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Effects of family violence and parental psychopathology on the psychological outcome of urban adolescents exposed to community violence

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EFFECTS OF FAMILY VIOLENCE AND PARENTAL PSYCHOPATHOLOGY ON
THE PSYCHOLOGICAL OUTCOME OF URBAN ADOLESCENTS EXPOSED TO
COMMUNITY VIOLENCE

A Dissertation

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Louisiana State University and
Agricultural and Mechanical College in
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the Department of Psychology

by

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ABSTRACT

Previous research has documented an association between adolescents' exposure to community violence and a range of mental health problems. However, some violence-exposed youth maintain high levels of adaptive behavior and exhibit good psychological functioning. Thus, it appears that protective and/or risk factors are involved in the community violence-psychological outcome relation, which mitigate the conditions under which community violence exposure leads to adverse adolescent outcome. According to the ecological transactional model, protective and/or risk factors may exist within the family that influence adolescent outcome in response to community violence exposure. The purpose of this study was to delineate the relations among community violence exposure and family factors, including family violence and parental psychopathology, on adolescent psychological symptomatology and personal adjustment. Participants consisted of 121 pairs of junior high or high school students and their parent/guardian. Adolescents completed the Screen for Adolescent Violence Exposure, the Trauma Symptom Checklist for Children, and the Behavior Assessment System for Children-Self Report of Personality. The parents/guardians completed a Demographic Questionnaire, the Behavior Assessment System for Children-Parent Report, the Symptom Checklist-90-R, and the Posttraumatic Stress Diagnostic Scale. Hierarchical regression analyses were conducted and results indicated that family violence exposure did not serve as a moderator variable in the association between adolescent community violence exposure and positive or negative adolescent outcome. In contrast, parental psychopathology was found to be a moderator variable in the relationship between community violence exposure and adolescent-rated PTSD and psychological distress, but not in the

relationship between community violence exposure and parent-rated adolescent internalizing and externalizing problems or adolescent-rated personal adjustment. Clinical implications and limitations of this study are discussed.

INTRODUCTION

Adolescent community violence exposure and victimization constitute major public health concerns in the United States (Koop & Lundberg, 1992; Prothrow-Stith & Weissman, 1991). Research consistently has demonstrated that children and adolescents living in urban communities marked by poverty, crime, and drug-related activities are victims and witnesses of significant numbers of homicides, assaults, robberies, and physical altercations (Gladstein, Slater Rusionis, & Heald, 1992; Hausman, Spivak, & Prothrow-Stith, 1994; Lorion & Saltzman, 1993; Osofsky, Wewers, Hann, & Fick, 1993; Ritchers & Martinez, 1993a; Schubiner, Scott, & Tzelepis, 1993). For instance, in an urban neighborhood in New Orleans, LA, Osofsky et al. (1993) found that 51% of children were victims of and 91% were witnesses to some type of violence. Various national and regional large-sample surveys have revealed that approximately one third of urban adolescents report having been threatened with physical harm (American School Health Association, 1989; Centers for Disease Control, 1993) and a far larger proportion of these adolescents have witnessed violence (Campbell & Schwartz, 1996).

Previous research has documented an association between adolescents' exposure to chronic and acute episodes of community violence and a range of distress symptoms, including internalizing and externalizing behavioral problems, posttraumatic stress disorder, and impaired social, emotional, and cognitive functioning (Bell & Jenkins, 1991; Freeman, Mokros, & Poznanski, 1993; Martinez & Richters, 1993; Osofsky et al., 1993). However, some violence-exposed youth maintain high levels of adaptive behavior and exhibit good psychological functioning (Cicchetti & Lynch, 1993). Thus, it appears that moderating factors are involved in the community violence-psychological outcome relation that mitigate the conditions under which community violence exposure leads to adverse outcomes (Holmbeck, 1997).

Cicchetti and Lynch (1993) proposed an ecological/transactional model to serve as a framework for understanding potential moderating factors associated with community violence exposure. Based on this model, potentiating, or risk factors, and, compensatory, or protective factors exist at the individual, family, community, and societal levels of children's ecologies. An emphasis has been placed on investigating family factors as potential moderating variables, as the family is considered the most influential of the ecological levels on child and adolescent development.

Past studies have identified family characteristics such as family cohesion, parental support, and parent availability as moderating factors in the relation between community violence and various child and adolescent mental health problems (Berman, Kurtines, Silverman, & Serafini, 1996; Boney-McCoy & Finkelhor, 1995; Lanclos, 2002). However, other potentially important family factors, such as family violence and parental psychopathology, have not been thoroughly examined. Family violence may serve as a potentiating variable for the mental health outcome of adolescents exposed to community violence given that adolescent exposure to violence across multiple settings is associated with more severe mental health problems than if violence is experienced in one setting (Elze, Stiffman, & Dore, 1999). Furthermore, examining the effects of parental psychopathology as it pertains to the psychological outcome of adolescents exposed to community violence is necessary as prior research has demonstrated that trauma exposed children are at significant risk for negative psychological outcome when their parents have psychological problems (Green et al., 1991; Rossman, Bingham, & Emde, 1997).

Therefore, the purpose of this study is to delineate the relations among community violence and family factors, including family violence and parental psychopathology, on adolescents' positive and negative outcomes. In this study, community violence exposure will

be defined as adolescents who have been witnesses to or victims of violence that occurs in the neighborhood and school setting (Flowers, Lanclos, & Kelley, 2002; Hastings & Kelley, 1997; Lanclos, 2002; LeBlanc, 2002). The following review examines the literature on youths' exposure to community violence, as well as the effects of community violence on their behavioral and emotional functioning. Furthermore, prior research investigating family factors that may serve to protect against or exacerbate risk in the relation between community violence and adolescent outcome will be discussed.

Exposure to Community Violence

Children and adolescents living in urban communities in the United States often are exposed to community violence as part of their everyday life experience (Berman et al., 1996; Freeman et al., 1993; Jaffe, Wolfe, Wilson, & Zak, 1986, Jaffe, Wolfe, & Wilson, 1990; Osofsky, 1995; Richters & Martinez, 1993a). Community violence has been defined as frequent and continual exposure to the use of guns, knives, drugs, and random violence in neighborhoods and schools (Osofsky, 1995). People can be exposed to community violence in many ways including knowing victims of violence, witnessing violence, and being victimized. Although children of all ages are subjected to community violence, past research has indicated that adolescents are at greatest risk for exposure (Schwab-Stone et al., 1995). For example, Schwab-Stone and colleagues found significant age differences in community violence exposure, with 10th graders reporting significantly greater violence exposure than 6th and 8th grade students.

The incident rates of community violence for adolescents living in urban environments far exceed that of teens living in other areas. For instance, a study by Gladstein et al. (1992) compared the rates of community violence exposure for inner-city adolescents to that of upper-middle class adolescents. As expected, inner-city youth were more likely to be victims and

witnesses of assaults and murders than upper-middle class adolescents. Such differences are likely due to the risk factors for violence that are characteristic of most urban communities, including a higher concentration of people with inadequate housing, lower income levels, limited education, and higher rates of unemployment and substance abuse (Groves, 1997; Warner & Weist, 1996).

Research results consistently have demonstrated that the vast majority of urban adolescents have witnessed or been victims of some form of violence (Fitzpatrick & Boldizar, 1993; Gladstein et al., 1992; Mazza & Reynolds, 1999). With regard to witnessing violence, over half of the two thousand urban youth who participated in the Schwab-Stone et al. (1995) study reported that they had witnessed violence. Exposure rates were even more alarming for a sample of impoverished African-American children, of which 85% reported witnessing at least one act of violence (Fitzpatrick & Boldizar, 1993). Other research has indicated that up to 50% of adolescent males and 25% of adolescent females have witnessed stabbings and shootings in their neighborhoods, while 40% to 50% of these adolescents have viewed attacks with knives in the school setting (O'Keefe, 1997). Furthermore, a study by Jenkins & Bell (1994) indicated that 45% of the adolescents who participated in their study had seen someone murdered.

Although adolescents are witnesses to violence more often than they are victims, the rates of victimization are alarmingly high. This is not surprising given that in the United States adolescents are victims of crime more often than any other age group (Schwab-Stone et al., 1995). Fitzpatrick and Boldizar (1993) surveyed low-income African American children, ranging in age from 7 to 18 years, to assess the rates of violence victimization, which included being chased, hit by family or nonfamily members, shot or shot at, as well as whether their residence had been broken into while they were home. Seventy percent of children and

adolescents in this sample reported being the victim of at least one of these violent acts. A study by Springer and Padgett (2000) indicated that up to 46% of young urban adolescents had been victims of violent crimes including physical assault, sexual assault, and robbery. Schwab-Stone and colleagues (1999) found that 36% of the junior high and high school students assessed in their study had been the victim of at least one violent act, including 5% to 10% who reported being attacked with a knife, beaten, shot or shot at, or seriously wounded. These studies provide initial evidence of the magnitude of community violence exposure faced by urban adolescents.

Gender and ethnic differences in community violence exposure have been empirically investigated (Berman et al., 1996; Cooley-Quille, Boyd, Frantz, & Walsh, 2001; Cooley-Quille, Turner & Beidel, 1995; Fitzpatrick & Boldizar, 1993; O’Keefe, 1997; Singer, Anglin, Song, & Lunghofer, 1995). Overall, the majority of studies have found that males are more likely than females to be victims, witnesses, or instigators of community violence (Fitzpatrick & Boldizar, 1993; O’Keefe, 1997; Richters & Martinez, 1993a; Schwab-Stone et al., 1999), although some studies have not found significant gender differences (Bell & Jenkins, 1991; Berman et al., 1996). In terms of ethnicity, studies consistently indicate that African American children are significantly more likely to witness and/or be a victim of violence than their white counterparts (Gladstein et al., 1992; Hammond & Yung, 1994; Selner-O’Hagan, Kindlon, Buka, Raudenbush, & Earls, 1998).

Psychological Consequences of Community Violence Exposure

Clinical evidence suggests that children exposed to violence are more likely than those not exposed to suffer from a variety of social and emotional problems, as well as experience challenges in the school environment (Fitzpatrick & Boldizar, 1993; Farrell & Bruce, 1997). The deleterious consequences for children and adolescents exposed to community violence are

so vast that parallels have been drawn between children growing up in urban areas in the United States and those living in war zones (Osofsky, 1999). Adolescents may be at greater risk for poorer outcome than young children given that they are exposed to higher rates of community violence and have experienced chronic, long-term exposure as compared to young children (Elze et al., 1999; Jones, Ajitutu & Johnson, 1996). Studies of exposure to neighborhood and community violence indicate that violence exposed adolescents exhibit externalizing symptoms, such as alcohol and drug use, weapon use, trouble in school, antisocial behavior, and aggression (Attar, Guerra, & Tolan, 1994; Gorman-Smith & Tolan, 1998; Miller, Wasserman, Neugebauer, Gorman-Smith, & Kamboukos, 1999), as well as internalizing symptoms, including anxiety, depression, and posttraumatic symptoms (Fitzpatrick, 1993; Freeman et al., 1993; Osofsky et al., 1993; Singer et al., 1995). Existing research has generally failed to show consistent differences in the mental health outcomes of adolescents who have witnessed versus been victimized by community violence (Kliewer, Lepore, Oskin, & Johnson, 1998).

With regard to externalizing problems, studies have reported that community violence exposure is related to an increase in aggressive and antisocial behaviors (DuRant, Getts, Cadenhead, Emans, & Woods, 1995; Osofsky et al., 1993). For instance, DuRant and colleagues (1995) examined the relationship of community violence exposure to current violent behavior in a sample of 225 urban African-American youth, aged 11 to 19 years. While males reported engaging in significantly more violent behavior, including fighting and using a weapon, exposure to community violence was the strongest predictor of violent behavior for both males and females.

In terms of internalizing problems, depressive and anxiety symptoms have been the focus of many studies examining the outcomes of exposure to community violence during adolescence

(DuRant et al., 1995; Freeman, et al., 1993; Fletcher, 1996; Hill & Madhere, 1996). In general, most studies report a positive relationship between exposure to community violence and depressive and anxiety symptoms. For example, in a sample of 3,735 high school students, Singer et al. (1995) reported that exposure to community violence accounted for a significant proportion of the variance in depressive and anxiety symptoms, even after controlling for important demographic variables, such as age and family structure.

Exposure to community violence has been associated with Posttraumatic Stress Disorder (PTSD) symptoms in children and adolescents more than any other psychological problem (Fitzpatrick & Boldizar, 1993). PTSD is classified as an anxiety disorder. Unlike other anxiety disorders, PTSD is partly defined by an etiological event: exposure to trauma. According to the *Diagnostic and Statistical Manual-Fourth Edition-Text Revision* (DSM-IV-TR; American Psychiatric Association [APA], 2000), traumatic exposure involves experiencing, witnessing, or being confronted with an event that is life threatening or involves serious threat to oneself or others. The individual's response to the trauma must involve intense fear, helplessness, or horror. The characteristic symptoms of PTSD resulting from trauma exposure are generally divided into three broad categories: persistent reexperiencing of the event, avoidance of trauma-relevant stimuli and numbing of general responsiveness, and persistent hyperarousal. In order to meet full criteria for PTSD, an individual's response must include at least one reexperiencing symptom, three avoidance/numbing symptoms, and two increased arousal symptoms.

Children and adolescents who have been exposed to community violence have exhibited distress symptoms from all three PTSD categories (Overstreet, 2000). Common symptoms of distress associated with community violence exposure in adolescents include reexperiencing the event, nightmares and intrusive thoughts, constricted affect and loss of interest in activities,

avoidance behaviors, and startle reactions (Bell & Jenkins, 1991; Osofsky et al., 1993). School and community based studies consistently have reported high levels of PTSD and related symptomatology among urban North American adolescents exposed to community violence (Berman et al., 1996; Giaconia et al., 1995; Singer et al., 1995). Both witnesses and victims of community violence report experiencing significant levels of PTSD symptoms, with no significant differences between groups (Fitzpatrick & Boldizar, 1993; Freeman et al., 1993; Martinez & Richters, 1993; Raia, 1996). This significant relationship has held true for children ranging from 7 to 18 years old, even after statistically controlling for age, gender, presence of a primary caretaker in the home, and the effects of child maltreatment (Fitzpatrick & Boldizar, 1993).

Traumatic events that qualify as a PTSD stressor are relatively common in urban areas. Consequently, the base rate of PTSD in urban children and adolescents is likely higher than that of PTSD in the general child and adolescent population. In a study by Berton and Stabb (1996) high school students living in a large urban area were assessed for the presence of PTSD. Twenty-nine percent of participants achieved scores indicative of clinical levels of PTSD. In a similar study, 27% of 7-18 year olds met PTSD diagnostic criteria (Fitzpatrick & Boldizar, 1993). Overstreet, Dempsey, Graham, and Moely (1999) examined the emotional and behavioral functioning of African-American youth age ten to fifteen years residing in or near public housing communities. Children reported an average of 6.2 PTSD symptoms and 33% met criteria for PTSD.

Gender differences in prevalence of PTSD have been inconsistent across studies. Some studies have found no differences between male and female distress symptomatology (Berman et al., 1996; Li, Howard, Stanton, Rachuba, & Cross, 1998; Schwab-Stone et al., 1999), but

generally, studies have shown that females are at greater risk for developing PTSD and exhibit more PTSD symptoms than males when exposed to community violence (Fitzpatrick & Boldizar, 1993; Giaconia et al., 1995; Raia, 1996; Singer et al., 1995; Song, Singer, & Anglin, 1998). A study by Springer & Padgett (2000) examined gender differences in levels of PTSD in a sample of school-based adolescents from impoverished, high-crime neighborhoods. In this study, 58.9% of females as compared to 44% of males reported severe PTSD symptomatology, indicating a significant difference for gender. The results also indicated different predictors for PTSD according to gender, with males meeting the diagnostic criteria for PTSD more often in response to direct victimization in community, indirect victimization at school, minimization coping, and fear in community. For females, predictors of PTSD included direct victimization and indirect victimization in the community, minimization coping, low levels of perceived social support from peers, and fear at school.

Some researchers have speculated that PTSD symptoms serve as a mechanism through which exposure to community violence leads to other mental health problems in children and adolescents (Overstreet, 2000). This may be the result of overlap between DSM criteria sets, especially between PTSD and other anxiety or depressive disorders, as well as Attention Deficit Hyperactivity Disorder (March & Amaya-Jackson, 1993). A study by Mazza and Reynolds (1999) examined the degree to which exposure to community violence in a middle school population was related to suicidal ideation, depression, and PTSD when controlling for the shared variance among these diagnostic categories. Results demonstrated that PTSD symptomatology mediated the relation between community violence and depression, as well as community violence and suicidal ideation. This suggests that exposure to violence has a unique relationship with PTSD symptomatology. PTSD symptomatology may then lead to other mental

health problems, such as depression and suicidal ideation, as well as significant impairment in overall functioning (Mazza & Overstreet, 2000). Thus, PTSD symptomatology may be an important risk factor linking exposure to community violence to other mental health problems.

The potential seriousness of PTSD symptoms and related symptomatology documented by prior research exemplifies the importance of conducting further research to examine compensatory and potentiating factors related to the development of adolescent psychological problems in the face of community violence. An ecological/transactional model will be utilized in this study to examine potential compensatory and potentiating factors in this study. This theoretical framework is presented in the following section.

Ecological/Transactional Model of Community Violence

The experience of community violence takes place within a larger context for most children. Children and adolescents living in communities characterized by high levels of violence typically are faced with an accumulation of risk factors, including poverty, single-parent families, parental incapacity due to mental illness or substance abuse, and exposure to domestic violence (Garbarino, Kostelny, & Dubrow, 1991). Even within the most violent neighborhoods there are often considerable differences in the extent to which children living in the communities are exposed to violence and suffer the untoward consequences of violence exposure. Theorists have suggested that contextual factors in children's lives determine whether children have positive or negative outcome in the face of community violence (Cicchetti & Lynch, 1993). Risk and resilience have been conceptualized as the individual differences in people's responses to stress and adversity, with risk representing the negative factors that lead one to succumb to adversity and resilience leading to positive outcome or overcoming adversity (Rutter, 1987). It is necessary to have some understanding of both risk and resilience in relation to community

violence because the two concepts are inextricably related and have important implications for prevention and intervention programs. Contextual factors that determine risk and resilience in children exposed to community violence can be studied utilizing an ecological/transactional model.

Cicchetti and Lynch (1993) conceptualized an ecological-transactional model to provide a framework for understanding the importance of ecological context when assessing youth's reaction to violence. Implicit in this model is the assumption that individuals are not equally vulnerable to nor similarly affected by violence exposure. These authors propose that individuals exist within a multilevel exosystem. According to this perspective, individuals do not exist in isolation from their environment but rather are surrounded by multiple ecological contexts that directly influence developmental outcomes. A thorough assessment of context should contain relevant information from each level of ecology overtime. The various ecological contexts include society, community, family, and individual characteristics of a child that come together to shape individual development and adaptation. Within each context, there exist potentiating and compensatory factors, which serve to increase or decrease the risk of poor psychological outcome in the face of community violence exposure. Cicchetti and Lynch (1993) differentiated these factors according to temporal characteristics, identifying them as transient, temporary factors or chronic, enduring factors. Potentiating and compensatory factors that are enduring and immediate to the individual are proposed to assert the most potential influence upon development.

Exposure to community violence can be regarded as an enduring potentiating factor within the community level (Lynch & Cicchetti, 1998). The outcome of community violence exposed youth can differ according to the general balance of other potentiating or compensatory

factors found in their ecological contexts. Such factors that exist within the ecological context of family are especially important as the family environment is thought to play a unique role in the development and adjustment of children and adolescents (Richters & Martinez, 1993b). For instance, children with fractured families, who have abusive or mentally impaired caregivers, are likely at greater risk for poor psychological outcome in the face of community violence than are children from intact and functional families. Greater understanding of compensatory and potentiating factors that exist at the family level can aid in the explanation of differential child and adolescent outcomes to community violence exposure.

From an ecological/transactional perspective, the familial factors of family violence and/or parental psychopathology could be considered as potentiating variables that may interact with community violence exposure to exacerbate a negative impact on adolescent development. In this study, family violence and parental psychopathology will be tested as moderator variables in the association between community violence and adolescent outcome. This will be examined through analyses that test for the interaction between community violence and family violence, as well as community violence and parental psychopathology. If the interaction is significant, this indicates that the impact of community violence on adolescent outcome varies according to the level of family violence and/or parental psychopathology (Baron & Kenny, 1986).

Compensatory and Potentiating Factors in the Community Violence-Outcome Relation

The impact of community violence exposure on children and adolescents depends on many factors, including the age and gender of the child, frequency and type of violence exposure, degree of violence exposure, characteristics of the neighborhood, amount and quality of support provided by caregivers, experience of previous trauma, proximity to the violent event, and familiarity with the victim or perpetrator (Pynoos, 1993). In general Warner and Weist

(1996) have found that children, who are from intact and supportive families, do not have premorbid emotional and behavioral difficulties, and receive mental health treatment close to the trauma show the best recovery from community violence exposure. Furthermore, studies have indicated that children exposed to more severe forms of community violence, such as shootings or stabbings, exhibit worse overall outcome as compared to those who have witnessed less severe violence, such as muggings or beatings (Osofsky et al., 1993).

Researchers have recently begun investigating factors that moderate the relationship between community violence exposure and positive and negative outcomes. For instance, gender has been investigated as a moderator in the association between violence exposure and internalizing psychological symptoms in inner-city, African American youth (Foster, Kuperminc, & Price, 2004). Gender was found to moderate the relation between community violence exposure and anxious and depressive symptomatology, such that females had higher levels of these psychological symptoms than males at high levels of community violence exposure.

Social support and positive coping style have also been demonstrated to moderate the link between exposure to community violence and positive/negative outcome in adolescents from impoverished inner-city neighborhoods (Berman et al., 1996; Springer & Padgett, 2000). A study by Berman and colleagues (1996) found that perceived availability of social support predicted positive outcome in adolescents exposed to community crime and violence. In contrast to these results, Springer and Padgett (2000) found that increased social support from family, friends, and school personnel was linked with increased levels of PTSD symptomatology in girls' ages 11 to 14 years. Overstreet (2000) noted that differences in the significance of social support in the community violence-PTSD relation may depend on the definition of social support that is utilized. Overall, she reported a trend for studies that defined social support in terms of

availability, such as the presence of others whom they can turn to for emotional care, have failed to find moderating effects for social support for PTSD (Fitzpatrick & Boldizar, 1993; Springer & Padgett, 2000). On the other hand, researchers who have defined social support in more qualitative terms, such as the child's perceptions of social support, have found that this serves as a protective factor against the development of PTSD in the face of community violence (Overstreet, 2000).

The role of family factors in the competent outcome of children exposed to community violence exposure has been empirically investigated. These factors are especially important to consider within an ecological/transactional framework because family is considered the most proximal and often the most influential of the ecological levels (Cicchetti & Lynch, 1993; Tolan & Gorman-Smith, 1997; Tolan & Guerra, 1994). Lanclos (2002) investigated specific parenting behaviors as a moderator between community violence and positive outcome in terms of academics, social skills, and self-concept in a sample of urban youth. Specific parenting behaviors assessed in this study included parental involvement, monitoring, and discipline. Results indicated that parenting quality moderated the relationship between community violence and children's academic functioning and social skills. That is, children being reared by parents who were involved, provided adequate supervision, and utilized positive discipline techniques maintained a higher level of academic and social functioning. These results suggest that parenting quality plays a role in protecting children from the negative effects of violence exposure.

Familial factors also have been investigated as moderating factors in the relation between community violence and distress symptomatology in children and adolescents. For instance, there is consistent evidence that children who are separated from family members following

violence exposure are most apt to develop posttraumatic stress disorder as well as other mental health problems (Breslau & Davis, 1992, Kinzie, Sack, Angell, Manson, & Ben, 1986). Furthermore, lack of family structure, with family structure defined as the amount of organization and support in the family, was determined to be a significant predictor of aggression, anxiety, and depression in 245 violence exposed boys in grades five and seven (Gorman-Smith & Tolan, 1998). In contrast, positive parent-child relationships have been found to minimize the development of PTSD symptoms in adolescents who have been victimized by aggravated or simple assault, physical assault, kidnapping, and/or sexual assault (Boney-McCoy & Finkelhor, 1995). Additionally, family support, defined as the mother's presence in the home and family size, was found to be a moderator for depression but not PTSD symptoms in young adolescents exposed to community violence (Overstreet et al., 1999).

Parents' with a history of community violence exposure may serve as another risk factor for poor psychological outcome in children exposed to community violence. Dulmus & Wodarski (2000) compared a group of children whose parents had received inpatient treatment for injuries related to community violence to children from the same community whose parents had not been victims of community violence. Parents completed the Child Behavior Checklist (Achenbach, 1991) regarding their child's behavior. Children were screened for violence exposure and assessed for PTSD symptoms via self-report and interview methods. According to the parents' total scores on the CBCL, children of victimized parents exhibited more symptoms than did those whose parents had not been victimized. On distress measures, children whose parents had been victims reported more distress symptoms than did those whose parents had not. This study indicated that a large percentage of children's distress symptoms (22% to 44%) were

related to previous exposure to community violence; however, a substantial percentage (11% to 13%) was related to their parents' victimization.

Family factors that have been hypothesized to moderate the community violence-PTSD relation, but have yet to be examined include overcrowding and large family size, paternal criminality, child placement outside of the family, single parent families, parent-child and marital violence, and parental psychopathology (Grizenko & Pawliuk, 1994; LeBlanc, 2002; Rae-Grant, Thomas, Offord, & Boyle, 1989). Clearly, more research concerning factors that promote successful adaptation and those which thwart successful growth is needed. The present study focuses on family factors, specifically family violence and parental psychopathology, as risk factors for the development of PTSD and distress symptoms among urban adolescents.

Family Violence Exposure

Considering family violence may be important to the study of community violence exposure due to the possible association between violence in the community and violence in the home (Osofsky, 1999). For this review, family violence exposure will incorporate violence that occurs in the home between caregiving adults and caregivers and children in the home. Family violence affects a significant proportion of American families, with almost one million children a year abused by their adult caretakers (American Medical Association, 1995). In 1990, adolescents ages 12 to 16 accounted for 25% of all abuse cases reported to child protective service agencies. With regard to interparental violence, well over 3.3 million children witness interparental violence each year, many of which are adolescent witnesses (Carlson, 1990). Malik, Sorenson, and Aneshensel (1997) found that over 50% of their sample of urban high school students had witnessed spousal violence. Overall, past research suggests that significant

numbers of adolescents are victimized by or exposed to violence within their homes (Flannery, Singer, Williams, & Castro, 1998).

In a study that addressed both parent-child and spousal abuse exposure, O'Keefe (1996) assessed 935 high school students ranging in age from 14 to 20 years of age. The students were mostly from inner-city and urban neighborhoods, and represented a diverse racial/ethnic and socioeconomic population. Results revealed that 63% percent of males and females were victims of severe parent-child violence on at least one occasion in their lifetime. Additionally, adolescents reported witnessing severe acts of violence between their parents, with 33% stating that one parent had hit the other with an object and 16% stating that they had witnessed one parent beat up the other. No significant gender differences emerged for interparental violence, but boys reported significantly higher levels of parent-child violence than girls.

The deleterious effects on the social and emotional development of children who have witnessed domestic violence or experienced maltreatment are well documented in the literature (Freeman et al., 1993; Flannery et al., 1998). For instance, significant correlations between marital violence exposure and posttraumatic stress symptoms have been identified in adolescents (Flannery et al., 1998). It is thought that witnessing such violence is akin to direct personal victimization, explaining the finding that posttraumatic stress disorder has been reported to be prevalent in child witnesses of parental murder, suicide, and rape (Kilpatrick & Williams, 1997). Furthermore, adolescent maltreatment by family members is associated with depression, suicidality, anxiety, substance use, delinquency, and somatic complaints (Berenson, San Miguel, & Wilkinson, 1992; Boney-McCoy & Finkelhor, 1995; Silva et al., 2000).

Limited research has addressed the potential connection between family violence exposure and community violence exposure for placing children at accumulated risk for poor psychological outcome. In a study by DuRant et al. (1995) adolescents living in or around public housing were screened for exposure to community and/or family violence, depression, hopelessness, and purpose in life. Researchers found that higher levels of depression and hopelessness and lower purpose in life were associated with the frequency with which adolescents had been exposed to or victims of violence throughout their life. Although each outcome variable was significantly associated with community violence, intrafamilial violence was a stronger correlate to psychological distress than community violence. However, this study did not assess for posttraumatic stress symptoms.

A study by Elze, Stiffman, and Dore (1999) addressed the association between community violence, family violence, and PTSD in 792 adolescents who had been exposed to high rates of violence in their families, neighborhoods, and schools. Intrafamilial violence, personal victimization outside the family, and witnessing a beating or murder were the strongest predictors of posttraumatic symptoms. This study supported the idea that adolescents' exposure to violence across multiple settings is associated with more severe mental health problems than if violence is experienced in one setting. However, this study did not assess the potential moderating role of interfamilial violence as it pertains to the relationship between community violence exposure and adolescent psychological outcome.

Osofsky and colleagues (1993) have proposed that the effects of community violence exposure may be moderated by family violence exposure. From an ecological/transactional perspective, it is important to consider both variables as diverse environmental factors that may serve to accumulate risk in these already stressed adolescents (Cicchetti & Lynch, 1993). Using

this theoretical framework, LeBlanc (2002) examined the relations among neighborhood violence exposure, family violence exposure, and positive and negative outcomes in a sample of 100 urban adolescents. Results indicated that family violence exposure moderated the relation between neighborhood violence exposure and conduct problems, such that adolescents with high family violence exposure were at greater risk for increased delinquent behavior as neighborhood violence increased. However, family violence did not serve as a moderating variable for the relation between community violence and positive outcome variables including adolescent adaptive skills and personal adjustment. This study did not assess adolescent PTSD symptoms or parent-reported adolescent psychological distress symptomatology.

In summary, family violence exposure, including exposure to marital violence and child physical abuse, is related to deleterious consequences in children and adolescents. Few studies have investigated family violence exposure within the context of community violence. Those studies that have addressed this relation have neglected to study the role of family violence as a moderator or have not assessed adolescent PTSD or distress symptoms as an outcome variable. This study will add to the literature on community violence exposure by investigating the role of family violence as a moderator for the community violence-psychological distress relation.

Parental Psychopathology

In addition to family violence serving as a potential moderating factor in the association between community violence exposure and adolescent psychological distress, parental psychopathology may also serve as a potentiating factor within the family ecological context. Parents living in urban environments may be at risk for mental health problems secondary to the high rates of crime, assault, community and interfamilial violence. Research has shown that adults who reside in urban neighborhoods with documented high rates of violent crime are likely

to witness chronic, violent events among strangers, neighbors, family members, and police officers involving the use of threat or physical force (Linares et al., 2001). Results of past research has demonstrated that adult victims of and witnesses to community violence report significantly greater levels of depression and aggression as compared to those who have experienced lower levels of witnessing or victimization (Scarpa, 2001). Furthermore, Breslau, Davis, Andreski, Peterson, and Schultz (1997) found that 25% of a sample of urban, African American adults endorsed PTSD symptomatology resulting from exposure to life threat and/or witnessing of people being killed or badly injured.

A study by Ford (2002) attempted to assess rates of violence exposure and PTSD in African American women living in an urban community. This sample of women reported high levels of violence exposure, including childhood and adult sexual assault, adult physical assault, murder, illness, and natural disasters. On average, the women in this study were exposed to three traumatic events during their lifetime. This group of women endorsed high levels of posttraumatic stress symptoms on the Posttraumatic Stress Diagnostic Scale by Foa (1995), with the majority endorsing symptom severity scores in the moderate range. This study provides evidence that adults exposed to high levels of violence exposure and trauma may experience significant levels of psychological symptomatology and lower levels of well being.

Parental psychopathology has been consistently linked with adverse outcomes in children and adolescent who are exposed to traumatic events (Green et al., 1991; Breton, Valla, & Lambert, 1993; McFarlane 1987; Sack, Clarke, & Seely, 1995; Sullivan, Saylor, & Foster, 1991). Although there is a paucity of studies in the community violence literature investigating the interaction of violence exposure and parental psychopathology on child and adolescent psychological outcome, this relation has been studied in maltreated children, as well as children

exposed to other types of traumatic events. For instance, Walker, Downey, and Bergman (1989) studied groups of 7- to 15-year old children who either had suffered from maltreatment, had parents with schizophrenia, or both. Results indicated both main effects and interaction effects. The children who had experienced maltreatment and had a parent with schizophrenia scored significantly higher on the CBCL scale of aggression. These results amplify the need to study the role of parental psychopathology in the outcome of children and adolescents who have been exposed to violence.

Rossmann, Bingham, and Emde (1997) examined predictors for PTSD in children, ages 4 to 9 years, exposed to mild stressors, adverse single events (dog attacks), and repetitive adverse events (interfamilial violence). These authors investigated the role of maternal distress and support in predicting traumatic symptoms. Mothers' PTSD symptoms played a role in predicting child PTSD symptoms and internalizing problems, whereas supportiveness in the mother-child relationship was related to fewer child trauma symptoms, fewer problem behaviors, and better school performance. These findings are consistent with previous research showing that maternal coping and distress are related to child trauma reactions (Green et al., 1991).

Disaster and war research provide the major empirical database for the study of intergenerational effects of parental psychopathology on children's response to traumatic events (Green et al., 1991; Sack et al., 1995). Parents' psychological functioning contributed to PTSD levels in children who witnessed a natural disaster in West Virginia in 1972. Both mothers and fathers' overall psychological severity were related to child PTSD symptoms, however, father's functioning contributed only marginally after accounting for mothers' functioning. This study divided the children into three age groups and found that the adolescent group displayed more

PTSD symptoms than younger children and that parental psychopathology contributed to the prediction of PTSD symptoms in the adolescent group (Green et al., 1991).

A study of PTSD in Cambodian refugees by Sack et al. (1995) investigated the relationship of war-related PTSD across two generations (parent and adolescent). Findings from this study indicated that the relationship between PTSD in a parent and the adolescent were consistently significant, as was the relationship between PTSD-NOS across the two generations. There was a trend for adolescent PTSD to increase when both parents met diagnostic criteria for PTSD. PTSD concordance in families was not mediated by SES, greater amount of war trauma, a greater reporting of loss, or a different living arrangement following the war. This study also assessed for major depression in the parents and adolescents. No significant intergenerational results were found relative to this disorder.

Given that research has demonstrated that parental psychopathology serves as a potentiating factor for children and adolescents exposed to various types of traumatic events, researchers have begun to focus attention on the importance of maternal mental health when examining the outcome of children who are exposed to community violence. A study by Linares and colleagues (2001) examined how maternal distress influenced the link between exposure to community violence and the development of behavior problems in young children. Mothers of children ranging in age from 3 to 5 years of age, who lived in high crime neighborhoods, provided information regarding their own and their child's rates of violence exposure. Furthermore, mothers' provided self-report information regarding their own psychological distress, as well as information on their children's internalizing and externalizing behavior problems. Results indicated that mothers who were exposed to community and/or family violence reported more psychological distress. Children who were exposed to high levels of

community violence displayed more internalizing and externalizing problems than those children who had lower levels of community violence exposure. The levels of community violence exposure and child behavior problems were influenced by mothers' psychological distress. These findings provide empirical support for a mediation model in which the direct association between community violence and early behavior problems becomes nonsignificant when maternal distress is included as a mediator. This study demonstrated the crucial role a mother can play in buffering or exacerbating a young child's internalizing and or externalizing behavior in response to community violence.

In summary, research has demonstrated that adults who are exposed to community violence are at risk for poor psychological outcome (Scarpa, 2001). One of the most important protective factors for children being reared in violent communities is the presence of a stable protective, nurturing parent (Hill, Levermore, Twaite, & Jones, 1996; Richters & Martinez, 1993a). Parents overwhelmed with their own psychological problems are less likely to provide a stable, supportive environment for their child, which is necessary to ameliorate the negative effects of community violence exposure (Cicchetti & Lynch, 1993; Kliwer et al., 1998). In the literature investigating the effects of parental psychopathology on the outcome of children who have been exposed to traumatic events, results have consistently demonstrated a positive association between parental psychopathology and poor psychological outcome in children (Green et al., 1991; Sack et al., 1995).

The role of parental psychopathology in the relation between adolescent exposure to community violence and psychological distress has been largely neglected. This is surprising given that exposure to community violence has been more consistently linked to PTSD and distress symptomatology than other types of traumatic experiences (Osofsky, 1999). Based on

an ecological/transactional model, parental psychopathology may serve as a potentiating factor for the relation between community violence and poor psychological outcome in adolescents.

This relation will be investigated in this study.

Problems in Past Community Violence Research

Prior research investigating adolescent community violence exposure has been hindered by the lack of psychometrically sound measures available for evaluating the incidence rates and consequences of community violence (Cooley-Quille et al., 1995; Guterman, Cameron, & Staller, 2000; Overstreet, 2000). In past studies, various instruments used to assess exposure to community violence lacked rigor and adequate psychometric properties (Richters & Saltzman, 1990; Schwab-Stone et al., 1995). Hastings and Kelley (1997) developed a measure to address deficiencies in the existing measures of adolescent violence exposure. The Screen for Adolescent Violence Exposure (SAVE) was designed to offer a socially valid and clinically sensitive measure of violent events experienced by adolescents. The SAVE is an adolescent self-report scale which assesses the frequency of violence exposure in settings relevant to adolescent adjustment, including home, school, and neighborhood. The SAVE is distinguished from other violence exposure instruments by its sound psychometric properties and stable factor structure. The SAVE offers researchers a rapid screening tool which provides examination of the severity of violence exposure adolescents have been exposed to in the home, school, and neighborhood.

Another major methodological issue within the area of community violence research is related to the assessment of emotional and behavioral outcomes associated with exposure. The majority of studies documenting outcomes associated with exposure to community violence have relied exclusively on child self-report measures. Some researchers have argued that exclusive use of self-report raises the possibility of shared method variance and prohibits a comprehensive

assessment of child functioning (Lynch & Cicchetti, 1998; Overstreet et al., 1999). Given the problems inherent in the exclusive use of child report, a more valid approach would be to gather data from multiple informants, which would allow for a comprehensive assessment of child functioning and may produce more reliable results across studies (Overstreet, 2000).

Lastly, prior research in the area of community violence has been limited by the focus on single mental health outcomes when examining moderating variables associated with community violence exposure. The research conducted thus far on moderators of community violence highlights that compensatory and potentiating factors vary in their importance depending on the mental health outcome that is being studied. For example, one study found family support to be a moderator for depression, but not PTSD in an adolescent sample exposed to community violence (Overstreet et al., 1999). This indicates the importance of the assessment of multiple mental health problems in research investigating potentiating and compensatory moderating factors (Mazza & Reynolds, 1999). This would provide an increased understanding of the shared and unique relationships between exposure to violence and broad based mental health problems in adolescents.

The current study purports to improve on the problems found in community violence research in several ways. First, the SAVE will be utilized as the assessment tool for community and family violence exposure. Unlike other screens for violence exposure, this measure has demonstrated excellent psychometric properties and a stable factor structure. Second, multi-informant assessment methods will be utilized to gather information related to adolescent psychological functioning. Finally, the scope of adolescent mental health problems assessed will include PTSD, as well as broad-based internalizing and externalizing problems. This will allow

for the examination of how family violence exposure and parental psychopathology relates to various mental health concerns associated with adolescent community violence exposure.

Summary and Purpose of Current Study

Although specific rates of exposure to community violence vary depending on the definition of exposure and the nature of the study sample studied, it is clear that children and adolescents in urban communities are exposed to community violence at alarmingly high rates (Overstreet, 2000). Research results consistently have reported that the vast majority of urban junior and senior high school students have either witnessed or been victims of violence (Fitzpatrick & Boldizar, 1993; Gladstein et al., 1992; Mazza & Reynolds, 1999). The relationship between community violence and various mental health outcomes has been well documented in children adolescents, with these youth reporting a plethora of psychological problems including externalizing problems, depression, anxiety, and PTSD (Bell & Jenkins, 1991; Berton & Stabb, 1996; Fitzpatrick, 1993; Osofsky, 1995).

Despite the evidence for negative outcome in children and adolescents exposed to community violence, some violence-exposed youth maintain high levels of adaptive behavior and exhibit good psychological functioning (Cicchetti & Lynch, 1993). Thus, it appears that moderating factors are involved in the community violence-psychological outcome relation, which mitigate positive and negative outcomes in those who are exposed to community violence. Moderating factors are variables that change the causal relationship between predictor and outcome variables. Potential moderators should be investigated when an inconsistent link between the predictor and criterion variable exists. Because adolescents exposed to community violence often exhibit different psychological outcomes, an examination of potential moderating variables in this relation is warranted. Greater understanding of moderating factors associated

with community violence exposure is essential for the development of effective clinical prevention and intervention strategies.

Cicchetti and Lynch (1993) proposed an ecological/transactional model, which suggests that there are compensatory and potentiating moderating variables that exist at the individual, family, community, and society level that may account for differences in adolescent outcomes in the face of community violence. This study will investigate two familial variables, family violence and parental psychopathology, that could serve as compensatory or potentiating factors in the relation between community violence and adolescent outcome. Each of these familial variables has been associated with adolescent PTSD and psychological distress in prior studies (Flannery et al., 1998; Boney-McCoy & Finkelhor, 1995; Green et al., 1991; Rossman et al., 1997). From an ecological/transactional perspective, the presence of either or both of these variables could exacerbate risk for poor outcome in adolescents, evidenced by PTSD and psychological distress symptomatology. The absence of these factors within the family environment may serve as a protective factor for community violence exposure, which will result in positive adolescent psychological outcome and higher levels of adaptive functioning.

The purpose of this study is to investigate the relations among community violence exposure, family violence, parental psychopathology, and positive and negative outcome in adolescents. This is the first study to examine these familial variables as potential moderating variables for the association between adolescent community violence exposure, psychological distress, and adaptive outcome. There are six main hypotheses:

Hypothesis 1: That family violence exposure will moderate the relation between community violence exposure and adolescent-rated posttraumatic stress and psychological distress symptoms. Increased levels of family violence exposure in community violence exposed

adolescents will be associated with greater levels of adolescent posttraumatic stress and psychological distress symptoms.

Hypothesis 2: That family violence exposure will moderate the relation between community violence exposure and parent-rated adolescent internalizing and externalizing behavior problems. Increased levels of family violence exposure in community violence exposed adolescents will be associated with greater levels of adolescent behavior problems.

Hypothesis 3: That family violence exposure will moderate the relation between community violence exposure and positive or adaptive outcome. Decreased levels of family violence in adolescents who have been exposed to community violence will be associated with better personal adjustment.

Hypothesis 4: That parental psychopathology will moderate the relation between community violence exposure and adolescent-rated posttraumatic stress and psychological distress symptoms. Higher severity ratings of parental psychopathology in adolescents exposed to community violence will be associated with greater levels of adolescent posttraumatic stress and psychological distress symptoms.

Hypothesis 5: That parental psychopathology will moderate the relation between community violence exposure and parent-rated adolescent externalizing and internalizing behavior problems. Higher severity ratings of parental psychopathology in adolescents exposed to community violence will be associated with greater levels of adolescent behavioral problems.

Hypothesis 6: That parental psychopathology will moderate the relation between community violence and positive or adaptive outcome. Lower severity ratings of parental psychopathology in adolescents who have been exposed to community violence will be associated with better adolescent personal adjustment.

METHOD

Participants

Participants were one hundred thirty-eight 13 to 16-year-old junior high and high school students and their parent/guardian. Seventeen adolescents or parents were excluded from the study as they provided incomplete or invalid data that were unusable, yielding 121 participant pairs included in the analyses. The adolescent participants attended a public junior high or high school located in a high-crime neighborhoods within a mid-sized southern city, which has crime rates that are higher than the national average for murders, robberies, aggravated assaults, burglaries, and theft (Baton Rouge Louisiana Crime Statistics and Data Resources, 2002). According to data provided by the Baton Rouge Police Department (2003), Baton Rouge, LA crime statistics were as follows for July 2002-July 2003: 56 homicides, 145 reports of domestic violence, 138 forcible rapes, 595 incidents of assault, 393 drug offense reports, and 1186 robberies. The selected schools consisted of 99% minority students and free/reduced lunch rates between 74 and 86 percent. This convenience sample included 60 males and 61 females with a mean age of 15 (range from 13 to 16 years), and 97% of the sample was African American. The sample was predominately of low socioeconomic status, with 71% reporting a yearly income of less than \$20,000. The majority of parent/guardian questionnaires were completed by mothers (88%). See Table 1 for details concerning demographic information.

Materials

Demographic Questionnaire. Participants provided information on child age, grade, gender, and race/ethnicity, as well as parent age, marital status, education level, occupation, and income level on this one-page demographic questionnaire.

Table 1

Demographic Characteristics of Sample

Child Age	Number of Participants	Percent of Sample
13	6	5
14	19	16
15	35	29
16	61	50
Child Grade	Number of Participants	Percent of Sample
7	1	1
8	14	11
9	44	37
10	50	41
11	12	10
Parent Relationship	Number of Participants	Percent of Sample
Mother	107	88
Father	6	5
Grandparent	6	5
Aunt/Uncle	1	1
Other relative	1	1
Parent Education	Number of Participants	Percent of Sample
Junior High School	7	6
Some High School	16	13
GED	7	6
High School Diploma	50	41
Some College	33	27
College Degree	8	7
Family Income	Number of Participants	Percent of Sample
Under 10,000	44	36
11-20,000	42	35
21,000-30,000	21	17
31,000-40,000	11	9
41,000-50,000	1	1
Above 50,000	3	2

Screen for Adolescent Violence Exposure (SAVE). The SAVE is an adolescent self-report scale, which assesses frequency of violence exposure in settings relevant to adolescent adjustment (School, Neighborhood, and Home). The SAVE consists of 32 items, which are administered in a five-point Likert format. Scores range from 0 to 160, with higher scores reflecting greater violence exposure. Three factors have been identified for each setting scale: Traumatic Violence, Indirect Violence, and Interpersonal Aggression. The SAVE has been found to successfully classify low- and high-violence groups, and has demonstrated good internal consistency, test-retest reliability, and validity. The SAVE has obtained significant correlations with both independent violence data and theoretically related constructs (Hastings & Kelley, 1997). The School and Neighborhood subscales were used as a measure of adolescent community violence exposure, while the home subscales were used as a measure of adolescent family violence exposure.

Trauma Symptom Checklist for Children (TSCC). The TSCC is a self-report measure of posttraumatic stress and related psychological symptomatology in children aged 8 to 16 years. The full version of the TSCC consists of 54 items that yield validity scales (Underresponse and Hyperresponse) and clinical scales (Anxiety, Depression, Anger, Posttraumatic Stress, Dissociation, Sexual Concerns). The TSCC has demonstrated high internal consistency, as well as construct, convergent, and discriminant validity (Briere, 1995). The Posttraumatic Stress clinical scale was utilized as a measure of adolescent posttraumatic stress symptomatology in this study. Furthermore, the hyperresponse validity scale was used as a measure of adolescent's tendency to indiscriminately over endorse uncommon TSCC items.

Behavior Assessment System for Children-Parent Report (BASC-PRS) and the Self-Report of Personality (BASC-SRP). The BASC-PRS and BASC-SRP have demonstrated adequate internal

consistency, test-retest reliability, and validity (Reynolds & Kamphaus, 1998). The BASC-PRS is a 126-item parent-report scale of adolescents aged 12 to 18 years. Items are rated on a 4-point scale ranging from “Never” to “Almost Always”. The scale yields four composite scores, including Externalizing Problems (Hyperactivity, Aggression, and Conduct Problems), Internalizing Problems (Anxiety, Depression, Somatization), School Problems (Attention and Learning Problems), and Adaptive Skills (Social Skills, Leadership). The Internalizing Problems and Externalizing Problems composites were used in this study.

The BASC-SRP is a 186-item, self-report measure for adolescents’ ages 12 to 18 years. Items are written in at “True/False” format, from which 3 composite scores are derived. The three composite scores are Clinical Maladjustment (Anxiety, Atypicality, Locus of Control, Social Stress Somatization), School Maladjustment (Attitude to School, Attitude to Teachers, Sensation Seeking), and Personal Adjustment (Relationship with Parents, Interpersonal Relationships, Self-Esteem, Self-Reliance). The measure also includes three validity indexes (F Index, L Index, and V Index). An Emotional Symptoms Index can be derived from this measure. This is a global indicator of emotional disturbance and internalizing symptomatology composed of the Social Stress, Anxiety, Interpersonal Relations, Self-Esteem, Depression, and Sense of Inadequacy scale. The Emotional Symptoms Index was used as a measure of adolescent psychological distress and Personal Adjustment score was used as a measure of positive outcome in this investigation. Furthermore, the F Index, which measures a person’s tendency to endorse items in an effort to look severely disturbed, was used as a measure of valid responding.

Symptom Checklist-90-R (SCL-90). The SCL-90-R is a self-report inventory of adult psychological symptom patterns. Nine primary symptom dimensions (Somatization; Obsessive-Compulsive; Interpersonal Sensitivity; Depression; Anxiety; Hostility; Phobic Anxiety; Paranoid

Ideation; Psychoticism) and three global indices (Global Severity Index; Positive Symptom Distress Index; Positive Symptom Total) are derived from this scale. This measure has demonstrated satisfactory internal consistency and test-retest reliability, as well as good internal structure and convergent/divergent validity (Koeter, 1992). Parents completed this measure and the Global Severity Index was used as a measure of parent global psychological distress.

Posttraumatic Stress Diagnostic Scale (PDS). The PDS is a self-report scale that contains 49 items. The PDS has demonstrated high internal consistency and test-retest reliability, high diagnostic agreement with the PTSD module of the Structured Clinical Interview, and good sensitivity and specificity. The PDS has satisfactory validity as supported by its high correlations with other measures of trauma-related psychopathology (Foa et al., 1997). Parents completed this measure and the PTSD severity score was used as a measure of parental PTSD severity.

Table 2

Summary of Measures and Predictor, Moderator, and Outcome Variables

Measure	Description	Variable Type
SAVE	Adolescent-rated community violence	Predictor Variable
	Adolescent-rated family violence	Moderator Variable
SCL-90	Parental Global Psychological Distress	Moderator Variable
PDS	Parental PTSD Severity	Moderator Variable
TSCC	Adolescent-rated PTSD	Outcome Variable
BASC-SRP	Adolescent-rated Psychological Distress	Outcome Variable
	Adolescent-rated Personal Adjustment	Outcome Variable
BASC-PRS	Parent-rated Internalizing Problems	Outcome Variable
	Parent-rated Externalizing Problems	Outcome Variable

Procedure

Adolescents in grades 7 through 11 were recruited during lunchtime at local urban junior high and high schools. Those interested in participating in the study were provided with a brief explanation regarding the study, as well as verbal and written instructions delineating the procedures and time commitment involved. Adolescents who agreed to participate were provided with packets containing the following: Parent consent form, Demographic questionnaire, BASC-PRS, SCL-90, PDS, Adolescent assent form, SAVE, BASC-SRP, and TSCC. Verbal and written instructions were provided that explained to the adolescent that he/she was responsible for taking the packet home, reading over and signing the assent form, completing the adolescent portion of the packet, having the parent/guardian read over and sign the consent form, and complete the parent portion of the packet. Adolescents were required to return the packet within one week. Parental and adolescent responses were anonymous and packets were coded to match parent and adolescent data. Following the completion of questionnaires, the adolescents were debriefed regarding the purposes of the study. At that time, participants were allowed the opportunity to ask questions regarding the study and the measures they have completed. Referral cards for psychological services were provided to all participants. All participants were paid \$5 for their participation. Following data collection, 10% or 13 parents were contacted to insure that the adolescents had not falsified parental data. All parents contacted indicated that they had signed the consent form and completed the parent questionnaires included in the study materials.

RESULTS

Missing Data/Invalid Data Analyses

Seventeen subjects were excluded from the data analyses because of missing data (more than 5% of data overall) or invalid data (high scores on the TSCC Hyperresponse and BASC-SRP F Index). Analyses were conducted to determine whether significant differences existed between the groups with incomplete/invalid vs. complete data. Chi-square analyses were used to analyze differences between the included (121) and excluded (17) participant groups with regard to gender and results indicated no significant differences. A one-way analysis of variance was used to compute group differences for the demographic variables of age, income, and parent education. No significant group differences emerged for these demographic variables.

Description of the Predictor Variable

The frequencies of SAVE community violence items and the corresponding subscales were examined to assess the rates of community violence exposure. The numbers presented in Table 3 represent the percentage of participants who endorsed each item as occurring “sometimes” or greater, as well as the total percentage of items rated “sometimes” or greater on each factor scale, Traumatic Violence, Physical/Verbal Aggression, and Indirect Violence.

Description of Moderating Variables

Each moderating variable, adolescent family violence exposure, parental global psychological distress, and parental PTSD, was examined to determine the percentage rates of occurrence within this population. For family violence exposure, frequencies of SAVE family violence factor scales were examined to assess the percentage of participants who endorsed “sometimes” or greater on any items on the Traumatic Violence, Physical/Verbal Aggression, and Indirect Violence. Results indicated that 38% of adolescent subjects had been exposed to a

Table 3

Frequency of Endorsement of “Sometimes” or Greater for SAVE Community Violence Items and Subscales

	<u>Community Violence</u>
Traumatic Violence	61%
Someone pulled a gun on me	1%
I have been shot	0%
I have seen someone get killed	8%
Someone has pulled a knife on me	4%
I have had shots fired at me	3%
I have seen someone get shot	6%
I have been attacked with a knife	4%
I have seen someone pull a gun on someone else	12%
I have seen someone pull a knife on someone else	15%
I have been badly hurt	9%
I have seen someone attacked with a knife	7%
I have seen someone get badly hurt	26%
 Physical/Verbal Aggression	 45%
Grownups beat me up	0%
Someone my age has threatened me	15%
Someone my age hits me	11%
Grownups threaten to beat me up	4%
Grownups scream at me	18%
Grownups hit me	5%
 Indirect Violence	 96%
I have seen someone carry a gun	2%
I have seen the police arrests someone	53%
I have seen a grown up hitting a kid	41%
I have heard about someone getting shot	60%
I have seen someone carry a knife	35%
I have seen a kid hit a grownup	25%
I have seen people scream at each other	85%
I have seen someone get beaten up	81%
I have heard about someone getting killed	55%
I have heard about someone getting attacked with a knife	22%
I have heard about someone getting beat up	68%
I hear gunshots	41%
I have run for cover when people started shooting	13%
I have heard of someone carrying a gun	39%

traumatic event, 32% had been exposed to physical or verbal aggression, and 77% had been exposed to indirect violence in their home environment.

The SCL-90 and Posttraumatic Diagnostic Scale were scored to determine the severity of parental psychological distress and posttraumatic stress symptomatology. Results of the SCL-90 indicated that 88% of parents scored at less than the 50th percentile for global psychological distress, while 9% scored between the 50th and 98th percentiles, and 3% scored above the 98th percentile. On the PDS, 81% of parents scored within the mild symptom severity range, 9% scored in the moderate range, and 6% scored in the severe range.

Zero-Order Analyses

Bivariate correlations between the control variables, predictor variables, moderator variables, and outcome variables were conducted and are presented in Table 4. For the control variables, gender correlated significantly with adolescent PTSD and internalizing problems, such that females were rated as experiencing higher levels of symptomatology. Parent education was positively and significantly correlated with family income and adolescent personal adjustment, but negatively and significantly correlated with family violence exposure, parental global psychological distress, parental PTSD severity, adolescent PTSD, and adolescent internalizing and externalizing problems. Community violence exposure, the predictor variable, was positively and significantly correlated with family violence exposure, parent global psychological distress and PTSD, as well as adolescent PTSD, psychological distress, internalizing, and externalizing problems. The moderating variables of family violence exposure, parental global psychological distress, and parental PTSD severity were each significantly and positively correlated with one another, as well as significantly and positively linked to the outcome variables of adolescent PTSD, psychological distress, internalizing, and

externalizing problems. Each of the moderating variables had a significant inverse relationship with adolescent personal adjustment. Each of the adolescent psychological outcome variables, including adolescent-rated PTSD and psychological distress, and parent-rated internalizing and externalizing problems, was significantly and positively associated with one another, as well as negatively associated with adolescent personal adjustment.

Table 4

Correlation Matrix of the Control, Predictor, and Outcome Variables

Variable	1	2	3	4	5	6	7	8	9	10	11	12	13
1.Age	-	-.13	.05	-.11	.01	.03	-.03	-.07	-.08	-.00	-.07	-.09	.07
2.Gender		-	.06	-.07	.09	.10	-.04	-.05	.24*	.10	.02	.19*	.15
3.Parent education			-	.19*	-.09	-.19*	-.16*	-.19*	-.16*	.01	-.21**	-.17*	.21*
4.Family Income				-	.02	-.13	-.14	-.11	-.09	-.07	-.13	-.13	.09
5.Community Violence Exposure					-	.77**	.35**	.35**	.41**	.23**	.37**	.39**	-.11
6.Family Violence Exposure						-	.45**	.39**	.49**	.36**	.45**	.45**	-.24**
7.Parent Global Psychological Distress							-	.59**	.49**	.32**	.67**	.61**	-.40**
8.Parent PTSD Severity								-	.33**	.33**	.68**	.61**	-.42**
9.Adolescent PTSD									-	.57*	.47**	.62**	-.34**
10.Adolescent-Rated Psychological Distress										-	.37**	.46**	-.37*
11.Adolescent Externalizing Problems											-	.80**	-.31**
12.Adolescent Internalizing Problems												-	-.37**
13.Adolescent Personal Adjustment													-

Note. * $p < .05$, ** $p < .01$

Regression Analyses

Hierarchical regression analyses were conducted to determine whether family violence exposure and parental psychological functioning moderate the relations among community violence and the outcome variables of adolescent PTSD, adolescent psychological distress, adolescent externalizing and internalizing problems, and adolescent personal adjustment. Separate analyses were conducted for family violence exposure and parental psychological functioning with each outcome variable. Prior to data analyses, the predictor variables were centered to prevent the negative impact of multicollinearity as recommended by Aiken and West (1991). The mean was subtracted from each individual scale score to create variables with means of zero. The centered predictors were multiplied to create the interaction terms. Univariate and multivariate outliers were examined, but were not excluded from the analyses.

First, hierarchical regression analyses were calculated investigating family violence exposure, as measured by adolescent ratings on the home scale of the SAVE, as a potential moderator between community violence exposure and each outcome variable. For each regression analyses, demographic variables (age, gender, parent education, and income) were entered on the first step to control for their effects. In step two, the main effects of family violence exposure and community violence exposure were entered. A two-way interaction between family violence and community violence was entered on step three. Second, hierarchical regression analyses were conducted to investigate the relationship between parental psychological functioning, as measured by parent self-report ratings on the SCL-90 global severity index and the PDS PTSD severity composite, as potential moderators between community violence exposure and each outcome variable. For each regression analyses, demographic variables (age, gender, parent education, and income) were entered on

the first step to control for their effects. In step two, the main effects of SCL-90 global severity, PDS severity, and community violence exposure were entered. Two-way interactions between parental psychological distress and community violence were entered on step three.

Significant interactions identified in the regression analyses were examined in follow-up simple slope analyses and plots. Post-hoc probing with t-tests of the significant interactions was conducted to determine which simple slopes were significantly different from zero and verifies the conditions of the moderator for which the interaction term is significant. Plots were created by solving the regression equation at specific levels of the moderator variable, particularly one standard deviation above and below the mean (Aiken & West, 1991; Holmbeck, 2002; Tabachnick & Fidell, 2001).

Regression Analyses with Family Violence Exposure as a Moderator

In the regression equation in which adolescent-reported PTSD was the criterion variable, the final model was significant (See Table 5). Control variables were entered on the first step and, taken together, were significant predictors on the first step [$F(4, 116) = 2.78, p < .05$]. Community violence exposure (CVE) and family violence exposure (FVE) were entered on the second step and, taken together, were significant [$F(6, 114) = 7.81, p < .01$]. The interactions between CVE and FVE were entered on the third step, and the third step was significant [$F(7, 113) = 6.65, p < .01$]. The results revealed that 29% of the variance in adolescent PTSD was accounted for by these variables. Examination of the variables within the third block revealed that gender was a significant predictor ($B = 2.02, p < .01$), such that females reported higher levels of PTSD symptomatology. Furthermore, FVE was a significant predictor ($B = .09, p < .01$), such that higher levels of family violence exposure

was associated with higher levels of adolescent PTSD symptomatology. The interaction between community and family violence was not significant, thus, hypothesis 1 was not supported for this outcome variable.

Table 5

Hierarchical Regression Analysis Evaluating the Moderating Effects of Family Violence Exposure on Adolescent-Rated PTSD

Variable	Step One		Step Two		Step Three	
	<i>B</i>	β	<i>B</i>	β	<i>B</i>	β
Age	-.27	-.04	-.40	-.06	-.42	-.07
Gender	2.63*	.24*	2.06*	.19*	2.02*	.18*
Par Ed	-.67	-.16	-.33	-.08	-.33	-.08
Income	-.20	-.04	-.06	-.01	-.07	-.02
CVE			.03	.09	.02	.09
FVE			.09*	.39*	.09*	.37*
CVE X FVE					.00	.03

Note. $R^2 = .09$ Step 1; $\Delta R^2 = .20^*$ Step 2; $\Delta R^2 = .00$ Step 3. * $p < .05$. Adolescent PTSD = PTS scale on TSCC; CVE = Community Violence Exposure; FVE = Family Violence Exposure.

In the regression equation in which adolescent-reported psychological distress, as measured by the emotional symptoms index, was the criterion variable, the final model was significant (See Table 6). The control variables were not significant predictors on the first step. CVE and FVE were entered on the second step and, taken together, were significant [$F(6, 114) = 3.18, p < .01$]. The interaction of CVE and FVE was entered on the third step, and this step was significant [$F(7, 113) = 2.86, p < .01$]. These results revealed that 15% of the variance in adolescent psychological distress was accounted for by these variables.

Examination of the variables within the third block revealed that FVE was a significant

predictor ($B = .06, p < .01$), such that more family violence exposure was associated with greater psychological distress. The interaction between community and family violence was not significant, thus, hypothesis 1 was not supported for the outcome variable.

Table 6

Hierarchical Regression Analysis Evaluating the Moderating Effects of Family Violence Exposure on Adolescent-Rated Psychological Distress

Variable	Step One		Step Two		Step Three	
	<i>B</i>	β	<i>B</i>	β	<i>B</i>	β
Age	.01	.00	-.04	-.01	-.00	-.00
Gender	.49	.10	.30	.06	.38	.07
Par Ed	.03	.02	.17	.09	.17	.09
Income	-.14	-.06	-.04	-.03	-.02	-.01
CVE			-.01	-.12	-.01	-.12
FVE			.05*	.46*	.06*	.53*
CVE X FVE					-.00	-.12

Note. $R^2 = .01$ Step 1; $\Delta R^2 = .13^*$ for Step 2; $\Delta R^2 = .01$ Step 3. * $p < .01$. Adolescent Psychological Distress = Emotional Symptoms Index on BASC-SRP; CVE = Community Violence Exposure; FVE = Family Violence Exposure.

In the regression equation in which parent-rated adolescent externalizing problems was the criterion variable, the final model was significant (see Table 7). The control variables on the first step were not significant. CVE and FVE were entered on the second step, and taken together, this step was significant [$F(6, 114) = 5.72, p < .01$]. The interaction was entered on the third step, and, taken together, the third step was significant [$F(7, 113) = 5.03, p < .01$]. These results revealed that 24% of the variance of adolescent externalizing problems was accounted for by these variables. Examination of the variables within the third block revealed that neither individual predictors nor the interaction between community and

family violence were significantly associated with adolescent externalizing problems, thus, hypothesis 2 was not supported for this outcome variable.

Table 7

Hierarchical Regression Analysis Evaluating the Moderating Effects of Family Violence Exposure on Parent-Reported Adolescent Externalizing Problems

Variable	Step One		Step Two		Step Three	
	<i>B</i>	β	<i>B</i>	β	<i>B</i>	β
Age	-.21	-.07	-.27	-.09	-.31	-.10
Gender	.11	.02	-.16	-.03	-.24	-.49
Par Ed	-.42*	-.20*	-.26	-.12	-.26	-.12
Income	-.20	-.08	-.14	-.06	-.17	-.07
CVE			.01	.10	.01	.10
FVE			.04*	.35*	.03	.28
CVE X FVE					.00	.11

Note. $R^2 = .06$ Step 1; $\Delta R^2 = .18^*$ Step 2; $\Delta R^2 = .01$ Step 3. * $p < .05$. Adolescent Externalizing Problems = externalizing problems subscale on BASC-PRS; CVE = Community Violence Exposure; FVE = Family Violence Exposure.

With parent-reported adolescent internalizing problems as a criterion variable (Table 8), the control variables together were not significant predictors on the first step. CVE and FVE were entered on the second step, and taken together, were significant [$F(6, 114) = 6.18, p < .01$]. The interactions were entered on the third step, and, taken together, the third step was significant [$F(7, 113) = 5.33, p < .01$]. These results revealed that 25% of the variance in adolescent internalizing problems was accounted for by these variables. Examination of the variables within the third block revealed that neither the individual variables nor the interaction of community and family violence were significant predictors of adolescent internalizing problems, thus, hypothesis 2 was not supported for this outcome variable.

Table 8

Hierarchical Regression Analysis Evaluating the Moderating Effects of Family Violence Exposure on Parent-Reported Adolescent Internalizing Problems

Variable	Step One		Step Two		Step Three	
	<i>B</i>	β	<i>B</i>	β	<i>B</i>	β
Age	-.22	-.07	-.27	-.09	-.30	-.10
Gender	.99*	.18*	.73	.13	.68	.12
Par Ed	-.33	-.16	-.18	-.08	-.18	-.08
Income	-.23	-.09	-.18	-.07	-.20	-.08
CVE			.01	.14	.01	.14
FVE			.04*	.31*	.03	.26
CVE X FVE					.00	.08

Note. $R^2 = .08$ Step 1; $\Delta R^2 = .17^*$ Step 2; $\Delta R^2 = .00$ Step 3. * $p < .01$. Adolescent Internalizing Problems = internalizing problems subscale on BASC-PRS; CVE = Community Violence Exposure; FVE = Family Violence Exposure.

With adolescent-rated personal adjustment as a criterion variable (see Table 9), as measured by the personal adjustment composite on the BASC-SRP, the control variables were not significant predictors on the first step. CVE and FVE were entered on the second step, and taken together, were significant [$F(6, 114) = 2.81, p < .02$]. The interaction was entered on the third step, and, taken together, the third step was significant [$F(7, 113) = 2.50, p < .03$]. These results revealed that 13% of the variance in adolescent personal adjustment was accounted for by these variables. Examination of the variables within the third block revealed that gender was a significant predictor such that females had higher levels of personal adjustment than males ($B = .30, p < .05$). However, the interaction between community and family violence was not significant, thus, hypothesis 3 was not supported for this outcome variable.

Table 9

Hierarchical Regression Analysis Evaluating the Moderating Effects of Family Violence Exposure on Adolescent-Rated Personal Adjustment

Variable	Step One		Step Two		Step Three	
	<i>B</i>	β	<i>B</i>	β	<i>B</i>	β
Age	.24	.09	.27	.10	.30	.11
Gender	.73	.15	.83	.17	.89*	.19*
Par Ed	.33	.18	.25	.14	.24	.13
Income	.15	.07	.07	.03	.09	.04
CVE			.01	.15	.01	.15
FVE			-.03*	-.34*	-.03	-.28
CVE X FVE					-.00	-.10

Note. $R^2 = .07$ Step 1; $\Delta R^2 = .06^*$ Step 2; $\Delta R^2 = .01$ Step 3. * $p < .05$. Adolescent Personal Adjustment = Personal Adjustment subscale on BASC-PRS; CVE = Community Violence Exposure; FVE = Family Violence Exposure.

Regression Analyses with Parental Psychological Distress as a Moderator

With adolescent-rated PTSD as a criterion variable (see Table 9), the control variables taken together were significant predictors in the first step [$F(4, 116) = 2.77, p < .05$]. Community violence exposure (CVE), parental global psychological distress (PGPD), and parental PTSD severity (PPTS) were entered on the second step and, taken together, were significant [$F(7, 113) = 9.57, p < .01$]. The interactions of CVE and PGPD, as well as CVE and PPTS were entered on the third step and taken together, the third step was significant [$F(9, 111) = 8.38, p < .01$]. The results indicated that 40% of the variance in adolescent PTSD was accounted for by these variables. Examination of variables within the third block revealed that gender was a significant predictor ($B = 2.25, p < .02$), such that females had higher levels of PTSD symptomatology than males. Community violence ($B =$

.04, $p < .01$) and PGPD ($B = 28.56, p < .01$) were also significant predictors of adolescent PTSD, such that adolescents with more community violence exposure and whose parents reported higher levels of psychological distress endorsed more PTSD symptomatology. The CVE main effect was negated as the interaction of CVE and PPTS ($B = .00, p < .02$) was significant. Therefore, the regression line for adolescents whose parents endorsed high levels of PTSD was significantly different from the regression line for adolescents whose parents indicated low levels of PTSD. This finding indicates that PPTS serves as a moderating variable in the relation between community violence exposure and adolescent PTSD, supporting hypothesis 4 for this outcome variable.

Follow-up simple slope analyses were conducted for the interaction of CVE and PPTS. Analyses revealed that the interaction was significant at higher levels of PPTS, $t(118) = 4.01, p < .01$, but not at lower levels of PPTS $t(118) = 1.612, p > .05$. The plot revealed that, adolescents whose parents reported high levels of posttraumatic stress severity had more posttraumatic stress symptomatology as violence exposure increased. The relation between community violence exposure and adolescent PTSD symptomatology was not significant at lower levels of parental PTSD severity. This is illustrated in Figure 1.

Table 10

Hierarchical Regression Analysis Evaluating the Moderating Effects of Parental Psychological Distress Exposure on Adolescent-Rated PTSD

Variable	Step One		Step Two		Step Three	
	<i>B</i>	β	<i>B</i>	β	<i>B</i>	β
Age	-.27	-.04	-.21	-.03	-.33	-.05
Gender	2.63*	.24*	2.57*	.23*	2.25*	.20*
Par Ed	-.68	-.16	-.33	-.08	-.33	-.08
Income	-.20	-.04	-.02	-.00	.05	.01

(Table cont.)				
CVE	.04*	.24*	.04*	.23*
PGPD	21.64*	.41*	28.56*	.54*
PPTS	-0.00	-0.00	-0.14	-0.22
CVE X PGPD			-0.22	-0.20
CVE X PPTS			.00*	.33*

Note. $R^2 = .09$ Step 1; $\Delta R^2 = .28^*$ Step 2; $\Delta R^2 = .03$ Step 3. * $p < .01$. Adolescent PTSD = PTS clinical scale on TSCC; CVE = Community Violence Exposure; PGPD = Parent Global Psychological Distress from SCL-90; PPTS = Parent PTSD severity from PDS.

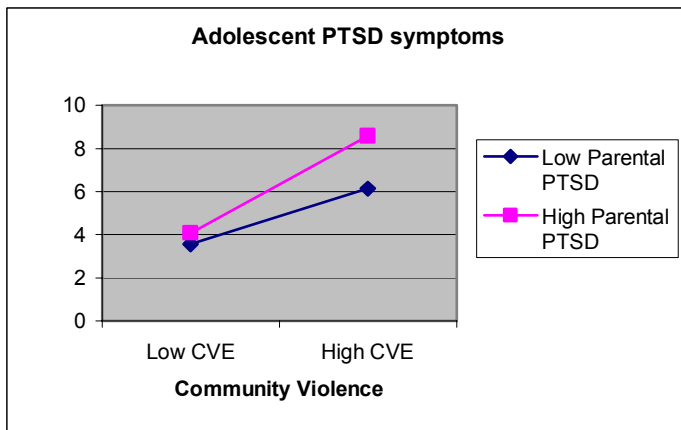


Figure 1

Moderator Effect of Parental PTS Symptomatology on the Association Between Community Violence Exposure and Adolescent-Rated PTSD

In the regression equation in which adolescent-rated psychological distress, as measured by the emotional symptoms index, was the criterion variable (see Table 11), the control variables were not significant predictors on the first step. CVE, PGPD, and PPTS were entered on the second step and taken together were significant [$F(7, 113) = 2.98, p < .01$]. The interaction of CVE and PGPD as well as CVE and PPTS were entered on the third step, and taken together, the third step was significant [$F(9, 111) = 3.02, p < .01$]. These results revealed that 20% of the variance in adolescent psychological distress was accounted

for by these variables. Examination of the variables within the third block revealed that PGPD ($B = 9.5, p < .01$) was a significant predictor of adolescent psychological distress, such that adolescents whose parents endorsed higher levels of global psychological distress reported higher levels of psychological distress. The main effect of PGPD was negated as the interaction of CVE and PGPD ($B = -.16, p < .03$) was significant. Therefore, the regression line for adolescents whose parents endorsed high levels of PGPD was significantly different from the regression line for adolescents whose parents indicated low levels of PGPD. This finding indicates that PGPD serves as a moderating variable in the relation between community violence exposure and adolescent psychological distress, supporting hypothesis 4 for this outcome variable.

Follow-up simple slope analyses were conducted for the interaction of CVE and PGPD. Analyses revealed that the interaction was not significant at low or high levels of PGPD. This relation approached significance at lower levels of PGPD $t(118) = 1.79, p < .09$, but not at higher levels of PGPD $t(118) = .74, p > .4$. The plot revealed that, adolescents whose parents reported lower levels of global psychological distress had more psychological distress as violence exposure increased. The relation between community violence exposure and adolescent psychological distress symptomatology was weaker at higher levels of parental global psychological distress. This is illustrated in Figure 2.

Table 11

Hierarchical Regression Analysis Evaluating the Moderating Effects of Parental Psychological Distress Exposure on Adolescent-Rated Psychological Distress

Variable	Step One		Step Two		Step Three	
	<i>B</i>	β	<i>B</i>	β	<i>B</i>	β
Age	.01	.00	.06	.02	.04	.02
Gender	.49	.10	.54	.11	.53	.10

(Table cont.)

Par Ed	.03	.02	.16	.08	.15	.08
Income	-.14	-.06	-.06	-.03	-.01	-.00
CVE			.01	.09	.01	.10
PGPD			5.38*	.22*	9.5*	.39*
PPTS			.05	.16	-.01	-.04
CVE X PGPD					-.16*	-.32*
CVE X PPTS					.00	.30

Note. $R^2 = .01$ Step 1; $\Delta R^2 = .15^*$ Step 2; $\Delta R^2 = .04$ Step 3. * $p < .01$. Adolescent Psychological Distress = Emotional Symptoms Index from BASC-SRP; CVE = Community Violence Exposure; PGPD = Parent Global Psychological Distress from SCL-90; PPTS = Parent PTSD severity from PDS.

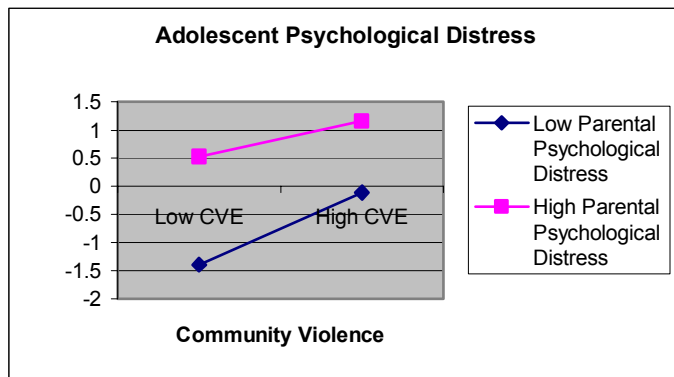


Figure 2

Moderator Effect of Parental Global Psychological Distress on the Association Between Community Violence Exposure and Adolescent-Rated Psychological Distress

In the regression equation in which parent-rated adolescent externalizing problems was the criterion variable (see Table 12), the control variables on the first step were not significant. CVE, PGPD, and PPTS were entered on the second step, and taken together, this step was significant [$F(7, 113) = 17.14, p < .01$]. The interactions were entered on the third step, and, taken together, the third step was significant [$F(9, 111) = 13.13, p < .01$]. These

results revealed that 52% of the variance in adolescent externalizing problems was accounted for by these variables. Examination of the variables indicated within the third block revealed that PGPD was a significant predictor of adolescent externalizing problems ($B = 13.69, p < .01$), such that adolescents with parents who endorse greater psychological dysfunction had higher levels of parent-reported externalizing problems. However, neither of the interactions were significant, thus, hypothesis 5 was not supported for this outcome variable.

Table 12

Hierarchical Regression Analysis Evaluating the Moderating Effects of Parental Psychological Distress Exposure on Parent-Rated Adolescent Externalizing Problems

Variable	Step One		Step Two		Step Three	
	<i>B</i>	β	<i>B</i>	β	<i>B</i>	β
Age	-.21	-.07	-.11	-.04	-.11	-.04
Gender	.11	.02	.24	.04	.21	.04
Par Ed	-.42*	-.20*	-.18	-.08	-.18	-.08
Income	-.20	-.08	-.02	-.01	-.02	-.01
CVE			.01	.12	.01	.11
PGPD			14.09*	.52*	13.69*	.51*
PPTS			.06*	.17*	.06	.18
CVE X PGPD					.01	.04
CVE X PPTS					-.00	-.01

Note. $R^2 = .06$ Step 1; $\Delta R^2 = .46^*$ Step 2; $\Delta R^2 = .00$ Step 3. * $p < .01$. Adolescent Externalizing Problems = Parent-reported Externalizing Problems subscale on BASC-PRS; CVE = Community Violence Exposure; PGPD = Parent Global Psychological Distress from SCL-90; PPTS = Parent PTSD severity from PDS.

With parent-reported adolescent internalizing problems as a criterion variable (See Table 13), the control variables were not significant predictors on the first step, but the

second step, taken together, was significant [$F(7, 113) = 14.46, p < .01$]. The interactions were entered on the third step, and, taken together, the third step was significant [$F(9, 111) = 11.73, p < .01$]. Results revealed that 49% of the variance in adolescent internalizing problems was accounted for by these variables. Examination of the variables within the third block revealed that gender ($B = 1.01, p < .02$) and PGPD ($B = 15.10, p < .01$) were significant predictors. Results revealed that females have significantly higher rates of internalizing disorders than males and adolescents whose parents endorsed high levels of PGPD have higher levels of internalizing problems. However, neither of the interactions were significant, thus, hypothesis 5 was not supported for the outcome variable of parent-rated adolescent internalizing problems.

Table 13

Hierarchical Regression Analysis Evaluating the Moderating Effects of Parental Psychological Distress Exposure on Parent-Rated Adolescent Internalizing Problems

Variable	Step One		Step Two		Step Three	
	<i>B</i>	β	<i>B</i>	β	<i>B</i>	β
Age	-.22	-.07	-.13	-.04	-.16	-.05
Gender	.99	.18	1.08*	.20*	1.02*	.18*
Par Ed	-.32	-.16	-.11	-.05	-.11	-.05
Income	-.23	-.09	-.07	-.03	-.04	-.02
CVE			.01	.15	.01	.15
PGPD			12.42*	.47*	15.10	.57*
PPTS			.05	.15	.00	.01
CVE X PGPD					-.09	-.17
CVE X PPTS					.00	.21

(Table cont.)

Note. $R^2 = .08$ Step 1; $\Delta R^2 = .39^*$ Step 2; $\Delta R^2 = .02$ Step 3. * $p < .01$. Adolescent Internalizing Problems= Internalizing Problems composite from BASC-PRS; CVE = Community Violence Exposure; PGPD= Parent Global Psychological Distress from SCL-90; PPTS- Parent PTSD severity from PDS.

With adolescent-rated personal adjustment as a criterion variable (See Table 14), the control variables were not significant predictors on the first step. CVE, PGPD, and PPTS were entered on the second step, and taken together, were significant [$F(7, 113) = 5.35, p < .01$]. The interactions were entered on the third step, and, taken together, the third step was significant [$F(9, 111) = 4.14, p < .01$]. These results revealed that 25% of the variance in adolescent personal adjustment was accounted for by these variables. Examination of the variables within the third block revealed that PGPD was a significant and negative predictor ($B = -5.7, p < .05$), such that adolescents whose parents had higher levels of psychological distress, had lower levels of personal adjustment. Neither of the interactions were significant, thus, hypothesis 6 was not supported for this outcome variable.

Table 14

Hierarchical Regression Analysis Evaluating the Moderating Effects of Psychological Distress on Adolescent-Rated Personal Adjustment

Variable	Step One		Step Two		Step Three	
	<i>B</i>	β	<i>B</i>	β	<i>B</i>	β
Age	.24	.09	.15	.06	.15	.05
Gender	.73	.15	.57	.12	.55	.12
Par Ed	.33	.18	.21	.11	.21	.11
Income	.15	.07	.02	.01	.03	.02
CVE			.01	.07	.01	.07
PGPD			-6.6*	-.29*	-5.7*	-.25*
PPTS			-.06*	-.22*	-.07	-.27

(Table cont.)

CVE X PGPF	-.03	-.07
CVE X PPTS	.00	.08

Note. $R^2 = .07$ Step 1; $\Delta R^2 = .17^*$ Step 2; $\Delta R^2 = .01$ Step 3. * $p < .01$. Adolescent Personal Adjustment = Personal Adjustment Composite from BASC SRP; CVE = Community Violence Exposure; PGPD = Parent Global Psychological Distress from SCL-90; PPTS = Parent PTSD severity from PDS.

DISCUSSION

This study was a first attempt to examine the role of family violence exposure and parental psychopathology in the relationship between community violence exposure and adolescent psychological outcome and personal adjustment. Previous research has documented an association between adolescents' exposure to community violence and a range of psychological distress symptoms (Bell & Jenkins, 1991; Freeman et al., 1993; Martinez & Richters, 1993; Osofsky et al., 1993). From an ecological/transactional model, family violence exposure and parental psychopathology may intensify the risk of poor psychological outcome for community violence exposed adolescents. Furthermore, the absence of these factors may serve to promote positive personal adjustment in community violence-exposed adolescents (Cicchetti & Lynch, 1993). These predictions were partially supported by the findings in this study. Family violence exposure did not serve as a moderator variable in the relationship between adolescent community violence exposure and adolescent outcome. In contrast, parental psychopathology was found to be a moderating variable in the relationship between community violence exposure and adolescent-rated PTSD and psychological distress, but not in the relationship between community violence and parent-rated psychological problems or adolescent-rated personal adjustment. These findings will be addressed in greater detail below.

Rates of Community Violence Exposure and Association With Mental Health Outcomes

High rates of community violence were identified in this sample of urban adolescents. The majority of adolescents in the sample knew someone who had been killed by violence (55%) and had witnessed someone being beaten up (81%), while approximately half of the adolescents had heard gunshots in their neighborhood (44%). Overall, 61% of the adolescent

sample reported that they had been exposed to some type of traumatic violence, 45% reported exposure to physical or verbal aggression, and 96% indicated exposure to indirect violence in the community setting. The rates of adolescent community violence exposure observed in this study are consistent with the markedly high levels documented in other community violence studies (Flowers et al., 2002; Mazza & Reynolds, 1999; O'Keefe, 1997; Overstreet & Braun, 1999).

Prior research has documented a strong relationship between community violence exposure and poor mental health outcome in adolescents (e.g. Gorman-Smith & Tolan, 1998; Kliewer et al., 1998; Lynch & Cicchetti, 1998; Schwab-Stone et al., 1999). The results of this study provided further support for this association. In this study, adolescent community violence exposure was significantly associated with adolescent-rated PTSD and global psychological distress, as well as parent-rated externalizing and internalizing problems.

Family Violence Exposure

Within the home environment, 38% of adolescents reported exposure to traumatic violence, 32% endorsed physical/verbal aggression, and 77% indicated exposure to indirect violence. Hypotheses regarding family violence as a moderator variable in the community violence-adolescent outcome relation were not supported. This is contrary to previous theory proposed by Osofsky et al. (1993), suggesting that levels of family violence exposure would specify under what conditions community violence is related to positive and negative outcomes in adolescents. Perhaps this finding is a result of the strong correlational relationship found between family and community violence exposure in this study. According to Baron and Kenny (1986), it is desirable that a moderator variable and predictor variable have a weak relationship to provide a clearly interpretable interaction term.

Although family violence did not emerge as a moderating variable in this study, significant main effects were found for family violence and adolescent-rated PTSD and psychological distress. Consistent with previous research, adolescents exposed to higher levels of family violence endorsed greater psychological difficulties (Berenson et al., 1992; Boney-McCoy & Finklehor, 1995; Silva et al., 2000). In contrast, no main effects were found between community violence exposure and these outcome variables. This is an interesting finding because it suggests that family violence is a stronger correlate to poor adolescent psychological outcome than community violence. This helps illuminate the differential impact of community and family violence on adolescent mental health and emphasizes the importance of assessing violence exposure across multiple settings.

No significant main effects were found for family violence or community violence with parent-rated internalizing or externalizing problems. This was surprising considering the vast literature that supports such an association (e.g. Attar et al., 1994; Fitzpatrick, 1993; Gorman-Smith & Tolan, 1998; Singer et al., 1995). Interestingly, as previously mentioned, there was a main effect between family violence exposure and adolescent-rated psychological distress, a measure of internalizing symptomatology. It has been well established that adolescents are better reporters than parents of their own internalizing symptomatology (Achenbach, McConaughy, & Howell, 1987; Stallings & March, 1995). Thus, precedence was given to the adolescent-self report findings of internalizing problems. As for externalizing problems, much of the past research establishing a relationship between violence exposure and the externalizing problems assessed in this study, including hyperactivity, conduct, and aggression, has been conducted with younger samples. Whereas, research examining externalizing problems in violence-exposed adolescents has focused on

violent and risk behavior (Farrell & Bruce, 1997; Halliday-Boykins & Graham, 2001; Linares et al., 2001; Shahinfar, Fox, & Leavitt, 2000). Thus, more research is necessary before the effects of violence exposure on adolescent externalizing problems can be fully understood.

A significant main effect for gender was demonstrated with adolescent-rated PTSD and personal adjustment, with females endorsing higher levels of PTSD psychological problems, and, contrarily, better personal adjustment than males. Past studies generally have shown that females are at greater risk for developing PTSD and have higher rates of internalizing symptomatology than males (Fitzpatrick & Boldizar, 1993; Giaconia et al., 1995; Lewinsohn, Hops, Roberts, Seeley, & Andrews, 1993; McGee, Feehan, Williams, & Anderson 1992; Raia, 1996; Singer et al., 1995; Song et al., 1998). As for adolescent personal adjustment, high scores on this composite are indicative of positive coping skills and sufficient support systems in adolescents (Reynolds & Kamphaus, 1998). Past studies have shown that adolescent females report higher levels of support than adolescent males, which may be associated to positive outcome and resiliency in the face of community violence (Berman et al., 1996; DuBois et al., 2002; Hill et al. 1996).

Parental Psychopathology

Approximately 3% of parents in this study indicated significant levels of psychological distress on the SCL-90. Furthermore, on the PDS, 74% of parents reported that they had experienced at least one traumatic event, and 6% indicated significant PTSD symptomatology in response to this traumatic experience. Hypotheses regarding parental psychopathology as a moderating variable in the relationship between community violence exposure and adolescent outcome were partially supported.

With regard to adolescent-rated PTSD, parental PTSD was found to be a moderating variable. Results indicated that at higher levels of Parental PTSD severity, adolescents with higher levels of community violence exposure endorsed significantly higher levels of posttraumatic symptoms than adolescents with lower levels of community violence exposure. At lower levels of parental PTSD severity, there was not a significant difference in the levels of PTSD symptomatology endorsed by adolescents who had been exposed to high versus low levels of violence exposure. Therefore, parental PTSD severity served as a potentiating factor for adolescents in the presence of community violence exposure, making them more susceptible to the negative effects of community violence exposure.

The moderating effect of parental PTSD is consistent with previous research that suggests parental PTSD increases the offspring's vulnerability to this disorder; however, genetic factors, at best, only partially account for the increased vulnerability of these individuals (Davidson, Smith, & Kudler, 1989). This finding suggests that other factors likely contribute to the added risk these adolescents face. It is well accepted that parental psychiatric symptoms can have a negative impact on parenting behavior (Campbell et al., 1996; Kendler, Sham, & MacLean, 1997). For instance, parents with PTSD may model violent interactions, hyperarousal, and helplessness, as well as be emotionally unavailable, overprotective, avoidant, and intolerant with their children. These negative parenting behaviors have been associated with increased traumatic reactions in children exposed to war and disaster trauma (Nader & Pynoos, 1993). Perhaps parents suffering from PTSD are overwhelmed with their own psychological problems and, consequently, engage in negative parenting behaviors that increase the likelihood of poor psychological outcome for adolescents exposed to community violence.

With adolescent psychological distress as the outcome variable, parental global psychological distress was found to be a moderating variable. However, post-hoc probing of the significant interactions demonstrated that the simple slopes did not significantly differ from zero at high or low levels of parental psychological distress. Thus, the significant interaction indicates that adolescents who have parents with high levels of psychological distress significantly differ from those whose parents have low levels of psychological distress; however, the post-hoc probes indicate that adolescents are not significantly different at high versus low levels of community violence (G. Holmbeck, August 25, 2003). Visual inspection of the regression lines suggest that at high levels of parental psychological distress, adolescents exposed to both low and high levels of community violence exposure endorsed similar levels of psychological distress. At low levels of parental psychological distress, those adolescents with low levels of community violence exposure endorsed lower levels of adolescent psychological distress than did adolescents with high levels of community violence exposure. Therefore, it appears that when parents are experiencing psychological difficulties, adolescents' experience psychological problems irrespective of community violence exposure. However, adolescents who have parents with low levels of distress are more negatively influenced by community violence exposure, with violence-exposed adolescents exhibiting higher levels of psychological distress than those with lower levels of exposure. The results based on visual inspection should be considered with caution, as they are merely conjecture, and are not based on significant differences determined by statistical analyses. Despite the nonsignificant post hoc analyses, these findings do suggest that parent mental health is a good predictor of adolescent psychological outcome in populations facing accumulated risk factors.

When parent-reported adolescent psychological problems and adolescent-rated personal adjustment were considered, parental psychopathology did not emerge as a moderating variable. As mentioned earlier, research has shown that adolescents' self-ratings of internalizing problems have greater validity than parent reports (Achenbach et al., 1987). So again, greater emphasis is placed on the adolescent-reported internalizing problems. In contrast, parents are considered the most accurate raters of adolescent externalizing problems (Achenbach et al., 1987). Based on these findings, perhaps parental psychopathology serves as a moderator for internalizing problems, but not externalizing problems in community violence exposed adolescents. In terms of personal adjustment, no prior research has assessed the association between parental psychopathology and adaptive outcome in violence-exposed adolescents, so hypotheses were merely speculative and were not confirmed by the results of this study.

Results indicated a significant main effect for parent psychopathology and adolescent PTSD, with adolescents whose parents endorsed higher levels of parent global psychological distress reporting more PTSD symptomatology. This finding was consistent with family history studies of PTSD, suggesting that there is an increased risk for PTSD in individuals with a family history of psychiatric illness (Davidson et al., 1989). Another main effect was found for parental psychopathology and parent-rated externalizing and internalizing problems, such that parents with higher levels of psychological distress rated their adolescents as exhibiting more externalizing and internalizing problems. Although this finding is consistent with previous research, it should be interpreted with caution as parents with higher levels of psychopathology often overrate their offspring's psychological difficulties (Kilpatrick & Williams, 1997). Lastly, parent psychological dysfunction was

found to be significantly and negatively correlated with personal adjustment, with adolescents of psychologically healthy parents endorsing higher levels of positive adjustment. This indicates a possible compensatory effect for adolescents who have psychologically healthy parents.

Strengths of Current Investigation

This study was a first attempt to examine the influence of family violence exposure and parental psychopathology on adolescent PTSD, psychological distress, internalizing and externalizing problems, and personal adjustment in the context of community violence exposure. The present study addressed limitations in existing community violence literature by employing a multi-informant design to assess adolescents' psychological functioning. In addition, assessment measures utilized in this study have demonstrated excellent psychometric properties and those measuring adolescent psychological symptoms included validity scales to insure the quality of the clinical information provided. Another strength of the study was the assessment of multiple risk factors, as well as specific and broad based indicators of adolescent emotional adjustment. Finally, this study improved upon many prior community violence studies by including a similar number of male and female adolescents, which allowed for adequate power to determine gender effects as they relate to community violence and family factors.

Limitations

This study had several limitations. First the correlational nature of the study did not allow for causal associations to be established. Second, no observational data was included in this study. Third, the sample was recruited from schools in a restricted area of a mid-size southern city, which increases the risk of confounding variables and decreases

generalizability, since results may be uniquely influenced by locale. Lastly, parent/guardian reports of parental psychopathology were limited to the report of one parent/guardian even when there were two caretakers in the home. It would have been useful to investigate the psychological functioning of both parents when applicable.

Clinical Implications

These data suggests that when assessing and treating urban adolescents, clinicians would be well advised to take a multifocal approach. Assessment with this population should include a thorough evaluation of adolescent violence exposure across multiple environments as well as family psychological history. This information should be gathered through interviews and questionnaires from both the adolescent and his/her caretakers (Kazdin & Marciano, 1998). Once adolescents have been identified as being exposed to community violence, it is recommended that psychological assessment include evaluation of PTSD, depression, and anxiety symptoms due to the comorbidity of community violence exposure and these mental health problems. Those adolescents who report high levels of violence exposure and have parents that endorse psychological problems should be considered at greatest risk for poor adjustment.

Given that hostile communities are difficult to change, interventions for adolescents exposed to community and family violence should occur at the individual and family level (Mazza & Overstreet, 2000). Currently, there are empirically validated cognitive-behavioral techniques, including exposure therapy, coping skills training, and cognitive restructuring, that can assist adolescents in overcoming psychopathology related to trauma and violence exposure (Vernberg & Johnston, 2001). In terms of family interventions, recommended interventions include teaching parents and adolescents appropriate communication, coping,

and support techniques to deal with traumatic events and related symptomatology (Lyons, 1987). However, in order for parents to be receptive to and capable of family interventions, therapy addressing parental psychopathology and distress may be necessary. Once parents have coped with their own trauma and psychological issues, they will likely be a more reliable resource for assisting their adolescents in overcoming violence exposure (Groves, 1997).

Directions for Future Research

Future research examining family violence and parental psychopathology in the context of adolescent community violence exposure is warranted. This relationship could best be examined through the critical assessment of parenting behaviors in the context of family violence and parental psychopathology. Parenting is no doubt influenced by multiple determinants and further understanding of parenting behaviors involved with poor psychological outcome in violence exposed adolescents would provide the most direct link to the development of effective assessment and treatment. Additionally, there is a dire need for longitudinal projects to validate the cross-sectional findings of this and other studies and explore new pathways between exposure to community violence and emotional and behavioral functioning. Furthermore, community violence research would benefit from methodology that incorporates both observational and interview data.

Most importantly, future research should focus on compensatory factors that promote resilience or positive outcome for adolescents exposed to violence (Osofsky, 1995). It is widely known that not all children who grow up in violent environments have poor outcome; however, the protective factors that shield adolescents from negative outcome remain poorly understood. Identifying resiliency factors may provide a more solid basis for prevention and

intervention programs designed to help adolescents overcome the negative consequences associated with living in high-risk, violent environments.

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APPENDIX A

DEMOGRAPHIC QUESTIONNAIRE

CHILD INFORMATION

Child Age: _____ **Child Gender:** Male _____ Female _____ **Child Grade:** _____

PARENT INFORMATION

Age: _____

Marital Status:

- _____ 1. Married
- _____ 2. Divorced
- _____ 3. Separated
- _____ 4. Never Married
- _____ 5. Living Together
- _____ 6. Widow

Your Relationship to Child:

- _____ 1. Mother
- _____ 2. Father
- _____ 3. Stepmother
- _____ 4. Stepfather
- _____ 5. Grandparent
- _____ 6. Aunt/Uncle
- _____ 7. Other relative
- _____ 8. Someone other than family

Total Family Income:

- _____ 1. Under \$10,000
- _____ 2. \$11,000-\$20,000
- _____ 3. \$21,000-\$30,000
- _____ 4. \$31,000-\$40,000
- _____ 5. \$41,000-\$50,000
- _____ 6. Above \$50,000

Race:

- _____ 1. African American
- _____ 2. Caucasian
- _____ 3. Hispanic
- _____ 4. Asian
- _____ 5. Other

Your Education:

- _____ 1. Elementary
- _____ 2. Junior High
- _____ 3. Some High School
- _____ 4. GED
- _____ 5. High School Diploma
- _____ 6. Some College
- _____ 7. College Degree
- _____ 8. Post College

Spouse Education:

- _____ 1. Elementary
- _____ 2. Junior High
- _____ 3. Some High School
- _____ 4. GED
- _____ 5. High School Diploma
- _____ 6. Some College
- _____ 7. College Degree
- _____ 8. Post College

Your Occupation: _____

Spouse's Occupation: _____

APPENDIX B

INFORMED CONSENT FORM

1. **Study Title:** Effects of Family Violence and Parental Psychopathology on the Psychological Outcome of Adolescents Exposed to Community Violence
2. **Performance Sites:** Parents and adolescents will be recruited on a voluntary basis from Baton Rouge area middle and high schools.
3. **Names and Telephone Numbers of Investigators:** If you have questions concerning this form or the study, please contact Mary Lou Kelley, Ph.D. or Shannon Self-Brown, M.A. at (225) 358-1321, Monday through Friday, 8:00 a.m. to 4:30 p.m.
4. **Purpose of the Study:** The purpose of this research study is to assess the effects of different family factors on the emotions and behaviors of adolescents who have seen or heard about violent events in the community. The information that we get from this study will help clinicians better assist other adolescents who have seen or heard about violent events in their school, homes, and neighborhood. This study will evaluate if certain family factors help adolescents develop successfully even when they are exposed to violent events in the community.
5. **Who is involved:** Adolescents who are ages 12 to 16 years and their parents/guardians will participate in the study. The study will involve 130 adolescents and their parents/guardians.
6. **What is involved:** Adolescents and their parents/guardians will be approached through schools, and asked if they would be interested in participating in the study. Only adolescents and their parents/guardians who have signed the consent and assent forms will be allowed to participate in the study. If you agree to voluntarily participate in the study, you and your adolescent will spend about 45 minutes completing several measures. The measures will ask your adolescent to provide information about violence exposure, his/her emotions, and his/her behavior. You will be asked to provide information relating to your emotions as well as the emotional and behavioral concerns of your adolescent. If anyone has difficulty reading the forms, assistance will be provided by the researcher. You and your adolescent will have no further obligations after you complete the measures.
7. **Benefits to Subject:** Each parent/child dyad that agrees to participate in this study will receive \$5 after the measures have been completed. In addition, completion of the project will help us to determine the effects of violence exposure on adolescents and whether family factors, such as parental emotions and behaviors, will help or hurt adolescents in coping with seeing or hearing about violent events. Such information may assist professionals in providing quality health care and preventive services to adolescents and their families.
8. **Risks to the Subject:** First, you and/or your adolescent may become upset while completing the questionnaires because there are questions related to violent events, emotions, and behavior. We will give referral cards to everyone in case you or your child becomes emotionally upset at anytime. Second, if we find out that your child is being physically, emotionally, or sexually abused or neglected, we are required to report this information. We will immediately tell you that we are making a report to Child Protective Services if your adolescent is in danger of abuse or has been abused.

9. **Risk Reduction:** If you or your child becomes worried or upset about the questions we ask, a trained clinician will be present during data collection to help you. If you want help immediately, we can go to a private room to discuss the worries you or your adolescent have. If you would like to be seen by a clinician at a later time, we can make an appointment or the clinician can give you a referral card to a local agency that helps adolescents and parents who have seen and heard about violent events or are experiencing emotional difficulties.
10. **Participation is Voluntary:** This study is designed to gather research information and is not mandatory. Your participation is completely voluntary.
11. **Right to Privacy:** All information gathered is strictly for research purposes. The privacy and confidentiality of all subjects will be protected. Only the researchers involved in this study will have access to participant's information. Furthermore, the information collected will be coded by number, not by name. No one will be identified in any way. With the exception of signing the consent form, parents/guardians and adolescents will be asked not to document their name, address, telephone number, or any other identifying information on any of the forms. The results of this study may be published, released to a funding agency, or presented in a scholarly fashion, but the privacy of the participants will be protected and their names will not be used in any manner. Data will be kept confidential unless release is legally compelled. If the adolescent is thought to be at risk of doing harm to himself or herself, confidentiality will be waived and a referral to the appropriate professional will be made.
12. **Financial Information:** There is no cost for participation in this study. Subjects who agree to participate in this study and complete the consent/assent forms, as well as all measures provided by the researcher, will receive \$5 as compensation for their time.
13. **Withdrawal:** You and your adolescent may decide not to participate in this study. There will be no penalty if you do not wish your son or daughter to be in the study, and he or she may withdraw at any time during the study.

“This study has been discussed with me and all my questions have been answered. I may direct additional questions regarding study specifics to the investigators. If I have questions about subjects' rights or other concerns, I can contact Robert C. Mathews, Chairman, LSU Institutional Review Board, (225) 578-8692. I agree to participate in the study described above and acknowledge the researchers' obligation to provide me with a copy of this consent form if signed by me.”

Signature of Parent/Guardian

Date

“The study subject has indicated to me that he/she is unable to read. I certify that I have read this consent form to the subject and explained that by completing the signature line above the subject has agreed to participate. “

Signature of Reader

Date

APPENDIX C

ASSENT FORM

- 1. Purpose of this study:** This is a research project that is studying the types of violent things that teenagers may see, hear about, or experience. By telling us about your experiences through honest answers on the measures provided, we can learn about how teenagers feel when they have heard or seen violent events.
- 2. Participants:** We are trying to get 130 teenagers in grades 7 through 11 to participate in this research study.
- 3. Description of the study:** If you choose to participate, you will be asked to complete some questionnaires that ask about violent events, your behavior, and your emotions. It will take approximately 45 minutes to fill out the questionnaires. Your parents will also complete questionnaires about your behavior, as well as their own behavior and emotions.
- 4. Benefits:** You and your parents will be paid a total of \$5 for participating in this study. This research study may help you think about your feelings and behavior. It may help other teenagers because the information you provide us will help us learn more about what teenagers' feel and behave when they see, hear about, or experience violent events.
- 5. Risks:** One possible risk is that some teenagers who participate may get upset when we ask them about violent events they have seen, heard about, or experienced. Secondly, if you tell us that you are being physically, emotionally, or sexually abused or neglected, we are required to report this information to Child Protective Services.
- 6. Right to Refuse:** You may choose not to participate in this study, or decide to quit the study at any point. You will not be penalized in any way for these decisions.
- 7. Privacy:** All your responses on these measures will be private. Your name will not be on the questionnaire and your answers will not be shared with anyone except the researcher.
- 8. Investigators:** Mary Lou Kelley, Ph.D. and Shannon Self-Brown, M.A. are the primary investigators.

This study has been discussed with me and all my questions have been answered. I will be given a copy of this form after I sign it.

Participant's Age _____

Participant's Name (print) _____

Participant's Signature

Date

Witness

VITA

Shannon Renee Self-Brown earned her Bachelor of Arts degree with a major in psychology in August 1995 and Master of Arts in psychology in August 1997 at the University of West Florida in Pensacola, Florida. Ms. Self-Brown is currently a Doctor of Philosophy candidate in the Department of Psychology at Louisiana State University and Agricultural and Mechanical College in Baton Rouge, Louisiana. She is in the Child Clinical Psychology program and is under the supervision of Mary Lou Kelley, Ph.D. Her main research interests are the effects of trauma exposure and child maltreatment on the psychological outcome of children and adolescents. Ms. Self-Brown will complete her predoctoral internship at the University of Miami School of Medicine in Miami, Florida, in August 2004. She plans to pursue a research postdoctoral fellowship at the Medical University of South Carolina-National Crime Victims Center beginning September 2004.