

INFLUENCE OF INTER-PARENTAL CONFLICT ON GENERAL HEALTH AND  
FEELINGS OF AGGRESSION IN ADOLESCENTS

BY

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CERTIFICATION

I certify that this study was carried out by Odiase Linda Ese in the Department of Psychology, of the Federal University Oye Ekiti under my supervision.


  
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EXTERNAL EXAMINER

## DEDICATION

This research is dedicated to the Almighty God for His grace and protection for seeing me through this project.

I also want to appreciate my amazing father, Mr. Friday Odiase, for his fatherly love and constant support. Appreciation goes also to my late mother, Mrs. Eunice Odiase, for her constant words of encouragement. To my father, Dr. Biodun Adeneye-Marcus, thanks also for your support.

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## ABSTRACT

*This study investigated the influence of inter-parental conflict on general health and feeling of aggression among adolescent students in selected secondary schools in Ado and Oye towns of Ekiti State. A sample of 394 students consisting 227 males and 167 females were purposively selected for the study. Data were collected using self-report instruments namely; the Children's perception of Inter-Parental Conflict Scale (CPIC), General Health Questionnaire (GHQ) and Aggression Scale (AS). Three hypotheses were tested using Multiple Regression and Multivariate Analysis of Variance. Results suggested that only two dimensions of inter-parental conflicts (i.e. frequency and intensity) predicted aggression. It was also shown that only intensity and resolution dimensions of inter-parental conflict independently predicted general health. In addition, result demonstrated that there was no gender difference in levels of general health and aggression among adolescents. Results were discussed in line with previous literatures. The study recommends that inter-parental conflict should be tamed as well as making parents aware of the fact that children learn by observation and imitation; and such learned behavior can be detrimental if it becomes utterly maladaptive.*

*Key-words- Inter-parental conflict, general health, aggression, adolescents*



# CHAPTER ONE

## INTRODUCTION

### 1.1 BACKGROUND OF THE STUDY

Over the past decades, research on the concept of inter-parental conflict and its influence on General health and Aggression have been widely researched in the fields of family psychology and amongst other field ( Cummings & Davies,1994; Sturge-Apple, Davies, & Cummings, 2006). Reasons are that in today's world of neglect parents are becoming less attentive to the effects that their conflicts could have on their children. Parental conflicts is referred to as marital conflict, it consist of disagreements, arguments, and disputes between parents. Also noted is that children of parents who engage in significant conflict are more likely to experience internalizing and externalizing symptoms ( Buehler, Anthony & Krishuakumar,1997; Stone, Gerard, & Pemberton, 1997). These child's externalizing symptoms typically refer to negative behaviors directed at others, such as verbal and physical aggression, destruction of property, and theft, while internalizing behaviors typically refer to difficult feelings that are turned inward, such as anxiety, depression, and somatic symptoms (Mash & Dozois, 2003, p.27).

In addition, the National Comorbidity Survey reported a lifetime prevalence rate for any psychiatric disorder in 48.0% of a representative population of adults (e.g., Kessler, Gruber & Hettema, 1994; Irving, Sampson & Kimberly, 1994). These elevated rates of disorders across adolescents and adults, were a striking reason for researches to be conducted on examining the risks and protective factors that are associated with the development of internalizing and

externalizing disorders in children and adolescents, in an effort to decrease risk for health issues as well as aggressive tendencies in youth.

Studies have shown that witnessing parental conflicts between parents may put children at risk for increased aggressive and depressive symptoms. Inter-parental conflict being either (physical/verbal) abuse of one's spouse or partner could most times result to physical violent abuse. These violent conflicts exposure can be interpreted by the child to mean that the world is unsafe, resulting to the child attempting to intervene during conflict interactions by playing the role of a peacekeeper, mediator and confidante. And if these efforts are futile, these children might end up believing that they are to blame for the continued parental conflicts. Additionally, adolescents might also feel threatened by these parental conflicts, as there is a possibility that these conflicts could lead to separation or divorce, or that the conflict will escalate and become directed towards them. Feelings as such can contribute to negative self-perceptions, health issues and aggressive tendencies. Likewise when the family environment then includes additional stressor such as poverty or violence, children are exposed to a range of health difficulties, which includes: digestive problems, fatigue, reduced physical growth, headaches and abdominal pains (Stiles, 2002) and sleeping problems (e.g., Kimberly, Leslie, Gordon, Mannering, Neiderhiser, Shaw, Natsuaki & Reiss 2011).

## **1.2 STATEMENT OF PROBLEM**

The aim of any parent is to have their children healthy, helping them grow up to be functional members of the society. The concept of a child's general health circles around a whole range of issues relating to the personal development of a child, from their physical and mental capacities to their psychological state.

While some authors see children's health as something affected by their physical

environment, others relate the concept to the emotional needs and state of the child (Berkman & Kawachi, 2000; Marmot & Wilkinson, 2006) meanwhile; many other authors refer to the issue of children's well-being as a cause that could have negative impacts on the individual later in life as adults, with range of psychological health challenges (e.g., Low self-esteem, Anxiety, Depressive symptoms, reduced physical growth, headaches and abdominal pains etc.)

Aggressive behaviors amongst adolescents are becoming rampant. With adolescents bullying and inflicting harms on each-other, controlling or dominating others. Aggressive tendencies which could either be physical or verbal or can bring about physical and mental harm and possible long term outcomes which include peer difficulty, early school withdrawal, future anti-social behavior (Kupersmidt & Coie, 1990) and substance abuse (Moss & Kirisci, 1995).

While many researches have been conducted on investigating the predictors of aggression and general health issues among adolescents, much thought haven't been given to inter-parental conflict has an important factor, that through its frequency and intensity could result to aggressive tendencies and general health issues in adolescents. Inter-parental conflict could be viewed by parents as minimal, but research has shown that parental conflicts can cause damage to a child's health and behavioral development (Davies & Cummings, 1994). The intensity, frequencies of parental conflicts have been found to cause issues in a child's well-being, resulting to these adolescents exhibiting aggressive tendencies towards their peers and parents (Grych & Fincham, 1990).

Researches and recent statistics have shown that a sizeable amount of children have been laying complaints about how they are feeling and their overall mental and physical health. Complaints such as (frequent tiredness, nightmares, problems involving sleep-wake cycle, low self-worth, anxiety, loss of appetite, depression (El-Sheikh & Cummings, 1992) they have tried

to assess the possible causes surrounding general health issues and the development of aggressive behaviors amongst children, precisely how inter-parental conflict can result to increased arousal, distress and aggression as well as long-term adjustment difficulties, social and academic problems.

While various studies have been conducted on inter-parental conflict, there have been inconclusive findings on gender and inter-parental conflict. And the purpose of this work is to examine the proposition that inter-parental conflict (IPC) is associated positively youth problem behaviors.

### **1.3. OBJECTIVES OF THE STUDY**

Specifically, the research objectives of this study are as follows:

- 1.) To assess whether dimensions of inter-parental conflict will predict level of aggression among adolescents.
- 2) To examine whether dimensions of inter-parental conflicts will predict level of general health among adolescents.
- 3) To examine sex difference in levels of aggression and general health among adolescents.

### **1.4 SIGNIFICANCE OF STUDY**

The result and findings of this study will help psychotherapists in understanding the extent of inter-parental conflicts on children and how best to introduce a parent-child therapy. Likewise helping parents understand that inter-parental conflict can be detrimental to children's emotional and well-being. The outcome of this study will expose the detrimental consequences of frequent, intense, and unresolved inter-parental conflict on how it could result to adolescent's having emotional and behavioral problems.

The results of this study will provide information on the importance, of parents working on reducing the frequency and intensity of their conflicts. Helping parents develop more effective communication and conflict resolution skills through the effectiveness of parent-child interaction therapy.

### **1.5 RESEARCH QUESTIONS**

1. What is the influence of Inter-parental conflict on general health of secondary school students?
2. How does inter-parental conflict influence feelings of aggression among secondary school students?
3. Are there gender differences in general health and feelings of aggression?

### **1.6 HYPOTHESIS**

1. The dimensions of inter-parental conflict will significantly predict general health among adolescents?
2. The dimensions of inter-parental conflict will significantly predict level of aggression among adolescents
3. There will be sex difference in levels of aggression and general health among adolescents.

## CHAPTER TWO

### LITERATURE REVIEW

#### **Theoretical Framework**

#### **Theories of Inter-Parental Conflict**

##### **2.1 The concept of inter-parental conflict**

Differences and disagreements between parents over familial and non-familial issues are part of family life (Buehler & Trotter, 1990). Inter-parental conflict is a multidimensional construct that includes frequency, mode of expression, chronicity or duration, intensity, and degree of resolution all of which are important elements that should be considered when examining the impact of inter-parental conflict on children (Tittsworth, & Stone 1994).

Frequent disagreements, when considered, are associated with negative parent-child relationships. However, the mode of expression of these disagreements may be hostile. Three hostile modes of conflict expression includes: overt, covert, and avoidant conflict styles (Buehler, 1997).

##### **2.1.1 Hostile modes of conflict expression**

**Overt conflict style** - an overt conflict style includes frictional behaviors in which couples display verbal expressions of anger or physical violence, Overt is out in the open and explicit. Dealing with differences in a direct and straightforward manner.

**Covert conflict style** - this exists when people express their feelings and disagreements indirectly, a common form of covert conflict is passive aggression, which is acting aggressive while denying feelings, been cold and distant while also denying that anything is wrong at all.

**Avoidant conflict style** - this attempt to avoid directly confronting the issue at hand. Methods of doing this include changing the subject, putting off a discussion until later, or simply not

bringing up the subject of contention.

One significant factor is whether or not these conflicts are resolved (Cummings & Davies, 1994). And children who are exposed to high levels of inter-parental conflict are vulnerable to a wide range of emotional, behavioral, social, and academic problems (Cummings & Davies, 1994; Dunn & Davies, 2001; Erel & Burman, 1995)

## **2.2 Cognitive-contextual theory.**

Rooted in information processing and stress and coping theories (John Grych & Frank Fincham, 1990), developed the cognitive-contextual theory to help explain children's responses to inter-parental conflict. This model hypothesizes that children's appraisals mediate the impact of conflict and guide children's coping efforts (Grych & Cardoza-Fernandes 2001). Appraisals are defined as children's attempts to understand the conflict and its implications for themselves and are affected by the manner in which the conflict is expressed and contextual factors such as previous exposure to conflict and the quality of the parent-child relationships. Appraisals occur in a two-stage sequence. Primary processing refers to children's initial determination of the relevance and level of threat posed by the conflict. Secondary processing represents attempts to understand why the conflict has occurred. For example, children may look for someone to blame for the conflict and those that tend to blame themselves are at higher risk for depressive symptomatology and for becoming involved or triangulated into the conflict, a situation that is linked with adverse outcomes (Grych, 2000). Children's appraisals of their own coping efforts also are important to consider. According to this theory, the more confident children feel in their ability to cope with the conflict, the less likely they are to be threatened (Grych & Cardoza-Fernandez 2001).

### **2.2.1 Emotional security hypothesis.**

(Patrick Davies & Mark Cummings 1994), proposed the emotional security hypothesis as a means of understanding the impact of marital conflict on children. This theoretical model focuses on the meaning children ascribe to marital conflict and the extent to which children can perceive the conflict as threatening to their level of emotional security and the integrity of their family system. Children's emotional security is hypothesized to be a function of three regulatory systems, each of which may be disturbed by inter-parental conflict: emotion regulation (i.e., emotional reactivity and arousal), internal representations of family relationships (i.e., interpretations of the meaning and the potential consequences of the conflict for one's own well-being), and regulation of exposure to family affect (i.e., level of involvement in or withdrawal from conflict). There is some suggestion that children who engage in the conflict exhibit higher levels of difficulty than those who withdraw (Kerig, 2001).

Studies have found marital conflict prior to the birth of a child predicts insecure attachment (Howes & Markman 1989) through its association with insensitive parenting (Owen & Cox, 1997).

## **2.3 Theories of general health**

### **2.3.1 The concept of general health**

In 1948, in a radical departure from previous definitions, the World Health Organization (WHO) proposed a definition that aimed higher, linking health to well-being in terms of "physical, mental, and social well-being, and not merely the absence of disease and infirmity". WHO played a leading role when it fostered the development of the health promotion movement in the 1980s. This brought in a new concept of health, not as a state, but in dynamic terms of resiliency, in other words, as "a resource for living". The 1984 WHO revised definition of health



defined it as "the extent to which an individual or group is able to realize aspirations and satisfy needs, and to change or cope with the environment. (WHO, 2006). Health is a resource for everyday life, not the objective of living; it is a positive concept, emphasizing social and personal resources, as well as physical capacities". (Taylor & Marandi, 2008). Thus, health refers to the ability to maintain homeostasis and recover from Mental, intellectual, emotional, and social ordeals. Health refers to a person's ability to handle stress, to acquire skills, to maintain relationships, all of which form resource and independent living.

### **2.3.2 Social-cognitive theory**

This theory evolved from social learning theory. It posits a multifaceted causal structure in the regulation of human motivation, action and well-being and offers both predictors of adherence and guidelines for its promotion. The basic organizing principle of behavior change proposed by this theory is reciprocal determinism in which there is a continuous, dynamic interaction between the individual, the environment and behavior.

Social-cognitive theory suggests that while knowledge of health risks and benefits are a prerequisite to change, additional self-influences are necessary for change to occur. Beliefs regarding personal efficacy are among some of these influences, and these play a central role in change. Health behavior is also affected by the expected outcomes – which may be the positive and negative effects of the behavior or the material losses and benefits. Outcomes may also be social, including social approval or disapproval of an action. A person's positive and negative self-evaluations of their health behavior and health status may also influence the outcome. Other determinants of behavior are perceived facilitators and barriers. Behavior change may be due to the reduction or elimination of barriers. In sum, this theory proposes that behaviors are enacted if people perceive that they have control over the outcome, that there are few external barriers

when individuals have confidence in their ability to execute the behavior.

### **2.3.3 The health belief model (HBM)**

This is one of the first theories of health behavior. It was developed in the 1950s by a group of U.S. Public Health Service social psychologists who wanted to explain why so few people were participating in programs to prevent and detect disease. HBM is a good model for addressing problem behaviors that evoke health concerns (e.g., high-risk sexual behavior and the possibility of contracting HIV; Croyle, 2005). The health belief model proposes that a person's health-related behavior depends on the person's perception of four critical areas:

1. The severity of a potential illness,
2. The person's susceptibility to that illness,
3. The benefits of taking a preventive action, and
4. The barriers to taking that action.

HBM is a popular model applied in nursing, especially in issues focusing on patient compliance and preventive health care practices.

The model postulates that health-seeking behavior is influenced by a person's perception of a threat posed by a health problem and the value associated with actions aimed at reducing the threat. HBM addresses the relationship between a person's beliefs and behaviors. It provides a way to understanding and predicting how clients will behave in relation to their health and how they will comply with health care therapies.

- **Perceived Susceptibility:** refers to a person's perception that a health problem is personally relevant or that a diagnosis of illness is accurate.

- Perceived severity: even when one recognizes personal susceptibility, action will not occur unless the individual perceives the severity to be high enough to have serious organic or social complications.
- Perceived benefits: refers to the patient's belief that a given treatment will cure the illness or help to prevent it.
- Perceived Costs: refers to the complexity, duration, and accessibility and accessibility of the treatment.
- Motivation: includes the desire to comply with a treatment and the belief that people should do what.
- Modifying factors: include personality variables, patient satisfaction, and socio-demographic factors.

## **2.4 Theories of aggression**

### **2.4.1 The concept of aggression**

The term aggression refers to a range of behaviors that can result in both physical and psychological harm to oneself, other or objects in the environment (Kendra cherry 2016). This type of social interaction centers on harming another person, either physically or mentally.

The expression of aggression can occur in several ways including verbally, and physically. A number of different factors can influence the expression of aggression. Biological factors can play a role. Men are more likely than women to engage in physical aggression. While researchers have found that women are less likely to engage in physical aggression, they also suggest that women do use non-physical forms such as verbal aggression.

Environmental factors also play a role, including how people were raised. People who grow up witnessing more forms of aggression are more likely to believe that such violence and

hostility are socially acceptable.

#### **2.4.2 Psychoanalytic approach to aggression:**

Psychoanalysis, the most well-known theory under Psychodynamic approach was founded by Sigmund Freud. According to this theory, human aggression is an instinctive drive, related to the person and not the situation, and therefore an unavoidable part of human life (Glassman, 2004). Freud believed that all humans possess two basic drives from birth that contribute to personality development and behavior: the drive for aggression (Thanatos) and the drive for pleasure (Eros). Thanatos, or destructive energy, expresses itself in aggression to others, as well as self-destructive behavior. Moreover, the two primitive forces, life and death instincts, seek constant expression and satisfaction, while at same time, opposing one another in our subconscious. This conflict is the origin of all aggression.

Freud viewed the aggressive drive as part of Id , the part of the psyche that motivates behavior, while ego , our rational self, and superego , our ideal image of ourselves, oppose or repress the aggressive impulses. The conflict between the different parts of personality creates tension in the individual, who then uses defense mechanism or ways to cope and block conscious awareness of this conflict. Anna Freud, Freud's psychoanalytic heir, also emphasized the impaired parent-infant bonding as one of the causes of pathogenic behavior, and believed that emotional attachments in early childhood help to 'fuse and neutralize' aggressive urges in later life (Freud, 1965). Thus, according to this theory, one can never eliminate aggression, but try to control it by channeling it into ways involving symbolic gratification. This indirect gratification results in Catharsis or the release of drive energy, and a failure to do so leads to aggressive behavior.

### **2.4.3. Cognitive approach to aggression**

Cognitive approach also claims that cognitive schemata that develop in the individual's mind with experience, also affect the possibility of aggression. One field study on street culture of young people shows how their behavior is influenced by a "code" or schema that forms a set of informal rules on public behavior, and the use of violence to respond if challenged. (Anderson, 1994) Leonard Berkowitz, one of the pioneers of cognitive neo-association theory suggests the idea of priming, according to which violent thoughts and memories can increase the potential for aggression, even without imitating or learning aggression. In one study, he shows how individuals shown pictures of guns are more willing to punish another person than those shown neutral objects (Berkowitz, 1984).

However, Anderson and Bushman have given a comprehensive general aggression model (GAM), which integrates social learning theory and neo association, along with biological data on arousal. By recognizing both personal and situational factors, this theory suggests that aggression is the result of both the personality and interaction of the person and the situation. (Anderson & Bushman, 2002)

## **2.5 Review of empirical studies**

This section presents the review of various empirical studies that have been conducted in the past on the relationship among variables under investigation. The aim was to be able to identify loophole in this study and to be able to serve as guides in conducting the present study.

### **2.5.1 Influence of inter-parental conflict and general Health**

Health journal published by Kimberly Rhoades examined the relations between children's cognitive, affective, behavioral, and physiological responses to inter-parental conflict. Studies included children between 5 and 19 years of age. Moderate effect sizes were found for the

associations between cognition and internalizing (e.g. fear, self-blame & threat, low self-worth, depression). Likewise in findings made by García, Marín and Currea (2006) it was found that the inter-parental conflicts, particularly those of elevated frequency and intensity; present themselves as predictors in the development of psychopathological symptomatology in adolescents, such as interpersonal sensitivity, depression and anxiety. Thus, the conflicts may carry the weight of less availability from the part of the parents, being that they are more preoccupied in resolving their own difficulties, they become more irritable and unavailable, which limits their availability to their children (Grych, 2000). This study suggested that if children view their parents' conflicts as threatening to themselves or the family system or feel that they are unable to cope with the conflict they are likely to feel anxious and helpless. Likewise, if children feel that they are to blame for their parents' conflicts they are likely to feel guilt, shame, and sadness (Grych & Fincham, 1990; Grych et al., 2000).

Children's cognitions could also be associated with aspects of development other than internalizing and externalizing behavior problems. For example, if a child feels that they are to blame for their parents' conflict or that they are unable to cope with the conflict, they may be likely to have low self-esteem or self-worth (Rogers & Holmbeck, 1997).

Child negative effect in response to IPC has also been investigated as a possible mediator of the relation between IPC and child adjustment. In response to IPC, sadness has been shown to be positively correlated with internalizing and externalizing behavior problems (Cummings, Goeke-Morey, & Papp, 2003).

### **2.5.2 Inter-parental conflict and aggression**

In a research study done by Cummings (1994), he investigated the degree to which conflict is expressed overtly as opposed to covertly and its significance in the relationship

between inter-parental conflict and child adjustment. However, other factors regarding the expression of conflict are also important such as the use of constructive versus destructive conflict tactics.

Concern over the effects of inter-parental aggression on child adjustments is well founded. Estimates indicate that 15.5 million American children live in families which inter-parental violence occurs (McDonald, Jourles, & Green, 2006). This is why the Emotional theory suggests that inter-parental aggression undermines children's feelings of safety and security in the family, which heighten the risk for adjustment problems (Cummings & Davies, 1996). Children's exposure to inter-parental conflicts at home often show significant behavioral maladjustment and particularly elevated aggressive – disruptive behavioral problems and conflictual relationship with siblings and peers

Researchers interested in the relationship between conflict factors and child aggression used parental conflict diaries, kept for 15 days, from 108 families with children between the ages of 8 and 16 to examine the relationship between child aggression and constructive (e.g., calm discussion, humor, affection, problem solving) versus destructive conflict tactics (e.g., verbal hostility, threat, physical aggression, defensiveness, withdraw) and expression of positive versus negative emotions (Cummings, 2003). His research indicates that exposure to destructive tactics and negative emotion in parental conflict has been found to be related to increased likelihood of child aggression, while the use of constructive tactics and expression of positive emotion during disagreements was associated with a reduced risk of child aggression (Cummings, 2004). Thus, conflict alone does not appear to be responsible for aggression in children; however, specific styles of conflict are associated with higher levels of aggression in children.

### 2.5.3 Sex and general health

Gender differences in the relationship between inter-parental conflict and child adjustment problems have received significant attention in the literature. Findings have been inconsistent, with some research noting significant gender differences while other research finding no notable differences based on gender.

Research in this area is reviewed below. First, research that reports no significant gender differences in the relationship between inter-parental conflict and child adjustment is presented, followed by research supporting gender differences (Buehler, 1998). This empirical study examined the role of the frequency and style (i.e., overt vs. covert) of inter-parental conflict in the internalizing and externalizing behaviors, they also tested for possible gender differences. Using regression analyses these researchers found no significant differences in the effects of inter-parental conflict on boys and girls (Buehler, 1998).

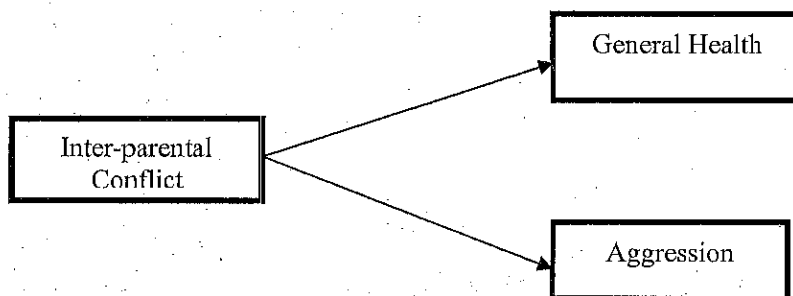
Buhler and Gerard (2002) examined the role of parenting styles, in the relationship between inter-parental conflict and child adjustment and examined differences in this relationship based on child gender. This study found that the pathway from marital conflict to adolescent maladjustment as mediated by parent-child conflict was stronger for girls than boys, supporting the case that marital conflict may have more detrimental effects for parent-daughter relationships, than for parent-son relationships. This finding could indicate that daughters are at a greater risk of negative outcomes from inter-parental conflict, or that the pathways by which inter-parental conflict affects adolescents is different for boys and girls. However, gender differences did not hold for younger children (Buehler & Gerard, 2002) and (Jessica Fear, 2007).



#### 2.5.4 Sex and aggression

Osborne and Fincham (1996) examined the relationship between inter-parental conflict, parent-child relationship, parent gender, child gender, and child adjustment. Researchers recruited (169) 6th and 7th grade students to complete measures of inter-parental conflict, parent-child relationships, and internalizing symptoms, while participants' teachers completed measures of internalizing and externalizing behavior problems and 28 school peers identified students who were bossy and students who started fights. Structural equation modeling was used to identify the pathway by which perceptions of inter-parental conflict, perceptions of parent-child relationship, and child adjustment were related for both boys and girls. The researchers found that marital conflict had both direct and indirect effects on child adjustment for both boys and girls, though the role of parent-child relationships depended on parent and child gender.

#### 2.5.5 Conceptual model



This model displays how inter-parental conflict as a predominant factor, could have detrimental effects on general health and feelings of aggression in adolescents. This shows that living in conflict home may be a chronic psychological stressor that could negatively affect children's health and increase their chances of imitating and exhibiting aggressive tendencies.

## 2.6 Operational definition of terms

- **Inter-parental conflict:** These conflict consist of disagreements, arguments, and disputes between parents. Inter-parental conflict was measured using a scale that consisted of (48) items organized into 9 conceptual designed subscales, with reports of 3-factor high order structure to the 9 subscales. The subscales are (frequency, intensity, resolution, content, perceived threat, coping efficacy, self-blame triangulation, stability).
- **General health:** A state of complete physical, mental, and social well-being, this variable was measured using a 12item scale which was designed to assess the severity of a mental problem. With efficacy to assess people's overall psychological well-being and to detect non psychotic psychiatric problems.
- **Aggression:** Feelings of Anger resulting in hostile or violent behavior; readiness to attack or confront. This variable was also measured using a scale that consists of 11 items designed to measure self-reported aggressive behaviors among middle school students (sixth, seventh, and eighth graders).

## **CHAPTER THREE**

### **METHOD**

#### **3.1 RESEARCH DESIGN**

An expo-facto research design was used in this study; there was no manipulation of variables, with the researcher examining how the existing independent variable, affects the dependent variable.

#### **3.2 SETTING**

The study was carried out in Oye and Ado Local Government Areas (LGAs), Ekiti State. The two LGAs are sub urban. The LGAs are saturated with senior secondary schools which include both public and private schools. This makes collection of data conducive given the availability of students at the adolescent stage.

#### **3.3 STUDY SAMPLE**

The study made use of purposive sampling; this was based on the judgment of the researcher, with a specific population in mind, which was the senior secondary school student. And those who weren't senior students were excluded from filling the self-report instrument. Data was collected by means of questionnaires. The sample size for this study was three hundred and ninety four (394) participants who were senior secondary school students from different secondary schools in Ado-Ekiti and Oye-Ekiti, Ekiti State. They were sampled using purposive sampling method. Of those According to gender, there were 227 (58%) males and 167 (42%) females. Based on religion, 310 (78%) were Christians, 75 (19%) were Muslims and 9 (2%) were traditionalists. According to age range, 182 (46%) were between the age of 12-15years and 213 (54%) were between the age of 16-19years. Based on information about parents, 329 (84%) parents are living together and 65 (16%) parents are separated. According to their

classes, 173 (44%), are SS1 students, 211 54(%) are SS2 students and 10 2(%) are SS3 students.

### **3.5 INSTRUMENTS**

The main instruments for the study are children's perception of inter-parental conflict scale questionnaire, (CPIC) General health questionnaire, and Aggression scale questionnaire. The instrument contains four sections A, B, C and D as presented below.

#### **3.5.1 (Section A): Demographic Information**

It comprises of items measuring the demographic feature of participants, such as age, gender, name of school, parental status (living together or separated).etc.

#### **3.5.2 (Section B): Children's Perception of Inter-parental Conflict (cpic) Scale.**

The inter-parental conflict scale was developed by (CPIC; Grych, Seid, & Fincham 1992). It consists of (48) items organized into 9 conceptual designed subscales, with reports of 3-factor high order structure to the 9 subscales. The subscales are (frequency "items" 1,10, 16, 20, 29, 37) (intensity "items" 5, 14, 24, 33, 38, 40, 45) (resolution "items" 2, 11, 21, 30, 41, 48) (content "items" 3, 22, 31, 39) (perceived threat "items" 7, 17, 26, 35, 42, 47) (coping efficacy "items" 6, 15, 25, 34, 46, 51) (self-blame "items" 9, 19, 28, 43, 50) (triangulation "items" 8, 18, 27, 36, 44) (stability "items" 13, 23, 32, 49).The children's perception of inter-parental conflict scale was initially examined in a sample of 144 similarly aged children, 3 factor analytically derived subscales (Conflict properties, Threat, Self-blame) demonstrated acceptable levels of internal consistency and test-retest reliability(Grych et al, 1992). The present study obtained a Cronbach alpha coefficient of .85. The validity of the conflict properties scale was supported by significant relations with parent reports of conflict and indices of child adjustment, the threat and self-blame scales correlated with children's responses to specific conflict. The CPIC scale thus appears to be a promising instrument for assessing perceived marital conflict. The scale asks kids what they

think or feel when their parents have arguments or disagreements. To tell whether they agree by ticking YES, do not agree by ticking NO or think that it is true

Sometimes.

### **3.5.3 (Section C) General health scale (ghq-12)**

The general health questionnaire (GHQ-12) is a self-administered screening self-report, aimed at detecting individuals with a diagnosable psychiatric disorder. It is the most extensively used screening instruments for common mental disorders, in addition to being a more general measure of psychiatric well-being. In its original version, it had 60 items (GHQ-60), which were reduced to 30 (GHQ-30), 28 items by (Roca, & Bernard, 2000) 12 items by (Goldberg & Williams, 1988). The 12 items were designed to assess the severity of a mental problem.

In a study by Maria & Dresch (2008), they analyzed the external and structure validity of the GHQ=12. Using the GHQ-12 and the inventory of situations and responses of Anxiety-ISRA were administered. A Cronbach's alpha of .76 (Standardized Alpha .78) and a 3 factor structure (with oblique rotation and maximum likelihood procedure) were obtained. The present study obtained a Cronbach alpha coefficient of .67. The GHQ=12 can be used with efficacy to assess people's overall psychological well-being and to detect non psychotic psychiatric problems (Maria & Dresch, 2008)

### **3.5.4 (Section D) Aggression scale**

This scale was developed by Orpinas & Frankowski, (2001), it measures the frequency of self-reported overt aggressive behaviors that may result in physical or psychological injury to other students, for example, pushing, name-calling, hitting, and/or threatening. The scale consists of 11 items designed to measure self-reported aggressive behaviors among middle school students (sixth, seventh, and eighth graders). The scale was evaluated in two independent samples of young adolescents ( $n = 253$  and  $n = 8,695$ ). Reliability scores were high in both

samples, and did not vary significantly by gender, ethnicity, or grade level in school. Aggression scores also were stable in a 2-year follow-up study. The present study obtained a Cronbach alpha coefficient of .75. Mean scores on the Aggression Scale were associated positively with teachers' independent rating of student aggression, other measures of aggression, and known predictors of aggression. The scale is brief, is easy to administer, and focuses on overt behaviors. Thus, the Aggression Scale could be a useful tool for program evaluation and for further research on violence prevention in schools. This scale is scored by adding all responses. Possible range is between 0 and 66 points, each point represents one aggressive behavior the student reported engaging in during the week prior to the survey. If four or more items are missing, the score cannot be computed. If three or less items are missing, these values are replaced by the respondent's average. Reliability, the range of Test-retest Value isn't assessed. The range of Inter-rater reliability isn't assessed. The range of internal consistency is 0.87 to 0.88. (Orpinas & Frankowski, 2001).

### **3.6 Procedures for data collection**

The researcher collected data through the aid of self-report instruments, the school principals were visited with the aim of seeking permissions and a possible date that was comfortable for both the teachers and the students in conducting the research. The schools were visited with a total number of 450 questionnaires and with the support of their school principals and teachers the questionnaires were administered. 433 was properly collected and taken for data analysis.

### **3.7 Statistical analyses**

The data collected were subjected to analysis using Statistical Package in Social Sciences (SPSS). Demographic characteristics of the participants were analyzed using descriptive

statistics such as mean, standard deviation, frequency table and percentage. Hypotheses one and two were analyzed using multiple regressions, while hypothesis three was tested using multivariate Analysis of Variance (MANOVA).

## CHAPTER FOUR

### RESULTS

**Table 1 Mean score and standard deviations of study variables**

Variables	M	S.D	Range
AGE	15.57	1.74	12-19
Frequency	5.32	1.97	0-12
Intensity	5.90	3.06	0-14
Resolution	4.42	2.25	0-11
Content	3.15	1.49	0-6
Perceive threat	6.92	2.59	0-12
Coping efficacy	5.51	2.26	0-12
Self-blame	4.09	1.84	0-10
Triangulation	5.08	2.06	0-10
Inter-parental conflict	44.14	12.60	6-83
General health	27.83	7.14726	10-48
Aggression	21.65	6.450	11-44

**Table 2: Mean, standard deviation scores and correlations among study variable**

Variables	1	2	3	4	5	6	7	8	9	10
N=										
1. Aggression	-									
2. General health	.24**	-								
3. Inter-parental	.26**	-.56*	-							
4. Frequency	.21**	.28**	.57*	-						
5. Intensity	.25**	.54**	.79*	.38*	-					
6. Resolution	.17**	.47**	.71*	.30*	.55*	-				
7. Content	.10	.20**	.51*	.28*	.28*	.24*	-			
8. Perceived threat	.12*	.34**	.75*	.41*	.48*	.43*	.36*	-		



9. Coping efficacy	.21**	- .41**	.68* *	.35* *	.44* *	.41* *	.27* *	.46**	-	
10. Self-blame	.14**	- .41**	.63* *	.23* *	.44* *	.42* *	.33* *	.38**	.34**	-
11. Triangulation	.13*	- .26**	.63* *	.24* *	.42* *	.38* *	.29* *	.50**	.31**	.34

\*  $p < 0.05$  (2-tailed) \*\*  $p < 0.001$  (2-tailed)

The result of correlation analyses are presented in table 3. All dimensions of inter-parental conflict including the full scale are positively and significantly related with aggressive feelings [Inter parental conflict- full scale:  $r(378) = .26, p < .0001$ ; Frequency:  $r(378) = .21, p < .000$ ; intensity  $r(378) = .26, p < .0001$ , Resolution:  $r(378) = .17, p = .001$ ; Content:  $r(378) = .10, p = .05$ ; perceived threat:  $r(378) = .12, p = .02$ ; coping efficacy:  $r(378) = .21, p < .0001$ ; Self-blame:  $r(378) = .14, p = .005$ ; Triangulation:  $r(378) = .13, p = .13$ ]. On the other hand, all dimensions of inter-parental conflict including the full scale are negatively and significantly related with general health [Inter parental conflict- full scale:  $r(378) = -.56, p < .0001$ ; Frequency:  $r(378) = -.28, p < .000$ ; intensity  $r(378) = -.54, p < .0001$ , Resolution:  $r(378) = -.47, p < .0001$ .; Content:  $r(378) = -.20, p < .0001$ ; perceived threat:  $r(378) = -.34, p < .0001$ ; coping efficacy:  $r(378) = -.41, p < .0001$ ; Self-blame:  $r(378) = -.41, p < .0001$ ; Triangulation:  $r(378) = -.26, p < .0001$ ].

## Hypothesis 1

The dimensions of inter-parental conflict will significantly predict level of aggression among adolescents.

**Table 4: Regression analysis- dimensions of inter-parental conflict on aggression**

Variable	$\beta$	T	R	$R^2$	F
Frequency	.13*	2.26			
Intensity	.16*	2.41			
Resolution	.02	.32			
Content	.003	.06	.30	.09	4.47**
Perceive threat	-.09	-1.40			
Coping efficacy	.11	1.77			
Self-blame	.03	.41			
Triangulation	.02	.40			

**Dependent variable:** Aggression

\* $p < .05$ ; \*\* $p < .01$

Table 4 showed that all dimensions of inter-parental conflict interactively predict aggression [ $F(8, 370) = 4.47, p < .0001, R^2 = .08$ ]. However, frequency [ $\beta = .13, p = .02$ ] and intensity [ $\beta = .16, p = .02$ ] independently predict aggression while resolution [ $\beta = .02, p = .75$ ], content [ $\beta = .003, p = .95$ ], perceive threat [ $\beta = -.09, p = .16$ ], coping efficacy [ $\beta = .11, p = .08$ ], self-blame [ $\beta = .03, p = .68$ ] and triangulation [ $\beta = .02, p = .69$ ] did not.

Therefore, hypothesis one supported.

## Hypothesis 2

The dimensions of inter-parental conflicts will significantly predict level of aggression among adolescents.

**Table 6: Regression analysis- dimensions of inter-parental conflict on general health**

Variable	$\beta$	T	R	$R^2$	F
Frequency	-.03	-.69			
Intensity	-.32**	-5.83			
Resolution	-.19**	-3.59			
Content	.02	.33	.61	.38	27.81**
Perceive threat	.02	.28			
Coping efficacy	-.14**	-2.84			
Self-blame	-.15**	-3.15			

Triangulation	.04	.77
<b>Dependent variable: General health</b>		

\*\* $p < .01$

Table 4 showed that all dimensions of inter-parental conflict interactively predict general health [F (8, 370) = 4.47,  $p < .0001$ ,  $R^2 = .38$ ]. However, intensity [ $\beta = -.32$ ,  $p < .0001$ ], resolution [ $\beta = -.19$ ,  $p < .0001$ ], coping efficacy [ $\beta = -.14$ ,  $p = .005$ ] and self-blame [ $\beta = -.15$ ,  $p = .002$ ] independently predict general health while frequency [ $\beta = -.03$ ,  $p = .49$ ], content [ $\beta = .02$ ,  $p = .74$ ], perceive threat [ $\beta = .02$ ,  $p = .78$ ] and triangulation [ $\beta = .02$ ,  $p = .69$ ] did not.

Therefore, hypothesis two is supported.

### Hypothesis 3

There will be sex difference in levels of aggression and general health among adolescents.

**Table 8: Means and standard deviations for general health and aggression by sex**

Variables	General health	Aggression
Sex	M (SD)	M (SD)
Male	28.19 (7.29)	21.30 (5.95)
Female	27.34 (7.00)	22.12 (7.07)

**Table 8.1: One-way MANOVA- sex on general health and aggression**

Variables	Wilks' Lambda	F	df	Error df	P	$\eta^2$
Sex	.99	1.09	2.00	376	.34	.01

Table 8.1 presents a one-way MANOVA testing the effect of sex on general health and aggression. The effect of sex [Wilks'  $\Lambda = .99$ ,  $F(2, 376) = 1.09$ ,  $p = .34$ ] was not significant on the combined dependent variables. Therefore, hypothesis four is supported.

## CHAPTER FIVE

### DISCUSSION, CONCLUSION, IMPLICATION, RECOMMENDATION, AND LIMITATION

#### 5.1 DISCUSSION

From hypotheses one, the results indicate that inter-parental conflicts, would influence aggressive behaviors in adolescents.

This present findings is of the opinion that some students tend to watch their parents display aggressive behaviors during conflicts at home and this predisposes them to observe and display their parents actions in schools. Therefore inter-parental conflict to an extent has negative influence on aggressive behavior of students. In a research conducted by Finger, (2010), he figured out that children's social relationship in the society can be affected, due to the aggressive behaviors exhibited, the children prone to developing poor interpersonal skills. Likewise, difficulties getting along with parents, siblings, peers, teachers and in longer term, even romantic partners (Cui & Fincham, 2010).

The results from hypothesis two showed that all dimensions of inter-parental conflict interactively predict general health. These finding supports the findings made by García, Marín and Currea (2006) in which they found that the inter-parental conflicts, particularly those of elevated frequency and intensity; present themselves as predictors in the development of psychopathological symptomatology in adolescents, such as interpersonal sensitivity, depression and anxiety. Thus, while parents are preoccupied in resolving their own difficulties, they become more irritable and unavailable; this limits their availability to their children's health. Therefore, due to troublesome family conflicts, in addition to the unavailability of parental figures, the children become vulnerable and susceptible to the development of psychopathological

symptomatology. In a study performed by Elkington, Bauermeister & Zimmerman (2010), with a sample of 850 African-American adolescents and young adults, the existence of inter-parental conflicts seemed to be a risk factor in the children's developmental and behavioral process. Following this line of thought, Féres-Carneiro & Diniz Neto (2010) highlighted the importance of the couples reducing negativity and promoting positive affection during marital conflict. In addition, the results showed that the perception of a low conflict resolution presents itself as a predictor of anxiety. Therefore, it seems that the parental figures' inability to resolve their own conflicts triggers, in their children, emotional states characterized by high levels of anxiety. Also in a study conducted by Schermerhorn, Chow & Cummings (2010), they investigated the influence and interaction of children in inter-parental conflicts as well as their effects on the family system. It was found that the exposure and involvement of children in inter-parental conflict, in an attempt of resolution, can result in negative implications on the children's adjustment. Therefore, children can be involved in these triangles, however, they risk developing maladaptive behaviors, as well as developing internalizing symptomatology such as anxiety and depression. As stated by Amato & Afifi (2006), the fact that children grow up in intact families, even when there are high levels of conflict between the parents, does not save the children from the effects of inter-parental conflicts, especially since these conflicts also result in damage to the psychological well-being of the children, regardless of their age.

The result from Hypothesis 3 suggests that the effect of sex was not significant on aggression and general health. This result suggests that sex (gender) doesn't have an effect on both general health and aggression. Supporting the results of this study some researchers find no gender differences or rather inconclusive results. (Grych, 1992) Others find that threat cognitions are a stronger predictor of dysfunction in boys, and self-blame cognitions are a stronger predictor

of dysfunction in girls, even though boys and girls report similar rates of self-blame and threat cognitions (Cummings, 1994; Kerig, 1998). For example, El-Sheikh (2005) found that relations between self-reported anger and internalizing and externalizing behavior problems and self-reported sadness and externalizing behavior problems are stronger for girls than for boys. While other studies like that of (Buehler, 1997) which consists of meta-analysis of 68 studies measuring the association between the frequency of inter-parental conflict and the internalizing and externalizing problems of youth between the ages of 5 and 18, he found that there were no significant differences in adjustment between boys' and girls' global assessment of adjustment, nor in reports of internalizing versus externalizing symptoms. The researchers investigated if such gender differences would be found when only studies of clinical populations were examined and found no significant gender differences. (Cummings, 2006; Davies, Harold et al., 2002), or have not directly examined the role of gender (Dukewich, 2001).

## **5.2 CONCLUSION**

The result of this dissertation suggests that;

1. The dimensions of inter-parental conflict will significantly predict level of aggression among adolescents; this result shows that the level of frequency and intensity of the conflict would independently predict aggression and this is due to the fact that the level of frequent and intense parental conflict is more observable by children than the other dimensions.
2. The dimensions of inter-parental conflict will significantly predict general health among adolescents; this result shows that the level of intensity, resolution, coping efficacy and self-blame would independently predict general health.

3. There will be sex difference in levels of aggression and general health among adolescents; this result suggests that the effect of sex on general health and aggression isn't significant.

### **5.3 IMPLICATIONS OF THE RESULTS**

The implication of findings suggested that students from conflict homes may be prone to exhibit general health issues and aggressive behaviors, because children who are exposed to inter-parental conflicts are vulnerable to a wide range of emotional, behavioral and social problems (Dunn & Davies, 2001).

Children who experience conflicts at home, act different from their peers, they tend to display negative attitude towards others. This study opens up to the urgent need to visit the issue of ensuring a stable non-violent home for the benefit of the society.

### **5.4 Recommendations**

Sequel to the result of the findings of this research work, the following recommendations are offered; firstly, parental conflicts at home should be tamed, parents should display positive attitude towards their children, they should note that children learn by observation and imitation and such learned behavior can be positive or negative.

This dissertation would also help the school counselors to understand that inter-parental conflict observed by children at home, could also result to their aggressive behaviors in schools and how best to provide help for the child.

Likewise, improved partnership and conflict management skills between couples/parents should be improvised on by therapists.

## 5.5 Limitations of the study

This study met some limitations which includes;

1. It was observed during the instrument administration that some of the students falsified their responses to the test instrument; they didn't want their friends or peers to know what they go through at home. To counter this, the researcher requested to acquire a much larger classrooms or auditoriums in order to space the students to prevent the other students next to them, who could view their responses. The researcher also requested for them to be objective as much as possible, to be sincere with their answers, stating that their names weren't needed so they could be more relaxed while ticking the questionnaires.
2. Another limitation in the study was that data was limited to senior secondary school students, which may undermine the "generalizability" of findings to junior secondary school students. Thus, future researchers could also include junior secondary school students.



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APPENDIX

FEDERAL UNIVERSITY OYE-EKITI, EKITI STATE  
FACULTY OF SOCIAL SCIENCE  
DEPARTMENT OF PSYCHOLOGY

Dear Respondent,

I am a final year student of the Department of Psychology, Federal University Oye Ekiti State, conducting a research in the area of "Psychology and behavior".

Please give your immediate impressions about the questions on this survey. There is no right or wrong answers. Your response will be treated with utmost confidentiality.

Odiase ese linda

Please express your interest to participate by ticking 'Yes' or 'No' below:

I agree to participate: Yes ( ), No ( ).

**SECTION A**

Instruction

Please read the statement carefully and indicate your opinion by ticking in the appropriate box provided.

**BIOGRAPHIC DATA:**

Gender: Female  Male

Name of school: \_\_\_\_\_

Class: \_\_\_\_\_

Parents/guardian Living together  Parents separated

Are you living with your parents? Yes  No

Religious Affiliation: Christianity ( ), Islam ( ), Traditional ( ).

Age: ..... (As at last birthday).

**SECTION B**

Instruction

In every family there are times when the parents don't get along. Below are some things that kids sometimes think or feel when their parents have arguments or disagreements. We would like you to tell us what you think or feel when your parents argue or disagree by answering each of the

sentences below.

Please tick an option to each item to indicate how much you agree or disagree with that item.

**Note: there is no right or wrong answers, Thank you.**

S/ N	Items	YES	SOME TIMES	NO
1	I never see my parents arguing or disagreeing.			
2	When my parents have an argument they usually work it out			
3	My parents often get into arguments about things I do at school			
4	When my parents argue I end up getting involved somehow.			
5	My parents get really mad when they argue.			
6	When my parents argue I can do something to make myself feel better.			
7	I get scared when my parents argue.			
8	I feel caught in the middle when my parents argue.			
9	I'm not to blame when my parents have arguments.			
10	They may not think I know it, but my parents argue or disagree a lot.			
11	Even after my parents stop arguing they stay mad at each other.			
12	When my parents argue I try to do something to stop them.			
13	When my parents have a disagreement they discuss it quietly.			
14	I don't know what to do when my parents have arguments.			
15	My parents are often mean to each other even when I'm around.			
16	When my parents argue I worry about what will happen to me.			
17	I don't feel like I have to take sides when my parents have a disagreement.			
18	It's usually my fault when my parents argue.			
19	I often see or hear my parents arguing.			
20	When my parents disagree about something, they usually come up with a solution			
21	My parents' arguments are usually about me.			
22	When my parents have an argument they say mean things to each other.			
23	When my parents argue or disagree I can usually help make things better.			
24	When my parents argue I'm afraid that something bad will happen.			

25	My mom wants me to be on her side when she and my dad argue.			
26	Even if they don't say it, I know I'm to blame when my parents argue.			
27	My parents hardly ever argue.			
28	When my parents argue they usually make up right away.			
29	My parents usually argue or disagree because of things that I do.			
30	I don't get involved when my parents argue.			
31	When my parents have an argument they yell at each other.			
32	When my parents argue there's nothing I can do to stop them.			
33	When my parents argue I worry that one of them will get hurt.			
34	I feel like I have to take sides when my parents have a disagreement.			
35	My parents often nag and complain about each other around the house.			
36	My parents hardly ever yell when they have a disagreement.			
37	My parents often get into arguments when I do something wrong.			
38	My parents have broken or thrown things during an argument.			
39	After my parents stop arguing, they are friendly towards each other.			
40	When my parents argue I'm afraid that they will yell at me too.			
41	My parents blame me when they have arguments.			
42	My dad wants me to be on his side when he and my mom argue.			
43	My parents have pushed or shoved each other during an argument.			
44	When my parents argue or disagree there's nothing I can do to make myself feel better.			
45	When my parents argue I worry that they might get divorced.			
46	My parents still act mean after they have had an argument.			
47	Usually it's not my fault when my parents have arguments.			
48	When my parents argue they don't listen to anything I say.			

**SECTION C**

**Instruction:**

Please read the following statements and for each one tick only the option in front to indicate how you have been feeling recently.

**Note: there is no right or wrong answers, Thank you.**

	ITEMS	VERY FREQUENTLY	FREQUENTLY	OCCASIONALLY	RARELY	NEVER
	Able to concentrate on what I do?					
	Loss of sleep over worry?					
	Playing a useful part at home and in school?					
	Capable of making decisions?					
	Felt constantly stressed up?					
	Couldn't overcome difficulties that I face?					
	Able to enjoy day to day activities?					
	Able to face problems that comes my way?					
	Feeling unhappy and depressed?					
	Losing confidence?					
	Thinking of self as worthless?					
	Feeling reasonably happy?					

**SECTION D**

**Instruction:**

The following are a number of statements that describes the way in which you may have being acting recently. Please indicate with all sincerity.

**Note: there is no right or wrong answers, Thank you.**

	ITEMS	NOT TRUE	MOSTLY UNTRUE	MOSTLY TRUE	TRUE
	I teased students to make them angry.				
	I got angry very easily with someone.				
	I fought back when someone hit me first.				
	I said things about other kids to make other students laugh.				



I encouraged other students to fight.				
I pushed or shoved other students.				
I was angry most of the day.				
I got into a physical fight because I was angry.				
I slapped or kicked someone.				
I called other students bad names.				
I threatened to hurt or to hit someone.				

SPSS

Frequencies

Statistics

	Sex	NS	CLASS	PARENTS	Religious Affiliation	Age1
N	Valid	394	394	394	394	394
	Missing	0	0	0	0	0

Frequency Table

Sex

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Male	227	57.6	57.6	57.6
Valid Female	167	42.4	42.4	100.0
Total	394	100.0	100.0	

NS

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Oye Egbo	184	46.7	46.7	46.7
Valid St. Augustine	46	11.7	11.7	58.4
Valid Glory	31	7.9	7.9	66.2
Valid Ado Commercial	69	17.5	17.5	83.8
Valid Ola-Oluwa	34	8.6	8.6	92.4
Valid Our Lady	8	2.0	2.0	94.4
Valid Concentric	5	1.3	1.3	95.7
Valid Ado Grammer	17	4.3	4.3	100.0
Total	394	100.0	100.0	

CLASS

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid SSI	173	43.9	43.9	43.9
Valid SS2	211	53.6	53.6	97.5
Valid SS3	10	2.5	2.5	100.0
Total	394	100.0	100.0	

PARENTS

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Living together	349	88.6	88.6	88.6
Separated	45	11.4	11.4	100.0
Total	394	100.0	100.0	

**Religious Affiliation**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Christianity	310	78.7	78.7	78.7
Islam	75	19.0	19.0	97.7
Traditional	9	2.3	2.3	100.0
Total	394	100.0	100.0	

**Age1**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 12-15yrs	182	46.2	46.2	46.2
16-19yrs	212	53.8	53.8	100.0
Total	394	100.0	100.0	

DESCRIPTIVES VARIABLES=Frequency Intensity Resolution Content Threat CP SB  
 Triangulation IPCG GH AGG  
 /STATISTICS=MEAN STDDEV MIN MAX.

**Descriptive**

**Descriptive Statistics**

	N	Minimum	Maximum	Mean	Std. Deviation
Frequency	394	.00	12.00	5.3223	1.97185
Intensity	394	0	14	5.90	3.055
Resolution	394	0	11	4.42	2.253
Content	394	0	6	3.15	1.491
Perceive threat	394	0	12	6.92	2.594
Coping efficacy	394	0	12	5.51	2.256
Self blame	394	0	10	4.09	1.840
Triangulation	394	0	10	5.08	2.061

Interparental conflict	394	6.00	83.00	44.1371	12.79955
General health	380	10.00	48.00	27.8342	7.14726
Aggression	379	11	44	21.65	6.450
Valid N (listwise)	379				

CORRELATIONS

/VARIABLES=AGG GH IPCG Frequency Intensity Resolution Content Threat CP SB  
Triangulation

/PRINT=TWOTAIL NOSIG

/MISSING=PAIRWISE.

Correlations

Correlations

		Aggression	General health	Interparental conflict	Frequency	Intensity	Resolution	Content
Aggression	Pearson Correlation	1	-.240**	.262**	.209**	.246**	.173**	.098
	Sig. (2-tailed)		.000	.000	.000	.000	.001	.056
	N	379	379	379	379	379	379	379
General health	Pearson Correlation	-.240**	1	-.557**	-.281**	.540**	-.473**	.197**
	Sig. (2-tailed)	.000		.000	.000	.000	.000	.000
	N	379	380	380	380	380	380	380
Interparental conflict	Pearson Correlation	.262**	-.557**	1	.574**	.787**	.712**	.508**
	Sig. (2-tailed)	.000	.000		.000	.000	.000	.000
	N	379	380	394	394	394	394	394
Frequency	Pearson Correlation	.209**	-.281**	.574**	1	.378**	.296**	.275**
	Sig. (2-tailed)	.000	.000	.000		.000	.000	.000
	N	379	380	394	394	394	394	394

Intensity	Pearson Correlation	.246**	-.540**	.787**	.378**	1	.554**	.276**
	Sig. (2-tailed)	.000	.000	.000	.000	.000	.000	.000
	N	379	380	394	394	394	394	394
Resolution	Pearson Correlation	.173**	-.473**	.712**	.296**	.554**	1	.236**
	Sig. (2-tailed)	.001	.000	.000	.000	.000	.000	.000
	N	379	380	394	394	394	394	394
Content	Pearson Correlation	.098	-.197**	.508**	.275**	.276**	.236**	1
	Sig. (2-tailed)	.056	.000	.000	.000	.000	.000	.000
	N	379	380	394	394	394	394	394
Perceive threat	Pearson Correlation	.122*	-.343**	.754**	.409**	.475**	.430**	.360**

#### Correlations

		Perceive threat	Coping efficacy	Self blame	Triangulation
Aggression	Pearson Correlation	.122	.210**	.144**	.128**
	Sig. (2-tailed)	.018	.000	.005	.012
	N	379	379	379	379
General health	Pearson Correlation	-.343**	-.413	-.405**	-.261**
	Sig. (2-tailed)	.000	.000	.000	.000
	N	380	380	380	380
Interparental conflict	Pearson Correlation	.754**	.676**	.631	.632**
	Sig. (2-tailed)	.000	.000	.000	.000
	N	394	394	394	394
Frequency	Pearson Correlation	.409**	.345**	.231**	.242
	Sig. (2-tailed)	.000	.000	.000	.000
	N	394	394	394	394
Intensity	Pearson Correlation	.475**	.441**	.443**	.415**
	Sig. (2-tailed)	.000	.000	.000	.000

Resolution	N	394	394	394	394
	Pearson Correlation	.430**	.408**	.415**	.375**
	Sig. (2-tailed)	.000	.000	.000	.000
Content	N	394	394	394	394
	Pearson Correlation	.360	.271**	.325**	.290**
	Sig. (2-tailed)	.000	.000	.000	.000
Perceive threat	N	394	394	394	394
	Pearson Correlation	.1*	.463**	.378**	.495**

		Aggression	General health	Interparental conflict	Frequency	Intensity	Resolution	Content
Coping efficacy	Sig. (2-tailed)	.018	.000*	.000*	.000**	.000**	.000**	.000
	N	379	380	394	394	394	394	394
	Pearson Correlation	.210	-.413	.676	.345	.441	.408	.271
	Sig. (2-tailed)	.000**	.000*	.000*	.000**	.000**	.000**	.000**
Self-blame	N	379	380	394	394	394	394	394
	Pearson Correlation	.144	-.405	.631	.231	.443	.415	.325
	Sig. (2-tailed)	.005**	.000*	.000*	.000**	.000**	.000**	.000**
	N	379	380	394	394	394	394	394

Triangulation	Pearson	.128	-.261	.632	.242	.415	.375	.290
	Correlation							
	Sig. (2-tailed)	.012**	.000*	.000*	.000	.000**	.000**	.000**
	N	379	380	394	394	394	394	394

### Correlations

		Perceive threat	Coping efficacy	Self blame	Triangulation
Perceive threat	Sig. (2-tailed)		.000**	.000**	.000**
	N	394	394	394	394
Coping efficacy	Pearson Correlation	.463	.1	.337	.313
	Sig. (2-tailed)	.000**		.000**	.000**
	N	394	394	394	394
	Pearson Correlation	.378	.337	.1	.338
Self blame	Sig. (2-tailed)	.000**	.000**		.000**
	N	394	394	394	394
	Pearson Correlation	.495	.313	.338	.1
	Sig. (2-tailed)	.000**	.000**	.000**	
Triangulation	N	394	394	394	394

\*\* . Correlation is significant at the 0.01 level (2-tailed).

\* . Correlation is significant at the 0.05 level (2-tailed).

### REGRESSION

/MISSING LISTWISE

/STATISTICS COEFF OUTS R ANOVA

/CRITERIA=PIN(.05) POUT(.10)

/NOORIGIN

/DEPENDENT GH

/METHOD=ENTER Frequency Intensity Resolution Content Threat CP SB Triangulation.

### Regression

#### Variables Entered/Removed<sup>a</sup>

Model	Variables Entered	Variables Removed	Method
1	Triangulation, Frequency, Content, Self blame, Coping efficacy, Resolution, Intensity, Perceive threat <sup>b</sup>		Enter

a. Dependent Variable: General health

b. All requested variables entered.

#### Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.612 <sup>a</sup>	.375	.361	5.71158

a. Predictors: (Constant), Triangulation, Frequency, Content, Self blame, Coping efficacy, Resolution, Intensity, Perceive threat

#### ANOVA<sup>a</sup>

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	7257.743	8	907.218	27.810	.000 <sup>b</sup>
	Residual	12102.813	371	32.622		
	Total	19360.555	379			

a. Dependent Variable: General health



b. Predictors: (Constant), Triangulation, Frequency, Content, Self blame, Coping efficacy, Resolution, Intensity, Perceive threat

**Coefficients<sup>a</sup>**

Model	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	Std. Error	Beta		
1 (Constant)	39.280	1.116		35.197	.000
Frequency	-.118	.172	-.033	-.687	.492
Intensity	-.757	.130	-.322	-5.829	.000
Resolution	-.592	.165	-.188	-3.592	.000
Content	.074	.221	.015	.334	.739
Perceive threat	.042	.151	.015	.275	.784
Coping efficacy	-.453	.160	-.142	-2.842	.005
Self blame	-.601	.191	-.154	-3.150	.002
Triangulation	.131	.169	.038	.772	.440

a. Dependent Variable: General health

**REGRESSION**

/MISSING LISTWISE

/STATISTICS COEFF OUTS R ANOVA

/CRITERIA=PIN(.05) POUT(.10)

/NOORIGIN

/DEPENDENT AGG

/METHOD=ENTER Frequency Intensity Resolution Content Threat CP SB Triangulation

**Regression**

**Variables Entered/Removed<sup>a</sup>**

Model	Variables Entered	Variables Removed	Method
-------	-------------------	-------------------	--------

1	Triangulation, Frequency, Content, Self blame, Coping efficacy, Resolution, Intensity, Perceive threat <sup>b</sup>		Enter
---	---	--	-------

a. Dependent Variable: Aggression

b. All requested variables entered.

#### Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.297 <sup>a</sup>	.088	.068	6.225

a. Predictors: (Constant), Triangulation, Frequency, Content, Self blame, Coping efficacy, Resolution, Intensity, Perceive threat

#### ANOVA<sup>a</sup>

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	1385.087	8	173.136	4.467	.000 <sup>b</sup>
	Residual	14339.536	370	38.756		
	Total	15724.623	378			

a. Dependent Variable: Aggression

b. Predictors: (Constant), Triangulation, Frequency, Content, Self blame, Coping efficacy, Resolution, Intensity, Perceive threat

#### Coefficients<sup>a</sup>

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	16.287	1.219		13.366	.000
	Frequency	.424	.187	.130	2.260	.024

Intensity	.341	.142	.161	2.409	.016
Resolution	.057	.180	.020	.318	.751
Content	.014	.242	.003	.059	.953
Perceive threat	-.232	.165	-.094	-1.402	.162
Coping efficacy	.309	.174	.107	1.774	.077
Self blame	.086	.208	.025	.414	.679
Triangulation	.074	.185	.024	.403	.687

a. Dependent Variable: Aggression

GLM GH AGG BY Sex  
 /METHOD=SSTYPE(3)  
 /INTERCEPT=INCLUDE  
 /EMMEANS=TABLES(Sex)  
 /PRINT=DESCRIPTIVE  
 /CRITERIA=ALPHA(.05)  
 /DESIGN= Sex.

**General Linear Model**

**Between-Subjects Factors**

	Value Label	N
Sex	1 Male	219
	2 Female	160

**Descriptive Statistics**

	Sex	Mean	Std. Deviation	N
General health	Male	28.1872	7.28620	219
	Female	27.3688	6.96679	160
	Total	27.8417	7.15521	379
Aggression	Male	21.30	5.950	219
	Female	22.12	7.069	160
	Total	21.65	6.450	379

**Multivariate Tests<sup>a</sup>**

Effect	Value	F	Hypothesis df	Error df	Sig.	
Intercept	Pillai's Trace	.971	6374.414 <sup>b</sup>	2.000	376.000	.000
	Wilks' Lambda	.029	6374.414 <sup>b</sup>	2.000	376.000	.000
	Hotelling's Trace	33.906	6374.414 <sup>b</sup>	2.000	376.000	.000
	Roy's Largest Root	33.906	6374.414 <sup>b</sup>	2.000	376.000	.000

Sex	Pillai's Trace	.006	1.089 <sup>b</sup>	2.000	376.000	.338
	Wilks' Lambda	.994	1.089 <sup>b</sup>	2.000	376.000	.338
	Hotelling's Trace	.006	1.089 <sup>b</sup>	2.000	376.000	.338
	Roy's Largest Root	.006	1.089 <sup>b</sup>	2.000	376.000	.338

a. Design: Intercept + Sex

b. Exact statistic

**Tests of Between-Subjects Effects**

Source	Dependent Variable	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	General health	61.933 <sup>a</sup>	1	61.933	1.210	.272
	Aggresion	61.769 <sup>b</sup>	1	61.769	1.487	.223
Intercept	General health	285355.516	1	285355.516	5576.768	.000
	Aggresion	174303.827	1	174303.827	4195.439	.000
Sex	General health	61.933	1	61.933	1.210	.272
	Aggresion	61.769	1	61.769	1.487	.223
Error	General health	19290.568	377	51.169		
	Aggresion	15662.853	377	41.546		
Total	General health	313138.000	379			
	Aggresion	193312.000	379			
Corrected Total	General health	19352.501	378			
	Aggresion	15724.623	378			

a. R Squared = .003 (Adjusted R Squared = .001)

b. R Squared = .004 (Adjusted R Squared = .001)