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Effect of Perceived Parent Child Relations on Adjustment of Young Women Exposed to Mutual Intimate Partner Violence During Childhood

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1 INTRODUCTION

Domestic violence is now a public health issue in France. Historically, until the end of the twentieth century, the public authority gave them little interest. As Couturier (2011) points out, the important thing was to preserve the social order embodied by a long-standing traditional family institution. However, from the 60s to the 70s, our society has undergone many changes concerning the family and the place of the child. It is no longer defined by a single model, like patriarchal system, but by a variety of family organizations (Couturier, 2011). In France, the first laws on the repression and the prevention of violence within the couple appeared in 1992 and have been regularly reinforced since the law of 4 April 2006. Now, thanks to the law of 5 March 2007, the authors conjugal violence can be condemned to socio-judicial follow-up. In terms of protection, the law of 9 July 2010 created a protection order for female victims allowing the implementation of emergency measures such as the eviction of the violent spouse. These measures were reinforced with the law of 4 August 2014, including the setting up of accountability courses for perpetrators of domestic violence. Intimate partner violence (IPV) is now regarded as a public health issue in France.

However, if protection measures have been put in place for women who are victims of violence, these only concern children indirectly. The recognition and legal recognition of children exposed to domestic violence is much more recent. Although the law of 5 March 2007 reforming the protection of children has widened the notion of child in danger, it is only in 2010 that measures have been established specifically for child witnesses of domestic violence (protection order and interim measures for the exercise of parental authority). However, it is necessary to wait until 2014 for the public authority to officially recognize that "children are victims of domestic violence, including as witnesses of violence within the family". Since then, several devices have been created. If this initiative is to be welcomed, it deserves to be more extensive because these measures remain limited (protected meeting

places for parents and children, parenting support actions for women victims and children, awareness program for young people in school). It would be particularly appropriate to diversify services to adapt to the needs of children according to their experience, their sex, their age and the severity of the violence (Ovaere, Sardo-Infirri, Touahria-Gaillard, Lévy, 2007).

Domestic violence affects men and women in equal measure, but they are not the only victims, for although they are often ignored by researchers, children also suffer indirectly-and sometimes even directly-from IPV. In France alone, nearly 143,000 children were exposed to IPV each year between 2010 and 2015, according to the newsletter of the French National Observatory on Violence Against Women (Ministry of Social Affairs, Health and Women's Rights, 2015). Despite these alarming figures, children still garner very little attention in the French scientific literature (Savard & Zaouche-Gaudron, 2010).

Domestic violence is a complex phenomenon as it is embedded in social, economic, cultural and political contexts. The expression of this violence differs considerably from one country to another and even within a country (Garcia-Moreno et al., 2005). Domestic violence is thus difficult to circumscribe, so that their definition is not the subject of a consensus in the Western scientific literature.. There is indeed a theoretical and methodological debate between the authors of the feminist approach and those of the so-called "family violence" approach (Bonnet, 2015). In France, the feminist trend is dominant. It results from the historical legacy of patriarchy. Indeed, for feminist theorists, domestic violence is rooted in unequal power relations between men and women. Male domination is the cause and consequence of violence against women. Therefore, when it comes to conjugal violence, the scientific literature and public policies systematically refer to on what Johnson (2011) called *intimate terrorism*. This term refers to a cycle of violence where one partner dominates and controls the other (Walker, 2009). In this sense, data collected in different

countries and cultures indicate that the more patriarchal values are strong and widely accepted, the higher the rate of violence against women. And at the same time, these same data reveal that in the developed western countries, where there is greater gender equality, women are more likely to resort to violence within their couple (Garcia-Moreno et al., 2005, Archer, 2006). In addition, studies indicate that the dynamics of violence are similar in heterosexual and homosexual couples (Merrill and Wolfe 2000, Eaton et al., 2008). Violence is also often associated with social vulnerability and mental health (poverty, unemployment, substance abuse, psychiatric disorders). These various points suggest at least that conjugal violence is not always entirely reducible to male domination (Bonnet, 2015). Although the main victims of violence are women (Lessard et al, 2015), the authors of the so-called "family violence" approach, accepting a broader definition of domestic violence, found that half of all violent couples, the violence is mutual. In other words, it is instigated and perpetrated equally by women and by men (Archer, 2000; Johnson, 2016). For some authors, mutual violence is the most common form in violent couples (Archer 2000, Johnson 2008, Strauss 2011, Strauss and Michel-Smith 2014). This type of violence, commonly referred to as *situational couple violence*, usually arises out of the dysfunctional couple's *relational dynamics*, when unresolved conflicts escalate into violence (Johnson, 2011; Lapierre, Côté, Buetti, Lambert, Lessard, & Drolet, 2015). Unlike intimate terrorism, where one partner exerts violent coercive control over the other, it is entirely circumstantial, triggered by specific disputes or disagreements. Violence can be rare and isolated, or chronic. As Bonnet rightly points out (2015), "the problem of the questions of definition is to amalgamate two different phenomena, and to attribute to one the properties which are in fact associated with the other". In this respect, Brown and Jaspard (2004) and, more recently, Zaouche-Gaudron and Paul (2014) denounce a common confusion of the notions of violence and conjugal conflict. However, by considering domestic violence as a multi-form reality,

Johnson (2011) points out the extent to which conjugal violence involves multiple dynamics, and the fact that these occur along a continuum of a single episode of violence. to continuous abuse. The author puts forward that if marital conflict and patriarchal violence correspond to distinct dynamics, they still belong to the same reality, that of conjugal violence.

Domestic violence can affect each family member and their relationships. Parental partners who experience domestic violence are directly affected, sometimes both physically (injuries, headache, chronic pain, etc.) and mentally (emotional and psychosomatic disorders, sleep disturbances, eating disorders, cognitive problems) (Racicot, Fortin, & Dagenais, 2010; Vanneau, 2006). Their children also suffer its effects, as they may see or hear violent scenes, and subsequently notice or perceive the consequences of that violence (Lapierre, 2006; Lessard & Paradis, 2003). This may lead them to feel threatened or powerless, experience shame, find themselves in major conflicts of loyalty, and possibly even blame themselves for the violence, believing that they are somehow responsible (Doucet & Fortin, 2010; Peled, 1997; Zaouche-Gaudron & Paul, 2014). Parentification is often observed, especially among girls (Cantin-Drouin & Chamberland, 2008).

A number of studies have found that these children are more likely to develop adjustment disorders, manifested in anxious and depressive symptomatology (Fortin, 2005; Fortin & Lachance, 2011; Renner & Boel-Studt, 2013; Zaouche Gaudron, & Paul, 2014). They also risk exhibiting more externalizing problems (aggression, anger, hyperactivity, etc.) than children who are not exposed to IPV (Hunter & Graham-Bermann, 2013; Jimenez et al., 1999; Renner & Boel-Studt, 2013; Zaouche Gaudron & Paul, 2014). Vu, Jouriles, McDonald, and Rosenfield (2016) emphasized that the link between domestic violence exposure and children's internalizing and externalizing disorders becomes stronger over time.

Whereas Renner and Boel-Studt (2013) failed to find a sex-related difference in children, several researchers have reported one in adolescence, with female adolescents at greater risk than their male counterparts of displaying internalizing disorders-the reverse being true for externalizing disorders (Davies, Evans, & DiLillo, 2008; Moylan, Herrenkohl, Sousa, Tajima, Herrenkohl, & Russo, 2010). Furthermore, young women who witnessed domestic violence in childhood are more depressive and have lower self-esteem than men with IPV exposure (Karyl, Waelde, Hodges, Starek, Heidt, & Min, 1995).

The social learning model is often used to support the view that an IPV context constitutes a social learning experience, leading children and adolescents to reproduce their experience of violence or victimization in their current and future relationships. For Zaouche Gaudron and Paul (2014), however, this theoretical model not only fails to take account of the possibility that the child played an active part in the violence, but also does not include any protective factors.

In a context of domestic violence, good parent-child relations may indeed play a key protective role in the child's development and future adult life (Racicot, Fortin, & Dagenais, 2010). According to the family dysfunction hypothesis (Jaffe, Wolfe, & Wilson, 1990, cited by Racicot, Fortin, & Dagenais, 2010, and Doucet, 2012), however, domestic violence is liable to impair the quality of parent-child relations, thus compromising development across childhood and adolescence. This hypothesis states that children's behavioral and emotional reactions to violence are influenced by their mothers' (in)ability to engage in appropriate childrearing behaviors (Ridez, 2013). Furthermore, the more severe and frequent the violence, the less likely parents are to display positive behaviors toward their children, and the more likely the latter are to exhibit internalizing and/or externalizing disorders (Dehon & Weems, 2010; De la Sablonnière & Fortin, 2010; Fortin, 2009; Fortin, Damant, Doucet, & De la Sablonnière, 2006; Racicot, Fortin, & Dagenais, 2010; Renner & Boel-Studt, 2013).

Similarly, when children and adolescents are directly questioned, their responses indicate that the more frequent the violence, the poorer their relations with their parents (Zaouche Gaudron, & Paul, 2014), and the greater their risk of displaying adjustment disorders (Bourassa, 2003; Doucet & Fortin, 2014).

For this reason, researchers seeking to establish exactly how domestic violence affects the development of children and adolescents have specifically explored parent-child relations in domestic violence context. The problem is that this violence has always taken the form of a patriarchal control mechanism. Furthermore, although interest in fatherhood in the context of domestic violence has been growing since the 2000s (Labarre & Roy, 2015), most studies continue to focus exclusively on the mother-child relationship. Moreover, these have generally relied on the mothers' accounts and representations, instead of those of the children or adolescents themselves (Savard & Zaouche Gaudron, 2010), and we know that there can be discrepancies between mothers' and children's perceptions of lived experience (Deshaies, 2012).

To our knowledge, no study has so far explored the long-term consequences of IPV on both parent-child relations and adjustment in young adulthood. More specifically, although recent studies have shown that the quality of parent-child relations can influence the emergence of internalizing (anxiety, depression) and/or externalizing (aggression, anger) disorders among children and adolescents exposed to domestic violence, we still do not know whether this applies to young adults who witnessed IPV during their childhood. Researchers have shown that women with IPV exposure are more likely to display internalizing disorders than men who have had the same experience. Moreover, in the wake of exposure to severe violence (SV), women may exhibit not only more internalizing disorders, but also more externalizing disorders (Rosenberg & Rossman, 1990).

As mentioned above, all this research concerns only children and adolescents who have witnessed conjugal violence. As a result, we are unaware of the short- and long-term effects of parental violence on children and the quality of the parent-child relationship. Our basic assumption is that mutual violence between parents, as well as conjugal violence, can have deleterious effects on the future development of the child, and the quality of parent-child relationships. It is now clearly established that the subjective experience of the child in the face of domestic violence is associated with his difficulties of adaptation. As such, mutual violence between parents can also pose a threat to the child and thus create a feeling of insecurity. Similarly, frequent mutual violence between parents could also alter the quality of the parent-child relationship. Starting from this postulate, our research will focus on the role of parent-child relationships. We therefore set out to examine the role of parent-child relations in the emergence of internalizing (anxiety and depression) and externalizing (aggression) disorders among young women who witnessed mutual interparental violence as children. Children's relations with their parents change when they reach adulthood and so, too, may their impact on adjustment.

1.1 OBJECTIVES AND HYPOTHESES

The objectives of this research are to determine first, whether exposure to mutual spousal abuse in childhood has influenced perceptions young women of the quality of current relationships with their parents secondly, whether exposure to mutual domestic violence influenced the adaptation of young women; and finally to assess whether the quality of relations with parents is a mediating variable in the relationship between exposure to mutual domestic violence and the symptomatology developed by young women.

We tested the following operational hypotheses:

- Young women exposed to IPV during their childhood exhibit higher levels of aggression and more severe symptoms of anxiety and/or depression than young women who had no such exposure;
- Young women exposed to IPV have significantly more negative perceptions of their current relationship with their parents than women who never witnessed domestic violence;
- Young women exposed to SV exhibit more severe anxious and/or depressive symptoms and a higher level of aggression than those exposed to minor violence (MV);
- Current perceptions of parent-child relations are significantly more negative among young women exposed to SV than among those with MV exposure;
- The perceived quality of current child-parent relations has a mediating effect on the link between exposure to IPV and young women's adjustment.

2 METHOD

2.1 Participants

The present study was conducted at Aix-Marseille University (France) in 2016. Our sample comprised 793 female students aged 18-25 years, who were in their first to fifth year of higher education, mainly in human and social sciences.

This sample was divided into two groups:

- A first group of 623 young women who had been exposed to IPV during their childhood ($M_{\text{age}} = 22.4$ years, $SD = 3.27$). This experimental group was further divided into two subgroups according to the participants' scores on the CTS2-CA scale described below: SV (289 students) and MV (334 students);
- A second group of 170 nonexposed young women ($M_{\text{age}} = 22.7$, $SD = 6.04$).

Participants anonymously completed an online battery posted on social media.

2.2 Tests used

The *Adult-Recall Version of the Revised Conflict Tactics Scale* (CTS2-CA; Straus, 1999) is a 62-item scale designed to assess young adults' perceptions of the severity and frequency of interparental violence during their childhood. For each item, participants indicate the frequency on an 8-point Likert-like scale, choosing one of the following responses: *This never happened, it did happen but not during my childhood, Once, Twice, 3-5 times, 6-10 times, 11-20 times, More than 20 times*. The items are divided into four subscales (negotiation, psychological aggression, physical assault, and injury), but we only retained those pertaining to psychological aggression and physical assault perpetrated by both partners. For the purpose of the present study, we adapted items taken from the French version of the CTS2 (Lussier, 1998), which has been scientifically validated. The original CTS has a broad applicability, as the same items can be used to probe all possible family-role relationships, including husband-wife and parent-child (Straus, 1999). We therefore simply needed to change the subject, replacing "My partner" in the original version with "My father/My mother".

The *Hospital Anxiety and Depression Scale* (HADS) was devised by Zigmond et al. (1983) and refined by Lépine (1985). Its 14 items (each scored out of 3) assess the current level of anxious and depressive symptomatology, yielding two specific scores. An optimum cut-off point of 13 has been defined for adjustment disorders, and 19 for major depressive episodes. Razavi, Delvaux, Farvacques, and Robaye (1990) suggested summing the scores on the anxiety and depression subscales to obtain an overall score of emotional distress. This scale has sound psychometric qualities (Hermann, 1997).

We then measured aggression with Bouchard (2007)'s French translation of the *Aggression Questionnaire* (Buss & Perry, 1992). This questionnaire comprises 29 items,

which are rated on a 5-point Likert-like scale ranging from *Extremely uncharacteristic* to *Extremely characteristic*. Adopting a multidimensional approach to aggression, the questionnaire comprises four subscales, probing two motor aspects (physical or verbal aggression), an affective aspect (anger) and a cognitive aspect (hostility) (Buss & Perry, 1988; cited by Bouchard, 2007). The total score reflects the respondent's overall predisposition to aggression. The French version has sound psychometric qualities (Bouchard, 2007).

The French translation (QERPE; Delforge, Le Scanff, & Fontayne, 2007) of the *Egna Minnen Beträffande Uppfostran* (EMBU; Perris, Jacobsson, Linndström, Knorrning, & Perris, 1980) is designed to assess the quality of current parent-child relations. This questionnaire comprises 21 items that measure the emotional support, rejection, or overprotection young adults feel they receive from each of their parents. Respondents rate each item on a 4-point Likert-like scale (*Never, Sometimes, Often, Always*), giving separate responses for their mother and father. This tool had satisfactory psychometric qualities (Delforge, Le Scanff, & Fontayne, 2007).

2.3 Statistical analyses

Data were subjected to statistical analysis with SPSS 22 software. As distribution was normal for all the variables, we were able to use parametric tests.

We began by carrying out descriptive analyses (mean/*SD*, χ^2). To look for differences between the groups, we then carried out mean comparisons using Student's *t* test. Finally, we tested a stepwise hierarchical regression model including age and violence intensity for each modality of symptomatic expression. This allowed us to analyze how perceptions of parent-child relations influence the expression of anxious and depressive symptoms, as well as aggression, in young women who were exposed to IPV during childhood.

3 RESULTS

3.1 Sample description

The mean age of the sample ($N = 793$) was 20.4 years (± 1.44). The young women in the first group ($n = 623$) had a mean age of 20.5 years (± 1.85), and those in the second group ($n = 170$) had a mean age of 20 years (± 1.58). Young women with MV exposure ($n = 334$) had a mean age of 20.55 years (± 1.96), and those who had been exposed to severe acts of mutual violence ($n = 289$) were aged 20.47 years (± 1.79).

Insert Table 1 about here

Table 1 set out our sample's clinical data. Prevalence of depression was 18.2% for the group of young women exposed to violence during childhood (13.7% for MV and 23.5% for SV), and 12.3% for the group of young women no exposed. We also found that 33.5% of the students who had witnessed SV exhibited adjustment disorders, compared with 22.7% of those who had witnessed MV. Participants in the SV subgroup reported a higher level of physical assault, mainly perpetrated by the father.

3.2 Mean comparisons

Tables 2 and 3 set out the results of the mean comparisons (Student's t test) between the experimental and control groups, as well as between the MV and SV subgroups, on the QERPE, aggression, and HADS scores.

Insert Table 2 about here

Results (see Table 2) revealed that young women exposed to interparental violence during their childhood exhibited a higher level of anxious symptoms than those who had not been exposed (group 1: $M = 8.77 \pm 3.83$; group 2: $M = 7.74 \pm 3.65$; $p < .01$). They also showed that perceptions of paternal rejection (group 1: $M = 9.12 \pm 3.23$; group 2: $M = 8.47 \pm 2.64$; $p < .01$), maternal rejection (group 1: $M = 9.13 \pm 3$; group 2: $M = 8.16 \pm 2.02$; $p < .0001$) and maternal overprotection (group 1: $M = 14.17 \pm 4.12$; group 2: $M = 13.12 \pm 3.63$; $p < .0001$) were significantly higher in the first group. Participants with IPV exposure received significantly less paternal support than those with no exposure (group 1: $M = 17.06 \pm 6.72$; group 2: $M = 18.65 \pm 6.46$; $p < .01$).

Insert Table 3 about here

Regarding the subgroups, Table 3 shows that young women who witnessed SV, as opposed to MV, in childhood exhibited significantly higher levels of anxious symptoms (SV: $M = 9.56 \pm 3.74$; MV: $M = 8.08 \pm 3.79$; $p < .01$), depressive symptoms (SV: $M = 4.66 \pm 3.28$; MV: $M = 3.62 \pm 2.84$; $p < .01$), and aggression (SV: $M = 74.95 \pm 17.8$; MV: $M = 68.08 \pm 15.81$; $p < .01$). There were also significant differences in their perceptions of some parental behaviors. Young women who had been exposed to SV had stronger perceptions of paternal rejection (SV: $M = 10.33 \pm 3.87$; MV: $M = 8.33 \pm 2.28$; $p < .01$), maternal rejection (SV: $M = 9.85 \pm 3.5$; MV: $M = 8.48 \pm 2.3$; $p < .0001$), and maternal overprotection (SV: $M = 14.52 \pm 4.4$; MV: $M = 13.87 \pm 3.84$; $p < .01$). They also had significantly weaker perceptions of both paternal support (SV: $M = 15.39 \pm 6.58$; MV: $M = 18.51 \pm 6.5$; $p < .01$) and maternal support (SV: $M = 19.99 \pm 6.36$; MV: $M = 21.96 \pm 5.5$; $p < .01$).

3.3 Hierarchical regression

To analyze the impact of perceptions of parent-child relations on anxious and depressive symptomatology, as well as on aggression, within the context of exposure to IPV during childhood, we tested a stepwise hierarchical regression model including age and intensity of violence for each modality of symptomatic expression.

The results are set out in Tables 4 and 5.

Insert Table 4 about here

Insert Table 5 about here

3.3.1 Anxiety (see Tables 4 and 5)

The only variables retained in the model for the first group and the MV and SV subgroups were maternal and paternal rejection. Maternal rejection seemed more discriminating than paternal rejection, and had a significant positive effect on the level of anxiety ($p < .0001$). By contrast, paternal support and paternal overprotection were found to be the relevant variables for the second group. Paternal support was the most discriminating variable, having a negative impact on anxious symptomatology ($t = -5.05, p < .0001$).

3.3.2 Depression (see Tables 4 and 5)

Maternal support, paternal support and maternal rejection were the variables retained in the model across all the groups. In the first group and SV subgroup, maternal support was the most discriminating variable, with a significant negative influence on depressive symptomatology (group 1: $t = -2.84$; SV: $t = -3.1$; $p < .0001$). By contrast, maternal rejection was the most discriminating variable in the second group ($t = 4.57, p < .0001$). Among the

young women who had been exposed to MV, paternal support had a more negative impact on the level of depressive symptoms ($t = -3.63, p < .0001$).

3.3.3 Aggression (see Tables 4 and 5)

Maternal rejection was the most discriminating variable across all the groups ($p < .0001$). Age also had a significant negative influence on the level of aggression in the first group ($t = -2.31, p < .0001$), meaning that the young women became less aggressive over time. Moreover, violence intensity had a significant positive effect on aggression in the MV subgroup ($t = 3.03, p < .0001$). Lastly, in the second group, paternal support also had a significant negative impact on the level of aggression ($t = -2.68, p < .0001$), such that the greater the perceived support, the lesser the aggression.

4 DISCUSSION

Our data show that many young women have been exposed to mutual psychological and physical violence between parents as children. According to the study of adolescents in Bourassa (2003), we find that, in general, these young women with IPV exposure had more negative perceptions of parental behaviors than participants from nonviolent families. Contrary to our expectations, their levels of depressive symptomatology and aggression were no higher than those of participants with no IPV exposure. However, statistical analysis revealed that 18.2% of the young women who had witnessed mutual IPV during their childhood exhibited depression, compared with 12.3% of nonexposed participants. This figure rose to 23.5% for participants with SV exposure, contrasting with 13.7% for MV exposure. Our results are therefore in line with the findings of several studies of children's outcomes exposed to intimate terrorism (Jimenez et al., 1999; Johnson et al., 2002). Even so, only 33.5% of the young women with IPV exposure exhibited an adjustment disorder, meaning that 66.5% of them were well adjusted. These results are consistent with research

showing that between 33% and 69% of children aged 2-16 years who have experienced adversity are well adjusted, according to the accounts of both the children themselves and their mothers. They therefore raise the issue of resilience (Doucet & Fortin, 2014; Martinez-Torteya, Bogat, Von Eye, & Levendosky, 2009; Spilsbury, Kahana, Drotar, Creedon, Flannery, & Friedman, 2008). Setting aside a possible *sleeper effect* of exposure to domestic violence (Vu, Jouriles, McDonald, & Rosenfield, 2016), our results suggest that participants had sufficient resources to cope with their lived experience. As they were all enrolled at university, we can postulate that HE is a protective factor against the effects of domestic violence exposure.

Our results also supported the findings of Rosenberg and Rossman (1990), who showed that IPV severity constitutes a long-term risk factor, negatively impacting child development and the quality of parent-child relations. Those female students in our sample who had been exposed to severe mutual interparental violence exhibited significantly higher levels of anxious/depressive symptomatology and aggression than those who had been exposed to only minor violence. We also found that their relationships with their parents were significantly more negatively affected. In the light of the scientific literature, we can assume that these young women's early SV exposure brought with it more intense and complex experiences of anguish, fear, distress, insecurity, anger, guilt and conflicts of loyalty (Peled, 1997), making them more liable to exhibit anxious and depressive symptoms (Fortin, 2005, 2009; Fortin & Lachance, 2011; Ridez, 2013) and/or aggression. The context of violence in which they grew up generated a relationship model that was based on acting out rather than verbalizing, and made violent behaviors seem more commonplace. These young women were therefore more likely to internalize aggressive and even violent behaviors as appropriate means of resolving conflicts (Temple, Shorey, Tortolero, Wolfe, & Stuart, 2014).

Over the long term, repeated experiences such as these may also lead young women to perceive their affective relations with their two parents more negatively, especially if the mutual violence they witnessed was both frequent and severe. At the same time, many studies (Holden & Ritchie, 1991; Levendosky, Huth-Bocks, Shapiro, & Semel, 2003 ; Fortin, 2009 ; De la Sablonnière & Fortin, 2010) have shown that domestic violence can have a detrimental impact on parents' behaviors, mainly owing to the mental and physical health problems they develop as result of undergoing violent acts. In the case of severe IPV, parents may thus be colder and less accessible, leading their children to perceive their relations with their parents more negatively, and to continue doing so into adulthood (Bourassa, 2003).

As well as highlighting the direct consequences of mutual domestic violence exposure, our results also lend weight to the family dysfunction hypothesis (Jaffe, Wolfe, & Wilson, 1990, cited by Racicot, Fortin, & Dagenais, 2010, and Doucet, 2012) by showing that the link between mutual domestic violence exposure and young women's adjustment can be influenced by the quality of parent-child relations. A feeling of maternal rejection seemed to be a key factor for the presence of internalizing and externalizing problems among young women who had witnessed IPV as children. This is consistent with two studies (Fergusson & Horwood, 1998; Taft, Schumm, Marshall, Panuzio, & Holtzworth-Munroe, 2008) that found that domestic violence exposure in childhood can give rise to symptoms of posttraumatic stress syndrome in young adulthood, especially when this exposure was coupled with parental rejection. Experiencing a poor relationship with one's parents, especially the mother figure, in addition to living in a climate of violence, can create or fuel feelings of insecurity and/or rejection, generating anxiety, depression and even aggression. Our study thus highlights that the quality of the relationship with parents is a determining factor for the mental health of young women exposed to mutual violence between parents during their

childhood. The support of parents in the management of their conflicts and the consolidation of parent-child relationships are unavoidable areas of work for professionals.

Several methodological limitations, concerning our choice of assessment tools and the way we recruited our sample, hinder the generalization of our results. First, the questionnaire we used to measure domestic violence exposure failed to take account of the context in which the violence was perpetrated, and did not allow us to assess its chronicity. Our study did not distinguish between coercive controlling violence and situational couple violence. Second, because we have not defined the period of childhood, we do not know at which age group (s) the subjects witnessed mutual violence between their parents and whether is for them an old, recent, or recurrent situation.

Finally, responses to the questions probing perceived parent-child relations may have been biased, as some questions were probably not adequately tailored to young women who had left the family home (e.g. “My parents set firm boundaries to what I can or cannot do, and still rigorously uphold them”, “When I get home, my parents want to know everything I’ve been doing”, or “My parents want to decide how I dress or how I look”). Moreover, our study focused on a youthful population made up entirely of female students, thus restricting the scope of our conclusions. Further analyses with an unselected population are therefore needed to confirm and consolidate our results. Our assessment nevertheless sheds light on the long-term consequences of early exposure to mutual interparental violence and the impact of the quality of current parent-child relations on young women’s adjustment.

5 CONCLUSION

Our results pave the way for further research, particularly in the field of emotions. For example, several studies have found that emotion regulation disorders, such as alexithymia, are often closely intertwined with the depressive and/or anxious symptomatology (Ciarrochi,

Scott, Deane, & Heaven, 2003; Honkalampi, Hintikka, Tanskanen, Lehtonen, & Viinamäki, 2000; Mikolajczak, Quoidbach, Kotsou, & Nelis, 2009) we observed in our female students with IPV exposure. Furthermore, Zarling et al. (2013) demonstrated that emotional dysregulation has a mediating effect on the link between domestic violence and children's internalizing and externalizing disorders. Repeated exposure to negative, sometimes even traumatic, events is thought to trigger emotion regulation disorders such as alexithymia (Jouanne, 2006), which prevents individuals from identifying their emotions and giving verbal expression to them. Difficulty verbalizing emotions as a consequence of early traumatic experiences may help to perpetuate and even reinforce an individual's engagement in aggressive behaviors (Thorberg, Young, Sullivan, & Lyvers, 2009).

Domestic violence is a complex issue. As the elements of understanding are multiple, it is necessary to reconsider them in reading each country concerned and new scientific data. Whatever the expression of the violence is harmful not only to the parents themselves, but also to any children who witness it. While in France, the public authority now attaches greater importance to violence against women, our data reveal, however, the need to recognize that conjugal violence can also be situational and mutual within couples, and that, like intimate terrorism, it has a negative impact on the quality of parent-child relationships children and the future development of the child. It seems important to us that the various actors, of the justice and the health, can be trained to identify the different dynamics of domestic violence in order to prevent the violence by proposing a care adapted according to the context. The psychosocial worker position differs with respect to the need to encourage a link between the father who is abusing his partner and his or her child (Drouin et al, 2014). This difference in position stems from a non-consensual understanding of domestic violence dynamics. For a better identification of children exposed to violence and appropriate care, it is necessary that a common base of information on the different dynamics of violence within

couples be provided to the stakeholders of schools, justice, health, and child protection. We also emphasize the importance of developing prevention programs in schools with several general objectives: promoting egalitarian and respectful relationships between girls and boys, raising awareness of the different forms of violence and helping young people to develop their social and communication skills. These programs should also be aimed at young people likely to be exposed to domestic violence because, because of the silence surrounding this violence, they are most often alone and deprived. It therefore seems essential that these programs teach young people concrete strategies to stay safe in the event of exposure to violence.

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Table 1. Description of population and clinical data.

Group	Anxiety/depressive symptomatology (HAD)		Psychological violence		Physical violence	
	score \geq 19** (n%)	score \geq 13** (n%)	father	mother	father	mother
(1) Domestic violence exposure	18.2%*	27.7%*	81%*	81.2%*	43.1%*	36.9%*
(2) No exposed	12.3%*	25.5%*	-	-	-	-
Minor Violence	13.7%*	22.7%*	76.1%*	75.7%*	35.2%*	25.9%*
Severe Violence	23.5%*	33.5%*	85.3%*	85.9%*	50%*	46.4%*

*Chi², significant for $p < .01$. HAD **Threshold score major depressive episode = 19; Threshold score adjustment disorders = 13.

Table 2. The means comparison between the domestic violence exposure group (1) and group no exposed (2) on HAD, QUERPE scale and aggressiveness questionnaire.

<i>DIMENSIONS</i>	<i>GROUP 1 (N=623)</i> <i>MEAN ; (SD)</i>	<i>GROUP 2 (N=170)</i> <i>MEAN ; (SD)</i>	<i>P</i>
Anxiety symptomatology	8.77 ; (3.83)	7.74 ; (3.65)	.01*
Depressive symptomatology	4.10 ; (3.09)	3.71 ; (2.75)	Ns
Aggressiveness	71.27 ; (17.1)	69 ; (18.4)	Ns
Hostility	19.49 ; (6.51)	18.77 ; (7.08)	Ns
Anger	18.52 ; (6.04)	17.74 ; (5.92)	Ns
Physical aggression	15.39 ; (4.11)	14.93 ; (4.39)	Ns
Verbal aggression	17.85 ; (6.45)	17.55 ; (6.75)	Ns
Paternal support	17.06 ; (6.72)	18.65 ; (6.46)	.01*
Paternal rejection	9.12 ; (3.23)	8.47 ; (2.64)	.01*
Paternal overprotection	11 ; (3.56)	11.33 ; (3.32)	Ns
Maternal support	21.05 ; (6.11)	21.74 ; (5.25)	Ns
Maternal rejection	9.13 ; (3)	8.16 ; (2.02)	.0001**
MATERNAL OVERPROTECTION	14.17 ; (4.12)	13.12 ; (3.63)	.0001**

*significant for $p < .01$; **significant for $p < .0001$; ns : not significant.

Table 3. The means comparison between the group of minor violence exposure and the group of severe violence exposure on HAD, QUERPE scale and aggressiveness questionnaire..

<i>DIMENSIONS</i>	<i>MINOR VIOLENCE EXPOSURE (N=334) MEAN ; (SD)</i>	<i>SEVERE VIOLENCE EXPOSURE (N=334) MEAN ; (SD)</i>	<i>P</i>
Anxiety symptomatology	8.08 ; (3.79)	9.56 ; (3.74)	.01*
Depressive symptomatology	3.62 ; (2.84)	4.66 ; (3.28)	.01*
Aggressiveness	68.08 ; (15.81)	74.95 ; (17.8)	.01*
Hostility	18.41 ; (6.11)	20.74 ; (6.73)	.0001**
Anger	17.55 ; (5.68)	19.63 ; (6.26)	.01*
Physical aggression	17.21 ; (6.06)	18.6 ; (6.81)	.01*
Verbal aggression	14.90 ; (4.04)	15.96 ; (4.13)	.01*
Paternal support	18.51 ; (6.5)	15.39 ; (6.58)	.01*
Paternal rejection	8.33 ; (2.28)	10.03 ; (3.87)	.01*
Paternal overprotection	10.96 ; (3.39)	11.04 ; (3.74)	Ns
Maternal support	21.96 ; (5.5)	19.99 ; (6.39)	.01*
Maternal rejection	8.48 ; (2.3)	9.85 ; (3.5)	.0001**
MATERNAL OVERPROTECTION	13.87 ; (3.84)	14.52 ; (4.4)	.01*

*significant for $p < .01$; **significant for $p < .0001$; ns : not significant.

Table 4. Impact of perception of parent-child relationships on anxiety / depressive symptomatology and aggressiveness, in the group of domestic violence exposure and in the group no exposed (Hierarchical Regression Model).

Group	Model	DV: Anxiety			DV : depression			DV : Aggressiveness		
		<i>B</i>	<i>t</i>	<i>p</i>	β	<i>t</i>	<i>p</i>	β	<i>t</i>	<i>p</i>
Domestic violence exposure	Maternal support	-	-	ns	-.069	-2.84	.0001*	-	-	ns
	Maternal rejection	.399	7.99	.0001*	.184	4.039	.0001*	1.47	6.5	.0001*
	Paternal support	-	-	ns	-.034	-2.82	.0001*	-	-	ns
	Paternal rejection	.159	3.42	.0001*	-	-	ns	.612	2.9	.0001*
	Age	-	-	ns	-	-	ns	-.810	-2.31	.0001*
		R2=.138; p<.0001*			R2=.105; p<.0001*			R2=.103; p<.0001*		
No exposed	Maternal support	-	-	ns	-	-	ns	-	-	ns
	Maternal rejection	.462	3.66	.0001*	.444	4.57	.0001*	-	-	ns
	Paternal support	-.209	-5.05	.0001*	-.098	-3.23	.0001*	-.453	-2.11	.0001*
	Paternal rejection	-	-	ns	-	-	ns	2.08	3.07	.0001*
	Paternal overprotection	.174	2.21	.01**	-	-	ns	.896	2.11	.01**
		R2=.215; p<.0001*			R2=.181 ; p<.0001*			R2=.104 ; p<.0001*		

*significant for p<.0001; **significant for p<.01; ns: no significant

Table 5. Impact of perception of parent-child relationships on anxiety / depressive symptomatology and aggressiveness, in the minor violence group and in the severe violence group (Hierarchical Regression Model).

Group	Model	DV: Anxiety			DV : depression			DV : Aggressiveness		
		<i>B</i>	<i>t</i>	<i>p</i>	β	<i>t</i>	<i>p</i>	β	<i>t</i>	<i>p</i>
Minor violence exposure	Maternal support	-	-	ns	-	-	ns	-	-	ns
	Maternal rejection	.437	5.01	.0001*	.152	2.25	.0001*	2.17	6.12	.0001*
	Paternal support	-	-	ns	-.087	-3.63	.0001*	-	-	ns
	Paternal rejection	-	-	ns	-	-	ns	.-		ns
	Violence intensity	-	-	ns	-	-	ns	.037	3.03	.0001*
		R2=.07; p<.0001*			R2=.061; p<.0001*			R2=.135; p<.0001*		
Severe violence exposure	Maternal support	-	-	ns	-.150	-5.16	.0001*	-	-	ns
	Maternal rejection	.363	6.98	.0001*	.180	3.01	.0001*	1.06	3.62	.0001*
	Paternal support	-.	-	ns	-	-	ns	-	-	ns
	Paternal rejection	.167	3.14	.0001*	-	-	ns	-	-	ns
		R2=.168; p<.0001*			R2=.107 ; p<.0001*			R2=.04 ; p<.0001*		

*significant for p<.0001; **significant for p<.01; ns: no significant