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THE ASSOCIATIONS BETWEEN PATERNAL DEPRESSIVE SYMPTOMS AND CHILDREN'S BEHAVIOR OUTCOMES VIA INTIMATE PARTNER VIOLENCE AND PATERNAL REJECTION IN KENYAN FAMILIES

Dickson Mukara Matsantsa Ong'ayi

Abstract

High rates of depressive symptoms and intimate partner violence in Kenya place children at risk for behavioral difficulties well beyond the preschool years. This study examined (a) whether paternal depressive symptoms, psychological and physical intimate partner violence, and rejection were associated with children's internalizing and externalizing behaviors above maternal risk factors, and (b) whether psychological and physical intimate partner violence and paternal/maternal rejection mediated the associations between depressive symptoms and children's internalizing and externalizing behaviors differently for mothers and fathers. Propositions within the developmental psychopathology framework and interpersonal acceptance-rejection theory guided the formulation of the research questions and hypotheses. A sample of 193 mothers and fathers with preschool-aged children from Kakamega County, Kenya participated in the study. Results of an additive model indicated that paternal depressive symptoms were associated with children's internalizing and externalizing behavior problems above and beyond maternal risk factors. Paternal depressive symptoms were not associated with children's internalizing and externalizing behaviors through psychological and physical intimate partner violence and paternal rejection. These findings may be of use in the development of progressive parenting policies and intervention programs that promote family welfare and childhood development in the low- and middle-income countries of sub-Saharan Africa.

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Table of Contents

List of Tables

List of Figures

Chapter 1: Introduction

Over the past two decades, children's safety and wellbeing have attracted increased attention and interest from several non-governmental organizations (e.g., World Health Organization, Prumondo), diverse childcare stakeholders, and researchers across the globe. This may be attributed, in part, to the fact that many children in low-income countries are exposed to a myriad of adverse conditions (e.g., intimate partner/spouse violence, parental depressive symptoms, poverty, child abuse, and punitive child discipline practices) within families and neighborhoods that have the potential of thwarting their optimal development (see Solberg et al., 2020; World Health Organization, 2012). The ongoing COVID-19 pandemic has exacerbated some of these challenges. Studies conducted in western, educated, industrialized, rich, democratic (WEIRD) countries have established the negative impact of adverse childhood experiences (ACEs) on children's socioemotional development (see Levendosky et al., 2002; McKinnon et al., 2013).

Using cross-sectional data from the National Survey of Children's Health, Cprek et al. (2020) investigated the impact of various dimensions of ACEs (e.g., socioeconomic hardship, parental divorce, exposure to domestic violence and or neighborhood violence, and parental mental health problems) on children's developmental progress. Both young and older children who were exposed to these adverse conditions were at a greater risk of having behavioral problems and poor social skills, after controlling for poverty, parental education, and ethnicity/race. Other researchers (e.g., Treat et al., 2020; Trotman, 2021) have also found associations between ACEs (witnessing domestic violence, psychological and physical abuse, parental depressive symptoms, and household dysfunction) and high levels of social maladjustment difficulties as well as emotional problems in children. Utilizing a diverse sample

of 2,004 families in the United States, McKelvey et al. (2017) demonstrated that exposure to poor parental mental health and witnessing domestic violence were positively associated with children's poor emotional regulation, mental health difficulties, and aggressive behaviors.

Despite the tremendous progress in research on the impact of ACEs on childhood outcomes across the globe, there is a dearth of studies in this area of inquiry in the low- and middle-income countries (LMICS) of sub-Saharan Africa. In general, data from certain low- and middle-income countries have shown associations between ACEs and children's social functioning that are similar to those found in high-income countries. As a case in point, Escueta et al. (2014) examined the associations between ACEs (exposure to traumatic experience, economic hardship, and parental depressive symptoms) and psychosocial development in children 6 - 12 years of age from five low-income countries (Kenya, Cambodia, Tanzania, Southeast Asia, Ethiopia, and India). ACEs were linked to behavioral difficulties in children. Along the same line of inquiry, Nazareth et al. (2021) assessed associations between intimate partner violence (IPV), economic hardship, and caregiver depressive symptoms as indicators of ACEs and childhood outcomes in a sample of (N=1,032) 4 - 6-year-old children in South Africa. Exposure to elevated levels of intimate partner violence and caregiver's depressive symptoms were significantly associated with elevated levels of behavioral difficulties in children after controlling for children's age, family socioeconomic status, and household chaos.

Several studies have focused on specific dimensions of adverse childhood experiences and childhood outcomes (see Fletcher et al., 2011; Huang et al., 2017; Ramchandani et al., 2005). For instance, preschool-aged children who were exposed to intimate partner violence (IPV) tended to display low levels of social functioning (Levendosky et al., 2002) and internalizing and externalizing behavior problems (Jouriles et al., 2014). Children exposed to

IPV and parental depressive symptoms were more likely to experience low parental warmth which was characterized by punitive parenting practices and strategies (Holmes, 2013). At the same time, children are at a higher risk of sustaining physical injuries and psychological problems in home environments in which they witness different forms of intimate partner violence (see Ravi & Casolaro, 2018).

Research has also indicated that parental depressive symptoms, which might be either a cause or outcome of IPV, have implications for parent-child relationships (Kane & Garber, 2009) and social and behavioral outcomes in children (McKinnon et al., 2013). Data from sub-Saharan African countries indicate that parental depressive symptoms have severe negative effects on children's socio-emotional development, social adjustment, and social behaviors (see Hadley et al., 2008; Huang et al., 2017). Besides its influence on childhood outcomes, paternal depressive symptoms have the ability to alter parenting practices. Parents with no or less depressive symptoms are more likely to use positive parenting approaches compared to parents with high/more depressive symptoms who are more likely to be less warm and display more rejecting behaviors towards their children (see Fletcher et al., 2011; Kane & Garber, 2009; Ramchandani et al., 2005). It is suggested that the use of positive parenting approaches such as being warm and showing acceptance, setting child-friendly rules, hugging, and using reasoning when addressing children’s behavioral transgressions promote favorable developmental outcomes such as better academic and social competence in children (see Ashiono & Mwoma, 2013; Khaleque & Rohner, 2012). By contrast, the use of negative and punitive parenting practices such as rejection and harsh discipline contribute to poor social skills in children (Ashiono & Mwoma, 2013; Dede Yildirim et al., 2020; Gershoff et al., 2018; Gershoff & Grogan-Taylor, 2016).

The mediating roles of intimate partner violence and negative parenting practices on the links between paternal depressive symptoms and different dimensions of young children's development have been explored in low-, middle-, and high-income countries. Among families in Ghana, harsh parenting mediated the pathways of associations between paternal depressive symptoms and children's internalizing and externalizing behaviors (Huang et al., 2017). In another study, it was found that paternal depressive symptoms were associated with high interparental conflict which, in turn, increased parental use of harsh parenting practices resulting in high internalizing and externalizing behaviors in children (Leinonen et al., 2003)

Despite the steady increase in research on fathers in a global context (see Roopnarine & Yildirim, 2019; Volling et al., 2019), much of the work on ACEs and childhood development has focused on mothers. Information on the associations between specific paternal risk factors (e.g., depressive symptoms, intimate partner violence, and paternal rejection) and childhood behavioral outcomes is limited in the low-income countries of sub-Saharan Africa. Likewise, data on the role of intimate partner violence and parental rejection in mediating the links between poor parental mental health and behavioral outcomes in children are relatively absent. That said, this study focused on paternal risk factors and childhood outcomes by examining: (a) whether paternal depressive symptoms, paternal rejection, and physical and psychological IPV were associated with preschool-aged children’s internalizing and externalizing behaviors, above and beyond the influence of maternal depressive symptoms, maternal rejection, and physical and psychological IPV in Kenya, and (b) whether the pathways of associations between paternal depressive symptoms and children’s internalizing and externalizing behaviors through physical and psychological IPV, and paternal rejection were different from the pathways between

maternal depressive symptoms through physical and psychological IPV, and maternal rejection in Kenya.

This study is situated within propositions outlined by interpersonal acceptance-rejection theory (Rohner & Khaleque, 2005) and the developmental psychopathology framework (Rutter & Sroufe, 2000). Propositions within these conceptual frameworks guided the formulation of the research questions and hypothesis and aided in the selection of measures. Interpersonal acceptance-rejection theory (Rohner & Khaleque, 2005) stresses links between sensitively attuned caregiving and the development of early cognitive and social skills in children. The developmental psychopathology framework emphasizes the importance of considering multi-level risk factors that influence parental interpersonal and intrapersonal relationships and parenting practices and childhood outcomes (see Rutter & Sroufe, 2000). The latter focuses on risk factors within and external to the family that influence interparental relationships, parenting, and childhood development (see Masten, 2011, 2001).

Given the high levels of intimate partner violence and that mental health difficulties are serious concerns in sub-Saharan African countries such as Kenya, where economic stress is high, and access to health care is challenging (see Goodman et al., 2020; Jeong et al., 2020), data from this study has several implications. Foremost, they can assist in filling the gap in our current understanding of associations between paternal risk factors and behavioral outcomes in preschool-aged children in sub-Saharan Africa. Additionally, they may be of use in the formulation of policies and intervention programs aimed at promoting parenting practices and child and family welfare that assist in advancing the positive development of children across low- and middle-income countries of Africa.

Chapter 2: Literature Review

The Direct and Indirect Links Between Paternal Risk Factors and Childhood Outcomes via Mediating Factors

Parental risk factors such as intimate partner violence, paternal depressive symptoms, low paternal warmth, and paternal rejection are independently or jointly associated with children's social adjustment and early academic performance (Roopnarine & Yildirim, 2018; Shelton & Harold, 2008). This chapter provides an overview of some of the contemporary literature on the links between paternal depressive symptoms, IPV, paternal rejection, and internalizing and externalizing behaviors in children across cultural communities. Although much of the research in these areas is from high-income countries, every attempt is made to integrate the small number of studies from low- and middle-income countries of Africa into this review. Before proceeding, it is first necessary to provide some basic information on the cultural context of this study.

Cultural Practices and Childrearing in Kenya

Kenya is a post-colonial, East African country of about 47.6 million people (The State of Kenya Population, 2020). It is bordered by Ethiopia in the north, Uganda in the west, and Tanzania in the south. The country comprises up to seventy ethnic groups that include Kikuyu, Kalenjin, Luhya, Luo, Turkana, and Kisii, among others. Kenya's Human Development Index value is estimated to be 0.590, which ranks 147 globally (United Nations Development Programme, 2018). This marks a 26.1% growth from 1990 (UNDP, 2018). There was also a 28.9% increase in Gross National Income per capita between 1990 and 2017. Despite this progress, Kenya has a 79% national literacy rate (CDIP 2013-2017). The low literacy rate is largely linked to poverty and lack of access to adequate educational resources across families as most citizens survive on US $ 1.25 per day (UNICEF, 2012).

Kenya is traditionally a collectivist society, with extended families and the clan as the center of the community (see Putnick et al., 2012; Oburu, 2011). However, families also reflect both nuclear and polygamous living arrangements. Most ethnic communities in Kenya firmly adhere to the societal and cultural norms that stipulate men as superior, dominant, authoritative, and as heads of the household. Women are expected to be submissive and to take on traditional feminine and subordinate roles within the family and community (see Kimuna & Djamba, 2008; Ochieng, 2019). Along with other females, mothers are the primary caregivers to children. Fathers are tasked with the responsibility of economic provision and protection of family members. According to Ochieng (2019), children are considered an essential part of the family as childlessness attracts ridicule and shame, especially for men. Families without children are deemed incomplete. Given the overall strong kinship ties and collectivist structure of Kenyan society, childcare is still considered a communal responsibility (see Mwoma, 2015). Various household members, such as grandparents, siblings, relatives, and close family friends, assist in childcare activities, especially in rural areas.

As much as there is a collective approach to childcare, fathers' direct engagement with young children is generally limited in some ethnic groups. This may be attributed to cultural beliefs that prohibit fathers from being physically involved in the care of children (Harkness & Super, 1992) and to the expectation that they assume economic responsibility for family members, which keeps them working for longer hours outside of the homestead (Lasser et al., 2011). Among the Kipsigis ethnic community in Kenya, fathers are not permitted to be in close proximity to or care for the newborn during the first month of life (Harkness & Super, 1992). Fathers are also not supposed to engage in childcare activities such as feeding and dressing children, even though they are expected to meet the basic needs and provide resources (i.e., food,

safety, and clothing) to children and other family members. This notwithstanding, Kenyan fathers are actively involved in other tasks such as the naming of the child, initiation (circumcision), socialization, and disciplining the child (Watson, 2000).

In most Kenyan ethnic communities, parental socialization of children is centered around warm and harsh parenting and the child's gender (see Putnick et al., 2012; Oburu, 2011). Fathers are more open and involved in cultural socialization with their sons than daughters who are mostly socialized by mothers and other female caregivers (see Mwoma, 2015). For example, in the Luhya ethnic group, fathers socialize with their sons on how to engage in farming (planting and harvesting crops) and building a small house. Luo fathers socialize their sons to fish mainly along Lake Victoria. This gender preference pattern also extends to disciplining children as most Kenyan fathers are perceived to be firmer and harsher toward their sons than daughters, while mothers are firmer and harsher toward their daughters than sons (see Putnick et al., 2012). Fathers believe that it is their responsibility to socialize their sons by instilling in them skills, values, and attitudes that match societal expectations. With this brief discussion on maternal and paternal roles and cultural practices, in the next few sections, the focus turns to links between selected risk factors and childhood outcomes.

Direct Links between Paternal Risk Factors and Childhood Outcomes

Theoretical models on risk and resilience and related studies have identified various intrapersonal and interpersonal factors such as intimate partner violence, parental depressive symptoms, and punitive parenting that can impede family relationships and childrearing and negatively influence children's development across diverse cultures. Studies in high-, middle- and low-income countries alike indicate that prolonged exposure or being a victim of domestic violence, parental depressive symptoms, and harsh parenting practices negatively affect the

cognitive and social functioning of school-age children, including adolescents (Mhlauli, 2020; Miller-Graff et al., 2016). Furthermore, it is suggested that preschool-aged children are more affected by these adverse conditions than older children due to developmental limitations in emotional coping strategies and cognitive abilities to interpret harsh events (see Gartland et al., 2014). These limitations increase the risk of problem behaviors and low performance on cognitive skills in young children (see Gustafsson et al., 2014; Howell et al., 2016), though all children exposed to IPV will most likely experience these outcomes as well. In this section of the chapter, I provide an overview of studies on the pathways of associations between IPV, parental depressive symptoms, harsh parenting practices, and behavioral and cognitive outcomes among children in diverse cultural contexts.

Prevalence rates in Depressive Symptoms. The prevalence rate of depressive symptoms across the globe before the emergence of COVID-19 was 4.4% (WHO, 2017). Meta-analysis and systematic reviews have indicated that there was a drastic increase in depressive symptoms during the initial stages of the COVID-19 pandemic (Bello et al., 2022; C´enat et al., 2021; Salari et al., 2020; Wang et al., 2020). In these reviews, the prevalence of depressive symptoms ranged between 28% and 33.4%. For example, in one meta-analysis that included sixty-eight studies with a total sample of 288,830 participants conducted during the COVID-19 pandemic, Wang et al., (2020) found that 30% of the participants experienced mild to severe depressive symptoms. This estimate was lower than that found (33.7%) in a review of 14 studies (N=44,531) (Salari et al., 2020). In the United States, the prevalence of depressive symptoms before the COVID-19 pandemic (2017-2018) was 8.7%. This rate almost doubled during the pandemic to between 10.6% and 14.4% in March and April 2020 (Daly et al., 2021). In middle-

income countries such as Brazil, depressive symptoms in the general population increased from 3.9% before to 29.1% during the COVID-19 pandemic (Feter et al., 2021).

The rates of depressive symptoms in sub-Saharan Africa increased from 10% before (C´enat et al., 2021) to an average of 48% during the COVID-19 pandemic (Bello et al., 2022). In a meta-analysis of seventy-eight studies (Bello et al., 2022), the average rate of depressive symptoms was 67% in Egypt, 31% in Kenya, and 31% in Nigeria. In an assessment of 845 caregivers with young children in Kenya during the COVID-19 pandemic, 34% of the caregivers experienced mild to moderate depressive symptoms (Angwenyi et al., 2021). In sub-Saharan African countries, depressive symptoms in men are increasing due to persistent economic hardship, unemployment, adverse early childhood experiences, relationship conflicts, and alcohol abuse (see Hatcher et al., 2019; McKinnon et al., 2013). In a sample of 532 men aged 18-34 years from 11 townships in Meru county in Kenya, a stunning 42% reported experiencing depressive symptoms as a result of stressful events during the childhood period, family dysfunction, and high levels of poverty (see Goodman et al., 2020). Yet, research on men's mental health and parenting, and childhood development in Kenya remains sparse (see Rieder, 2019).

Paternal Depressive Symptoms and Children's Behavior Problems. As with mothers, paternal depressive symptoms are significant risk factors that negatively affect family functioning and children's wellbeing. In families where fathers or male caregivers are experiencing depressive symptoms, there is a greater likelihood of having poor parent-child relationships, and behavior problems and poor academic outcomes in children (see Fletcher et al., 2011; Kane & Garber, 2009). Studies across the globe have established that paternal depressive symptoms can be a result of intimate partner violence and vice versa. The interaction

between these two factors can be more catastrophic for children's development, especially if there is a good deal of conflict in the partner/spousal relationship during violent episodes (see Keller et al., 2005; Roopnarine & Yildirim, 2018).

In a middle-income sample of 235 European American and African American fathers and mothers and their preschool-aged children from Rochester, New York, it was reported that elevated levels of fathers' depressive symptoms were associated with an increase in destructive marital conflict behaviors. In turn, the interaction between these factors was associated with higher levels of internalizing behavior problems in children (Keller et al., 2005). Du Rocher Schudlich and Cummings (2003) examined the links between paternal and maternal depressive symptoms and children's internalizing behaviors in a community sample of 267 families with children aged 8 to10 years from middle- to upper-middle socioeconomic backgrounds in Indiana, United States. Mothers' and fathers' dysphoric symptoms were directly linked to children's internalizing behavior problems.

Longitudinal studies have also shown that exposure to IPV, paternal depressive symptoms, and negative interparental conflict behaviors during the early childhood years can have a detrimental effect on children later in life (see Fisher et al., 2015; Kingston et al., 2018). Relying on data from the Avon Longitudinal Study of Parents and Children (ALSPC) in the United Kingdom, Gutierrez-Galve et al. (2015) examined associations between paternal and maternal depressive symptoms, interparental conflicts, and children's social behaviors in a sample of 13,822 families. Paternal depressive symptoms had direct associations with children's behavior problems at 42 and 82 months after controlling for sociodemographic factors, maternal depressive symptoms, and noninvolvement. In a parallel study that examined links between paternal and maternal postnatal depressive symptoms and childhood outcomes, a positive

association was noted between mothers' and fathers' depressive symptoms and children's behavior problems at 42 months (Hanington et al., 2012).

Similarly, Fisher et al. (2015) assessed the effects of the interaction between fathers' postpartum depressive symptoms at 4.5 months post-birth and interparental conflict on children's social behaviors at 45.5 months using a community sample of 199 European American fathers and mothers from upper-income families. Paternal postpartum depressive symptoms and interparental conflict interacted to predict children's behaviors at 45.5 months. Even though it was inconclusive as to whether interparental conflict played a key role in the association, these researchers maintained that more destructive interparental conflicts had some influence on children's internalizing and externalizing behavior problems due to strong associations with paternal and maternal depressive symptoms. In support of the preceding view, results showed that paternal and maternal depressive symptoms covaried with interparental conflict at some point during toddlerhood.

Ramchandani et al. (2005) highlighted the detrimental and long-lasting impact of paternal depressive symptoms on children's early behavioral and emotional adjustment in the United Kingdom. Paternal depressive symptoms were examined when children were eight-weeks and 21 months old. Children of fathers who experienced more depressive symptoms during the postnatal period had higher odds of displaying behavior problems at 42 months, after controlling for demographic factors and maternal depressive symptoms. Data from a longitudinal study of 1,159 Norwegian children also showed that paternal depressive symptoms assessed when children were 6, 12, 24, and 36 months were associated with higher externalizing behavior such as aggression in children at 48 months, but this association disappeared after controlling for sociodemographic

factors such as parents' level of education, family income, and paternity leave (see Narayanan & Nærde, 2016).

Another study examined the impact of diverse levels of maternal depressive symptoms on childhood outcomes later in life in a community sample of mothers and children in Canada. The Hamilton Depressive Rating Scale and the Edinburg Postnatal Depressive Scale were used to assess maternal depressive symptoms from the prenatal period to 3 years postnatally. Mothers were divided into three groups depending on the level of their depressive symptoms: decreasing depressive symptoms, low depressive symptoms, and increasing depressive symptoms. Children's behavioral problems were assessed at 3 and 6 years using the Child Behavior Checklist. The regression analysis showed that children of mothers with increasing depressive symptoms postnatally displayed higher internalizing and externalizing behavior problems at 3 years of age compared to children of mothers with low and decreasing depressive symptoms. Children of mothers with low and decreasing depressive symptoms did not differ in internalizing and externalizing behaviors at 3 and 6 years of age (Park et al., 2018).

A small group of studies conducted in sub-Saharan Africa also highlight the plight of children exposed to poor parental mental health. In a sample of 1,238 mothers and their children under 5 years of age from South Africa, Gordon et al. (2021) found an association between maternal depressive symptoms and children's behavioral difficulties. Children whose mothers experienced depressive symptoms within five years after their birth displayed more aggressive behaviors than children of mothers who never experienced depressive symptoms. In a sample of 1,087 mothers and their adolescent children from sub-Saharan Africa, paternal depressive symptoms were significantly associated with children's internalizing behaviors after controlling for child gender, family socioeconomic status, maternal employment, and education (Orri et al.,

2021). Laurenzi et al. (2021) also examined whether paternal and maternal mental health was linked to children's behavioral outcomes. The sample included 465 caregivers with their 4-5-year-old children enrolled in community-based preschool centers in Kenya. The Patient Health Questionnaire and the Strengths and Difficulties Questionnaire were used to assess caregivers' depressive symptoms and children's behavior problems, respectively. Of this sample, approximately 53 caregivers exhibited high depressive symptoms and anxiety. Children of caregivers who reported higher levels of depressive symptoms displayed more internalizing and externalizing behaviors than children of caregivers who expressed lower levels of depressive symptoms.

Longitudinal studies conducted in Africa provide additional evidence on the long-term effects of exposure to parental depressive symptoms on children's behaviors. For example, Ramchandani et al. (2010) investigated associations between maternal depressive symptoms and children's behavioral problems in a sample of 953 mothers and their children in Johannesburg, South Africa. While children of mothers who experienced depressive symptoms during the prenatal period did not display behavioral problems (e.g., attention seeking and dependency, mood swings, worries, fears, and sleeping problems) at 2 years, they did exhibit these behavioral difficulties at age 4, after controlling for sociodemographic factors. Assessing the effects of postnatal parental depressive symptoms and child outcomes during the early years of life in a community sample of 1,035 mothers and their 2-year-old children again in the Johannesburg area of South Africa, Avan et al. (2010) found that children of mothers who reported more depressive symptoms at 6 months postnatally displayed more behavior problems such as sleep disturbances, hyperactivity, lack of concentration, poor relationships, tempers and fears at 2 years than

children of non-depressed mothers, after controlling for socioeconomic status, maternal age, preterm delivery, and child gender.

Yet another study (Verkuijl et al., 2014) demonstrated links between parental postnatal depressive symptoms and children's psychological outcomes at 10 years in a sample of 1,866 mothers and their young children in South Africa. Approximately 24% of mothers experienced postnatal depressive symptoms. The South Africa Child Assessment Schedule (SACAS) was used to assess children's psychological functioning along five domains: internalizing behavior, externalizing behavior, social difficulties, thought problems, and attention difficulties. Children of mothers who experienced depressive symptoms at 6 months after giving birth, exhibited higher internalizing and externalizing behavior problems at age 10 compared to children of mothers who never experienced depressive symptoms 6 months postnatally.

Progress has been made in the examination of pathways of associations between maternal and paternal depressive symptoms and childhood outcomes in diverse cultural contexts. Together, these studies demonstrate the crucial role played by paternal and maternal mental health in determining behavioral outcomes in children, irrespective of their age. The studies considered herein employed different designs (e.g., longitudinal, and experimental), large sample sizes, different cultural and ethnic groups, and multiple informants. No doubt, this has increased the confidence placed on the findings and our understanding of the impact of a father's mental health on behavioral difficulties in children. What is not clear is whether mothers' and fathers' depressive symptoms contribute to children's internalizing and externalizing behaviors in unique ways. That is, we know little about how fathers' depressive symptoms influence behavioral difficulties in children above and beyond maternal depressive symptoms.

Prevalence rates in Intimate Partner Violence. The World Health Organization conceptualizes IPV as an act of sexually, psychologically, and emotionally abusing, economically depriving, stalking, and destroying the current or previous spouse's personal property (see WHO, 2020, 2012). Intimate partner violence has been identified as one of the leading causes of global mental health problems in formal and informal close, intimate relationships (Gonzalez et al., 2014; Jouriles et al., 2014). It is estimated that between 15% and 71% of women worldwide experience violent acts and abuse such as physical, psychological, and sexual that are mainly perpetrated by men (see WHO, 2021). In rich democratic countries, the rates of IPV range between 9% and 29% in the United States and between 2.9% and 27% in select European countries (Reichel, 2017).

There has been a surge in the number of IPV cases across the world due to the COVID-19 pandemic (see Lausi et al., 2021; Ojeahere et al., 2021). According to the WHO (2021), COVID-19 has impacted the social and economic lives of families which increased the exposure of women to IPV among other risk factors, while limiting their access to support services. The lockdown and isolation policies, which forced intimate partners to spend more time together, may have also contributed to the increased risk of exposure to an abusive partner (see Lausi et al., 2021). For example, in North America, police departments reported increases in domestic violence reports in six cities (Boston, 27%, Chicago 10%, Philadelphia 7%, Portland 20%, Seattle 21%, and Toronto 19%) (see Matoori et al., 2020). In middle-income countries (e.g., Peru) calls regarding IPV increased by 58% during the COVID-19 pandemic for women 15-49 years of age (Agüero, 2020). A cross-sectional study using a sample of 490 Arab women aged 18 years and above reported similar trends as a majority of women interviewed reported an increase

in exposure to psychological, physical, and sexual violence (1-3 times per month during the COVID-19 lockdown period; see El-Nimr et al., 2021).

A review of 24 studies conducted in sub-Saharan African countries showed that between 25% to 75% of women have experienced IPV in their lifetime. Factors related to high levels of IPV included low educational attainment, unemployment, alcohol and substance abuse, polygamous unions, and community cultural norms that approved of wife-beating (see Guli & Geda, 2021). An analysis of data from the Demographic and Health Survey (DHS) revealed there were high rates of psychological, physical, and/or sexual violence across low-income countries in sub-Saharan Africa, with slight variations depending on the location. In West and central Africa, psychological and physical, and/or sexual violence ranged between 32.1% and 31.45 in Cameroon and between 29.4% and 36.7% in the Democratic Republic of the Congo. In East Africa, rates ranged between 23.8% and 25.4% in Kenya, and between 28.1% and 29.5% in Tanzania. In Southern Africa, rates ranged between 29.3% and 29.6% in Malawi and between 29.6% and 27.7% in Mozambique (Coll et al., 2020). In the next section, I discuss the links between intimate partner violence and childhood outcomes in low-, middle-, and high-income countries.

Intimate Partner Violence and Children's Behavior Problems. There is solid evidence of the negative effects of IPV on children's behavioral difficulties in rich, democratic countries (see Carter et al., 2020; Evans et al., 2022). A longitudinal study (Jouriles et al., 2014) that focused on 119 low-income European American, African American, Hispanic American, and Multiethnic families with 7–10-year-old children from battered women's shelters found that children's direct and indirect involvement in the interparental conflict was associated with developing and displaying internalizing and externalizing behaviors across all assessment

periods. Externalizing behaviors persisted into children's later life. Utilizing secondary data from the Hawaii Healthy Start Program, Bair-Merritt et al. (2015) examined pathways of associations between parenting stress, IPV, and school-age children's behavior problems. The unadjusted logistic regression analysis showed that during 1st-grade children whose mothers reported higher rates of IPV were at greater risk of exhibiting internalizing and externalizing behavior problems. Adjusted regression analysis also yielded similar findings during children's 2nd and 3rd-grade years. Juan et al. (2020) also found an association between children's exposure to IPV at the age of 3 years and externalizing behavior problems (e.g., bullying other children, and being cruel and attacking other people) at 5 and 9 years. These findings illustrate that exposure to IPV during the early developmental stages can influence children's social-emotional adjustment during the elementary school years.

Data from cross-sectional studies largely corroborate those of longitudinal studies regarding social outcomes among children who witnessed IPV in their families. Using a national representative sample of 7,743 preschool-aged children from the Avon Longitudinal Study of Parents and Children (ALSPAC) in the United Kingdom, Bowen (2017) investigated children's conduct disorder symptoms and children's exposure to IPV in middle- and high-income families. Preschoolers in the exposed group were more vulnerable to developing conduct problems than nonexposed preschoolers. In a community sample of 62 preschoolers between 3 to 5 years of age in the United States, Ybarra et al. (2007) also found that IPV-exposed children exhibited high levels of internalizing behaviors than their nonexposed counterparts after controlling for socioeconomic status, maternal depressive symptoms, and ethnicity. In a multiethnic sample of 2,000 children and caregivers from low-income families in the United States, Schnurr and Lohman (2013) found that an increase in exposure to intimate partner violence was associated

with more internalizing and externalizing behaviors and low academic performance in middle childhood. In related work, it was reported that children of mothers exposed to intimate partner violence exhibited higher levels of internalizing behavior after controlling for children's age and gender, maternal depressive symptoms, and educational attainment (Hawkins et al., 2019).

It should be mentioned that within the context of domestic violence, some children are exposed to single or multiple forms and incidences of IPV, together with other adverse experiences such as abuse, maltreatment, and neglect. These experiences concurrently seem to worsen children's emotional and behavioral problems (see Hardaway et al., 2012). In a study designed to determine how exposure to various forms of IPV impacted Canadian children (N=2184), Gonzalez et al. (2014) identified four subtypes of exposure: co-occurrence of IPV and other forms of maltreatment, emotional violence, direct physical violence, and indirect physical violence. In comparison to children who had indirect exposure to violence, those who were exposed to emotional violence and witnessed frequent co-occurrence of IPV exhibited higher levels of internalizing problem behaviors. However, children exposed to frequent co-occurrence of IPV, and maltreatment displayed more externalizing behavior problems than children exposed to indirect physical violence only, after controlling for the caregiver's mental health and socioeconomic status.

Utilizing data from the Fragile Families and Child Well-being Study, Chen and Lee (2021) investigated the associations between domestic violence and children's behavior problems. Children's behavioral difficulties were assessed using the Child Behavior Checklist. Exposure to psychological and physical IPV was directly linked to children's internalizing behavior problems such as anxiety, depressive symptoms, and withdrawal from social situations, though the impact of psychological IPV was stronger than that of physical IPV. Additionally, in

a multiethnic (European American, African American, and Biracial) sample of 190, 6-12 year-olds in the United States, children who experienced cumulative IPV exposure and abuse over time exhibited significantly more externalizing behavior problems when compared to the first time they witnessed the violence (Graham-Bermann & Perkins, 2010).

Within the context of intimate partner violence, different behaviors are used by partners that can potentially influence the intensity of the violence, especially among families who live in difficult circumstances. Escalated levels of marital conflicts, which can be fueled by destructive/poor resolution behaviors and strategies, can destabilize the state of parental mental health. This can affect parents' ability to attend to children's needs for love and attention leading to children using inappropriate behaviors to seek attention (see Oravecz et al., 2008; Thompson, 2006) and poor school adjustment. In a study that examined the pathways of associations between intimate partner violence, paternal and maternal depressive symptoms, and children's behaviors among 699 families from the National Institute of Child Health and Human Development (NICHD) Study of Early Child Care and Youth Development (SECCYD) in the United States, children of fathers with more depressive symptoms exposed to destructive marital conflict behaviors exhibited more behavior problems such as aggression at ages 11 and 15 years, after controlling for child's sex and maternal depressive symptoms (Papp, 2012). In a low-income, racially diverse (African American, Hispanic, White, Asian American, and others) sample of 1,297 parents in the United States, intimate partner violence through the use of destructive conflict resolution behaviors and more depressive symptoms were negatively linked to children's behavior problems (Lee et al., 2019). These studies underscore the importance of considering parents' or partners' behaviors during IPV and how these behaviors influence the

intensity of the violence directed at partners and their impact on developmental outcomes in children.

Beyond the various contexts and forms of IPV, most research studies have focused on paternal perpetrated IPV, with little focus on maternal perpetrated violence. It appears that parental gender in the perpetration of IPV can have different adverse effects on children's behavior. For instance, Harding et al. (2013) carried out a study in a psychology research laboratory to investigate the links between mother- and father-perpetrated IPV and children's internalizing and externalizing behaviors. The sample included 53 caregivers from African American, European American, and Hispanic American families and their 8- to 11-year-old children. In this study, caregivers' experiences of IPV were assessed using the Revised Conflict Tactic Scale (CTS-2) while children's behaviors were assessed using the Child Behavior Checklist for children 6-18 years of age. Mother-reported and paternal-reported IPV perpetration were directly linked to children's externalizing behaviors. But unlike maternal IPV perpetration, mothers' reports of paternal IPV perpetration had no direct link to children's internalizing behavior problems. More attention should be paid to paternal perpetration and paternal experiences of IPV as victims of children's behavioral difficulties to avoid the overgeneralization of the effect of IPV.

There is convincing evidence of associations between IPV and children's behavior problems in African countries as well (see Izugbara et al., 2020; Nyaranga et al., 2021). Laurenzi et al. (2020) examined the associations between exposure to intimate partner violence and behavioral difficulties in a sample of 497 preschool-aged children in Kenya. The five-item WHO Violence Against Women Multi-Country Study questionnaire was used to record women's experiences of physical, psychological, and sexual violence in intimate relationships. Children's

behavioral difficulties were measured using the 25-item Strengths and Difficulties Questionnaire that assesses emotional problems, peer problems, hyperactivity, and conduct problems. Children of parents who experienced domestic violence exhibited higher levels of internalizing and externalizing behaviors compared to children of mothers who never experienced domestic violence. Among studies conducted in South Africa, Chander et al. (2017) examined the influence of IPV and children's behavior problems using a population-based sample of 980 preschool-aged children. The Strengths and Difficulties Questionnaire was used to assess children's behavior problems. This study was unique in that it did not just focus on IPV but assessed how sexual and physical IPV independently influenced childhood outcomes. Even though both types of violence resulted in higher internalizing and externalizing behaviors in children, the strength of association was stronger for sexual IPV than physical IPV. A more recent study involving 3-to 4-year-old children living in Cape Town, South Africa found that children who resided in an IPV-prone household displayed more internalizing and externalizing behavior problems when compared to children from homes with minimal instances of IPV (Hayati Rezvan et al., 2020).

In summary, intimate partner violence has deleterious effects on children's social adjustment across cultural communities. This group of studies, including those from Africa, demonstrate that children exposed to intimate partner violence experience emotional difficulties and insecurities which lay a foundation for developing internalizing and externalizing behaviors irrespective of the cultural setting or background. These findings are derived from studies with large samples and diverse methodologies. A concern though is that IPV was often assessed as a unidimensional construct that is skewed toward physical violence. Assorted studies (Grasso et al., 2016; Greene et al., 2018) have demonstrated that psychological IPV has a greater impact on

children's behavior than physical IPV. Most studies conducted in Africa did not differentiate the impact of different forms of IPV on children's social skills development, nor did they adequately consider the range of difficulties that children may exhibit. More research is needed to accurately establish the independent and joint impact of paternal and maternal IPV on children's internalizing and externalizing behaviors.

Prevalence rates in Negative Parenting Practices. The World Health Organization estimates that one billion 2-17-year-old children experience physical abuse annually (WHO, 2019). In 2020, approximately 3 in 4 children between 2 and 4 years of age experienced physical punishment and/or psychological violence from their caregivers (see WHO, 2020). In the United States, about 37% of children experienced corporal punishment with younger children (0-9 years-old) experiencing more (47%) than those between10 and 17 years of age (23%) (Finkelhor et al., 2019). Data from other regions of the world have also reported elevated levels of parental use of physical and psychological aggressive methods in managing children's behavioral transgressions. In a recent study comprising 231,221 children between 2 and 14 years of age from 32 countries, it was reported that on average 67% were victims of parental psychological aggression. Rates range from 22% in Uruguay to 79% in the Democratic Republic of Congo, while 73% experienced physical aggression that ranged from 37% in Mongolia to 89% in Tunisia. Physical discipline was higher among 2-6-year-olds (65%) compared to10-14-year-olds (55%). Overall, boys reported receiving higher rates of physical aggression (64%) compared to girls (61%). They also were the recipients of more psychological aggression (73%) than girls (70%) (Beatriz & Salhi, 2019).

In a study conducted in twenty-one low- and middle-income countries, rates of corporal punishment ranged from 23% in Kosovo to 80% in the Central African Republic. It was further

established that parental use of harsh parenting practices was high among countries of sub-Saharan Africa, (Togo 76%, Swaziland 66%, Ghana 73%, and the Central African Republic 80%) compared to middle-income countries in Europe and other parts of the world (Ukraine 33%, Serbia 34%, Mongolia 3%). High rates of corporal punishment were tied to parental beliefs about its necessity in rearing children. For example, 50% of Ghanaians, 75% of those in Swaziland, and 43% of Cameroonian caregivers approved of the use of corporal punishment (Lansford et al., 2020). It appears that physical discipline and physical punishment are on the high end across the globe, and they pose great risks to children's development.

There are suggestions that more children experienced adverse conditions during the COVID-19 pandemic. According to the WHO (2020), there were marked increases in the maltreatment of children by primary caregivers during the COVID-19 pandemic, stemming from depressive symptoms, economic hardship, and loss of employment (Graffith, 2020; Wolf et al., 2021). In the Netherlands, approximately 25% of children experienced at least one form of maltreatment from their caregiver before the COVID-19 pandemic. This increased to 34% during the COVID-19 pandemic (Sari et al., 2022). In a nationally representative sample of 3,000 Canadian parents, 22% reported using more physical discipline and corporal punishment than before COVID-19 (Gadermann et al., 2021). Data on the impact of COVID-19 on parent-child relationships in sub-Saharan Africa is sorely lacking. In this segment of the chapter, I discuss the links between paternal parenting practices and childhood outcomes with an emphasis on communities in low-income countries.

Paternal rejection and Children's Behavior Problems. It is generally accepted that abusive parenting practices such as harsh physical punishment result in negative social and cognitive outcomes in children in different cultural communities (see Di Giunta et al., 2020;

Lansford et al., 2005; Rohner, 2021). Nonetheless, little attention has been paid to the impact of parental rejection on childhood development in sub-Saharan Africa where belief in parental harshness and physical punishment as appropriate disciplinary practices is high. The existing literature on parenting practices in Africa is mostly on mothers and older children (Devlin et al., 2018), making it difficult to discern whether paternal and maternal parenting practices have different influences on childhood social and cognitive development. A customary practice has been to describe parenting practices only, often ignoring connections between different modes of parenting practices and childhood outcomes.

Four meta-analyses (Gershoff et al., 2018; Gershoff & Grogan-Kaylor, 2016; McWayne et al., 2013; Pinquart, 2017; Rohner, 2021) drawing on studies from rich democratic countries (Australia, Canada, Great Britain, Netherlands, Spain, and the US) indicate that warm and consistent maternal parenting practices are associated with positive social and cognitive outcomes in young children from diverse ethnic groups (e.g., European American, African American, Hispanic American, and Asian American). They also indicate that harsh maternal parenting practices that involve low warmth and acceptance and high rejection and hostility are related to behavioral difficulties and poor cognitive outcomes in young children.

Focusing on individual studies, Gulenc et al. (2018) examined the associations between paternal mental health, parenting practices, and children's behavior problems. The sample consisted of 669 fathers and their 3-year-old children drawn from two randomized controlled trial intervention-based parenting programs in Australia. Of interest is the lasting impact of negative paternal parenting. Early exposure to high paternal hostility, such as low warmth and use of harsh discipline, was linked to the display of internalizing and externalizing behaviors in children before school entry, after controlling for various confounding variables such as maternal

parenting practices, socioeconomic status, and child gender. In another sample of 2,025 Australian fathers with children under five years of age, paternal hostility, which was contextualized as yelling and expressing low levels of warmth to children, was directly related to children's emotional and behavioral difficulties (see Giallo et al., 2014).

Tavassolie et al. (2016) investigated the links between perceived paternal and maternal parenting practices and children's behavior problems among 152 multiethnic (European American, Caucasian, Asian/Asian American, African American, Hispanic American), socioeconomically diverse families with 3- to 9-year children from the United States. Positive parenting strategies subsumed in the authoritative parenting style (such as display of high warmth, affection, reasoned discipline, and monitoring) were negatively linked to children's internalizing and externalizing behaviors, whereas negative parenting strategies associated with the authoritarian and permissive styles (such as low warmth, lack of supervision, and rejection) were positively correlated with increased internalizing and externalizing behaviors across all ethnic groups. Further, Gryczkowski et al. (2010) examined relations between mothers' and fathers' parenting practices and children's externalizing behaviors. The sample included 135 father-mother dyads and their 6- to 12-year-old children from middle- and high-socioeconomic African American, European American, and Hispanic American families. Elevated levels of parental hostility and controlling behaviors were directly related to children's externalizing behaviors after controlling for paternal depressive symptoms and interparental conflicts. Similarly, using a low-income sample of 1,152 parents with 10–14-year-old children in the United States, Chung et al. (2021) found that parental use of harsh parenting (e.g., spanking) was significantly associated with children's externalizing behaviors.

A Brazilian study involving a sample of 143 mothers and their 3- to 8-year-old children also found that punitive parenting practices had a detrimental effect on children's social behaviors and social adjustment. Children of mothers who adopted harsh parenting practices, such as physical discipline, high control, low warmth, and rejection, exhibited more internalizing and externalizing behaviors than children of mothers who used positive parenting practices such as reasoning and high levels of warmth (see Altafim et al., 2021). These findings are in agreement with those of a study involving 8,860 Chilean families with 35- to 60-month-old children. Paternal and maternal harsh parenting practices were linked to children's behavior problems. Children whose parents spanked and rejected them had higher externalizing behaviors compared to those whose parents never spanked them (Ugarte et al., 2021).

For the most part, reviews of work conducted in countries in the middle east (Rauf & Ahmed, 2017), Chile (Ugarte et al., 2021), and Latin America and the Caribbean (Lie-a-Ling et al., 2018; Roopnarine & Jin, 2016) have also arrived at similar conclusions regarding parental warmth and rejection and childhood outcomes. As mentioned earlier, studies on parenting practices in Africa have largely focused on levels of parental warmth and control. A good example, is a cross-sectional, comparative study of maternal and paternal warmth and hostility toward children in Kenya, Jordan, Thailand, the United States, Sweden, Italy, the Philippines, Colombia, and China (Putnick et al., 2012). Paternal warmth was comparably high across high- and low- and middle-income countries. Among Kenyan families, paternal warmth was moderately high as was paternal hostility. Other assessments of paternal practices in Kenya have revealed that most fathers used corporal punishment and authoritarian parenting practices (see Lansford et al., 2010; Oburu, 2011). In African countries, the use of hostile parenting (caning,

spanking, and hitting the child with an object) by fathers is perceived as a normative practice and as a strategy for managing children's behavior.

In a nationally representative survey conducted in South Africa, it was established that using physical punishment and being harsh to children while correcting and guiding them were regarded as acceptable parenting practices. Among fathers who participated in the study, 30% reported that they had smacked their children one month before participating in the study (see Dawes et al., 2005). In a survey conducted in low-income communities in Kenya, 47% of adults emphasized the importance of fathers using physical discipline and being strict during child upbringing to produce instant and desired behavior change (Mudany et al., 2013). Even though these studies did not examine the developmental implications of harsh parenting practices, they certainly raise questions about the possible impact of paternal hostility and rejection on children's cognitive and social development during the vulnerable preschool years.

As much as parents in some cultures see authoritarian parenting, such as the use of physical control as normative, the negative consequences of these parenting practices are becoming increasingly clear. Among families in Kenya, China, Thailand, Italy, the United States, the Philippines, Jordan, and Colombia (see Alampay et al., 2017), paternal use of negative parenting practices, such as corporal punishment and display of low levels of warmth towards children, was associated with increased externalizing behaviors in children across all countries. Recently, Di Giunta et al. (2020) investigated the pathways of association between paternal irritability, harsh parenting, low parental warmth, and children's socioemotional functioning over time using a sample of 1,298 families from Kenya, Jordan, Thailand, United States, Sweden, Italy, Philippines, Colombia, and China. Not unlike the findings of so many other studies on maternal discipline (see Gershoff et al., 2018; Van Zeijl et al., 2007), paternal use of harsh

discipline and low levels of warmth were directly related to internalizing and externalizing behaviors in children across all cultural groups represented in the study.

Ward et al. (2020) investigated the association between positive parenting strategies and behavioral outcomes in a sample of 269 South African families with young children who showed signs of conduct problems. Caregivers were divided into an intervention and a control group. Caregivers in the intervention group received coaching on the use of positive parenting strategies to manage children's behaviors. Follow-up assessments showed that parents in the intervention group who received training on positive parenting practices reported that their children expressed low levels of physical and psychological aggression. By contrast, parents in the control group expressed that their children continued to show more conduct problems. Parenting interventions underscore the importance of sensitizing parents to adopt positive parenting practices to promote appropriate behavioral outcomes in children.

As with those considered in the previous sections, these studies have strengths and limitations. First, there has been an increase in studies focusing on the associations between paternal parenting practices and childhood behaviors in low-income countries. Second, there has also been an increase in comparative research focusing on the unique ways in which parents from different cultural communities show love and affection towards their children. For example, Putnick et al. (2012) stated that in the western world, parents show love and affection and reward their children by holding, hugging, and kissing them, while in other cultural communities such as those in sub-Saharan Africa, parents give children tangible things such as material goods/treats, extra food, and privileges as a way of expressing love and affection. The cultural understanding of various ways in which parents show warmth, as well as rejection, can further help us

determine the unique contributions of fathers' and mothers' parenting practices to behavioral outcomes in children.

On the limitation front, a majority of studies in low-income countries did not focus on behavioral outcomes. Furthermore, the limited studies conducted in sub-Saharan Africa did not indicate whether maternal and paternal warmth and/or rejection influenced children's development differently. Therefore, it remains unclear as to whether fathers' parenting practices influence children's internalizing and externalizing behaviors above and beyond maternal practices. It is also the case that most studies failed to use multiple informants when assessing young children's behaviors. In most studies, either mothers or teachers rated children's internalizing and externalizing behaviors. Failure to use multiple informants has been found to increase biases tied to assessments (Alexander et al., 2017).

Indirect Links between Paternal Depressive Symptoms and Children Behavior Outcomes via IPV and Paternal Rejection

For some time now, models of risk and resilience have sketched out how intrapersonal and interpersonal family processes such as parental depressive symptomology, IPV, and punitive parenting practices influence children's social and cognitive development. As can be gathered from what has been detailed above, most studies have tended to examine the independent effects of parental risk factors on early developmental outcomes in children. Below, I discuss the possible mediating role of intimate partner violence and paternal rejection on the associations between paternal depressive symptoms and children's social behavior.

Paternal Depressive Symptoms, Paternal Rejection, and Children's Behavior Problems. Parental rejection has been shown to mediate the associations between various adverse social and environmental conditions, such as persistent mental health problems, family

conflicts, chronic poverty, economic instability, and children's social development (see Kopala-Sibley et al., 2017; Letourneau et al., 2019). From what has been said already, paternal depressive symptoms can negatively influence optimal parenting practices. Davis et al. (2011) examined whether fathers' depressive symptoms were related to positive and negative parenting behaviors using a nationally representative sample of 1,746 fathers with 1-year-old children in the United States. They reported that fathers who experienced high depressive symptoms were four times more likely to spank their children compared to non-depressed fathers, after controlling for socioeconomic background, father's age, education, employment status, and ethnicity. Barnett et al. (2021) also determined associations between parental relationship changes, depressive symptoms, parenting behaviors, and children's social behaviors. The bivariate correlations showed that increases in paternal and maternal depressive symptoms were associated with high levels of parental use of harsh parenting behaviors, after controlling for sociodemographic factors.

That paternal depressive symptoms and parenting practices can jointly influence developmental outcomes in children has been aptly demonstrated. Kim (2013) investigated the mediating role of warm and harsh parenting practices on the associations between parental depressive symptoms and children's behavioral difficulties. The sample included 186 Korean American families with 5- to 10-year-old children from the Pacific Northwest. The Center for Epidemiologic Studies Depression (CES-D) scale and parents' acceptance-rejection questionnaire was used to assess levels of depressive symptoms and parenting behaviors respectively, while the Pediatric Symptoms Checklist was used to assess children's behavioral difficulties such as worries and complaints of pain. Paternal acceptance and rejection were significant mediators of the indirect links between paternal depressive symptoms and children's

behavior problems, with paternal rejection being a stronger mediator than paternal acceptance. In a similar vein, Ward and Lee, (2020) examined whether paternal and maternal mental health difficulties were indirectly linked to children's well-being via parental responsiveness in a community sample of 1,173 low-income families from the Building Strong Families Project in the United States. Fathers' and mothers' poor mental health were negatively associated with responsive parenting which was then associated with children's cognitive development, prosocial behaviors, and behavior problems.

A study involving a sample of 319 fathers and mothers with 5- to 9-year-old children in Germany showed indirect links between parental depressive symptoms and children's social adjustment via negative parenting practice. The Beck Depression Inventory and the Alabama Parenting Questionnaire for elementary school-aged children were used to assess parents' depressive symptoms and inconsistent parenting practices. A German checklist for behavior problems and behavior disorders scale was used to assess children's adjustment in four areas: internalizing behaviors, oppositional defiant behaviors, social-emotional competence, and hyperactivity behaviors. Inconsistent parenting practices and harsh discipline fully mediated the associations between fathers' and mothers' depressive symptoms and children's social adjustment in all four behavioral areas (Dette-Hagenmeyer & Reichle, 2014).

In a later study, Chueng et al. (2021) examined the mediating role of parents' mindfulness on the links between parents' depressive symptoms and children's behavior problems. The sample included 320 Chinese families and their 35- to 56-month-old children. A parent health questionnaire and the Bangor Mindful Parenting Scale were used to assess depressive symptoms and parenting practices, while the Child Behavior Checklist was used to assess children's internalizing and externalizing behaviors. Low mindfulness, which was

characterized by low parental awareness and understanding of the child's feelings, positively mediated the association between parental depressive symptoms and children's internalizing behaviors.

In additional work on the mediating role of parenting practices, Cummings et al. (2013) conducted a longitudinal study that examined the association between parental depressive symptoms and children's internalizing behaviors via parental rejection using a multiethnic sample (European American, African American, Hispanic/Latino, Biracial, and others) of 235 socio-economically diverse families in Rochester, New York, and South Bend, Indiana. Parents' depressive symptoms and children's behavior problems were assessed when children were in kindergarten, first grade, and second grade. Parental depressive symptoms assessed when children were in kindergarten had significant indirect associations with children's internalizing behaviors in first and second grade through high parental rejecting behaviors, with the impact being more pronounced in second than first grade. Similarly, Elgar et al. (2007) investigated the associations between parental mental health problems and children's internalizing and externalizing behaviors via parenting behaviors using a nationally representative sample of 4,184 Canadian mothers and fathers with 10–15-year-old children from the National Longitudinal Survey of Children and Youth (NLSCY). Parents' behaviors were assessed along three dimensions: nurturance, monitoring, and rejection in two waves at an interval of two years. Hierarchical linear modeling indicated that mothers' and fathers' depressive symptoms at Time 1 were indirectly linked to children's internalizing and externalizing behaviors at Time 2 via high parental rejection, more externalizing behaviors via low nurturance, and more internalizing behaviors via low monitoring.

A handful of studies have also explored the indirect links between parental depressive symptoms and children's behaviors through various parenting practices in low- and middle-income countries (see Gelaye et al., 2016). More often than not, parental depressive symptoms were associated with higher internalizing and externalizing behaviors in children via harsh parenting practices in low-income countries. Allen et al. (2014) investigated whether paternal depressive symptoms were indirectly associated with children's externalizing and internalizing behaviors via harsh parenting in a sample of 361 mothers with 6–10-year-old children in Tshwane, South Africa. An increase in parental depressive symptoms led to an increase in the parental use of harsh and inconsistent parenting strategies (e.g., negative, and punitive reactions) which in turn was associated with an increase in children's externalizing and internalizing behaviors. Huang et al. (2018) investigated whether parental depressive symptoms were associated with children's behavioral difficulties via negative parenting practices among 262 parents and their preschool to grade 3 children in Ghana. Harsh parenting, characterized by the use of corporal punishment, mediated the association between parental depressive symptoms and children's externalizing behaviors. There was also a direct association between paternal depressive symptoms and children's internalizing and externalizing behaviors. What these studies show is that paternal rejection increases the negative impact of paternal rejections on children's internalizing and externalizing behaviors.

Paternal Depressive Symptoms, IPV, Paternal Rejection and Children's Behavior Problems. Meta-analyses and reviews of the literature have suggested that parental depressive symptoms and interparental conflicts have adverse effects on parenting (Burkhart et al., 2013; Gardner et al., 2019) and children's social adjustment (Goodman et al., 2020; Kingston et al., 2012). Research suggests that there is a strong correlation between parental depressive symptoms

and IPV and that these two risk factors often mediate the effect of each other in influencing parenting practices and childhood outcomes (Cowan et al.,2019; Gibson et al., 2015; Stocker et al., 2003).

Graham-Bermann et al. (2009) examined the associations between exposure to IPV, social support, and children's behavioral difficulties in a community sample of 219, 6-12-year-olds from low- and middle-income European American, African American, and Biracial families in southeastern Michigan. Children were categorized into four groups: adjustment problem, struggling, depressed only, and resilient. Internalizing and externalizing behavior problems in each group were evaluated using the Child Behavior Checklist. Parenting and family functioning were evaluated using the Anxiety and Parental Childrearing Styles Scale (APCSS) to determine which parenting practices (e.g., warmth, guilt induction, control, severity, and child-centered) contributed to children's behavioral difficulties. As might be expected, children in the resilient category exhibited fewer internalizing and externalizing behaviors compared to children in the adjustment problem and struggling groups. Differences in behavioral outcomes were attributed to the nature of the family environment as children in the resilient group had mothers who were responsive, child-centered, and warm during the plight of domestic violence. This was also demonstrated in a study by Thompson-Walsh et al. (2021) in which fathers' depressive symptoms and hostility mediated the links between interparental conflicts and children's internalizing and externalizing behaviors, after controlling for children's gender, age, parental education, and family socioeconomic status. Low paternal warmth was not a significant mediator of these associations**.**

Longitudinal studies also suggest that early exposure to parental depressive symptoms and IPV could have a later impact on children's behavioral difficulties. In this regard, Holmes,

(2016) determined the associations between IPV, maternal depressive symptoms, and children's aggressive behaviors. The sample included an ethnically diverse (European American, African American Hispanic, and others) group of 1,399 families with young children from the National Survey of Child and Adolescent Well-Being (NSCAW-1) in the United States. The Composite International Diagnostic Interview, Conflict Tactic Scale, and Child Behavior Checklist were used to evaluate maternal depressive symptoms, IPV, and children's behavior problems, respectively, when children were 2-3, 4-5, and 6-8 years old. Maternal depressive symptoms mediated the association between IPV at 2-3 years and children's aggressive behaviors at 6-8 years. In other work, Jones et al. (2021) investigated the long-term, indirect influence of parental depressive symptoms on children's social adjustment via interparental conflict using a multiethnic sample of 314 families and children drawn from the Longitudinal Studies of Child Abuse and Neglect (LONGSCAN) in the United States. Data were collected on parents when their children were 6, 12, and 14 years old. Parental depressive symptoms were significantly associated with increased interparental conflicts, which in turn was significantly associated with an increase in children's internalizing and externalizing behaviors at ages 12 and 14, after controlling for child behavior symptoms at age 6, gender, parent educational level, and family income.

More evidence of the persistent associations between IPV, parental depressive symptoms, and children's behavioral problems is seen in a nationally representative sample of 2,422 European American, African American, Hispanic/Latino American, and other children from the Child Health Improvement Through Computer Automation (CHICA) data set. Children of mothers who experienced both IPV and parental depressive symptoms at 3 years after childbirth exhibited more behavioral problems at 6 years compared to children of mothers who experienced

either IPV or depressive symptoms only, or experienced neither of them. It was argued that the intensity of the effect could be related to the joint associations between IPV and parents' depressive symptoms, hence a stronger impact on children's behavior problems (Bauer et al., 2013).

Research suggests that the negative influence of poor paternal mental health on children's internalizing and externalizing behaviors could intensify as result of interparental conflict and parenting behaviors as well. Leinonen et al. (2003) assessed the indirect links between parents' mental health and children's behavioral difficulties via marital interaction and parenting practices in 527 Finnish mothers and fathers and their 12-year-olds who participated in the Longitudinal Project on Children Mental Disorders. Parental punitive parenting practices (e. g., yelling and rejection) mediated the links between fathers' and mothers' depressive symptoms and children's internalizing but not externalizing behaviors. The indirect pathway through both mediators indicated that fathers' and mothers' depressive symptoms were associated with high interparental conflict and an increase in parental use of punitive parenting which was then associated with children's internalizing behaviors. Schudlich et al. (2019) also investigated whether paternal depressive symptoms were associated with children's behavior problems via interparental conflict and parenting practices in 74 European American, Asian American, African American, Hispanic American, and Biracial families with 6–14-month-old infants. Paternal depressive symptoms were associated with interparental conflict which was associated with lower paternal sensitivity contributing to emotional and behavioral dysregulation such as screaming, thumb sucking, fussiness, throwing objects, and kicking in children.

There is a scarcity of research on the mediating role of IPV and parental rejection on the associations between parental depressive symptoms and children's behavior problems in sub-

Saharan African countries. In as much as a large portion of the studies focused only on the association between maternal depressive symptoms and occurrences of IPV, progress has been made in determining the spillover effects of these associations on either parenting practices or child outcomes, or both (see Christodoulou et al., 2019; Mutahi et al., 2022). For example, Ogbonnaya et al. (2019) found that paternal and maternal depressive symptoms and IPV were strongly associated with psychologically aggressive parenting practices. IPV and parental depressive symptoms were associated with parental physically aggressive and neglectful parenting practices independently. However, parental depressive symptoms and IPV were associated with a rise in levels of parental use of punitive parenting practices in Rwanda, Ghana, and South Africa (Roelen et al., 2017). Although these studies did not include child outcomes, they affirm the existence of a strong correlation between IPV and parental depressive symptoms and how each can alter parenting practices irrespective of the cultural context.

A few studies did focus on the spillover effects of adverse childhood experiences on childhood development in sub-Saharan African countries. Alenko et al. (2020) considered the associations between maternal depressive symptoms and IPV and children's emotional and behavioral problems in 734 mothers with 3- to 10-year-old children recruited from the neighborhood of Jimma township in Ethiopia. The Parent Health Questionnaire and Hurt/Insult/Threaten/Scream (HITS) scales were used to assess maternal depressive symptoms and experiences of IPV, while the Strengths and Difficulties Questionnaire was used to assess children's behavior problems. Maternal depressive symptoms and maternal experiences of IPV were associated with children's behavioral difficulties such as conduct problems, hyperactivity, and peer relationship problems. These patterns of associations were also shown in 338 rural children in the Democratic Republic of Congo (Glass et al., 2018) and 446 low-income children

in South Africa (Garman et al., 2019). In the study conducted in the Democratic Republic of Congo, the influence of depressive symptoms through IPV on childhood behavioral difficulties persisted through the early childhood years.

In a nutshell, these studies highlight the detrimental effects of the association between paternal depressive symptoms and IPV and parenting on children's behavioral difficulties within family settings in diverse cultural communities across the globe. Despite the increasing prevalence of paternal depressive symptoms in the middle- and low-income countries of Africa, the mediating role of IPV and paternal rejection on the associations between paternal mental health and children's social skills are yet to be delineated fully across these countries.

Strengths and limitations of the literature

This review provides a glimpse into relations between various ecological and family factors in predicting behavioral and social outcomes in children in diverse cultural settings. The strengths and weaknesses of the studies have been discussed in the respective sections above. To wrap up this chapter, I would like to reiterate some general strengths and weaknesses gleaned across studies regarding the nature of the associations between paternal risk factors and childhood behavioral outcomes. To begin with, there is an increase in the number of studies that focus on paternal risk factors and how they influence children's behavioral outcomes within a global context. The limited number of studies within sub-Saharan African countries, notwithstanding, those from the middle- and high-income countries provide a good foundation for understanding the interactions between paternal risk factors and behavioral difficulties in young children.

Progress has also been made towards developing culturally valid and reliable assessment tools that can be used to capture accurate information on the dynamics of ecological,

interpersonal, and intrapersonal relationships in sub-Saharan African cultural contexts. For example, Verkuijl et al. (2014) developed the South Africa Child Assessment Schedule (SACAS) questionnaire by borrowing items from the Child Behavior Rating Scale, and information from the International Classification of Disease, 10th revision, and the Diagnostic and Statistical Manual of Mental Disorder 4th revision. This scale is used to evaluate children's internalizing and externalizing behaviors. These developments along with more focus on pathways of associations between multisystem paternal risk factors and childhood development would certainly help in providing much-needed information that would be of interest to governmental and nongovernmental agencies that deliver services to families and children.

Concerning drawbacks, the growing body of work on risk factors and the mediating role of intimate partner violence and negative parenting on the links between paternal depressive symptoms and behavioral problems in children aside, few studies did address the mediating role of IPV and paternal rejection in the same model. However, it remains to be seen how paternal depressive symptoms influence children's internalizing and externalizing behavior through IPV and paternal rejection in the low-income countries of sub-Saharan Africa. There has been an overwhelming focus on maternal risk factors and childhood development in African families with little emphasis on fathers (see Dede Yildirim & Roopnarine, 2019). There is a need for more research on the links between paternal risk factors and childhood outcomes amidst challenging social and economic conditions in low-income countries such as Kenya. in sub-Sahara Africa.

With the aforementioned in mind, this study attempts to fill the gap by providing information on links between paternal risk factors within families and their influence on children's behavioral difficulties above and beyond maternal risk factors in a culturally rich

society of sub-Saharan Africa, namely Kenya. It is hoped that it will extend our understanding of how paternal risk factors such as IPV and paternal rejection independently or jointly mediate the associations between paternal depressive symptoms and children's behavior problems in an African cultural context, above and beyond the influence of maternal depressive symptoms, physical and psychological IPV, and maternal rejection. This information should be helpful in the development of (a) parenting policies and intervention programs that target fathers in promoting family welfare and children's optimal development in the low- and middle-income countries of sub-Saharan Africa, and (b) contribute to guiding the development of contextually and culturally based theoretical frameworks and models that apply to studying sub-Saharan African families and children. The next chapter discusses the core tenets of the conceptual frameworks that guided the conceptualization of the research questions and the development of hypotheses, the selection of measures, and the interpretation of the findings.

Chapter 3: Theoretical Framework

Theories and models on family processes and parenting have vastly improved over the past two decades. Even though most theories and models have focused on mothers, some conceptual frameworks have focused on differences in parenting between men and women (see Marsiglio & Pleck, 2005). Some researchers (e.g., Cabrera et al., 2007, 2014) have proposed models that are process-oriented and highlight fathering within various cultural contexts. In this chapter, the focus is on the developmental psychopathology model and parenting theories and frameworks that examine the range of factors that have relevance for maternal and paternal engagement with children and childhood development. More specifically, propositions within two frameworks that guided the formulation of the questions and hypotheses in this study and that speak to the risk and protective factors and childhood development are discussed below.

Developmental Psychopathology Framework

In the main, the developmental psychopathology framework identifies risk and protective factors that influence parenting practices and childhood outcomes broadly. The developmental psychopathology perspective underlines the importance of considering risk and protective factors that influence adults' personal and interpersonal functioning and childhood outcomes within a socially dynamic network of family relationships and cultural systems (Masten, 2004; Masten & Motti-Stefanidi, 2020; Rutter & Sroufe, 2000). Even though the developmental psychopathology framework stresses the importance of resilience in mitigating the negative effects of risk factors, it is imperative to understand how multiple risk factors interact to influence childhood outcomes. For instance, the principle of multicausality denotes that the observable behaviors in children are a result of exposure to multiple factors (e.g., punitive parenting, and parental depressive symptoms) through diverse levels of interactions

within and external to the family. It is also worth noting that exposure to these multiple risk factors can potentially lower the capacity of the developed resilience from effectively buffering the negative effects of the risks on optimal child development (see Masten & Mott-Stefanidi, 2020). By and large, it is expected that children would exhibit similar behavioral manifestations when exposed to the same parental risk factors such as depressive symptoms and interparental violence. However, the cascading effects of exposure to different risk factors may manifest via different developmental trajectories, depending on the severity and length of exposure, the nature and number of risk factors, and the role of protective factors in mitigating risks (Masten & Cichetti 2010; Masten & Motti-Stefanidi, 2020). This can also be mirrored through the principle of equifinality which stipulates that difficulties in children could be due to exposure to multiple risk factors resulting in cumulative effects that spread across developmental domain, such as socio-emotional, cognitive, and behavior through various processes (Ollendick & Hirshfeld-Becker, 2002).

As indicated in the previous chapter, intimate partner violence, parental depressive symptoms, and parental rejection are related to behavioral difficulties in young children (see Levendosky et al., 2002; Roopnarine & Yildirim, 2018). Research that utilized risk and resilience models suggests that the links between parental risk factors (e.g., depressive symptoms, intimate partner violence, and punitive parenting) could have both direct and indirect influences on childhood outcomes. For instance, Harvey et al. (2011) found that both maternal and paternal depressive symptoms were directly and indirectly associated with children's internalizing and externalizing behaviors through negative parenting which was characterized by laxness and low warmth. Moreover, the impact of maternal depressive

symptoms on children's behavior problems worsened when other risk factors such as interparental conflict and harsh parenting were considered.

Although tenets of the developmental psychopathology model have not been adequately tested in cultural communities in low- and middle-income countries, they provide a preliminary conceptual basis for identifying mechanisms through which depressive symptoms and IPV influence parenting and childhood behavioral difficulties. Attempts to examine parental risk and protective factors and outcomes in low- and middle-income Caribbean countries speak to the utility of the developmental psychopathology model in cultural communities outside of high-income countries (see Dede Yildirim & Roopnarine, 2018). In the Kenyan context, families face multiple risk factors such as poverty, domestic and community violence, and poor mental health in their daily lives. The impact of these risk factors on childhood development is largely unchecked. With the WHO emphasis on parenting as a major platform for advancing the welfare and well-being of children in difficult circumstances, the developmental psychopathology framework seems suited to examine multiple risk factors in fathers and internalizing and externalizing behaviors in preschool-aged children relative to mothers in Kenya

Parental Acceptance-Rejection Theory

Parenting theories stress sensitively attuned practices as essential components in the promotion of children's social skills from the early childhood years onward, irrespective of the cultural community (Khaleque & Rohner, 2002; Pinquart & Kauser, 2018; Roopnarine et al., 2006). In this vein, interpersonal acceptance-rejection theory (IPARTheory) (Rohner, 1986, 2021; Rohner & Khaleque, 2005) suggests that parental warmth and control exert different degrees of influence on the social adjustment of children. Drawing on elements in

three sub-theories (personality sub-theory, coping sub-theory, and sociocultural sub-theory), interpersonal acceptance-rejection theory offers insights into why some parents are warm and accepting while others are cold and rejecting across cultural communities. Parental acceptance is characterized by high levels of warmth, affection, nurturance, and support children receive from their parents which in turn lead to better social adjustment. By contrast, parental rejection is characterized by experiences of low levels of parental warmth, support, parental involvement, and exposure to physical and psychological harmful behaviors all of which are associated with poor social adjustment in children. Warmth and rejection are perceived to be at different ends of a continuum. It has been asserted that in most cultural communities across the world parents are generally warm with smaller percentages displaying high levels of hostility and rejection (Di Giunta et al., 2020; Lansford et al., 2010; Rohner, 2021; Rohner & Rohner, 1981).

Numerous studies have used interpersonal acceptance-rejection theory to link parental warmth and rejection to social adjustment in high-, middle-, and low-income countries (see Khaleque & Rohner, 2002, 2012; Putnick et al., 2012) In a meta-analysis that included 66 studies with 19,511 mothers, fathers, and children from twenty-two countries across the globe, it was demonstrated that parental acceptance was associated with better social adjustment, whereas harsh parenting that involves hostility and rejection was associated with aggression, antisocial behaviors, and poor literacy skills in children (see Khaleque & Rohner, 2012). In a similar vein, Putnick et al. (2015) examined children's perception of parental acceptance-rejection in 1,247 families in Kenya, China, Thailand, Italy, the United States, the Philippines, Jordan, Colombia, and Sweden. Maternal and paternal acceptance were positively associated with prosocial behaviors and rejection was directly linked to higher internalizing and externalizing behaviors, low academic achievement, and less prosocial

behaviors in children, after controlling for parents' level of education, age, and social desirability bias across all countries.

Given the central role of sensitive parenting practices for optimal childhood development and the fact that interpersonal acceptance-rejection theory has pancultural validity and that related assessment instruments have been demonstrated to have structural equivalence across cultures, parental rejection was included in the assessment model outlined below. Along with depressive symptoms and interpersonal violence, parental rejection can compound risks to children's socioemotional functioning.

Summary

Together, the developmental psychopathology framework and interparental acceptance-rejection theory target proximal processes within the family that influence the development of early social skills in young children. Quality parent-child relationships during the early childhood years can have long-term effects on childhood development. Studies that have utilized these conceptual frameworks in diverse cultural contexts have demonstrated the power of fathers' and mothers' interpersonal and intrapersonal functioning in influencing childhood development (Lansford et al., 2014; Putnick et al., 2012; Rhoner & Khaleque, 2012). Given the rising levels of poverty, increases in depressive symptoms among adults, high rates of IPV perpetrated by men, and the societal belief in the use of inconsistent and punitive parenting practices in sub-Saharan Africa, the marrying of principles in the developmental psychopathology and interpersonal acceptance-rejection frameworks appear appropriate for understanding the pathways of associations between depressive symptoms, IPV, and parental rejection and children's behavior problems in the low-income nation of Kenya.

Development of the Model and Selection of Measures

In this study, the major focus was on the links between paternal depressive symptoms, IPV, paternal rejection, and children's internalizing and externalizing behaviors. Paternal depressive symptoms, intimate partner violence, and paternal rejection are considered predictor variables, and children's internalizing and externalizing behaviors are designated as behavioral outcomes. Previous studies have shown that paternal depressive symptoms, intimate partner violence, and paternal rejection are risk factors that can, directly and indirectly, have adverse effects on children's behaviors (see Khaleque & Rohner, 2012; Rauf & Ahmed, 2017; Roopnarine & Yildirim, 2018).

As was discussed in the previous chapter, developmental outcomes (e.g., aggression, distractibility, anxiety, and self-exclusion from social situations) in children are greatly influenced by the type of nurturance they receive from family members and the relationship they have with their parents (see Lakhdir et al., 2021; Miranda et al., 2016). It has repeatedly been demonstrated that high parental depressive symptoms, IPV, lack of or low parental warmth, and parental rejection pose great risks to children's optimal social development (Altafim et al., 2021; Carter et al., 2020; Gartland et al., 2014; Gulenc et al., 2018; Juan et al., 2020; Laurenzi et al., 2021; Ramchandani et al., 2005) which is essential for better social adjustment in the home and school environments across high-, middle-, and low-income countries (Dougherty, 2013; Laurenzi et al., 2021; Slopen & McLaughlin, 2013). In considering these associations, the first model in this study assessed the direct influence of paternal depressive symptoms, intimate partner violence, and paternal rejection on children's behavioral difficulties above and beyond the influence of maternal depressive symptoms, IPV, and maternal rejection.

Research suggests that parents who experience depressive symptoms are more likely to have an impaired ability to develop and sustain healthy intrapersonal and interpersonal relationships leading to behavioral problems in children. Although paternal depressive symptoms have a direct impact on children's social adjustment, their impact can increase appreciably in conjunction with IPV and negative parenting practices (Green et al., 2018; Neppl et al., 2016; Schudlinch et al., 2019; Silva-Rodrigues et al., 2021). Leinonen et al. (2003), Dette-Hagenmeyer and Reichle, (2013), and Schudlich et al. (2019) found that IPV and parental harshness/rejection independently and jointly increased the deleterious impact of paternal depressive symptoms on children's behaviors. Given these findings, this study attempted to assess the cumulative effects of paternal depressive symptoms, physical and psychological IPV, and rejection on children's behavioral difficulties above and beyond the cumulative influence of maternal depressive symptoms, physical and psychological IPV, and maternal rejection.

Noteworthy is that in both models, IPV was assessed via two dimensions: physical IPV and Psychological IPV. This approach differs from prior work that has assessed interparental conflict as a unidimensional construct. The decision to investigate IPV as a multidimensional construct was made based on previous research which has shown variations in behavioral outcomes attributed to physical, psychological, and sexual IPV (see Grasso et al., 2016; Greene et al., 2018; Leen-feldner et al., 2013). It appears that when exposure to IPV is studied as a multidimensional construct (physical, psychological, emotional, and sexual IPV) it provides a more complete picture of its impact on children's internalizing and externalizing behaviors compared to when it is considered as a unidimensional construct (Chander et al., 2017; Grasso et al., 2016; Greene et al., 2018; Vu et al., 2016).

Children's externalizing and internalizing behaviors are considered outcome measures because they are good indicators of children's behavioral difficulties in diverse cultural communities and can influence children's transition to school and interpersonal relationships with peers and teachers (e.g., Khaleque & Rohner, 2012; Roopnarine & Dede Yildirim, 2017). Internalizing and externalizing behaviors were assessed via an instrument that was used in studies conducted across cultural communities in high- and low-income countries and has been shown to have good psychometric properties (Chen & Lee, 2021; Garman et al., 2019; Graham-Bermann et al., 2009).

In the current study an additive model was utilized to examine the distinctive influence of paternal risk factors (paternal depressive symptoms, psychological and physical IPV, and paternal rejection) on children's internalizing and externalizing behaviors above and beyond the influence of maternal risk factors while a mediation model examined whether the pathways of associations between paternal/maternal depressive symptoms and children's internalizing and externalizing behaviors via psychological and physical IPV and parental/maternal rejection were different for fathers and mothers. The decision to run these separate models was based on methodological reasons as discussed below.

Additive model

Additive models have been widely used to examine the unique and cumulative contributions of multiple predictor variables on outcomes variables (Criss et al., 2009; Guardabassi et al., 2018; Wu et al., 2018). Consequently, additive models become handy in family settings especially when determining the influence of similar paternal and maternal risk factors on children's adjustment (see Paulson et al., 2006; Volling et al., 2019) and whether one parent's risk factors predict the outcomes above and beyond the other parent's risk factors (see

Akhter et al., 2011; Guardabassi et al., 2018). Previous studies suggests that concurrent paternal and maternal risk factors such as depressive symptoms, harsh parenting, and IPV contribute uniquely to children's social adjustment and behavioral difficulties (Paulson et al., 2006; Ponnet 2014; Weinfield et al., 2008). For example, using a sample of 1,140 mothers and fathers with their young children drawn from the Behavior Outlook Norwegian Developmental Study (BONDS), Narayanan and Naerde (2016) found that concurrent maternal and paternal depressive symptoms independently accounted for unique variance in children's internalizing and externalizing behaviors. Similar trends were reported in studies that examined the unique contributions of fathers' and mothers' parenting practices and children's social adjustment. A study involving 2,776 Chinese families with preschool aged children also found that children from families where both fathers and mothers used an authoritative parenting style exhibited higher levels of internalizing and externalizing behaviors as compared to children from families where only mothers used an authoritarian parenting style (Luo et al., 2021). In short, these studies underscore the importance of using additive models in understanding how similar concurrent paternal and maternal risk factors contribute to childhood outcome above and beyond the contribution of the other parent.

In this study, the model was used for two purposes, (a) to assess the independent influence of maternal and paternal risk factors on children's behavioral problems, and (b) to examine whether paternal risk factors influenced children's internalizing and externalizing behaviors above and beyond the influence of maternal risk factors.

Mediation model

Through the lens of theoretical frameworks such as developmental psychopathology, mediation models have advanced research in understanding the complex mechanism through

which multiple risk factors in families interact in predicting developmental outcomes in children (Cheung et al., 2021; Kopala-Sibley et al., 2017; Criss et al., 2009; Stein et al., 2020). For instance, investigations examining whether the links between parental depressive symptoms and children's behavior problems are mediated by intimate partner violence, and negative parenting practices are based on the premise that, parents' poor mental health is more likely to interfere with marital stability leading to interparental hostility and conflict (Gustafsson et al., 2014; Lamela et al., 2018; Stein et al., 2020) and parental physical and psychological aggression behaviors toward children (Callender et al., 2012; Greene et al., 2018; Silva-Rodrigues et al., 2021). The joint effect of these risk factors exacerbates the behavioral problems in children (Chan et al., 2017; Cheung et al., 2021; Marcal, 2021; Yoo & Huang, 2013). In the current study, the mediation model was used to establish the process through which paternal and maternal depressive symptoms influenced children's internalizing and externalizing behavior problems through psychological and physical IPV and paternal and maternal rejection independently.

In the next section, model 1 demonstrates the direct links between family risk factors and childhood outcomes while model 2 demonstrates the mediated associations between family processes and children's internalizing and externalizing behaviors.

Research Questions and Hypothesis

Drawing on propositions in the psychopathology framework (Rutter & Sroufe, 2000) and interparental acceptance-rejection theory (Rohner & Khaleque, 2005) and research findings on associations between, paternal depressive symptoms, IPV, parenting practices, and children's social development (see Roopnarine & Dede Yildirim, 2017; Voisin & Hong, 2012; Ybarra et al., 2007), this study investigated links between paternal depressive symptoms, physical and psychological IPV, and paternal rejection and children's behavioral difficulties in Kenyan

families. The proposed study seeks to explore the following questions and hypotheses. Figure 1 depicts conceptual model 1 which illustrates the direct links for hypothesis 1, while figure 2 depicts conceptual model 2 which illustrates the indirect links for hypothesis 2.

Question 1

Are paternal depressive symptoms, physical, and psychological IPV, and paternal rejection directly linked to children's internalizing and externalizing behaviors above and beyond maternal depressive symptoms, physical and psychological IPV, and maternal rejection in Kenya?

Hypothesis 1

Consistent with previous research across the world (Huang et al., 2017; Kane & Garber, 2009; Trotman, 2021; Volling et al., 2019), it was expected that paternal depressive symptoms, physical and psychological IPV, and paternal rejection would be positively associated with children's internalizing and externalizing behaviors above and beyond maternal depressive symptoms, physical and psychological IPV, and maternal rejection.

Question 2

Are the pathways between depressive symptoms and children's internalizing and externalizing behaviors through physical and psychological IPV, and paternal rejection different for mothers and fathers in Kenya?

Hypothesis 2

Consistent with previous research across the world (Barnett et al., 2021; Bauer et al., 2013; Chueng et al., 2021; Davis et al., 2011; Goodman et al., 2020), it was expected that the pathways between paternal depressive symptoms and children's internalizing and externalizing behaviors through physical and psychological IPV, and paternal rejection would be similar for mothers and fathers.

Figure 1

Conceptual Model 1. Direct Links

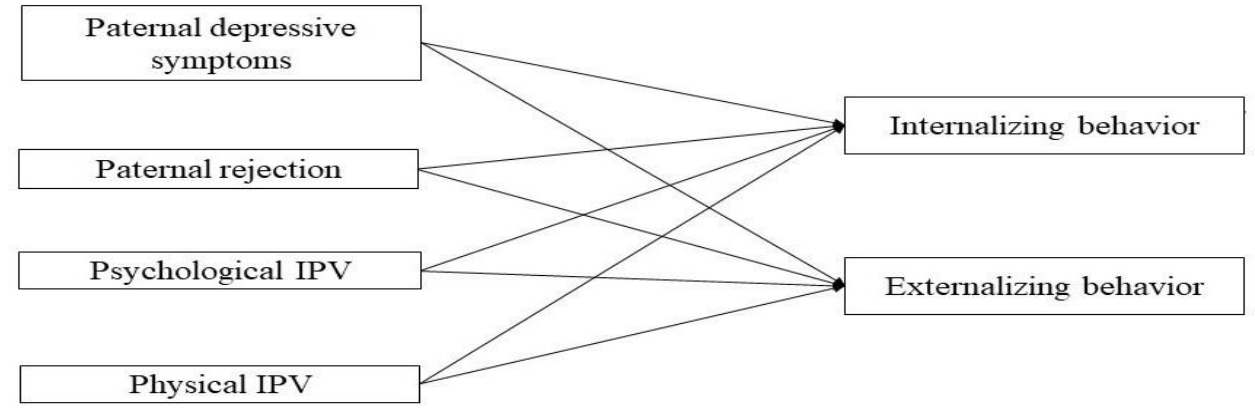
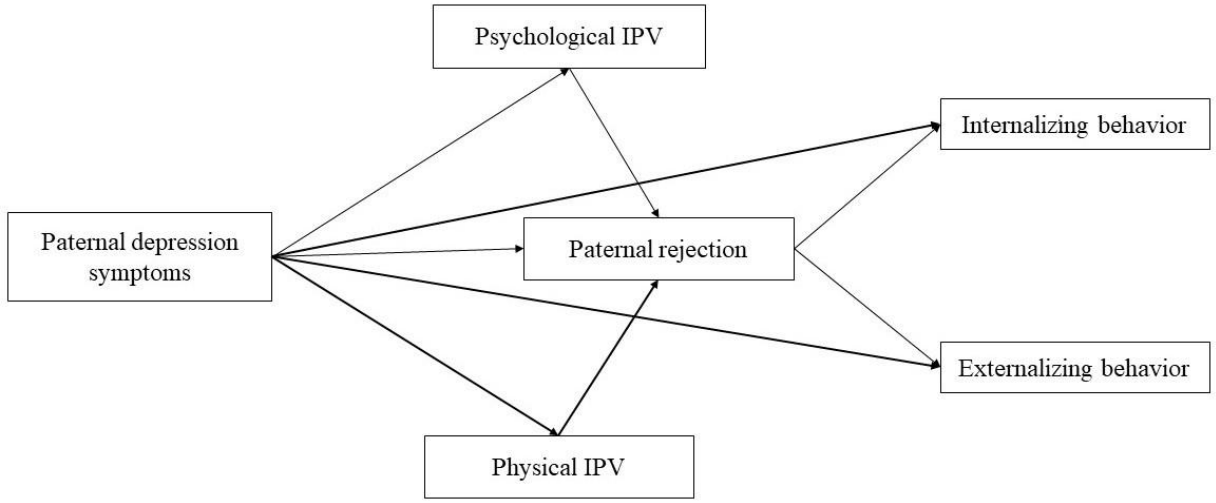


Figure 2

Conceptual Model 2. Indirect Links



Chapter 4: Method

Participants

Participants were recruited from Kakamega county located in the Western part of Kenya. Among the poorest in Kenya, Kakamega county has a poverty rate of 56%, with a literacy rate of 72.7% (Kenya National Bureau of Statistics, 2017). The main sources of economic sustenance are crop production and animal rearing. Kakamega county is predominantly populated by Luhya that consists of 18 sub-ethnic groups (i.e., Banyala, Banyore, Batsotso, Bukusu, Gisu, Idakho, Isukha, Kabras, Khayo, Kisa, Marachi, Maragoli, Marama, Masaaba, Samia, Tachoni, Tiriki and Wanga) (see Kagwanja & Southall, 2009), each speaking a different dialect but share similar cultural practices. Other ethnic groups include Luo and Kalenjin. Fathers and mothers and their 4 – 6-year-old children were recruited from both rural and urban communities via posters and word of mouth.

Two hundred and sixty-four couples expressed an interest in participating in the study after which they were contacted by phone to determine whether they met the inclusion criteria: a) being a couple, 18 years and above in age, and residing in Kakamega county, b) having a biological child currently enrolled in a preschool program, and c) the couple and their biological child resided in the same household regardless of marital status, socio-economic background, and ethnicity. Before data collection, participants were provided with a brief description of the study and its purpose, their role in it, issues of confidentiality on information gathered, their right to withdraw from the study at any time without penalty, and the risks and benefits of participating in the study. Written consent was sought from all couples during the initial home visit. Approval to conduct the study was granted by the Institutional Review Board at Syracuse University (IRB No. 20-333, 2019).

Two hundred and eleven couples met the selection criteria indicated above. Ten couples withdrew from the study and 8 were dropped because only one or both partners were not available due to difficulties with scheduling a home visit. Of the 211 couples who expressed an interest in the study and were contacted, 193 (91%) completed the questionnaires. Families were representative of the local population with 57% being Luhya, 28% Luo, 5% Kalenjin, and 11% from other ethnic groups (e.g., Kikuyu, Kamba, Mijikenda, Masai, and Turkana among others). Sixty-nine percent of couples were married, 8% were in a long-term committed relationship, and 22% were in common-law unions. On average, fathers were 35 years (SD = 5.83 years) and mothers 30 years (SD = 5.07 years) of age. Four percent of fathers and 6% of mothers had attained a primary education certificate, 22% of fathers and 29% of mothers had attained a secondary education certificate, 45% of fathers and 48% of mothers were college graduates, 26% of fathers and 15% of mothers were university graduates, and 3% of fathers and 3% of mothers had post-graduate degrees. Forty-five percent of mothers were employed full-time, 32% had casual employment, and 23% were unemployed. Family incomes ranged from less than US$ 100 to more than US$ 1,000 per month, with most families reporting an average income of between US$ 301 and US$ 400 per month.

Children (78 boys and 115 girls) had a mean age of 5.11 years (SD = .786), and all were enrolled in preschool programs. The preschool programs in Kenya are attached to primary schools and accommodate children between 3 and 6 years of age. Preschool education in Kenya is divided into three levels based on children's age: play class for 3-year-old children and below, pre-primary I for 4–5-year-old children, and pre-primary II for children 6 years of age. Sixty-two percent of the children were residing with their biological father and mother while 38% were

residing with their biological father, mother, and other relatives. Table 1 provides more information on the characteristics of the participants.

Table 1

Demographic Details on Participants (N = 193 couples)

Variable	N (%)	Mean	Standard Deviation
Child age		5.11	.786
Boys	78(40.4%)	5.17	.813
Girls	511(59.6%)	5.07	.769
Living arrangement			
Living with biological father and mother	119(61.7%)		
Biological father, mother, and other relatives	74(38.3%)		
Mother's age	(Range 22-44 years)	30.11	5.06
Father's age	(Range 20-57 years)	34.65	5.83
Ethnicity			
Luhya	109(56.5%)		
Luo	53(27.5%)		
Kalenjin	10(5.2%)		
Others	21(10.9%)		
Marital status			
Married	135(69.9%)		
Long-term commitment	15(7.8%)		
Common-law	43(22.3%)		
Mather's education level		2.79	.861
Primary	12(6.2%)		
Secondary	55(28.5%)		

Variable	N (%)	Mean	Standard Deviation
College	93(48.2%)		
University	28(14.5%)		
Post-graduate	5(2.6%)		
Father's education level		3.02	.869
Primary	8(4.1%)		
Secondary	42(21.8%)		
College	87(45.1%)		
University	51(26.4%)		
Post-graduate	5(2.6%)		
Employment status			
Permanent employment	86(44.6%)		
Casual employment	62(32.1%)		
Unemployed	45(23.3%)		
Family income		3.58	2.29
Bellow US$ 100	35(18.1%)		
US$ 101 – 200	44(22.8%)		
US$ 201 – 300	31(16.1%)		
US$ 301 – 400	28(14.5%)		
US$ 401 – 500	22(11.4%)		
US$ 501 – 600	9(4.7%)		
US$ 601 – 700	9(4.7%)		
US$ 701 – 800	3(1.6%)		
US$ 801 – 1,000	9(4.7%)		
Above US$ 1,001	3(1.6%)		

Procedure

Fathers and mothers filled out a sociodemographic questionnaire (e.g., age, ethnic group, gender, education level, socio-economic status, employment, marital status, etc.), a parent depressive symptom scale, and a parenting scale. Mothers were asked to fill out an intimate partner violence scale (IPV) and provided assessments of their children's internalizing and externalizing behaviors. The instruments were administered in English as most of the Kenyan population can read and write in English. Assistance was provided to parents who had difficulties with literacy skills. Mothers and fathers completed the instruments in the privacy of their homes. To avoid risks to women who may have reported family violence, mothers and fathers completed the instruments in separate rooms and returned them in a sealed envelope to the researcher on the premises. Each household had a unique identification number which was assigned to the questionnaires.

Measures

Family socioeconomic status

Family socioeconomic status was evaluated using seven indicators. Of these indicators, 4 (source of water, electricity, television, and furniture) were adopted from the World Food Program Survey (2017) and were rated as 0 = no and 1 = yes. Two indicators (mothers' and fathers' education) were adopted from research conducted by Nonoyama-tarumi et al. (2010) and Sun et al. (2016) and were coded as (0 = primary and high school, 1 = college, university, and postgraduate/professional school). Finally, one indicator (income) was adopted from the Kenya National Bureau of Statistics (2017) which categorized low-income households as those with a net monthly income of less than 30,000 Kenya shilling (an equivalent of $300 US) as 0 = below $300 and 1 = above $300. It is worth noting that the World Food Program (2017) used nine

indicators which included the source of water, house floor material, house roof material, electricity, radio, television, sofa-set, wooden chair, and meals. In the current study, house roof materials, house floor materials, radio, wooden chairs, and meals were dropped as they did not load on this factor. Seven items loaded on the socioeconomic factor with factor loadings ranging from .43 to .69. All seven indicators were summed up to obtain the family socioeconomic variable with low scores indicating low socioeconomic status and high scores indicating high socioeconomic status. The Cronbach's alpha for this scale was .70.

Adult Measures

Paternal Depressive symptoms. Fathers' and mothers' depressive symptoms were assessed using the Centre for Epidemiological Studies–Depression Scale (CES-D-12) (Radloff, 1977). The CES-D-12 contains 12 items such as "I did not feel like eating or my appetite was poor," and "I felt that I could not shake off the blues even with help from my family or friends". Responses on each item were rated on a four-point Likert-type scale that ranged from 1 (rarely or none of the time) to 4 (most or all of the time). In this study, the items were recorded as 1=0, 2=1, 3=2, and 4=3. Item responses were summed to provide a total score that ranged between 0 and 36, with lower scores reflecting fewer and higher scores reflecting more depressive symptoms. This scale showed good psychometric properties when used with mothers and fathers in low-income countries (e.g., the Caribbean region). In previous studies, Cronbach's alphas ranged from .80 to .87 (Elgar et al., 2007; Paulson et al., 2009; Roopnarine & Yildirim, 2018). In this study, Cronbach's alphas for the CES-D-12 were .95 for mothers and .94 for fathers.

Intimate Partner Violence. The Revised Conflict Tactics Scales (CTS2) were used to record the level of intimate partner violence within families. Mothers were asked to report on experiences of intimate partner violence as victims, not perpetrators. This scale consists of 39

items that assess five dimensions of IPV experience: psychological aggression (8 items), e.g., “Threatened to hit or throw something at partner”; physical assault (12 items), e.g., “Kicked, bit, or hit partner”; negotiation (6 items), e.g., “Refused to talk about an issue”; sexual coercion (7 items), e.g., "Insisted on sex when a partner did not want to but did not use physical force”; and injury (6 items), e.g., “Felt physical pain that still hurt the next day because of a fight with partner”. Only the psychological aggression and physical assault subscales were utilized in this study. Respondents reported how many times they experienced psychological aggression and physical assault from their partner in the past year by choosing one of eight levels (0=has never happened,1 = once, 2 = twice, 3 = 3–5 times, 4 = 6–10 times, 5 = 11–20 times, 6 = more than 20 times, and 7 = has not happened in the past year but happened before). In this study, category 7 was recorded as 0 because the focus was on instances of IPV for the past year as recommended by Straus et al. (1996).

Following the recommendations made by Lucente et al. (2001) and Newton et al. (2001), the original scores were collapsed into two categories: psychological IPV and physical IPV. Factor analysis indicated that 10 of the 20 original items loaded onto the physical IPV construct with factor loadings ranging between .33 and .69 and that 8 items loaded onto the psychological IPV construct with factor loadings ranging between .35 and .69. Two items were dropped because they loaded on the wrong factor. Items that loaded on each factor were summed to obtain a total score for the physical IPV and psychological IPV subscales, respectively (see Appendix D, Table D1 for full factor loading details). The CTS2 has good internal consistency with Cronbach’s alphas ranging from .79 to .95 (Straus et al., 1996; Roopnarine & Dede Yildirim, 2017). Cronbach’s alphas for these subscales in this study were .78 for physical IPV and .80 for psychological IPV.

Parental Behavior. The Parental Acceptance-Rejection Questionnaire (PARQ) (Rohner & Khaleque, 2005) was used to assess levels of parental acceptance and rejection. The PARQ has 29 items which are rated on a 4–point Likert-type scale from 1 (almost never true) to 4 (almost always true). This scale measures perceptions of parenting along five dimensions: warmth and affection (8 items) e.g., "I treat my child gently and with kindness"; hostility and aggression (6 items) e.g., "I hit my child, even when she/he does not deserve it"; indifference and neglect (6 items) e.g., "I pay no attention to my child"; undifferentiated rejection (4 items) e.g., "I see my child as a big nuisance"; and control (5 items) e.g., "I control whatever my child does".

Because of the focus on parental rejection, the hostility and aggression, indifference and neglect, and undifferentiated rejection subscales were used in this study. The control subscale was not used as it focuses on behavioral rather than psychological control. As per Rohner and Cournoyer (1994), the sixteen items (HRN) were summed to obtain a composite for rejection. Putnick et al. (2012) found that the HRN had good internal consistency when used in cultural communities in Kenya, Colombia, Thailand, China, Sweden, Jordan, Italy, the United States, and the Philippines, with alphas ranging from .84 and .85 for mothers, and .86 and .87 for fathers. In a review of 66 studies conducted in 22 countries across the world, the PARQ showed generally good internal consistency with alphas ranging from .62 and .89 (see Rohner & Khaleque, 2012). For this sample, the Cronbach's alphas for hostility-aggression, undifferentiated-rejection, and neglect-indifference were .87, .69, and .81 respectively for mothers, and .83, .68, and .74 respectively for fathers. Cronbach's alphas for the overall rejection subscale were .93 for mothers and .91 for fathers.

Child Measures

Internalizing and Externalizing Behaviors. Mothers were asked to complete the short version of the Child Behavior Checklist (Achenbach & Ruffle, 2000) which consists of 26 items scored on a 3-point Likert-type scale (1= often true to 3= never true). Eight items assess children's internalizing behavior problems (e.g., "Feels worthless or inferior," and "Is too fearful or anxious"), nine items assess externalizing behavior problems (e.g., "Bullies or is cruel or mean to others," and "Is stubborn, sullen, or irritable"), and nine items assess both internalizing and externalizing behaviors (e.g., "Is impulsive, or acts without thinking," and "Is easily confused or seems be in a fog". Responses to all items were reverse coded (1 = never true, 2 = sometime true, and 3 = often true). In this study, only items for internalizing and externalizing behaviors were utilized in the analysis. Because the data were not normally distributed, Bloom's formula was used to standardize the scores into univariate normal scores before they were summed up to obtain individual subscales for internalizing and externalizing behaviors. Higher scores on both the internalizing and externalizing dimensions indicated greater behavioral difficulties. This clinical instrument has been used successfully in over 60 cultures around the world and shows good internal consistency and cultural validity (see Achenbach, 2016; Ruttle et al., 2011). In this study, Cronbach's alphas were .85 for internalizing behaviors and .86 for externalizing behaviors.

Covariates

Because research has demonstrated that family contextual factors, such as socioeconomic status, are correlated with family and marital stability (see Salisbury et al., 2016), and parent's mental health status (Neamah et al., 2018; Joeng et al., 2016), family socioeconomic status was used as a covariate. It has also been demonstrated that children's age and gender are associated

with children's social skills (Kühhirt & Klein, 2020; Sun et al., 2016). Thus, these variables were entered as covariates in the analyses. Given that mothers have been found to influence fathers' parenting activities and interpersonal functioning (e.g., PTSD, depressive symptoms, anxiety) in rich democratic countries (Olsavsky et al., 2020; Schoppe-Sullivan et al., 2008) and gendered caregiving roles are common in Sub-Sharan Africa where mothers are the primary caregivers (see Cotton & Beguy, 2020; Delprato et al., 2017), maternal depressive symptoms, physical and psychological IPV and maternal rejection were also entered as covariates in the analysis of the paternal additive model (Third step). Child age, gender, and socioeconomic status were entered as covariates in the maternal, paternal, and mediation models, and also in the maternal and paternal cumulative model to discern the paternal influence on children's behaviors above and beyond maternal influence.

Analytic Strategies

Data were screened to determine the distribution of responses across variables/items and to address missing responses. Missing responses for most variables ranged between .5% and 2%. Following the guidelines suggested by Tabachnick and Fidell (2013), mean imputation was used as follows; age (1) replaced by (M = 5), gender (3) replaced by (M = 1), mother's education level (4) and fathers' education level (4) replaced by (M = 3), family income (1) replaced by (M = 4). Further, on the maternal depressive symptoms scale, 10 responses on five items (item 6 (4), item 8 (2), item 10 (1), item 11 (2), and item 12 (1) were missing, and they were replaced by (M = 2). On paternal depressive symptoms, one response was missing across the 12 items, and it was replaced by (M = 2). On the intimate partner violence scale, items 2,5,7,13,14, 16, 17, and 18 had one response missing on each, and item 11 had two responses missing. All missing values were replaced by (M = 2).

The frequency analysis of the maternal rejection scale indicated that items 7,13,15,19, and 21, each had one missing response, while items 14 and 17 had 2 and 3 missing responses, respectively. All of these items, except item 7 (replaced by the mean of 2), were replaced by (M = 3). On the paternal rejection scale, items 12,17,19,23, and 26 had one missing response each, and item 14 had three missing responses. All of the missing responses were replaced by (M = 3).

Scanning the internalizing and externalizing behavior problems scale revealed that items 5,6,13,14,16,17 and 26, each had one missing response, items 1,9,22 and 24, each had two missing responses, items 7,8 and 18 each had three missing responses, and items 2,4,11 and 19 each had four missing responses. These missing values were replaced by (M = 2).

The first part of the analysis involved running an exploratory factor analysis using principal component and direct oblmin rotation to determine whether factor loadings and structure patterns of the intimate partner violence and the behavior problem measures matched those in prior studies (Graham et al., 2003). In the second part of the analysis, Amos 28.0 software (Blunch, 2012) was used to perform path analysis with maximum likelihood (ML) estimation to test the hypothesized models.

First, an additive model was created to assess whether paternal risk factors directly influenced children's internalizing and externalizing behaviors above and beyond the influence of maternal risk factors. In the first step, I assessed the direct impact of the covariates (socioeconomic status, child age, and gender) on children's internalizing and externalizing behaviors. In the second step, maternal depressive symptoms, physical and psychological IPV, and maternal rejection were added to the model to assess their links and variance they accounted for in children's internalizing and externalizing behavior problems, controlling for socioeconomic status, child age, and gender. In the third step, paternal depressive symptoms and

paternal rejection were added to the model again to assess their links and variance they accounted for in children's internalizing and externalizing behaviors controlling for maternal risk factors and covariates. In a nutshell, the simultaneous addition of the maternal and paternal risk factors was to determine both the cumulative and unique variance accounted for by the covariates, maternal risk factors, and paternal risk factors on children's internalizing and externalizing behaviors in step two and three respectively. The fourth step represented the final model (additive model) which included only variables that were significantly associated with children's internalizing and externalizing behaviors in the third step and the paths recommended by the modification indices when testing the model fit. The tests of model fit for the data were provided for this model only.

Secondly, three mediation models were created to assess the indirect pathways of association between paternal and maternal depressive symptoms and children's internalizing and externalizing behaviors through multiple mediators (psychological IPV, physical IPV, paternal rejection, and maternal rejection), controlling for socioeconomic status, child age, and gender. The test of the hypothesized mediation models utilized 5,000 bootstrap samples with 95% bias-corrected confidence intervals. The paternal and maternal mediation structural models were tested independently and jointly. Model 2a assessed the mediated pathways of associations between maternal depressive symptoms and children's internalizing and externalizing behaviors through psychological IPV, physical IPV, and maternal rejection controlling for socioeconomic status, child's age, and gender, while Model 2b assessed the mediated pathways of associations between paternal depressive symptoms and children's internalizing and externalizing behaviors through psychological IPV, physical IPV, and paternal rejection, again after controlling for socioeconomic status, child's age and gender. Model 2c was created to jointly assess the

mediated effects of maternal and paternal depressive symptoms on children's internalizing and externalizing behaviors through psychological IPV, physical IPV, maternal rejection, and paternal rejection after controlling for socioeconomic status, children's age, and gender.

In the joint mediated model (model 2c), the indirect effects of maternal depressive symptoms were only assessed through both IPVs and maternal rejection while for paternal depressive symptoms the indirect effects were assessed through both IPVs and paternal rejection. The Chi-square statistic value above .05: Goodness of Fit Index value of above .95; Root Mean Square Error of Approximation (RMSEA) (Browne & Cudeck, 1993) value of less than .05, Comparative Fit Index (CFI) (Hoyle, 1995) value of above .95; and Tucker-Lewis Index (TLI) (Tucker & Lewis, 1973) value of above .95 (Hu & Bentler, 1999) were used to determine whether the hypothesized models fit the data.

Chapter 5: Results

To reiterate, this study examined the direct and indirect effects of paternal depressive symptoms on children's internalizing and externalizing behaviors through physical and psychological intimate partner violence and paternal rejection above and beyond maternal interpersonal and interpersonal risk factors in Kenyan couples with preschool-aged children. In this chapter, a set of preliminary analyses are introduced first followed by a presentation of the main findings of the study as expressed in the different models tested.

Preliminary analysis

Table 2 presents Cronbach's alphas, means, and standard deviations for the key measures used in this study. Table 3 presents the intercorrelations of the key predictor and outcome variables. Maternal depressive symptoms were significantly associated with paternal depressive symptoms ($r = .34$, $p < .01$), psychological IPV ($r = .27$, $p < .01$), physical IPV ($r = .24$, $p < .01$), maternal rejection ($r = .42$, $p < .01$), paternal rejection ($r = .17$, $p < .05$), children's internalizing ($r = .21$, $p < .01$) and externalizing behaviors ($r = .36$, $p < .01$). Similarly, paternal depressive symptoms were associated with psychological IPV ($r = .36$, $p < .01$), physical IPV ($r = .25$, $p < .05$), maternal rejection ($r = .21$, $p < .01$), paternal rejection ($r = .32$, $p < .01$), children's internalizing ($r = .26$, $p < .01$) and externalizing behaviors ($r = .46$, $p < .01$). There were significant associations between psychological IPV and physical IPV ($r = .52$, $p < .01$), maternal rejection ($r = .36$, $p < .01$), paternal rejection ($r = .33$, $p < .01$), and children's internalizing ($r = .22$, $p < .01$) and externalizing behaviors ($r = .32$, $p < .01$), and between physical IPV and maternal rejection ($r = .27$, $p < .01$), paternal rection ($r = .26$, $p < .01$) and children's externalizing behaviors ($r = .22$, $p < .01$). Maternal rejection was associated with paternal rejection ($r = .52$, $p < .01$), children's internalizing ($r = .25$, $p < .01$), and externalizing behaviors

($r = .39$, $p < .01$). Likewise, paternal rejection was significantly associated with children's internalizing ($r = .22$, $p < .01$) and externalizing behaviors ($r = .27$, $p < .01$), and children's internalizing behaviors was associated with their externalizing behaviors ($r = .68$, $p < .01$).

Among the covariates, children's age was correlated with children's externalizing behaviors ($r = .17$, $p < .05$), and socioeconomic status was correlated with maternal depressive symptoms ($r = .16$, $p < .05$), maternal rejection ($r = .22$, $p < .01$), and paternal rejection ($r = .17$, $p < .05$) (See table 3 for more details).

Table 2

Information on the Scales

Scale	Cronbach's alpha	Mean	Standard deviation
Maternal depressive symptoms	.95	10.50	8.62
Paternal depressive symptoms	.94	13.85	8.81
Physical IPV	.78	6.66	7.54
Psychological IPV	.80	7.44	7.48
Maternal Rejection			
Hostility/Aggression	.87	11.19	4.58
Undifferentiated Rejection	.69	6.59	2.55
Indifference/Neglect	.81	10.63	3.87
Total maternal rejection	.93	28.41	10.42
Paternal Rejection			
Hostility/Aggression	.83	13.02	4.35
Undifferentiated Rejection	.68	7.54	2.59
Indifference/Neglect	.74	12.39	3.72
Total Paternal rejection	.91	32.96	10.01
Internalizing behaviors	.85	14.31	4.44
Externalizing behaviors	.86	15.80	4.98
* Socioeconomic status (control variable)	.70	2.11	1.9

Note: IPV= Intimate Partner Violence

Table 3

Matrix of Intercorrelations Among the Study Variables (n = 193)

	Variables	1	2	3	4	5	6	7	8	9	10	11
1	Child age	-										
2	Child gender	.06	-									
3	Socioeconomic status	.02	-.05	-								
4	Maternal depressive symptoms	-.03	.09	.16*	-							
5	Paternal depressive symptoms	.02	.10	.08	.34**	-						
6	Psychological IPV	-.04	.01	.13	.27**	.36**	-					
7	Physical IPV	-.13	.06	.08	.24**	.25*	.52**	-				
8	Maternal rejection	.02	.13	.22**	.42**	.21**	.36*	.27**	-			
9	Paternal rejection	.01	.04	.17*	.17*	.32**	.33**	.26**	.52**	-		
10	Internalizing behaviors	.11	-.10	.08	.21**	.26**	.22**	.06	.25**	.22**	-	
11	Externalizing behaviors	.17*	-.06	.09	.36**	.46**	.32**	.22**	.39**	.27**	.68**	-

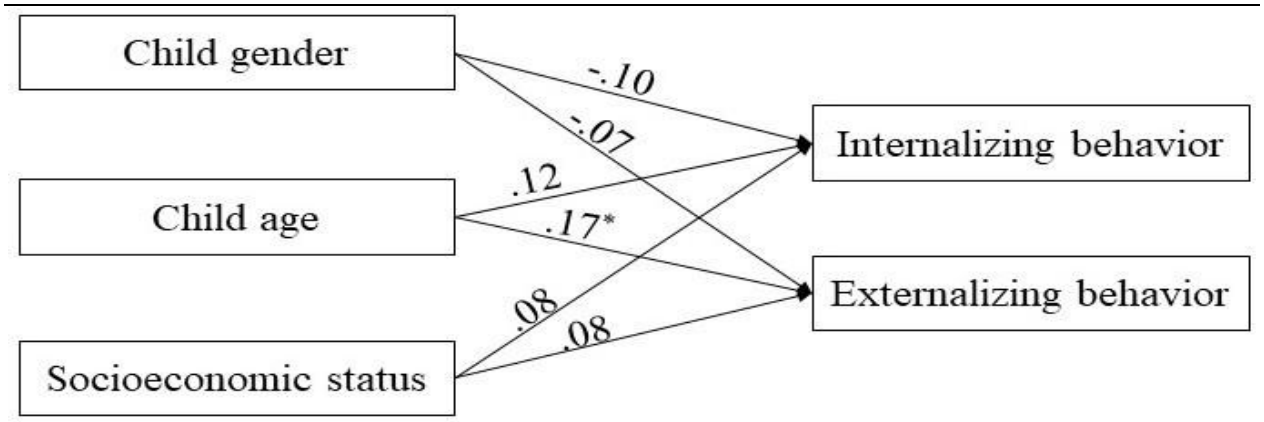
*$p < .05$ **$p < .01$ ***$p < .001$ level.

1. Child age; 2. Child age; 3. socioeconomic status; 4. Maternal depressive symptoms; 5. Paternal depressive symptoms; 6. Psychological IPV; 7. Physical IPV; 8. Maternal rejection; 9. Paternal rejection; 10. Internalizing behaviors; 11. Externalizing behaviors.

Direct Links Between Maternal and Paternal Risk Factors and Children's Behaviors

Figure 3

Association Between Covariates and Children's Behavior

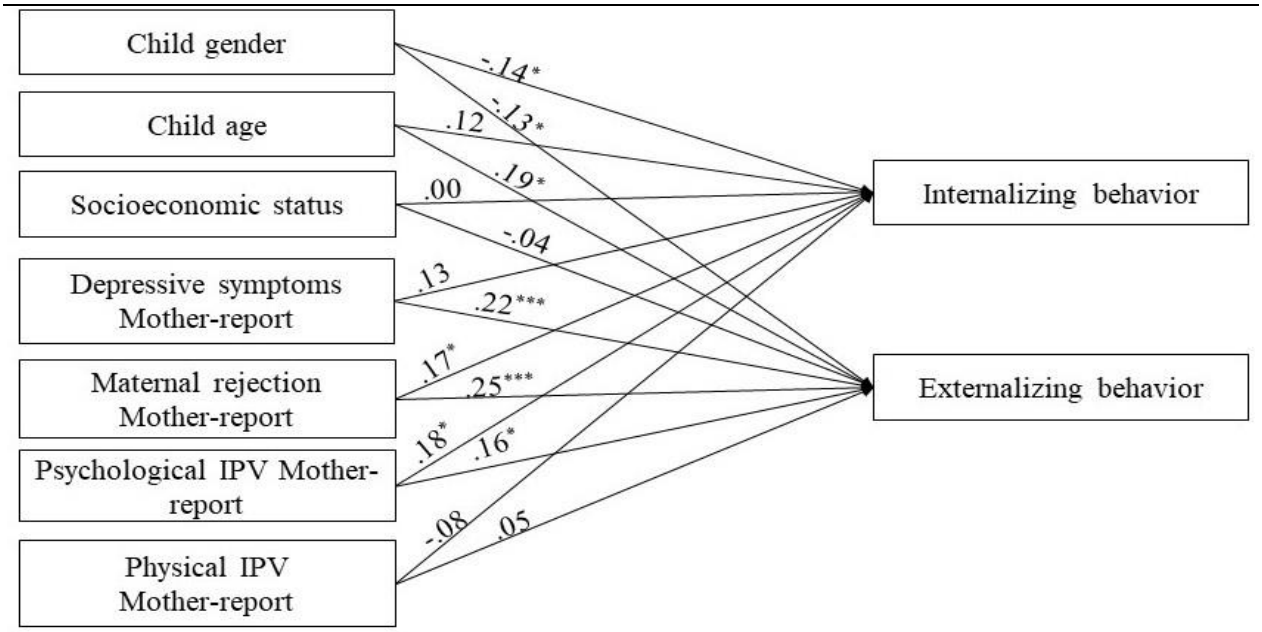


Note. Note: IPV=Intimate Partner Violence. Figure values are standardized coefficients. *$p < .05$, **$p < .01$, ***$p < .001$

The first step of the additive model involved assessing the associations between child gender, child age, and socioeconomic status (covariates) and children's behavioral problems (see Figure 3). As can be seen, children's age was positively associated with children's externalizing behaviors (standardized β = .17, p = .01), but not internalizing behaviors (standardized β = .12, p = .09). There were no significant associations between socioeconomic status and children's internalizing or externalizing behaviors. Also, no significant associations were found between child gender and children's internalizing and internalizing behaviors. The model explained 3% of the variance in internalizing and 4% of the variance in externalizing behaviors.

Figure 4

Associations Between Maternal Risk Factors and Children's Behavior



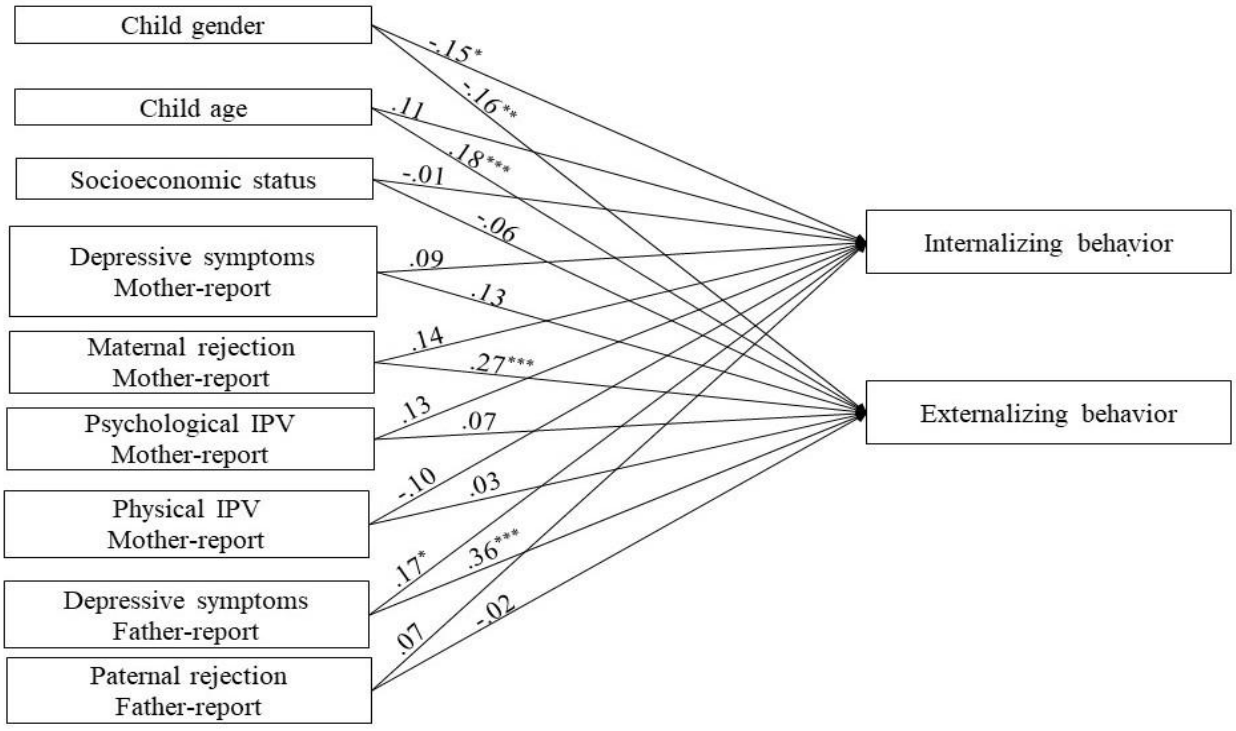
Note. Note: IPV=Intimate Partner Violence. Figure values are standardized coefficients. $^{*}p < .05$, $^{**}p < .01$, $^{***}p < .001$

In the second step, the direct links between maternal depressive symptoms, maternal rejection, physical IPV and psychological IPV and children's internalizing and externalizing behaviors were assessed controlling for socioeconomic status, child's age, and gender (see Fig.

4). Maternal depressive symptoms were positively associated with children's externalizing (standardized β = .22, p = .001) but not internalizing behaviors (standardized β = .13, p = .09). Further, maternal rejection was positively associated with children's internalizing (standardized β = .17, p = .03) and externalizing behaviors (standardized β = .25, p = .001). There were positive significant associations between psychological IPV and children's internalizing (standardized β = .18, p = .03) and externalizing behaviors (standardized β = .16, p = .04). No significant associations were found between physical IPV and children's internalizing (standardized β = -.08, p = .30) and externalizing behaviors (standardized β = .05, p = .48). The model explained 13.2% and 27.3% of the variance in internalizing and externalizing behaviors, respectively.

Figure 5

Associations Between Paternal Risk Factors and Children's Behavior

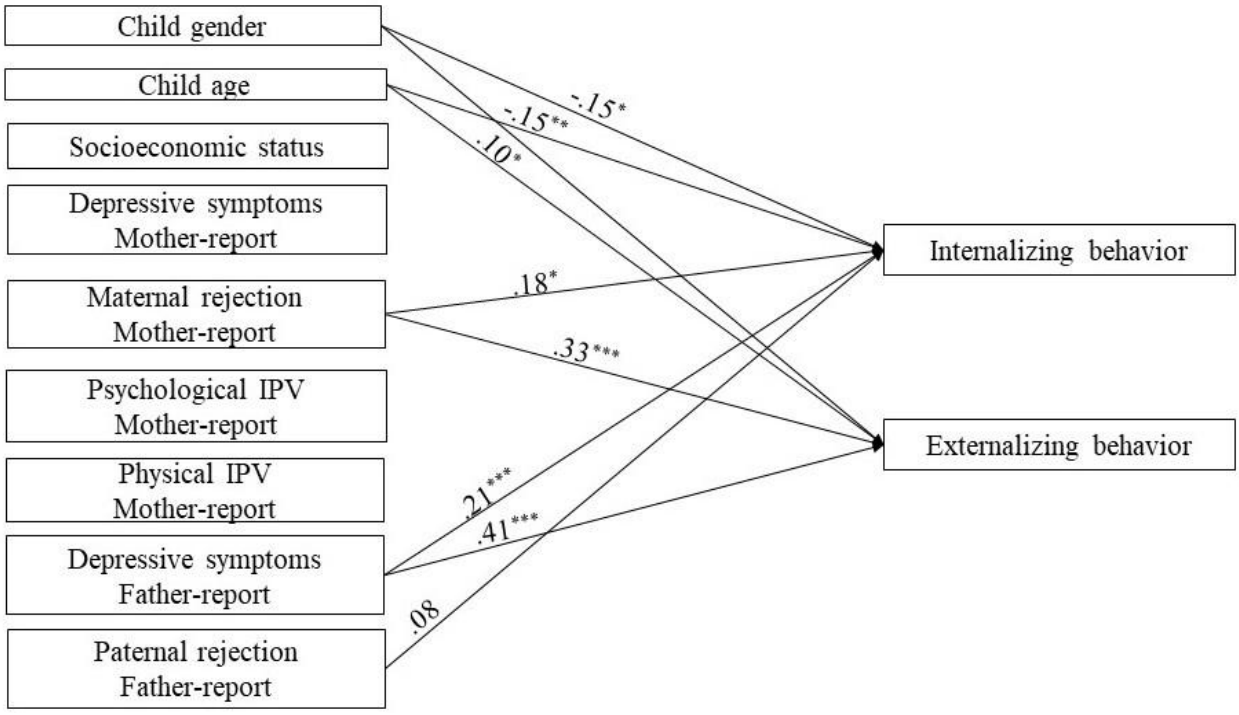


Note. Note: IPV=Intimate Partner Violence. Figure values are standardized coefficients. $^{*}p < .05$, $^{**}p < .01$, $^{***}p < .001$

In the third step, the links between paternal depressive symptoms and paternal rejection and children's behavioral difficulties were assessed controlling for covariates and maternal risk factors (see Fig. 5). Paternal depressive symptoms were positively associated with children's internalizing (standardized β = .17, p = .02), and externalizing behaviors (standardized β = .36, p = .001). No significant associations were found between paternal rejection and children's internalizing (standardized β = .07, p = .40) and externalizing behaviors (standardized β = -.02, p = .78). Overall, the model explained 16.3% and 37.2% of the variance in children's internalizing and externalizing behaviors, respectively. This indicated that, paternal risk factors accounted for additional 3.1% and 9.9% of variance in internalizing and externalizing behaviors, respectively.

Figure 6

Associations Between Maternal and Paternal Risk Factors and Children's Behaviors



Note. Note: IPV=Intimate Partner Violence. Figure values are standardized coefficients. $^{*}p < .05$, $^{**}p < .01$, $^{***}p < .001$

Figure 6 represents an additive model which determined whether paternal risk factors predicted children's behavioral problems above and beyond maternal risk factors. To determine this, significant pathways were retained from the third step. They included paths from children's gender and paternal depressive symptoms to children's internalizing behaviors, and paths from children's gender, age, maternal rejection, and paternal depressive symptoms to children's externalizing behaviors. This model had poor fit for the data (X^2 (df 12) = 24.89, $p < .02$, GFI = .98, TLI = .87, CFI = .97, and RMSEA = .08). To improve the model fit, direct pathways from paternal rejection and maternal rejection to children's internalizing behaviors were added to the model. The final model showed good fit for the data (X^2 (df 10) =13.43, $p < .20$, GFI = .99, TLI = .96, CFI = .99, and RMSEA = .04) (see Fig. 6). Children's gender was negatively associated with internalizing (standardized β = -.15, p = .03) and externalizing behaviors (standardized β = -.15, p = .01). Further, children's age was positively associated with externalizing behaviors (standardized β = .10, p = .03). There were significant, positive links between maternal rejection and children's internalizing (standardized β = .18, p = .03) and externalizing behaviors (standardized β = .33, p = .001). Paternal depressive symptoms had significant, positive associations with children's internalizing (standardized β = .21, p = .003) and externalizing behaviors (standardized β = .41, p = .001). There was no significant association between paternal rejection and children's internalizing behaviors (standardized β= .08, p = .20). These associations indicate that paternal depressive symptoms fully predicted children's internalizing and externalizing behaviors above and beyond maternal depressive symptoms. With regards to parenting, paternal rejection did not predict children's internalizing behaviors above and beyond maternal rejection. Overall, the model explained 13.4% of the variance in internalizing and 33.9% of the variance in externalizing behaviors.

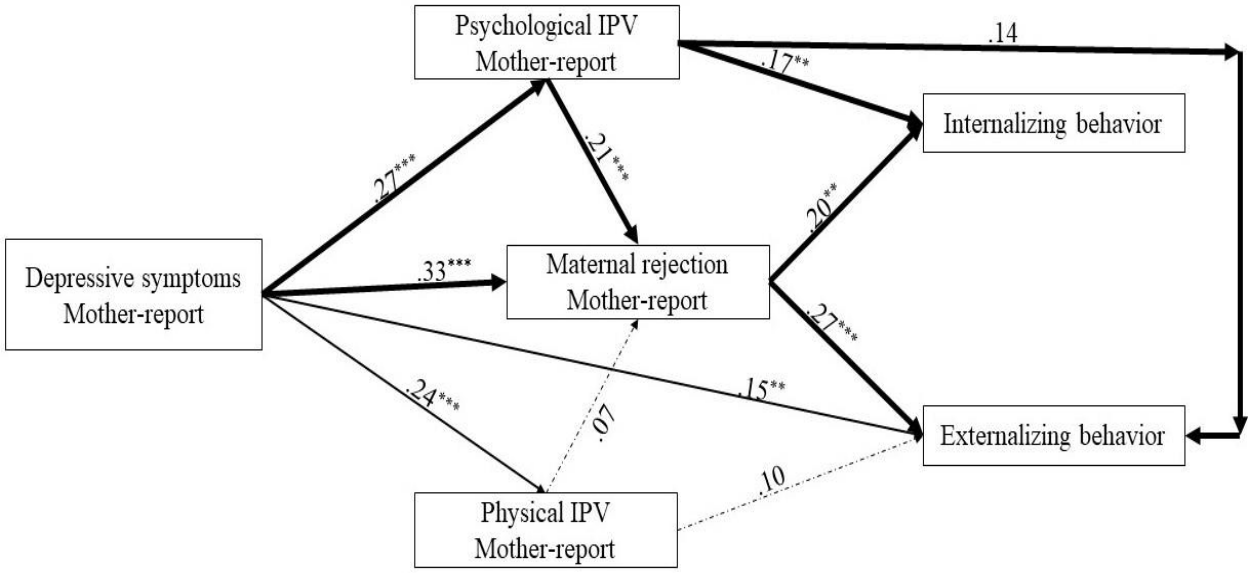
Mediating Roles of Psychological and Physical IPV and Maternal and Paternal Rejection

This final set of analyses probed whether physical and psychological IPV, and rejection mediated the associations between depressive symptoms and preschool children's internalizing and externalizing behaviors differently for mothers and fathers. Three mediation models were tested to establish the independent and cumulative influence of maternal and paternal depressive symptoms on children's internalizing and via physical and psychological IPV, and maternal and paternal rejection.

Model 2a examined the impact of maternal depressive symptoms on children's internalizing and externalizing behaviors through psychological IPV, physical IPV, and maternal rejection, controlling for socioeconomic status, children's gender, and age (see Figure. 7). The initial model did not show a good fit for the data (X^2 (df 17) = 196.85, $p < .001$, GFI = .84, TLI = -.24, CFI = .42, and RMSEA = .24). To improve the model fit, five pathways were added: (a) a direct path between socioeconomic status and maternal rejection, (b), a direct path between psychological IPV and children's internalizing behaviors, (c) a direct path between maternal depression and children's externalizing behaviors (d) a direct path between psychological IPV and children's externalizing behaviors, and (e) a direct path between physical IPV and children's externalizing behaviors. In addition, the error terms for psychological and physical IPV, and those of for internalizing and externalizing behaviors were covaried. After these adjustments, the model showed good fit for the data (X^2 (df 10) = 13.11, $p > .22$, GFI = .99, TLI = .96, CFI = .99, RMSEA = .04).

Figure 7

Model 2a: Indirect Links Between Maternal Risk Factors and Children's Behaviors



Note. Bold solid lines = mediation pathways, solid lines = significant paths, doted lines = nonsignificant paths. IPV=Intimate Partner Violence, Figure values are standardized coefficients; $^{*}p < .05$, $^{**}p < .01$, $^{***}p < .001$.

Table 4

Maternal Risk Factors and Childhood Outcomes: Mediation Pathways

	Bootstrap estimate			95% Confidence interval
Path/effects	*B*	*SE*	*P*	Bootstrap with bias correction
Path a; Maternal depressive symptoms → Psychological IPV → Maternal rejection → Internalizing	.006	.004	.004	.001, .017
Path b; Maternal depressive symptoms → Psychological IPV → Maternal rejection → Externalizing	.009	.004	.003	.003, .022
Path c; Maternal depressive symptoms → Maternal rejection → Internalizing	.034	.015	.003	.010, .072
Path d; Maternal depressive symptoms → Maternal rejection → Externalizing	.051	.017	.000	.024, .093
Path e; Maternal depressive symptoms → Psychological IPV → Internalizing	.022	.012	.022	.003, .050
Path f; Maternal depressive symptoms → Psychological IPV → Internalizing	.022	.013	.041	.001, .051

Note: IPV=Intimate Partner Violence $^{*}p < .05$, $^{**}p < .01$, $^{***}p < .001$.

Maternal depressive symptoms affected children's behavior problems through six pathways of associations (see Table 4). In path (a), maternal depressive symptoms had a significant indirect effect on children's internalizing behaviors through psychological IPV and

maternal rejection (estimated indirect effects and 95% Bootstrap CIs = $\beta_{indirect}$ .006, [.001, .017], p = .004). Because there was no direct link between maternal depressive symptoms and children's internalizing behaviors, this path indicates that psychological IPV and maternal rejection fully mediated the association. In path (b), maternal depressive symptoms had a significant, indirect effect on children's externalizing behaviors via psychological IPV and maternal rejection (estimated indirect effects and 95% Bootstrap CIs = $\beta_{indirect}$ .009, [.003, .022], p = .03). In this pathway, maternal depressive symptoms were positively associated with psychological IPV which had a positive association with maternal rejection which in turn was positively associated with children's externalizing behaviors. Thus, psychological IPV and maternal rejection mediated the association between maternal depressive symptoms and children's externalizing behaviors.

In path (c), maternal depressive symptoms had a significant indirect effect on children's internalizing behaviors through maternal rejection (estimated indirect effects and 95% Bootstrap CIs = $\beta_{indirect}$ .034, [.010, .072], p = .003). Maternal rejection fully mediated the association between paternal depressive symptoms and children's internalizing behaviors as there was no direct link between maternal rejection and children's internalizing behaviors. Path (d) also indicated that maternal depressive symptoms showed a positive indirect association with children's externalizing behaviors through maternal rejection (estimated indirect effects and 95% Bootstrap CIs = $\beta_{indirect}$ .051, [.024, .093], p = .001). These pathways signified the presence of a mediation effect of maternal rejection on the associations between maternal depressive symptoms and children's internalizing and externalizing behaviors.

In path (e), psychological IPV fully mediated the association between maternal depressive symptoms and children's internalizing behaviors (estimated indirect effects and 95%

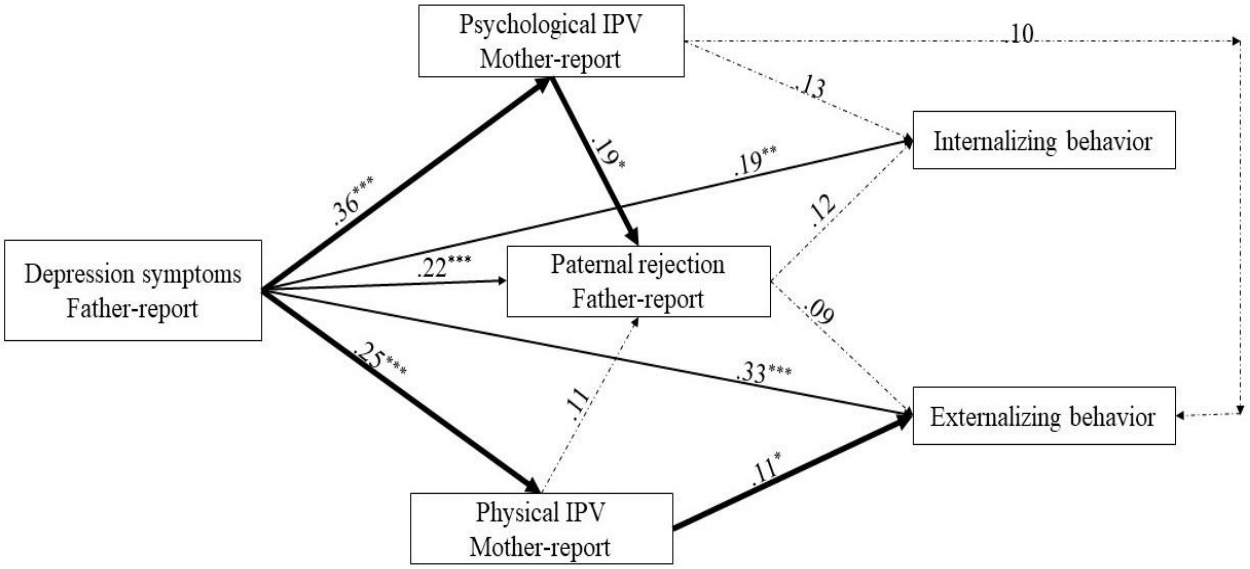
Bootstrap CIs = $\beta_{indirect}$ .022, [.003, .050], p = .02). In path (f) psychological IPV partially mediated the indirect links between maternal depressive symptoms and children's externalizing behaviors (estimated indirect effects and 95% Bootstrap CIs = $\beta_{indirect}$ .022, [.001, .051], p = .04). After entering psychological IPV in the model, maternal depressive symptoms still predicted children's externalizing behaviors (standardized β = .15, p = .007) indicating that psychological IPV partially mediated this link.

The total effect of maternal depressive symptoms on children's internalizing and externalizing behaviors via psychological IPV and maternal rejection was examined. There was a significant total indirect effect of maternal depressive symptoms on children's internalizing (estimated indirect effects and 95% Bootstrap CIs = $\beta_{indirect}$ .063, [.030, .108], p = .001) and externalizing behaviors (estimated indirect effects and 95% Bootstrap CIs = $\beta_{indirect}$ .082, [.049, .133], p = .001) via psychological IPV and maternal rejection. Even though maternal depressive symptoms had a direct association with physical IPV (standardized β = .24 p < .001), physical IPV was not associated with maternal rejection and therefore this mediation pathway was not assessed. Overall, the model explained 11.9% of the variance in internalizing behaviors and 26.8% of the variance in externalizing behaviors.

Model 2b examined the impact of paternal depressive symptoms on children's internalizing and externalizing behaviors through psychological IPV, physical IPV, and paternal rejection, controlling for socioeconomic status, children's gender, and age (see Figure. 8). The initial model did not show a good fit for the data (X^2 (df 17) = 220.16, p < .001, GFI = .82, TLI = -.44, CFI = .32, and RMSEA = .25).

Figure 8

Model 2b: Indirect Links Between Paternal Risk Factors and Children's Behaviors



Note. Bold solid lines = mediation pathways, solid lines = significant paths, doted lines = nonsignificant paths. IPV=Intimate Partner Violence. Figure values are standardized coefficients; $^{*}p < .05$, $^{**}p < .01$, $^{***}p < .001$.

Model fit was improved by adding five pathways: (a) a direct path between paternal depressive symptoms and children's internalizing behaviors, (b) a direct path between paternal depressive symptoms and children's externalizing behaviors (c) a direct path between psychological IPV and children's internalizing behaviors, (d) a direct path between psychological IPV and children's externalizing behaviors, and (e) a direct path between physical IPV and children's externalizing behaviors. In addition, the error terms for psychological and physical IPV, and for internalizing and externalizing behaviors were covaried. The adjusted model showed a good fit for the data (X^2 (df 10) = 11.30, p =.33, GFI = .99, TLI = .98, CFI = 1.00, RMSEA = .03).

Table 5

Paternal Risk Factors and Childhood Outcomes: Mediation Pathways

Path/effects	Bootstrap estimate			95% Confidence interval
	B	*SE*	*P*	Bootstrap with bias correction
Paternal depressive symptoms ⟶ Physical IPV ⟶ Externalizing	.015	.009	.04	.001, .037

Note: IPV=Intimate Partner Violence $^{*}p < .05$, $^{**}p < .01$, $^{***}p < .001$.

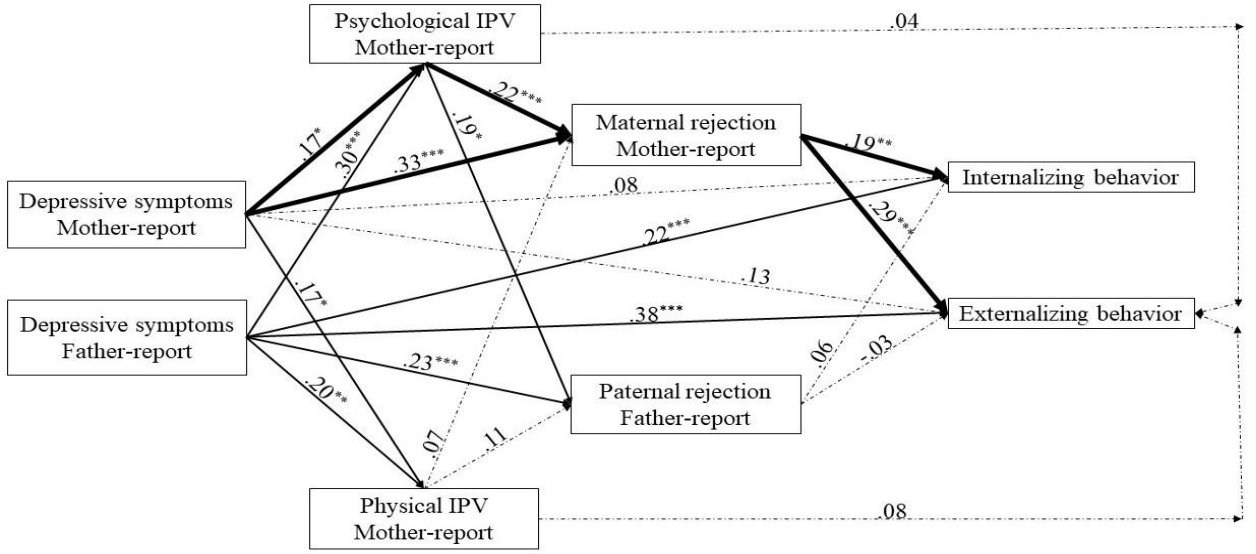
An examination of the indirect paths showed one indirect link between paternal depressive symptoms and children's externalizing behaviors through physical IPV (estimated indirect effects and 95% Bootstrap CIs = $\beta_{indirect}$ .015, [.001, .037], p = .04). Physical IPV partially mediated this association since there was a direct link between paternal depressive symptoms and children's externalizing behaviors (standardized β = .33 p < .001). Overall, the model explained 13.2% of the variance in internalizing behaviors and 30.2% of the variance in externalizing behaviors.

Model 2c combined both maternal and paternal risk factors in examining the indirect pathways of associations between maternal and paternal depressive symptoms and children's behavior problems via multiple family process mediators (psychological IPV, physical IPV, maternal rejection, and paternal rejection) controlling for socioeconomic status, children's gender, and age (see Figure. 9). The initial cumulative model did not show a good fit for the data (X^2 (df 24) = 161.42, p < .000, GFI = .88, TLI = .29, CFI = .69, and RMSEA = .17). Model fit was improved by adding six pathways: (a) a direct link between socioeconomic status and maternal rejection, (b) a direct path between maternal depressive symptoms and children's externalizing behaviors, (c) a direct path between paternal depressive symptoms and children's internalizing behaviors, (d) a direct path between paternal depressive symptoms and children's externalizing behaviors, and (e) a direct path between psychological IPV and children's

externalizing behaviors. In addition, the error terms for psychological and physical IPV, internalizing and externalizing behaviors, and maternal rejection and paternal rejection were covaried, respectively. The adjusted model showed a good fit for the data (X^2 (df 17) = 16.93, p = .46, GFI = .98, TLI = 1.00, CFI = 1.00, RMSEA = .001).

Figure 9.

Model 2c: Indirect Links Between Paternal and Maternal Risk Factors and Children's Behaviors



Note. Bold solid lines = mediation pathways, solid lines = significant paths, doted lines = nonsignificant paths. IPV=Intimate Partner Violence. Figure values are standardized coefficients; $^{*}p < .05$, $^{**}p < .01$, $^{***}p < .001$.

Table 6

Maternal and Paternal Risk Factors and Childhood Outcomes: Mediated Pathways

	Bootstrap estimate			95% Confidence interval
Path/effects	*B*	*SE*	*P*	Bootstrap with bias correction
Path a; Maternal depressive symptoms → Psychological IPV → Maternal rejection → Internalizing	.004	.003	.018	.000, .013
Path b; Maternal depressive symptoms → Psychological IPV → Maternal rejection → Externalizing	.006	.004	.010	.001, .018
Path c; Maternal depressive symptoms → Maternal rejection → Internalizing	.032	.015	.011	.007, .068
Path d; Maternal depressive symptoms → Maternal rejection → Externalizing	.055	.018	.001	.026, .098

Note: IPV=Intimate Partner Violence $^{*}p < .05$, $^{**}p < .01$, $^{***}p < .001$.

As can be seen in table 6, direct and indirect effects were established for some factors within the model. However, these effects did not extend to children's behavior problems. For example, paternal depressive symptoms were indirectly (via psychological IPV) and directly associated with paternal rejection, but paternal rejection was not associated with children's internalizing and externalizing behaviors. Hence, the mediation pathways between paternal depressive symptoms and children's internalizing and externalizing behaviors were not confirmed.

With respect to mothers, the model indicated the existence of four fully mediated pathways (see table 6) between maternal depressive symptoms and children's externalizing behaviors. In path (a), maternal depressive symptoms had a significant indirect effect on children's internalizing behaviors via psychological IPV and maternal rejection (estimated indirect effects and 95% Bootstrap CIs = $\beta_{indirect}$ .004, [.000, .013], p = .02). In this pathway of association, maternal depressive symptoms were positively associated with psychological IPV which had a positive association with maternal rejection which in turn was positively associated with children's internalizing behaviors. In path (b), maternal depressive symptoms had a significant indirect effect on children's externalizing behaviors via psychological IPV and maternal rejection (estimated indirect effects and 95% Bootstrap CIs = $\beta_{indirect}$ .006, [.001, .013], p = .01). In this pathway of associations, maternal depressive symptoms were positively associated with psychological IPV which had a positive association with maternal rejection which in turn was positively associated with children's externalizing behaviors. This suggests that psychological IPV and maternal rejection mediated the association between maternal depressive symptoms and children's externalizing behaviors.

Path (c) indicated that maternal depressive symptoms were positively and indirectly associated with children's internalizing behaviors through maternal rejection (estimated indirect effects and 95% Bootstrap CIs = $\beta_{indirect}$ .032, [.007, .068], p = .01). Path (d) also indicated that maternal depressive symptoms were positively and indirectly associated with children's externalizing behaviors through maternal rejection (estimated indirect effects and 95% Bootstrap CIs = $\beta_{indirect}$ .055, [.026, .098], p = .001). Path (c) and (d) indicated that maternal rejection mediated these pathways. There were significant total indirect effects between maternal depressive symptoms and children's internalizing (estimated indirect effects and 95% Bootstrap CIs = $\beta_{indirect}$ .035, [.007, .076], p = .01) and externalizing behaviors (estimated indirect effects and 95% Bootstrap CIs = $\beta_{indirect}$ .061, [.030, .108], p = .001) through psychological IPV and maternal rejection. Overall, the model explained 14.8% of the variance in internalizing and 37.2% of the variance in externalizing behaviors.

Chapter 6: Discussion

There has been increasing attention to fathering and interpersonal and intrapersonal risk and protective factors and childhood outcomes across cultural communities (Gershoff et al., 2010; Lansford et al., 2005; Lansford et al., 2018; Putnick et al., 2018; Rothenberg et al., 2020). Theoretical frameworks and models and research studies in different fields such as developmental psychology, the health sciences, social work, sociology, anthropology, and human development and family science have been instrumental in disentangling how different paternal risk factors within families influence childhood development (Baumrind, 1966; Cprek et al., 2020; Masten & Cicchetti, 2010; Trotman, 2021; Volling et al., 2019). At the same time, studies have also demonstrated how chronic levels of maternal and paternal depressive symptoms influence children's behavioral difficulties through other familial factors such as interparental conflict and parenting practices (Chen & Lee, 2021; Chueng et al., 2021; Evans et al., 2022; Gelaye et al., 2016; Gryczkowski et al., 2010; Hardaway et al., 2012; Hayati Rezvan et al., 2020; Jones et al., 2021; Ogbonnaya et al., 2019).

Despite the progress made in examining paternal parenting and risk and protective factors and childhood outcomes, not much is known about these issues in the low-income countries of sub-Saharan Africa. The context of persistent adverse conditions in these countries include high poverty rates, political unrest, domestic violence, punitive parenting practices, attendant complex cultural belief systems, and poor sanitation and access to health care (see Goodman et al., 2020; Hatcher et al., 2019; McKinnon et al., 2013). Needless to say, the COVID-19 pandemic increased the economic and health burdens on African families disproportionately compared to those in other parts of the world (Agüero, 2020; El-Nimr et al., 2021; Feter et al., 2021; Gadermann et al., 2021; Matoori et al., 2020; Salari et al., 2020; Wang et al., 2020). That said,

this study provides information on how three highly prevalent paternal risk factors influence children's internalizing and externalizing behaviors in Kakamega County in Kenya. This chapter begins by introducing the findings on the direct links between paternal risk factors and children's behavior problems, after which, the indirect links between paternal risk factors and children's behavior problems through intimate partner violence and paternal rejection are laid out.

Drawing on propositions within developmental psychopathology and interparental acceptance-rejection theory, and research studies that focused on paternal and maternal risk factors and childhood outcomes across the globe (Huang et al., 2018; Kingston et al., 2018; Rohner & Khaleque, 2005; Roopnarine & Yildirim, 2018; Rutter & Sroufe, 2000; Volling et al., 2019), this study had two goals. First, an attempt was made to establish the independent influence of paternal depressive symptoms, intimate partner violence, and paternal rejection on children's internalizing and externalizing behaviors. Second, it determined the indirect influence of paternal depressive symptoms on children's internalizing and externalizing behaviors through intimate partner violence and paternal rejection above and beyond identical maternal risk factors.

Direct links between Paternal Depressive Symptoms, Intimate Partner Violence, Paternal Rejection, and Children's Behavior Problems.

Sociodemographic Factors and Children's Behavior Problems

Relations between paternal risk factors (e.g., paternal depressive symptoms, psychological and physical IPV, and paternal rejection) and children's social and cognitive skills have been established in middle- and high-income countries (Du Rocher Schudlich & Cummings, 2003; Fletcher et al., 2011; Keller et al., 2005; Khaleque & Rohner, 2012; Kingstone et al., 2018; Laurenzi et al., 2021; Lausi et al., 2021; Ojeahere et al., 2021; Ramchandani et al., 2005; Roopnarine & Yildirim, 2018). In the current study, it was hypothesized that paternal

depressive symptoms, physical and psychological IPV, and paternal rejection would be positively associated with children's internalizing and externalizing behaviors above and beyond the influence of maternal depressive symptoms, physical and psychological IPV, and maternal rejection.

Although the focus in this section is on hypothesized associations, it is equally important to discuss how child characteristics (e.g., child sex and gender) and other family factors (e.g., socioeconomic, and marital status) influenced links between parental risk factors and childhood development. Consistent with prior investigations (Bair-Merritt et al., 2015; Jouriles et al., 2014; Juan et al., 2020; Ugarte et al., 2021), it was found that children's gender and age were significantly linked to internalizing and externalizing behaviors. However, unlike prior studies (see Hosokawa & Katsura, 2017), there were no significant associations between socioeconomic status and children's internalizing and externalizing behaviors. The lack of associations could be due to the composite measure used to assess family socioeconomic status. Research suggests that financial strain and unemployment are among the major causes of depressive symptoms in families (Anderson et al., 2022), and oftentimes are related to family socioeconomic status and parents' abilities to provide for their children (see Altafim et al., 2018; Sutin et al., 2022). This study did not use these indicators which could have potentially influenced the nature of the associations between socioeconomic status and the childhood outcome measures.

Maternal Depressive Symptoms, Physical and Psychological IPV, Maternal Rejection and Children's Behavior Problems

Although maternal mental health has been found to have a negative impact on children's social and cognitive functioning (Avan et al., 2010; Laurenzi et al., 2021; Ramchandani et al., 2010; Verkuijl et al., 2014), data on relations between maternal depressive symptoms and

children's behavioral difficulties have been inconsistent. Whereas some studies have reported significant associations between maternal depressive symptoms and both internalizing and externalizing behaviors (Hanington et al., 2012; Narayanan & Nærde, 2016), others have only found links to internalizing (Mesman et al., 2017; Park et al., 2018) or externalizing behaviors (Giallo et al., 2014; Sidor et al., 2017). Maternal depressive symptoms in these Kenyan families were associated with children's externalizing but not internalizing behaviors. These findings suggest that when children are exposed to higher levels of maternal depressive symptoms, they respond by directing inappropriate behaviors toward others (e.g., bullying others, being disobedient, cheating, and arguing). Perhaps, this is a way that Kenyan children cope with the lack of emotional access to parents. A study by Trapolini et al. (2007) found associations between maternal depressive symptoms and marital adjustment and children's externalizing behavior problems (e.g., being disobedient, and aggressive).

Prior studies have also shown that the quality of maternal parenting practices influences children's and adolescent's behavioral difficulties (Gershoff et al., 2018; Gershoff & Grogan-Kaylor, 2016; Rauf & Ahmed, 2017; Rohner, 2021; Ugarte et al., 2021). Among these Kenyan families, maternal rejection was positively associated with children's internalizing and externalizing behaviors. Similar patterns have been found in studies conducted in other parts of the world (see Hosokawa & Katsura, 2019; Jackson & Choi, 2018; Lamela et al., 2018). Children who were exposed to harsh maternal parenting practices displayed a range of behavioral problems: internalizing and externalizing behaviors, emotional dysregulation, and hyperactivity. According to Hosokawa and Katsura (2019), maternal use of negative parenting strategies such as spanking, corporal punishment, and inconsistent discipline interferes with achieving optimal parent-child relationship which then makes the child feel unwanted and less loved by their

parents. As a result, children may exhibit more internalizing and externalizing behaviors. The families in the current study represent a cultural community that supports caregivers' use of harsh parenting practices such as caning and spanking as effective strategies for controlling children's behaviors. Regardless of the cultural normative use of these harsh parenting strategies in sub-Sharan Africa, children displayed internalizing and externalizing behaviors in the face of parental difficulties (see Delvin et al., 2018; Lansford et al., 2018; Putnick et al., 2018). This suggests the importance of sensitizing parents about the detrimental effects of negative and punitive parenting practices, irrespective of the cultural beliefs surrounding their use in rearing children.

As with maternal depressive symptoms and rejection, research has also demonstrated that different forms of intimate partner violence have severe effects on children's emotional regulation and social adjustment (Chen & Lee, 2021; Evans et al., 2022; Graham-Bermann & Perkins, 2010; Lee et al., 2019; Papp et al., 2012; Ybarra et al., 2007). As declared in earlier chapters, a great share of studies has investigated the general effect of IPV (as opposed to various typologies of IPV) on childhood outcomes as a unidimensional construct. In this study, the expectation was that experiences of physical and psychological IPV would be positively associated with children's internalizing and externalizing behaviors. Consistent with prior investigations (Coley et al., 2014; McFarlane et al., 2003), it was found that psychological IPV was positively associated with children's internalizing and externalizing behaviors. For example, in a recent study involving a sample of 203 multiethnic families (European Americans, African Americans, Asian, and Hispanics/Latina) drawn from the longitudinal "Following First Families" (Triple F) study in Southeast United States, mothers who experienced psychological IPV

reported more internalizing and externalizing behaviors in their children compared to mothers who never experienced psychological IPV (Fu & Rodriguez, 2021).

In these Kenyan families, physical IPV was not associated with children's internalizing or externalizing behaviors. These findings are contrary to those of prior studies (e.g., Capaldi et al., 2020; Lopez-Soler et al., 2017) which reported that exposure to interparental physical aggression increases the risk of children developing behavioral difficulties. Remember that this study was conducted in a cultural setting that supports and approves of men's violence toward women (see Izugbara et al., 2020). The nonsignificant associations between physical violence and children's behavioral difficulties could be due to cultural socialization about violence and beliefs about gender roles in Kenyan society (Dawes et al., 2005; Lansford et al., 2020; Sutton & Alvarez, 2016; Uthman et al., 2011). Benavides (2015) found that family cultural socialization reduced the risk of children developing internalizing and externalizing behaviors when exposed to adverse home environments preoccupied with frequent occurrences of interparental conflicts and harsh parenting practices. Broadly, this indicates that psychological IPV has a unique influence on children's behavior problems compared to physical IPV. This uniqueness may be accounted for by the context of psychological IPV as in most cases it is hidden and its effects on children are expressed through parental behaviors such as high levels of parental harshness and rejection (see Levendosky et al., 2003; Loucks & Shaffer 2014). Children often respond to these behaviors by bullying other children, breaking things on purpose, social anxiety, crying often, and being worried (see Capaldi et al., 2020; Grasso et al., 2016; Greene et al., 2018; Levendosky et al., 2003). More studies are needed on the mitigating effect of cultural beliefs about violence on behavioral risks to children.

Paternal Depressive Symptoms, Physical and Psychological IPV, Paternal Rejection and Children's Behavior Problems

It was suggested that paternal depressive symptoms would negatively influence children's internalizing and externalizing behaviors in Kenyan families. Consistent with studies from high-income countries (Fisher et al., 2015; Gutierrez-Galve et al., 2014; Ramchandani et al., 2005), paternal depressive symptoms were negatively associated with children's internalizing and externalizing behaviors. Data from sub-Saharan Africa also lend credence to these findings. For instance, Laurenzi et al. (2021) found that children whose fathers reported higher levels of depressive symptoms displayed more internalizing and externalizing behaviors compared to children whose fathers exhibited low or no depressive symptoms. The consensus in patterns of associations may imply that paternal depressive symptoms influence children's behavioral outcomes in similar ways irrespective of the cultural or ethnic background. It is likely that the risks to children due to paternal depressive symptoms may increase in cultural communities (e.g., Kenya) in which adults are ridiculed and stigmatized for being mentally ill (see Kulisewa et al., 2019).

Parenting theories and models and research studies on family relationships have emphasized that positive paternal parenting practices that consist of high warmth, setting realistic limits, and adequate use of guidance strategies play a crucial role in the development of prosocial behaviors in young children (Baumrind, 1966; Smetana, 2017; Ullsperger et al., 2016). By contrast, poor father-child relationships characterized by frequent negative parenting practices such as spanking, hitting with objects, and use of ridicule and shaming are associated with behavioral difficulties in young children across cultural communities (Roopnarine & Yildirim, 2019; Tavassolie et al., 2016; Wittig & Rodrigues, 2019). It was proposed that paternal rejection

would be associated with children's behavioral problems in Kenyan families. This proposition was not substantiated. That paternal rejection was not associated with children's internalizing and externalizing behaviors in Kenyan families is inconsistent with a significant body of work on the negative effects of harsh parenting on children's behavior problems (Macrone et al., 2017; Di Guinta et al., 2020; Ugarte et al., 2021). As indicated above, it is possible that in cultural settings in which paternal use of negative parenting practices (e.g., caning, spanking, show of low/no warmth and love towards children) is highly accepted, children may perceive it as necessary and good practice in shaping appropriate behaviors (Lansford e al., 2004). Some have argued that the normative use of harsh parenting may lessen the impact of rejection on childhood outcomes (Dawes et al., 2005; Lansford et a., 2005; Lansford et al., 2012).

An area of research in the field of child development that is now gaining traction has to do with paternal influences on children's social and cognitive skills above and beyond maternal influence. To further address this focus, an additive model sought to establish the independent effects of paternal risk factors in the presence of maternal risk factors. Research has shown that paternal parenting practices play a crucial role in contributing to childhood development beyond maternal influence (Hovarth et al., 2015; Lamb & Lewis, 2011; Macrone et al., 2017). Although most studies are skewed towards the examination of the independent effects of maternal and paternal risk factors on children's emotional and social development, the pattern has shifted toward having more comprehensive investigations of the joint effects of maternal and paternal risk factors on childhood development (Weinfield et al., 2009; Wittig & Rodrigues, 2019). The argument is that investigating childhood outcomes in the presence of concurrent maternal and paternal risk factors provides a clearer picture of fathers' influence on childhood development,

which would help construct effective intervention and prevention programs that may enhance family and child well-being.

Paternal and Maternal Depressive Symptoms, Physical and Psychological IPV, and Paternal and Maternal Rejection and Children's Behavior Problems

It was hypothesized that paternal depressive symptoms, physical and psychological IPV, and paternal rejection would negatively influence children's internalizing and externalizing behaviors above and beyond the influence of maternal depressive symptoms, physical and psychological IPV, and maternal rejection. Previous investigations (e.g., Braza et al., 2015; Luo et al., 2021; Oliveira et al., 2022; Wang et al., 2021; Wang et al., 2021; Xiao et al., 2021) have demonstrated that paternal rejection is associated with children's internalizing and externalizing behaviors above and beyond the influence of maternal rejection. However, in the current study, these associations were not supported as paternal rejection was not associated with children's internalizing and externalizing behaviors. This may indicate that, unlike in other regions of the world, in Kenyan families, when children are exposed to concurrent paternal and maternal negative parenting practices (e.g., rejection, hostility, and neglect), they are affected by maternal rejection and react by turning inward and express behaviors in nonaggressive ways by withdrawing from social situations, expressing sudden change in moods, fear and feeling frightened, all characteristics of internalizing behaviors. Similarly, under the same family circumstances, these children again appear to only develop and express externalizing behaviors such as cheating, being disobedient, and stubbornness related to mothers' but not fathers' negative parenting practices.

An underlying explanation for the nonsignificant influence of paternal rejection to children's behaviors may reside in the prescribed roles of mothers and fathers in Kenyan society,

and in particular, the rural county of Kakamega where this study was conducted. As stated previously, fathers are viewed as disciplinarians in African cultural communities, (Mwoma, 2015; Van den Berg et al., 2013) and children tend to show more respect and obedience to their fathers and would avoid engaging in or displaying inappropriate behaviors overtly that might warrant punishment (Dawes et al., 2005; Mudany et al., 2013). As for mothers, by being primary caregivers, not only do they spend more time with their children they are the ones who assist children in co-regulating their social behaviors, and therefore, children are more frequently exposed to their negative parenting practices than those of fathers. This may increase the odds of children expressing both internalizing and externalizing behaviors as a function of maternal than paternal risk factors.

To summarize, the findings of this study indicate that paternal depressive symptoms were associated with children's internalizing and externalizing behaviors above and beyond the influence of maternal depressive symptoms (see also Connell & Goodman, 2002; Weinfield et al., 2009). Interestingly, even though maternal depressive symptoms were linked to children's externalizing behaviors in the independent maternal model, in the additive model, the association disappeared. In the presence of maternal depressive symptoms, paternal depressive symptoms contributed unique variance to children's externalizing behaviors over maternal depressive symptoms. It has been suggested that men and fathers have higher odds of overtly expressing their depressive states, whereas mothers tend to internalize their depressive symptoms and have less freedom to express their emotional distress (see Addis, 2008; Shafer et al., 2017). This could account for the differential outcomes between Kenyan mothers and fathers.

Indirect Pathways between Paternal Depressive Symptoms and Children's Behavioral Problems via Intimate Partner Violence and Paternal Rejection

Association between Maternal Depressive Symptoms and Children's Internalizing and Externalizing Behaviors via Physical and Psychological IPV and Maternal Rejection

As expressed at the beginning of this chapter, maternal depressive symptoms emerge from a range of factors such as family instability, high levels of poverty, and financial strain. The mechanisms through which maternal mental health influences children's developmental outcomes have received considerable scrutiny in middle-and high-income countries (Nicholson et al., 2011; van der Storm et al., 2022). In this regard, studies have identified various family-related factors such as poor-parent child relationships, parenting behaviors, interparental conflict, and family instability that can amplify the impact of maternal depressive symptoms on children's problem behaviors (Evans et al., 2022; Fong et al., 2019; Holmes, 2013; Lamela et al., 2018; van der Storm et al., 2022). At this point, it should be mentioned that in the association between parental mental health and IPV is not clear as to which factor has a greater influence on the other. The overwhelming tendency has been to assess their influences interchangeably with some assessing how parental mental health influences IPV (e.g., Leinonen et al., 2003; Schudlinch et al., 2019) and vice versa (Graham-Bermann et al., 2009; Holmes, 2013; Thompson-Walsh et al., 2021). In this study, influences were assessed from depressive symptoms to two modes of IPV (physical and psychological).

Maternal psychological IPV and rejection but not physical IPV were found to mediate the links between maternal depressive symptoms and children's internalizing and externalizing behaviors in these Kenyan families, which is consistent with other work in this area of inquiry (Benner et al., 2020; Derlan et al., 2019). Mothers who experienced elevated levels of depressive

symptoms and were frequently subjected to psychological IPV by their partners were more likely to use negative parenting practices in managing their children's behaviors. Children of these mothers exhibited elevated levels of internalizing and externalizing behaviors (e.g., Fear et al., 2009; Grasso et al., 2016; Gravener et al., 2012; Greene et al., 2018; Neppl et al., 2016). Similar trends have been reported in a few qualitative studies (Bacchus et al., 2017; Fogarty et al., 2019; Guli & Geda, 2021). A systemic review of qualitative studies conducted in low- and middle-income countries found that majority of fathers and mothers who experienced different forms of IPV reported distress and use of harsh parenting such as spanking or beating their children using a stick or objects whenever they misbehaved. Their children expressed behaviors such as depression and fear as well as being stubborn and sometimes disobedient, irrespective of cultural background (see Bacchus et al., 2017).

What stands out is the mediating influence of psychological IPV but not physical IPV through maternal rejection on children's behaviors. A potential reason for the difference in mediation pathways of the two forms of IPV is that psychological IPV may have a stronger impact than physical IPV on victims (Coker et al., 2002). Parents who experience psychological IPV are ten times more likely to use harsh and inconsistent parenting practices than parents experiencing physical IPV (Grasso et al., 2016). Mothers who experienced psychological IPV and mental health difficulties were less responsive, used negative parenting strategies, and expressed less warmth and acceptance toward their children than those who did not, again supporting the spillover hypotheses. Simultaneously, the non-significant mediation effect of physical IPV and maternal rejection supports the compartmentalization hypothesis possibly indicating that mothers are better able to remain positively responsive, supportive, and sensitive

to their children by not allowing the emotional turmoil caused by the violence to influence the parent-child relationship in significant ways.

Staying with the spillover hypothesis for a moment, there were significant associations between maternal depressive symptoms and children's internalizing and externalizing behaviors through maternal rejection. In prior research maternal depressive symptoms significantly increased maternal use of physical and psychological aggression (Marcal, 2021; Silva-Rodrigues et al., 2021) and hostility (Wolford et al., 2019) toward children, which in turn led to children displaying increased levels of internalizing and externalizing behavior (Bolsoni-Silva et al., 2020; Chueng et al., 2021; Shuang et al., 2020). In a sample of mother-child dyads in the United States, Kuckertz et al. (2017) reported that, although maternal depressive symptoms were directly linked to children's internalizing and externalizing behaviors, the introduction of maternal negative parenting practices such as psychological and physical aggression toward the child as a mediator significantly increased the magnitude of the effects. Correspondingly, Marcal, (2021) reported that maternal depressive symptoms influenced maternal use of harsh parenting strategies which subsequently led to higher internalizing and externalizing behaviors in children.

Previous studies have demonstrated that maternal depressive symptoms increase the odds of couples experiencing marital conflicts and hostility and that the interaction between these risk factors can result in poor social adjustment and behavioral difficulties in children (Burkhart et al., 2013; Goodman et al., 2020; Shelton & Harold, 2008; van Eldik et al., 2020; Wang et al., 2021). In this study, psychological IPV was found to have a mediating effect on the links between maternal depressive symptoms and children's internalizing and externalizing behaviors. Similar patterns were also reported in other studies across the world (Cumming et al., 2014;

Wang et al., 2021). In a study involving 320 predominantly European American families and preschool-aged children in the United States, mothers who experienced elevated levels of depressive symptoms reported high scores on interparental hostility (e.g., quarrelling, verbal attacks, and sarcasm) which in turn was associated with more internalizing and externalizing behaviors in their children compared to the children of non-depressed mothers (Cumming et al., 2014). Based on the findings of this study and prior research (Bauer et al., 2013; Jones et al., 2021; Leinonen et al., 2003), it appears that psychological IPV play an integral role in mediating the links between maternal depressive symptoms and children's internalizing and externalizing behaviors. According to Shelton and Harold, (2008) and Alenko et al. (2020), mothers who experience psychological IPV are less responsive to their children's needs, become less involved in their lives, and use aggressive behaviors towards them. Children raised in such abusive environments are more likely to respond to non-responsive caregivers through inappropriate behaviors such as crying, destroying things, and cheating (Carter et al., 2020; Labella & Masten, 2018) or become anxious or nervous when they witness this form of violence (Yoon et al., 2017). In short, psychological IPV and maternal rejection influence the effects of maternal depressive symptoms on children's problem behaviors in similar ways.

Links between Paternal Depressive Symptoms and Children's Internalizing and Externalizing Behaviors via Physical and Psychological IPV and Paternal Rejection

The negative impact of paternal depressive symptoms and other family contextual risk factors such as poor father-child relationship, family instability, and negative paternal parenting practices on childhood development in low-, middle-, and high-income countries is documented (Breslend et al., 2016; Chunying et al., 2020; Sweeney & MacBeth, 2016). Unlike prior research, psychological and physical IPV through paternal rejection did not mediate the links between

paternal depressive symptoms and children's internalizing and externalizing behavior problems. However, physical IPV mediated the links between paternal depressive symptoms and children's externalizing behaviors. These findings may suggest that physical IPV play a significant role in the links between paternal depressive symptoms and children's externalizing behaviors. Overall, it may be the case that among Kenyan families, exposure to physical IPV has less of an influence on the father's use of positive parenting practices which otherwise would have negatively influenced behavioral outcomes in children. As indicated above, this study was conducted in Kenyan families in which experiences of domestic violence are steeped in cultural beliefs about traditional gender roles that support men's use of aggressive behaviors towards women as a way of exerting authority. It is likely that through social learning (see Bandura, 1977) children observe, imitate, and reproduce these aggressive behaviors in different social contexts. Establishing mechanisms that can reduce or prevent physical IPV among fathers experiencing depressive symptoms may improve behavioral outcomes and social adjustment in children.

On the parenting front, it has also been demonstrated that paternal depressive symptoms disrupt optimal parenting leading to lower use of positive parenting practices (e.g., low expression of love and affection, responsiveness, and sensitivity) and increase the use of punitive and inconsistent parenting practices (e.g., yelling, spanking, hitting, rejection) (see Benner et al., 2020; Du Rocher Schudlich & Cumming 2003; Elgar et al., 2007; Grasso et al., 2016; Ponnet 2014). However, prior investigations on the mediating role of negative paternal parenting on these links have yielded inconsistent findings. For instance, Giallo et al. (2014) reported that fathers who exhibited high levels of depressive symptoms seem to score high on paternal hostile parenting behaviors such as yelling and hitting children and their children displayed elevated levels of internalizing and externalizing behaviors, whereas other studies (e.g., Taraban et al.,

2019; Nath et al., 2016) did not find a mediation effect of negative paternal parenting in these links. Analysis failed to find a mediation effect of paternal rejection on the associations between paternal depressive symptoms and children's internalizing and externalizing behaviors. The lack of a mediating effect suggests that even though paternal depressive symptoms may disrupt optimal parenting leading to lower use of positive parenting practices (e.g., low expression of love and affection, responsiveness, and sensitivity) and increases in the use of punitive and inconsistent parenting practices (e.g., yelling, spanking, hitting, rejection), negative parenting did not place children at greater risk for developing internalizing and externalizing behaviors. As discussed earlier, failure of paternal rejection to mediate these links could be as a result of cultural normative approach in paternal use of harsh parenting practices (see, Dawe et al., 2005; Macrone et al., 2017). It is plausible that among Kenya families, parents and children's positive perception and accepting attitude of paternal use of such parenting practices helps to filter out their potential negative effects on children's problem behaviors.

Cumulative Links between Paternal and Maternal Depressive Symptoms and Children's Internalizing and Externalizing Behaviors via Physical and Psychological IPV and Paternal and Maternal Rejection

It was hypothesized that the pathways of associations between depressive symptoms and children's internalizing and externalizing behaviors via psychological and physical IPV, and parental rejection would be different for fathers and mothers. Along with other studies (Benner et al., 2020; Parke et al., 2004) and the findings on mothers in this study, physical and psychological IPV and paternal rejection did not mediate the associations between paternal depressive symptoms and children's internalizing and externalizing behaviors. These findings should be viewed with caution because several studies (e.g., Breslend et al., 2016; Cumming et

al., 2013; Elgar et al., 2007; Harold et al., 2012; Shelton & Herold, 2008; Ponnet, 2012) have found that in the context of maternal depressive symptoms, interparental hostility, and maternal harsh parenting, paternal depressive symptoms still predicted children's behavioral difficulties through IPV and paternal harsh parenting. In this context, Ponnet et al. (2014, 2016) showed that both mothers' and fathers' depressive symptoms were positively associated with interparental conflicts (e.g., verbal aggression) which resulted in impaired parenting behaviors such as low warmth and sensitivity contributing to more internalizing and externalizing behaviors in children.

The current study demonstrates that both spillover and compartmentalization effects are evident in these data on Kenyan families in which both mothers and fathers reported varying levels of depressive symptoms. The links from paternal depressive symptoms to children's internalizing and externalizing behaviors through physical and paternal rejection support the compartmentalization hypothesis. The pathways of paternal depressive symptoms through psychological IPV to paternal rejection offer support for the spillover hypothesis without extending to children's internalizing and externalizing behaviors. That aside, the influence of maternal depressive symptoms on children's internalizing and externalizing behaviors through psychological IPV and maternal rejection fully supports the spillover hypothesis. This indicates that by confronting depressive symptoms and physical IPV, both Kenyan parents may be capable of partially containing negative affective states emanating from depressive symptoms and physical IPV within the couple's relationship from affecting children's day-to-day behavioral functioning. Because psychological IPV is more hidden, it may be more difficult to accomplish the same with young children.

It is edifying that even though both paternal and maternal parenting may have been compromised, only maternal rejection influenced children's internalizing and externalizing

behaviors. The analysis also indicated that psychological IPV was a significant mediator than physical IPV of maternal depressive symptoms. It should be stressed that all forms of IPV have the potential to negatively influence the parent-child relationship, but psychological IPV has been found to have a more detrimental impact on children's behaviors than physical or sexual IPV (Capaldi et al., 2020; Coker et al., 2002; Grasso et al., 2016; Laurenzi et al., 2020; Vu et al., 2016). In Kenya, there are high rates of depressive symptoms as well as physical and psychological IPV with men being the main perpetrators (Laurenzi et al., 2020). Prior studies have indicated that during IPV episodes, women are more affected than men (Ansara et al., 2011; Tjaden & Thoennes, 2000; Tran et al., 2016). It has been stipulated repeatedly, that Kenyan mothers are the primary caregivers, and given the strong association between mental health and IPV, it is more likely that exposure to these major risk factors increases mothers' risks of experiencing emotional dysregulation which may then extend to parenting and children's social adjustment (Benner et al., 2020; Du Rocher Schudlich & Cumming 2003; Lamela et al., 2018; Lamela & Figueiredo, 2013).

Paternal and maternal depressive symptoms affect optimal parenting through hostile parent-child relationships (Dette-Hagenmeyer & Reichle, 2013), negligence of children's well-being (Miner & Clarke-Stewart, 2008), and use of inconsistent discipline and rejection (Cummings et al., 2013), all of which can influence children's internalizing and externalizing behaviors. In this study, paternal depressive symptoms did not influence children's internalizing and externalizing behaviors via paternal rejection above and beyond the influence of maternal depressive symptoms and maternal rejection. These findings are in agreement with those of previous investigations (Kane & Garber, 2009; Kopala-Sibley et al., 2017) in demonstrating that even when both maternal and paternal depressive symptoms are strongly associated with various

typologies of parenting practices, paternal rejection does not mediate the pathways of associations between depressive symptoms and children's internalizing and externalizing behaviors. The sample for this study was drawn from a population that emphasizes gender-bifurcated roles in which mothers are the primary caregivers while fathers provide material services to their families. Consequently, mothers spend more time with their children and may have a stronger influence on their socioemotional functioning. Research has shown that the influence of mothers' functioning on children's social behaviors surpassed that of fathers' when both were experiencing depressive symptoms (Khan et al., 2014; Vallotton et al., 2016). Further, in the Kenyan setting, children and adults have an accepting attitude towards father's use of harsh parenting practices in rearing children as they are perceived as the disciplinarians (Lasser et al., 2011; Mudany et al., 2013; Mwoma, 2015). It is also likely that the normative approach to parental harshness tends to lessen the negative impact of harsh parenting on children's behavioral difficulties as children exhibited less internalizing and externalizing behaviors (Gershoff et al., 2010; Lansford et al., 2005; Rothenberg et al., 2020).

Summary

The influence of optimal paternal parenting and involvement on children's social and cognitive development has received greater attention in low-, middle-, and high-income countries over the last two decades (Bauer et al., 2013; Chung et al., 2021; Roelen et al., 2017; Roopnarine & Yildirim, 2018). This study adds to our understanding of how paternal depressive symptoms, physical and psychological IPV, and paternal rejection influence children's internalizing and externalizing behaviors above and beyond maternal risk factors during the early childhood years. In high-income countries (Cowan et al., 2019; Jones et al., 2021; Thompson-

Walsh et al., 2021) multiple paternal risk factors worsen developmental outcomes in children. Whether these outcomes are the same in the low-income countries of Africa remain sketchy.

In the current study conducted in a rural county of Kenya, paternal depressive symptoms and paternal rejection appear to be stronger predictors of children's internalizing and externalizing behaviors above and beyond maternal depressive symptoms and rejection. This was not the case for physical and psychological IPV, as neither predicted children's behavioral difficulties. Additionally, psychological IPV and paternal rejection but not physical IPV appear to be significant mediators of the links between paternal depressive symptoms and children's internalizing but not externalizing behaviors. As far as mothers are concerned, psychological IPV and maternal rejection but not physical IPV appeared to be significant mediators of the links between paternal depressive symptoms and children's internalizing and externalizing behaviors. In a cumulative model that included both paternal and maternal risk factors, both psychological and physical IPV and paternal rejection failed to mediate the links between paternal depressive symptoms and children's internalizing and externalizing behaviors above and beyond the influence of maternal depressive symptoms, psychological and physical IPV, and maternal rejection. In short, paternal depressive symptoms directly predicted children's internalizing behaviors.

Hopefully, these findings lay a preliminary foundation for future research on paternal and maternal risk factors and developmental outcomes in young children in low-income communities in sub-Saharan Africa. The ever-increasing parental mental health challenges, high poverty rates, child abuse, domestic violence, poor sanitization, and toxic masculinity across African cultural communities necessitate exploring how these factors collectively influence childhood outcomes

from a gendered perspective. Such data would be of great benefit in guiding family policies and parenting programs in Kenya and beyond.

Limitations

The focus on the complex links between paternal risk factors (depressive symptoms, physical and psychological IPV, and rejection) and children's internalizing and externalizing behaviors aside, this study has several limitations. First, the findings of this study cannot be generalized to the entire Kenyan population as it was limited to fathers and mothers living in the same household with their children in a single county. In most African communities, there are diverse mating and union patterns. Because men and fathers are still highly regarded as heads of the family and the breadwinner, a significant number of men are separated from their families for long periods due to work commitments. Such fathers were not represented in this study, which eliminates the opportunity to discern how interparental relationships and paternal parenting practices in different family compositions, directly and indirectly, influence childhood outcomes.

This study relied on self-reports to collect data from fathers and mothers. Only mothers reported on children's behavioral problems and IPV. The lack of multiple informants could have increased biases in reports of maternal and paternal functioning and children's social skills, especially during the COVID-19 pandemic. Moreover, paternal and maternal struggles during the pandemic could have led to under-reporting of family mental health difficulties due to stigma regarding mental health issues in Kenya (Fjermestad et al., 2017; Ponnet et al., 2016; Rinaldi & Howe, 2012). Reports and assessments from multiple informants (e.g., teachers, and mental health professionals) could have reduced self-reporting biases (see Brewer & Hunter, 2006; Majdandzic et al., 2016).

Future studies in sub-Saharan Africa should consider using different approaches such as qualitative methods to provide more information and support on the aforementioned associations. Qualitative perspectives and views of participants regarding various societal issues would certainly help in providing a clearer picture of the context under study. Unlike maternal parenting and psychological IPV, paternal parenting and physical IPV did not seem to influence children's behavior problems in this investigation. These discrepancies may potentially raise concerns of how these constructs are conceptualized in Kenyan communities. In a semi-structured interview study, Izugbara et al. (2020) indicated that a majority of women had a positive and accepting attitude of men's use of violent behaviors towards women such as wife-beating. It was also suggested that some women do not acknowledge psychological violence as a form of domestic violence as it does not cause physical harm (Guli & Geda, 2021; Kimuna & Djamba, 2008; Uthman et al., 2009). Based on these perceptions, the use of qualitative data may be useful in the conceptualization of constructs such as intimate partner violence and parenting practices in situations which would be helpful in developing culturally sound theoretical frameworks and models that enhance a deeper understanding of the implications of paternal risk factors and childhood outcomes.

Implication of the study

The main aim of this study was to enhance our knowledge base on the associations between paternal depressive symptoms, physical and psychological IPV, paternal rejection, and children's internalizing and externalizing behaviors above and beyond maternal depressive symptoms, physical and psychological IPV, and rejection. This study provides a glimpse into the direct associations between paternal risk factors and children's behavior problems in a low-income country during the COVID-19 pandemic. Findings from this study shows the harmful

effects of paternal and maternal depressive symptoms not only on children's optimal development but also on fathers' and mothers' interpersonal and intrapersonal relationships as well as parenting practices. Even though this study was inclined towards nuclear families, previous studies (e.g., Goodman et al., 2020; Laurenzi et al., 2021) also found similar patterns among Kenyan men and women who reported mild and severe depressive symptoms in different family settings.

The results of this study illustrate the need to develop intervention programs that address depressive symptoms, IPV, and parenting practices targeting fathers in different family settings such as nuclear, single father-headed families, and extended families. More emphasis should be placed on paternal depressive symptoms as they seem to have deleterious effect on children's social and behavioral adjustment. The intervention programs should provide various services such as counseling and medication, screening for mental health illness, providing secure and accessible hotlines for parents to report experiences of depressive symptoms and IPV, and sensitizing the community on the benefits of supporting people experiencing depressive symptoms. In addition to intervention programs, appropriate mental health, parenting, and family policies may also be formulated to address the aforementioned risk factors within African men in diverse family settings that may enhance healthier marriages, father-child relationships, and childhood development.

Appendix A

Institutional Review Board Approval

Syracuse University

INSTITUTIONAL REVIEW BOARD
MEMORANDUM

TO: Jaipaul Roopnarine
DATE: April 22, 2021
SUBJECT: **Full Board Approval - Use of Human Participants**
IRB #: 20-333
TITLE: *Paternal Risk Factors and Preschoolers Academic and Behavior Outcomes in Kenya: The Mediating Role of Protective Factors*

The above referenced protocol was reviewed at the **March 11, 2021** convened meeting of the Institutional Review Board (IRB) and has been evaluated for the following:

1. the rights and welfare of the individual(s) under investigation;
2. appropriate methods to secure informed consent; and
3. risks and potential benefits of the investigation.

The IRB determined that your protocol conforms to the University's human participants research policy and its assurance to the Department of Health and Human Services, available at: http://researchintegrity.syr.edu/human-research/.

Your protocol is approved for implementation and operation from **April 22, 2021** until **March 10, 2022** (Continuing review must occur within one year of the date of the convened IRB meeting). Attached is the protocol's approved informed consent document, date-stamped with the expiration date. This document is to be used in your informed consent process. If you are using written consent, Federal regulations require that each participant indicate their willingness to participate by signing the informed consent document and be provided with a copy of the signed consent form. Regulations also require that you keep a copy of this document for a minimum of three years.

CHANGES TO APPROVED PROTOCOL: Proposed changes to this protocol during the period for which IRB approval has already been given, cannot be initiated without IRB review and approval, except when such changes are essential to eliminate apparent immediate harm to the participants. Changes in approved research initiated without IRB review and approval to eliminate apparent immediate hazards to the participant must be reported to the IRB within five days. Protocol changes are requested on an amendment application available on the IRB web site; please reference your IRB number and attach any documents that are being amended.

CONTINUATION BEYOND APPROVAL PERIOD: To continue this research project beyond **March 10, 2022**, you must submit a renewal application for review and approval. A renewal reminder will be sent to you approximately 60 days prior to the expiration date. *(If the researcher will be traveling out of the country when the protocol is due to be renewed, please renew the protocol before leaving the country.)*

UNANTICIPATED PROBLEMS INVOLVING RISKS: You must report any unanticipated problems involving risks to subjects or others within 10 working days of occurrence to the IRB at 315.443.3013 or orip@syr.edu.

STUDY COMPLETION: Study completion is when all research activities are complete or when a study is closed to enrollment and only data analysis remains on data that have been de-identified. A Study Closure Form should be completed and submitted to the IRB for review (Study Closure Form).

Thank you for your cooperation in our shared efforts to assure that the rights and welfare of people participating in research are protected.

Katherine McDonald
IRB Chair

DEPT: FALK Human Development and Family Science, 174 White Hall

CC: Dickson Mukara Matsantsa Ong'ayi

Office of Research Integrity and Protections
214 Lyman Hall, 100 College Place
Syracuse, NY 13244

T: 315.443.3013
orip@syr.edu

Appendix B

Recruitment Materials

Flyer

Family Relationships, Parenting Practices and Childhood Outcomes Study in Kakamega County

You are invited to be part of a research study on family relationships, parenting practices, and childhood outcomes being conducted in Kakamega County by Dickson Ong'ayi who is a doctoral student in Human Development and Family Science at Syracuse University, New York, USA.

If your answer is **YES** to the following questions, you qualify to participate in this research study.

- Are you a couple above 18 years of age living in Kakamega County?
- Do you have a biological child between 3 and 5 years of age, and currently enrolled in a preschool in any region or location in Kakamega County?
- **Are you, your partner, and your child residing in the same household?**

Your participation will be voluntary and will take about 60 minutes of your time to complete paper questionnaires. The research will be conducted in your home.

Please call Dickson Ong'ayi at 0708154021 for more information if you are interested in participating.

Thank you.

Father consent form

DEPARTMENT OF HUMAN DEVELOPMENT AND FAMILY SCIENCE

Paternal Risk Factors and Preschoolers Academic and Behavior Outcomes in Kenya: The Mediating role of Protective Factors

Jaipaul Lalla Roopnarine, Professor of Human Development and Family Science, Syracuse University,174 White Hall, (315) 443-4586, New York, United states, email: jroopnar@syr.edu, Principal Investigator responsible for guiding the student during the study.

Dickson Mukara Matsantsa Ong'ayi, doctoral student in Human Development and Family Science, Syracuse University, 144 White Hall, (315) 278-2984, New York, United states, email: dmongayi@syr.edu, Student researcher responsible for data collection.

I am Dickson Mukara Matsantsa, a student researcher from Syracuse University, and my advisor is Professor Jaipaul Roopnarine, the principal investigator of this study. This consent form provides you with information about participation in a research study and your rights as a participant. After reading it to you, I will give you time to ask any questions that you may have, and I will be happy to explain anything in detail. If you choose to participate, you will be asked to complete a set of questionnaires in your home. Participation is voluntary and you do not have to answer questions you do not want to. Your participation in this study will be permitted only when you and your partner agree to full participation. That is, if you or your partner decide not to participate or withdraw from the study for any reason, both of you will be disqualified as participants, without penalty.

I am interested in learning and understanding about the associations between interparental relationships, paternal depression, parenting practices, social support, conflict resolution, cultural socialization, and children's academic and social skills in Kakamega County. You will be asked to complete paper questionnaires that include items on depression (e.g., I did not feel like eating or my appetite was poor; I felt that I could not shake off the blues even with help from my family or friends), parenting practices (e.g., I treat my child gently and with kindness; I hit my child, even when she/he does not deserve it), conflict resolution (e.g., Even when arguing we can keep a sense of humor), social support (e.g., There is a special person who is around when I am in need), and cultural socialization (e.g., our home is decorated with things that reflect my ethnic/cultural background). The questionnaires you are asked to fill out will take approximately 45-60 minutes to complete. I will distribute the envelopes with the questionnaires to you and your partner. You and your partner will fill the questionnaires in different rooms in the privacy of your home. After you complete filling the questionnaires, you will put them in the envelope, seal it, and return it to me (Dickson Ong'ayi) as I will be waiting at your home.

There is some risk involved in this study. You might experience psychological distress, anxiety, and or become more emotional when responding to some of the items that are potentially linked to events in your personal life (e.g., depressive symptoms). You will be provided with a list of parenting, social, legal, and mental health services (e.g., counseling) in your community and at the County level. In case you experience psychological distress or strong negative emotions, during and after completing the questionnaires, you are encouraged to reach out for help by contacting the different agencies through the contact information provided. Further, if law enforcement in Kenya request to see the collected data, I will have to turn over the surveys to them.

Even though there are no direct benefits to you as a participant, the findings of the study will help us better understand the links between intimate partner violence, paternal depression, parenting practices, social support, ethnic socialization, conflict resolution strategies, and children's academic and social skills in Kakamega County. This could be very helpful in the development of appropriate family policies and intervention programs that promote healthy relationships in families, positive parenting practices, and childhood outcomes in the county and nationally.

The privacy of the information you will provide will be maintained in the following ways. Your consent to participate will be obtained during the first phone meeting to ensure that participants' names and other identifiable information will not be linked to the couple number on the questionnaires. You and your spouse/partner will complete the questionnaires separately and in the privacy of your home. Your surveys will have a number that will link them together. Therefore, the number shown on each survey will serve as you, your couple/partner, and child number. No other identifiable information such as place of work, phone number, email addresses home addresses, or photos will appear on the consent form or the questionnaires. The collected data will never be shared with any other person or used in any other studies in the future. However, as noted above, if law enforcement in Kenya demand to see the collected data, I will have to give it to them. Further, in any written reports, data will be reported for the group, never to individuals.

The confidentiality of your information will be maintained through the same number assigned to you and your spouse/partner. You and your spouse/partner data will be kept in a locked metallic box only accessible to the researcher. Participants' names and other identifiable information will not be linked to the couple number on the surveys. During data collection and travel, completed questionnaires will be placed in locked suitcase, and only the student researcher will have access to the suitcase. After data are transported to the United States, questionnaires will be stored in a locked cabinet and only the student researcher will have access to the cabinet. The data will then be recorded and saved as a soft copy in a securely locked and password protected laptop that is owned by the student researcher. No one will be allowed access to the laptop.

As a research participant you have the following rights:

- Your participation is voluntary
- You may skip and/or refuse to answer any question for any reason
- You are free to withdraw from this research study at any time without penalty

For questions, concerns, or more information about this research, you may contact Dickson Mukara Matsantsa Ong'ayi at 0708154021 or send an e-mail to dmongayi@syr.edu. If you have

any questions or concerns about your rights as a research participant, you may contact the Syracuse University Institutional Review Board at +1 315-443-3013.

Do you have any questions?

Are you above 18 years of age?

Do you agree to participate and allow me to come to your home?

Do you have separate rooms in your home in which you and your partner/spouse can complete the surveys?

Do you agree to let me wait at your home while you fill out the questionnaires?

Mother consent form

DEPARTMENT OF HUMAN DEVELOPMENT AND FAMILY SCIENCE

Paternal Risk Factors and Preschoolers Academic and Behavior Outcomes in Kenya: The Mediating role of Protective Factors

Jaipaul Lalla Roopnarine, Professor of Human Development and Family Science, Syracuse University,174 White Hall, (315) 443-4586, New York, United states, email: jroopnar@syr.edu, Principal Investigator responsible for guiding the student during the study.

Dickson Mukara Matsantsa Ong'ayi, doctoral student in Human Development and Family Science, Syracuse University, 144 White Hall, (315) 278-2984, New York, United states, email: dmongayi@syr.edu, Student researcher responsible for data collection.

I am Dickson Mukara Matsantsa, a student researcher from Syracuse University, and my advisor is Professor Jaipaul Roopnarine, the principal investigator of this study. This consent form provides you with information about participation in a research study and your rights as a participant. After reading it to you, I will give you time to ask any questions that you may have, and I will be happy to explain anything in detail. If you choose to participate, you will be asked to complete a set of questionnaires in your home. Participation is voluntary and you do not have to answer questions you do not want to. Your participation in this study will be permitted only when you and your partner both agree to full participation. That is, if either you or your partner decide not to participate or withdraw from the study for any reason, both of you will be disqualified as participants, without penalty.

I am interested in learning about the associations between interparental relationships, paternal depression, parenting practices, social support, cultural socialization, and children's academic and social skills in Kakamega County. You will be asked to complete paper questionnaires that include items on sociodemographic factors, depression (e.g., I did not feel like eating or my appetite was poor; I felt that I could not shake off the blues even with help from my family or friends), parenting practices (e.g., I treat my child gently and with kindness; I hit my child, even when she/he does not deserve it), social support (e.g., There is a special person who is around when I am in need), and cultural socialization (e.g., our home is decorated with things that reflect my ethnic/cultural background). In addition, you will also be asked to complete questionnaires that include items on intimate partner violence (e.g., Kicked, bit, or punched by partner; Threw something at partner that could hurt), and on your child's social behavior (e.g., Cries too much; Feels or complains that no one loves him/her) and academic skills (e.g., Can tell a story; Do simple math). These questionnaires will take between 45-60 minutes to complete. I will distribute the envelopes with the questionnaires to you and your partner. You and your partner will fill the questionnaires in different rooms in the privacy of your home. After you complete

filling out the questionnaires, you will put it in the envelope, seal it and return it to me (Dickson Ong'ayi) who will be waiting in your home.

There is some risk involved in this study. You might experience psychological distress, anxiety, and or become more emotional when responding to some of the items that are potentially linked to events in your personal life that you might never have wanted to be reminded of. Example of these items are, "your partner kicked, bit, or hit you" or "I felt that people dislike me". Also, you might feel uncomfortable as your response to items of intimate partner violence might escalate the violence if your husband knows you are reporting on his behavior toward you. To avoid this situation, the information you provide will be treated as confidential and will never be shared with your husband/partner. Further, you will be provided with a list of parenting, social, legal, and mental health (e.g., counseling) services in your community and at the County level. According to Kenyan law, if I suspect that an offence of domestic violence is being or has been committed, I am required to give such information to the police or any other person in authority. Further, if law enforcement in Kenya request to see the intimate partner violence data, I will have to give it to them. In case you experience psychological distress or feel that your safety is threatened during and after completing the questionnaires especially on intimate partner violence, you are encouraged to reach out for help by contacting different agencies through the contact information provided.

Even though there are no direct benefits to you as a participant, the findings of the study will help us understand the links between intimate partner violence, paternal depression, parenting practices, social support, ethnic socialization, conflict resolution strategies, and children's academic and social skills in Kakamega County. This information could be of use in the development of appropriate family policies and intervention programs that promote healthy relationships in families, positive parenting practices, and childhood outcomes in the county and nationally.

The privacy of the information you will provide will be maintained in the following ways. Your consent to participate will be obtained during the first phone meeting to ensure that participants' names and other identifiable information will not be linked to the couple number on the questionnaires. You and your spouse/partner will complete the questionnaires separately and in the privacy of your home. Your surveys will have a number that will link them together. Therefore, the number shown on each survey will serve as you and your couple/partner number. No other identifiable information such as place of work, phone number, email addresses and home addresses or photos will be taken or linked to your identification numbers on the surveys. The collected data will never be shared with any other person or used in any other studies in the future. However, as noted above, in case law enforcement officers demand to see the collected data, I will have to give it to them. Further, in any written reports, data will be reported for the group, never to individuals.

The confidentiality of your information will be maintained through the same number assigned to you and your spouse/partner surveys. You and your spouse/partner data will be kept in a locked metallic box only accessible to the researcher. Participants' names and other identifiable information will not be linked to the couple number on the surveys. During data collection and travel, completed questionnaires will be placed in locked suitcase, and only the student researcher will have access to the suitcase. After data are transported to the United States, questionnaires will be stored in a locked cabinet and only the student researcher will have access

to the cabinet. The data will then be recorded and saved as a soft copy in a securely locked and password protected laptop that is owned by the student researcher. No one will be allowed access to the laptop.

As a research participant you have the following rights:

- Your participation is voluntary
- You may skip and/or refuse to answer any question for any reason
- You are free to withdraw from this research study at any time without penalty

For questions, concerns, or more information about this research, you may contact Dickson Mukara Matsantsa Ong'ayi at 0708154021 or send an e-mail to dmongayi@syr.edu. If you have any questions or concerns about your rights as a research participant, you may contact the Syracuse University Institutional Review Board at +1 315-443-3013.

Do you have any questions?

Are you above 18 years of age?

Do you agree to participate and allow me to come to your home?

Do you have separate rooms in your home in which you and your partner/spouse can complete the surveys?

Do you agree to let me wait at your home while you fill out the questionnaires?

Appendix C

Data Collection Surveys

Mother Questionnaires

Family I.D Number _____ **Date……..…**

This questionnaire concerns general information about you, your partner/family and your child. Please fill in this information to the best of your knowledge. You may skip and/or refuse to answer any question for any reason. Thank you.

Age of Child: _____ Gender: Male___ Female___

Birth Order of Child: ____First Born _____Second Born _____Third Born _____Other

This child has been enrolled in the current Early Childhood Program for: ____ Years _____Months

The child enrolled in the Early Childhood Center is currently living with: (Check the one that applies)

___Biological mother and biological father

___Biological mother and biological father and other relatives (e.g., uncles, aunts, grandparents)

___Biological father and partner

___Biological father and partner and other relatives (e.g., uncles, aunts, grandparents)

___Biological mother and grandparent(s)

___Biological father and grandparent(s)

___Biological mother only

___Biological father only

___Grandparents only

___Guardian(s)

Age of Child's Biological Mother_____

Age of Child's Biological Father_____

Age of Child's Guardian/Primary Caregiver_____ Gender of Guardian/Primary Caregiver_____

Ethnicity of Biological Father: _____

Ethnicity of Biological Mother: _____

Ethnicity of Guardian/Primary Caregiver: _____

(Ethnicity refers to the group you most identify with. For example, Luhya, Luo, Kalenjin, etc.).

What is your marital status? (Please check one):

_____ Single parent

_____ Married

_____ Long-term commitment (non-married)

_____ Common Law

_____ Visiting Relationship

_____ Divorced/separated

_____ Widow

Number of children from current relationship/marital union_____

Number of children from all prior relationships/marital unions_____

How many years of education did the biological mother complete? (Check the highest):

___Primary School ____High School ____ College ___University

____Post-Graduate/Professional School

How many years of education did the biological father complete? (Check the highest):

___Primary School ____High School ____College ___University

____Post-Graduate/Professional School

How many years of education did the guardian/primary caregiver complete? (Check the highest):

___Primary School ____High School ____College ___University

____Post-Graduate/Professional School

What is your employment status? (please check one);

1= permanent employment (paid salary at the end of the month)

2= Casual employment (paid every day after working)

3= Unemployed

Which category would you estimate that your family's monthly income falls in?

____below Ksh 10,000
____Khs11,000-Ksh 20,000
____ Ksh 21,000- Ksh 30,000
____ Ksh 31,000- Ksh 40,000
____ Ksh 41,000- Ksh 50,000
____ Ksh 51,000-$60,000
____ Ksh 61,000-$70,000
____ Ksh 71,000- Ksh 80,000
____ Ksh 81,000- Ksh 99,000
____above Ksh 100,000

How many people in your household contribute to the income you listed above? _____

How many people in your family live on the income you listed above? _____

Please estimate your standard of living compared to others in Kakamega County (please check one).

_____very high, we always have enough to live comfortably and to have nice things
_____comfortable, we occasionally have nice things but not all the time
_____ ok, we have enough for the necessities but, we don't get many "extras"
_____we sometimes seem to barely get by, and it is often hard to make ends meet
____constant struggle, we never seem to have enough money for daily needs

What is the source of drinking water?

_____ Tap

_____ Borehole

_____ River

How many bedrooms does your house have? _____

What type of material is the floor of your house made of?

_____ Cement

_____ Soil

-------Wood

What type of material is the roof of your house made of?
_____ Tiles
_____ Iron-sheet
_____ Grass,

Do you have access to electricity?
_____ Yes
_____ No

What household assets do you have?

_____ Television

_____ Radio

_____ Sofa-set

_____ Wooden chairs

Which meals can you afford every day? (Please check multiple if you are able to afford more than one)

_____ breakfast

_____ lunch

_____ supper

Below is a list of some ways you may have felt or behaved. Please indicate how often you have felt this way during the last week by checking the appropriate space. Please only circle one answer to each statement.

Rarely or none of the time" would mean less than 1 day in the past week; "some of the time" would mean 1 or 2 days in the past week; "a moderate amount of time" would mean 3 or 4 days in the past week; and "most of or all of the time" would mean 5 to 7 days in the past week.

	Statement	**Rarely or none of the time**	**Some of the time**	**A moderate amount of time**	**Most or all of the time**
a	I was bothered by things that usually don't bother me.	1	2	3	4
b	I did not feel like eating; my appetite was poor.	1	2	3	4
c	I felt that I could not shake off the blues even with help from my family or friends.	1	2	3	4
d	I had trouble keeping my mind on what I was doing.	1	2	3	4
e	I felt depressed.	1	2	3	4
f	Everything I did felt like an effort.	1	2	3	4
g	I felt fearful.	1	2	3	4
h	My sleep was restless.	1	2	3	4
i	I talked less than usual.	1	2	3	4
j	I felt lonely.	1	2	3	4
k	I felt sad.	1	2	3	4
l	I could not get "going."	1	2	3	4

No matter how well a couple gets along, there are times when they disagree, get annoyed with the other person, or just have fights because they're in a bad mood or tired or for some other reason. They also use many different ways of trying to settle their differences. Below is a list of behaviors your partner may have done during the past 12 months. Please check how many times your partner did each of these things in the past year.

		This has never happened	**Once in the past year**	**Twice in the past year**	**3–5 times in the past year**	**6–10 times in the past year**	**11–20 times in the past year**	**More than 20 times in the past year**	**Not in the past year, but it did happen before**
a	Kicked, bit, or punched by partner								
b	Slapped by partner.								
c	Beat up by partner								
d	Hit by partner with something								
e	Choked by partner								
f	Slammed by partner against wall								
g	Grabbed by partner								
h	Threw something at partner that could hurt								
i	Used knife or gun on partner								
j	Pushed or shoved by partner								
k	Twisted partner's arm or hair								
l	Burned or scalded by partner on purpose								
m	Insulted or swore at by partner								
n	Shouted at by partner								
o	Partner stomped out of room								
p	Threatened to hit or throw something at by partner								
q	Destroyed something of partners								
r	Did something to spite partner								
s	Called fat or ugly by partner								
t	Accused by partner of being a lousy lover								

The following statements also describe how you relate with or act towards your child.

	ACTIVITY	**Almost always true**	**Sometimes true**	**Rarely true**	**Almost never true**
a	I pay no attention to my child	1	2	3	4
b	I hit my child even when she or he does not deserve it	1	2	3	4
c	My child is a nuisance for me	1	2	3	4
d	I punish my child severely when I am angry	1	2	3	4
e	I am too busy to answer my child's questions	1	2	3	4
f	I resent my child	1	2	3	4
g	I say unkind things to my child	1	2	3	4
h	I pay no attention to my child when he or she asks for help	1	2	3	4
i	I insist that my child do exactly what he or she is told	1	2	3	4
j	I hurt my child's feelings	1	2	3	4
k	I forget important things my child thinks I should remember	1	2	3	4
L	When my child misbehaves, I make him or her feel I don't love him or her anymore	1	2	3	4
M	I let my child do anything he or she wants to do	1	2	3	4
N	When my child does something wrong, I frighten or threaten him or her	1	2	3	4
O	I feel the child is no better than he or she is no matter what he or she does	1	2	3	4
P	I let my child know he or she is not wanted	1	2	3	4
Q	I want to control whatever my child does	1	2	3	4
R	I pay no attention to my child as long as he or she does nothing to bother me	1	2	3	4

For each of the following, please answer how true is the statement about your child's behavior

	Statement	**Often true**	**Sometimes true**	
a	Is too fearful or anxious.	1	2	3
b	Feels or complains that no one loves (him/her).	1	2	3
c	Is rather high strung, tense, and nervous	1	2	3
d	Cheats or tells lies.	1	2	3
e	Has sudden changes in mood or feeling.	1	2	3
f	Argues too much.	1	2	3
g	Has difficulty concentrating or cannot pay attention for long.	1	2	3
h	Is easily confused or seems to be in a fog.	1	2	3
1	Bullies or is cruel or mean to others.	1	2	3
j	Is disobedient.	1	2	3
k	Does not seem to feel sorry after (he/she) misbehaves.	1	2	3
l	Has trouble getting along with children (his/her) age.	1	2	3
m	Is impulsive or acts without thinking.	1	2	3
n	Is not liked by other children (his/her) age.	1	2	3
o	Feels worthless or inferior.	1	2	3
p	Has a lot of difficulty getting (his/her) mind off certain thoughts.	1	2	3
q	Is restless or overly active or cannot sit still	1	2	3
r	Is stubborn, sullen, or irritable.	1	2	3
s	Has a very strong temper and loses it easily.	1	2	3
t	Is unhappy, sad, or depressed.	1	2	3
u	Is withdrawn or does not get involved with others.	1	2	3
v	Breaks things on purpose or deliberately destroys (his/her) own or another's things.	1	2	3
w	Cries too much.	1	2	3
x	Demands a lot of attention.	1	2	3
y	Is too dependent on others.	1	2	3
z	Worries too much.	1	2	3

Father Questionnaires

Family I.D Number _____ **Date……...…**

This questionnaire concerns general information about you and your family. Please fill in this information to the best of your knowledge. You may skip and/or refuse to answer any question for any reason. Thank you.

Below is a list of some ways you may have felt or behaved. Please indicate how often you have felt this way during the last week by checking the appropriate space. Please only circle one answer to each statement.

Rarely or none of the time" would mean less than 1 day in the past week; "some of the time" would mean 1 or 2 days in the past week; "a moderate amount of time" would mean 3 or 4 days in the past week; and "most of or all of the time" would mean 5 to 7 days in the past week.

Statement		**Rarely or none of the time**	**Some of the time**	**A moderate amount of time**	**Most or all of the time**
a	I was bothered by things that usually don't bother me.	1	2	3	4
b	I did not feel like eating; my appetite was poor.	1	2	3	4
c	I felt that I could not shake off the blues even with help from my family or friends.	1	2	3	4
d	I had trouble keeping my mind on what I was doing.	1	2	3	4
e	I felt depressed.	1	2	3	4
f	Everything I did felt like an effort.	1	2	3	4
g	I felt fearful.	1	2	3	4
h	My sleep was restless.	1	2	3	4
i	I talked less than usual.	1	2	3	4
j	I felt lonely.	1	2	3	4
k	I felt sad.	1	2	3	4
l	I could not get "going."	1	2	3	4

The following statements also describe how you relate with or act towards your child

	ACTIVITY	**Almost always true**	**Sometimes true**	**Rarely true**	**Almost never true**
a	I pay no attention to my child	1	2	3	4
b	I hit my child even when she or he does not deserve it	1	2	3	4
c	My child is a nuisance for me	1	2	3	4
d	I punish my child severely when I am angry	1	2	3	4
e	I am too busy to answer my child's questions	1	2	3	4
f	I resent my child	1	2	3	4
g	I say unkind things to my child	1	2	3	4
h	I pay no attention to my child when he or she asks for help	1	2	3	4
i	I insist that my child do exactly what he or she is told	1	2	3	4
j	I hurt my child's feelings	1	2	3	4
k	I forget important things my child thinks I should remember	1	2	3	4
L	When my child misbehaves, I make him or her feel I don’t love him or her anymore	1	2	3	4
M	I let my child do anything he or she wants to do	1	2	3	4
N	When my child does something wrong, I frighten or threaten him or her	1	2	3	4
O	I feel the child is no better than he or she is no matter what he or she does	1	2	3	4
P	I let my child know he or she is not wanted	1	2	3	4
Q	I want to control whatever my child does	1	2	3	4
R	I pay no attention to my child as long as he or she does nothing to bother me	1	2	3	4

Appendix D

Factor Loadings

Table D1: Intimate Partner Violence

Items	Physical IPV	Psychological IPV
Kicked, bit, or punched by partner	.69	.33
Used knife of gun on partner	.68	
Hit by partner with something	.67	
Beat up by partner	.64	.30
Slapped my partner	.59	
Grabbed by partner	.53	
Threw something at partner that could hurt	.51	
Choked by partner	.45	
Pushed or shoved by partner	.41	
Slammed by partner against wall	.33	
Destroyed something of partners		.69
Threatened to hit or throw something at by partner		.67
Accused by partner of being a lousy lover		.66
Did something to spite partner		.65
Shouted at by partner		.63
Called fat or ugly by partner		.62
Partner stomped out of room		.56
Twist partner's arm or hair		.54
Burned or scalded by partner on purpose		.40
Insulted or swore at by partner		.35

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Wu, Q., Ge, T., Emond, A., Foster, K., Gatt, J. M., Hadfield, K., ... & Wouldes, T. A. (2018). Acculturation, resilience, and the mental health of migrant youth: a cross-country comparative study. *Public Health, 162*, 63-70.

Xiao, B., Bullock, A., Coplan, R. J., Liu, J., & Cheah, C. S. (2021). Exploring the relations between parenting practices, child shyness, and internalizing problems in Chinese culture. *Journal of Family Psychology*.

Ybarra, G. J., Wilkens, S. L., & Lieberman, A. F. (2007). The influence of domestic violence on preschooler behavior and functioning. *Journal of Family Violence, 22*(1), 33–42. https://doi.org/10.1007/s10896-006-9054-y

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CURRICULUM VITAE

Dickson Mukara Matsantsa Ong'ayi

CONTACT INFORMATION

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EDUCATION and TRAINING

2022: Ph.D Human Development and Family Science
Syracuse University

2016 - Master of Arts in Child Development
University of Haifa - Israel

2014 - Bachelor of Education in Early Childhood Studies
Kenyatta University - Kenya

Other training/courses

2020 Future Professoriate Program, Syracuse University- United States.
2018 Family Violence Prevention – National Resource Center for Healthy Marriage and Families.

RESEARCH INTEREST

I have collected primary data and used large secondary data sets to establish association between family and societal factors and childhood outcomes. The use of Structural Equation Modeling technique was significant in identifying the pathways of associations. That said, my research interest includes father-child relationship and childhood outcomes in diverse cultural contexts; mental health issues within families and impact on children in developing countries; intimate partner violence and children's psychological well-being, and social skills outcomes; early childhood education in global contexts.

PUBLICATIONS

Peer-reviewed Journal Articles

Ong'ayi, D. M. M., Dede Yildirim, E., & Roopnarine, J. L. (2019). Fathers', Mothers', and Other Household Members' Involvement in Reading, Storytelling, and Play and Preschoolers' Literacy Skills in Kenya. *Early Education and Development*, 1-13

Book chapter

Roopnarine, J. L., **Ong'ayi, D. M. M.,** & Dede Yildirim, A., (2021). Father Involvement in Different Family Systems Across Cultural Communities: Links to Childhood Development. Shackelford, T. & Weekes-Shackelford (Eds.), *Oxford handbook on evolutionary psychology and parenting*, Oxford, England: Oxford University Press

Roopnarine, J. L., **Ong'ayi, D. M**. M., Parella, M. (in press). Play and Early Schooling Across Cultural Communities. In Holmes, R. & Roopnarine, J. L. (Eds.) Culture and schooling. New York: Oxford University Press.

Under review journal

Roopnarine, J. L., **Ong'ayi, D, M. M.,** & Krishnakumar, A., (2022). Maternal and Paternal Depressive Symptoms and Physical Intimate Partner Violence and Children's Literacy, Numeracy, and Social Skills: Mediating Role of Parental Cognitive Engagement and Warmth.

Roopnarine, J. L., **Ong'ayi, D, M. M.,** Krishnakumar, A., Ali, A., & Primus, A. M. (2022). Maternal and Paternal Depressive Symptoms and Physical Intimate Partner Violence and Children's Internalizing and Externalizing Behaviors in Guyana: Mediating Role of Constructive Conflict Behaviors and Partner Support and Affection.

Krishnakumar, A., Roopnarine, J. L., Narine, L., Logie, C., Oddo, O. O., & **Ong'ayi, D. M. M**. (2021). Parenting Typologies of Mothers in Trinidad and Tobago: A Latent Profile Analysis.

WORK EXPERIENCE

Teaching

2017 – 2021 Graduate Teacher Assistant.
Department of Human Development and Family science
Falk College- Syracuse University

Courses (undergraduate)

HFS 345: The Developing Infant (taught independently- Fall 2021 and 2022)
This course introduces the student to various aspects of infant's development which include pregnancy and neonatal, child development from birth to three years, child development theories, and biological, psychological, and family-related issues.

Served as a Teaching Assistant

HFS 388: Human Sexuality
This course covered broad areas of human sexuality: the developmental and social aspects of sexuality as reflected in an individual and within relationships, multicultural and multiethnic aspects of human sexuality, and specific sexual behavior that represents alternatives to conventional behavior.

HFS 467: Child and Family in Cross-Cultural Perspectives
The course covered an introduction to field methods, the study of childhood, sex roles, and family from a cross-cultural perspective.

HFS 201: Family Development
This course provided a theoretical and functional approach to marital and family life with a developmental perspective. Further, it touched on issues related to marital and parental careers, family communication, sexuality and gender, domestic violence, and family stress and coping strategies.

HFS 493 and 494: Youth and Family Practicum I and II respectively
The purpose of these course was to provide an opportunity for students to have a fieldwork experience in a community setting. It enhanced the application of academic knowledge in the internship site.

HFS 363: Midlife Development and Gerontology
This course focused on different aspects of biological, physiological, and cognitive changes related to aging within the context of an older adult's social context such as their living arrangements, employment, and family supports.

HFS 479: Power, Conflict, Violence, and the Family
This course presented to students' an interdisciplinary approach to the study of human sexuality from historical, cultural, developmental, behavioral, physiological, sociological, and relational perspectives.

HFS 474: Promises and Problems in Youth and Emerging Adulthood
This course introduced students to broad areas related to the roles of parents, peers, social structures, and institutions in youth and emerging adult development.

Responsibilities

- Preparing course materials, such as lesson plans, PowerPoints and exams
- Providing in-class and out-of-class course assistance to students.
- Supervising, and grading examinations.
- Giving guest lectures.

2017 Instructor/Part-time Lecturer
Department of Early Childhood Studies,
Kenya College of Accounts University (KCA).

Courses taught (undergraduate)

ECE 102: Child Development
This course familiarized students with various concepts of infant growth and development from conception to birth.

ECE 107: Philosophical and Sociological Foundations of Early Childhood Education
The unit introduced the student to philosophical ideas related to early childhood education, child in cross-cultural contexts, and the role of the family in the socialization of children.

ECE 306: The Role of Family in Changing Society
The course introduced students to different parenting practices, family patterns, and relationships and how they shape the role of the family in society and child development.

2012 – 2017 Instructor/Tutor
Department of Early Childhood Education,
Imara ECDE college - Kenya

Diploma Courses/Units Taught

Personality Development
This unit introduced students to theories of personality development and their application in the process of learning for young children

Research in Early Childhood Development and Education
This unit introduced the students to research in child and family studies and familiarizing them with data collection, analysis, and report writing techniques.

Historical Development of Early Childhood Education
This course provided an overview of the historical global evolution of educational principles and practices that support child development from birth through the school-age years.

Responsibilities

- Lecturing
- Guidance of students in Early Childhood Education in Career development
- Overseeing students research projects
- Engage in community outreach programs with students.
- Overseeing and assessing students on teaching practices.

ACADEMIC LEADERSHIP

2017 - Participated in reviewing Early Childhood Studies curricula for KCA University - Kenya
2016; Developed **Teacher Capacity Building Training Program** for Imara Early Childhood Education College.
2013 – 2014 Participated in setting Early Childhood Development and Education (ECDE) mock exams for diploma and certificate candidates under Kenya Early Childhood Education Private Training Institutions Association (KECEPTIA)

SCHOLARSHIP/FELLOWSHIP/ASSISTANTSHIP/GRANT

2021 Syracuse University Dissertation Fellowship
2020 **Patrice Engle Dissertation Grant**- Society for Research in Child Development
2017 – 2022 Syracuse University full-time Graduate Assistant and Instructor
2015 University of Haifa Masters' scholarship in Child Development

AWARDS/RECOGNITION

2020 **Alice Sterling Honig Award** – *Graduate Student Outstanding Scholarship in Child Development and Family Studies*- Human Development and Family Science Falk College of Sports and Human Dynamics - Syracuse University
2018 **Outstanding Graduate Teaching Award** - Human Development and Family Science Falk College of Sports and Human Dynamics -Syracuse University

CONFERENCE/SEMINARS/WORKSHOPS

Conference presentation
26th – 29th February 2020: 49th Conference of The Society for Cross-Cultural Research- Seattle,

Washington – United States
Paper presentation "Paternal Risk Factors and Preschoolers Academic and Social Skills in Kenya; The Mediating role of Protective Factors"

Others

7th November 2013: 21st International Conference on Reconceptualizing Early Childhood Education (RECE), held at Kenyatta University- Kenya

10th October 2014: Workshop on Leadership Development and Mentorship- Kenyatta University

21st March 2014: Workshop on proposal writing, analysis, and presentation – Kenyatta University

19th October 2018: Certificate in University teaching seminar on Online teaching and learning: Challenges and opportunities

13th February 2019: Certificate in University teaching seminar on leading effective classroom discussion! Questions are the answers

4th March 2019: Certificate in University teaching seminar on crafting teaching Philosophy

18th November 2019: Certificate in University teaching seminar on active learning: Making the most of "lecture" time

17th April 2021: Webinar – Family Violence Seminar
"Family Violence in Surname, Trinidad, and Tobago and the wider Caribbean"
Focusing on Contemporary research, policy, and intervention

SERVICE TO THE UNIVERSITY

2021- 2022 - Student member of the Falk College Promotion and Tenure Committee for 2021-2022 academic year

Responsibilities

- Participate in reviewing the Faculty Handbook concerning tenure/promotion procedures
- Participate in the review of promotion and tenure materials of applicants

August-December 2020 –**Student Support Assistant**
Taishoff Center for Inclusive Higher Education-School of Education, Syracuse University, USA

Responsibilities

- Provided academic coaching for students with intellectual disabilities
- Assisted students with course planning, time management, and organizational strategies

August-December 2020 – **Covid-19 Contact tracer**
Department of Public Health, Syracuse University, USA

Responsibilities

- Conduct contact tracing for students exposed to Covid-19.

MEMBERSHIP IN PROFESSIONAL BODIES

Early Childhood Professionals Association Kenya
Early Childhood Network for Kenya

COMMUNITY OUTREACH

12th July 2013: Mama Ngina Children's home- provision of foodstuffs and clothes to needy children.
January 2010 – April 2011: Volunteer teacher at The Talent School Musembe