultar más significativo que incluso la violencia contra la madre (McCloskey y cols., 1995). Los resultados obtenidos sostienen que particularmente los problemas exteriorizados están más fuertemente relacionados con el castigo físico que con la VP. Las/os niñas/os físicamente abusadas/os tienden a ser defensivamente hipervigilantes a señales hostiles, a sobre atribuir hostilidad a los otros, a adquirir repertorios de altamente accesibles respuestas agresivas a los problemas interpersonales y a evaluar el uso de su propia agresión más positivamente (Dodge, Pettit, Bates, y Valente, 1995; Dodge y Pettit, 2003). Es importante señalar que el abuso infantil de las madres se relacionó con el castigo físico hacia las/os niñas/os a través de la VP. Al respecto, es posible que los traumas infantiles de las madres sean un factor más distal que incrementa el riesgo para experimentar otros estresores más próximos, como la VP, los que afectan la parentalidad (Banyard y cols., 2003).

En las diferentes relaciones estudiadas, una alta frecuencia y significativos efectos mediadores fueron encontrados para los eventos vitales negativos. Destaca que el porcentaje de niñas/os expuestas/os a seis o más eventos vitales negativos alcanzó un 69% para aquellas/os cuyas madres sufrieron abuso infantil, tendiendo al incremento para aquellas/os cuyas madres experimentaron VP o ambas (79.3% y 84.6%, respectivamente). Los modelos de mediación analizados sugieren que las/os hijas/os de mujeres que han sufrido estos tipos de violencia pueden tener una mayor probabilidad de crecer en un ambiente que los ponen en riesgo de vivir experiencias traumáticas, las cuales pueden perturbar su desarrollo normal. Al respecto, Collishaw y cols. (2007), encontraron que las/os hijas/os de madres abusadas en su infancia tuvieron un mayor riesgo de experimentar un amplio rango de eventos vitales estresantes; la exposición de las/os niñas/os a eventos abusivos-atemorizantes y los cambios en la unidad familiar fueron los mediadores más importantes que explicaron cómo las experiencias maternas de abuso infantil afectan el ajuste psicológico de sus hijas/os. Por otro lado, la investigación ha mostrado que la exposición a VP puede alterar ampliamente el funcionamiento y el ambiente familiar (Holt y cols., 2008) y que un "paquete de adversidades", esto es, múltiples factores estresantes, pueden acumularse e impactar la vida de las/os niñas/os expuestos a VP (Rossman, 2000). McCloskey y cols. (1995) informan que las/os niñas/os expuestas/os a VP tienen un serio

riesgo de sufrir abuso sexual, el cual puede ser utilizado por las parejas como una estrategia para dañar o coaccionar a la mujer. Tal como postulan Martinez-Torteya y cols. (2009), los eventos vitales negativos experimentados por las/os niñas/os expuestas/os a VP pueden reflejar el desorganizado ambiente que las mujeres y sus hijas/os están enfrentando.

Por último, los modelos de mediación que valoraron la violencia acumulada aportan evidencia acerca del efecto conjunto de dos importantes experiencias de violencia (abuso infantil y VP). Sólo en estos modelos, la parentalidad paterna, concretamente la sobreprotección, emerge como un predictor significativo de problemas de comportamiento de las/os niñas/os. Esto corrobora que en familias afectadas por VP futuros estudios son necesarios para examinar la relación padre-hija/o (Guille, 2004). También, sustentan la potencial utilidad de examinar diferentes experiencias traumáticas, tanto individualmente como en combinación (Banyard y cols., 2001).

4.2 Implicaciones clínicas

Los resultados que se presentan en esta tesis aportan conocimientos que podrían tener implicaciones prácticas a nivel preventivo y clínico, contribuyendo a diseñar intervenciones pertinentes y sensibles a las particulares condiciones que pueden estar afectando a las/os niñas/os y adolescentes que acuden a servicios de salud mental.

Considerando la magnitud del problema de la violencia contra la mujer en España, tanto abuso infantil como VP, y sus profundas consecuencias no sólo en la salud mental de las mujeres, sino también en la de sus hijas/os, los clínicos y otros profesionales de la salud mental deberían ser conscientes de la relevancia que tiene la detección temprana de esta vulnerable población. La evaluación de la historia materna de violencia, así como del castigo físico hacia las/os niñas/os, puede ayudar a identificar oportunamente a aquellas/os que tienen un riesgo aumentado de presentar serios problemas psicopatológicos. Los clínicos que trabajan con niñas/os que manifiestan problemas comportamentales y emocionales deberían rutinariamente explorar y registrar la historia de violencia que han sufrido las madres. Un cribado sobre victimización materna aparece como prioritario, en tanto puede ayudar a orientar intervenciones efectivas que provean soporte y resguarden la protección y seguridad tanto de las madres como de sus hijas/os. Así también, desde otro ámbito, los profesionales que trabajan con mujeres que han sido victimizadas deberían tener en cuenta que las/os hijas/os de éstas pueden estar sufriendo las consecuencias asociadas. Al respecto, se destaca la necesidad de desarrollar intervenciones preventivas y terapéuticas con las/os niñas/os y sus madres, activar recursos protectores de tipo

individual, familiar, social o legal para detener la violencia (VP y castigo físico hacia las/os niñas/os), minimizar su dañino impacto y evitar futuras exposiciones a experiencias traumáticas.

En los estudios presentados se identifican varios factores contextuales y familiares como importantes mecanismos que subyacen a los problemas psicopatológicos que presentan las/os hijas/os de mujeres con historia de violencia, sugiriendo posibles objetivos de intervención. En el caso que los clínicos, que trabajan con niñas/os y adolescentes, detecten experiencias maternas de abuso en la infancia y/o VP, sería recomendable valorar la presencia de depresión materna, estrategias de disciplina abusivas y eventos negativos en la vida de las/os niñas/os. Esto, permitiría distinguir las necesidades específicas de tratamiento para la familia y, también, posibilitaría identificar factores externos que pueden influenciar o reducir la efectividad del tratamiento.

Proporcionar asistencia focalizada en la salud mental de las madres con historia de violencia, puede ser un importante objetivo en la prevención e intervención en niñas/os con dificultades de comportamiento. En este sentido, la evaluación del estado psicológico de las madres puede orientar a los clínicos para diseñar planes de intervención. Por ejemplo, ayudar a las madres a buscar tratamientos efectivos para eliminar la sintomatología depresiva y, también, para elaborar y superar las vivencias traumáticas; promover el desarrollo de relaciones saludables y nutritivas entre madres e hijas/os; entregar pautas educativas a las madres que favorezcan una adecuada socialización y un óptimo desarrollo en sus hijas e hijos, entre otros.

Los incrementados problemas disruptivos encontrados en las/os hijas/os de mujeres que han sufrido violencia subrayan la relevancia clínica de realizar una rigurosa evaluación y un tratamiento efectivo para reducir el riesgo de comportamientos agresivos y antisociales. La intervención en esta área, constituye una oportunidad para interrumpir el círculo de la violencia y ayudar a que las madres y sus hijas e hijos puedan vivir en un contexto libre de violencia.

Con relación a lo anterior, surge la pregunta acerca del rol de la investigación y la práctica clínica para reconocer y mitigar los niveles de violencia en la familia como un factor protector, no sólo para esta generación, sino también para la siguiente. Al respecto, los hallazgos de esta tesis sustentan la necesidad de ampliar los conocimientos sobre la interconexión entre diferentes tipos de violencia - abuso infantil, exposición a VP y castigo físico parental - y sus dañinos efectos a corto y largo plazo. Debido a que la violencia no es un acto aislado, sino que está presente en la vida de las personas, no puede ser investigada de manera restrictiva (White y cols., 2010b). Por ello, tal como plantea Saunders (2003), los clínicos e investigadores que trabajan en el ámbito de la violencia tienen el desafío de integrar los conocimientos

provenientes de diferentes campos de estudio a través un trabajo interdisciplinario y colaborativo. Mediante un trabajo coordinado entre distintas áreas de especialización, sería posible desarrollar una mirada más comprensiva acerca del sujeto que ha sufrido violencia y las experiencias de los miembros de su familia (Hughes, Humphrey, y Weaver, 2005)

4.3 Direcciones para futuras investigaciones

Considerando el carácter multidimensional de la violencia y la diversidad de factores asociados a sus consecuencias, numerosas preguntas quedan aún sin responder y podrían ser foco de futuras investigaciones.

Los resultados de esta tesis indican que factores como el sexo y la edad de las/os niñas/os no son variables significativas para comprender el impacto diferencial de la violencia. No obstante, debido a que en población española esta cuestión ha sido escasamente estudiada, adicionales investigaciones podrían contribuir a dilucidar el papel modificador de estas variables. Además, futuros trabajos podrían examinar si otros factores individuales predicen los resultados de las/os hijas/os de mujeres con historia de violencia. En el área de la exposición a VP, la literatura sugiere la relevancia de investigar variables como el temperamento de las niñas y los niños, sus actitudes hacia las relaciones violentas o ante interacciones agresivas, y sus estrategias de afrontamiento (Kitzmann y cols., 2003; Martínez-Torteya y cols., 2009; McCloskey y Lichter, 2003; Wolfe y cols., 2003). Más investigaciones son necesarias para identificar factores concurrentes de las madres y sus hijas/os, y sus efectos, por ejemplo, Martínez-Torteya y cols. (2009) informan que entre las/os niñas/os expuestas/os a VP, la combinación de un temperamento fácil y la ausencia de depresión materna se asocia a resultados positivos.

La literatura actual recomienda diseñar investigaciones basadas en modelos comprensivos que examinen los mecanismos a través de los cuales la violencia ejerce sus efectos (White y cols., 2010a). Comprender cómo el castigo físico, la exposición a VP y otros factores, se relacionan unos con otros es un importante primer paso para la prevención y la intervención (Herrenkohl y cols., 2008). De acuerdo a una reciente revisión de Wolfe (2010), tres factores claves sobre el rol de las madres/padres en el maltrato a las hijas/os han sido identificados: 1) características de la interacción diaria entre madre/padre e hija/o; 2) aumentada frustración-agresión parental en relación a la crianza; 3) dificultades en el procesamiento cognitivo y social de la información. Examinar la influencia de estas variables en los problemas psicopatológicos de las/os hijas/os de mujeres que han sufrido diferentes tipos de violencia, aportaría valiosa

información para la intervención. En este sentido, estudios adicionales que consideren las características tanto de la parentalidad materna como paterna son fundamentales.

Factores como la cohesión familiar, la cualidad de las relaciones en la familia y el soporte social percibido, tanto por las madres como por sus hijas/os, han mostrado importantes efectos mediadores en la relación entre exposición a VP y los problemas de las/os niñas/os (Owen y cols., 2009; Owen y cols., 2008). Futuros trabajos con muestras que incluyan madres con experiencia de abuso infantil o violencia acumulada (abuso infantil y VP) podrían examinar el rol mediador de estas variables. La información de las niñas y los niños sobre la violencia y factores asociados debería ser incluida.

Como se ha mencionado, una incipiente y significativa área de investigación se focaliza en explorar los efectos de la violencia que han sufrido las mujeres a lo largo de la vida (White y cols., 2010b). Sería recomendable examinar varios tipos de violencia y valorar cómo diferentes características de éstas, tales como su severidad o su naturaleza episódica/continua, pueden alterar el desarrollo de sus hijas/os. En especial, más estudios se requieren sobre la violencia acumulada y los mecanismos a través de los cuales afecta a las/os niñas/os. La continua investigación sobre los resultados de las mujeres que han sufrido violencia y sus hijas/os, ayudaría a identificar factores que pueden mantener comportamientos disfuncionales, así como aquellos que pueden atenuar sus dañinos efectos.

5. CONCLUSIONES

Los artículos científicos que se han presentado en esta tesis permiten delinear las siguientes conclusiones respecto a las hijas y los hijos de mujeres con historia de violencia que acuden a servicios de salud mental:

- Las experiencias de violencia que han sufrido las madres influencian significativamente los problemas clínicos de sus hijas/os. El abuso en la infancia, la exposición a VP o ambas, constituyen un importante factor de riesgo para severos problemas de conducta en las/os niñas/os y adolescentes. En términos de diagnósticos DSM-IV, las experiencias maternas de victimización infantil y de re-victimización (abuso infantil y posterior VP) aumentan el riesgo de trastornos disruptivos. Las/os hijas/os de mujeres que han sufrido abuso infantil, y además VP, presentan la más alta prevalencia de este tipo de trastornos.

- Los efectos del abuso infantil de la madre sobre los trastornos disruptivos, así como los de la exposición a VP sobre los problemas de comportamiento exteriorizados, son similares para las hijas y los hijos, independientemente que estén en la etapa escolar o en la adolescencia.

- Cuando las/os niñas/os padecen dos tipos de violencia, como son la exposición a VP y el castigo físico por parte de sus madres/padres, tienen un riesgo aumentado de sufrir problemas de comportamiento interiorizados, incluyendo síntomas de ansiedad, depresión y somatización. Esta sintomatología no aparece como significativa cuando las/os niñas/os únicamente han estado expuestas/os a VP.

- Tanto el abuso infantil como la VP incrementan el malestar psicológico general y los síntomas depresivos de las madres, los que a su vez incrementan los problemas de comportamiento exteriorizados de las/os hijas/os. Y, estos problemas aumentan el deterioro en su funcionamiento habitual. El sexo de las/os niñas/os no modifica este patrón de relaciones.

- Diferentes factores relacionados con el contexto de desarrollo de las/os niñas/os contribuyen conjuntamente a comprender el impacto de la historia materna de

violencia sobre los problemas psicopatológicos de sus hijas/os. El abuso infantil de la madre, la exposición a VP y la violencia acumulada (abuso infantil y VP) incrementan los síntomas depresivos maternos y la exposición de las/os niñas/os a eventos vitales negativos. A su vez, éstos incrementan los problemas de comportamiento de las/os niñas/os y adolescentes. El castigo físico que sufren las/os niñas/os específicamente media los efectos de la exposición a VP sobre los problemas de comportamiento agresivos y antisociales.

- La VP tiene un papel mediador en la relación entre el abuso infantil de las madres y factores de riesgo para problemas psicopatológicos de las/os niñas/os, como son el castigo físico y la exposición a eventos vitales negativos.

Los estudios presentados en esta tesis ayudan a visibilizar la compleja trama que entrelaza distintos tipos de violencia contra las mujeres y las/os niñas/os, los factores de riesgo asociados y, fundamentalmente, las negativas consecuencias que genera la interrelación entre estos elementos. Estos nuevos conocimientos contribuyen a esclarecer focos de divergencias y a responder preguntas actuales en el ámbito de la investigación científica. Asimismo, atienden a necesidades que parecen prioritarias en el contexto de la práctica clínica en España, en tanto una mayor comprensión de esta problemática puede ayudar a fortalecer los esfuerzos en la prevención y la erradicación de la violencia.

6. TRABAJOS EMPÍRICOS

6.1 Primer estudio

Maternal experiences of childhood abuse and intimate partner violence: Psychopathology and functional impairment in clinical children and adolescents

Miranda, J., de la Osa, N., Granero, R., & Ezpeleta, L. (2011). Maternal experiences of childhood abuse and intimate partner violence: Psychopathology and functional impairment in clinical children and adolescents. *Child Abuse & Neglect, 35,* 700– 711.

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Maternal experiences of childhood abuse and intimate partner violence: Psychopathology and functional impairment in clinical children and adolescents☆

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ABSTRACT

Objectives: The current study examined the independent effects of mothers' childhood abuse (CA) and intimate partner violence (IPV) on psychopathology and functional impairment in children; and the potential moderating and mediating role of individual and family factors in these relationships. Additionally, this study explored the potential cumulative effects of both maternal CA and IPV on children's outcomes.
Method: The sample included 547 Spanish children and adolescents aged between 8 and 17 years, and their parents, who had accessed mental health services. The assessment was based on structured interviews with the children and their parents. Statistical analyses were carried out through hierarchical multiple, negative-binomial and logistic regressions, and Structural Equation Models.
Results: Children whose mothers experienced CA and those whose mothers suffered physical IPV showed increased DSM-IV disruptive disorders and externalizing behavior problems, respectively. Children who directly observed physical IPV and also suffered physical punishment by parents showed increased internalizing problems. IPV had effects, either direct or indirect by physical punishment, on children's externalizing problems. Cumulative effect analyses indicated that the prevalence of disruptive disorders was highest in children whose mothers had suffered both CA and IPV.
Conclusion: Spanish children whose mothers have suffered CA, IPV or both, are at high risk of serious conduct problems, whereas children exposed to IPV and who were also physically abused are at greater risk of internalizing problems. Physical punishment of children contributes in part to explain externalizing problems of IPV-exposed children. These findings indicate potential targets of assessment and intervention for families seeking help in mental health services.

Childhood abuse experienced by mothers (CA) and intimate partner violence (IPV) have been significantly linked to poorer outcomes in children (Collishaw, Dunn, O'Connor, & Golding, 2007; Holt, Buckley, & Whelan, 2008). Most research has separately examined children whose mothers suffered CA or IPV (Kitzmann, Gaylord, Holt, & Kenny, 2003; Roberts, O'Connor, Dunn, & Golding, 2004; Wolfe, Crooks, Lee, McIntyre-Smith, & Jaffe, 2003). Examining the independent effects

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of CA and IPV can offer a detailed report on the possible risk to children's psychopathology. In this field, there has been growing interest in examining the impact of maternal lifetime violence on the mental health problems in children (Koverola et al., 2005; Morrel, Dubowitz, Kerr, & Black, 2003), with recent research suggesting that cumulative maternal violence experiences can adversely affect psychological outcomes in children (Dubowitz et al., 2001).

In Spain, the first epidemiological study on childhood abuse (CA), conducted in 1988, reported a high prevalence, with 4 per thousand of the population under 16 years being victims of maltreatment (Inglés, 1991). Current data on the prevalence of child sexual abuse in Spanish university students indicate that a 19% of women reported such an experience, suggesting that this is a widespread problem in Spanish society (Pereda & Forns, 2007). Likewise, IPV, defined as violence that occurs in couples, is now a serious social and health problem, reaching a prevalence of 3.19 per thousand women, with an increased incidence of 153.7% between the years 2000 and 2004 (Queen Sofia Center, 2007). According to the report from United Nations Secretary in Spain each year around 188,000 children are exposed to IPV (UNICEF, 2006). However, published data could not be found on the link between the experiences of violence during the lifetime of the mothers and the psychological outcomes in Spanish children.

Research indicates that mothers' CA is associated with adverse effects in their children, including high levels of hyperactivity, emotional and behavioral problems, difficulties in relationships with peers (Roberts et al., 2004), adjustment problems and poor prognosis in mental health (Collishaw et al., 2007). On the other hand, IPV is related to internalizing and externalizing problems, symptoms of trauma, and a wide range of cognitive, social and emotional difficulties in children (Evans, Davies, & Dilillo, 2008; Kitzmann et al., 2003; Wolfe et al., 2003). In adolescence, offspring of mothers who have suffered IPV are at greater risk of anxiety and conduct disorders, alcohol problems, criminality (Fergursson & Horwood, 1998), depressive disorders and physical aggression against peers and parents (McCloskey & Lichter, 2003).

Developmental psychopathology provides an integrated theoretical framework to understand how mothers' CA and IPV could affect the child's psychological functioning. From this perspective, adaptive or maladaptive development results from a complex interplay of individual variables, the developmental stage and external environmental factors (Cicchetti, 1993; Rutter & Sroufe, 2000). A child who has suffered abuse usually fails to achieve development-tasks successfully (Cicchetti & Lynch, 1995). In this way, mothers who have suffered CA may show psychological impairment and parenting problems, which in turn negatively affect their children's functioning (Collishaw et al., 2007; Roberts et al., 2004). Likewise, children who live in violent households growing up in an environment that fails in providing the necessary conditions for normal development (Cicchetti & Lynch, 1995). Therefore, violence between family members, such as mothers' experiences of IPV, may lead to efforts by the children to accommodate to these situations which are often characterized by intense emotions (Wolfe et al., 2003).

Studies have shown that the effects of violent experiences vary depending on the individual factors related to the child. The child's sex and age are recognized as important variables in interpreting the effects of family violence (Wolfe et al., 2003). However, literature shows discrepancies about the potential moderating role of these variables. Two meta-analyses (Kitzmann et al., 2003; Wolfe et al., 2003) and research by Sternberg, Baradaran, Abbot, Lamb, and Guterman, (2006) found no significant differences for girls and boys exposed to IPV, whereas Evans et al. (2008) reported that the link between IPV and externalizing symptoms was significantly stronger for boys. The age of the child was found to contribute to the effects of IPV in research by Sternberg et al. (2006), while three meta-analyses (Evans et al., 2008; Kitzmann et al., 2003; Wolfe et al., 2003) found that the child's age was not a significant moderator.

Family factors such as child physical punishment may also influence the psychological problems of children whose mothers suffered violence. Nevertheless, there is inconclusive evidence on the potential moderating or mediating role of these factors. Mothers with CA experiences may be more likely to display harsh physical discipline (DiLillo & Damashek, 2003) or abusive parenting (Cicchetti & Lynch, 1995). Physical punishment of children is frequent in families experiencing IPV (McCloskey, Figueredo, & Koss, 1995; Osofsky, 2003) and studies have reported high rates of co-occurrence between IPV and child physical abuse ranging from 45 to 70% (Holt et al., 2008). Exploring child abuse as a moderator of IPV, Wolfe et al. (2003) reported preliminary evidence that the children who were both IPV-exposed and direct targets of abuse showed a worse functioning, compared with those who were only IPV-exposed. Sternberg et al. (2006) found a greater risk of internalizing problems when children had been physically abused, in addition to being exposed to IPV. Besides, a recent study found a significant interaction between these two forms of violence, showing increased psychological symptoms in abused children who are exposed to higher levels of IPV (Kaslow & Thompson, 2008). However, Kitzmann et al. (2003) reported no significant differences between children in IPV-contexts who suffered physical abuse and those who did not. On the other hand, child abuse has been suggested as a mediator, that is, one of the mechanisms through which IPV could affect children (Jouriles, Barling, & O'Leary, 1987; Levendosky & Graham-Bermann, 2001). Literature provides support that IPV would lead to child abuse, which in turn would lead to psychopathological problems in children (Salzinger et al., 2002). Similarly, parental hostility has found to be a pathway that could explain the adjustment problems in offspring of mothers that suffered abuse in childhood (Collishaw et al., 2007).

Research has indicated that mothers with a history of violence show increased mental health problems (Koverola et al., 2005; Morrel et al., 2003). Poor maternal mental health was found to play a significant moderating role in the relation between IPV and psychological outcomes of adolescents (Levendosky, Huth-Bocks, & Semel, 2002). Adolescents in IPV contexts were more likely to exhibit depression and trauma symptoms, when their mothers were suffering such symptoms (Levendosky et al., 2002). A previous study of IPV-exposed children also reported findings in this line (Levendosky & Graham-Bermann, 2000). On the other hand, studies examining the potential mediating role of mothers' mental health have indicated that

maternal depressive symptoms significantly mediated the effect of mothers' violence history on their children's psychological problems (Koverola et al., 2005; Morrel et al., 2003); as well as affective and anxiety symptoms of mothers were the pathways by which maternal CA experiences negatively affected their children's well-being (Collishaw et al., 2007; Roberts et al., 2004). In contrast, studies have reported that, although mothers involved in IPV had an elevated psychopathology it was unrelated to their children's problems and did not act as a mediator (McCloskey et al., 1995). Other researchers that have examined mothers' and fathers' mental health problems reported that IPV was associated with parental alcoholism and criminality (Fergursson & Horwood, 1998) and fathers involved in IPV were more likely to show psychopathology problems (Eckhardt, Samper, & Murphy, 2008). However, there are scarce studies exploring the moderating or mediator role of the fathers' mental health.

Some recent studies that have examined mothers' lifetime exposure to violence (in childhood or adulthood) suggest that the mothers who have suffered any such exposure report more behavioral, emotional, and social problems in their children, compared with other mothers not exposed (Koverola et al., 2005; Morrel et al., 2003). Nevertheless, few researchers have explored the potential cumulative effect of mothers' experiences of violence on children's outcomes. Dubowitz et al. (2001) found that the mothers, who have suffered violence both as an adult and as a child, reported a greater degree of psychological problems in their children than those who have not suffered at all or who have only suffered in one period of their life. According to the cumulative risk model (Rutter, 1979), which proposes that the prevalence of clinical problems increases as the number of risk factors increases, Dubowitz et al. (2001) suggest that greater exposure to violence in the mothers is associated with worse psychological outcomes in children.

Researchers in health services have found that the mothers' experiences of violence are a common problem (Dubowitz et al., 2001; Morrel et al., 2003). McDonald, Jouriles, Norwood, Shinn, and Ezell (2000), in a study with families seeking clinical services for their children's behavioral difficulties, found that IPV occurred in 48% of families. This research highlights the relevance of extending studies in clinical populations and promoting the identification of factors that may influence differentially on children's clinical problems. In this regard, and on the basis that a particular event may result in different difficulties (Cicchetti, 1993), research in clinical samples also provides an opportunity to examine the link between maternal violence experiences and a wide range of child's psychopathological problems, including externalizing and internalizing behavior, as well as different DSM-IV diagnostic categories.

Considering the significant prevalence of experiences of violence in Spanish women and the increased risk of harmful consequences for their offspring, this study aims to examine, in a large sample of Spanish outpatient children and adolescents: (1) the independent effects of mothers' CA and IPV on psychopathology and functional impairment, and the potential moderating and mediating role of individual and family factors; (2) the potential cumulative effect of both mothers' CA and IPV on the psychopathology and functioning of their children. It was hypothesized that (1) mothers' CA and IPV would be positively associated with psychopathological problems and impairment in children; (2) family factors (parental psychopathology, physical punishment of children) would increase the effects of maternal CA and IPV on children's psychopathological problems; (3) maternal CA and IPV would be associated with children's psychopathological problems through family factors (parental psychopathology, physical punishment of children). Because of the inconclusive evidence about the moderating role of children's sex and age, no hypotheses was proposed for these analyses; (4) the mothers' exposure to violence in two periods of life (both CA and IPV) would be related to worse outcomes in children, compared with maternal exposure in just one period or no exposure at all.

Method

Participants

The sample included 547 children and adolescents, between 8 and 17 years of age, and their parents, who were recruited from psychiatric outpatient settings of the public health network in the metropolitan area of Barcelona (Spain). Families from 27 municipalities of this geographic area were included, representing populations living in north-eastern Spain. Subjects were referred by their general practitioner, regardless of socioeconomic status. All the participants were included in this study after coming into contact with mental health centers. The children visited the centers for the first time and were interviewed as part of their diagnostic process, but did not receive treatment at the time of the study.

The individuals who had mental retardation or pervasive developmental disorders were excluded from the study ($n = 5$). Thirty individuals refused to participate in this study, there were no differences in age and socio-economic status among those who participated in the study and those who rejected it. Nevertheless, there was a significantly higher percentage of girls among those who refused to participate ($p = .031$).

Measures

The Schedule of Risk Factors (SRF; UED, 1997) is a structured interview based on the Service Utilization and Risk Factors interview (Goodman et al., 1998). Inter-interviewer reliability and concurrent validity are acceptable in Spanish populations (Guillamón, 1999). It comprises a comprehensive compendium of factors and situations that may affect mental disorders in children and adolescents. There are versions for parents and children. In this study the following sections, which provide categorical data, were used: (1) information from mothers about their CA (psychological, physical and/or sexual); (2)

information from children about the presence of IPV through the *Child's Perception of Interparental Conflict Scale*, which has demonstrated adequate levels of internal consistency (alpha values above .70) and test–retest reliability (correlations above .68) (Grych, Seid, & Fincham, 1992); (3) information from children and parents about the occurrence of child physical punishment, measured through *Parental Discipline Practices Scales* (Goodman et al., 1998), which has showed acceptable internal consistency in previous psychometric studies (alpha value around .70). Physical punishment was defined present if either the parents or the child reported a positive answer on some of the two items: "spank or slap (you/her/him)" and "hit (you/her/him) with a belt or other object." Also, the presence of mental disorders in parents was assessed through the *Family Psychiatric History Screen for Epidemiologic Studies* (Lish, Weissman, Adams, Hoven, & Bird, 1995). Mothers and fathers are rated with a value if they presented problems related to the 15 DSM-IV diagnoses included in this screening (mood disorders, anxiety disorders, substances, psychosis and disruptive disorders). Based on the answers, each parent is then classified as positive (value 1) or negative (value 0) for each diagnostic category. From this binary information a quantitative variable was created, which is the count of the number of disorders reported by each parent. For adult informants reporting on themselves, specificity was very good (average .84%) and sensitivity was moderate (average .64%) (Lish et al., 1995).

Diagnostic Interview for Children and Adolescents-IV (DICA-IV; Reich, Leacock, & Shanfeld, 1997). This is a semi-structured diagnostic interview that assesses the presence of the most frequent psychological problems in children and adolescents, according to diagnostic categories of DSM-IV (American Psychiatric Association, 1994). There are 3 versions: for children (8–12 years), adolescents (13–17 years) and their parents. The DICA has been adapted and validated for Spanish populations with satisfactory psychometric properties. The agreement between interviewers ranged from good to excellent (kappa values from .65 to 1) (de la Osa, Ezpeleta, Domènech, Navarro, & Losilla, 1996; Ezpeleta, de la Osa, Júdez, et al., 1997) and the test–retest reliability was good (kappa values from .41 to 1) (Ezpeleta, de la Osa, Domènech, Navarro, & Losilla, 1997). The diagnoses were generated by combining information from parents and children at symptom level, that is to say, the symptom was present if either the parent or the child reported it. The DICA was used as a categorical measure of psychopathology in children and adolescents.

Child Behavior Checklist (CBCL; Achenbach & Rescorla, 2001) is an inventory informed by parents that covers a variety of behavioral and emotional problems in children and adolescents between 6 and 18 years. It has 113 items with 3 response options (0-never; 1-sometimes; and 2-always). The CBCL has adapted for Spanish populations with satisfactory psychometric properties. Factorial studies confirmed the internal structure of the instrument and reliability and accuracy were excellent for the empirical scales (Cronbach's alpha values above .8) (Sardinero, Pedreira, & Muñiz, 1997). The CBCL was used as a dimensional measure (continuous data) of psychopathology in children and adolescents.

Child and Adolescent Functioning Assessment Scale (CAFAS; Hodges, 1997) is a dimensional measure of the level of functional impairment in children and adolescents. It contains the following 8 psychosocial areas: school, home, community, behavior toward others, mood/emotion, self-harmful behavior, substance use and thinking. Each scale is scored in 4 levels of impairment (0-no impairment; 10-mild; 20-moderate; and 30-severe). A total score is also generated as a lineal combination of the direct scores in the 8 sub-scales. In this study, the higher (worse) of the 2 scores resulting from the information from parents or children was used. The psychometric properties of this instrument have been studied in Spanish populations with satisfactory results: the agreement between interviewers ranged from good to very good (kappa values from .79 to .94), except for behavior toward others (.45) and for substance use (.64) (Ezpeleta, Granero, de la Osa, Domènech, & Bonillo, 2006). In this study the total scores (continuous data) were used as a measure of global functional impairment in children.

Procedure

The study had the approval of the Ethics Committee of the Universitat Autònoma of Barcelona. Informed written consent from parents and oral assent from children and adolescents to participate in the study was obtained. Afterwards, the DICA-IV and SRF were administered. Different interviewers (PhD students and psychologists) previously trained in the use of all the assessment instruments, interviewed separately and simultaneously parents and their children. After completing the interview, the interviewers rated the CAFAS. This assessment was later incorporated into the study and was administered to 515 children, who did not differ significantly in demographic features from the total sample. The CBCL was given to the parents to be returned at a later time but it was administered verbally if they had reading difficulties. It was returned by 339 parents (62%), whose children did not differ significantly in sex, age, and socioeconomic status from those who did not return it. Once the full assessment was completed, the researchers gave a detailed report on the results of the evaluation to the clinicians of the centers concerned. All significant recorded indication of risk was properly informed to the centers' staff. The Spanish public health system has support services for battered women, but as this was not the reason for the clinical consultation, information regarding the specific treatment services that is provided to caregivers was not made available to the researchers.

Statistical analysis

Data were analyzed with SPSS 15.0.1 for Windows and EQS6.1. The comparisons of demographic data between the groups studied were based on Chi-square procedures for categorical variables (the exact method using the Monte-Carlo estimation was used in the case of frequencies expected to be lower than 5) and ANOVA for quantitative.

Table 1
Sociodemographic characteristics of the sample.

	Total ($N = 547$)	Maternal exposure to violence				p
		S0 ($N = 422$)	S1 ($n = 49$)	S2 ($n = 58$)	S3 ($n = 18$)	
Sex						
Girls (%)	46.3	45.3	61.2	34.5	66.7	.013*
Boys (%)	53.7	54.7	38.8	65.5	33.3	
Age. Mean (SD)	13.3 (2.3)	13.3 (2.3)	13.2 (2.4)	13.2 (2.5)	13.7 (2.1)	.859
Mother's age. Mean (SD)	40.6 (5.5)	40.8 (5.4)	40.1 (5.5)	39.2(5.6)	41.8 (7.6)	.154
Father's age. Mean (SD)	43.2 (5.8)	43.5 (5.8)	42.6 (5.6)	41.8(6.1)	43.8 (7.5)	.280
SES[a] (%)						
Upper/Middle Upper	14.2	14.2	10.6	15.8	17.6	.983
Middle/Lower Middle	60.8	61.0	63.8	59.6	52.9	
Lower	25.0	24.8	25.5	24.6	29.4	

S0: No exposure to experiences of violence.
S1: Only childhood abuse.
S2: Only IPV in adulthood.
S3: Both childhood abuse and IPV in adulthood.
* $p < .05$.
[a] SES: Socioeconomic status (Hollingshead, 1975). SD = standard deviation.

Bivariate correlations valued the degree of association between the study variables. Hierarchical regression analyses were used to measure the independent effects of CA and IPV on children's psychopathology and functional impairment, while controlling for the covariates. The set of covariates were entered into the models in the first-step: child's sex and age, mother's and father's psychopathology and physical punishment against children. Because comorbidity is a common problem in child psychopathology, the models related to specific DSM-IV diagnostic categories also included the presence of other different comorbidity as covariate. In the second step, the two main variables were added into the models: maternal CA and IPV. In the third step, the interaction terms between mothers' violent experiences (CA, IPV) and potential moderating variables (individual and family factors) were entered in the models to explore whether the proposed factors modified the effects of maternal CA and IPV on children's outcomes. The moderation was considered present when interaction terms between mothers' experiences of violence and hypothesized moderating variables achieved p-values < 05. If interaction terms were significant, they were kept in the final model and the effects of maternal experiences of violence were estimated separately for different levels of moderating variable. Binary outcomes (DSM-IV disorders) were analyzed using logistic regressions and quantitative responses (CBCL, CAFAS) using multiple regressions. Count data were analyzed with negative binomial regression, this technique is the equivalent to Poisson-regression but it controls the over-dispersion problem of recounts (Hilbe, 2007). Predictive accuracy was evaluated by the change (increases) in R^2.

Structural Equation Models (SEM) were used to test the potential mediating role of parents' mental health and physical punishment of children in the link between maternal history of violence (CA, IPV) and children's psychopathological problems (CBCL). A series of regression equations were used in order to test these mediational models for the binary outcome variables (DSM-IV disorders). All the mediation analyses included children's sex and age as covariates. Following the conditions and procedures outlined by Baron and Kenny (1986), the mediation was supported when four criteria were satisfied: (1) maternal CA or IPV (predictor) was significantly related to parents' mental health or physical punishment of children (hypothesized mediator); (2) maternal CA or IPV (predictor) was significantly related to children's psychopathology problems (outcome); (3) parents' mental health or physical punishment (hypothesized mediator) was significantly related to the children's psychopathology problems (outcome); (4) maternal CA or IPV (predictor) reduced its effect or had no effect on children's psychopathological problems (outcome), when the parents' mental health or physical punishment (hypothesized mediator) was included in the mediational models. The goodness-of-fit of final SEM was valued through the usual indexes: Chi-square test (χ^2), Comparative Fit Index (CFI) and the Root Mean Squared Error of Approximation (RMSEA). It was considered a good fit if: the Chi-square achieved a p value above .05, the CFI coefficient was higher than .90, and the RMSEA was lower than .08 (Byrne, 2001). The method of Kenny, Kashy, and Bolger (1998) was used to test the mediator's significance.

Next, the contribution of lifetime maternal violence experiences was evaluated (not general exposure to violence; CA only, IPV only, and both) in terms of the effect on the child's psychopathology and functioning. Considering that these experiences could be seen as an ordered scale, trend analyses were used. Polynomial contrasts were obtained through regression models to explore the linear and quadratic trends into the relationship between life-time maternal experience of violence and children's psychopathological problems and functioning. The set of covariates were also included.

Results

Demographic characteristics of the participants are shown in Table 1. Participants were classified into the 4 groups according to life-time maternal violence experiences, based on the mothers' and children's reports to the *Schedule for Risk Factors* (SRF). Of the 547 mothers participating in this study, it was reported that 77% ($n = 422$) were not exposed to any experience of violence, 8.96% ($n = 49$) had suffered CA only, 10.6% ($n = 58$) IPV only and 3.29% ($n = 18$) had both experiences.

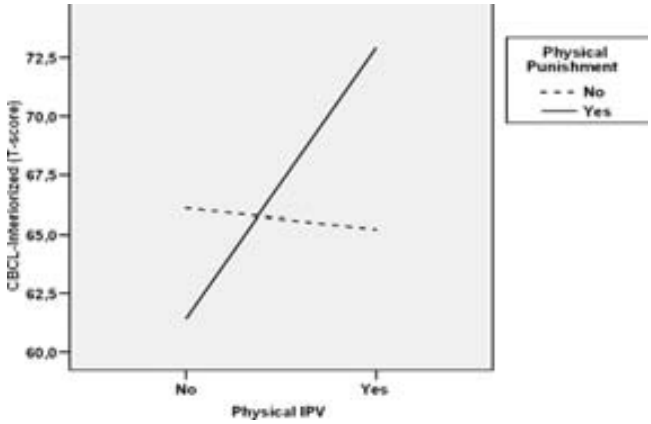

Fig. 1. Interaction effect of physical punishment against children and physical IPV for internalizing behavior problems.

Considering the associations between some socio-demographic features and the incomes and outcomes of this study we assessed the comparability of subsamples. It was found that the subsamples were homogeneous in age of the children, mothers and fathers. Likewise, there were no differences in socioeconomic status. As shown in Table 1, the only statistical difference between groups was for the child's sex: there were a higher percentage of boys in the groups not exposed to experience of violence (S0) and only exposed to IPV in adulthood (S2) ($p = .013$).

Table 2 presents bivariate correlations between the variables of the study. Maternal CA showed positive and significant associations with children's eating disorders, CBCL externalizing behavior problems and numbers of DSM-IV disorders. IPV was significantly correlated with CBCL externalizing behaviors problems and total score, global functional impairment (CAFAS total score) and DSM-IV total number of symptoms. Mother's psychopathology achieved significant correlations with all dependent variables, with the exception of presence of DSM-IV disorder and disruptive disorders. Father's psychopathology was significantly correlated with elimination disorders only. Physical punishment of children was positively correlated with DSM-IV disruptive disorders, CBCL externalizing behavior problems and total score, CAFAS global functional impairment and DSM-IV total number of symptoms.

Table 3 presents the results of the hierarchical models. Regression coefficients show the independent effects of CA and IPV on their children's psychopathology and functional impairment, as well as the covariates. The first-step of the model showed that the child's sex and age, mother's psychopathology, other comorbidities and physical punishment against children were associated with certain psychopathological problems and functional impairment in children and adolescents. This relationship was not found for fathers' psychopathology.

The mothers' CA was significantly associated only with an increase in the odds of DSM-IV disruptive behavior disorders of children and adolescents. On the other hand, IPV was related to a significant increase in the mean score of the CBCL externalizing behavior scale. Changes in R^2 between the first and the second step were low (over 2.5%), indicating that maternal CA and IPV did not clinically increase the predictive accuracy on the child's psychopathology and functioning, while controlling for individual, clinical and socio-familiar covariates.

The third step of the model indicated that the association of IPV with CBCL internalizing behavior problems was moderated by the presence of physical punishment of children (Table 3). As Fig. 1 shows, when the presence of physical punishment of children was reported, IPV was associated with a significant increase in the internalizing behavior problems score ($B = 5.149$, $p = 024$). However, IPV was not significantly related to internalizing behavior problems when physical punishment was reported as absent ($p = .230$). No other significant interactions were found between mothers' violent experiences (maternal CA, IPV) and potential moderating variables (child's sex and age, mother's and fathers' psychopathology).

Next, different models were built to test the mediator effect of parent's mental health and physical punishment of children. When the three first mediate criteria were found at bivariate level (Table 2), the mediation analyses were conducted separately for each of the hypothesized mediators. Given that the father's mental health was not significantly associated with maternal CA and IPV (see Table 2); it did not meet the criteria to test for mediation.

Fig. 2 shows the SEM for CBCL externalizing problems with physical punishment of children as mediator. The model achieved good fit values ($\chi^2 = 10.64$, $p = .16$; CFI = .94; RMSEA = .04; $R^2 = .102$). IPV was directly and positively associated with CBCL externalizing problems. Physical punishment of children partially mediated the association of IPV with CBCL externalizing problems ($z = 2.38$, $p = .017$). IPV was positively associated with physical punishment of children, and physical punishment was associated with CBCL externalizing problems.

Although the SEM for CBCL total also achieved adequate fit statistics ($\chi^2 = 5.63$, $p = .58$; CFI = .99; RMSEA = .01; $R^2 = .039$), the test for the significance of the paths showed that physical punishment was not a significant mediator of IPV ($z = 1.71$, $p = .086$). Likewise, the analyzed SEM showed that mothers' mental health did not mediate the effect of the maternal CA and IPV on CBCL externalizing ($z = .60$, $p = .55$; $z = .59$, $p = .55$, respectively); nor the link between IPV and CBCL total ($z = 1.86$, $p = .60$).

Table 2
Intercorrelations among study variables.

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
1. Any disorder	–																
2. Disruptive behavior	.36*	–															
3. Mood disorders	.21*	−.10*	–														
4. Anxiety disorders	.32*	−.10*	.24*	–													
5. Eating disorders	.00	−.05	.17*	.10*	–												
6. Elimination disorders	.12*	.11*	−.01	.00	−.06	–											
7. CBCL internalizing	.19*	.13*	.23*	.25*	.15*	.04	–										
8. CBCL externalizing	.17*	.49*	−.08	−.08	.04	−.00	.37*	–									
9. CBCL total	.20*	.44*	.03	.06	.09	.003	.73*	.84*	–								
10. CAFAS total	.20*	.30*	.24*	.10*	.20*	.07	.35*	.48*	.44*	–							
11. N° DSM-IV disorders	.42*	.38*	.43*	.51*	.10*	.29*	.38*	.27*	.36*	.46*	–						
12. Total n° symptoms	.32*	.44*	.32*	.21*	−.01	.11*	.30*	.43*	.48*	.53*	.66*	–					
13. Maternal CA	.01	.06	.002	.07	.12*	.02	.06	.12*	.11	.08	.10*	.08	–				
14. IPV	.00	.06	.05	.04	.05	.01	.06	.21*	.14*	.12*	.08	.20*	.14*	–			
15. Mother's psychopathology	.08	.05	.09*	.12*	.11*	.09*	.25*	.16*	.26*	.09*	.18*	.14*	.21*	.19*	–		
16. Father's psychopathology	.03	.06	.01	−.02	.07	.08*	.03	.08	.05	.06	.08	−.01	.06	.24*	.10*	–	
17. Physical punishment	.01	.18*	−.07	−.10*	−.00	.04	−.06	.22*	.14*	.11*	.02	.15*	.00	.22*	−.02	.09*	–

* $p < .05$.

Table 3
Predictive models of children's psychopathology and functional impairment.

	Logistic regression models[a] (95% CI)				
	Any disorder	Disruptive behav.	Mood disorders	Anxiety disorders	Eating disorders
Step 1					
Sex: male	1.95† (.94; 4.1)	3.19* (2.1; 4.8)	.315* (.21; .47)	.515* (.35; .75)	.360* (.24; .53)
Age (years)	1.26* (1.1; 1.5)	.975 (.90; 1.1)	1.31* (1.2; 1.4)	1.08† (.10; 1.2)	1.17* (1.1; 1.3)
Mother psych.	1.26 (.93; 1.7)	1.09 (.95; 1.2)	1.04 (.91; 1.2)	1.12† (.99; 1.3)	1.08 (.95; 1.2)
Father psych.	1.11 (.77; 1.6)	1.06 (.89; 1.3)	1.01 (.84; 1.2)	.952 (.80; 1.1)	1.16 (.97; 1.4)
PP	1.47 (.59; 3.6)	2.80* (1.7; 4.7)	.797 (.49; 1.3)	.665† (.43; 1.0)	1.12 (.70; 1.8)
Comorbidity	–	1.07 (.60; 1.9)	3.04* (1.0; 8.8)	.986 (.54; 1.8)	.719 (.34; 1.5)
Step 2					
Maternal CA	1.39 (.39; 4.9)	1.91* (1.0; 3.6)	.703 (.39; 1.3)	1.31 (.73; 2.4)	1.71† (.97; 3.0)
IPV	.66 (.23; 1.9)	.919 (.51; 1.7)	1.51 (.84; 2.7)	1.28 (.73; 2.2)	1.12 (.63; 2.0)
Change in R^2	.004	.010*	.006	.004	.009†
Step 3					
IPV X PP	–	–	–	–	–
Change in R^2	–	–	–	–	–
Total R^2	.067†	.149*	.243*	.085*	.162*

	Negative-binomial model[a]		Multiple regression[b] (95% CI)			
	Number disorders	Total symptoms	CBC interior.	CBC exterior.	CBC total	CAFAS total
Step 1						
Sex: male	.993 (.81; 1.2)	1.06 (.88; 1,3)	−.953 (−2.8; .91)	2.91† (.69; 5.1)	4.78† (−.72; 10.3)	3.44 (−1.8; 8.7)
Age (years)	1.05* (1.0; 1.1)	1.03 (.99; 1.1)	.589* (.19; .99)	.411† (−.07; .89)	.418 (−.75; 1.6)	5.56* (4.4; 6.7)
Mother psych.	1.05 (.99; 1.1)	1.03 (.97; 1.1)	1.14* (.59; 1.7)	.708* (.05; 1.4)	3.29* (1.7; 4.9)	.543 (−1.1; 2.2)
Father psych.	1.03 (.94; 1.1)	.972 (.90; 1.1)	.058 (−.74; .85)	.202 (−.76; 1.2)	−.105 (−2.5; 2.2)	1.06 (−1.3; 3.4)
PP	1.05 (.82; 1.3)	1.14 (.92; 1.4)	−1.90 (−4.5; .56)	4.77* (2.1; 7.4)	7.85* (1.2; 14.5)	10.9* (4.7; 17.1)
Comorbidity	–	–	–	–	–	–
Step 2						
Maternal CA	1.14 (.84; 1.5)	1.07 (.82; 1.4)	−.546 (−3.3; 2.2)	2.78† (−.44; 6.0)	5.05 (−3.0; 13.1)	6.90† (−.83; 14.6)
IPV	1.04 (.77; 1.4)	1.19 (.91; 1.6)	−2.16 (−5.7; 1.4)	3.58* (.23; 6.9)	3.65 (−4.6; 11.9)	5.53 (−2.1; 13.2)
Change in R^2	.002	.004	.001	.024*	.008	.009†
Step 3						
IPV X PP	–	–	7.31* (1.8; 12.8)	–	–	–
Change in R^2	–	–	.020*	–	–	–
Total R^2	.021	.015	.098*	.103*	.078	.173†

(–) Variable not included in the model.
CI: confident interval.
PP: physical punishment of children.
* Significant comparison ($p < .05$).
† Quasi-significant comparison ($p < .10$).
[a] OR: odds ratio.
[b] *B*-Coefficients.

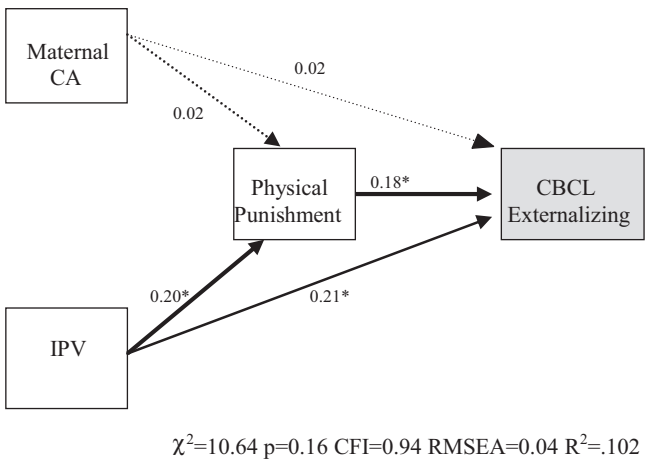

Fig. 2. Mediation model: effects of maternal CA, IPV on CBCL externalizing problems through physical punishment of children. Bold line indicates significant mediator path. Continuous line indicates significant association. Dashed lines represent effects that were not statistically significant. *$p < .05$.

Table 4
Maternal exposure to violence, psychopathology and functional impairment in children and adolescents.

	Maternal exposure of violence: %			Trends[c]	
	Not exposed to violence (n = 413)	One violence experience (n = 106)	Both violence experiences (n = 18)	Linear	Quadratic
DICA					
Disruptive behavior[a]	62.7	65.5	80.8	.047*	.332
Mood disorders[a]	38.3	44.8	24.2	.440	.146
Anxiety disorders[a]	57.2	69.4	51.2	.097†	.015*
Eating disorders[a]	31.7	41.0	39.4	.006*	.029*
Elimination disorder[a]	18.1	13.9	24.6	.634	.657
		Means (SE)		Linear	Quadratic
N° disorders[b]	3.2 (.19)	3.6 (.41)	3.6 (.98)	.730	.747
Total n° sympt.[b]	24.9 (1.3)	27.8 (2.8)	33.2 (8.2)	.319	.791
CBCL	(n = 246)	(n = 61)	(n = 13)	Linear	Quadratic
Internalizing[b]	14.1 (.51)	14.9 (1.1)	13.8 (2.4)	.898	.528
Externalizing[b]	15.6 (.62)	19.3 (1.3)	21.0 (2.8)	.062†	.597
Total[b]	51.2 (1.5)	56.8 (3.1)	57.4 (6.8)	.375	.576
CAFAS	(n = 387)	(n = 102)	(n = 18)		
Total score[b]	60.3 (1.5)	67.5 (2.9)	70.3 (6.9)	.164	.622

OR: odds ratio. SE: standard error. MD: means difference.
* Significant comparison (p < .05).
† Quasi-significant comparison (p < .10).
[a] Adjusted by children's sex and age, comorbidity, mother's psychopathology, father's psychopathology and physical punishment of children.
[b] Adjusted by children's sex and age mother's psychopathology, father's psychopathology and physical punishment of children.
[c] Trends considering three levels of exposure: not-exposed, exposed to violence in one moment (childhood or adulthood) and exposed to violence in both moments (childhood and adulthood).

The regression equation models showed that the maternal CA was not significantly associated with physical punishment of children (B = .811, p = .524); whereas there was a positive and significant association between maternal CA and mothers' mental health (B = 1.712, p = .001). However, mothers' mental health was not significantly associated with either eating (B = 1.088, p = .170) or disruptive disorders of children (B = 1.079, p = 239). Therefore, the maternal CA, eating and disruptive disorders of children were not associated through mothers' mental health.

Initial trend analyses show that the maternal exposure to CA only and to IPV only did not indicate a statistical difference in the criteria; these groups were merged into a single one. Next, mothers' lifetime exposure to violence was analyzed according to the following groups: those not exposed, those characterized by one period of violence (CA or IPV only) and those who had been subject to both violent periods (CA and IPV). Table 4 presents prevalence rates of psychopathology and functional impairment in children whose mothers have lifetime experiences of violence. The results of trend analyses are also shown. The analyses comparing the diagnostic categories of DSM-IV between the three groups revealed a significant linear trend for disruptive disorders, reaching its highest prevalence in clinical children when the mother had been exposed to violence in both periods (CA and IPV). Anxiety disorders showed a quadratic trend, reaching its highest prevalence when the mothers were exposed to violence in one period. As an unexpected result, eating disorders showed a positive linear trend: the prevalence of eating disorders tends to increase as the mother's exposure to violence increases; and also a quadratic trend, reaching its greatest increase in prevalence with the mother having exposure to violence in one period. CBCL externalizing and total mean scores and global functional impairment did not show a significant trend.

Discussion

In this study the independent effects of mothers' CA and IPV on their children's psychopathological problems showed few significant results and partially confirm the study's hypotheses; maternal CA was related to children's disruptive disorders and IPV was associated with an increase of externalizing behavior problems. Results also indicated that physical punishment of children moderated the effects of IPV on children's internalizing behavior problems. Moreover, the IPV had effects, either direct or indirect by physical punishment, on children's externalizing behavior problems. The cumulative effect of both maternal CA and IPV was associated with higher levels of disruptive disorders in children and adolescents.

Present findings support the negative outcomes in the offspring of childhood-abused mothers, which is consistent with previous studies (Collishaw et al., 2007; Dubowitz et al., 2001; Koverola et al., 2005; Morrel et al., 2003; Roberts et al., 2004). The results indicate that girls and boys, regardless of age, were similarly affected by mothers' CA, showing disruptive disorders. Parents' psychopathology and physical punishment of children did not act as moderators or mediators in the analyzed relationship. Mothers with CA experiences may have a more permissive parenting style and avoid the use of the authority due to their own experience of abuse by an adult (DiLillo & Damashek, 2003). Mothers' difficulties in establishing clear boundaries with their children could explain the increased disruptive problems in their offspring. On the other hand, the fact that the mothers' mental health was not a significant mediator could be related to the measure used in this study,

which is a mental health screening and does not assess the specific disorders in detail. Alternatively, there may be other mechanisms, not included in this research, through which mothers' CA may affect problems in children, such as negative life events, family type or maternal social support (Collishaw et al., 2007; Koverola et al., 2005).

The present study also shows that IPV was associated with children's externalizing problems, and this link was not modified by children's sex and age. The results did not provide support for findings which indicate that externalizing problems are greater for sons than for daughters from violent families (Evans et al., 2008). Consistent with previous reports (Kitzmann et al., 2003; Sternberg et al., 2006; Wolfe et al., 2003), the results suggest no differences in externalizing behaviors of IPV-exposed girls and boys. Likewise, the child's age did not influence the effect of IPV on externalizing problems, as has been reported by Evans et al. (2008), Kitzmann et al. (2003), and Wolfe et al. (2003). These results suggest that the relationship between IPV and clinical externalizing problems is similar for children and adolescents of both sexes. Additional research is needed to examine individual factors like temperament (Kitzmann et al., 2003), attitudes toward violent relationships (Wolfe et al., 2003) or aggressive interactions (McCloskey & Lichter, 2003), which could clarify a differential impact of IPV on girls and boys.

The current results indicated that physical punishment of children modified the relation between IPV and internalizing problems. Children who directly observed physical IPV and also suffered physical punishment by parents showed increased internalizing problems. These results confirm previous studies on the co-occurrence of IPV and physical aggression against children (Kaslow & Thompson, 2008; McCloskey et al., 1995; Osofsky, 2003). In line with other reports (Sternberg et al., 2006) the present findings suggest that there is a high risk of fearful and inhibited behaviors (internalizing problems) when children are exposed to both kinds of violence. Children living in physical-IPV context are affected by broad patterns of emotional, verbal and physical abuse (El-Sheikh, Cummings, Kouros, Elmore-Staton, & Buckhalt, 2008) and an increase in physical IPV is related to increased children's internalizing problems (Holt et al., 2008). McCloskey et al. (1995) suggested that after observing violent physical assaults and, at its most extreme, having seen the potential lethality of IPV, the experience of direct physical abuse against children could be more frightening and terrifying for them.

Path analyses indicated that physical punishment of children partially mediated the effect of IPV on externalizing problems. These results suggest that physical punishment is one pathway by which IPV may impact children's well-being (Salzinger et al., 2002). IPV may have a deleterious impact on parents' capacities, showing negative affects and physical abusive behaviors in parent-to-child interactions (Holt et al., 2008). Children who are abused may manifest serious problems coping with emotionally stressful situations and may develop negative representational models of family interactions, which may be generalized to their interactions with others (Cicchetti & Lynch, 1995). It is important to note that despite the inclusion of physical punishment as mediator, IPV maintains a direct effect on children's aggressive and antisocial behaviors (externalizing problems). These results are in line with prior findings, which suggest that independently of familial factors, IPV-exposed children may have been at increased risk of externalizing problems (McDonald et al., 2000) and conduct disorder (Fergursson & Horwood, 1998). As proposed by other researchers, it is complex to separate the unique effects of IPV from those of other risk factors that are often present in children's lives (Wolfe et al., 2003). Therefore, it is possible that the relationship found indicates that other environmental or genetic risk factors might contribute to psychological problems of IPV-exposed children (Fergursson & Horwood, 1998; McCloskey et al., 1995). On the other hand, literature suggests that IPV context affects children's emotional security, involving their abilities to regulate their emotions and behaviors, which in turn increase their externalizing problems (El-Sheikh et al., 2008). As a whole, the present finding may support what was proposed by McDonald et al. (2000) regarding the relevance of extending the investigation to examine IPV contexts as a precursor or a maintaining factor for externalizing problems in clinical children.

In terms of the cumulative effects, the results corroborate with and expand on prior research suggesting that each experience of violence suffered by the mothers adds to the overall burden, leading to a negative psychological functioning in children (Dubowitz et al., 2001). The findings of this study suggest that the cumulative violence suffered by mothers represents an important risk, specifically for disruptive mental health problems in children and adolescents. Mothers with a history of CA and their families may experience greater levels of psychosocial stress (Collishaw et al., 2007); in the context of IPV children may learn that aggression is permissible and acceptable in intimate relationships (Osofsky, 2003) and mothers may be less aware of their children's conduct problems or less able to effectively manage their aggression.

In this study we note that the strength of the association between maternal violent experiences, specially IPV and children's psychological outcomes is lower compared with previous research (Evans et al., 2008; Kitzmann et al., 2003; Wolfe et al., 2003). One possible explanation is that the effects of CA and IPV on children's outcomes decrease when statistically monitoring the covariates. IPV can differently impact children's functioning depending on other individual and contextual influences (Wolfe et al., 2003) and research findings vary depending on the extent to which researchers control for potentially confounding factors (Kitzmann et al., 2003).

This is one of the first studies providing evidence on lifetime maternal experiences of violence and child outcomes in the Spanish population. The results suggest that Spanish children whose mothers suffered CA, IPV or both, are at high risk of serious conduct problems, whereas children exposed to IPV and who were also physically abused are at greater risk of internalizing problems. Besides, it suggests that physical punishment of children is an important mechanism that contributes in part to explain externalizing problems of IPV-exposed children. These findings indicate potential targets of assessment and intervention for families seeking help in public mental health services. This study uses a semi-structured diagnostic interview (DICA), combining parents and children's reports, which contribute to a significant increase in the

predictive validity of children's outcomes and complements the report obtained only from parents (CBCL). Future research could be benefit from focusing on the diverse mechanisms through which maternal CA and IPV negatively impacts children's psychological functioning, including the assessment of different DSM-IV diagnoses.

This study has some limitations that should be considered when interpreting the results. Primarily, cautions should be taken due to the cross-sectional design of the study. Secondly, CA was based on retrospective self-reports, which might have led to consequent possible biases due to distortions in memory. Thirdly, IPV was assessed through the children's reports alone; therefore possible reporter biases must be considered. However, other researchers have stated that mothers' and children's reports about IPV were significantly correlated, suggesting that there is a shared perception of family violence (McCloskey et al., 1995). On the other hand, we registered the presence of physical violence between parents without defining the role of aggressor and/or the victim. Nevertheless, the evidence argues that women have a significantly higher risk of experiencing IPV and show greater negative impact on health, compared to men (Tjaden & Thoennes, 2000). Fourthly, due to the instances of child or mother self-reporting, the common method variance should be considered; although the assessment of DSM-IV disorders using semi-structured interviews (DICA-IV) combined the reports of both parents and children. In addition, the children's outcomes reported by mothers are limited and more accurately reflect the maternal perceptions of children's behavior. It would be useful for future research not to rely only on children's or parents' reports and to include other methods such as observational measures, which would increase external validity. Fifthly, the results of this research are based on a mental health clinical sample and cannot be generalized to other populations. Nevertheless, two reviews conducted by Evans et al. (2008) and Kitzmann et al. (2003) have reported that the link between IPV and child's outcomes did not vary significantly among samples recruited from clinical settings, battered women's shelters and community or school environments. Lastly, despite the large sample size, the classification based on the mothers' experiences of violence involved the emergence of some small groups which hindered the statistical power of some contrasts and the sensitivity to detect true discrepancies between the different groups analyzed. For instead, in the trend analyses, the fact that one maternal experience of violence was significantly linked to certain psychopathological problems of children (anxiety and eating disorders) may be due to the more proximal effects of IPV, as well as to the small size of the group with two experiences of violence. Therefore, more research is needed to examine a broad range of psychological problems in children and different maternal experiences of violence. Future research would benefit from the use of larger samples, particularly of mothers who have suffered both CA and IPV, to explore the potential mediational processes that may be operating. In this field, a key direction for future research is to examine more complex models to test how abuse of mothers in childhood could lead to intimate partner violence, which in turn could lead to their children's psychological problems. The present research is one step in this direction and future investigations could focus on multiple types of violence suffered by mothers over their lifetime and its links to mediators of children's outcomes. A relevant line of investigation is the impact that the interrelations among childhood abuse, adult violence and stress across lifespan could have on parenting (Banyard, Williams, & Siegel, 2003). Examining the outcomes of women who have suffered violence and also the outcomes of their children, research would help identify individual and family factors that may endorse dysfunctional behavior across family relations, as well as those which may buffer its harmful effects.

In the light of these study limitations, these findings have some practical implications. First, they confirm the clinical relevance of lifetime violence experienced by mothers as an important factor that can significantly affect children's psychological outcomes. Secondly, they could encourage clinicians to be aware that assessment of the mother's history of violence, as well as physical punishment against children, may help early detection of children who are at increased risk of serious psychopathological problems. It also promotes a timely identification of family factors that may influence or reduce the effectiveness of treatment (McDonald et al., 2000). Thirdly, findings show the need to develop effective preventive and therapeutic interventions for children and their families; clinicians and other health professionals could activate protective resources (individual, social or legal) to minimize the negative impact of violence. Finally, the question is raised about the role of research and clinical practice to recognize and reduce the level of violence within families as a protective factor for both this generation and the next.

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6.2. Segundo estudio

Maternal childhood abuse, intimate partner violence and child psychopathology: the mediator role of mothers' mental health

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Dear Jenniffer,

I am pleased to write to inform you that your manuscript, "Maternal Childhood Abuse, Intimate Partner Violence and Child Psychopathology: The Mediator Role of Mothers' Mental Health" has been accepted for publication in *Violence Against Women*. You will receive directly from Sage Publications page proofs of your manuscript four to six weeks before publication. This will give you an approximate date for your manuscript to appear in the journal.

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Please let me take this opportunity to tank you for your valuable contribution to *Violence Against Women* and to invite you to call or email me if you have any questions or concerns. Note my change in address, as the journal's editing office has moved to Dayton, Ohio. The correct mailing address and contact information is below. Thank you for your patience during our period of transition.

Sincerely,

Claire M. Renzetti

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Carta de aceptación del manuscrito "Maternal Childhood Abuse, Intimate Partner Violence and Child Psychopathology: The Mediator Role of Mothers' Mental Health" por parte de la editora de *Violence Against Women*, Claire M. Renzetti.

Abstract

This study examined the mediator role of mothers' mental health in the relationship among maternal childhood abuse, intimate partner violence and offspring's psychopathology, and explored whether mediational pathways were moderated by children's sex. Participants were 327 Spanish outpatient children, 8-17 years-old, and their mothers. Mothers' global psychological distress and depressive symptoms mediated the associations between mothers' violence history and children's externalizing problems. However, only depressive symptoms fully mediated these relationships. Children's sex did not have a moderating role in adjusted paths. Mothers' depressive symptoms are an important mechanism by which maternal violence experiences could affect externalizing problems in Spanish children.

Keywords

Maternal Childhood Abuse, Intimate Partner Violence, Mothers' Mental Health, Child and Adolescent Psychopathology.

Maternal childhood abuse, intimate partner violence and child psychopathology: the mediator role of mothers' mental health

Violence against women and girls is a major social problem. The literature has shown a high prevalence of women globally enduring some type of violence during their lifetime, such as childhood abuse (CA) and intimate partner violence (IPV), which are recognized as public health priorities (WHO, 2002). In Spain, data from a national study on childhood sexual abuse indicated that 22.5% of Spanish women aged 18-60 reported sexual abuse during their childhood (López, 1994). Studies of abuse in childhood, with university populations, have shown that 96.4% of women reported physically abusive behavior and 16.7% some form of physical abuse sequelae (De Paúl, Milner, & Múgica, 1995), while between 14.8% and 19% reported sexual abuse in childhood (De Paúl et al., 1995; Pereda, & Forns, 2007), revealing CA as a severe problem in Spanish society. With regard to IPV, findings from a national representative survey suggest that its levels in Spain are not markedly different from those found in other countries with similar cultural and economic backgrounds (Medina-Ariza & Barberet, 2003). Data from 2007 show that the Spanish judicial system received 63,347 reports from women of violence by a partner or ex-partner (Woman's Institute, 2007), and prevalence reached 3.22 per thousand women (Queen Sofia Center, 2007). In the period 2003 to 2007 the incidence had increased by 26.47%, while prevalence showed an increase of 15.83% (Queen Sofia Center, 2007). Moreover, it is important to note that figures based on the number of reports to the judicial system are likely to underestimate the actual prevalence of IPV. A recent review by Ezpeleta and Bayarri (2010) indicates that in Spain approximately 10% of women in the general population reported IPV in the last year, whilst 25% of women attending healthcare reported some experience of IPV in their lifetime.

Despite these data, little is known about Spanish children whose mothers experienced CA in the past, or about children living in households in which they witness violent acts involving their parents. According to estimates based on data from the United Nations, 188,000 children are exposed to IPV each year in Spain (UNICEF, 2006). Offspring of mothers who suffered CA or IPV showed significant emotional and behavioral problems (Collishaw, Dunn, O'Connor, & Golding, 2007; Evans, Davies, & Dilillo, 2008), including several internalizing and externalizing symptoms (Dubowitz et al., 2001; Wolfe, Crooks, Lee, McIntyre-Smith, & Jaffe, 2003). Mothers' CA was related to children's overall psychological distress, hyperactivity, interpersonal and behavior problems (Dubowitz et al., 2001; Roberts, O´Connor, Dunn, & Golding, 2004; Thompson, 2007), as well as to increased adjustment problems and poorer

prognosis over time (Collishaw et al., 2007). With respect to IPV, several reviews have reported that witnessing this type of violence may have a detrimental impact on children, who may exhibit traumatic symptoms, lower social competence, externalized difficulties such as hostile and aggressive behavior, and internalized problems including anxiety, depression and somatic complaints (Evans et al., 2008; Holt, Buckley, & Whelan, 2008; Kitzmann, Gaylord, Holt, & Kenny, 2003; Sternberg, Baradaran, Abbot, Lamb, & Guterman, 2006; Wolfe et al., 2003). As Holt et al. (2008) point out, numerous studies have shown the relevance of directly exploring children's experience of IPV exposure, insofar as it helps us to understand how children are involved in the violence between their parents and can struggle while trying to make sense of this complex experience. Moreover, parents' reports may underestimate or overestimate their children's awareness of violence, whereas direct reports by children may provide more accurate estimates of their perception of IPV (Grych, Seid, & Finchman, 1992).

Children are particularly vulnerable to violence, which may have an impact on them even when they are not the direct target but have a close relationship with the victim (Margolin & Gordis, 2004). Although several researchers have found that exposure to IPV may have a significant influence on children's well-being, the pathways by which this occurs require further investigation (Holt et al., 2008; Wolfe et al., 2003). In this regard, developmental psychopathology has indicated that research perspectives need to be broadened, highlighting the relevance of a pathway approach that recognizes both direct and indirect effects (Rutter & Sroufe, 2000). Wolfe et al. (2003) argued that there is rarely a direct pathway leading to a particular outcome, and raised the unresolved question concerning the mechanisms that mediate the impact of violence in children.

Mothers' mental health has been identified as an important factor that may influence children's psychological well-being, particularly when mothers have a history of violence. Experiences of CA were associated with a wide variety of health and functioning problems in survivors, even long after the abuse had ended (Kendall-Tackett, 2002). In women with CA experiences, research has found a high probability of their suffering from mental health problems such as increased levels of depression, anxiety and anger (Springer, Sheridan, Kuo, & Carnes, 2007), panic disorders, alcohol and drug abuse/dependence, bulimia nervosa and attempted suicide (Kendler et al., 2000). In addition to the long-term effects of CA, the association between IPV and mental health problems in women has been well documented, and also includes a broad range of negative consequences (Golding, 1999). According to Herman (1992) mothers who experience IPV may present a complex syndrome whose diagnosis is

similar to that of PTSD (post-traumatic stress disorder), but which includes additional symptoms such as depression and anxiety. Pico-Alfonso et al. (2006) have showed that IPV-affected Spanish women had a higher incidence and severity of depressive and anxiety symptoms, PTSD and suicidal thoughts than a control group. Several studies have reported that the psychological problems of children living in violent homes are substantially related to mothers' poor mental health, such as maternal depression (English, Marshall, & Steward, 2003; Graham-Bermann, DeVoe, Mattis, Lynch, & Thomas, 2006), anger and anxiety (Jarvis, Gordon, & Novaco, 2005), and trauma symptoms (Bogat, DeJonghe, Levendosky, Davidson, & von Eye, 2006). Similarly, the mental health problems of mothers who suffered CA in the past may affect their children's well-being (Lang, Gartstein, Rodgers, & Lebeck, 2010).

Studies exploring the mediator role of maternal mental health have suggested that mothers' violence history can lead to maternal psychopathological symptoms, which in turn can have a negative impact on children's functioning (Koverola et al., 2005; Morrel, Dubowitz, Kerr, & Black, 2003). However, there are still mixed findings on this topic. Levendosky and Graham-Bermann (2001) found that maternal CA and IPV were significant predictors of mothers' negative psychological functioning (a global index), which influenced their children's adjustment. Furthermore, mothers' psychological functioning had a direct impact on children's adjustment problems, including effects such as emotional and behavioral difficulties, depression, lower social competence and global self-worth. The authors suggest that even if mothers are able to engage in proper parenting, fluctuations in their mood could have a harmful effect on their children's well- being. In this line of research, some studies found that maternal depression fully mediated the effects of mothers' violence history (CA, IPV) on children's internalizing behavior problems (Koverola et al., 2005; Morrel et al., 2003;), and partially mediated its effects on externalizing problems (Morrel et al., 2003). Others studies reported that IPV affected both the internalizing and externalizing problems of children through maternal depression (Dehon, 2005) and overall psychological distress (Owen, Thompson, Shafer, Jackson, & Kaslow, 2009; Street, King, King, & Riggs, 2003). Research has also shown that maternal affective symptoms significantly mediated the association between maternal CA and children's adjustment problems (Collishaw et al., 2007), whilst anxiety symptoms partially mediated this association (Roberts et al., 2004). Conversely, McCloskey, Figueredo and Koss (1995) found that even though mothers experiencing IPV were more likely to have mental health problems, this did not mediate the effects of IPV on children's psychopathology. Other research findings fail to support the mediating role of depression in the relationship between

maternal CA and children's problems (Roberts et al., 2004; Thompson, 2007). To summarize, some studies suggest a relationship among CA, IPV and children's problems that is completely or partially mediated by mothers' mental health, whereas others studies have found no support for such mediation. These disparate findings could be related to methodological variability across studies, such as the samples characteristics or the methods for assessing mediation.

Some research has suggested that children's sex may modify the relationship between IPV and children's outcomes (Evans et al., 2008; Holt et al., 2008; Jaffe, Wolfe, Wilson, & Zack, 1986; Reynolds, Wallace, Hill, Weist, & Nabors, 2001); as well as the associations between parents' and children's psychopathology (Crawford, Cohen, Midlarsky, & Brook, 2001). From this perspective, Cumming, Pepler, and Moore (1999) argued that the mechanisms linking the risk to well-being may be different for boys and girls. Nevertheless, studies examining sex differences showed discrepant findings. For instance, in girls, maternal distress and marital discord were significantly associated with internalizing symptoms; however, in boys the associations between these variables was statistically non-significant (Crawford et al., 2001). In contrast, Street et al. (2003) found that marital violence affected internalizing and externalizing problems of both girls and boys through mothers' psychological distress.

Considering the heterogeneity of research findings, the present study set out to extend current knowledge about the associations between women's violence history and their offspring's psychological problems. Given the high prevalence of violence against women and girls in Spain, both CA and IPV, and the risk of adverse consequences of these experiences, the aim of this study was to examine the mediator role of mothers' mental health in the relationship among maternal CA, IPV and psychopathology in Spanish children and adolescents. In addition, this study explored whether the mediational pathways were moderated by children's and adolescents' sex. As the literature review reveals these issues have not yet been studied in a Spanish population. Since recent findings have shown that IPV-exposed Spanish children have high functional impairment (Olaya, Ezpeleta, de la Osa, Granero, & Domènech, 2010), this outcome was also examined. Thus, it was hypothesized that: (1) maternal CA and IPV would be positively associated with psychopathological problems and functional impairment in children and adolescents; (2) maternal CA and IPV would be positively associated with mothers' mental health problems; (3) mothers' mental health problems would be positively associated with children's and adolescents' psychopathological problems and functional impairment; and (4) the relationship between maternal CA, IPV and children psychopathological problems would be mediated by mothers' mental health problems. Because

of the inconclusive evidence on the moderating effect of children's sex, no specific hypothesis was proposed for an analysis in this regard.

Method

Sample

This study was part of a wider research project on risk and protective factors for children's and adolescents' psychopathology problems, and participants were recruited from psychiatric outpatient settings within the public health network in Barcelona (Spain). Exclusion criteria were the presence of mental retardation or pervasive developmental disorders. An initial sample of 547 mothers and one of their offspring were asked to complete a series of mental health measures, 327 of whom (61.8%) completed all the measures included in this analysis. There were no significant differences between those who completed all the measures and those who did not as regards child's sex (p=.294), child's age (p=.775), mother's age (p=.341), ethnicity (p=.300), or socio-economic status (p=.495).

With respect to the participants in this study (N=327), children's age ranged from 8 to 17 years (mean age=13.3; SD=2.3), and 44.3% (N=145) were girls and 55.7% (N=182) boys. Mothers' mean age was 40.4 years (SD=5.7). Participants' ethnicity was predominantly Caucasian (97.9%). According to the Hollingshead Socioeconomic Index (Hollingshead, 1975), 62.3% were of the middle and lower-middle level, 24.9% lower level and 12.8% high and middle-high level. Of the 327 participating mothers, approximately 23% (N=75) had been exposed to some experience of violence in their lifetime. A total of 9.8% (N=32) of the mothers reported CA only, 9.2% (N=30) IPV only, and 4% (N=13) both CA and IPV. The group of mothers not exposed to violence and those who had suffered from any type of violent experience (CA, IPV or both) were similar with regard to socioeconomic status (p=.812), child's age (p=.702), and mothers' and fathers' age (p=.265; p=.731). The only significant difference concerned child's sex (p=.006), with a higher percentage of boys than girls in the group of mothers that were not exposed to any violent experiences and in the IPV- exposed group.

Ninety-three percent of children included in this study showed some form of psychopathological disorder (based on a structured interview at intake). The clinical characteristics of the children and mothers in this sample are shown in Table 1.

---- Insert TABLE 1 ----

Measures

Maternal CA and IPV. Mothers' experiences of CA and children's IPV exposure were assessed through the *Schedule of Risk Factors* (SRF; Unitat d'Epidemiologia i Diagnòstic en Psicopatologia del Desenvolupament, 1997). The SRF is a structured interview based on the Service Utilization and Risk Factors interview (Goodman et al., 1998). It comprises a comprehensive set of factors and events that may affect mental disorders in children and adolescents. There are versions for parents and children. In this study different sections providing categorical data (presence/absence) were used. The first of these was mother's reports of their CA experiences (psychological, physical and/or sexual). Mothers were rated as having experienced CA if they answered affirmative to any of six items: During your childhood, 1) did you receive any physically abusive behaviors? (Examples of violent acts were given, such as being pushed or slapped); 2) were you forced to submit to any sexual contact?; 3) did you experience both physically and sexually abusive behavior?; 4) did you receive any psychologically abusive behavior (e.g.: being threatened, scared or controlled); 5) did you experience both psychologically and physically abusive behavior?; 6) did you experience both psychologically and sexually abusive behaviors?. The interviewers also recorded whether more than one of the six categories listed were experienced. On the other hand, children were asked about their exposure to IPV. Items measuring IPV were adapted from the *Child's Perception of Interparental Conflict Scale* (CPICS; Grych et al., 1992); specifically, this study used a question about whether children have ever seen their parents hitting each other during an argument. These children's reports were used as a direct measure of children's exposure to violence, as well as a proxy measure of their mothers' experiences of IPV. The SRF has demonstrated good psychometric properties in research on IPV-exposed Spanish children (Olaya et al., 2010), as well as on other risk factors (Ezpeleta, Granero, & Doménech, 2005). Inter-interviewer reliability and concurrent validity were found to be acceptable in a Spanish population (Guillamón, 1999).

Children's Psychopathology Problems. The *Child Behavior Checklist* (CBCL; Achenbach & Rescorla, 2001) was completed by mothers. The CBCL is a widely-used inventory for assessing a range of behavioral and emotional problems in children and adolescents aged 6 to 18. It has 113 items with three response options (0-not true; 1-somewhat or sometimes true; and 2-very true or often true). Two broad scales were used in this study: the Internalizing scale, which mainly reflects problems within the self, and includes the Anxious/Depressed, Withdrawn/Depressed, and Somatic Complaints Syndromes subscales; and the Externalizing scale, which represents

conflicts with other people and their expectation about children's behavior, and is made up of the Aggressive Behavior and Rule-Breaking Behavior Syndromes subscales. The CBCL has been adapted for Spanish populations and has satisfactory psychometric properties. Factorial studies confirmed the original internal structure of this instrument, and reliability and accuracy were excellent (Cronbach's alpha values above .80) (Sardinero, Pedreira, & Muñiz, 1997).

Children's Functioning. Interviewers rated the *Child and Adolescent Functioning Assessment Scale* (CAFAS; Hodges, 1997). The CAFAS is a multidimensional measure of level of functional impairment in children and adolescents between the ages of 7 and 17. It contains the following eight psychosocial areas: Role performance at school, at home and in the community, Behavior toward others, Mood/emotion, Self-harmful behavior, Substance use and Thinking. Each area is scored on an ordinal scale with 4 impairment levels (0-no impairment; 10-mild; 20-moderate; and 30-severe). A total score, generated as a linear combination of the direct scores on the 8 sub-scales, was used for this analysis. In this study the higher (poorer) of the two scores resulting from the information from parents or children was used. The psychometric properties of this instrument have been studied in Spanish populations with satisfactory results. Agreement between interviewers ranged from good to very good (kappa values from .79 to .94), except for behavior towards others (.45) and for substance use (.64) (Ezpeleta, Granero, de la Osa, Domènech, & Bonillo, 2006).

Mothers' Mental Health Problems. Mothers' were asked to report on their own mental health using the *Symptom Checklist 90 items-Revised* (SCL-90-R) (Derogatis, 1983). The SCL-90-R is a multidimensional self-administered questionnaire measuring psychopathology and psychiatric distress levels. It includes 90 items grouped in nine symptom dimensions. Participants answer each item on a Likert-type five-point scale from 0 (never) to 4 (very much). In this study three symptom dimensions were used: depression (DEP), anxiety (ANX) and hostility (HOST). The Global Severity Index (GSI), a widely used global index, was also used. This is the average rating given to all 90 items and represents the extent or depth of the present psychiatric disturbance**.** These indicators include the key maternal mental health problems associated with children's behavior problems. The SCL-90-R has been adapted to Spanish populations, with a high reliability (internal consistency; $\alpha = .96$) for the assessment of psychiatric symptoms (Robles, Andreu, & Peña, 2002).

Procedure

Ethical approval was obtained from the Ethics Committee of our institution. Children and adolescents attending public mental health centers in Barcelona were recruited once they were referred to clinicians for mental health problems. The referred youngsters and their parents were invited to participate in a study on child mental health problems. After obtaining written consent from mothers and verbal consent from the children and adolescents, mothers and children/ adolescents were interviewed at the same time and separately by interviewers trained in the use of all the assessment instruments. Based on the reports of the interviews, the interviewers assessed the children's functioning through the CAFAS. Finally, mothers responded to the CBCL and the SCL-90-R. These questionnaires were given to mothers to be returned at a later time, but were administered verbally if mothers had reading difficulties. Once the assessment was complete, the researchers gave a full report to clinicians at the mental health centers, who carried out the follow-up on all the individuals involved, including those who returned all the questionnaires and those who did not.

Statistical Analysis

Data were analyzed with PASW17.0.1 and EQS6.1. To test the mediational hypotheses, Structural Equation Models (SEM) were adjusted. The mediation analyses considered maternal CA and IPV as predictors, mothers' mental health (GSI, DEP, ANX, HOST) as mediators, and children's psychopathology (CBCL) as outcome. To examine the role of each hypothesized mediator in explaining the relationship among maternal CA, IPV and children's psychopathological problems, two-step mediation analyses were carried out. In the first step each potential mediator was tested using individual mediator analyses. Thus, four individual structural equation models were constructed with maternal CA and IPV as predictors, GSI, DEP, ANX or HOST as a mediator, and CBCL behavior problems as the outcome variable. In the second step each variable that had previously demonstrated mediation was included in a single and integrated model, with the exception of GSI, which was an indicator of overall psychological distress. Each mediator's specific pathway was evaluated to establish which variables significantly mediated the effect of maternal CA and IPV on CBCL behavior problems, while jointly analyzing all the mediators in the same model. All the structural equation models included children's sex and age as covariates.

According to the procedures defined by Baron and Kenny (1986), the mediational path was considered as adequate for the data when the following criteria were met: 1) Maternal CA

or IPV (predictor) was associated with children's psychopathology problems (outcome) and mothers' mental health (hypothesized mediator); 2) Mothers' mental health (hypothesized mediator) was associated with children's psychopathology problems (outcome); 3) Maternal CA and IPV (predictor) had limited or no effect on children's psychopathological problems (outcome) when mothers' mental health (hypothesized mediator) was controlled for. Goodness-of-fit of the final models was assessed with the usual indexes: chi square test (χ^2), Comparative Fit Index (CFI) and the Root Mean Squared Error of Approximation (RMSEA). In this study, a fit was considered to be good if: the Chi-square did not achieve a significant result ($p>.05$), the CFI coefficient was higher than .90, and the RMSEA was lower than .08 (Byrne, 2001). Effect sizes for path analyses were estimated through R^2-coefficients and 95% confidence intervals (Preacher & Hayes, 2008).

Finally, the moderating role of children's sex on the relationship between mothers' mental health problems and CBCL behavior problems was tested through multiple regression models. The moderation effect was considered to be present if there was a significant interaction ($p<.05$) between children's sex and mothers' mental health problems. If the interaction terms were significant, path models were adjusted separately for girls and boys.

Results

Degree of association between the variables of the study

Table 2 shows the bivariate associations among maternal CA, IPV, children's outcomes and the mediators variables. Maternal CA correlated significantly with CBCL externalizing problems, whilst IPV was significantly correlated with CBCL externalizing problems and children's functional impairment.

As expected, maternal CA and IPV were significantly associated with all maternal indicators of mental health problems, so that mothers' experiences of CA and IPV correlated with higher levels of mothers' global severity index (GSI) and depression (DEP), anxiety (ANX) and hostility symptoms (HOST). Likewise, as predicted, all the variables related to mothers' mental health problems (GSI, DEP, ANX, HOST) were significantly and positively correlated with CBCL externalizing and internalizing behavior problems, as well as with children's functional impairment (exception for HOST).

According to the first criteria for mediation (Baron & Kenny, 1986), CBCL internalizing behavior problems could not be included as outcome variables in the mediational models because they did not significantly correlate with the predictors, maternal CA or IPV. On the

other hand, all maternal mental health variables met conditions 1 and 2 to test for a mediator variable. Therefore, mothers' GSI and DEP, ANX and HOST symptoms were examined as potential mediators in the relationship among maternal CA, IPV and children's externalizing behavior problems.

---- Insert TABLE 2 ----

The mediating effects of mothers' mental health problems

First-step analyses showed that all four maternal mental health variables had mediating effects in the relationship among maternal CA, IPV and children's CBCL externalizing behavior problems. Individual mediation analyses showed good fit indexes for the GSI model (see Figure 1). Mothers' GSI fully mediated the relationship between maternal CA and CBCL externalizing problems (z=3.356 p<.001, 95%CI=2.00, 7.10). As expected, maternal CA was positively and significantly associated with GSI, and mothers' GSI was positively associated with CBCL externalizing problems. On the other hand, mothers' GSI partially mediated the association between IPV and CBCL externalizing problems (z=3.418 p<.001, 95%CI=1.83, 7.12). IPV was positively associated with GSI, and mothers' GSI and CBCL externalizing symptoms were positively associated.

---- Insert FIGURE 1 ----

The individual mediational analyses also showed good fit values for the DEP (χ^2 (3)=3.65 *p*=.30; CFI=1.00; RMSEA=.03; R^2=.252), ANX (χ^2(3)=3.93 *p*=.27; CFI=.99; RMSEA=.03; R^2=.257) and HOST models (χ^2(3)=7.94 *p*=.05; CFI=.97; RMSEA=.07; R^2=.248). Tests on the significance of mediational paths demonstrated that the relationship between maternal CA and CBCL externalizing problems was fully mediated by mothers' DEP (z=2.951 p=.003, 95%CI=1.56, 6.47) and HOST symptoms (z=2.964 p=.003, 95%CI=1.42, 6.62). Mothers' ANX symptoms did not mediate this relationship (z=1.881 p=.059, 95%CI=.437, 4.22). On the other hand, the association between IPV and CBCL externalizing problems was partially mediated by mothers' DEP (z=3.356 p<.001, 95%CI=1.75, 7.06), HOST (z=3.679 p<.001, 95%CI=2.06, 7.50) and ANX symptoms (z=2.986 p=.002, 95%CI=1.15, 5.63). Lastly, all these individual models indicated that CBCL externalizing problems were significantly and positively related to functional impairment in children.

Second-step analyses showed that the integrated model had good fit indexes (see Figure 2), and demonstrated that mothers' depressive symptoms (DEP) were the sole pathway that significantly and fully mediated the association among maternal CA, IPV and CBCL externalizing behavior problems (z=2.371 p=.018, 95%CI=1.12, 8.08; z=2.888 p=.004,

95%CI=1.41, 7.57; respectively). Even though mothers' HOST symptoms were significantly associated with maternal CA and IPV, as well as with CBCL externalizing problems, the significance of the mediational path test showed that HOST did not act as a mediator (z=1.566 p=.117, 95%CI=.649, 4.91; z=1.763 p=.078, 95%CI=.903, 5.83). In a similar way to the cases of the mediation models described above, children's externalizing problems were positively associated with functional impairment.

---- Insert FIGURE 2 ----

Sex differences in the mediational models

Multiple regression analyses did not show any significant interactions between mothers' mental health problems (DEP, ANX and HOST symptoms) and children's sex for the CBCL externalizing behavior problems (p=.256). These results indicate that children's sex did not have a moderating effect on the examined relationship.

Discussion

This study examined the mediating role of mothers' mental health in the relationship among maternal CA, IPV and psychopathological problems in Spanish children and adolescents. It also explored the moderating role of children's sex in this relationship. The results confirmed that mothers' violence history, CA and IPV, was significantly associated with children's externalizing problems. As predicted, these associations were mediated by mothers' mental health problems, including global psychological distress and depressive symptoms. The results also showed that children's sex did not moderate the mediational pathways tested. In addition, all mediational models showed that children's externalizing problems significantly increased their functional impairment.

Consistent with the findings of previous studies, these results confirm that mothers who have suffered violence in the past exhibit a variety of mental health problems, which may negatively affect their children's well-being (Collishaw et al., 2007; Levendosky & Graham-Bermann, 2001; Owen et al., 2009; Street et al., 2003). The findings provide evidence on two forms of violence against women and girls, CA and IPV. Moreover, they support the view that the individual functioning of mothers exposed to these experiences is an important factor significantly contributing to the explanation of children's psychopathology problems. In this regard, Lieberman, Van Horn, and Ozer (2005) suggested that the level of life stress experienced by mothers can be understood as a risk factor predisposing children to behavior problems, while

the negative impact of stressful life events on mothers' psychological functioning is the mechanism that actualizes this risk.

With respect to the mediation models analyzed, maternal depressive symptoms was the main variable mediating the relationship among maternal CA, IPV and children's externalizing problems. These findings corroborate those of previous research indicating that maternal depression is a significant predictor of psychological problems in children who live in violent homes (English et al., 2003; Graham-Bermann et al., 2006; Graham-Bermann, Gruber, Howell, & Girz, 2009), as well as in those whose mothers experienced CA (Lang et al., 2010). The findings also support those of earlier studies in which maternal depressive symptoms were found to be an important path through which maternal history of violence adversely affected children's externalizing problems (Dehon, 2005; Morrel et al., 2003). Maternal depression is very frequent in women who suffered from violence (Kendall-Tackett, 2002; Golding, 1999; Graham-Bermann et al., 2009). Depressed mothers may show reduced levels of social interaction and responsiveness, thus being less emotionally available or increasing negative affect towards their children (Cummings & Davies, 1994). Children who have experienced negative-quality interactions with depressive mothers are more likely to show higher levels of externalizing problems, possibly because such children develop poor interactional skills or learn to respond negatively during an interaction (Harnish, Dodge, & Valente, 1995).

The present findings suggest that children's sex does not act as a moderator in the mediational pathways examined. They do not confirm those from previous studies on IPV-exposed children, which indicated that mothers' psychological adjustment is a better predictor of daughters' adjustment than sons' (Cummings et al., 1999). Nonetheless, the findings are in line with several reports showing no differences in the outcomes of girls and boys living in violent households (Kitzmann et al., 2003; Sternberg et al., 2006; Wolfe et al., 2003). Moreover, they are in agreement with evidence reflecting that youngsters, regardless of their sex, may be negatively affected by mothers' psychopathology (McCauley et al., 2005). In concordance with Street et al. (2003), the results of this study suggest that the relationship among mothers' violence history, mental health problems and their offspring's externalizing problems is similar for boys and girls. Kitzmann et al. (2003) suggested that other child characteristics (e.g., coping strategies) could be more important than sex in predicting the outcomes of IPV-exposed children. Bearing in mind the inconsistency of results in the literature and the paucity of research in Spanish populations, further research is required to clarify the role of children's sex in the analyzed relationship.

In this study maternal experiences of violence (CA and IPV) were significantly associated with children's externalizing problems, but not with internalizing problems. As highlighted by Evans et al. (2008), the literature has shown several different patterns of IPV-related outcomes. Violence is a general risk factor for childhood problems (Margolin, 2005) and children may have diverse adjustment profiles related to individual, maternal and family characteristics (Graham-Bermann et al., 2009). On the other hand, and in agreement with prior research, the present study found (at bivariate level) that IPV was significantly associated with an alteration in the psychological functioning of children.

There are some limitations to consider on interpreting these findings. First, the use of a cross-sectional design and the subsequent data based on retrospective reports: maternal CA was assessed through the self-reports of mothers who provided data on their own adverse experiences in childhood, something which might have entailed recall biases (Koverola et al., 2005). Nonetheless, several studies have suggested that childhood abuse is underreported, which implies that many adults recalling abuse experiences are likely to have had them (Springer et al., 2007). Second, experiences of violence suffered by mothers (CA and IPV) were measured using a screening instrument, so that specific experiences were not assessed in detail, and this could be related to the low levels of violence found in the study. Studies that include more comprehensive measures of these types of violence are necessary in future. Third, the role of IPV-perpetrator and/or IPV-victim was not assessed in this research; moreover, mothers' reports about their experiences of IPV were not obtained. Instead, the focus was on children's perceptions and reports of violence between parents. Previous research has found that episodes of children's IPV-exposure are underreported by some parents, compared to what their offspring might describe (O'Brien, John, Margolin, & Erel, 1994). In any case, future research would benefit from the use of multiple informants. Fourth, children's behavioural problems were measured only through mothers' reports, and it is possible that the women's mental health problems influenced the way they reported their children's problems. Nevertheless, no significant differences have been found among evaluations of children's behavior provided by depressed mothers, by mothers in a neutral mood, and by independents observers (Joulires & Thompson, 1993). Fifth, the results of this research are based on a clinical sample only and cannot be generalized to other populations.

The results of this study have practical implications, insofar as they confirm the clinical relevance of considering the effects of women's childhood abuse and IPV not only on their own mental health, but also on their children's psychopathology. The findings suggest that targeting

different mental health problems in mothers who have experienced violence could be an important objective in relation to prevention and intervention in children and adolescents with behavior problems, and that incorporating the assessment of mothers' mental health may help clinicians design intervention plans. Following Koverola et al. (2005), early identification of mothers who suffered from violence, mainly through screening for maternal history of victimization, as well as early intervention to provide support services, may help reduce the risk of children's problems. Furthermore, it is important to help mothers seek adequate treatment for depression (Graham-Bermann et al., 2006) and to consider such symptoms in the design of therapeutic programmes for victimized mothers (Morrel et al., 2003). In addition, clinicians could help develop healthy attachment relationships between mothers and their children, and improvements in maternal mental health would result in fewer problems among their children. In this line of research, Graham-Bermann et al. (2009) pointed out that the absence of maternal mental health problems characterized IPV-exposed resilient children, and could be considered a key protective feature. Additional studies are required to examine how different characteristics of women's violent experiences (CA, IPV), such as their severity or their episodic/continuous nature, might modify development aspect in their children. Future research should also focus on cumulative victimization across the mothers' life span, its associations with diverse areas of maternal and family functioning (e.g. parenting practices, social support) and the mechanisms that might explain outcomes in their children. Finally, further work on the identification of individual and contextual factors operating as protective resources in mothers and children affected by violence would appear to be a crucial challenge for clinical research.

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Table 1: Clinic characteristics of the sample.

	Mean	SD	T≥70 (%)
Children's Psychopathology Problems-CBCL			
Anxious/Depressed	62.9	14.6	29.2
Withdrawn/Depressed	61.7	15.4	26.9
Somatic Complaints	62.8	16.5	26.7
Social Problems	60.7	13.5	23.7
Thought Problems	58.8	15.9	20.5
Attention Problems	63.2	12.2	28.4
Rule-Breaking Behavior	58.3	14.2	18.3
Aggressive Behavior	64.7	14.0	34.8
Internalizing	65.4	15.0	36.3
Externalizing	64.0	14.4	33.0
Total Behavior Problems	66.2	13.3	35.5
Functional impairment	Mean	SD	
CAFAS Total	60.0	30.9	
Mothers' Mental Health Problems	Mean	SD	
SCL-90-R GSI	0.67	0.55	
SCL-90-R DEP	0.96	0.80	
SCL-90-R ANX	0.61	0.61	
SCL-90-R HOST	0.57	0.67	

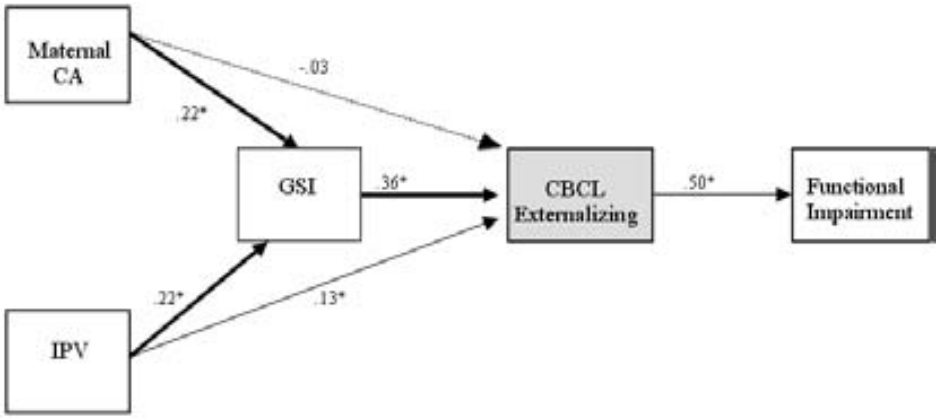
SD: Standard deviation.

Table 2: Intercorrelations among study variables.

	1	2	3	4	5	6	7	8	9
1 Maternal CA	---								
2 IPV	.19*	---							
3 SCL-90-R GSI	.25*	.26*	---						
4 SCL-90-R DEP	.21*	.25*	.92*	---					
5 SCL-90-R ANX	.15*	.23*	.90*	.80*	---				
6 SCL-90-R HOST	.22*	.27*	.76*	.65*	.68*	---			
7 CBCL Internalizing	.04	.07	37*	.32*	.34*	.29*	---		
8 CBCL Externalizing	.11*	.21*	.39*	.42*	.34*	.40*	.40*	---	
9 CAFAS Total	.10	.19*	.15*	.17*	.12*	.11	.34*	.50*	---

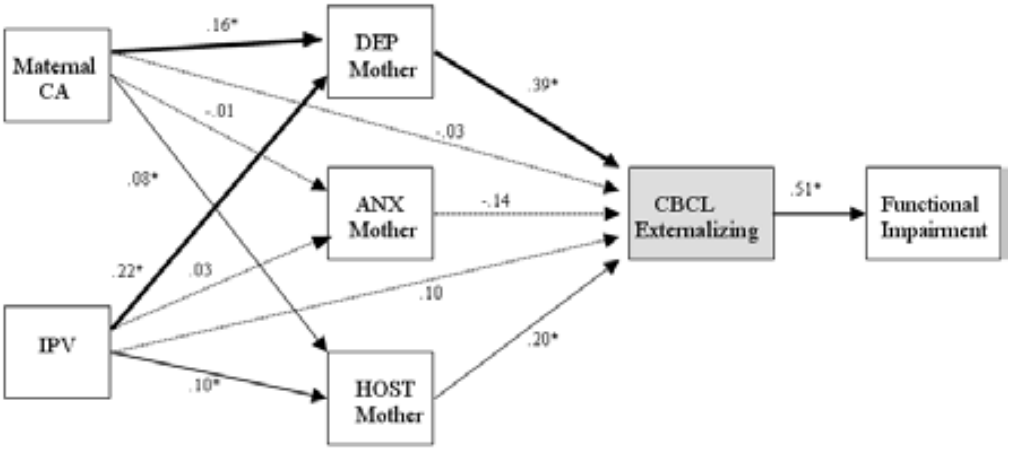
* p<.05.

Figure 1: Mediation Model: Effects of Maternal CA, IPV on CBCL externalizing. problems through GSI. Dashed lines represent effects that were not statistically significant. *p<.05.



$\chi^2(3)=4.37$ p=0.22 CFI=0.99 RMSEA=0.04 $R^2=.252$

Figure 2: Mediation Model: Effects of Maternal CA, IPV on CBCL externalizing. problems through DEP, ANX, HOST. Dashed lines represent effects that were not statistically significant. *p<.05.



$\chi^2(5)=8.69$ P=0.12 CFI=0.99 RMSEA=0.05 $R^2=.257$

Bios

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8. ANEXOS

8.1. Tercer estudio

Multiple mediators of the relationships among maternal childhood abuse, intimate partner violence and offspring psychopathology

Miranda, J., de la Osa, N., Granero, R., & Ezpeleta, L. Multiple Mediators of the relationships among Maternal Childhood Abuse, Intimate Partner Violence and Offspring Psychopathology (Manuscrito enviado para su publicación).

Abstract

The aim of the study was to examine whether maternal depression, mothers' and fathers' parenting, child physical punishment and negative life events (NLE) mediate the effect of maternal childhood abuse (CA), intimate partner violence (IPV) and cumulative violence (both CA and IPV) on children's psychopathology. Furthermore, multiple mediator models examine whether IPV mediates the effect of CA on the contextual and family factors mentioned above. Three hundred and eighteen Spanish outpatients aged 7 to 18 and their parents were assessed using a structured interview and other instruments for measuring the study variables. Structural Equation Models showed multiple pathways explaining psychopathological problems among offspring of mothers who suffered CA, IPV and both of these violent experiences. In particular, mothers' depression mediated the link between maternal CA, IPV, cumulative violence and children's externalizing and total behavior problems. Child NLE was an important pathway between maternal CA and total behavior problems, as well as between cumulative violence and both externalizing and total problems. IPV contributed to explaining the link between maternal CA and contextual and family factors, such as child physical punishment and NLE, which were in turn, associated with children's behavior problems. Findings show the complex interconnections between different types of violence and their harmful effects on the mental health of women and their offspring, as well as the need to extend our knowledge on this subject.

Keywords

Maternal Childhood Abuse, Intimate Partner Violence, Child and Adolescent Psychopathology, Mediator.

Multiple mediators of the relationships among maternal childhood abuse, intimate partner violence and offspring psychopathology

Childhood abuse (CA) and intimate partner violence (IPV) are crucial issues in research work, given their alarming magnitude, their harmful consequences in the short and long term, and their inestimable individual, social and economic costs (White, Koss & Kazdin, 2010). Being a victim of CA is an important risk factor for poor mental health in adulthood, as well as for parent-to-child difficulties and IPV (Banyard, 1997; Banyard, Williams, & Siegel, 2001, 2003). Although some studies have found a high risk for mental health problems among the offspring of childhood-abused mothers (Collishaw, Dunn, O'Connor, & Golding, 2007; Roberts, O'Connor, Dunn & Golding, 2004), as Collishaw et al. (2007) point out, only a few studies have explored this issue. In contrast, a great body of research has established the negative outcomes of IPV-exposed children, including academic/cognitive, behavioral, social and emotional problems (Holt, Buckley, & Whelan, 2008; Wolfe, Crooks, Lee, McIntyre-Smith & Jaffe, 2003). However, most of the literature on family violence has focused on the direct link between IPV and children's outcomes, and less is known about the mechanisms through which this type of violence impacts on children's well-being (Wolfe et al, 2003).

Given the considerable overlap between different types of childhood violence (Hughes, Humphrey, & Weaver, 2005), and the high risk for adult revictimization among survivors of CA (Fergusson, Boden, & Hordwood, 2008), a life-course approach has been proposed, which has been clinical, empirical and theoretically supported (Banyard et al., 2001; Becker, Stuewig, & McCloskey, 2010). According to this perspective, examining past history of CA and also recent IPV may contribute to a better understanding of the psychological consequences of violence (Becker et al., 2010). Recent studies focusing on maternal lifetime violence report that any violent experience suffered by mothers, in childhood or adulthood, could adversely affect their offspring's mental health (Koverola et al., 2005; Morrel, Dubowitz, Kerr, & Black, 2003). Further, research has found some evidence for cumulative effects – that is, cumulative violence suffered by mothers (both as a child and as an adult) was linked to poorer outcomes in their offspring, such as higher externalizing and internalizing problems (Dubowitz et al., 2001) and disruptive disorders (Miranda, de la Osa, Granero, & Ezpeleta, 2011). Nevertheless, to our knowledge, the direct and indirect effects of these different types of maternal violence (mothers' CA, IPV and cumulative violence) on children's outcomes have not been examined altogether in a single study. Moreover, although studies provide evidence for examining IPV as a mediator between CA and women's adult outcomes (Banyard et al., 2001; Becker et al., 2010), the way

in which women's violent history and multiple related factors jointly impact on their offspring's well-being remains unanswered.

Depression is one of the most commonly documented mental health consequences among women with a history of CA (Wise, Zierier, Krieger, & Harlow, 2001) and of IPV (Golding, 1999); also, poorer outcomes in depression have been reported among women who experienced violence during both childhood and adulthood (Dubowitz et al., 2001). Nevertheless, research on the potential mediating effects of maternal depression has shown inconclusive evidence. Some studies have found that maternal affective symptoms and depression mediated the effects of mothers' violence history (CA or IPV) on children's internalizing, externalizing or adjustment problems (Collishaw, et al., 2007; Koverola et al., 2005; Miranda, de la Osa, Granero, & Ezpeleta, in press; Morrel et al., 2003). In contrast, other studies failed to find support for the mediating role of mothers' mental health problems in general (McCloskey, Figueredo, & Koss, 1995) and depression in particular (Roberts et al., 2004).

Parenting may also significantly influence the way in which offspring are affected by mothers' history of violence. Several parenting difficulties have been reported among women survivors of CA, such as negative views of themselves as mothers, and greater use of permissive behaviors and physical discipline toward their children (Banyard, 1997; DiLillo & Damashek, 2003). Some studies provide support for the mediational role of parenting for offspring's outcomes, showing that low maternal confidence (Roberts et al., 2004) and maternal hostility (Collishaw et al., 2007) contribute to explaining the psychological problems in the children of CA survivors. With respect to IPV and its impact on maternal parenting, mixed findings have been reported. Previous studies suggest that IPV can affect children's outcomes through different maternal parenting problems, such as damaged general qualities of parenting (Levendosky & Graham-Bermann, 2001), maternal verbal aggression (Morrel et al., 2003) and physical child abuse (Salzinger et al., 2002). Conversely, research suggests that IPV does not *necessarily* damage maternal parenting, and that mothers may try to compensate for the violent environment (Casanueva, Martin, Runyan, Barth, & Bradley, 2008). On the other hand, few studies have focused on paternal parenting among violent families. Nevertheless, previous research suggests that the dysfunctional parenting of abuser fathers may disrupt children's development, highlighting the importance of further research exploring this issue (Guille, 2004).

Moreover, detrimental impact of exposure to multiple stressors and negative life events (NLE) has been found among offspring of mothers with CA (Collishaw et al., 2007) and IPV experiences (Holt et al., 2008; Rossman, 2000). In this regard, the cumulative risk model

(Rutter, 1979) provides theoretical support for testing how multiple NLE can explain psychological problems among these children.

The current study builds on and extends previous research by examining whether maternal depression, mothers' and fathers' parenting, child physical punishment and NLE mediate the effect of maternal CA, IPV and cumulative violence (CA and IPV) on children's psychopathology. Furthermore, multiple mediator models examine whether IPV mediates the effect of CA on the contextual and family factors referred to above.

Method

Participants

Participants were part of a larger study on risk and protective factors for children's and adolescents' psychopathology problems. They were recruited from public outpatient mental health centers in Barcelona, Spain. Exclusion criteria were the presence of mental retardation or pervasive developmental disorders. Starting out from an initial sample of 689 children and adolescents aged 7-18, together with their parents, 318 individuals with complete data for the measures analyzed in this work were included in the final study sample. There were no statistical differences by child's sex (p=.44), age (p=.66), ethnicity (p=.10) or socioeconomic status (p=.75; SES, measured with Hollingshead's scale) (Hollingshead, 1975) between those who were included in the final sample and those who were not.

Based on the mothers' and children's reports to the *Schedule for Risk Factors* (SRF; Unitat d'Epidemiologia i Diagnòstic en Psicopatologia del Desenvolupament, 1997), participants (N=318) were classified into four groups according to the types of violence suffered by mothers over their lifetime: not exposed to violence (n=246, 77.4%), CA only (n=30, 9.4%), IPV only (n=29, 9.1 %), and both CA and IPV (n=13, 4.1%). Table 1 shows the demographic characteristics of the participants.

--- Insert TABLE 1 ---

Measures

Schedule of Risk Factors (SRF; Unitat d'Epidemiologia i Diagnòstic en Psicopatologia del Desenvolupament, 1997). The SRF is a comprehensive structured interview based on the Service Utilization and Risk Factors interview (Goodman et al., 1998), which assesses a wide range of factors that may affect the mental health of children and adolescents. Separate versions were used for parents and for children. The SRF presents acceptable inter-interviewer reliability

and concurrent validity in a Spanish population (Guillamón, 1999). In the current study several sections were used: *mothers' reports of CA experiences* (psychological, physical and/or sexual); *children's exposure to IPV* specifically, in this research we used a question about whether children had ever seen their parents hitting each other during an argument – an item adapted from the Child's Perception of Interparental Conflict Scale (Grych, Seid, & Finchman, 1992); *child negative life events* (Life Events Checklist; Johnson & McCutcheon, 1980), through which children were asked about the occurrence of a wide range of possible stressful life events; *child physical punishment* (Parental Discipline Practices Scales; Goodman et al., 1998) – mothers' and fathers' physical punishment toward child were assessed separately, and then a single composite measure was created; *mothers' cumulative violence*, an index of cumulative violence suffered by mothers was created – participants scored 1 if they answered yes to questions about maternal CA and also IPV, whereas a score of 0 was given if participants did not report both types of violence.

Child Behavior Checklist (CBCL; Achenbach & Rescorla, 2001). The CBCL is an extensively validated 113-item questionnaire to assess behavioral and emotional problems in children and adolescents aged 6-18. Parents completed a 3-point scale: 0-not true, 1-somewhat or sometimes true, 3-very true or often true. Three global scales were used in this study: Internalizing, Externalizing and Total behavior problems.

Symptom Checklist 90 items-Revised (SCL-90-R) (Derogatis, 1983). The SCL-90-R is a well-established 90-item questionnaire to assess the presence of psychopathology and psychiatric distress levels. Mothers answered each item on a Likert-type 5-point scale ranging from 0-never to 4-very much. In this study, the Depression symptom subscale (DEP) score was used.

EMBU (Egna Minnen Beträffande Uppfostran, My memories of upbringing; Perris, Jacobson, Lindström, Von Knorring, & Perris, 1980). The EMBU is a well-documented 81-item questionnaire that assesses parental styles. The versions for children (between 8 and 12 years old), adolescents (from 13 years old) and parents were used. Mothers' and fathers' parenting styles were assessed separately. Participants answered a 4-point scale ranging from 1-never to 4-almost always. In this study, three scales were analyzed: Emotional Warmth, Rejection and Overprotection.

Procedure

Approval was obtained from the Ethics Committee of the authors' institution. Youngsters referred to mental health services within the Barcelona public health network were recruited.

All children and adolescents were visiting the centers for the first time, and were not receiving treatment at the time of the assessment. Parents signed a written informed consent document, and verbal assent was obtained from the children and adolescents. Interviews were conducted separately for children and parents (but at the same time) by trained interviewers. Questionnaires were given to the participants to be returned at a later date. After the assessment, the researchers made a full report to the clinicians at the mental health centers.

Statistical Analysis

Analyses were carried out with SPSS17.0.1 for Windows and the EQS6.1. The procedure outlined by Baron and Kenny (Baron & Kenny, 1986) was used to test whether the relationships among maternal CA, IPV and children's behavior problems were mediated by the variables proposed in this study as mediators. Structural Equations Models (SEMs) were adjusted, including maternal CA and IPV as predictors, mothers' depression, parenting styles, child physical punishment and negative life events as mediators, and children's behavior problems as outcomes. SEMs were also used for testing the link between maternal CA and IPV and for the joint analysis of potential mediating variables. Separately, SEMs exploring mothers' cumulative violence as predictor were also built. The significance of each specific pathway was assessed with the method described by Kenny, Kashy, and Bolger (1998). All the SEMs included as covariates children's sex and age, with the aim of controlling the potential effects of both variables in the pathways. Goodness of fit was assessed by several indices: Chi-square test (χ^2), Comparative Fit Index (CFI) and the Root Mean Square Error of Approximation (RMSEA). In the present study, fit indices were considered good if: the Chi-square achieved p-values lower than .05, the CFI coefficient was higher than .90, and the RMSEA was lower than .08 (Byrne, 2001).

Results

Correlations between variables and descriptive statistics

Table 2 shows bivariate correlations between the variables analyzed in this work. These coefficients allow assessment of the initial criteria established by Baron and Kenny (1986) for considering mediation: a) predictors must be related to both outcomes and potential mediators; b) potential mediators must be related to outcomes.

--- Insert TABLE 2 ---

The variables that met the listed criteria for mediation were included in the SEMs. Descriptive information for potential mediators and outcomes are shown in Table 3.

--- Insert TABLE 3 ---

Mediator Models

Figure 1 indicates that Model 1 had good fit indices (χ^2=5.35 p=.15; CFI=.99; RMSEA=.05; R^2=.293) and showed that mothers' DEP mediated the link between maternal CA, IPV and CBCL externalizing behavior problems (z= 2.62 p<.001; z=2.44 p=.015, respectively). As expected, maternal CA and IPV were positively associated with DEP, and mothers' DEP was positively associated with CBCL externalizing behavior problems. Also, Model 1 showed that maternal CA was positively associated with IPV, and IPV was positively associated with child NLE and physical punishment. Tests on the significance of pathway showed that IPV mediated the relationship of maternal CA with child NLE and physical punishment (z=2.31 p=.018; z=2.21 p=.027, respectively). Child NLE and physical punishment mediated the effect of IPV on CBCL externalizing behavior problems (z=2.44 p=.015; z=2.01 p=.044, respectively). Although mothers' rejection and child NLE were significantly associated with maternal CA and CBCL externalizing behavior problems, the significance of the mediational path test showed that mothers' rejection and child NLE did not achieve the role of mediators (z=1.78 p=.075; z=1.90 p=.057, respectively). The results indicated no direct pathways between maternal CA, IPV and CBCL externalizing problems.

--- Insert FIGURE 1 ---

Model 2, including pathways from maternal CA and IPV to CBCL total behavior problems, also obtained good fit statistics (Figure 2). Mothers' DEP mediated the effect of maternal CA and IPV on CBCL total behavior problems (z=2.82 p=.005; z=2.03 p=.043, respectively). Both maternal CA and IPV were positively associated with mothers' DEP, and DEP was positively associated with CBCL total behavior problems. On the other hand, maternal CA and IPV were positively associated, and IPV was positively associated with child NLE and physical punishment. The relation between maternal CA and child NLE and physical punishment was mediated by IPV (z=2.29 p=.022; z=2.21 p=.027). However, maternal CA was also directly and positively associated with child NLE, and NLE was positively associated with CBCL total behavior problems. Child NLE mediated the effects of both maternal CA and IPV on CBCL total behavior problems (z=1.98 p=.047; z=2.90 p=.004). Child physical punishment was not associated with CBCL total behavior problems. Mothers' rejection was positively associated with maternal CA and CBCL total behavior problems, but did not mediate this relationship (z=1.91 p=.056).

--- Insert FIGURE 2 ---

Model 3, examining the effects of mothers' cumulative violence on CBCL externalizing problems through multiple mediators, showed good fit values. As Figure 3 shows, mothers' DEP and child NLE mediated the link between mothers' cumulative violence and CBCL externalizing problems (z=2.33 p=.020; z=2.00 p=.046, respectively). Mothers' cumulative violence was positively associated with both mothers' DEP and child NLE, and DEP and NLE were positively associated with CBCL externalizing behavior problems. Even though fathers' overprotection and physical punishment were associated with mothers' cumulative violence and CBCL externalizing behavior problems, they did not play a mediator role (z=1.72 p=.086; z=1.79, p=.073, respectively).

--- Insert FIGURE 3 ---

Figure 4 shows the good fit indices for Model 4. The link between mothers' cumulative violence and CBCL total behavior problems was mediated by mothers' DEP and child NLE (z=2.40 p=.016; z=2.46 p=.014, respectively). Mothers' cumulative violence was positively associated with mothers' DEP and child NLE, and DEP and NLE were positively associated with CBCL total behavior problems. Fathers' overprotection was associated with mothers' cumulative violence and CBCL Total behavior problems, though no mediating effect was found (z=1.75 p=.080). Physical punishment was associated with mothers' cumulative violence, but not with CBCL Total behavior problems.

--- Insert FIGURE 4 ---

Discussion

This study found multiple pathways explaining psychopathological problems among offspring of mothers who had suffered CA, IPV or both. Particularly, mothers' depression mediated the effect of maternal CA, IPV and cumulative violence on children's externalizing and total behavior problems. Child NLE was an important pathway between maternal CA and total behavior problems, as well as between cumulative violence and both externalizing and total problems. IPV contributed to explaining the link between maternal CA and contextual and family factors, such as child physical punishment and NLE, which in turn were associated with children's behavior problems. These results support the potential utility of examining different types of traumatic exposure individually and in combination (Banyard et al., 2001), assessing the effects of lifetime violence on both survivors' (Banyard et al., 2001, 2003) and their offspring's functioning (Dubowitz et al., 2001; Miranda et al., 2011), and exploring possible explanatory factors.

The findings of the present study suggest that the effects of mothers' experiences of childhood violence and/or violent partner relationship depend on different risk factors, rather than impacting directly on offspring's well-being. Previous research reported several risk factors that fully explained the association of maternal CA with children's adjustment and prognosis, suggesting an intergenerational continuity in psychosocial risk, which may have a cumulative impact on children's development (Collishaw et al., 2007). Also, the models tested support a comprehensive view of the consequences of IPV, highlighting the mediating role of variables related to the context in which children grow up. As Levendosky and Graham-Bermann proposed (2001), models that only examine the direct effects of IPV could overlook significant environmental factors that help us to understand its differential impact on outcomes in children and women.

All the models analyzed showed that maternal depression had an important mediator role. These findings support the argument that mothers' depression is a key pathway through which their experiences of violence impair their offspring's capabilities to manage aggression (externalizing problems) (Dehon, 2005; Miranda et al., in press; Morrel et al., 2003), and also other aspects of their social and cognitive functioning (total behavior problems). Similarly, a high frequency and significant mediating effects were found for child NLE in the different relationships analyzed. The models tested suggest that offspring of women who have experienced these types of violence may be more likely to grow up in an environment that puts them at risk of having traumatic experiences, which may disrupt their normal development. Offspring of mothers abused in childhood were more likely to experience a broad range of negative life events (Collishaw et al., 2007), and multiple stressful factors may accumulate and impact on the lives of IPV-exposed children (Rossman, 2000). On the other hand, child physical punishment had a mediating effect specifically on the association of IPV with offspring's externalizing behavior problems. Consistent with previous research (Miranda et al., 2011), these findings suggest that children exposed to IPV are at high risk for experiencing parent-child aggression, and this dysfunctional parental behavior can lead to the development of aggressive and delinquent behaviors in offspring. It is important to note that mothers' CA was associated with child physical punishment via IPV. As in previous reports, these findings show that some survivors of childhood abuse are still living with abuse (Banyard et al., 2001; Becker, et al., 2010), but also suggest that their own children are suffering abuse from parental practices, which may place them at risk for aggressive behavior.

The models testing mothers' cumulative violence provide some evidence about the joint effect of two major experiences of violence (CA and IPV), suggesting its negative impact on adults' outcomes, as well as on their offspring's mental health. Interestingly, only in these models does paternal parenting, specifically fathers' overprotection, emerge as a significant predictor of children's behavior problems. These findings suggest that for offspring whose mothers suffered childhood and adulthood violence, the nature of the father-offspring relationship may have a strong influence on children's clinical symptomatology. It has been clearly shown that more studies are needed to examine the relation between fathers and children in families affected by IPV (Guille, 2004). Moreover, our results indicate that specific risk factors may be affecting the offspring of dual-exposed mothers.

The findings of this study should be interpreted in the light of its limitations. First, the cross-sectional design used in the study precludes causal relationships. Second, limitations related to the measures should be considered. Retrospective self-reports could be affected by recall and report biases. Since most of the factors analyzed in this study are difficult to observe directly, as argued by Fergusson et al. (2008), the accuracy of the data depends on how accurately the participants reported the events. Reports of mothers about their offspring's behavior problems may be influenced by depressive symptoms. Further studies that include multi-informant and observational methods would be useful. Third, in spite of the large initial sample, relatively small groups emerge for the different types of violence examined, which could reduce the statistical power of the analyses. Additional research with larger samples should continue to focus on violence experienced over the lifetime and its consequences for mothers and offspring. And fourth, the current results could only be generalized to children and adolescents who consult mental health services.

Despite these limitations, the study's findings have important clinical implications. First, they identify several contextual and familial factors as important mechanisms underlying psychopathology problems in offspring of mothers with violent experiences, suggesting possible targets for healthcare interventions. Clinicians and mental health providers who work with behaviorally disordered children should routinely inquire about mothers' history of violence. If maternal childhood abuse and/or violent partner relationships are detected, screening for maternal depression, parental harsh discipline strategies, as well as stressful events faced by children, would be recommended, with a view to distinguishing specific treatment needs for the family. Second, they underscore the clinical relevance of assessment and interventions designed to reduce risk for aggressive behaviors in offspring of mothers who have

suffered violence in childhood and/or adulthood, in an attempt to stop the circle of violence. The multiple risk factors found in families of women with a history of violence suggest that plans for interventions must be aimed at both mothers and children, in order to help them make progress toward violence-free lives. And finally, they support the need to extend our knowledge about the complex interconnections between different types of violence and their harmful effects on both women's and their offspring's mental health.

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Table 1: Sociodemographic Characteristics.

		Maternal Exposure to Violence				
		S0	S1	S2	S3	Total
		(N=246)	(n=30)	(n=29)	(n=13)	(N=318)
Sex: girls; *%*		43.1	70	27.6	61.5	45
Age (years); *Mean (SD)*		13.3 (2.3)	13.0 (2.2)	12.9 (2.5)	13.6 (2.3)	13.3 (2.3)
Mother's age (years) *Mean (SD)*		40.6 (5.6)	38.9 (5.4)	39.6 (5.6)	41.6 (7.8)	40.4 (5.7)
Father's age (years-old)		43.1 (5.7)	42.5 (5.2)	41.8 (6.3)	42.0 (8.3)	42.9 (5.8)
SES[1]; *%*	*Upper/Upper-Middle*	12.8	6.9	14.3	23.1	12.8
	Middle/Lower-Middle	62.0	65.5	64.3	46.2	61.9
	Lower	25.2	27.6	21.4	30.8	25.3
Ethnicity; *%*	*Caucasian*	98.4	96.7	100	92.3	98.1
Mother's educational	*Unfinished primary school*	12.2	13.8	11.1	7.7	12.1
	Primary school	48.1	55.2	33.3	53.8	47.7
	Unfinished high school	15.6	13.8	22.2	15.4	16.0
	High school	16.9	13.8	25.9	7.7	17.0
	Undergraduate degree	1.7	3.4	3.7	0.0	2.0
	College degree	4.2	0.0	3.7	7.7	3.9
	Graduate degree	1.3	0.0	0.0	7.7	1.3
Father's educational level;	*Unfinished primary school*	12.0	11.5	21.7	0.0	12.4
	Primary school	46.2	53.8	43.5	50.0	46.8
	Unfinished high school	16.4	7.7	4.3	25.0	14.9
	High school	13.8	11.5	13.0	25.0	13.8
	Undergraduate degree	5.8	3.8	13.0	0.0	6.0
	College degree	0.9	3.8	4.3	0.0	1.4
	Graduate degree	4.9	7.7	0.0	0.0	4.6
Stepfamily; *%*	*Yes (%)*	8.5	6.7	21.4	15.4	9.8

S0: Not exposed to violence; S1: Only childhood abuse; S2: Only IPV in adulthood; S3: Both childhood abuse and IPV in adulthood

[1]SES: Socioeconomic status (Hollingshead, 1975). SD: Standard deviation. p<.05*.

Table 2: Intercorrelations among the variables of the study.

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
1 Maternal CA	---																				
2 IPV	.15*	---																			
3 Maternal Cumulative Violence	.50*	.47*	---																		
4 SCL Mother's depression	.22*	.23*	.12*	---																	
5 EMBU-C maternal rejection	.10*	.01	-.01	.11*	---																
6 EMBU-C paternal rejection	.07	.05	.02	.09	.78*	---															
7 EMBU-C maternal warmth	.04	-.05	-.07	-.07	.50*	.53*	---														
8 EMBU-C paternal warmth	-.01	-.06	-.09	-.07	.46*	.48*	.96*	---													
9 EMBU-C maternal overprotection	.06	-.05	-.05	.05	.69*	.65*	.61*	.60*	---												
10 EMBU-C paternal overprotection	-.03	-.07	-.11*	-.02	.55*	.66*	.59*	.60*	.85*	---											
11 EMBU-P paternal rejection	-.01	-.01	.02	.19*	.06	.15*	-.02	-.04	.04	.10	---										
12 EMBU-P maternal rejection	.09	.03	.05	.23*	.30*	.24*	.13*	.15*	.19*	.17*	.35*	---									
13 EMBU-P paternal warmth	.06	-.02	-0.2	-.13*	.07	.06	.32*	.34*	.17*	.20*	-.33	-.20*	---								
14 EMBU-P maternal warmth	.01	-.06	-.04	-.14*	-.03	.01	.25*	.24*	.11*	.11*	-.14*	-.35*	.38*	---							
15 EMBU-P paternal overprotection	-.07	.01	.02	.16*	.13*	.16*	-.07	-.05	.13*	.16*	.41*	.26*	.01	-.15*	---						
16 EMBU-P maternal overprotection	.07	.04	.06	.30*	.16*	.13*	-.04	-.02	.22*	.13*	.25*	.52*	-.12*	-.16*	.38*	---					
17 Child Physical Punishment	.04	.22*	.12*	.01	.22*	.25*	.05	.07	.26*	.22*	.20*	.19*	-.01	-.08	.17*	.21*	---				
18 Child Negative Life Events	.11*	.30*	.16*	.20*	-.12*	-.13	-.35*	-.35*	-.18*	-.20*	.08	.03	-.18*	-.19*	.14*	.08	.15*	---			
19 CBCL Internalizing	.08	.07	.03	.34*	.09	.04	-.06	-.05	.05	.01	.16*	.15*	-.11	-.06	.13*	.12*	-.01	.28*	---		
20 CBCL Externalizing	.11*	.20*	.13*	.39*	.30*	.32*	.004	-.02	.19*	.16*	.30*	.32*	-.15	-.22*	.34*	.41*	.22*	.19*	.38*	---	
21 CBCL Total	.14*	.14*	.10*	.45*	.30*	.26*	.01	.004	.18*	.13*	.28*	.33*	-.15*	-.19*	.29*	.37*	.15*	.27*	.76*	.84*	---

EMBU-C: offspring's reports; EMBU-P: parents' reports. *Significant correlation (.05 level).

Table 3: Descriptive statistics on study variables.

	S0 (N=246)			S1 (N=30)			S2 (N=29)			S3 (N=13)			Total (N=318)		
	Mean	SD	T≥70 (%)	Mean	SD	T≥70 (%)	Mean	SD	T≥70 (%)	Mean	SD	T≥70 (%)	Mean	SD	T≥70 (%)
Children's Psychopathology: CBCL															
Externalizing	62.7	13.7	29.3	64.2	16.2	26.7	69.7	14.2	58.6	74.4	14.9	69.2	64.1	14.3	33.3
Total Behavior Problems	65.2	13.0	32.5	68.3	13.2	43.3	70.0	14.5	44.8	73.3	12.6	53.8	66.2	13.3	35.5
Mothers' Mental Health Problems															
SCL-90-R Depression	.82	.67		1.34	.95		1.37	1.1		1.53	.90		0.95	0.80	
Parenting Style															
EMBU-C Maternal Rejection	13.6	7.6		17.3	7.5		15.4	9.5		14.0	7.7		14.1	7.8	
EMBU-C Paternal Overprotection	22.0	6.8		22.7	5.3		22.2	8.4		16.8	4.6		21.9	6.8	
Child Physical Punishment (%)															
Children's Report															
Father hit/slap/spank	5.3			0.0			8.0			27.3			5.8		
Mother hit/slap/spank	5.0			6.6			6.8			15.4			5.8		
Father hit with an object (belt)	3.9			0.0			0.0			9.1			3.4		
Mother hit with an object (belt)	2.1			0.0			6.9			7.7			2.6		
Parents' Report															
Father hit/slap/spank	2.9			0.0			15.3			23.1			4.6		
Mother hit/slap/spank	6.5			3.3			6.9			15.4			6.6		
Father hit with an object (belt)	2.9			0.0			11.5			7.7			3.6		
Mother hit with an object (belt)	2.8			0.0			3.4			7.7			2.8		
Composite Physical Punishment	18.8			10.3			37.9			61.5			21.5		
Negative Life Events (≥6) (%)	47.1			69.0			79.3			84.6			53.7		

S0: Not exposed to violence; S1: Only childhood abuse; S2: Only IPV in adulthood; S3: Both childhood abuse and IPV in adulthood.

SD: standard deviation. T: T-score (on a scale of mean=50 and SD=10; values above 70 are into the clinical range).

Figure 1: Model of multiple mediators in the relations among maternal CA, IPV and offspring's externalizing behavior problems. Dashed lines represent effects that were not statistically significant. Bold lines represent significant paths. *p<.05.

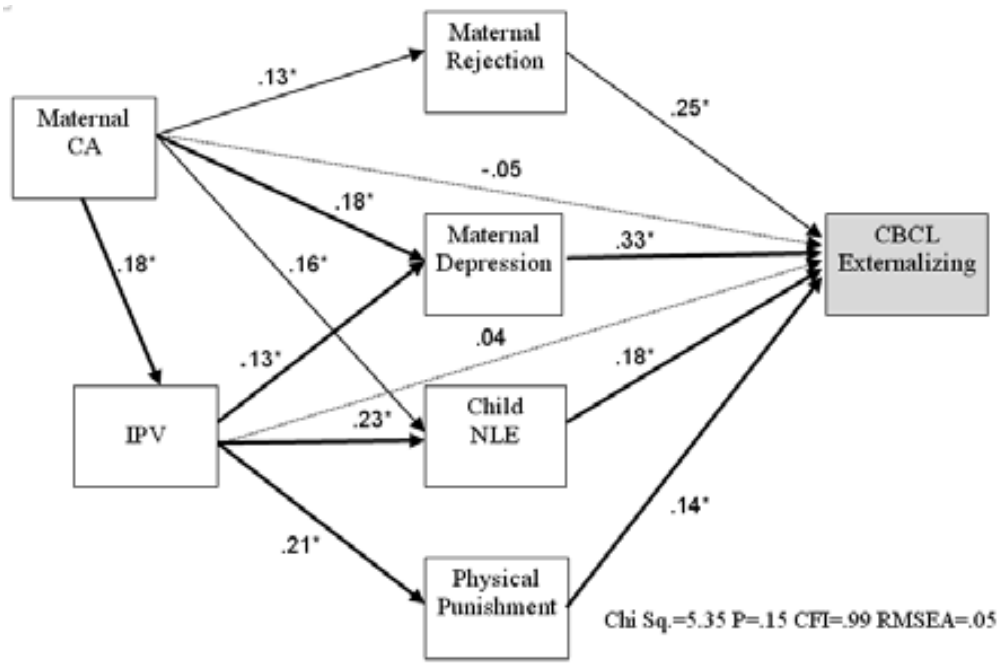


Figure 2: Model of multiple mediators in the relations among maternal CA, IPV and offspring's total behavior problems. Dashed lines represent effects that were not statistically significant. Bold lines represent significant paths. *p<.05.

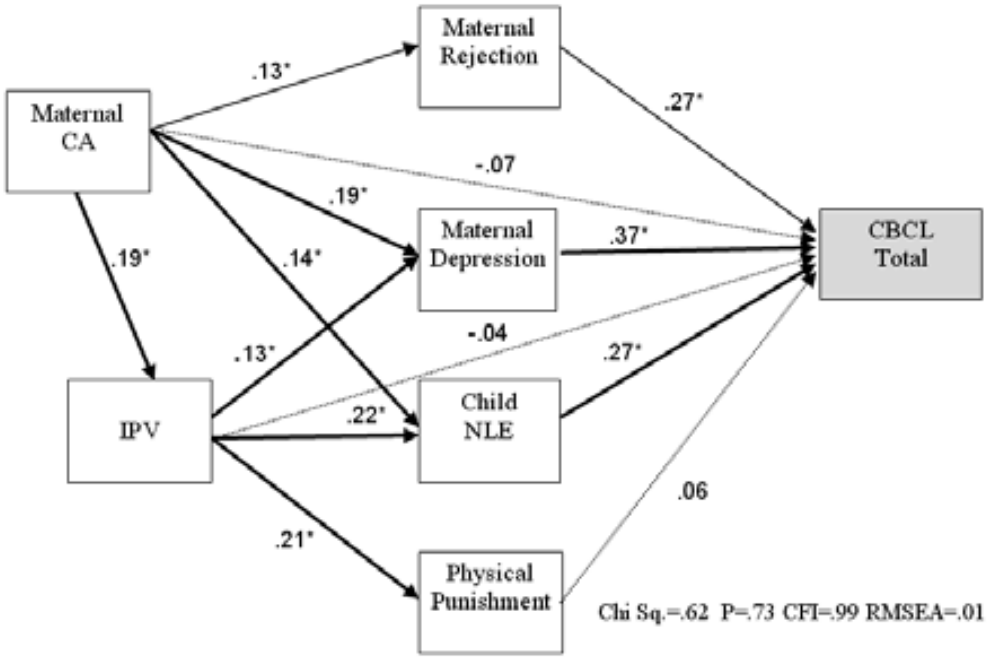


Figure 3: Model of multiple mediators in the relation between maternal cumulative violence and offspring's externalizing problems. Dashed lines represent effects that were not statistically significant. Bold lines represent significant paths. *p<.05.

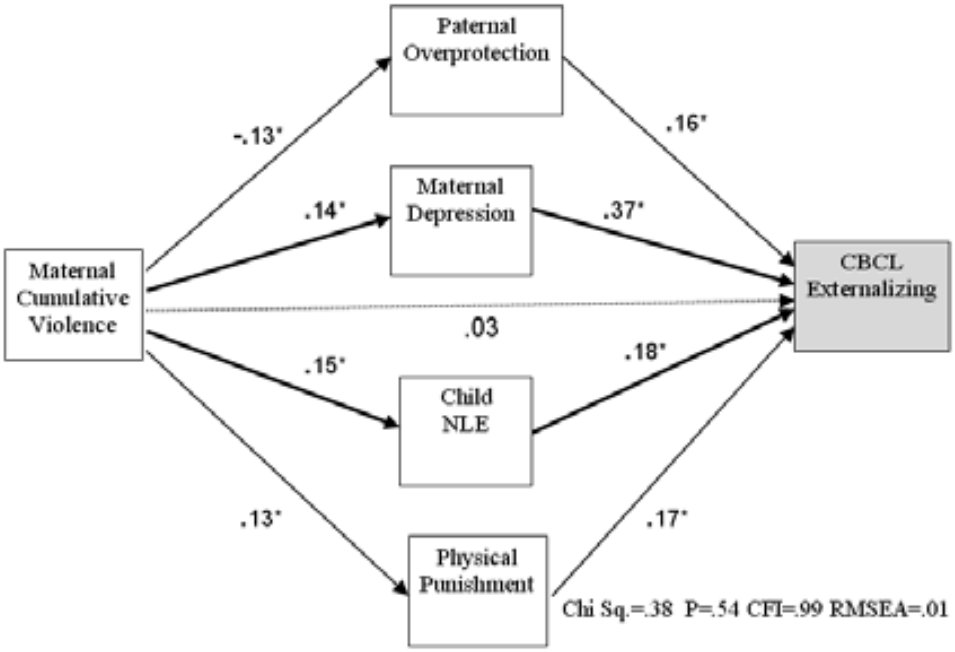
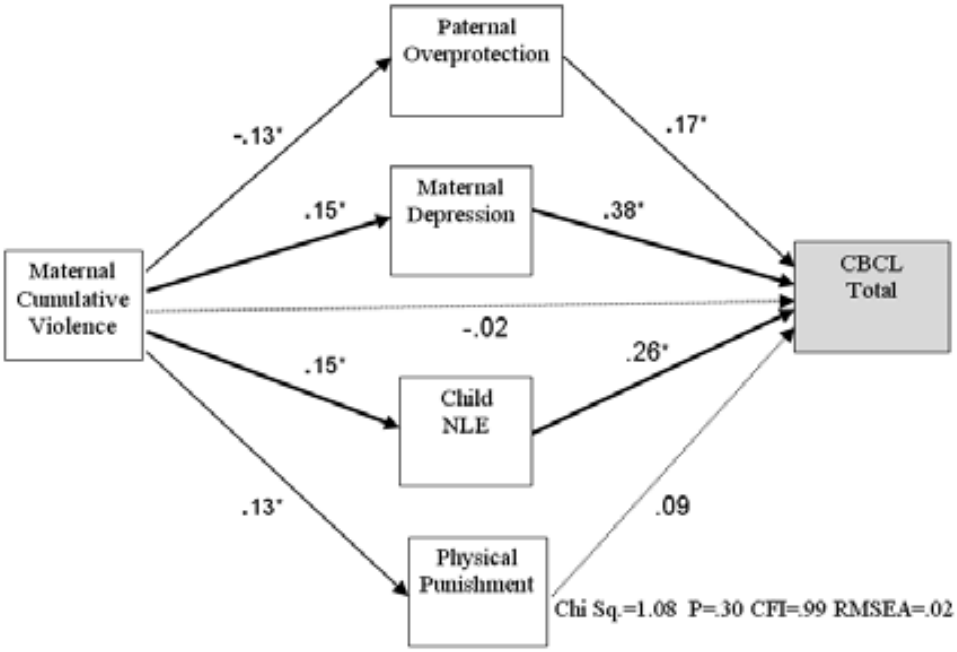


Figure 4: Model of multiple mediators in the relation between maternal cumulative violence and offspring's total behavior problems. Dashed lines represent effects that were not statistically significant. Bold lines represent significant paths. *p<.05.



Bios

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