5 Domestic violence: bullying in the home

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In this chapter we consider domestic violence, including physical and psychological abuse, harm, bodily injury, assault and the infliction of fear between family or household members in the home. We suggest that almost all domestic violence constitutes bullying since it involves the 'systematic abuse of power' (Smith and Sharp, 1994, p. 2), which relies on the aggressor's and target's unequal access to power (Farrington, 1993). First, we consider the prevalence of abuse that occurs between adults in intimate relationships; the abuse of children and adolescents by adults; and abuse that occurs between child and adolescent siblings. This is followed by the correlates and impact of each of these types of abuse. We acknowledge that children and adolescents abuse their parents and carers and that this should not be minimised, but because studies of these topics are very sparse we do not consider them here. We then consider theoretical accounts of domestic violence where we feel that they cast light on the phenomenon. Finally, we conclude with implications, as we see them, for policy and professional practice, and with suggestions for further research in the field.

Nature and prevalence of domestic violence

Abuse between adults

The term domestic violence is often used to refer to men as perpetrators of violence in heterosexual relationships. A large proportion of domestic violence between adults consists of intimate partner violence (IPV). The World Health Organization (WHO, 1997) defined IPV in terms of what male intimate partners do to adult and adolescent women. More recently, the WHO (2002) acknowledged that women can also be violent towards their male partners and there is no reason why the term cannot be applied to IPV in gay and lesbian relationships.

While acknowledging that female-on-male IPV exists, the number of women reporting abuse by men is far greater than the converse

(e.g. Coker *et al*. (2002) reported a prevalence of 29 per cent). Empirical findings on the prevalence of IPV in heterosexual and homosexual relationships have been found to be similar, at 25–35 per cent (Gunther and Jennings, 1999). Other prevalence studies, however, suggest that IPV by men on women is higher, at 33–54 per cent (Abbott *et al*., 1995; Ernst *et al*., 1997), and the number of women reporting physical injury arising from IPV is greater than it is for men (Phelan *et al*., 2005).

IPV probably exists in all countries, cultures and societies, but estimating the prevalence across cultures is difficult as a result of inconsistencies in definition, under-reporting and a lack of epidemiological studies (Bradley *et al*., 2002). Nonetheless, data suggest that around one in three women worldwide experience IPV at some point in their lives (WHO, 1997). Cross-sectional population surveying is often considered to be the most accurate method for determining the prevalence of IPV. For instance, a review of 48 population-based surveys from around the world revealed that between 10 and 50 per cent of women report experiencing IPV at some point in their lives, with 10–30 per cent experiencing sexual violence by an intimate partner (WHO, 2002).

Reviews suggest that prevalence rates vary both between countries and between studies. This variance may be due to inconsistencies in how IPV is defined, and cultural contexts may play a role here. In order to confront these issues and to assess the extent of the problem, the WHO sponsored a multi-country study on women's health to determine the prevalence of physical and sexual IPV (Heise *et al*., 1999). The study spanned 10 countries and used standardised population-based household surveys. The findings showed a reported lifetime prevalence of physical and sexual violence that ranged from 15–71 per cent for women aged 15–49 years (n = 2,097). Specifically, the proportion of women who had ever experienced physical violence ranged from 13 per cent in Japan to 61 per cent in Peru, with a very similar pattern for sexual violence (6 per cent in Japan; 59 per cent in Peru) (Garcia-Moreno *et al*., 2006).

Children's exposure to IPV between adults

Children's vicarious witnessing of violence (Domestic Violence Exposure – DVE) between adults in the home, most commonly spouses or partners, represents a second, important dimension of domestic bullying. The methodological problems involved in assessing the proportion of children exposed to DVE are well summarised by Osofsky (2003). Nevertheless, the papers that Osofsky reviews indicate prevalence levels of between 16 and 25 per cent in non-clinical populations. Fusco and Fantuzzo conclude that about 40 per cent of

investigated domestic violence incidents in the USA, according to their definition, involve children. The subtypes of DVE discovered included: direct sensory exposure (75 per cent), physical involvement of the child (37 per cent), participation of the child in the precipitating event (35 per cent) and occasions when the child called for help (28 per cent).

Abuse of children and adolescents by adults

When researchers define adult-on-child domestic violence they typically seek to differentiate abuse from harm, that is, ill-treatment from its effects (Fakunmoju, 2009). One recent definition of child abuse refers to 'acts of commission or omission which directly or indirectly result in harm to the child and prevent a normal development into healthy adulthood' (Mok, 2008, p. 979). US investigations of reported abuse among 889,000 children suggest that about 40 in 1,000 children experience some form of abuse by adults while living with parents or guardians (Donohue, 2004; Wells, 2008). In order of prevalence, based on UK statistics for children and young people involved with child protection services (Department for Children, Schools and Families (DCSF), 2008), such abuse is typically divided into: neglect, emotional abuse, physical abuse, mixed abuse and sexual abuse.

Neglect or emotional maltreatment is experienced by 16 per cent of children known to child protection services in the USA (Wells, 2008), and about 44 per cent of their English counterparts (DCSF, 2008). Emotional abuse comprises persistent acts 'which are considered potentially psychologically damaging, by conveying to children that they are worthless, flawed, unloved, unwanted, endangered, or of value only in meeting another's needs' (Jones, 2000, Section 9.3.1). This category includes allowing a child to experience the maltreatment of another person (Mok, 2008). During the years 2004–08, about 23 per cent of children subject to child protection measures in the UK had experienced emotional abuse (DCSF, 2008).

Child physical abuse (CPA) consists of non-accidental events including: battering, shaking (DiScala *et al*., 2000), close confinement such as tying or binding of arms or legs, locking in a cupboard and refusal to allow needed treatment for a professionally diagnosed medical problem (Wells, 2008). Government sources estimate the prevalence of CPA at 5.7 per 1,000 children in the USA and about 0.8 per 1,000 children in England (Department of Health, 2000; Sedlak and Broadhurst, 1996). In contrast, a larger proportion (7 per cent) of respondents to a population-based retrospective survey of 18–33-year-olds in the UK reported having experienced serious physical abuse while growing up

(Brooker *et al.*, 2001). A school-based survey study in China placed prevalence levels of severe and very severe physical punishment at 15.1 per cent and 2.8 per cent, respectively (Leung *et al.*, 2008).

Adult-on-child sexual abuse (CSA) is defined by the presence of two elements: (1) contact and non-contact (e.g. exhibitionism) sexual activities, and (2) the abusive condition (Jones, 2000, Section 9.3.1). The second criterion is founded on the premise that sexual interaction between minors and adults always involves coercion, because of the power differential between the parties involved (Jones, 2000). Approximately 8 per cent of the cases involving child protection in England for 2004–08 involved CSA (DCSF, 2008). In contrast, Gorey and Leslie's (1997) integrative review combined data from 16 studies of non-clinical, North American samples and found levels of 14.5 per cent for female and 7.2 per cent for male children. Since some studies reported on girls only, an overall prevalence level across genders was not given. As a result of methodological differences, these results are considerably lower than the 27 per cent for females and 14 per cent for males cited in a contentious meta-analysis by Rind and colleagues (1998).

Abuse between child and adolescent siblings

'Sibling' refers to brothers and sisters who are genetically related (full- and half-siblings), or not genetically related (step-siblings), but who share the same home for most of the time. This last criterion is particularly important as it provides familiarity and makes opportunities for abuse available. Bullying and violence between siblings may be emotional (e.g. persistent verbal attacks), as well as physical or sexual. Wiehe (1997, p. 33) says that emotional abuse:

> … refers to rejection; to coercive, punitive, and erratic discipline; to scapegoating, ridiculing, and denigration; to unrealistic behavioural expectations … or the use of excessive threats in an attempt to control a [person].

Physical abuse includes hitting, punching, pulling, pushing, shoving or throwing things at the other (Goodwin and Roscoe, 1990). Sexual abuse includes acts of physical contact and those involving intended or unintended non-contact (such as indecent exposure and exposure to pornography). Sibling incest involves specific intentional sexual contact, including inappropriate fondling, oral sex, digital penetration and attempted or completed sexual intercourse. It may be true that incest can occur consensually, where partners provide nurture and safety to one another in abusive and painful family conditions (Canavan *et al.*, 1992). Such incest would be non-abusive if the partners had equal access

to resources of power. Typically, however, the picture regarding the issue of consensual sexual abuse and incest is mixed. In Hardy's (2001) community sample, only 3 of the 14 undergraduates reporting this behaviour said that it was non-consensual. However for clinical samples the picture is different, since most perpetrators deny using threats to maintain secrecy while most of their targets report having been threatened or bribed to remain silent (e.g. Adler and Schutz, 1995; Laviola, 1992). As Christensen (1990) notes, it seems that most sibling incest involves coercion and repeated abuse.

The little we know about the prevalence of physical, verbal and emotional abuse in community samples comes from a US study (Hardy, 2001). Perhaps surprisingly, almost half of the 203 undergraduate participants reported that they had been physically abused during childhood by an older sibling, with 11 per cent saying that this happened on a daily basis. Compared with the number of studies of bullying amongst schoolchildren and adults in the workplace, studies of sibling bullying are few in number. In fact, only Duncan's (1999) US-based study of sibling (and peer) bullying amongst roughly equal numbers of male and female adolescents (n = 336 with at least one sibling) gives any indication as to its prevalence in the general population. Of these participants, about a third reported having been frequently bullied by siblings, with slightly more boys than girls affirming such abuse. About two-fifths of equal proportions of boys and girls also reported that they bullied their siblings.

Hardy (2001) also found that 14 women and 1 man said that they had been incestuously abused as children. Clinical and forensic samples, however, give some indication of the prevalence of different types of sexual abuse. Almost 90 per cent of abusers in two studies (Pierce and Pierce, 1987) attempted or completed some form of intercourse (vaginal, anal or oral penetration). In stark contrast, this was only true for one fifth of Gilbert's 14 cases (1992). It is probable that at least some of the disparity in these findings is explained by differences in the operational definitions of types of abuse and sampling methods used by these investigators.

Correlates and impact of domestic violence

Domestic violence between adults

Domestic violence often has extensive physical and psychological consequences for its victims, some of which are life-threatening. Physical effects include injuries ranging from cuts and bruises, skin punctures and bites, to more severe injuries leading to chronic conditions such as loss

of hearing, sexually transmitted diseases (STDs), miscarriage, gynaecological problems, chronic pelvic pain and irritable bowel syndrome (Campbell, 2002; Casique and Furegato, 2006). Effects on mental health include fear, depression, low self-esteem, anxiety disorders, headaches, obsessive-compulsive disorder, post-traumatic stress disorder (PTSD), sexual dysfunction and eating problems (Romito *et al*., 2005). Women experiencing physical and sexual violence report higher rates of poor health, decreased ability to walk, vaginal discharge, pain, loss of memory and dizziness (Ellsberg *et al*., 2008; Vung *et al*., 2009). For many women the only avenue of escape may seem to be suicide (Krug *et al*., 2002). Male victims of female IPV report being kicked, bitten, punched or choked (Archer, 2002; Mechem *et al*., 1999) and stabbed and burned (Vasquez and Falcone, 1997). Commonly reported effects of IPV in same-sex relationships include anxiety, depression, low self-esteem, disassociation, sleep disorders, shame, guilt, self-mutilation, suicidal ideation and attempts, drug and alcohol abuse, eating disorders and PTSD (Sloan and Edmond, 1996). In addition to the direct impact of IPV on adults, several studies indicate that witnessing this violence can have profound negative effects on children.

Exposure of children and adolescents to IPV

Some of the correlates of domestic violence exposure are similar to those of physical abuse (Fusco and Fantuzzo, 2009; Hiilamo, 2009). Age correlates with domestic violence exposure in that most of those exposed (52 per cent) in Fusco and Fantuzzo's (2009) community-based study were less than six years old (mean age of 4.8 years). Although the prevalence by family ethnicity ranged from 45 per cent among African-Americans to 4 per cent among Asians, ethnicity had no impact on the likelihood of domestic violence exposure when other factors such as poverty were controlled for (Fusco and Fantuzzo, 2009). The same study also found that children were more likely to be exposed to violence if the perpetrator and target were both parents of the child concerned. IPV exposure was also more common in single-parent households in which the carer had a lower educational level (Fantuzzo *et al*., 1997). A recent French study found that chronic parental illness, housing problems and unemployment correlated with exposure (Roustit *et al*., 2009). In contrast to physical abuse, no correlation was found in Fantuzzo and colleagues' studies between parental substance abuse and domestic violence exposure among children, though Roustit's group did find such an association.

Studies have indicated the increased likelihood of internalising (e.g. depression, anxiety) and externalising (conduct problems such as

bullying) symptoms for children who witness domestic violence and bullying. Evans *et al*. (2008) showed a small to medium mean effect size for DVE on internalising problems and noted a similar effect size for externalising. Further analysis suggested that boys who witness violence at home are significantly more likely to develop challenging behaviour than girls in similar situations, while gender differences for internalising symptoms were *not* noted. In contrast, narrative reviews have concluded that girls seem to be more at risk for internalising problems (Buka *et al*., 2001). These difficulties include a likelihood of post-traumatic reactions such as hyper-vigilance, flashbacks and diminished concentration in school, which may, in turn, lead to depression, substance abuse, suicidal ideation, anxiety, eating disorders (Wonderlich *et al*., 1997), weight problems and poor performance in school. Externalising outcomes may include aggression (Kolko, 1998).

The experience of witnessing abuse between adults also perpetuates the cycle of violence in other ways. For example, Roustit *et al*. (2009) found that participants who had witnessed inter-parental violence as children were significantly more likely to become involved in intimate partner violence or to perpetrate child abuse across the lifespan. In addition, studies have indicated a link between exposure to domestic violence and a propensity to become involved in aggressive interactions with peers (Anooshian, 2005).

Furthermore, DVE as a child is associated with adult difficulties in parent–child relationships, parental separation and divorce, imprisonment, depression, alcoholism (Roustit *et al*., 2009) and other mental health problems, including suicide attempts (UNICEF, 2000). These effects appear to be exaggerated when compensatory, supportive adult–child relationships are lacking; the child's parents suffer from mental health problems; children experience the violence more directly; children are more closely related to the adults involved; or violence is more overt or longstanding (Osofsky, 2003; Roustit *et al*., 2009). Roustit and colleagues also suggest that girls who witness IPV are more likely to go on to become depressed as adults, while boys are more likely to become physically abusive or dependent on alcohol.

Abuse of children and adolescents by adults in the home

The volume and diversity of literature on the subject means that, for the sake of integration, this section follows from left to right the developmental and ecological model of Jones (2000), which is reproduced here as Figure 5.1.

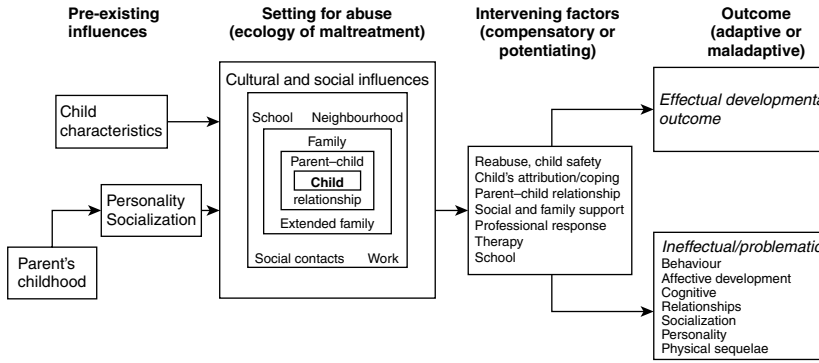

Figure 5.1 A developmental and ecological perspective on child maltreatment (Jones, 2000, p. 1825). By permission of Oxford University Press.

Parental precursors of neglect and physical abuse may include genetic susceptibility and childhood experiences, including prior abuse, leading to weak self-efficacy, depression and other mental health difficulties, high stress levels, anger-control problems, substance abuse, smoking and social isolation, including employment difficulties and also involvement in criminality (Anooshian, 2005; Donohue, 2004; Mok, 2008; Paz *et al.*, 2005; Stith *et al.*, 2009; Vostanis, 2004). Child predictive factors include the child's age (girls may be at more risk of sexual abuse between 8 and 14 years and boys between 8 and 12-years; Dhaliwal *et al.*, 1996). Children with conditions such as conduct disorder and learning difficulties/intellectual disabilities appear to be particularly at risk for all forms of abuse, while those with cerebral palsy appear to be at risk for physical maltreatment and neglect only (Govindshenoy and Spencer, 2007).

Within Jones' (2000) 'ecology of maltreatment' itself, the filial relationships of parents who neglect their children and also abuse substances tend to be characterised by unwanted pregnancies, inapt developmental expectations, problem-solving deficits in child care, uncontrolled expressions of anger, erratic discipline, lack of maternal warmth and responsiveness and, consequently, poor parent–child attachments (Donohue, 2004; Wilson *et al.*, 1996). The ecology of physical abuse includes, like that of neglect, inconsistent discipline, prior child abuse by the mother's partner, poor relationships between the mother and her own parents, overly punitive punishment, low levels of supervision and a dearth of warmth in parental–child interactions, leading to weak attachments (Anooshian, 2005; Wilson *et al.*, 1996).

Moving to family context beyond the immediate parent–child relationship, it is critical to note that, of all the forms of maltreatment, neglect is most strongly associated with parental substance abuse (Donohue, 2004). More specifically, the drugs used most frequently by mothers identified as neglectful are, in order: cocaine (67 per cent), mixed drugs (24 per cent), alcohol and illegal drugs (14 per cent), opiates (10 per cent) and heroin (9 per cent) (Kienberger Jaudes *et al.*, 1995). Hines *et al.* (2004) argue, however, that the link between substance abuse and child maltreatment is best explained by reference to common contextual factors such as deprivation, parental psychiatric difficulties, IPV and parental imprisonment. Second, it is also noteworthy that physical abuse overlaps with IPV in 45–70 per cent of families where it is found (Holt *et al.*, 2008). Child physical abuse also co-occurs with general high levels of family conflict (Stith *et al.*, 2009). Holt and colleagues' review found less consistent findings for the overlap of IPV and child sexual abuse, with estimates ranging from 4 to 77 per cent of families, depending on definition and study design. Children in larger families may also be more at risk of maltreatment than others, as may those of unmarried parents (Paz *et al.*, 2005). In general, individual factors clearly interact with the context to increase the risks of abuse for children from ethnic minorities.

Furthermore, in cases where the family is homeless, a reciprocal relationship between social isolation and aggression within and outside the family is more likely to arise (Anooshian, 2005). Nevertheless, as Anooshian points out, it can be difficult to discriminate between effects of the family environment and neighbourhood effects in deprived areas (Paz *et al.*, 2005), particularly those in which violence is frequent and normalised (Buka *et al.*, 2001). The mother's attendance at or lack of access to antenatal classes is also associated with the abuse of young children (Wilson *et al.*, 1996).

The recurrence of abuse, which, in general, may occur in between 3.5 to 22.2 per cent of cases within six months, clearly plays a role in moderating the impact of maltreatment (Hindley *et al.*, 2006). DePanfilis and Zuravin's review (1998) found that a majority of studies indicated that neglect was more likely to recur than other forms of abuse, while the first month or two following an initial child protection report may be a particularly risky period for recurrence of all forms of abuse, with the hazard rate declining over time. Contrary to widespread opinion, in more than half of US families where abuse recurs, this happens only once.

A child's attributions about the abuse may also moderate its impact (Vostanis, 2004). Dhaliwal *et al.* (1996) and Rind *et al.* (1998) found

that men tended to view childhood sexual abuse in a less negative light than women, and this difference appeared to reduce the impact for men. Rind *et al*. (1998) also found that, when males perceived partial consent with CSA, this factor was also positively correlated with better adjustment in young adulthood. It should be noted here that Rind and colleagues' findings have been challenged by later researchers and by policy makers. For both genders, the use of force in CSA is particularly associated with adverse outcomes (Rind *et al*., 1998). Dhaliwal *et al*. (1996) concluded that boys are more likely to use avoidance coping strategies (including aggression), whereas girls are more likely to employ emotion-focused coping (such as focusing on the feelings experienced). Adult internal working models and social information processing are also believed to mediate the effects of maltreatment (Paz *et al*., 2005). Lastly, parent–child relationships appear to play a critical role in mediating the impact of physical abuse on children (Anooshian, 2005).

Geeraert *et al*.'s (2004) meta-analysis of early selective interventions to protect at-risk children during the prenatal period to age three years from physical abuse and neglect found a small to moderate effect size, which was nonetheless significant and positive. Their results did not suggest that one intervention approach was more powerful than another, but the common elements in many of the programmes studied included the use of home visits, pre- or neonatal onset of the programme, services to support the parent, work on parent–child interaction and psychoeducational sessions concerning child development while, at the same time, enhancing social networks. Nevertheless, these elements may be more effective in combination than, for example, home visiting alone (Mok, 2008). For those children whose families do not respond to such intervention, foster care and adoption may seem the most plausible option, though Glaser (2000) cautions that desirable outcomes are more likely for younger children than for those who are older. In addition, preliminary data suggest that children who are placed with members of the extended family in 'kinship care' tend to achieve better outcomes than those placed with non-relatives (Winokaur *et al*., 2009). As a result of institutional racism, disadvantaged ethnic groups such as African-Americans in the USA and aboriginal children in Canada may be more likely to enter and remain in the child-protection system (Hines *et al*., 2004). Hines and colleagues also argue that policy changes may hinder ethnic minority parents from reuniting with their children to a disproportionate extent. For older children, universal school-based educational programmes may help to improve children's capacity to avoid sexual abuse through practising 'protective behaviours' (Zwi *et al*., 2007). For those children who have already been abused, cognitive behavioural

therapy (CBT) may help to ameliorate the consequences, although studies to date on the effectiveness of CBT have failed to achieve statistical significance (Macdonald *et al*., 2006).

In terms of immediate impact, the injuries that children sustain during physical abuse, compared to accidents, are more likely to include damage to the thorax or abdomen, including rib fractures (71 per cent chance of abuse), or to numerous areas of the body (DiScala *et al*., 2000). Abused children were also more likely to experience severe injuries, including brain damage, than those with accidental wounds to the head (Discala *et al*., 2000). Changes in brain structure may also occur as a result of acute or chronic stress responses (Glaser, 2000). Physical abuse victims are therefore more likely to be admitted to an intensive care unit than accident patients, resulting in more extended hospital stays and an increased likelihood of multiple long-term impairments necessitating follow-up care, such as rehabilitative therapy. Children who have been sexually abused are clearly at risk of contracting STDs, though many common STDs may also be acquired through means other than sexual contact (Hammerschlag, 1998).

Abuse survivors in general are less likely to achieve necessary levels of academic achievement at school-leaving age than their peers, although these effects may be explained by factors within the child's developmental context rather than the abuse itself (Boden *et al*., 2007). Children who have been neglected face significant difficulties in developing appropriately into adulthood (Hildyard and Wolfe, 2002). In comparison with those who have been physically abused, neglected children are more likely to display cognitive, language (Donohue, 2004; Paz *et al*., 2005) and achievement difficulties, interpersonal isolation, poor acceptance by peers and internalising (rather than externalising) problems. Donohue (2004), however, argues that neglected children are particularly at risk of conduct problems. This discrepancy may be explained through different genotypes responding to the same stressor in different ways (Paz *et al*., 2005), though such a hypothesis has been questioned (in relation to one gene at least) by recent work (Risch *et al*., 2009). Furthermore, following changes in the brain, in the longer term, children who have been physically abused are prone to developing internalising and externalising psychological symptoms (Anooshian, 2005). In most studies, sexual abuse has been seen as a 'special destroyer of mental health' (Seligman, 1994, p. 232), with children who have been sexually abused appearing prone to emotional instability, eating disorders, depression and suicidality but not, surprisingly, addiction, at least as far as males are concerned (Dhaliwal *et al*., 1996; Wonderlich *et al*., 1997). Such findings were questioned by Rind *et al*. (1998), who

stated that the deleterious effects of CSA had been exaggerated through over-reliance on clinical samples. The evidence linking CSA to sexual offending appears to be robust, but a connection between physical abuse as a child and adult sexual offending is not borne out by the literature (Jespersen *et al*., 2009).

Domestic violence between child and adolescent siblings

Some studies suggest that during early and middle childhood, first-born children are more likely to be physically aggressive than their younger siblings (Felson and Rosso, 1988; Howe *et al*., 2002), supporting the idea that bullying is associated with an imbalance of power. Howe *et al*. also found that, by comparison with boys, girls are more submissive in arriving at the resolution of physical aggression. This may suggest a power imbalance in favour of boys. In a rare longitudinal study in this field, Updegraff *et al*. (2002) studied 179 pairs of 13-year-old (second-born) and 15-year-old (first-born) adolescent siblings' 'domineering control' of peers and siblings. Findings showed that irrespective of gender, first-borns were more controlling of their siblings than they were of their best friend and that over the three years of the study there was a decline in the amount of control exhibited.

Most studies report that older brothers are perpetrators of sexual abuse and younger sisters are their targets (e. g. Adler and Schutz, 1995; Laviola, 1992). However, some studies report brother–brother incest (e.g. Becker *et al*., 1986; Gilbert, 1992) and some sister–sister incest (e.g. Pierce and Pierce, 1987; Smith and Israel, 1987). There is also some evidence suggesting that step-siblings are particularly at risk of sibling sexual abuse and incest (Gilbert, 1992; Pierce and Pierce, 1987).

Although none of the reviewed studies provides any causal evidence for physical, verbal and emotional abuse between siblings, a number of correlates are suggested. For example, many sibling physical abusers have been physically abused or neglected by their parents or carers (Rosenthal and Doherty, 1984). Other studies suggest a link between discord in adults in families and inter-sibling aggression (e.g. Bush and Ehrenberg, 2003). In contrast, Hardy (2001) could find no link between inter-sibling physical abuse and other types of domestic violence. Rosenthal and Doherty found that levels of physical health and emotional well-being tended to be lower in sibling abusers when compared to non-abusers. Furthermore, significant differences were found between abusive and non-abusive groups on parent-report measures assessing sadness, unhappiness, helplessness and the degree of medical illness experienced by the child.

There is also a lack of causal evidence for sibling sexual abuse and incest, although the literature does suggest correlates that indicate some causal factors. For example, Pierce and Pierce (1987) found that 63 per cent of perpetrators had experienced long-term parental physical and verbal abuse. However, this was true for only around one- fifth of the perpetrators studied by Kaplan *et al.* (1988) and by Becker *et al.* (1986). Smith and Israel (1987) and Worling (1995) have found that most adolescent sibling sexual abusers have been sexually exploited by adults, most often within the context of the family. Kaplan *et al.* (1988), however, found that only 15 per cent of their sexual abusers reported having been sexually abused. Nevertheless, we conclude that the likelihood of sibling sexual abusers having been incestuously abused themselves is high.

Other correlates of sibling sexual abuse and incest have been found. These include marital discord between parents (e.g. Canavan *et al.*, 1992; Hardy, 2001); sexual dysfunction of mothers (Kaplan *et al.*, 1990); other contemporaneous incestuous relationships of fathers and grandfathers; and children witnessing their parents or other adults engaging in sexual activity (Pierce and Pierce, 1987). On the other hand, repressive parental attitudes to sex have also been found to be linked to sibling sexual abuse and incest (Smith and Israel, 1987), and other studies (e.g. Adler and Schutz, 1995; Kaplan *et al.*, 1988) have found that parents typically either deny that sibling sexual abuse has occurred or downplay its importance.

Most of the evidence concerning the short- and long-term impact of sibling maltreatment stems from studies of sexual abuse. Laviola's (1992) study of 17 women incestuously abused in childhood found that long-term effects included mistrust of men and women, sexual response problems and intrusive thoughts concerning the incest. Similarly, Canavan *et al.* (1992) reported that four women sexually abused by their older brothers in childhood all had low self-esteem.

Theoretical accounts of IPV and bullying

Over the years many theories have been proposed to account for domestic violence between adults and to distinguish abusive or violent personalities from those of non-violent and non-abusive people. Broadly, these theories can be classed as biological, psychological, psycho-social and/or ecological.

The biological perspective on IPV studies the roles of genetic factors (Saudino and Hines, 2007), brain injury, brain infections and illnesses and structural or functional changes in the brain secondary to trauma

in the development of violent and aggressive behaviour (Cunningham *et al*., 1998) and neurotransmitters such as testosterone and serotonin (Soler *et al*., 2000; Young and Leyton, 2002). However, very little evidence is presented to support the relationship of these factors with domestic violence and further research is needed to establish the links between biological factors.

The psychological perspective explores the role in IPV of various psychological and psychiatric problems. Some evidence suggests that perpetrators of IPV are more likely to suffer from a history of disturbed attachment needs in childhood (Stith *et al*., 2004), aggressiveness (Baron *et al*., 2007), substance and alcohol abuse (Stith *et al*., 2004; Thompson and Kingree, 2006), lower self-esteem (Papadakaki *et al*., 2009) and a lack of assertiveness, communication and problem-solving skills (Toro-Alfonso and Rodríguez-Madera, 2004; Schumacher *et al*., 2001). A major difficulty is that accounting for violent and aggressive behaviour in terms of psychological or psychiatric issues may in some way be seen as excusing or justifying the abuser's behaviour, and may not help the victim to any real extent. It is also important to note here that none of the factors has been identified as the sole cause, as the findings of the studies are typically inconsistent.

The psycho-social perspective examines factors such as societal norms and broadly held attitudes towards violence (Erchak and Rosenfield, 1994). Various theories offered under this perspective include social learning theory (Bandura, 1977), resource theory (Blood and Wolfe, 1960), exchange theory (Homans, 1974), conflict theory (Quinney 1970) and stress theory (Jasinski, 2001). In general, these theories suggest that men's violence towards women arises from the behavioural models they were presented with when they were children, that is, fathers being violent towards mothers and mothers seemingly putting up with the abuse. This suggests that families play an important role in not only exposing children to violent behaviour, but also in inculcating in them an acceptance and approval of the use of such behaviour.

Blood and Wolfe (1960) proposed that, in marital or intimate relationships, the person who has more resources in terms of income, occupational status and education may have more power in the relationship. This so-called resource theory maintains that the root cause of IPV is not men's lack of absolute resources but lack of resources relative to their wives. There is some empirical confirmation of this theory. For example, employed women with unemployed husbands are more likely to be abused than when the converse is true (Macmillan and Gartner, 1999), and women who earn higher incomes than their husbands are at greater risk of experiencing IPV than where the converse

is true (e.g. Melzer, 2002). A major problem with these psychosocial theories is the variation in the definition of terms such as what constitutes witnessing violence as a child. Moreover, resource theory contradicts those theories which suggest that the further empowerment of women through, for example, education and improving their employment opportunities, is key to tackling IPV against women.

Another perspective, based on the feminist paradigm, concerns the issues of power and control. Scholars believed that abusers use violence as a means of controlling their partner (e.g. Bograd, 1988). This idea led to the development of 'the power and control wheel' in 1980–81 as the outcome of a US Domestic Abuse Intervention Project (DAIP). This model attempts to explain the tactics used by an abuser to keep the victim in a submissive position and to maintain his or her power and control. Further, this model maintains that the responsibility for abusive control rests with the abuser and not the abused. Believers in structural patriarchal ideology tend to view IPV against women as acceptable, necessary, beneficial and justified by blaming women for what men perceive as their punishable behaviour (e.g. Haj-Yahia and Schiff, 2007; WHO, 2005). Structural patriarchy is characterised by cultural and personal values and beliefs that seek to justify male dominance. However, Dutton (1994) rejects the idea that there are causal relationships between structural patriarchy and IPV and concludes that IPV is more common in lesbian than in heterosexual relationships.

Walker (1979) developed the cycle of violence model with the aim of elucidating how and why women remain in abusive relationships. The cycle of violence is often predictable and consists of three phases: tension building; abuse or explosion; and honeymoon or forgiveness. In the first phase tension builds up between the couple and the abuser becomes frustrated, which he takes out on his female partner by acting violently. Violence may be exhibited in a variety of forms that may last from seconds to days. Following the violent attack the abuser feels relieved and calm and may express remorse to his partner. The couple then enjoys a honeymoon period in which the abused person thinks the abuser will change and will never become violent again. In some cases, the intensity of violence decreases and may stop for some time until the cycle is repeated (Walker, 2006). Constant exposure to the cycle typically results in the abused feeling helpless and fearful (Walker, 2006), blaming herself for the abuse and trying to avoid situations that may precipitate violence. This theory has also been applied to explain IPV in same-sex intimate relationships (Chesley *et al.*, 1998; McClennen *et al.*, 2002).

Finally, the ecological perspective is one of the most widely used frameworks. This perspective attempts to offer a comprehensive view of

IPV by looking at how personal, situational and socio-cultural factors interact (Heise, 1998). This model suggests that behaviour is shaped through interaction between individuals and their social surroundings (Dasgupta, 2001). The framework uses four domains of analysis: the individual; the interpersonal, the group or community; and the societal. The individual domain covers the biological and personal factors which influence individual behaviour such as age, gender, education, income, psychological difficulties and substance abuse. The interpersonal domain includes what happens in the family, between intimate partners and close friends and in the workplace. This domain attempts to explain the role of these relationships in contributing to the risk of perpetuating or accepting violence. The group domain investigates the role of the community in which the person lives and it considers factors such as the role of friends, school-mates and work colleagues that may increase a person's vulnerability to commiting or sustaining violent acts. Finally, the societal domain considers the broader structures and systems in which the person lives, such as parental roles and responsibilities, societal norms and the social and health structures affecting people's lives. Altogether, the model suggests that, in order to reduce IPV, factors in each domain of analysis need to be considered and dealt with simultaneously.

Implications for policy and professional practice

Domestic violence and children/adolescents

Fusco and Fantuzzo (2009) conclude that it would be judicious for policy makers to develop a surveillance system that would serve both to identify children exposed to domestic violence and also to connect protective agencies, including the police and social services. In bringing to light the high levels of child involvement in domestic violence, both as victims and by exposure, these authors envisage an extended role for police officers as 'public health sentinels' (Fusco and Fantuzzo, 2009, p. 255). Within this role, when attending to an incident of domestic violence, police would gather data on the demographic characteristics of the abused partner, the type of incident and whether any children live in the home, and enter these details into a database shared with child protection agencies. For such agencies themselves, the evidence reviewed here suggests the need to develop an ecological harm model that determines the type and extent of injury and trauma experienced and that considers the circumstances in which any incident(s) took place, as well as the events themselves (Fakunmoju, 2009). Moreover, in drawing links

between the studies described here, practitioners should bear in mind that IPV is indicated as a risk factor for child abuse (Hiilamo, 2009).

For psychotherapists and counsellors who work with recovering victims of physical abuse or domestic violence exposure, the notion of the therapeutic value of recovered memory (Ladd, 1991) is questioned by some analogue studies which have shown that intentional forgetting plays a lesser role in post-traumatic responses than previously believed (Cloitre, 1998). Approaches to therapy for physically abusive parents and carers include behavioural models, which emphasise reinforcement and social learning (Kolko, 1998); systemic models, which examine and seek to alter child, parent and family variables that maintain cycles of violent interaction; and parent–child interaction therapy (Eisenstadt *et al*., 1993), which incorporates both behavioural and systemic perspectives. For children who have been exposed to domestic violence, the models with the best indications appear to be group counselling (Kolko, 1998), which incorporates psycho-education about the nature and causes of domestic violence together with cognitive behavioural elements such as social skills development and training in relaxation and causal attribution. However, such technical approaches to therapy should also take into account that domestic violence represents a disturbance of lived experience (Langdridge, 2007), including the dimension of time. It is therefore important to elicit appreciative attitudes toward the present (Ladd, 1991), while working from current achievements and planning goals and projects that allow for transcendence of the abusive situation (van Deurzen, 2002). The impact of such interventions and of placements for fostered and adopted children who have experienced domestic violence should be assessed from the child's perspective.

Proposals for further research

There are a number of methodology and method issues that future research into domestic violence might attempt to address. Most studies so far conducted have relied on self-reports in the absence of any attempt at independent verification of the victims' claims. We recognise, however, that there may well be ethical limitations to obtaining such verification data. Further, wherever possible, data from a number of measures (e.g. self-report questionnaires and semi-structured interviews) should be triangulated to give more complete and robust profiles of targets, perpetrators and their families. We suggest that future studies should also strive to operationalise concepts of abuse and violence more stringently. Specifically, in some existing studies the measures used do not relate closely enough to at least one of the concepts of abuse

as we have defined them here. We also suggest that, in order to unravel the causal mechanisms of domestic violence, there is need for greater use of longitudinal research. A lack of case-control and experimental designs to establish the efficacy and effectiveness of interventions also characterises the research reviewed here.

Much of the research on domestic violence is highly context specific and we feel that we need to know the extent to which existing findings generalise to other contexts. With the exception of studies of IPV, most of the research so far conducted has used small clinical samples from which it is difficult to generalise and so, for example, we know little about the prevalence of the many types of abuse in the general population. General population or community prevalence studies are urgently needed to inform policy makers and practitioners about the scale of problems. Further, we suspect that cross-cultural studies on the prevalence of sibling abuse would be illuminative regarding the qualitatively differential impacts on domestic violence of, for example, political and religious ideology; cultural values, beliefs, attitudes, social representations and discursive practices; education; and socioeconomic wealth.

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