

Trauma-Related Symptomatology Among Children of Parents Victimized by Community Violence

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Statement of the Research Problem

Though community violence has been decreasing in recent years (Rand, 1999), the United States continues to have the distinction of being the most violent country in the industrialized world. Community violence has become an increasingly prevalent part of life for many children (American Psychological Association, 1993). This exposure to violence, either directly or indirectly has the potential to negatively impact their development and mental health (Bell & Jenkins, 1991; Blechman, Dumas & Prinz, 1994). In spite of this problem, there has been minimal systematic research into the nature and consequences of children's exposure to violence in urban communities (Richters & Martinez, 1993). In particular, there is a dearth of research related to the effects on children when their parents are victims of community violence. The purpose of this study was to expand on the current knowledge base by examining trauma-related symptomatology among children of parents victimized by community violence and whose victimization the child did not witness.

Hypotheses

1. Children whose parents have been victimized by community violence will exhibit more distress symptoms than children whose parents have not been victimized.
2. Controlling for previous community violence exposure, children whose parents have been victimized by community violence will exhibit more distress symptoms than children whose parents have not been victimized.
3. The level of distress symptoms experienced by children will be affected by the frequency of contact they had with their parents prior to their parents' victimization.

Methodology

The study design involved a static-group comparison (Campbell & Stanley, 1963). The convenience sample consisted of 60 children, 6 through 12 years of age. Thirty children were in the experimental group and thirty were in the comparison group. Children between the two groups were matched on the following variables: age; gender;

and neighborhood in which they lived. The sample size was the ideal number of subjects necessary to maintain a power level of .80 at an alpha level of .05, and to establish a large effect size (Cohen, 1992). This was consistent with Cohen's reasonable standard of power established at .80 (Cohen, 1988). Data collection began in December 1997 and was completed in May 1998. Each consecutive admission into the trauma unit at the Erie County Medical Center (ECMC) in Buffalo, NY was screened and assessed over this six month period to determine if they met the inclusion criteria until the 30 subjects were recruited for the study. Since all subjects were measured at one point in time, no follow-up was necessary. Thus, attrition was not problematic.

Inclusion criteria were as follows: (a) subjects had to be the biological children of parents victimized as a result of community violence; (b) the parents had to have received inpatient treatment (admitted to a medical floor for at least one-night of stay) for related injuries at ECMC; (c) the child could not have witnessed their parents' victimization; and (d) the children could not have been currently receiving mental health services. Children with a documented history of mental retardation were excluded from the study. In addition, children whose parents were hospitalized due to domestic violence and/or self-inflicted wounds were also excluded from the study.

Written parental consent was obtained for their children's participation in the study. In addition, all children completed an individual assent form. The comparison group was matched to the experimental group on the specific variables of age, gender, and neighborhood. To recruit subjects for the comparison group, parents of the children in the experimental group were asked for names of other parents in their neighborhoods with a child the same gender and age as their own child. These parents were contacted and screened, and their children were recruited for the comparison group if they met the inclusion criteria and if they consented to participate in the study.

All subjects were volunteers. To encourage full participation, participants were compensated with cash (\$5 per child and \$20 per parent) if they completed the instrument package. In addition, transportation was provided as necessary.

Measures

Two data collection forms were developed for this study to collect socio-demographic information and other pertinent data. One form was for the parents to complete and the other was for the children to complete. The measurement package included the following:

Children (9 through 12 years of age):

Checklist of Children's Distress Symptoms (CCDS) (Self-Report Version) (Richters & Martinez, 1990a). The CCDS questionnaire is scored on a Likert scale and includes 28 symptom descriptions developed from diagnostic criteria in the *Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R)* (American Psychiatric Association, 1987). Previous research found that children's composite symptom scores

on the CCDS were significantly related to children's scores on the *Child Depression Inventory* (CDI) (Kovaks, 1985), $r(37) = .49$, $p < .01$ (Richters & Martinez, 1990).

Survey of Exposure to Community Violence (SECV) (Self-Report Version) (Richters & Saltzman, 1990). The SECV is a fairly new, 54-item questionnaire designed to evaluate children's exposure to mild, moderate, and severe levels of violence within their communities. It details the frequency and context of children's exposure to various forms of community violence. The instrument was revised for this study to exclude questions about child abuse and sexual abuse. At this time information regarding reliability and validity are not available.

Children (6 through 8 years of age):

Things I Have Seen and Heard: An Interview for Young Children about Exposure to Violence (Richters & Martinez, 1990b). This instrument is a 20-question structured interview that probes young children's exposure to violence and violence-related themes. It includes questions regarding exposure to violence in the community and in the home. Questions are presented in an age-appropriate manner which facilitates the children's ability to understand and respond. Information regarding reliability and validity is not yet available.

Levonn: A Cartoon-Based Interview for Assessing Children's Distress Symptoms (Richters, Martinez, & Valla, 1990). This age-appropriate instrument consists of 39 questions and utilizes a cartoon-based interview to assess symptoms associated with post-traumatic stress disorder. Children listen to questions regarding distress symptoms while they look at the corresponding cartoons on the pages. They are then asked to respond to the questions using pictured thermometers next to each cartoon which provide three possible responses: "never", "some of the time", or "a lot of the time." One study of this particular instrument found that the 1-week test-retest reliability of the composite variable reflecting the sum of all instances of child-reported exposure was $r = .81$ for a random subsample of 21 children, with a small, non-significant attenuation in the absolute levels of exposure reported at time 2, $t(20) = 1.34$ (Richters & Martinez, 1990).

Parents

Parents used the *Child Behavior Checklist* (Revised) (CBCL) (Achenbach, 1991). The CBCL is a 118-item checklist for parents to evaluate the behavior of their children 4 through 18 years of age. It asks questions regarding a wide variety of symptoms/behaviors their children may have experienced in the past 6 months and asks parents to respond to each question with three possible answers: "not true"; "somewhat true or sometimes true"; or "very true or often true." It is widely used and accepted in the field and has demonstrated good reliability and validity. The test-retest reliability of CBCL scale scores was supported by a mean test-retest ($r = .87$ for competency scales and $r = .89$ for problem scales over a 7-day period). Construct validity was supported by numerous correlates of CBCL scales, including significant associations with analogous scales on the Conners (1973) *Parent Questionnaire* and the *Revised Behavior Problem Checklist* (Achenbach, 1991).

Data collection procedures

The primary investigator collected all data for this project at the Erie County Medical Center (ECMC). Data collection appointments were made for each participant 2 to 8 weeks following parents' victimization. Telephone follow-up was done to re-schedule those who failed to maintain their initial appointments. All measures were administered to child participants on an individual basis. Prior to completing the measures, the children were anchored in time and asked to respond to the events in each question as if they had occurred within the past six months.

The parents who completed the parent measures were the ones with whom the child resided. The primary investigator helped the parents complete the parent measures as necessary. It took approximately one hour for each subject to complete his/her instrument package.

All subjects and their parents were assured of the confidentiality of their responses throughout the study. There were minimal physical, psychological, legal, or social risks for participants. Some children and parents appeared to feel some anxiety before, during, or after completion of the instrument package. To help alleviate any anxieties, the primary investigator, a researcher with a master's degree in social work, was available to the children and/or parents to discuss any feelings they may have experienced as a result of the interview.

Results

It was hypothesized that children whose parents had been victimized by community violence would exhibit more distress symptoms than children whose parents had not been victimized. Utilizing the t-test, the study found that children of parents who had been victims of community violence experienced more distress symptoms than did children of parents who had not been victimized. Further analysis examined the relationship between parents' victimization and their children's development of distress symptoms when controlling for community violence. Using hierarchical regression, results indicated that a large percentage of the children's distress symptoms were related to their previous exposure to community violence, however a substantial percentage of their distress symptoms were related to their parents' victimization. Lastly, the relationship between the children's levels of distress and the frequency of the children's contact with their parents before parents' victimization was examined. Utilizing the t-test to examine this relationship, the results indicated that such contact did not impact the children's development of distress symptoms.

Utility for Social Work Practice

Social workers encounter victims of violence in various settings. The literature clearly indicates that children exposed to chronic community violence may suffer grave consequences as a result of that exposure. This particular study further illustrates that parents' victimization as a result of community violence may also constitute a risk factor

for some children to develop distress symptoms. For these reasons, social workers must be educated about these potential risk factors for children and remain aware of them when they provide assessment and intervention.

Based on the findings of this study, hospital social workers who provide services to patients in trauma units may consider expanding their assessment to include the victim's family. When victims of community violence have children, social workers should educate them about the potential consequences their victimization may have for their children and offer a referral for the children for assessment (and possible intervention as indicated). This should become standard protocol. Development of hospital-based support groups for children of victimized parents may also be desirable.

Furthermore, social workers working with children in inpatient and outpatient clinic settings should expand their psycho-social assessment to include questions about previous exposure to violence. They should also ask if the children's parents have ever been victims of violence themselves. In addition, the results of this study indicate that if the children have knowledge of their parents' victimization, regardless of how often they have contact with their parent, there is reason to be concerned. Social workers must be aware of this when they work with children so they do not discount the potential impact of this knowledge on their clients.

This particular study added a new dimension to this field of research through its examination of children's responses to their parents' community violence victimization. Researchers must continue towards developing a full understanding of children's responses to parents' victimization by, and other ramifications of, community violence. Further research must examine the effects of chronic community violence on children, including any effects due to their parents' victimizations, and must develop empirically-tested interventions as indicated. Finally, researchers should not limit their inquires to individuals, but must also direct them towards communities as a whole, where interventions are desperately needed to combat community violence.

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