THE IMPACT OF DOMESTIC VIOLENCE ON ADOLESCENTS:

"THE SILENT VICTIMS"

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CHAPTER 1

1. INTRODUCTION

South Africa is an extremely violent society and is a country in which the incidence of crime and violence are well above the world average (Robertson & Davidson, 2002). The world-renowned incident of the rape of "baby Tshepang" and the murder of FullBright scholar "McBiel" did not help change this perception.

There has been a great deal of attention focused on the problem of violent crimes such as car hijackings and armed robbery. Some reports in the media also show that a lot of violence also takes place in the home, regardless of the socioeconomic status of the victims, for example "Tracy Going" a top and her partner physically abused core person of SABC's Morning Live. Recently a child was locked in a room for a month fed only bread and water. However, very little attention is paid to the most dangerous place in our society – the home.

It is difficult to establish accurate figures reflecting the incidence of murder within the family, due to the fact that there are no reliable statistics available in South Africa. At present, homicides that occur within the family are included with homicide in general and the relationship of the perpetrator to the victim is not documented. Similarly, there are no accurate figures for domestic violence. The South African Police Service (SAPS) does not report domestic violence under a

separate category. These cases are recorded as crimes such as common assaults, grievous bodily harm and other such categories.

Despite the notoriously poor statistics, it has been estimated that up to 60% of marital relationships involve abuse (both physical and psychological) and that between 1 in 4 woman are abused (Robertson & Davidson, 2002). The above figures make it strikingly clear that numerous children who grow up in South African homes are exposed to high levels of violence within their homes. This is a paradoxical situation as the home is traditionally viewed as a safe haven and sanctuary from the harshness of the outside world, and yet, it is the one place that exposes children to the most exposure to violence. A study on intimate femicide suggests that between 1993–1994, one woman was killed every day by her partner in Gauteng (Robertson & Davidson, 2002). This is an alarming figure, especially if one considers this in relation to the child survivor of these grotesque deeds.

Domestic violence is wide spread and occurs among all socio-economic groups (Osofsky 1998). However, the frequency with which such victimization occurs varies greatly from one society to the next and from one culture to the next. However, this problem is not only unique to South Africa only. In a national survey of over 6,000 American families, it was estimated that between 53% and 70% of males also frequently abused their children (Volpe, 1996).

It has been estimated that 25%-30% of American women are beaten up at least once in the course of intimate relationships (Straus & Geles, 1990). Nationwide surveys show that nearly one-eighth of husbands in the US commit one or more acts of physically violence against their wives each year and one-fifth to one-third of all women are assaulted by a partner or ex-partner during their life-time (Frietz & Brown, 1990). How much of this violence occurs in the presence of children is unknown, which is why they are considered invisible victims.

It has been estimated that at least 3.3 million children witness physical and verbal spousal abuse each year, including a range of behaviors from insults and hitting to fatal assaults with guns and knives (Osofsky 1998). Partner violence is often described as unseen, because it usually occurs in the privacy of a home. But violent homes often include children "the silent victims" and these children do see the violence. Children hear their parents, the adults they love and depend on, screaming in anger, pleading in fear, sobbing in pain. They hear the thud of fists, witting bodies, and objects thrown and shattered, people thrown against walls and knocked to floors. They may see blood, bruises and weapons from children witnessing domestic rapes and even murder (Wolak & Finkehoir, 1999)

Children may be victimized directly through themselves being abused or indirectly, through witnessing the horror of a parent being repeatedly abused and sometimes killed in front of them. They are silent victims as their plight is seldom recognized

or reported by the media and frequently their own family disregards the impacts of their traumatic experiences (Robertson & Davidson, 2002).

Domestic violence causes a range of problems in the child's life (Hanafin 2000). The purpose of this study is to further the understanding of the current literature on the effects of domestic violence on the development of children specifically looking at self-esteem and anxiety. The biggest question: what is the relationship between domestic violence, self-esteem and anxiety of children who have experienced violent episodes between their parents?

Given the picture of the domestic violence on children as highlighted above, the present researcher attempted to answer questions, which she regards as the basic in the study. These questions are: Does domestic violence affect the self-esteem of adolescents? Does domestic violence expose adolescents to anxiety?

2. STATEMENT OF THE PROBLEM

Violence has become an increasingly pervasive problem in our society. Domestic violence has adverse effects on individuals, families and society in general. The cycle of violence does not begin in prisons. It begins early in life. It begins when an already stressed family has difficulty nurturing an unhealthy, demanding newborn. It begins when an unfed, abused or unattended child learns that their

life is of little value. It begins when an adolescent learns that violence is a means to solve problems.

The development of strong, clear feeling of whom one is, is the most important developmental task of adolescence. Adolescents need a safe and secured home to develop a positive sense of self, necessary to their growing into healthy, productive and caring adults.

The present spectra of increasing domestic violence are beginning to create awareness about its danger to adolescents. Therefore, a need to explicate the source of domestic violence particularly in our black community of the caring, nurturing environment of the adolescent and how it relates to their sense of worth and their anxiety have inspired the study.

3. OBJECTIVE OF THE STUDY

The study focused on adolescents. As such, attention was specifically directed to the adolescent students of 3 High Schools in Mmabatho, i.e. Mmabatho High, Batswana High School and Kebalepile High Schools. The aspects which were investigated and addressed in this study, related to domestic violence and self-esteem, domestic violence and anxiety. The objective of the present study was

thus to establish if exposure to domestic violence can affect the development of self-esteem and anxiety levels of the adolescent students of Mmabatho.

4. RATIONALE OF THE STUDY

The rationale of the study lies in the fact that there is very little research available regarding children's exposure to domestic violence. Exposure to domestic violence is not even listed in the statistics crimes related to children, only crimes such as sexual offences, attempted murder, assault with grievous bodily harm (GBH), common assault, abduction, kidnapping and neglect. How domestic violence affects children is often overlooked which is why they are considered invisible victims.

Adolescents learn from witnessing violence in their homes and what they learn may become precursors of later violent adult behaviors. Clinical evidence suggests that exposure to violence may lead to more high risk in adolescents.

Thus, the purpose of this study is really to understand how does domestic violence affect adolescent's self-esteem and anxiety levels. Possible support programs based on adolescents' experiences of violent situations may be developed.

CHAPTER 2

LITERATURE REVIEW

1. INTRODUCTION

The family is the child's introduction to society and has therefore borne the major responsibilities for socializing the child. The family functions as a system on interactions, and the way it conducts personal relationship has a very powerful effects on the psychosocial developments of children (Surajnarayan, 1991).

According to Berns (1995), socialization enables children to develop their potentialities and form satisfying relationships. Socialization aims to develop self-image. Certain characteristics of families influence socialization and behavior of adolescents, i.e. family functioning variables such as socioeconomic status. Family functioning variable refers to affectional relationship between parent and child, parenting style and parental disharmony. Socioeconomic status refers to the quality of family life.

This chapter will review and discuss literature associated with the concept exposure to domestic violence and its impact on adolescents, particularly self-

esteem and anxiety. An effort is also directed in to some kind of systematization of the theoretical foundation of the study.

2. DOMESTIC VIOLENCE

Domestic violence includes physical abuse, psychological abuse to women and children by someone with power over them and abuse also to property and pets (Ganley, 1989). Exposure to this form of violence has considerable potential to be perceived as life-threatening by those victimized and can leave them with a sense of vulnerability, helplessness, and in extreme cases, horror. Physical abuse refers to any behavior that involves the intentional use of force against the body of other person that risks physical injury, harm or pain (Dutton, 1994). Physical abuse includes pushing, hitting, slapping, choking, using an object to hit, twisting of a body part, forcing the ingestion of an unwanted substance and the use of a weapon. Sexual abuse is defined as any unwanted sexual intimacy forced on one individual by another. It may include oral, anal or vaginal stimulation or penetration, forced nudity, forced exposure to sexual explicit material or activity, or any other unwanted sexual activity (Dutton, 1994). Compliance may be obtained through actual or threatened physical force or through some other form of coercion. Psychological abuse may include derogatory statements or threats of further abuse, (e.g. threats of being killed by another individual). It may also

involve isolation, economic threats and emotional abuse. Domestic violence has adverse effects on individuals, families, and society in general.

2.1 PREVALENCE OF WITNESSING DOMESTIC VIOLENCE

No national prevalence studies of children who witness domestic violence have been conducted in South Africa (Robertson & Davidson, 2002). Much of the information about children's exposure to domestic violence is derived form retrospective studies of female survivors in women's shelters, anonymous telephone surveys, or retrospective accounts from adult survivors of spousal violence.

Very little attention is paid to the most crucial aspect, i.e. the impact of domestic violence on children. It is even difficult to establish accurate figures reflecting the incidence of murder within the family, because of the fact that there are no reliable statistics. Presently, homicides that occur within the family are included within homicide in general and the relationship of the perpetrator to the victim is not documented (Vetten, 1995)

There are also no accurate figures for domestic violence. The South African Police Service does not report domestic assault under separate category, i.e. all reported

assault cases are commonly listed. These cases are recorded as crimes such as common assaults, grievous bodily harm, etc.

Irrespective of the poor statistics, it has been estimated that up to 60% of marital relationships involve abuse and that between 1 in 4 woman are abused (Vetten, 1995).

One can conclude from the given statistics that many children who grow up in South African homes are exposed to high levels of violence within their homes.

2.2 HOW DO CHILDREN EXPERIENCE DOMESTIC VIOLENCE

Witnessing a violent event is most commonly defined as being within visual range of the violence and seeing it occur.

A mother in a different study described her daughter's involvement in a violent event this way:

"As (my husband) came back in the house and went in the bedroom and got another bullet and loaded the gun again and started to raise the gun, I really think my daughter saved my life right then…I was holding her behind me, and she came out in front of me and put her arms in the doorway like this (demonstrating with her arms outstretched), so as he raised the gun, it came right past her. And I reached out and took her hands down, and her hands were so strong against the

doorway. It was unbelievable the strength that was in her arms. I got her arms down and I turned, grabbed her in my arms and ran out of the door" (Osofsky, 1998).

Being an "eyewitness" to a violent event is not, however the only way that children describe their experiences. Many children describe very traumatic events that they have not visually observed, but rather that they have learned. One child described learning fights this way:

"I really thought some body got hurt. It sounded like it. And I almost started to cry. It felt really, I was thinking of calling, calling the cops or something because it was really getting, really big banging and stuff like that (Osofsky, 1998)".

There are several additional ways that children experience adult domestic violence. These include hitting or threatening a child while the child is trying to intervene, taking the child hostage in order to force the mother's return to the home, using a child as a physical weapon against the victim, forcing the child to watch assaults against the mother or to participate in the abuse, and using the child as a spy or interrogating him or her about the mother's activities. Children are also frequently told by abusive fathers that their families would be together were if not for their mother's behavior, thus attempting to put pressure on the mother through the children to return him or driving a wedge between the mother and her children.

However, this does not happen to mothers alone. There are also fathers who are being abused.

In addition to seeing, hearing or being used in a direct event of violence, many mothers and their children describe the aftermath of a violent event as having a traumatic effect on them. The aftermath can include a mother who is injured and in need of help, a father who alternates between physical violence and loving care, police intervention to remove a father from the home, or moving to a shelter for battered women.

One mother describe it as follows:

"It finally started to dawn on me that I was not the only person involved in it. It was when I left in an ambulance. They were so scared. And I thought, they don't really have a dad... And now they're not going to have a mom!" (Atnafou, 1995).

Definition of witnessing domestic violence may include all of these various ways in which children experience violent events. They may see the violence or be used as a part of it, but more often they may hear the violent event and experience its aftermath.

2.3 THE EFFECTS OF DOMESTIC VIOLENCE

Domestic violence causes a range of problems in children. These problems can be grouped into the three main categories; 1. Behavioral and emotional, cognitive functioning and longer-term effects.

2.3.1 BEHAVIORAL AND EMOTIONAL EFFECTS

Students using the child behavior checklist and similar measures hence found child witnesses of domestic violence to exhibit more aggressive and antisocial (often called "externalized" behaviors) as well as fearful and inhibited behaviors ("internalized" behaviors) and to show lower social competence than other children (Fantuzzo, 1991). Children who witnessed violence were also found to show more anxiety, low self-esteem, depression, anger and temperament problems than children who did not witness violence at home (Fantuzzo, 1991).

Children from homes where their mothers were being abused turned to have less skills in understanding how others feel and examining situations from others perspectives. Peer relationship, autonomy, self-control and overall competence turned to be a problem in children who have witnessed domestic violence.

Children may portray feelings of powerlessness, guilt and self-blame. They may also have conflicted loyalties, i.e. love v/s hate. The preceding feeling results in

fearfulness, anxiety and low self-worth, which result from sense of trust being betrayed. This may in turn lead to a learned "victim mentality" where the victim ceases trying to get away or gain relief. When victims learn that they are powerless, they may stop struggling and become passive (Grych & Fincham, 1992)

2.3.2 COGNITIVE FUNCTIONING

Studies have measured the association between cognitive development problems and witnessing domestic violence. The results have revealed that increased violence exposure was associated with lower cognitive functioning, (Rossman, 1998). Children who have witnessed domestic violence may have an inability to predict or make inferences. Hughes (1996) found that children often had difficulties in schoolwork, including poor academic performance and difficulty in concentration. Similarly, McKay (1997) sited in Jaffey, et. al. (1990), described such children as constantly fighting with peers, rebelling against adult instruction and authority, and being unwilling to do school work. Cognitive functioning may be impaired as a result of witnessing domestic violence and long-term trauma related symptoms are common (Edelson, 1999).

2.3.2.1 DOMESTIC VIOLENCE AS A CAUSE OF TRAUMATIC STRESS

As the incidence of interpersonal violence grows in our society, so does the need for investigation of the cognitive consequences produced by exposure to domestic violence especially in children. Traumatic stress is produced by exposure to events that are so extreme or severe and threatening, that they may demand extra ordinary coping efforts. Such events are often unpredicted and uncontrollable. They overwhelm a person's sense of safety and security.

Terr (1991) has described "Type I" and "Type II" traumatic events. Traumatic exposure may take a form of single, short-term event (e.g. rape, assault, severe beating) and can be referred to Type I trauma. Traumatic events can also involve repeated or prolonged exposure (e.g. chronic victimization such as child sexual abuse, battering); this is referred to as Type II trauma. Research suggests that this latter form of exposure tends to have greater impact on individuals functioning. Domestic violence is typically ongoing and therefore may fit the criteria for Type II traumatic event.

With repeated exposure to traumatic events, a proportion of individuals may develop Post Traumatic Stress Disorder (PTSD). PTSD involves specific patterns of avoidance and hyper-arousal. Individuals with PTSD may begin to organize their lives around their trauma. Although most people who suffer from PTSD (especially

in severe cases) have considerable interpersonal and academic or occupational problems, the degree to which symptoms of PTSD interfere with overall functioning varies a great deal from person to person.

The Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition (DSM IV, APA, 1994) stipulates that in order for an individual to be diagnosed with PTSD the following diagnostic criteria should be used:

A. The person has been exposed to a traumatic event in which both of the following were present:
    1. The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.
    2. The person's response involved intense fear, helplessness, or horror. (In children, this may be expressed instead by disorganized or agitated behavior).

B. The traumatic event is persistently re-experienced in one (or more) of the following ways:
    1. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. (In young children, repetitive play may occur in which themes or aspects of the trauma are expressed).
    2. Recurrent distressing dreams of the event. (In children, there may be frightening dreams without recognizable content.)

3. Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). (In young children, trauma-specific reenactment may occur).
4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
5. Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:
    1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma,
    2. Efforts to avoid activities, places, or people that arouse recollections of the trauma,
    3. Inability to recall an important aspect of the trauma,
    4. Markedly diminished interest or participation in significant activities
    5. Feeling of detachment or estrangement from others,
    6. Restricted range of affect (e.g. unable to have loving feelings),
    7. Sense of a foreshortened future (e.g. does not expect to have a career, marriage, children, or a normal life span).

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two or more of the following:

    1. Difficulty falling or staying asleep,
    2. Irritability or outbursts of anger
    3. Difficulty concentrating,
    4. Hyper vigilance,
    5. Exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C and D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Visser (2001) states that although the diagnostic criteria of PTSD account for many of the observed symptoms of childhood victimization, such as flashbacks, psychogenic amnesia, dread and nightmares, reduced affect and numbing, hyper vigilance, isolation, anger, stigmatization and intrusive recollections of the trauma, it cannot account for the full range of observed symptoms especially cognitive affects. Finkelhor (1998) in Visser (2001) argues that although including child victimization within the framework of PTSD has been an important step towards understating its impact, it nevertheless has some limitations. On the positive side subsuming a child with victimization under

PTSD has resulted in the clarification and description of some of the effects that children encounters. In addition PTSD enables this effect to be viewed as a syndrome with a core course, rather that just a catalogue of symptoms. These put child victimization into a broader context by highlighting similar dynamics that are seen in other trauma which may generate further understanding of childhood violent crime victimization by not viewing it in isolation. These has prompted renewed interest in the impact of childhood trauma and stimulated further research.

Including childhood trauma in the PTSD framework has also increased the recognition of the impact of this phenomenon as a measure of a psychological stressor, which may serve to reduce some of the stigma attached to it.

2.3.3 LONGER TERM PROBLEMS

Most studies have examined childhood problems associated with recent witnessing of domestic violence. A number of studies have mentioned much longer-term problems reported retrospectively by adults or indicated in archival records (Davis & Carlson, 1987). For example, Silvern et al (1995) study of 550 undergraduate students found that witnessing violence, as a child was associated with adult reports of depression, trauma related symptoms and low self-esteem among women and trauma related

symptoms alone among men. Witnessing violence appeared to be independent of the variants accounted for by the existence of parental alcohol abuse and divorce. In the same vein, Henning et al (1996) found that among 123 adult women who had witnessed domestic violence as a child, greater distress and lower social adjustment existed when compared to 494 non-witnesses. These findings persisted even after accounting for the effects of witnessing parental verbal conflict, being abused as a child and level of reported parental caring.

As one woman who grew up in a violent home explains, *"It completely colors the way I see my self, the way I interact with other people, and the way I perceive the world at large. To say it pervades, every cell of me is an under-statement. The thing I struggle with the most is a feeling of fundamental unsafe in the world. No one is safe, nothing is safe, and I am not safe. Because if the people you count on to raise are the ones who are abusive, then there is no refugee..."* (Lesley Bernnetts, 1994)

2.4 ADOLESCENTS

Adolescence marks an important developmental transition from the dependency of childhood to the self-sufficiency of adulthood. Peterson & Hamburg (1996) noted that adolescent is a time of measure changes in family, school and peer group structures. These changes combined with

life's daily experiences, often produce varying levels of stress, hence it is imperative that the adolescents home is warm and affectionate.

By the time the child reach adolescence, their cognitive skills and resources for adaptation have usually reached a stage of development, which encompasses both their own family dynamics, and outside social networks such as peer groups and school influences. In other words, they are becoming aware that there are different ways of thinking, feeling and acting in the world from those to which process of adolescents, who have been exposed to domestic violence, have become so entrenched that they find it difficult to engage in more positive ways of social interactions. For instance, (Davis and Carlson, 1987) in James (1994) concluded that growing up in a violent family increases the likelihood of becoming an abused wife, while (Hugheys and Bared, 1983) in James (1994) found that a high incidence of violent men and their victims have been raised in violent homes and witnessed domestic violence as children. However, it is emphasized that not all children who have lived with abusive relationship will repeat the experience (James 1994)

Given the importance of the developmental tasks associated with adolescence, it will be expected that an ongoing stressor, such as inter-parental conflict, would have a profound influence on adolescent development (Hitherington & Anderson, 1998). Indeed, there have been

several studies, which have revealed significant relationships between inter-parental conflict and anxiety, depression, stress and hostility in adolescents. For instance, Fordsstrom-Cohen & Rosenbaum's, (1985) research of those who witness violence in the home, revealed that adolescent females were significantly more depressed than their male counter-parts. Additionally, adolescent females who witness parental violence were significantly more depressed and aggressive than females from non-violent homes, whereas no similar interaction were found for males. Schwarz & Getter (1990) found support for their hypothesis that the level of inter-parental conflict, parental dominance and the gender of the adolescents were predictive of severe adolescent problems. In fact, conflict between parents in combination with a dominant opposite sex parent was significantly predictive of major adolescent psychopathology.

In another analysis, Widom (1989) revealed that exposure to continued violence was the strongest predictor of violent delinquent behavior. Based on research with other delinquent populations, Wexler (1990) estimates that between 20 percent and 40 percent of chronically violent adolescents had witnessed extreme parental conflict from childhood. Kalmuss (1984) found that observing aggression and violence between parents was more strongly related to future involvement in severe marital violence because of being the victim of abuse. Furthermore, the problem of marital violence in

adulthood increased dramatically when both types of family violence were experience. Similarly, the study of Miller et al (1991) indicated that a history of witnessing a domestic violence is a very high risk factor for a potential child abuse, as well as being associated with increased psychological stress, also some adolescents boys handled their frustration that has been most clearly modeled for them by assaulting their mother or siblings (Straus et al, 1980).

2.5. PSYCHOLOGICAL WELL BEING

Psychological well being is a broad area, which can include the person's happiness, meaningfulness, vitality, and their goals, intrinsic motives, such as social participation (parental care), which plays a large role in determining the individual's well being. Studies show that individuals who take on tasks they specially enjoy are likely to continue participating in this task and experience a sense of well being (Domenico & Windle, 1993).

Violence affects the quality of life of young people who experience or witness or feel threatened by it. Violence can adversely affect the victim's mental health and development, and increase the likelihood that they themselves will commit acts of serious violence (Child Trends, 1999).

The humanists believe that people are "noble savages", who will blossom into productive, fulfilled, happy, good human beings unless unfavorable experiences interfere with their ability to express their finest nature. Their viewpoints stress the importance of subjective unique experiences of the individual and emphasize the potential every one of us has for self-fulfillment through spontaneity, creativity and personal growth (Papalia & Olds, 1999).

Surajnarayan (1991) stated that homes characterized by friction and discord, lack of affectional interest in the child and breaks due to separation leads to emotional instability and poor adjustment on the child's part. As a result the child's psychological well being is affected. A number of investigators have pointed out the possible negative marital discord of parents on children. Among factors, which seem to have a fairly close relation to children's behavior and which may lead to deviation are domestic violence, emotional instability and financial stress of the bread winner (Surajnarayan, 1991).

As Maslow has indicated that for one to be satisfied with life one has to achieve the needs until he reach the peak. It is clear that children who have witnessed domestic violence, their safety needs; belonging and love needs, and esteem needs are not met. As a result there is likelihood that they may not be satisfied with their lives.

2.6. CYCLE OF VIOLENCE

The "cycle of violence", "violence begets violence", and "inter-generational transmission of violence" are often used interchangeably in the literature to refer to abused children becoming abusers, victims becoming violent offenders, and more recently witnesses of violence becoming victims or violent offenders (Zena & Powell, 1996).

One of the chilling aspects of domestic violence is that it becomes come part of an integral cycle of violence (Bell, 1995). In a study of 10,035, elementary and high school children in the inner city of Chicago, it was found that children in adolescents who witness violence and experienced personal victimization were more likely to become perpetrators of violence than those who were not exposed (Shakoor & Chalmers, 1991). Another study of 536 children in Grade two, four, six and eight, linked children's physical aggression with witnessing family violence, primarily spouse abuse (Jenkins & Thompson, 1986).

2.7. WHAT CHILDREN LEARN FROM WITNESSING DOMESTIC VIOLENCE

a) Violence is an appropriate way to resolve conflicts.

b) Violence is a part of family relationships.

c) The perpetrator of violence in intimate relationships often goes unpunished.

d) Violence is a way to control other people.

(Adapted from 'The Children of Domestic violence", a report by the Massachusetts Coalition of Battered Women Service groups and The Children's Working Group, 1995)

2.8. WHAT CAN BE DONE ABOUT CHILDREN WITNESSING DOMESTIC VIOLENCE?

a) Parents can learn how violence affects children.

b) Parents can learn and teach children effective non-violent coping skills.

c) Parents can listen to children in order to understand their interpretation of violent episodes.

d) Parents can seek help with issues of violence in the family.

From the preceding arguments one can clearly see that domestic violence has a range of symptoms on children. However, for the sake of this dissertation, a lot of attention will be based on self-esteem and anxiety.

2.9 SELF-ESTEEM

Self-esteem is a widely used concept both in popular language and in psychology. It refers to an individual's sense of his or her value or worth, or the extent to which a person values, approves of, appreciates, prizes, or like him or herself (Blascovich & Tomaka, 1991). The most broad and frequently cited definition of self-esteem within psychology is Rosenberg's (1965) who described it as a favorable or unfavorable attitude towards the self.

Self-esteem refers to how you feel about yourself. It includes such things as your self- confidence, self-respect, and pride in your self, your independence and your self-reliance. All the ways you feel about your self and your abilities are wrapped up in a term 'self-esteem".

Self-esteem is generally considered the evaluative component of the self-concept, a broader representation of the self that includes cognitive and behavioral aspects as well as evaluative or affective ones (Blascovich & Tomaka, 1991). While the construct is most often used to refer to a global sense of self-worth, narrower concepts such as self-confidence or body self-esteem are used to imply a sense of self-esteem in more specific domains. It is widely assumed that self-esteem functions as a trait, i.e. it is stable across time within an individual (Abood & Conway, 1992).

Self-esteem is an extremely popular construct within psychology and has been related to virtually every other psychologically concepts or domain, including personality (e.g. shyness), behavioral (e.g. task performance), cognitive (e.g. attributional bias), and clinical concept (e.g. anxiety and depression). Hence the focus of this research is on self-esteem.

In general, the more positive your self-esteem, the more successful you will be at dealing with life. The same holds for your children, the more positive their self-esteem, the more confident and proud they will be. They will try harder, be happier and have greater self-respect. They will make friends easier and be more giving. Children with positive self-esteem are more secure and loving than children with negative self-esteem (Thomas, 1999).

Negative self-esteem is related to low self-confidence, insecurity, underachievement, anxiety, depression, acting-out behavior, sleep problems and being a loner (Clark, et. al. 1995).

As a parent, you have a great influence over the self-esteem of your child, the more positive self-esteem the adolescents have, the easier it will be for them to resist negative peer pressure. Adolescents with more high self-esteem are more likely to believe in themselves and have a sense of importance and self-respect. Self-esteem affects how your children will approach new tasks and challenges and

how they interact with others (Clark, 1996). Teenage children with low self-esteem may avoid challenging activities or may give up quickly, quit or cheat are not going their way. A child with low self-esteem may also be a bully, bossy, controlling, have a low level of self-control and difficulty in making friends (Demo & Savin – Williams, 1983).

Children with high self-esteem feel a sense of trust, security and feel accepted by others. They understand their own self-worth, have self-control and are willing to take on challenging or difficult tasks.

Modise (1999) states that in most research areas, two extreme levels of self-esteem can be distinguished along a continuum, which places a "medium" level of self-esteem in the middle of this continuum. Modise however, contends that the two extreme positions of self-esteem, mainly high and low self-esteem, mark the dysfunctional level of psychological functioning and are as such not good for personal adjustments. In the same vein, Cole et al (1967) in Modise (1999) seem to be in for of a "medium" amount of self-esteem, which they believe is optimal to psychological functioning. A person with "medium" self-esteem according to the authors turns to be capable of handling difficult life situations.

Most of the researchers support the statement that children who witness domestic violence have a low self-esteem. This denotes that children who have witnessed domestic violence are more likely to be exposed to a variety of psychological problems, which might hamper their lives.

2.9.1 THE PATHOLOGICAL CRITIC

The pathological critic is a term to describe the negative inner voice that attacks and judges you. Everyone has critical inner voice. But people with low self-esteem tend to have a more vicious and vocal pathological critic.

The critic blames you for things that go wrong. The critic compares you to other, i.e. to their achievements and their abilities. The critic sets impossible standards of perfection and then beats you up for the smallest mistakes. The critic keeps an album of your failures, but never once reminds you of your strength or accomplishments. The critic has a script describing how you ought to live and screams that you are wrong and bad if your needs drive you to violate his rules. The critic tells you to be the best, and if you are not the best you are nothing. He calls you names, e.g. stupid, incompetent, ugly, selfish and weak. It makes you believe that all of them are true. The critic exaggerates your weaknesses by insisting that you "always says stupid things" or "always screw up a relationship" or "never finish anything on time" (McKay & Fanning, 1997).

2.9.1.1. THE ORIGIN OF THE CRITIC

The critic is born during your earliest experience of socialization by your parents (Mckay & Fanning, 1997). All through childhood, your parents are teaching you which behaviors are acceptable, which are dangerous, which are morally wrong, which are lovable and which are annoying. They do these by hugging and praising you for appropriate behavior and punishing you for a dangerous, wrong or annoying behavior. It is impossible to grow up without having experienced a great number of punishing events. Personality theorist, Harry Stack-Sullivian called these punishing events forbidding gestures (Mckay & Fanning, 1997).

By design, forbidden gestures are frightening and rejecting. A child who is spanked, scolded, traumatized feels the withdrawal of parental approval very acutely. He / she is for while a bad person. Either consciously or unconsciously, a child knows that his or her parents are source of physical and emotional nourishment. If he were to be rejected, cast out by the family, the child would be frustrated. So, parental approval is a matter of life or death to a child.

All children grow up with emotional residues from the forbidding gestures (McKay & Fanning, 1997). Children retain conscious and unconscious memories of all those times when they were traumatized. These are the unavoidable scars that growing up inflicts on your self-esteem. Early feeling of being not okay is where the critics

attack. It is important for parents to be good role models to their children as these can affect their self-esteem.

2.9.2 HOW TO BUILD THE CHILD'S SELF-ESTEEM

a) The more positive the parent self-esteem, the more positive the child will be. Be a good role model. Start by building your own self-esteem.

b) Honest praise is the quickest way to build person's self-esteem. Find some way to praise your child everyday. Make sure the praise is realistic and honest. When possible, praise your child trying to do something even is he or she was not successful. If need be give your child a task you know can be completed just so you can give the praise. As your self-esteem grows more positive, this process will become easier and more natural.

c) Focus on the positive aspects of the child's behavior. Even if you don't like some of the child's behavior, find something positive to focus on.

d) Put a picture of the child with family members next to the child's bed. This is a subtle reminder to your child that he has family support and they're not alone in the world. Yet, many children really do feel that way.

e) Communicate with your child, which means listening to how child feels without making judgments about those feelings. Try to find out why they feel the way they do. Once you know why, you may be able to offer a different interpretation so the child's feelings can change. Regardless, do

not judge the feelings. They are just there. How your child reacts to this feeling is important because behavior has consequences. If you listen and understand, you are better able to suggest behaviors that will have positive consequences rather than negative ones.

f) Keep criticism to a minimum. Criticism does not produce positive behavior. Praise does.

g) Show your child there is a way they can control their feelings. When your child is feeling bad, play this game with him, close eyes and remember something from the past that was fun and imagine or visualize that it was still going on. After two to three minutes, your child will begin to feel better. Explain to them that this is something they can do anytime they feel bad because they are in control of how they feel.

h) Spend lots of time with your children, especially in activities she enjoys and is good at, and allow her to make her own decisions, so she can learn responsibility and can feel that you trust her. **Adapted from Yarnell, (2001).**

2.10. **ANXIETY**

2.10.1 WHAT IS ANXIETY?

Anxiety is another word for fear. Fear and anxiety have the same physical symptoms. Anxiety is really a clinical term that is associated with a child or adult who is fearful most of the time for reasons that may not be clear or understandable (Michael, 2002). Fear of a barking dog is different than anxiety when you go to work. Anxiety is common with people who are naturally sensitive or threat sensitive. These people become fearful rather easily and they may experience some degree of fear most of the time. Children who are frightened a great deal of the time can also become anxious when there is nothing to be afraid of.

According to Kaplan and Sadock (1991), anxiety is a feeling which is characterized by diffuse, unpleasant, vague, sense of apprehension often accompanied by the following autonomic symptoms: diarrhea, dizziness, light headedness, hyperhidrosis, hyperreflexia, hypertension, palpitations, restlessness, tremors, upset stomach (butterflies), urinary frequency, hesitancy and urgency. A person may also feel restless, as indicated by inability to sit or stand still for a long time. Symptoms differ according to people.

2.10.2 WHAT IS A PANIC ATTACK?

A panic attack is simply intense fear reaction that happens all at once. It does not build over-time. It happens all at once, and it's powerful. The flood of chemicals that are released during a panic attack can actually interfere with many things including thinking, breathing, sensation and our ability to walk. The person having a panic episode may not even recognize what caused them to panic. Children rarely have panic attack unless they have been traumatized (Michael, 2002). Not knowing what caused the person to panic can make them more out of control, and feeling out of control can make the symptoms worse.

2.10.3 STRESS, CONFLICT AND ANXIETY

Whenever an event is perceived as stressful depends on the nature of the event and on the person's resources, psychological defenses and coping mechanisms (Kaplan & Saddock, 1991). For a person to manage his anxiety must have a well-developed ego. One whose ego is functioning properly is able to adapt by balancing both external and internal worlds. If the ego is not functioning properly, it leads to an imbalance and if it continues long enough, a person experience chronic anxiety.

The child, who is exposed to trauma, is likely to have a weak ego. The ego grows out of realization of what is possible and what is not. It is the rational or cognitive level of the personality. The child who experiences a rough childhood can develop Neurotic and Moral anxiety. Threats to the "balance of power" within the person evoke these. They signal to the ego that unless appropriate measures are taken, the danger may increase until the ego is over-thrown (Corey, 1998). When the ego cannot control anxiety by rational and direct methods, it relies on unrealistic ones, namely, ego-defense behavior. Neurotic anxiety is the fear that the instincts will get out of hand and cause one to do something, for which one will be punished, i.e. the development of pathology.

2.10.4 CAUSES OF ANXIETY

Probably, no single situation or condition causes anxiety disorder. Rather, nature and environmental triggers may combine to create a particular anxiety illness (Barrera, 1993). Further, psychoanalysts suggest that anxiety stems from unconscious conflict that causes discomfort during infancy or childhood and learning. Theorists believe that the way behavior is learned can be unlearned. Recently, many scientists and researchers found that biochemical imbalances are anxiety-causing (Barrera, 1993).

Each of these theories is most likely true to some extent. It is also possible that they may develop or inherit a biological susceptibility to anxiety disorders. Even early childhood experiences may lead to certain fears that, over time, develop into full-blown disorders (Barrera, 1993).

New technologies are enabling scientists to learn more about the psychological and social factors that may cause anxiety disorders. With an understanding of underlying causes, even better treatment and prevention of disorders will be closer at hand. For now heredity, brain chemistry, personal experiences are also believed to play roles in occurrence of anxiety disorders (Dodd & Roberts, 1994)

Personality

Researchers believe that personality may play a role, noting that people who have low self-esteem and poor coping skills may be prone to anxiety disorders. Consequently, anxiety disorders that begin in childhood may itself contribute to the development of low self-esteem (Bernard et al, 1996).

Life experiences

Researchers believe that the relationship between anxiety disorders and exposure to abuse and violence may affect individuals' susceptibility to these illnesses (Bernard et. al., 1996).

A prolonged experience of fear can be a problem for children when they are growing up. Prolonged anxiety over-time can impair a child's leaning as well as their health and safety, and it can have a very negative impact on a child' personality and approach to life. Children are usually afraid when they see their parent's fight, talk about leaving them or they talk about ending the marriage. Children are afraid when they are left alone, feel abandoned or when their parent's act worried at all the time (Bernard, 1996).

2.10.5 ANXIETY DISORDERS

Neurotic anxiety can result in several anxiety disorders. According to Kronenberger & Meyer (1996), anxiety disorders of childhood and adolescents appear under two sections, that is Disorders usually first diagnosed in infancy, childhood or adolescents and Anxiety Disorders. DSM-IV has consolidated certain anxiety disorders that were previously separated by developmentally different features. Over-anxious disorders from DSM-3R have been subsumed into the DSM-IV generalized anxiety disorder category. Like-wise, avoidant disorder of childhood or adolescents was eliminated as a diagnosis in DSM-IV. Most children who formally received this diagnosis will be diagnosed with social phobia in DSM-IV (Straus,

1992). In order to simplify the presentation of current anxiety disorder diagnosis, the focus will be on separation anxiety disorder, specific phobia, social phobia, obsessive compulsory disorder, post-traumatic stress disorder and generalized anxiety disorder.

2.10.5.1 WHAT IS A PHOBIA

A phobia is a fear reaction that is persistent over-time each time the person is facing a specific object or situation. A phobia can be learned or you can be born with it. Some children are naturally terrified of things like heights, snakes or bugs. Other children can develop a phobic reaction to things like dogs, water or darkness.

Fear is a natural reaction. It is common for children to be naturally afraid of heights, certain animals, darkness, being alone and even strangers. They usually grow out of it, especially if they don't have another traumatic experience. A child who is traumatized can develop a phobia, e.g. specific phobia, social phobia, etc.

2.10.5.1.1 SPECIFIC PHOBIA

Clinical description

Childhood fears arise normally and are often spontaneously outgrown, (Kronenberger & Meyer, 1996). However, phobic anxiety differs from these normal fear responses in a number of ways.

a) The object far out of proportion to the actual danger poses the child's fear.
b) Second, the child's fear is extreme, sometimes resulting in an anxious out burst or excessive avoidance of certain situations.
c) The child's fear has a significant negative impact on daily functioning.
d) The child's fear may cause resistance in an attempt to extinguish it.

The essential feature of specific phobia is an irrational fear of an object or situation that almost invariably produces an immediate anxiety response. In young children, this response may be expressed by crying, immobilization, clinging to an adult, aggressive, avoidance or tantrums. In adolescents, it may be reflected by aggressive behavior and tantrums. In order to reduce anxiety, the phobic stimulus is consciously avoided. This is more typical in adolescents. These may results in insignificance interference with the child's normal routine or with social activities or relationships. The chills may not be aware that this phobic reaction is a problem or is out of normal proportion to the stimulus, although such awareness is typical of adolescents.

2.10.5.1.2 SOCIAL PHOBIA

Clinical description

In social phobia, anxiety is focused on a specific type of situation: contact with unfamiliar people or negative social appraisal. Because of this anxiety, there is excessive shrinking from unfamiliar contact, which is sufficiently severe to interfere with social relationships. The children may seem socially withdrawn, embarrassed and timid in the company of unfamiliar people but they may not realize that the fear is unreasonable (Kronenberger & Meyer, 1996). Request to interact in even minor way with strangers bring on anxiety in the form of shaking, hiding, immobilization or clinging to familiar others. If social anxiety is severe, children may become inarticulate and even mute. In contrast, contact with familiar people is welcome and desired, indicating that the children can achieve normal social relationships. To warrant the diagnosis pf social phobia, the avoidant behavior must have been present for at least six months.

2.10.5.2 GENERALIZED ANXIETY DISORDER (GAD)

Clinical description

The criteria for childhood GAD includes:

a) Excessive worry and anxiety about a number of activities or events.

b) Difficulty controlling the worry

c) A variety of worry related symptoms such as restlessness, tiring easily, difficulty in maintaining concentration, irritability, body tension and disturbed sleep.

d) The frequency, intensity and duration of GAD worries, sets them apart from normal level of anxiety.

The children with GAD reports experiencing multiple worries in numerous situations, without precipitating circumstances. In addition, children with GAD reports difficulties controlling their worries and their worries interfere with daily activities.

2.10.5.3 POST-TRAUMATIC STRESS DISORDER (PTSD)

Clinical description

The essential feature of PTSD is development of intrusive and avoidance symptoms following exposure to a traumatic event. A traumatic event is described by two criteria:

a) The event involves a thread to the physical integrity (including death, injury, or either physical harm) of self or others. The person need to be present at the event if it involves a family member or a close friend, although some personal experience (at least witnessing the event) appears to be required if the event involved a less familiar person.

b) The experience of the event includes intense fear, terror, helplessness, disorganized behavior or agitated behavior (the latter criteria apply only to children (Bernstein & Borchardt, 1991).

PTSD's characteristics symptoms fall into three categories:

a) Intrusive re-experience of the event.

b) Avoidance of experiences related to the event.

c) A physiological arousal.

Intrusive re-experiences include memories of the event in children (in children, this may be through repetitive play or re-enactment), dreams or night-mares related to the events, reliving part of all the experiences and psychological or physiological up-set in response to cues related to the event. Avoidance symptoms include avoidance of thoughts connected with the experience, avoidance of activities, social interaction connected with the experience, amnesia for part of the trauma, reduced interest in activities, feeling of detachment, flat or constricted affect and sense of shortened future. Physiological arousal symptoms include difficulty sleeping, irritability, diminished concentration, hyper-vigilance, and exaggerated startled response.

PTSD symptoms are essentially the same for children and adults with some provisions or children to have less defined cognitive symptoms and more behavioral symptoms (Bowen et al, 1990). For example, children's memories may be expressed in play. PTSD has been established to occur in children at various ages including ages 6-9, 9-13 and with adolescents (Asigh, 1988). PTSD symptomatology must have been present for at least one month for the PTSD diagnoses to be made (American Psychiatric Association, 1994).

2.11 THE RELATIONSHIP BETWEEN SELF-ESTEEM AND ANXIETY

Studies have found that 18 year olds who use drugs frequently were using them as early as age seven, already more psychologically troubled than their peers. They were already anxious and unhappy, alienated from their family and peers and overly impulsive. Low self-esteem, lack of conformity, poor academic achievement and poor parental-child relationships are indicators of young children likely to end up using drugs (Domenico & Windle, 1993).

Low self-esteem is the universal common denominator among people suffering from addictions to any and all mind altering substances such as alcohol. In the book Alcoholism: A False Stigma: Low –Esteem, The True Disease, (1996) Candito reports "those who have identified themselves as "recovered alcoholics" indicated that low self-esteem is the most significant in their lives. Low self-esteem is the true problem and the true disease". Candito comes to the conclusion that is the underlying origin of the problematic behaviors and the true diseases that plug the world resulting in obsessive behaviors. This conclusion is also shared by Keegan (1999) who maintains that low self-esteem contributes to neuroses, anxiety, defensiveness and ultimately alcohol and drug abuse. The reason why some become alcoholic while others do not is dependent upon the ability to regulate their anxiety as related to their self-esteem.

Johnson (1977) documented that juvenile delinquency, not only had low self-esteem but that they also had higher feelings of anxiety. Kelley (1978) reported a direct correlation between delinquency and low self-esteem. He found evidence of a link between increased self-esteem and a reduction of delinquent behavior. He found that as programs were implemented to raise the level of self-esteem, the incidence of delinquent behavior was reduced.

Kelly (1978) conducted extensive studies into the causes of violence, including a study of 70 7th graders, and underscores the significance of self-esteem as a factor in crime and violence. He too found that violation to self-esteem serve as a major source of hostility and aggression. This conclusion is borne out in the study of those incarcerated for the most violent acts of murder. Gilligan in a study of murders concludes that low self-esteem is the most common reason for engaging in violence, and this is why violent behavior actually increases the self-esteem of those who commit it (Kelly, 1978).

Depression and suicide in young people are major concerns today. Both are closely related to the level of self-esteem. Battle (1980) was one of the first to document the close relationship between depression and self-esteem. He discovered several years ago that as depression arises, self-esteem tends to decline, and as self-esteem declines depression rises. There is also accumulating evidence that positive self-esteem can be an antidote to depression. Self-esteem serves as a buffer from

the onslaught of anxiety, guilt, depression, shame, criticism and other internal attacks. Since a major source of low self-esteem and depression among adolescents is due to increased stress currently found among teenagers, helping young people learn how to deal with this anxiety and stress can enable them to work through the stress in an effective way to reduce the impact.

Yellowlees (1996) states that low self-esteem seems to operate as a pre-disposing and contributory factor in the development of depression, anxiety, eating disorders, and alcohol and drug abuse.

Inability to over come problems can lead to anxiety. Anxiety can lead to constantly worrying about ones performance. Since dwelling on failure leads to low self-esteem and anxiety increase the amount of time one thinks about ones failure, anxiety indirectly can lead to low self-esteem.

3. THEORETICAL FOUNDATION OF THE STUDY

The next discussion delineates the theoretical foundation believed to be the base of this study. The theory of choice in this study is the psychoanalytic theory, a developmental approach by Erikson (1963). Erikson describes human development in eight stages, the first five of which span infancy, childhood, and adolescence. The last three describe adulthood. Each of Eriksson stages involves a basic conflict,

brought about primarily by a need to adapt to the social environment. Resolution to this conflict results in the development of sense of competence. An assumption of this and other stage theories is that the psychological development that takes place at each stage will have a significant impact on all subsequent stages. The stages are viewed as a sequence. Although one can anticipate issues that will occur at a later stage, one passes through the stages in an orderly pattern of growth (Newman & Newman, 1990).

3.1 PSYCHOSOCIAL CRISIS

According to Erikson, psychosocial crisis refers to the person's psychological efforts to adjust to the demands of the social environment at each stage of development. The word crisis refers to a normal set of stresses and strains rather that to an extraordinary set of events. At each stage of development, the society and social groups make psychic demands on the individual.

3.1.1 STATE OF TENSION

Societal demands differ from stage to stage. The individual experiences this demands as mild but persistent guidelines and expectations for behavior. They may be demands for greater state of control, further skill development or stronger commitments to goals. Before the end of each stage of development, the

individual tries to achieve a resolution adjusting to the demand of society while at the same time translating these demands into personal terms. This process produces a state of tension within the individual that must be reduced in order for him or her to proceed to the next stage. It is this tension state that produces the psychosocial crisis. The psychosocial crisis of a given stage, forces a person to use developmental skills that only recently have been mastered (Newman & Newman, 1990).

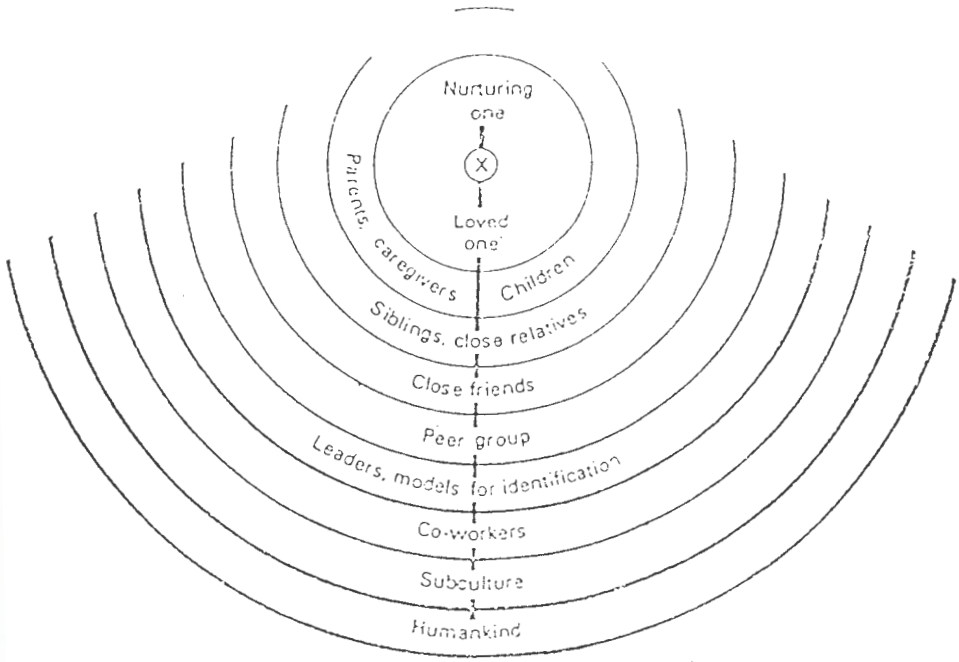
3.1.2 RADIUS OF SIGNIFICANT RELATIONSHIPS

Erikson point out that there is radius of significant relationships at each stage of development. There is an initial focus on a small number of relationships of a person's life. During childhood, adolescents and early adulthood, there is an expansion in a number of relationships and a greater variety in their levels of depth and intensity. These changing relationships make most of the demands made on a person.

In infancy the significant relationship is the social relationship with the maternal or nurturing person. In toddler hood the relationships with parental figures are significant. In early school age relationships with the basic family, which have expanded to include siblings and grandparents, are the significant ones. In middle schools age significant relationships are found with a widening circle of

acquaintance in the neighborhood and school. In early adolescents the peer group and out groups provides the relationships that formulates self-definition. In later adolescents one's radius of significant relationships expands to include leaders and role models as the person struggles to forge an integrated personal identity.

FIGURE 1: **RADIUS OF SIGNIFICANT RELATIONSHIP (**Newman & Newman, 1990).



Eriksson held that the development of trust is the initial step in forming healthy relationships. Trust develop early and is primarily contingent on the infants' relationship with his or her caregiver. If this first psychosocial stage of trust building is successfully resolved, the infant will learn to trust others, which will then help with later relationship building. Mistrust in contrast can result from a

single trauma or from chronic environmental stress. If parents are emotionally unavailable for instance, inconsistent, continually negative or abusive, the infant or child may fail to develop basic trust (Oesofsky, 1995). In light of this theoretical perspective, one must ask how growing up in a home marked by instability and violence may interfere with a child developing trust. For far too many children, those very relationships on which the development of trust and trusting relationships are building may be limited or changeable.

3.2 THE DEVELOPMENT OF SELF

The development of self does not occur in a vacuum. It occurs in a specific ecological context, a niche describable in terms of a wealth interaction and influences. In adolescents, the evaluation of the self becomes more cognitive. It is based on a more objective understanding of who and what the self is rather than mainly on how well adolescents like themselves and how competent they think they are in important areas. Adolescents make cognitive inferences about the self in different activities as they perceive and evaluate their behavior in these areas. All these inferences lead ultimately to general self-concept and although this general self-concept is arrived at through a series of cognitive inferences, it is clearly evaluative. It is difficult to make judgments about what the self is without also at least implicitly deciding whether that is good or bad, desirable or undesirable. The notions of self-identity are always evaluative (Lefrancois, 1993).

For Eriksson, the development of strong feelings of identity, of clear feeling of which one is, is the most important task of adolescence. Accordingly, the primary developmental crisis facing the adolescence is the conflict between accepting, choosing, discovering and identity and the diffusion of the adolescent ' energies resulting from the conflict and doubt concerning choice of identities. Hence the fifth of Eriksson eight developmental stages is labeled identity versus role diffusion.

One can describe the socialization of the adolescent in terms of three stages based on changing role of parents and peers. The first, a pre-adolescent stage is marked by a child's social, emotional and physical dependence on parents and is characterized by low conflict. The second, early adolescence involves increasing independence and is a period of increasing conflict. The third beginning in later adolescents is marked by declining conflict and the achievement of relative independence. However, there is a mutual interdependence between parents and their children that continues well beyond adolescence (Collins, 1991).

Alvy (1987) proposes that parents of adolescents have several important responsibilities: providing basic resources and care, protecting adolescent, guiding and supporting development, i.e. providing opportunities for intellectual, social,

emotional and spiritual growth; fostering self-esteem. Conflict between the adolescents and their parents may result in low self-esteem.

4. HYPOTHESIS

It is hypothesized in this study that:

- Children who have witnessed domestic violence have low self-esteem.
- There is a negative correlation between self-esteem and anxiety among children who witnessed domestic violence.

5. OPERATIONAL DEFINITIONS OF TERMS

5.1 DOMESTIC VIOLENCE

It refers to partner violence, which usually occurs in a privacy of a home where children are involved and these children do see the violence or become part of it. In this violence, children hear their parents, the adult they love and depend on, scream in anger, pleading in fear, sobbing in pain. They hear fists hitting bodies, people thrown against walls and knocked to floors. They may see blood, bruises and weapons. At the same time, these children can also be abused.

5.2 ADOLESCENTS

Adolescents in this study are construed to mean children of the ages 12-18 years who have witnessed domestic violence at the certain time in their lives or continue to witness it.

5.3 SELF-ESTEEM

Self-esteem in this study means the degree of regard the adolescent reflects, how he views and values the self at the most fundamental levels of psychological experiences and that different aspect of the self create a profile of emotions associated with the various roles in which the person operates.

5.4 ANXIETY

Anxiety refers to fear, which is experienced by adolescents due to the low self-esteem they possess and results into different psychological disorders. This fear is instilled by traumatic experiences, which the adolescents have experienced in their lives.

5.5 THE SILENT VICTIMS

Children who their plight of witnessing domestic violence is seldom recognized or reported to the police and their own family disregards the impact of their traumatic experiences.

CHAPTER 3

RESEARCH METHODOLOGY

1 RESEARCH DESIGN

The static group comparison design was used in the present study. According to Grinnel (1985), in a static group comparison design, one group is the experimental group, which is exposed to the independent variable (x). The other group, the comparison group is compared to the experimental group for purposes of providing evidence of associational knowledge.

The researcher chose the static group comparison design as researcher used two groups of adolescents for the present study viz., experimental group comprising: "adolescents who have witnessed domestic violence" as rated to the comparison group comprising adolescents who have not witnessed domestic violence. These groups were matched according to age, sex and educational status.

2. SAMPLE

A total sample comprising of 50 participants was selected from three High Schools in Mmabatho. The selection of the sample for the present study was a two-stage procedure involving: -

i) Selection of the schools

ii) Selection of the adolescents (pupils)

Selection of the school

A total number of three high schools fell within the geographic area of Mmabatho. To enable researchers to get a representative sample, the researcher chose all three high schools: Kebalepile, Letsatsing and Mmabatho high schools.

These schools were co-educational i.e. comprising of both boys and girls.

Selection of adolescents

The researcher visited the schools personally to discuss the purpose of the research with the principals and life skill educators. It was decided that life skill educators complete the "questionnaire to select the sample".

The life skill educator had a record of all pupils who have witnessed domestic violence. These were reported by parents, teachers, peers and significant others in the pupil's lives.

Group matching of a sample of adolescents who have witnessed domestic violence and those who have not, was carried out for a number of characteristics discussed below: -

Age group

Since the age modern high schools range from 15-20 years, the two samples were matched for ages between 15-18 as tabulated in table 1 below.

Table 1: **Distribution of adolescent sample according to age**

Age group	**15-16yrs**	**17-18yrs**	**Total**
Respondents Who witnessed Domestic violence	15	10	25
Who did not witness Domestic violence	15	10	25
Total	30	20	50

Educational qualification

Adolescents were matched according to their grade placements as tabulated in Table 2 below.

Table 2: **Educational Qualification of adolescents**

Grade	**10**	**11**	**Total**
Respondents: Who witnessed Domestic violence	16	9	25
Who did not witness Domestic violence	15	10	25
Total	31	19	50

Sex

The adolescents who have witnessed domestic violence were matched according to sex of those who did not witness domestic violence.

Table 3: **Distribution of adolescents sample according to sex**

Sex	**Males**	**Females**	**Total**
Respondents: Who witnessed Domestic violence	9	16	25
Who did not witness Domestic violence	10	15	25
Total	19	31	50

A Total number of 50 male and female students were selected from the three high schools. The table below summarizes demographic characteristic of the sample.

Table 4: **Demographic characteristics of the sample**

Variable		Frequency	%
Gender	Male	19	38
	Female	31	62
	Total	50	100
Age	15-16	30	60
	17-18	20	40
	Total	50	100
Education	Grade 10	31	62
	Grade 11	19	38
	Total	50	100

50% of the respondents had experienced incidences of domestic violence and the other 50% had not experience it. This point will be carried through in the analysis.

Parental permission

Before the researcher could proceed with the specific inclusion of a particular adolescent, the researcher had to obtain the consent of the adolescent's parent. This was a condition laid down by the Department of Education and Culture. The researcher dispatched a letter of consent to the adolescent's parents through the life skills educator explaining the reason for the research, confidentiality, anonymity and so forth. The parent had to sign the permission letter to indicate that he/she agrees that the can take part in the answering of the questionnaire (see appendix).

3. RESEARCH INSTRUMENT

A questionnaire was used for purposes of collecting data in this study (See appendix 1). The questionnaire comprises of five parts. The first part comprises of demographic questions about the respondents.

These questions included specific questions, which enquired about the respondent's age, sex, and educational qualification.

The second part of the questionnaire was taken over from Rosenberg 'Self-Esteem Scale' (Rosenberg, 1965). This scale was originally designed to measure adolescents' global feelings of self-worth or self-acceptance. The third part is composed of the IPAT, which is the Anxiety Scale whilst the fourth part comprises of the Satisfaction with Life Scale. The last part of the questionnaire comprises of a Self-Formulated Questions about personal life experiences, e.g. the nature of domestic violence one has witnessed.

3.1 ROSENBERG SELF-ESTEEM SCALE

Description

The scale comprises of ten items. Self-esteem items require the respondent to report feelings about the self directly. Although originally designed as a Guttman-

type scale, the self-esteem scale is typically scored using a four-point response format (strongly agree, agree, disagree, strongly disagree) resulting in a scale range of 10-40 with higher scores representing higher self-esteem. This scale is administered by interview and was designed to be applicable to both black and white children.

The present researcher advises that the interpretation of the results of the present study should be done with caution of the following reason:
The questionnaire was developed in 1965 and it is thus relatively old.

3.1.1 RELIABILITY OF THE SCALE

Internal consistency

Dobson et al, (1979), obtained a Cronbach alpha of .77 for their sample while Fleming (1984) reported a Cronbach alpha of .88.

Test-Retest

Silber & Tippett (1965 in Robinson et al 1991) reported a test-retest correlation of .85 for 28 subjects after a two-week interval. Fleming & Courtney (1984 in

Robinson et al 1991) reported a test-retest of .82 for 259 male and female subjects with a one-week interval.

3.1.2 VALIDITY

Convergent

The SES is associated with many self-esteem related contracts. For example, Lorr & Wunderlich (1986 in Robinson et al 1991) reported a correlation of .65 between SES scores and confidence and .39 between SES scores and popularity. Reynolds (1988 in Robinson et al 1991) found a correlation of .38 SES scores and overall academic self-concept with correlation between SES scores and specific facets of academic self-concepts ranging from .18 to .40. The Rosenberg measure correlated .72 with the learner self-esteem scale, .24 within "beeper" self-reports of self-esteem (a series of self-esteem measurements requested at quasirandom time over an extended period of time) and .27 with peer rating for an adolescent sample (Savin-Williams & Jaquish, 1981 in Robinson et al 1991)

Fleming & Courtney (1984 in Robinson et al 1991), demonstrated negative relationships between SES and several concepts associated with low self-regard, e.g. SES scores correlated -.64 with anxiety, -.54 with depression and -.43 with anomie. In addition, these authors reported that SES scores correlated .78 with general self-regard, .51 with social confidence, .35 with school abilities, .42 with

physical appearance and .66 with scores on a revised Janis & Field Scale. Finally, Demo (1985 in Robinson et al 1991) found SES scores correlated .55 with scores on the Coopersmith-SIE and .32 with peer rating of self-esteem. Correlations with social desirability range from .10 (Reynolds 1988 in Robinson et al 1991) to .33 Fleming & Courtney (1984 in Robinson et al 1991).

Discriminant

Considerable discriminant validity has also been demonstrated for the SES. Reynolds found no significant correlation between SES scores and grade point averages (.10), locus of control (-.04), scholastic aptitude test verbal (-.06) and quantitative (.10) scores, Robinson et al (1991). Fleming & Courtney found no significant correlation between SES score and gender (.10), age (.13), work experience (.07), marital status (.17) birth order (.02), grade point average (.01) vocabulary (-.04).

Location

Rosenberg (1965). Society and the adolescent self-image, Princeton, NJ: Princeton University Press.

The Rosenberg SES has enjoyed widespread use and utility as a unidimensional measure of self-esteem. In fact, the SES is the standard against which new measures are evaluated. Its ease of administration, scoring and brevity underlie our recommendation for the use of the SES as straightforward estimate of positive or negative feelings about the self.

The Rosenberg self-esteem however, is not completely troubled free, e.g. the items may be susceptible to socially desirable responding. In addition, scale score distributions among college tend to be negatively skewed so that even tripartite splits of a distribution produce low self-esteem groups that have relatively high self esteem in an absolutely sense. Alleviating this concern somewhat, however, is the argument that an individual who fails to endorse SES items at least moderately is probably clinically depressed.

3.2 IPAT ANXIETY SCALE

The third part of the questionnaire was adapted from the IPAT Anxiety Scale. The scale consists of 40 questions distributed among the five anxiety measuring factors according to each personality component's centrality as a source or expression of anxiety. The five anxiety measuring factors are defective integration, lack of

sentiment, ego weakness, suspiciousness or paranoid insecurity, guilt proneness and frustration tension or id pressure. Each question has three alternative answers, e.g. True, In-between and False.

The scale is a brief, non-stressful, clinically valid tool for measuring anxiety applicable to all but the lowest educational levels and appropriate for ages 14 years on upwards throughout the adult range. The scale gives an accurate appraisal of free anxiety levels supplementing clinical diagnosis and facilitating all kinds of research or mass screening operations where very little diagnostic or assessment time can be spent with each examinee (Catell, et. al., 1995).

The test is easily applied individually or to large groups at one time. It can be self-administering. The scale can be easily scored using a standard key, which means that all observers will agree on the exact anxiety level, which characterizes a given testing.

3.2.1 RELIABILITY

Three types of coefficient are reported: Test-Retest coefficient (Retest after approximately two weeks), Split-half coefficient and coefficient based on Ferguson's variation of the Kuder-Richardson formula 20 (32) (Catell, et. al. 1995).

Data for the calculation of stability coefficient (Test-retest after a long interval) are not yet available. The latter departs from unity as a rule more on account of real function fluctuation of the trade itself, i.e. function-fluctuation in anxiety itself as a state. From the viewpoint of internal consistency of homogeneity, too, the reliability of the test is highly satisfactory, more so as the scale is composed of five relatively distinct (hence deliberately not homogeneous) components (Catell, et. al. 1995).

3.2.2 VALIDITY

One way of estimating the construct validity of the scale is from comparing the scale with another instrument, which is said to measure the same anxiety factor. There was no instrument available, but it was hypothesized that maladjustment, as measured by the NB adjustment questionnaire of the National Bureau of Educational and Social Research would show some relationship with anxiety. The correlations are based on the data obtained from an investigation, which preceded the talent survey. Standard seven pupils in two English and two Afrikaans high schools in Pretoria were involved in this investigation (Catell, et. al. 1995).

4. SATISFACTION WITH LIFE SCALE (SWLS) (Diener, Emmons, Larsen and Girffen, 1985)

The SWLS is a five-item scale, which was developed to give an indication of a person's general satisfaction with life. A person's evaluation of his quality of life, according to his own criteria, is measured on a cognitive-judgmental level. Diener, et. al. (1985) reports a two-month test-retest reliability index of 0.82 and Chronbach alpha-reliability index of 0.87. Pavot and Diener (1993) also contest to the good psychometric characteristics of the scale. Wissing, Peterson, Winthrop (1999) also found the SWLS reliable and valid for use in an African context.

5. SELF FORMULATED QUESTIONNAIRE

This part of the questionnaire composed of eight questions about personal life experiences. The questionnaire includes questions like, "what kind of domestic violence were you exposed to?" Students were supposed to choose from physical violence, verbal violence, emotional violence and being part of the violence. The aim of such questions was to detect the exposure to violence.

6. PROCEDURE

The researcher collected data by first work-shopping the life skill educators of the three schools which were chosen around Mmabatho area. They were work-shopped on how to administer the questionnaire to the learners. Life skill educators administered the questionnaires. Each school was given 20 questionnaires of which 10 was to be answered by males and the other 10 by females from each school. However, only 50 questionnaires were returned.

5. DATA ANALYSIS

Both descriptive and inferential statistics were used in the study exploring the statistical program for social science (version 9.0). The descriptive statistics were used largely to explain nominal data by means of tables. Chi-square was also used for correlations. The statistic group comparison design was used as the researcher used two groups of adolescents, i.e. experimental group comprising of adolescents who witnessed domestic violence and comparison group comprising of adolescents who did not witness domestic violence.

CHAPTER 4

RESULTS

Generally, the results show that the majority of respondents had experienced some form of domestic violence (see table 5 below) and that they had a moderate to high self-esteem (see table 6 below), moderate to high anxiety (see table 7 below) and a moderate to high life satisfaction (see table 7 below).

The table below summarises the descriptive statistics of the self-esteem scale. When all respondents are taken into account (irrespective of whether they experienced domestic violence or not), they had a minimum score of 14 and a maximum score of 25 as opposed to the lowest possible score of 10 and the highest possible score of 40 based on the scale. There seems however to be a slight difference between the scores of the group which had experienced domestic violence (DV) and the group that had not experienced domestic violence NDV) as the table below shows.

Table 5: **Descriptive Statistics of the Self Esteem Scale**

Variable	Minimum Score	Maximum Score	Mean	Standard Deviation
DV	18	25	21.6	1.83
NDV	14	25	25	2.97
ALL	14	25	21.1	2.49

The anxiety of the respondents was examined. The lowest possible score on the IPAT is 40 and means that one has a low level of anxiety. In terms of the summative scores, it would appear that all respondents had relatively moderate to high anxiety scores. The table below shows the descriptive statistics from the IPAT scale.

Table 6: **Descriptive scores of the IPAT Scale**

Variable	Minimum Score	Maximum Score	Mean	Standard Deviation
DV	56	85	74	6.7
NDV	62	88	76	6.74
ALL	56	88	75	6.76

The table below summarizes the life satisfaction scores obtained by the respondents in the group that had experienced domestic violence (DV), the group that had not experienced domestic violence (NDV) and all respondents taken together (ALL). The table shows that on average the NDV group had a slightly high mean compared to the DV and ALL groups including a lower standard deviation.

Table 7: **Descriptive scores of the Life Satisfaction Scale**

Variable	Min	Max	Mean	SD
DV	9	31	19.72	6.79
NDV	7	34	22.6	6.62
ALL	7	34	21.6	6.79

The 3 main scales (viz. lifesat – life satisfaction scale; IPAT – anxiety scale; and sesteem – self-esteem) used in this study were correlated to ascertain the basic nature of their relationship if any. The table below shows that some weak positive correlations albeit a negative one between anxiety and self-esteem (r=-0.359) that was significant at the 0.01 level. The relationship between life satisfaction and anxiety was positive (r=0.022) and the one between life satisfaction and self-esteem was also positive (r=0.023) as the table below shows.

Table 8: **Correlations among 3 main scales**

Correlations

		LIFESAT	IPAT	SESTEEM
LIFESAT	Pearson Correlation	1.000	.022	.023
	Sig. (1-tailed)	.	.439	.437
	N	50	50	50
IPAT	Pearson Correlation	.022	1.000	-.359**
	Sig. (1-tailed)	.439	.	.005
	N	50	50	50
SESTEEM	Pearson Correlation	.023	-.359**	1.000
	Sig. (1-tailed)	.437	.005	.
	N	50	50	50

**. Correlation is significant at the 0.01 level (1-tailed).

The table below summarizes the types of domestic violence experienced by the respondents in this study.

Table 9: **Nature of domestic violence**

Nature of domestic violence	Frequency	Percent
Emotional violence	1	2
Verbal violence	5	10
Physical violence	10	20
Being part of the violence	3	6
All of the above	6	12
Total	**50**	**100**

The table above shows that when all respondents are taken together, physical violence had the highest frequency (20%), followed by a combination of all forms of domestic violence (all) (12%) and verbal violence (10%).

The table below summarizes the levels of anxiety experienced by respondents in the study.

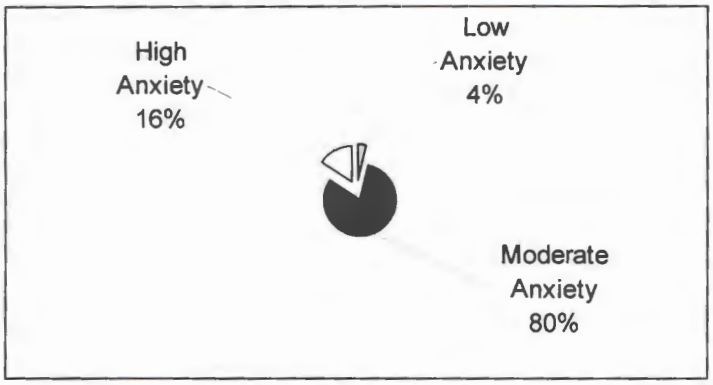
Table 10: **Levels of Anxiety**

Levels of Anxiety	DV	NDV	Total
Low Anxiety	1	0	1
Moderate Anxiety	20	17	37
High Anxiety	4	8	12
Total	25	25	50

Based on the table above, respondents had moderate anxiety overall. This also specifically applied to the DV group and the NDV group. The DV group however had the highest frequency of moderate anxiety.

The figure below shows the levels of anxiety experienced by the group of respondents that had experienced violence.

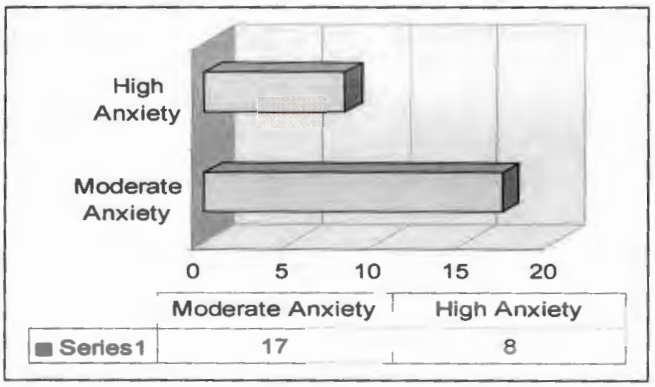
Figure 2: **Levels of anxiety experienced by the DV group**



As pointed out above, moderate anxiety had the highest frequency followed by the high levels of anxiety (16%).

The figure below shows the levels of anxiety experienced by the group that had not experienced domestic violence.

Figure 3: **Levels of anxiety experienced by the NDV group**



A cursory analysis above shows no major differences among the scores of those who experienced domestic violence and those who did not. Indeed this was confirmed by a test of association between the two variables. A cross-tabulation

between the 2 variables yielded an insignificant finding (χ^2 =2.577, df=2, p=0.276). This means that the experience of anxiety is not related to the witnessing of domestic violence and thus both groups seem to have an unusually high level of anxiety.

Regarding the finding above it should be noted despite the fact that only 50% of the respondents stated that they had experienced domestic violence, when all respondents were asked whether they had "*seen the parents quarrelling or fighting*", 98% responded in the affirmative.

The figure below represents the levels of self esteem experienced by the respondents in the group that experienced domestic violence (DV) and the group that did not experience domestic violence (NDV).

Figure 4**: Levels of Self esteem for the DV group**

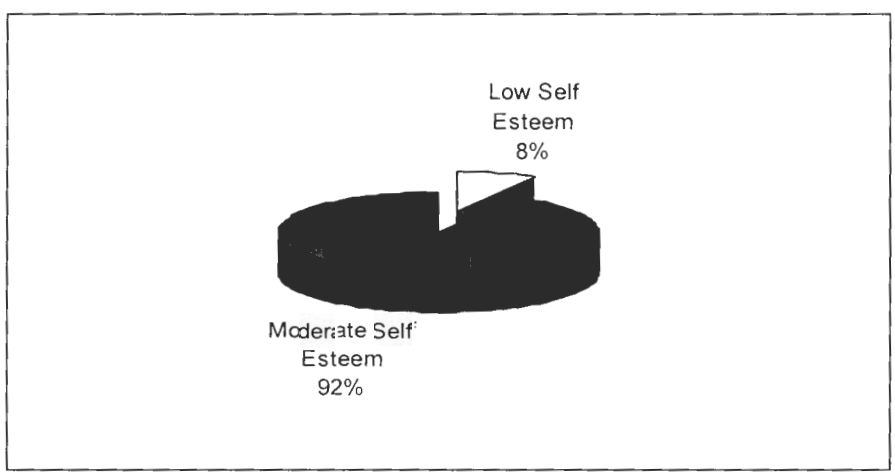
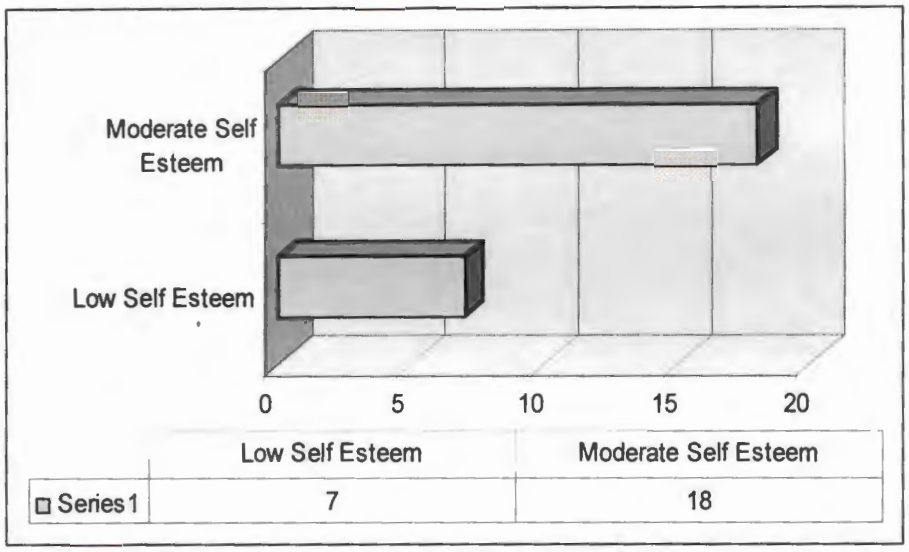


Figure 5: **Levels of Self esteem for the DV group**



Regarding the figures above, there was a high level of moderate self-esteem in both groups with 28% of the respondents in the NDV group registering a low self-esteem as opposed to 8% in the DV group.

The table below shows on the whole that there were more respondents who had moderate self esteem than low self esteem irrespective of whether the respondents were exposed to domestic violence or not. Taking all respondents together, 46% of the respondents who had experienced domestic violence had moderate self-esteem (n=23) and 36% of the respondents who had not experienced domestic violence had moderate self-esteem. In both age groups more respondents had moderate self-esteem compared to low self-esteem.

Table 11: **Self esteem and the experience of Domestic Violence**

		Recoded Self Esteem		
	Age	Low SESTEEM	Moderate SESTEEM	Total
DV	15 - 16	0	15	**15**
	17 - 18	2	8	**10**
	Total	**2**	**23**	**25**
NDV	15 - 16	4	11	**15**
	17 - 18	3	7	**10**
	Total	7	18	**25**

A cross-tabulation between the respondents' experience of domestic violence (yes & no) and their report of self-esteem yielded a significant finding (χ^2 =3.388, df=2, p=0.06). This means that the experience of domestic violence affects one's self esteem as the result means that these two variables are related.

The table below indicates that 4% of the males who were exposed to domestic violence have low self-esteem and females did not indicate low self-esteem. However, 14% of the males indicated moderate self-esteem and 16% of the females indicated moderate self-esteem.

The table further indicated that 6% of males from the non-domestic violence families could present with low self-esteem and 14% with moderate self-esteem. Eight percent of the females who were not exposed to domestic violence indicated low self-esteem and 22% of the respondents, their self-esteem tend to be moderate.

The results indicated that there is no major difference in the number of males from the two groups regarding the level of their self-esteem. However, there was a slight difference in both groups regarding the frequency of females when their self-esteem was compared (DV, n= 16, NDV, n=11).

Table 12: **Gender, the experience of domestic violence and self-esteem**

		Recoded Self Esteem		
	Sex	Low SESTEEM	Moderate SESTEEM	Total
DV	male	2	7	9
	female	0	16	16
	Total	2	23	25
NDV	male	3	7	10
	female	4	11	15
	Total	7	18	25

Respondents from domestic violence families in the age category 15-16 years did not show low anxiety. However, 26% indicated moderate anxiety and 4% high anxiety level. With the age 17-18 years 2% indicated low anxiety level, 14% moderate anxiety and 4% high anxiety.

The table continues to illustrate respondents who were not exposed to domestic violence. Those who are from the age category 15-16 years did not indicate low anxiety, yet 24% indicated moderate anxiety and 6% high anxiety level. The respondents who are from the age 17-18 years also did not indicate low anxiety. However, 10% of the respondents depicted moderate to high anxiety levels.

There is a slight difference of moderate anxiety from the two comparison groups when they are compared according to age. However, there is also a major difference of high anxiety level between the two groups. A high number from non-domestic violence families indicated high anxiety.

Table 13: **Age, the experience of domestic violence and level of anxiety.**

		Recoded Levels of Anxiety			
	Age	Low Anxiety	Moderate Anxiety	High Anxiety	**Total**
DV	15 - 16	0	13	2	**15**
	17 - 18	1	7	2	**10**
	Total	**1**	**20**	**4**	**25**
NDV	15 - 16	0	12	3	**15**
	17 - 18	0	5	5	**10**
	Total	**0**	**17**	**8**	**25**

When data was assessed to see if gender of the respondents would contribute in terms of the subjects' accuracy about their level of anxiety, data collected suggested that more males and females from domestic violence families tend to have moderate anxiety as compared to those who are from non-domestic violence families.

The data further suggested a huge difference of high anxiety level between the two groups. More males from domestic violence families tend to portray a high anxiety level as compared to males from non-domestic violence families. However, more females from non-domestic violence families portrayed high anxiety level as compared to females from domestic violence families.

Table 14: **Gender, the experience of domestic violence and level of Anxiety.**

		Recoded Levels of Anxiety			
	sex	Low Anxiety	Moderate Anxiety	High Anxiety	Total
DV	male	0	6	3	**9**
	female	1	14	1	**16**
	Total	**1**	**20**	**4**	**25**
NDV	male	0	4	6	**10**
	female	0	13	2	**15**
	Total	**0**	**17**	**8**	**25**

A test of the hypothesis stating, "the higher the self esteem the lower the level of anxiety" yielded the correlations below. Looking at the negative correlation coefficients below there seems to be an inverse relationship between the two variables meaning that as one increases the other decreases.

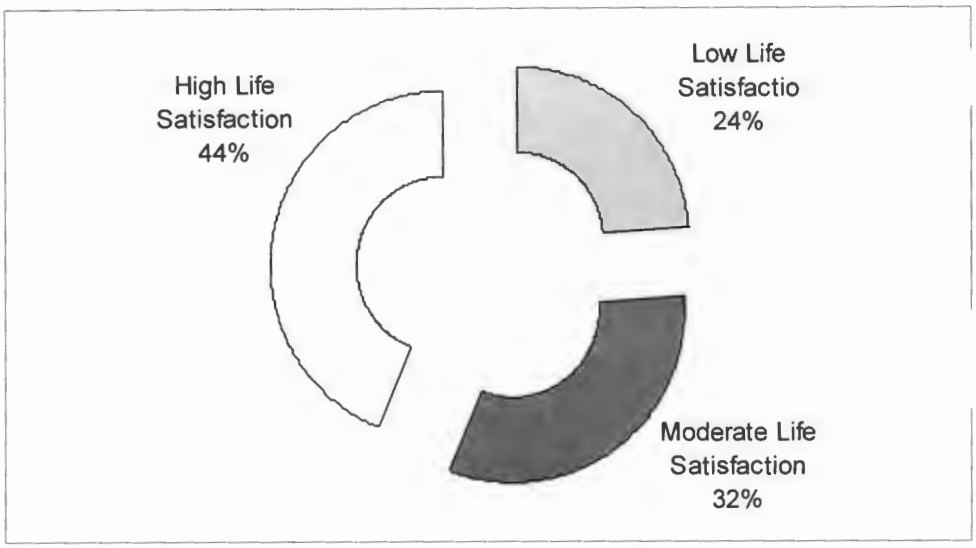
Table 15**: Correlation of Anxiety (IPAT) and self esteem (SESTEEM)**

Experience of Domestic Violence (DV)	SCALE	IPAT	SESTEEM
	IPAT	1.000	-0421*
	SESTEEM	-0.421*	1.000
No experience of Domestic Violence (NDV)	IPAT	1.000	-0.298
	SESTEEM	-0.298*	1.000
All Respondents taken together	IPAT	1.000	-0.359*
	SESTEEM	-0.359*	1.000

*Significant at the 0.05 levels

On the whole, taking all respondents together, there seemed to be a positive experience of life satisfaction as the figure below shows.

Figure 6: **Levels of Life Satisfaction**



The table below shows the levels of life satisfaction experienced by the respondents in the DV group and the NDV group.

Table 16: **Levels of Life satisfaction**

Life Satisfaction	DV	NDV	Total
Low Life Satisfaction	9	3	12
Moderate Life Satisfaction	8	8	16
High Life Satisfaction	8	14	22
Total	**25**	**25**	**50**

The table show that irrespective of the respondents' experience of domestic violence or not, their life satisfaction was moderate to high in the main as indicated at the beginning of the results section. The table also does show that there were more respondents who experienced low life satisfaction in the DV group (18%; n=9) compared to the NDV group (6%; n=3). More respondents in

the NDV group (28%; n=14) had the experience of higher life satisfaction compared to the DV group (16%). This may suggest that the experience of domestic violence can influence your life satisfaction.

The two figures below summarize the levels of life satisfaction by group, i.e., DV, and NDV.

Figure 7: **Levels of Life Satisfaction in the DV group**

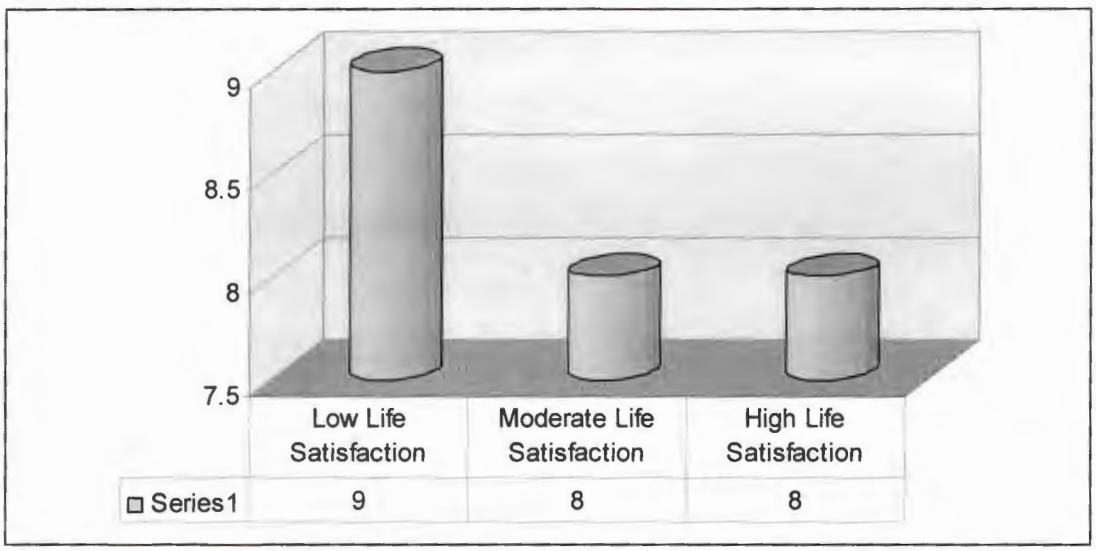
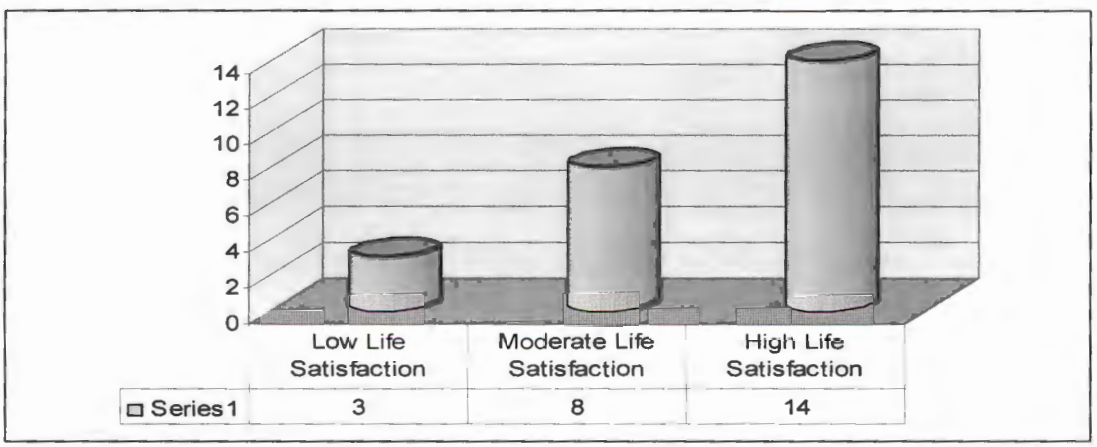


Figure 8: **Levels of Life Satisfaction in the NDV group**



CHAPTER 5

5.1. DISCUSSION

The results obtained in this study have illuminated many facets of experiencing the nature of domestic violence, in particular emotional violence, verbal violence, physical violence, being part of the violence and some of the respondents are involved in all of the above nature of domestic violence.

From the 50% of the respondents who have witnessed domestic violence, 20% have witnessed physical children violence, 10% verbal violence i.e. parents were either fighting or quarrelling in front of the children.

Different authors support this. Wolak & Finkehor (1996) mentioned that children hear their parents, the adults they love and depend on, screaming in anger, pleading in fear, sobbing in pain. They hear fists, witting bodies, and object thrown and shuttered, people thrown against walls and knocked to floors.

The results further revealed hat 2% of the respondents experienced emotional violence, 6% were part of the violence and 12% have experience almost all the nature of domestic violence. This is supported by Atnafon (1995) when he mentioned that children might see violence or being used as part of it. This

include hitting or threatening a child, taking the child hostage, using this against the mother and using the child as the physical weapon against the victim.

The main finding of the present study is that the experience of domestic violence affects one's self-esteem. This affirms the hypothesis, which states that children who have witnessed domestic violence have poor self-esteem.

A variety of authors have noted the effect of domestic violence on children's self esteem. Grych & Finchanan (1992) stated that children often become silent victims; they may portray feeling of powerlessness, guilt and self-blame. They may also have conflicted loyalties, i.e. love vs. hate. The proceeding feelings results in fearfulness and low self worth, which resulted from sense of trust being the trait. This may in turn lead to a learnt " victim mentality" were the victim is trying to gain relieve. Victims (children) learn that they are powerless; they may stop struggling and become passive.

In the same line, Fantuzzo (1991) also cited that, children who witnessed domestic violence were also found to show low self-esteem than children who did not witness domestic violence.

Rossman (1996) in his study reveal that increase violence exposure was associated with low self-esteem in the same line Davis & Carlson (1987) their results also

elicited that domestic violence can have longer-term problems such as poor self-esteem. In the same vain Henning found that women who have witnessed domestic violence as children had greater distress and lower social adjustment due to the low self-esteem.

Surajnarayan (1991) stated that family friction affects the adolescent personality unfavorably by upsetting his body homeostasis, which leads to anxiety, nervousness and insecurity, which damage the adolescent's self esteem. This was further supported by Sears et al (1997) when he found that children were likely to have a high self esteem when at least the home environment is warm and accepting.

It is very clear that warmth, involvement and affection for one's children are the key ingredients in successful parenting. Family structure, characteristics of parents and child rearing practice are important factors in the development of the child self esteem.

From the proceeding discussion, indeed there is a relationship between domestic violence and self-esteem. Self-esteem is the powerhouse of human psychological function if one's self esteem is affected there is a likelihood of psychological dysfunction. Low self-esteem is an indicator of young children likely to end up using drugs (Conenicon & Windle, 1993).

The question was, is there any relationship between the experience of domestic violence and the anxiety of children who have witnessed it? The results indicated that there is no major difference amongst the scores of those who experience domestic violence and those who did not. The experience of anxiety is not related to the witnessing of domestic violence only and thus both groups seem to have high levels of anxiety.

The above finding does not align itself with some of the findings documented by other researchers who state that there is a relationship between witnessing domestic violence and the level of anxiety experienced by children. Corey mentioned that the child who experiences a rough childhood could develop neurotic anxiety and moral anxiety. Grych & Ficham (1992) also supported these by saying children who witness domestic violence may experience feeling of powerlessness, guilt, and self blame, these feeling results in fearfulness and anxiety. Other researchers believe that the relationship between anxiety and exposure to abuse and violence may affect individual susceptibility to anxiety disorders (Belard, et. al. (1996).

However, there is some of the literature, which indicated that anxiety could be caused by different things. Barrera (1993) indicated that there is no single situation or condition, which causes anxiety disorders. Rather nature and environmental trigger may combine to create a particular anxiety disorder. The

psychoanalyst further suggests that anxiety stands from unconscious conflict that causes discomfort during infancy or childhood. Dodd & Roberts (1994) stated that heredity, brain chemistry, personal experiences are also believed to play roles in occurrence of anxiety disorders. Many scientists and researchers found that bio-chemical imbalances are anxiety-causing (Barrera, 1993).

From the preceding arguments one can clearly see that anxiety can be caused by various factors. One cannot attribute domestic violence only to anxiety however; there is a chance that domestic violence can be the cause of anxiety disorders.

The results indicated that there is a relationship between the age and self-esteem of children who have witnessed domestic violence. This suggests that the difference in age among respondents of domestic violence families could contribute to their self-esteem. As the child grows in a domestic violence, his level of self-esteem drops.

In other analyses, Widom (1989) revealed that exposure to continued violence was the strongest predictor of low self-esteem, which might lead to violent behavior. In the same light, Wexler (1990) estimated that between 20% and 40% of chronically violent adolescents had witnessed extreme parental conflict from childhood. Kalmus (1984) also indicated that observing aggression and violence

between parents as a child was more strongly related to future involvement in severe marital violence due to low self-esteem.

When the level of self-esteem was compared between the two groups looking at gender the results indicted that there was no huge difference between the two groups. However, with the females there was a slight difference. Males indicated that whether they are from violent families or non-violent families their esteem did not differ a lot. This implies that males react differently toward stimuli as compared to females. This was not the case with the females. Those who were domestic violence families slightly differed with those who were not from domestic violence families.

Fordsstrom-Cohen and Rosen (1985) research of those who witnessed violence in the home revealed that adolescent females were significantly more depressed than their male counterparts. Additionally, adolescent females who witnessed parents' violence were significantly more depressed and aggressive than females from non-violent homes, whereas no similar interactions were found for males (Schwarz and Getter, 1990).

When respondents' anxiety was compared by age a high number of those from non-domestic violence families indicated high anxiety as compared to those who are from domestic violence families. This implies that a range of factors can cause

anxiety. This is already mentioned by Barrera (1993) when he stated that no single situation or condition causes anxiety disorders. Rather, nature and environmental triggers may combine to create a particular anxiety illness.

The results further indicated that age contributes towards the level of anxiety whether one has experienced domestic violence or not. Older respondents tend to portray high levels of anxiety as compared to younger respondents. Barrera (1993) indicated that early childhood experiences might lead to certain fears that over time develop into full-blown anxiety disorders. In the same vein, Bernard, et. al (1996) stated that a prolonged experience of fear could be a problem for children when they are growing up.

When anxiety was measured according to gender, the results indicated that most of the males from domestic violence families have a moderate to high anxiety level. However, more females from non-domestic violence families portrayed a high anxiety level and there was a slight difference of anxiety among the females of the two groups.

This is an indication that gender might be one of the factors, which contribute to the level of anxiety. Hence Barrera (1993) has indicated that no single situation or condition can cause anxiety disorders. Rather nature and environmental factors

may combine to create a particular illness. Gender might be one of natural issues, which can lead to anxiety according to the test results.

A test of hypotheses stating that there is a correlation between self-esteem and anxiety among children who witnessed domestic violence revealed that there seems to be an inverse relationship between the two meanings that as one increases the other decreases.

The above is supported by Keegan (1993) when he maintains that low self-esteem contribute to neurosis, anxiety, defensiveness and ultimately alcohol and drug abuse. In the same light Johnson (1987) documented that juvenile delinquents not only had low self-esteem but they also had high feelings of anxiety.

Perhaps it was on this above stated grounds that Kelley (1978) reported a direct correlation between delinquency and low self-esteem. He found evidence of a link between increased self-esteem and reduction of delinquent behavior. Yellowlees (1996) also supported this by stating that low self-esteem seems to operate as a predisposing contributory factor in the development of depression, anxiety, eating disorders, and alcohol and drug abuse. Bernard, et. al. (1996) in the same line with other authors stated that anxiety disorders that begin in childhood might itself contribute to the development of low self-esteem.

When the above scenarios are combined, one can say there is a correlation between anxiety and self-esteem. When one possesses low self-esteem there is likelihood that anxiety level can be higher.

When levels of life satisfaction were measured the results suggested that the experience of domestic violence could influence one's life satisfaction. Cole (1993) stated that violence affects the quality of life of young people who experience, witness or feel threatened by it. In addition to the direct physical harm suffered by young victims of serious violence, serious violence can adversely affect victims' mental health and development, and increase the likelihood that they themselves will commit acts of serious violence (Child Trends, 1999). Maslow indicated that once comfortably nurtured by affectionate ties with other people he could then turn his attention to his basic need for self-respect. Not then, until an individual feels healthy, safe, loved and competent can he seek the self-actualization from the pursuit of knowledge, the appreciation of beauty, playfulness, self-sufficiency and insight into the truth (Papalia & Olds, 1999). The emotional climate of the home is determined largely by parents. Homes characterized by friction and discord, lack of affection and interest in the child and breaks due to separation lead to emotional instability and poor adjustment on the child's part (Surajnarayan, 1991). According to Pringle (1981), a child growing up in a discorded home is likely to become emotionally disturbed or antisocial. A quarrelling, inadequate, or disturbed parent makes a poor adult model. Parent hostility has a particularly

harmful effect on a child's later development, especially on his ability to give, as an adult, unselfish, loving care to his own children.

5.2. CONCLUSIONS AND RECOMMENDATIONS

It is clear that children, who are victims of domestic violence, are children who are severely emotionally wounded by their experience. Despite lack of accurate statistics it is evident that numerous children are at risk of being traumatized in this manner and the majority of them never receive help and family members often fail to understand the impact of their trauma. These children are at risk for longer-term difficulties and may themselves become victims or perpetrators of further violence. In order to break this ongoing cycle of violence, it is imperative that the plight of these children be taken in very serious light.

For some children questions about one's life may be difficult to answer, especially if the individual has been "warned" or threatened by a family member to refrain from "talking to strangers" about events that have taken place in the family. Referral to the appropriate school personnel (life skill educators) could be the first step in assisting the child in need of support. When there is a suggestion of domestic violence with a student, life skill educators can play an important role by involving psychologists and social workers. Although the circumstances surrounding each case may vary, suspicion of child abuse is required to be reported to the local child protection agency.

If the child expresses a desire to talk, they should be provided with opportunity to express their thoughts and feelings. In addition to talking, they may be encouraged to write in a journal, draw or paint, those are viable means of facilitating expression in children. Adolescents are typically more abstract in their thinking and generally have better developed verbal abilities than younger children. It could be helpful for adults who work with teenagers to encourage them to talk about their concerns without insisting on these expressions. Listening in a warm, non-judgmental and genuine manner is often comforting for victims (children) and may be an important step in their seeking further support. Group counseling should be considered at schools, as it will help children with support. Schools should also provide a list of names and phone numbers to contact in case of serious crises, as this can be helpful.

More social and mental health service needs to be provided for these children. Therapy can provide the child with a space to work through the horror of their experience and hopefully integrate it in a more constructive way and minimize the negative longer-term impact.

On a social level children need to be given recognition and respect. It is within a society that devalues children that such crimes can be perpetrated. In the longer term, improve socioeconomic conditions and education may reduce ignorance and the risk of such crimes being perpetrated. Early detection of "at risk" adolescents

may protect them from experiencing such events, equipping them with much needed "strategies" to protect themselves. Educating the public about domestic violence is an advantage. Awareness of the impact of domestic violence on children will lead to an understanding of their behavior and life-world of children, family members or friends that have been victimized. In educating the public and parents about caring a greater awareness of its numerous psychological facets will be stimulated.

It is essential that the police and criminal justice system take domestic violence more seriously and intervenes more readily. Programs that empower police officers about the effects of domestic violence on children should be created. By creating these programs, we are supporting the development of greater understanding between the police, the children and families who live in violent areas.

A 24-hour mental health crisis referrals and consultation service for children in collaboration with other community agencies should be created. The scars of children who witnessed domestic violence are invisible. Because these are silent victims, pediatricians and other primary care clinicians have to be consciously alert even in regular office visits, to the possibility of exposure and victimization and be proactive in providing help. They suggest a pattern of non-intrusive inquiry that can be used by pediatricians and nurses as a tool for uncovering problems that can then be addressed by the physician or handled through referral to a mental health

professional in those situations of extreme trauma or when post-traumatic or depressive symptoms are depicted.

Above all, we need to publicly acknowledge the horror of family violence and provide the silent victim with a strong voice against such activities if we want to be a progressive nation.

5.3. LIMITATIONS

The limitations of this study include the size of the sample used. This has implications for the generalization of the findings of the study to the population. Life skill educators had a problem of identifying children who have witnessed domestic violence, as it is a very sensitive issue hence, the sample size was small.

Methodological problems exist with the study. The study examined children who witnessed domestic violence without looking at other variables as contributory factors towards low self-esteem. Thus, more research is necessary to look into these other aspects, which are believed to contribute toward the development of self-esteem. Psychological well being, socioeconomic status, achievement, creativeness, social status, moral and ethical behavior are also important determiners of self-esteem.

There is no clear statistics on children who have witnessed domestic violence. Statistics is derived from the number of families who are involved in marital discord.

REFERENCES

Abood, D. A., & Conway, T. L. C. (1992). Health value and self-esteem as predictors of wellness behavior. **Health Values,** Vol. 16.

Alvy, A. (1987). **Post-Traumatic therapy with domestic violence survivors. Handbook of post-traumatic therapy**. West Port, CT: Greenwood press.

American Psychiatric Association, (1994). **Manual for Anxiety Disorders.**

American Psychiatric Association. (1994). **Diagnostic and Statistical Manual for Mental Disorder (DSM-IV),** Fourth edition. Washington, DC: American Psychiatric Association

Atnafou, R. (1995). Children as witnesses to community violence. **Options** (Newsletter of Adolescent Violence Resource Center: Educational Development Center, Inc.). 2, 7-11.

Barrera, M. (1993). Effects of social support and conflict on adolescent children of alcoholic and non-alcoholic fathers. **Journal of Personality and Social Psychology**, 64, 602-612

Battle, C. W. (1980). Factors associated with the use of violecce among urban black adolescents. **American Journal of Public Health,** 84, 612-617

Bell, C. (1995). Exposure to violence distresses children and may lead to their becoming violent**. Psychiatric News,** 15, 6-8.

Benard, L. L., Hutchison, S., Lovin, A., & Pennington, P. (1996). Ego-strength, hardiness, self-esteem, self-efficacy, optimism and maladjustment: Health-related Personality and "The Big Five" Model of Personality Assessment. **Psychological Assessment Resources. US**. 3, 115-131.

Bernnertts, L. (1994). Risk and reliance among children exposed to family violence. **Violence and Victims,** 11, 113-128

Berns, M. (1995). Linking marital violence, mother-child/father-child aggression and child behavior problems. **Journal of Family Violence,** 9, 63-78.

Bernstein, R., & Borchardt, S. (1991). Witness to violence. The child interview. **Journal of Child Psychiatry,** 23 (3).

Blascovich, J., & Tomaka, J. (1991). **Majors of Self-esteem**. Vol. 1, San Diego, LA: Academic Press.

Bowen, H., Barry, W. A., Hertel, R.K. (199). **Communication, Conflict and Marriage.** San Fransisco: Jossey-Bass

Campbell, J. C., & Alford, P. (1989). The dark consequences of marital rape. **American Journal of Nursing.** 946-949.

Candito, L. (1996). A false stigma: Low esteem. **The True Disease,** 97.

Carlson, B. E. (1990). Adolescent observers of marital violence. **Journal of Family Violence,** 5 (4), 285-299.

Cattel, R. B., Dubin, S. S., & Saunders, D. R. (1995). Personality structure in psychotics by factorization of objective clinical tests. **Journal of Mental Science,** 100, 154-176.

Child Trends. (1999). **Children and Welfare Reform: A Guide to Evaluating the Effects of State Welfare Policies on Children.** Washington, D.C.: Child Trend

Clark, D. O. (1996). Age, socioeconomic status and exercise self-efficacy. **The Gerontologist,** Vol. 36.

Clark, D. O., Patric D. L., Grembowski, D., & Durham, M. L. (1995). Socioeconomic status and exercise self-efficacy in late life. **Journal of behavioral medicine,** 18, 355-376

Carlson, B. E. (1984). **Battered Women and Their Families.** New York: Springer

Cole, M., & Cole, S. R. (1993). **The Development of Children.** New York: Scientific American.

Collins, L. (1999). The effects of minor events, optimism and self-esteem on health. **Journal of Clinical Psychology,** 33, 559-570

Compass, B. (1987). Coping with stress during childhood adolescence. **Psychological Bulletin 101**: 393-403.

Corey, G. (1998). **Theory and Practice of Counseling and Psychotherapy.** California: Brooks and Cole Publishing Company

Davis, D. (1991). Intervention with male toddlers who have witnessed parental violence. **Families in Society,** 515-524.

Davis, L. V., & Carlson, B. E. (1987). Observation of spouse abuse: What happens to the children? **Journal of Interpersonal Violence**. 2 (3), 278-291.

Demo, D. H., Javin-Williams, R. C. (1983). Early adolescent self-esteem as a function of social class: Rosenberg and Pearlin revisited. **American Journal of Psychology,** 88, 122-142.

Diener, M., Emmons, M., Larsen, J. N., & Girffen, P. M. (1987). **Satisfaction with life scale.**

Dobson, E., Dukes, W. F., Ewell, A. H. (1979). Psychological studies of values. **Psychological Bulletin**, 52, 24-50

Dods, D. T., & Roberts, R. L. (1994). Differences among adult COAs and adult non-COAs on level of self-esteem, depression and Anxiety. **Journal of Addictions and Offender Counciling,** 14, 49-56

Domenico, D., & Windle, M. (1993). Intrapersonal and interpersonal functioning among middle aged female adult children of alcoholics.

Dutton, M. A. (1994). **Women's response to battering: Assessment and intervention.** New York: Springer

Edelson, J. L. (1999). Children witnessing of adult domestic violence. **Journal of interpersonal violence,** 14.

Erikson, E. (1963). **Childhood and Society,** (2nd ed.). New York: Norton

Fantuzzo, J. W., DePaola, L. M., Lambert, L., Martina, T., Anderson, G., & Sutton, S. (1991). Effects of interpersonal violence on the psychological adjustment and competencies of young children. **Journal of Consulting and Clinical Psychology,** 59 (2), 258-365.

Finkelhor, D., & Dzuiba-Leatherman, J. (1994). Victimization of children. **American Psychologist,** 49 (3), 173-183.

Feming, H., & Courtney, A. (1984). A proposal for the empirical study of values. **American Sociological Review**, 30, 223-233

Fordsstrom-Cohen, A., & Rosenbaum, B. M. (1985). The Effects of parental mental violence on young adults: An exploratory investigation. **Journal of Marriage and Family,** 47(2), 467-472

Fretz, J., & Brown, D. (1990). **Violence in Marriage**. 163-218. Chicago: University of Chicago Press.

Ganley, A. (1980). **Integrating feminists and social learning analysis of**

aggression: Creating multiple models for intervention with men who battered. New York: Springer

Garmezy, N. (1983). **Stressors in Childhood.** In Stress, coping, and development in children, edited by N. Garmezy and M. Rutter. New York: McGraw-Hill.

Grinnel, G. (1985). Sexual abuse. In Visser, F. P. (2001). **A phenomenological Study of Children's Experience of Violent Crime.** University of North West.

Grych, J. H., & Fancham, F. D. (1990). Marital conflict and children's adjustment: A cognitive-contextual framework. **Psychological Bulletin,** 108 (2), 267-290.

Hafin, M. (2000). **"Domestic Violence Affect Children Too".** A Press Release.

Hawkins, J. D. (1995). Controlling crime before it happens: Risk-focused prevention. **National Institute of Justice Journal.** 22*9, 10-18.*

Hendriks, J., Black, D., & Kaplan, T. (1993). **When Father Kills Mother.** London: Routlege Press.

Henning, K., Leitenberg, H., Coffey, P., Turner, T., & Bennet, R. T. (1996). Long-term psychological and social impact of witnessing physical conflict between parents**. Journal of Interpersonal Violence,** 11 (1), 35-51.

Hitherington, E. M., & Anderson, E. R. (1998). **"The effects of divorce and marriage on early adolescents and their families", in early adolescents transitions.** Lexington, M A.

Hughes, H. M. (1996). Brief interventions with children in a battered women's shelter: A model preventive program. **Family Relations,** 31, 495-502.

Hughes, H. M. (1988). Psychological and behavioral correlates of family violence in child witness and victims. **American Journal of Orthopsychiatry**, 58, 116-204.

Jaffe, P. G., Wolfe, D. A., & Wilson, S. K. (1990). **Children of Battered Women.** Newbury Park, CA: Sage.

Jaffe, P. G., Wolfe, D. A., & Wilson, S. K. (1986). Promoting changes in attitudes and understanding of conflict resolution among child witnesses of family violence. **Canadian Journal of Behavioral Sciences**, Vol. 18.

James, K. A. (1994). Children of depressed parents: An integrative review. **Psychological Bulletin,** 108, 50-76.

Jenkins, A., & Thompson, K. S. (1986). **Children talk about violence: Preliminary findings from a survey of black elementary children**. Oakland CA.

Johnson, J. H. (1997). **Life events and stressors in childhood and adolescence.** New Bury Park: Sage Publications

Johnson, J. H. (1986). **Life Events as Stressors in Childhood and Adolescence.** Newbury Park, Calif.: Sage Publications.

Lewis, M. L., Osofsky, J. D., & Fick, A. C. (1995). **The new orleans violence and children intervention project: Development of a police education curriculum on the affects of violence on children.** Poster presented at the biennial meeting of the society for research in child development, Indianapolis IN.

Lefrancois, G. (1997). **The Life Span, fourth edition.** California: Wordsworth Publishing Company.

Kalmuss, D. (1984). "The intergenerational transmission of marital aggression". **Journal of marriage and the Family,** 46, 11-19

Kaplan, H. I., & Saddock, B. J. (1991). **Synopsis of Psychiatry: Behavioral Science Clinical Psychiatry,** (6^{th} ed.). Baltimore, MD: Williams and Wilkins.

Keegan, B. (1999). **Social Development.** New York: Harcourt Brace Jovanovich

Kelly, L. A. (1978). An integrative perspective on children's divorce adjustment. **American Psychologist,** 36, 856-866

Kronenberger, W. G., & Meyer, R. G. (1996). **The Child Clinician's Handbook.** Boston: Allyn and Bacon

Kotze, S. (1995). South Africa takes action against domestic violence and women abuse. **Journal of Social Work Practice,** 3.

Mckay, M. (1997). The link between domestic violence and child abuse: Assessment and treatment consideration. **Child Welfare Lague of America**, 73, 29-39

Mckay, M., & Fanning, P. (1997). **Self-esteem: The Ultimate Program for Self-help.** New York: MJF Books

McLoyd, V. C. (1990). The impact of economic hardship on black families and children: Psychological distress, parenting, and socioemotional development. **Child Development** 61: 311-46.

Michael, H. (2002). Research with children in shelters: Implications for clinical Services. **Children Today,** 15, 21-25

Miller, T., Handal, P., Gilner, F., & Cross, J. F. (1991). The relationship of abuse and witnessing violence on the child abuse potential inventory with black adolescents. **Journal of Interpersonal Violence,** 6, 353-363.

Miller, G. (1991). "Violence by and against America's children". **Journal of Juvenile Justice Digest,** Vol. 12.

Mullis, R. L. & Chapman, P. (2000). Age, gender and self-esteem differences in adolescent coping style. **The Journal of Social Psychology**, 140 (4).

Newman, B. M., & Newman, P. R. (1990). **Development through life: A Psychological approach.** Chicago: The Dorsey press

Osofsky, J. D. (1998). Children who witness domestic violence. The Invisible Victims, Social Policy Report. **Society for Research in Child Development,** Vol. 9.

Papalia, D. E., & Olds, S. W. (1999). **Psychology.** New York: McGraw-Hill Book Company.

Pavot, D., & Diner, L. (1993). **Personality Tests.** USA: JN Publishers

Perterson, J. L., & Hamburg, N. (1996). Marital disruption, parent-child relationships, and behavior problems in children. **Journal of Marriage and the Family,** 48, 295-307

Robertson, M., & Donaldson, M. (1997). No place like home. Family Murder: The child victims. **Center for the Study of Violence and Reconciliation.**

Robinson, J. P., Shaver, P. R., Wrightsman, L. S. (1994). **Measures of Personality and Social Psychological Attitude**. London: Academic Press

Rosenberg, M. (1965). **Society and the Adolescent Self-image.** Princeton, N. J: Princeton University Press.

Rossman, b. B. (1998). **Descartes' error and post-traumatic stress disoder: Cognition and emotion in children who are exposed to parental violence.** Washington, DC: American Psychological Association

Schwarz, K., & Getter, W. (1990). Short-term group psychotherapy with adult children of alcoholics. **Psychiatric Annals,** 2, 391-394.

Shakoor, L., & Chalmers, M. (1991). Violence exposure and emotional trauma as contributors to adolescents' violent behaviors. **Archives of Pediatric and Adolescent Medicine,** 152, 531-536

Silvern, L., Karyl, J., Waelde, L., Hodges, W. F., Strek, J., Heidt, E., & Min, K. (1995). Retrospective reports of parental partner abuse: Relationships to depression, trauma symptoms and self-esteem among college students. **Journal of Family Violence,** 10, 177-202

Spivak, G., & Shure, M. B. (1985). ICPS and beyond: Sentripetal and Sentrifugal forces. **American Journal of Community Psychology,** 13, 226-243

Strauss, M. A., & Gelles, R. J. (1990). **How violent are American families? Estimates from the National Violence Survey and other studies.** In M. A. Strauss & R. J. Gelles (Eds.), Physical Violence in American Families (pp. 95-112). New Brunswick, NJ: Transaction.

Strauss, M. A., Gelles, R. J., & Steinmetz, S. K. (1980). **Behind Closed Doors: Violence in the American family.** New York: Anchor/Doubleday.

Surajnarayan, G. (1991). **The Influence of the Family on the Adolescent's behavior.** University of South Africa.

Terr, L. (1991). Childhood traumas: An outline and overview. **American Journal of Psychiatry,** 148 (1).

Thomas, C. B. (1999). Values as predictors of social activist behavior. **Human Relations,** 39, 179-193

Vetten, L. (1995). **Man Shoots Wife, A Pilot Study Detailing Intimate Femicide in Gauteng, South Africa**. A Project of POWA and the NGO Secretariat for Beijing.

Visser, F. P. (2001). **A Phenomenological Study of Children's Experience of Violent Crime.** University of North West.

Volpe, D. A. (1996). "Child witnesses to violence between parents": Critical issues in behavioral and social adjustment. **Journal of abnormal Child Psychology,** 14, 95-104.

Wexler, R. (1990). **Wounded innocents: The real victims of the war against child abuse**. Prometheus books, Buffalo, New York.

Widom, C. S. (1989). "Dose violence beget violence? A critical examination of the literature". **Psychological Bulletin,** 106, 3-28.

Wising, G. D., Peterson, J. R., Winthrop, H. (1999). Children in trauma. **A Psychological Journal,** 15, 123-130.

Wolak, O., & Finkelhor, D. (1999). **A sourcebook of child sexual abuse.** Beverly Hill, CA: Sage

Yarnell, T. D. (2001). Building self-esteem in children. **Journal of Personal Growth.**

Yellowlees, D. R. (1996). A review of literature: **Domestic violence and children**. 52, 114-120

Zena, H. R., & Powell, D. S. (1996). **Family violence: A review of the literature.** Florida Mental Health Institute: University of South Florida.

Zuckerman, B., Augustyn, M., Grooves, B. M., Parker, S. (1995). Silent victims revisited: The special case of domestic violence. **Pediatrics**, 96, 511-513.

APPENDIX A

University of North West
Mmabatho
2735

To the parents

Kindly allow your children to participate in my research project on the impact of domestic violence as this might help your child to deal with the problem. The information will be treated in strict confidence and children are not be allowed to disclose their names during the interview.

Kindly indicate by signing the letter and return it back to school.

MF Makama

I..... allow my child to participate in the research project.

Signature: .....

APPENDIX B

University of North West

Private Bag X 2046

MAFIKENG

2745

To The Respondent

You are humbly requested to participate in this study, which is about the impact of domestic violence on children. These questions aim at helping the researcher understand how you feel about different things and yourself. There are no right or wrong answers, only you, know how feel. It is important that you answer how you really feel not how somebody else thinks you should feel.

The purpose of the questionnaire over-leaf is to obtain your honest opinion about the subject.

This project is a necessary portion of the requirements for satisfying the conditions of the degree.

Please answer questions as truthfully as you can. The information obtained will be treated confidentially. Please do not disclose your name.

Yours truly,

M.F. MAKAMA
(INTERN CLINICAL PSYCHOLOGIST)

APPENDIX C

PART 1

1. Age

15-16	
17-18	

2. Sex

Male	
Female	

3. Education

Grade 10	
Grade 11	

PART 2

1. I feel that I am a person of worth, at least on an equal basis with others.

1. STRONGLY AGREED	2. AGREED	3. DISAGREED	4. STRONGLY DISAGREED

2. I feel that I have a number of good qualities.

1. STRONGLY AGREED	2. AGREED	3. DISAGREED	4. STRONGLY AGREED

3. All in all, I am inclined to feel that I am a failure.

1. STRONGLY AGREED	2. AGREED	3. DISAGREED	4. STRONGLY DISAGREED

4. I feel I do not have much to be proud of.

1. STRONGLY AGREED	2. AGREED	3. DISAGREED	4. STRONGLY DISAGREED

5. I am able to do things as well as most other people.

1. STRONGLY AGREED	2. AGREED	3. DISAGREED	4. STRONGLY DISAGREED

6. I take a positive attitude towards myself

1. SRONGLY AGREED	2. AGREED	3. DISAGREED	4. STRONGLY DISAGREED

7. On the whole, I am satisfied with my self.

1. STRONGLY AGREED	2. AGREED	3. DISAGREED	4. STRONGLY DISAGREED

8. I wish I could have respect for myself.

1. STRONGLY AGREED	2. AGREED	3. DISAGREED	4. STRONGLY DISAGREED

9. I certainly feel useless at time.

1. STRONGLY AGREED	2. AGREED	3. DISAGREED	4. STRONGLY DISAGREED

10. At times I think I am no good at all.

1. STRONGLY AGREED	2. AGREED	3. DISAGREED	4. STRONGLY DISAGREED

PART 3

1. I find that my interests, in people and amusements, tend to change fairly rapidly … … … … ……

True In between False

☐ ☐ ☐

2. If people think poorly of me I can still go on quite Happily and without worrying too much. … … ……

True In between False

☐ ☐ ☐

3. I like to wait till I'm sure that what I'm saying is Correct before I put forward an argument……

Yes In between No

☐ ☐ ☐

4. I am inclined to let my actions get influenced by feelings Of jealousy. …. …. …. ……. …. …… …… .

Sometimes Seldom Never

☐ ☐ ☐

5. If I had my life to live over again I would:
(A) Plan very differently, (B) want it the same

A In between B

☐ ☐ ☐

6. In general; I admire my parents. … …….

Yes In between No

☐ ☐ ☐

7. I find it hard to " take ' no' for an answer", even When I know what I ask is impossible. …. .

True In between False

☐ ☐ ☐

8. I doubt the honesty of people who are more friendly Than I would naturally expect them to be. … …….

True In between False

☐ ☐ ☐

9. In demanding and enforcing obedience my parents (or guardian)
were:
(A) always very reasonable, (B) Often unreasonable…
…….. …… …… ……

A In Between B

☐ ☐ ☐

10. I need my friends more than they seem to need me…. … Rarely Sometimes Often

☐ ☐ ☐

11. I feel so sure that I could "pull myself together in an emergency…. Always Often Seldom

☐ ☐ ☐

12. As a child I was afraid of the dark…….. Often Sometimes Never

☐ ☐ ☐

13. People sometimes I show my excitement in voice And manner too obvious……. Yes Uncertain No

☐ ☐ ☐

14. If people take advantage of my friendliness I:
    a. Soon forget and forgive,
    b. Resent it and hold it against them. … A In between B

☐ ☐ ☐

15. I find my self upset rather than helped by the kind of personal criticism that many people make Often Occasionally- Never

☐ ☐ ☐

16. Often I get angry with people too quickly. … . ….. . …. True In between False

☐ ☐ ☐

17. I feel restless as if I want something but do not Rarely Sometimes Often

Know what. … …. … . . … . . . .. … .. . ….. … .. …..

☐ ☐ ☐

18. I sometimes doubt whether people I am talking to Are not really interested in what I am saying …. …..

True In between False

☐ ☐ ☐

19. I have always been free from vague feelings of Ill health, such funny pains in my head, stomach Or heart……..
….

True Uncertain False

☐ ☐ ☐

20. In discussion with some people, I get so annoyed That I can hardly trust myself to speak……

Sometimes Rarely Never

☐ ☐ ☐

21. Through getting "worked-up", I use up more energy Than most people in getting things done……

True Uncertain False

☐ ☐ ☐

22. I make a point of not being absent-minded or Forgetful……

True Uncertain False

☐ ☐ ☐

23. However difficult and unpleasant the obstacles, I always stick to my original intensions … … … … …
…… …… …….. …

Yes In between No

☐ ☐ ☐

24. I tend to get over-exited and "rattled" in upsetting situations …

Yes In between No

☐ ☐ ☐

25. I occasionally have vivid dreams that disturb my sleep
…… …… …… ……

Yes In between No

☐ ☐ ☐

26. I always have enough energy when faced with difficulties
…… …….. …… ……

Yes In between No

☐ ☐ ☐

27. I sometimes find myself counting things for no Particular reasons……..

True Uncertain False

☐ ☐ ☐

28. Most people are a little queer mentally, though They do not want to admit it…….. True ☐ Uncertain ☐ False ☐

29. If I make an awkward social mistake I can soon forget it …….. …….. …… …… Yes ☐ In between ☐ No ☐

30. I feel grumpy and just do not want to see people: A ☐ In between ☐ B ☐

(A) occasionally, (B) rather often … …. …. … … … … …

31. I am brought almost to tears by having things go wrong … … Never ☐ Very Rarely ☐ Some times ☐

32. In the midst of social groups I am nevertheless sometimes over Come by feelings of loneliness and worthlessness … …. .. Yes ☐ In between ☐ No ☐

33. I wake in the night and, through worry, have some difficulty in Sleeping again ….. …… …….. … ……. …… Often ☐ Sometimes ☐ Never ☐

34. My Spirit generally stay high no matter how many troubles I meet … .. …….. …… …… …… Yes ☐ In between ☐ No ☐

35. I sometimes feel guilty or very sorry over quite small matters ….. Yes ☐ In between ☐ No ☐

36. My nerves get on edge that certain sounds, e.g. a screechy hinge, Are unbearable and give me the shivers…….. Often ☐ Sometimes ☐ Never ☐

37. If something badly upsets me I generally calm down again quite quickly …….. …….. …… ……. True ☐ Uncertain ☐ False ☐

38. I tend to tremble or perspire when I think of a difficult task ahead ……. …. …….. …… …….. …….. Yes ☐ In between ☐ No ☐

39. I usually fall asleep quickly, in a few minutes, when I go to bed Yes ☐ In between ☐ No ☐

40. I sometimes get very excited or worked-up as I think about Things that have happen recently…… True ☐ Uncertain ☐ False ☐

PART 4

Below are five statements with which you may agree or disagree. Using the 1-7 scale below, indicate your agreement with each item by crossing the appropriate number in line with that item.

Strongly Disagree	Disagree	Slightly disagree	Neither agree nor disagree	Slightly agree	Agree	Strongly agree
1	2	3	4	5	6	7

1	In most ways my life is close to my ideal	1	2	3	4	5	6	7
2	The conditions of my life are excellent	1	2	3	4	5	6	7
3	I am satisfied with my life	1	2	3	4	5	6	7
4	So far I have gotten the important things I want in life.	1	2	3	4	5	6	7
5	If I could live my life over, I would change almost nothing	1	2	3	4	5	6	7

PART 5

1. Have you ever witnessed any form of domestic violence?

YES	
NO	

2. What was the nature of the domestic violence you were exposed?

Emotional violence	
Verbal violence	
Physical violence	
Being part of the violence	
All of the above	
N/A	

3. Do your parents quarrel/fight in front of you?

Always	
Usually	
Sometimes	
Never	

4. Do your parents displace their anger and aggression they feel for each other unto you?

Always	
Usually	
Sometimes	
Never	

5. How long did the violence occur in your family?

None	
0-2 years	
3-4 years	
5 and above	

6. How would you describe your feeling after you witnessed the domestic violence?

Sad	
Embarrassed	
Angry	
Mixed feelings	
N/A	

7. Did your relationship change with the person who started the domestic violence?

YES	
NO	
N/A	

8. How did you cope with the domestic violence situation?

Very well	
Not so well	
Not at all	
N/A	