Family Violence Exposure and Associated Risk Factors
to Child PTSD in a Mexican Sample

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Dedication

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Abstract

This dissertation study examines the interactional effects of trauma exposure on parent-child relationships with 87 mother-child dyads from a child maltreatment population in Monterrey, Mexico. The relational impact of trauma on youth is salient given the important role that the parent/caregiver plays in a child's life. Data from four standardized instruments of a larger study piloting an innovative multi-method assessment protocol was examined to gain a cultural and contextual understanding of trauma and family violence exposure and associated risk factors of child PTSD in this sample. Findings indicated high levels of exposure to any potentially traumatic stressor in children and mothers, particularly violence in the home and community. Socioeconomic and sociocultural cultural factors such as poverty, traditional gender role socialization, and excessive community violence were associated with greater PTSD symptomatology in children and mothers in this sample. Results from this study support the need for more family-based research to explore intra- and extrafamilial influences on parent-child relationship and the impact of larger cultural and community factors on the development of PTSD. Implications for families, practitioners, researchers, social institutions within the community and government, and the larger global community are discussed.

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Chapter I: Introduction

Psychological trauma has negative consequences for the individual, the family and society. According to Schauer, Neuner, and Elbert (2005), “the core of psychological trauma is the alienation from life of a wounded soul” (p. 1). Psychological trauma potentially destroys a person’s ability to act within the moment and ability to maintain intimate relationships with other people. Early research studies examining the effects of psychological trauma focused on adult populations, primarily war veterans and rape victims (Copeland, Keeler, Angold, & Costello, 2007). Over time, broader definitions of traumatic stressors were included to consider other types of events such as road traffic accidents, natural disasters, and community violence. The development of Posttraumatic Stress Disorder (PTSD) in children and adolescents has become a growing clinical topic of interest due to its debilitating effects on the child and its adverse effects on biological, psychological, and social development (Davis & Siegel, 2000). Given these concerns, it is not surprising that PTSD is one of the most commonly studied reactions to trauma.

There have been a significant number of research studies investigating the effects of psychological trauma on children and adolescents within the past 25 years. Childhood trauma studies have linked child outcomes and the development of PTSD with family support and parental/caregiver functioning, particularly related to the child’s mother (Cook et al., 2005). These studies have demonstrated positive associations between parent and child distress in response to shared traumatic experiences (Pynoos, Steinberg, & Goenjian, 2007). However, the studies were focused on PTSD-specific symptoms and the role of traumatic reminders such as parents’ reactive behavior that may accentuate

children's anxieties. Research examining negative effects of other dimensions of traumatic stress on parent-child relationships is minimal (Gewirtz, Forgatch, & Wieling, 2008). The overall goal of this dissertation study is to address this gap in literature by investigating the interactional effects of trauma exposure on mother-child relationships. The scope of the analysis presented here only captures a part of these parent-child variables and relational dynamics, which will help expand spectrum definitions and treatment modalities for traumatized populations beyond individually-based traditional medical models.

PTSD Definition and Symptoms

PTSD was first defined in the *Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition*¹ (*DSM-III*; American Psychiatric Association; APA, 1980) and was later revised to include child-specific criteria in the *DSM-III-R* (APA, 1987). The current *DSM Fourth Edition Text Revision* (*DSM-IV-TR*; APA, 2000) definition of PTSD is based on the presence of specific characteristics from three symptom clusters following exposure to a traumatic event (Criterion A). An individual must have direct experience with the event or have witnessed the event; and the experience involved perceived threat of death/serious injury to the self or others (A1), and feelings of intense fear, helplessness, or horror (A2). Characteristic PTSD symptoms include persistent re-experiencing of the incident (Criterion B), persistent avoidance of stimuli associated with

¹ The current *DSM-IV* version includes symptom clusters beyond PTSD under the rubric of disorders of extreme stress not otherwise specified (DESNOS); however this is a work in progress and may not fully represent traumatic stress symptomatology.

the trauma and emotional numbing (Criterion C), and persistent heightened arousal (Criterion D). These symptoms must have been present for at least one month (Criterion E) causing significant impairment in daily functioning (Criterion F).

Diagnostic factors. The traditional definition of PTSD is one-dimensional and “focuses on memory imprint of particular experiences” (van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005, p. 396). Treatment is typically focused on the individual and attempts to help the individual process and reintegrate traumatic memories into a coherent whole. Terr (1991) identified two types of childhood trauma: type I (single episode) and type II (ongoing or repeated). Examples of type I events are being involved in a car accident, witnessing a bombing, being in a shipwreck, and seeing someone shot. Type II traumatic events include child maltreatment, witnessing intimate partner violence, prolonged exposure to war, and chronic community violence (Graham-Bermann, DeVoe, Mattis, Lynch, & Thomas, 2006). There is a general consensus that chronic, ongoing traumatic events seem to put individuals at greater risk for psychopathology compared to acute events (Pine & Cohen, 2002).

Although there are many similarities in PTSD symptomatology between youth and adults, there are several instances in which these symptoms may differ for children and adolescents. For instance, the *DSM-IV* indicates that children’s responses to a traumatic event may involve disorganized or agitated behavior rather than intense fear, helplessness, and horror exhibited by adults (APA, 1994). Many studies (e.g., Margolin & Vickerman, 2007; Scheeringa, Zeanah, Meyers, & Putnam, 2003; van der Kolk et al., 2005) of children and women with histories of early physical and sexual abuse provide

support for a myriad of other symptoms not captured in the PTSD diagnosis, particularly in children. For example, traumatized children experience concentration difficulties (Laor et al., 1996), difficulty regulating emotions (Cicchetti & Toth, 1995), and altered relationships with themselves and others (Appleyard & Osofsky, 2003; de Zulueta, 2006; Scheeringa & Zeanah, 2001).

Developmental factors must be taken into consideration in the presentation of PTSD in childhood. Children at different developmental stages manifest different symptoms and as children age they interact with their social environment in ways that increase their exposure to traumatic stressors (Davis & Siegel, 2000). Younger children do not have as much knowledge and language skills as older children, which affects their understanding and the way information is coded about the traumatic event (Trickey, Siddaway, Meiser-Stedman, Serpell, & Field, 2012). Younger children's ability to regulate their emotions is also less sophisticated, potentially affecting the way that they process the event. Four major characteristics specific to childhood trauma are repeated memories, repetitive behaviors, trauma-specific fears, and altered attitudes about the future and life in general (Terr, 1991). With age, children's adaptive coping strategies improve such that older children and adolescents are better equipped to respond to traumatic events. Common manifestations of PTSD symptoms in adolescents are disturbed sleeping patterns (insomnia or withdrawal into heavy sleep), angry and aggressive behavior, and academic problems (Margolin & Vickerman, 2007).

The term *complex trauma* refers to children's exposure to multiple traumatic events such as abuse and neglect in addition to other types of events like witnessing

family violence or loss of their caregivers (Cook et al., 2005). The developmental effects of complex trauma are not fully captured in the *DSM-IV-TR* definition of PTSD, which creates impairments across seven domains: attachment, biology, affect regulation, dissociation, behavioral control, cognition, and self-concept. These impairments in core capacities for self-regulation and interpersonal relatedness often put children at risk for long-term difficulties including additional trauma exposure and cumulative impairment. These symptoms can occur in addition to PTSD symptoms, therefore, treatment models need to extend beyond the traditional PTSD diagnosis. Although the multidimensional nature of trauma is recognized within the trauma field, there are few assessment and treatment guidelines addressing these other symptoms. Furthermore, there is a dearth of validated instruments targeting the impact of trauma at the relational/systemic dyadic or family levels.

Family violence as a traumatic event. According to Margolin and Vickerman (2007) there is some confusion about whether or not family violence qualifies as a traumatic event. Family violence can include minor or severe acts of physical and emotional aggression that involves at least one family member as a victim and another as a perpetrator. The traditional conceptualization and diagnostic criteria of PTSD in the *DSM-IV-TR* does not address the chronic nature of complex trauma, which includes exposure to family violence and community violence. Children suffering from complex trauma are exposed to multiple acts of violence across various types of events. There “may not be one identifiable pretrauma state of the child’s functioning, there may not be one specific traumatic event that stands out, and violence episodes may not present life-

threatening circumstances” (Margolin & Vickerman, 2007, p. 614). Moreover, children with complex trauma live in constant threat of an additional violent act. This perpetual state of ambiguity and fear may potentially exacerbate pre-existing PTSD symptomatology.

Comorbidity. The wide-range of PTSD symptomatology raises concerns about misdiagnosis in children, since trauma-exposed youth frequently meet criteria for multiple diagnoses. Commonly co-occurring reactions to traumatic stress that have been examined in the child trauma literature are depression and anxiety disorders; separation anxiety, attention-deficit/hyperactivity disorder (ADHD), conduct disorders, and aggression (Copeland et al., 2007; La Greca, Silverman, Vernberg, & Prinstein, 1996). The expression of PTSD symptoms can also interfere with children’s ability to cope with other stressful life situations leading to more psychopathology. The potential harmful effects of misdiagnosis is evident in the example of a child being prescribed the drug Ritalin for problems associated with ADHD, which can increase symptoms of intrusion for some children (Rossman & Ho, 2000).

Comorbid features of PTSD in adolescents often appears in the form of acting out and risk taking behaviors such as substance abuse, suicide, eating disorders, delinquency, academic difficulties, sexual promiscuity, and violence in dating relationships (Davis & Siegel, 2000; Kearney, Weschsler, Kaur, & Lemos-Miller, 2009; Margolin & Vickerman, 2007). These behaviors may create a spiral effect where adolescents engage in problematic behaviors as a way to self-medicate, leading to further exacerbation of PTSD symptoms. The uncertainty about the nature of the relationship between comorbid

disorders and PTSD has significant implications for the assessment and treatment of child psychological disorders.

Ethnocultural considerations. The ethnocultural aspects of a person's heritage, such as traditions, religious and spiritual beliefs, language, and geographical location of where one resides can also influence the risk of exposure to trauma (Cook et al., 2005). The conventional understanding of trauma and PTSD is based on a Western disease model of psychiatric disorders that assumes the universality of identifiable symptoms and treatment protocols across cultures (Marsella, 2010). Many cross-cultural studies over the past few decades have raised the possibility of ethnocultural variations in the way key trauma-related constructs are understood and defined as well as how PTSD symptoms are expressed. Cultural and community contexts can affect subjective perceptions of the trauma and how a child and the family respond to and cope with the trauma (Margolin & Vickerman, 2007). Specific cultural norms and values about family roles, child rearing practices, and attitudes influence the extent of support that is available to meet children's needs (e.g., extended family members, close friends). The cultural context can also influence a family's openness to seeking and receiving mental health services or the types of treatment provided.

Purpose of Dissertation Study

Quantitative data from a larger study piloting an innovative multi-method trauma focused assessment protocol with a child maltreatment population in Monterrey, Mexico is used in this dissertation study. The analysis for this dissertation study examines data from four standardized screening instruments investigating exposure to traumatic events

and family violence. The overall goal of testing this multi-method assessment protocol is to gain a cultural and contextually-based understanding of family exposure to trauma and associated risk factors for developing child PTSD within a particular cultural and trauma context. The specific dissertation study objectives are: (a) to examine individual and family characteristics between mother-child dyads that differentiate between the presence or absence of a PTSD diagnosis for children; and (b) to examine potential trauma-related and posttrauma risk factors for the presence of child PTSD.

In order to develop a better understanding of how trauma is conceptualized within different populations, it is necessary to have culturally relevant and meaningful measures that assess how individuals and families make sense of their experiences and their responses to traumatic stressors. Assessment instruments demonstrating reliability and validity in other populations within the U.S. and other countries around the world are used as a starting point for exploring the effects of trauma with this sample in Mexico. In the present study, descriptive information about individual characteristics of the child and mother, and dyadic information about the perpetuation of PTSD symptomatology in parent-child relationships is presented. This information will be used for further development and testing measures targeting both the individual and family systems within various cultural and trauma contexts, and inform appropriate prevention and treatment efforts for these populations.

The larger assessment protocol pilot study represents a collaborative effort between a team of interdisciplinary and international scholars in the U.S., Mexico and Germany; the Mexican state government; and a non-governmental Mexican family

therapy clinical training and research institute. Knowledge gained from the study will contribute to the larger body of trauma literature by expanding the range of PTSD definitions, symptoms, and relational implications of trauma exposure for children and families.

Potential Significance to the Field

There are several innovative features of this dissertation study including: (a) scientific advancement in terms of understanding traumatic experiences from individual to interrelational impacts; (b) the development of a multi-dimensional conceptualization of trauma that takes into account ethnocultural contextual factors that influence the risk of exposure to traumatic stressors; and (c) the description of psychological and relational dimensions of trauma in mother-child interactions that can be used for the adaptation and development of parent-child and family-level interventions. Exposure to traumatic events and chronic stressors is felt globally through the devastation experienced from natural disasters, war and organized violence, terrorism, and community and intra-familial violence. These experiences permeate the context in which we live, shaping the psychological, social, economic, and political landscape of our global community.

Individuals exposed to traumatic events are at increased risk for developing a range of different physical and mental health complications such as chronic pain, depression and anxiety, substance abuse, and relational difficulties within family, work and community systems. Treatment can be costly given the range of problems experienced and the potentially enduring effects of traumatic stress. In order to effectively meet the needs of diverse populations, it is important to develop assessments

and treatments that match particular aspects of the local cultural and trauma context. Information gained from this dissertation study will contribute to future prevention and clinical intervention research that will help inform social policies about how to help individuals, families, and communities affected by trauma. Policy changes may result in increased funding for local and international non-government organizations and government to invest in research efforts to address this critical social issue that impacts humans worldwide.

Cultural Ecological Framework

A cultural ecological framework is the primary theoretical lens used for gaining a better understanding of trauma within the context of child maltreatment, childhood traumatic stress, and mother-child relations. This framework is based on Bronfenbrenner's (1977, 1979) ecological model of human development, which posits the importance of considering multiple ecological systems of interaction to gain an understanding of a particular phenomena or experience. The structure of the ecological environment consists of the microsystem, mesosystem, exosystem, and macrosystem. The microsystem is the relationship between an individual and his/her immediate settings such as school, home, and work. The mesosystem describes interrelations among major settings that contain the developing person at a particular point in his/her life (e.g., the peer group, family, and school). The exosystem consists of formal and informal social structures (e.g., neighborhood, mass media, government agencies) that interact with the immediate settings (microsystem) in which a person is embedded.

The macrosystem is the overarching institutional patterns of a culture or subculture that inform the structure and activities of daily life in a society, some of which are manifested at the concrete level in the micro-, meso-, and exosystems (Bronfenbrenner, 1977). For the most part these cultural patterns are implicit and informal ideologies made visible through customs and practices. These macrosystems are important in determining how a child and caretaker are treated and interact with each other in various settings. The macrosystem is the core cultural ecological framework, while culture forms the overarching context from which an understanding about the impact of trauma on parent-child relationships was gained.

Belsky (1993) builds upon the work of Bronfenbrenner (1977), providing a developmental-ecological perspective about the etiology of child maltreatment. He focuses on physical abuse and neglect, examining the developmental-psychological context (individual-level parent and child factors), the immediate context (parenting and parent-child interactions), and the broader context (community, cultural, and evolutionary) as multiple determinants of child maltreatment. At the individual-level, parents who are less able to manage negative emotions, have negative self-concepts, and have a childhood history of maltreatment may be at higher risk for the transmission of child maltreatment across generations. Age, health, and certain behavioral characteristics of the child may interact with parent factors to increase the risk of maltreatment. Generally, younger children have more difficulty regulating emotion, which may bring out hostile caregiving; premature infants tend to be more physically unattractive and produce abuse-eliciting cries; and maltreated children tend to have more disruptive

behaviors, which may serve to elicit or maintain maltreatment (Belsky, 1993; Bremner, 2008).

Within the immediate context of parenting and parent-child interaction, maltreatment is more likely to occur when the parent has a predisposition toward anxiety, depression, and hostility (Belsky, 1993; Cicchetti & Toth, 1995). The parent may attempt to physically and instrumentally discipline the child, but may become aroused to the extent of abusing the child. Within the broader cultural context, lack of social support and isolation, permissive attitudes towards violence, and a value-orientation of children as property combined with the cultural history of a society (e.g., Spanish colonization), may create an environment that is vulnerable to child maltreatment. Furthermore, the evolutionary interests between the parent and child may conflict, creating higher levels of parental stress that leads to increased risk for child maltreatment. For example, a lack of available resources may reduce parental investment in unplanned pregnancies. Belsky (1993) concludes that prevention and intervention efforts targeting a single pathway (e.g., individual-level parent and child factors) will not be effective.

Local Cultural Context

The local cultural context in Monterrey, Mexico was the starting point for conceptualizing, developing, and designing the larger assessment protocol pilot study. In accordance with Rogler's (1989) recommendations for conducting culturally sensitive research, the researchers first immersed themselves in the culture of the group being studied. Prior to the study implementation, focus group interview were conducted with knowledgeable informants from the community. The assessment protocol pilot study

focuses on the second phase of culturally sensitive research, the adaptation and translation of research instruments to participants' cultural context. Specific information about this process is described in the methods section of this paper. The third and final phase of conducting culturally sensitive research is the development of culturally appropriate interventions. A clinical randomized outcome study conducted in Mexico with children diagnosed with PTSD and their mothers builds upon the knowledge gained in the assessment protocol pilot study presented here.

The overarching goal of the research collaborators is to develop a body of research focused on understanding of the effects of psychological trauma on parent-child relationships at conceptual, methodological, and clinical levels. In essence, the researchers are questioning what we know about trauma and parent-child relationships and evaluating whether or not our conceptualizations fit within this context. The translation of assessment and treatments for diverse populations is a balance between process and content. Cultural issues are considered but not overemphasized, in order to reveal potential underlying processes that are more closely related to treatment outcomes (Bernal, Bonilla, & Bellido, 1995, p. 72). The researchers are continually striving to deconstruct and re-evaluate what is known while also bringing forth new knowledge to co-construct locally relevant, feasible, and potentially sustainable ways to engage and work with families in Mexico.

Challenges of cross-cultural research. The process of conducting culturally sensitive research is challenging on several levels. Theoretically, it is necessary to maintain scientific rigor and at the same time allow for and respect local realities that

influence and inform the scientific process. Maintaining this balance between etic and emic perspectives is intensive, time-consuming and requires much patience from all of those involved in the research endeavor. There were multiple stakeholders invested in the larger research project, including children and families, the researchers, clinicians, and state and national institutions. Institutional stakeholders were the University of Minnesota; Centro de Investigación Familiar, AC (CIFAC), a family therapy training and research center in Monterrey, Mexico; and the Department of Child Protective Services (DCPS) for the state of Nuevo León, Mexico.

Services for child maltreatment in families is a recognized area of need at the Mexican state level and the assessment protocol pilot study was partially funded by the federal government. However, given the ambitious scope of the project with an international team of researchers making multiple trips to Mexico in order to provide training and supervision of the project, it was necessary to pursue additional funding to offset the limited resources that were available. The present researcher applied for and received funding from the Minority Fellowship Program sponsored by the American Association for Marriage and Family Therapy and the Substance Abuse and Mental Health Services Administration branch of the U.S. Department of Health and Human Services to help support this dissertation research as a part of the larger project.

There were several structural and organizational challenges at the institutional level that influenced the design and implementation of the assessment protocol pilot study. The organizational structure of DCPS is very hierarchical; there are no consistent assessment or intervention guidelines, and the sustainability of social services programs

is limited. These factors made it difficult for clinicians and staff to stick to a highly structured assessment protocol and data entry procedures. Clinicians only had professional training in psychoanalysis with few opportunities for continuing education related to family/relational assessments and interventions. Many of the clinicians and staff reported feeling demoralized, and often expressed feeling hopeless and desperate since they wanted to help the families they worked with but felt inadequately prepared. Limited resources, low wages, exorbitant workloads, and tremendous time demands lead to burnout for clinicians and staff. Many individuals worked multiple jobs in order to sustain a basic standard of living. For example, one of the research team members worked as an employee at CIFAC, a clinician in private practice, and was the research project manager in Mexico all while completing her master's degree and maintaining her personal and family life. Unfortunately, this is not an unusual scenario for many residents in Mexico.

At the family-level, mothers and children were faced with the challenges of extreme poverty, lack of basic needs, high stress levels, illiteracy, lack of accessible transportation, and high levels of community violence. These families are entrenched in multi-generational family and contextual systems that are difficult to change. This becomes an isomorphic process where parents do not know how to help their children and professionals do not know how to help the families.

Successes of cross-cultural research. There were also several successes throughout the larger assessment protocol pilot project. The level of commitment from administrators, clinicians, and staff at DCPS and CIFAC was impressive. The few

resources available were used to support the research efforts across the various research phases – training, implementation, and data entry. Internal structural changes within the organizations were made in order to accommodate the training schedule. For example, time spent in trainings and interviewing families was included as a part of regular work hours. The trainings also served as continuing education, which increased the morale of the clinicians and staff to feel more confident and better equipped to help families and also reinforced their eagerness and commitment to the research process.

As an institution, DCPS is highly committed to the well-being of children. It is important to note that research is not integrated into government institutions as it is in the United States. DCPS directors were progressive in acknowledging the importance of investing in research with alternative ways of approaching trauma related to maltreatment with their children and families. As a result, the U.S. research team had to provide significant training related to research – its purpose, methods, and procedures. This was a necessary part of the research process in order to get buy-in from administrators, clinicians, staff, and families. Mothers also demonstrated their commitment to the health and well-being of their children by making the time and necessary sacrifices to participate in the research study.

At the beginning of the project the social and cultural context was one in which feelings of hopelessness were evident across all system levels – institutional, interventionist, and family. The research process and outcomes, which are still unfolding, helped instill a sense of hope that social services for children and families would improve. Going through the research process validated the complexity of conducting

culturally sensitive research. The larger research goal attempts to translate in both directions integrating local knowledge, perspectives, and practice to help inform U.S. majority research and translate assessments and treatments to a Mexican context.

Social Constructionism and Feminism

In addition to the primary cultural ecological framework, the theoretical models of social constructionism and feminism were used to conceptualize the impact of trauma on parent-child relationships in this dissertation study. From a social constructionism perspective, “reality” is based on the interpretive act of meaning-generation that is co-created through interactions and conversations with others and is influenced by the larger sociocultural and historical context (Gergen, 1985). The feminist perspective adds a political dimension to the social construction of “reality” raising awareness about systems of privilege and oppression with a particular emphasis on gender inequalities (Withers Osmond & Thorne, 1993). Discourse, language, and text are powerful tools to privilege particular realities and marginalize others (Miller & Wieling, 2002). As with other societal systems, families also replicate dominant value systems and ideologies within the home and participate in the oppression of others. Because systemic processes are not free of gender, culture or class, it is necessary to deconstruct dominant narratives of normality in order to validate marginalized voices and experiences.

Bracken (2001) contends that concern with trauma is a cultural event that has been constructed over time through particular practices, technologies, and narratives. There is no objective entity of PTSD in space waiting to be discovered. Rather, the concept of PTSD was socially created through the diagnosis, study, treatment, and

representation of trauma by various constituencies and interests. Culture is viewed as separate from the individual and social and cultural contexts are considered to be outside factors that either impede or accelerate the recovery process. This researcher argues that reaction to trauma is a culturally embedded phenomenon and that emotional states are not expressed universally across cultures. Therefore, it is necessary to understand the social and cultural context before and after a traumatic event in order to understand the impact of the trauma on the individual, family, and community.

Role of the researcher. Consistent with the tenets of social constructionism and feminism, this researcher believes it is necessary to be transparent about her beliefs and assumptions as an Asian American woman conducting research in Mexico and completing her doctorate degree at a U.S. university. Within the context of this academic setting, third person voice is being used throughout the entire dissertation even though it seemingly conflicts with the social constructionist/feminist perspective. At the same time working within the guidelines of traditional scholarship takes the local cultural context of academia into consideration, which is consistent with the researcher's perspective.

While conducting research in Mexico, the researcher was aware of bringing her value orientation of social justice to the project and was careful not to regard her experiences as an objective understanding of participants' experiences in Mexico. As a cultural outsider, the researcher was concerned with the process issues of credibility and giving back to the local community. At the level of training and supervision, it was important to build trust with Mexico research team members, assessors/interviewers, and data personnel in order to build credibility with study participants. They had to believe in

the importance of the research and trust in the U.S. research team to have an accurate understanding of Mexican culture and local issues in Monterrey. Since the researcher already had several years of relationship with CIFAC spending a considerable amount of time in Monterrey, it is her belief that she was perceived as credible.

Giving back to the community was also an important issue for the researcher in terms of her feminist beliefs in social justice for marginalized groups. Research occurs within the context of the distribution of power within a particular society. Since most societies have a hierarchical organizational structure with power differentials between certain groups of people, there is potential for one group to exploit another. Frequently, researchers will conduct studies within culturally diverse communities; gather their data, and disseminate the information without regard for accuracy or cultural issues. In many cases, there is also no return investment given to the communities leading these communities to feel betrayed.

In the larger assessment protocol pilot study, several measures were taken to ensure the safety of participants and great efforts were made to privilege their voices as experts of their experiences with trauma. More information about these efforts is included in the Methods chapter of this paper. Additionally, care was taken to avoid oppressive practices with Mexico researchers, clinicians, staff and personnel. For example, credit has been and will continue to be given to all of the research collaborators on all publications resulting from the project. On a personal level, the present researcher committed to continuing her collaboration with CIFAC offering her support of the organization in any capacity, beyond the assessment protocol pilot study.

Chapter II: Literature Review

There is a large body of knowledge about the epidemiology of traumatic stressors and PTSD in the general U.S. population from research databases such as the National Comorbidity Survey (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995) and large-scale epidemiological studies (e.g., Norris, 1992). These studies cover a spectrum of traumatic stressors from single-incident traumas such as motor vehicle accidents and person made and natural disasters, to recurring violence in the home and in the community. In comparison to the available trauma-related literature in the U.S., epidemiological data about traumatic exposure and PTSD prevalence in other countries is more limited, especially in developing countries. Although exposure to trauma is a common occurrence for many people, the development of PTSD in response to experiencing a traumatic event is more rare (Keane, Marshall, & Taft, 2006).

Epidemiology of Psychological Trauma and PTSD

PTSD prevalence adults. Prevalence rates of lifetime exposure to any potentially traumatic event range from 55% to 90% in the general U.S. adult population previously exposed to trauma (Norris et al., 2003). Common traumatic event types experienced by adults are sexual violence and other forms of interpersonal violence, followed by natural disasters and other types of non-intentional trauma. Kessler and colleagues (2005) recently replicated the results from the National Comorbidity Survey (Kessler et al., 1995) and found the same PTSD prevalence of 6.8% in a general population of U.S. adults with significantly higher rates for women than men (10.4% and 5%, respectively; Kessler et al., 1995). Reported PTSD prevalence following large-scale disasters has

ranged from 2.7% to 11.2% depending upon proximity to the trauma (Schlenger et al., 2002).

There is wide variation in prevalence rates of PTSD in different parts of the world. Reported estimates for adult populations have been as low as 0.6% in Iceland (no men met criteria; Lindal & Stefansson, 1993), 1.5% in the general population in Australia, and 5.4% within a sample of Australian Gulf War I veterans (Creamer, Burgess, & McFarlane, 2001; Rosenman, 2002). PTSD prevalence in economically disadvantaged countries tends to be much higher compared to developed countries. The majority of the research within developing countries has been with populations affected by war, terrorism, and violence. For example, the reported estimate of 18.6% in Sarajevo (Rosner, Paul, & Butollo, 2003) and 20.4% in Afghanistan (Scholte et al., 2004) are considerably higher than what has previously been documented in the U.S. and other industrialized countries.

PTSD prevalence in youth. Large-scale epidemiological studies with youth are minimal compared to the adult trauma literature. Lifetime exposure to any potentially traumatic event in U.S. children has been estimated to be anywhere between 43% (Giaconia, Reinherz, Silverman, Pakiz, Frost, & Cohen (1994) to 81% (Weine, Becker, Levy, Edell, & McGlashen (1997). Estimates of exposure to trauma in children and adolescents vary significantly depending upon the type of traumatic event and the chronicity of the trauma. For example, McDermott, Lee, Judd, and Gibbon (2005) reported a PTSD prevalence of 7% in a sample of children exposed to a wildfire. Studies with U.S. children and adolescents exposed to trauma resulting from physical and sexual

abuse, neglect, witnessing interpersonal violence, and community violence fall within the range of 3-56% (e.g., Graham-Bermann & Levendoskay, 1998; Lehmann, 1997; Margolin & Vickerman, 2007).

Youth lifetime trauma exposure in other countries appears to be on the higher end of what has been documented in U.S. samples. For example, Suliman, Kaminer, & Seedat, (2005) reported that 40-100% of South African youth were exposed to any traumatic event during their lifetime. Another study conducted by Catani and colleagues (2009) demonstrated a 51% prevalence rate in children exposed to war trauma and family violence in Afghanistan. Higher estimates of 82.4% were found in a sample of Tamil children exposed to war-related trauma in Sri Lanka (82.4%; Catani, Jacob, Schauer, Kohila, & Neuner, 2008) and 92% in a sample of youth exposed to the 1988 earthquake in Armenia (Pynoos et al., 1993).

Risk Factors for PTSD in Children

The identification of specific risk factors for the development of PTSD in children and adolescents aids with identifying which children are at greater risk for this disorder; it also allows for early intervention necessary for preventing problems from becoming more chronic (Trickey et al., 2012). Having a better understanding about potential predictors of PTSD may lead to better youth outcomes as more knowledge is gained about which individuals are more vulnerable to psychological consequences of traumatic stress as well as protective factors that ameliorate the negative effects of trauma exposure (Udwin, Boyle, Bolton, & O’Ryan, 2000). This information can be used to help inform assessment, prevention, and intervention efforts. Previously identified risk factors in the

child trauma literature have fallen into three broad categories: pretrauma variables, trauma-related variables, and posttrauma recovery (Cox, Kenardy, & Hendrikz, 2008).

Pretrauma factors. Pretrauma variables include demographics; emotional and behavioral problems (pretrauma psychopathology); exposure to prior trauma and adverse life experiences; multi-problem and isolated families; and low socioeconomic status (Cox et al., 2008). Past research findings about the impact of these variables on the development of PTSD is inconsistent. Some of the most frequently studied demographic characteristics are age, gender, and ethnicity. There have been discrepancies regarding age as both a significant and non-significant variable (Foy, Madvig, Pynoos, & Camilleri, 1996) as well as whether younger children (Graham-Bermann et al., 2006) or older children (Levendosky, Huth-Bocks, Semel, & Shapiro, 2002) are at greater risk for psychopathology related to trauma.

Female gender has frequently been linked to increased risk for PTSD (e.g., Cauffman, Feldman, Waterman, & Steiner, 1998; Udwin et al., 2000) particularly with children who have been sexually abused (Davis & Siegel, 2000). This has been explained by the tendency of females to internalize psychological distress leading to higher rates of mood and anxiety symptoms, whereas males are more likely to exhibit externalizing symptoms (Pine & Cohen, 2002; Udwin, Boyle, Yule, Bolton, & O’Ryan, 2000). Additionally, female children may experience more extreme acute reactions to a traumatic event than males (Pine & Cohen, 2002). Although sex differences are generally assumed, other studies have shown that gender had no effect on the development of PTSD in children (e.g., De Vries, Kassam-Adams, Cnaan, & Sherman-Slate, 1999). With

regards to racial/ethnic differences some studies have demonstrated higher levels of PTSD symptoms in African American and Hispanic children compared to white and Asian American children (La Greca et al., 1996) while other studies have reported fewer symptoms for racial/ethnic minorities (Foy, Madvig, Pynoos, & Camilleri, 1996; O'Keefe, 1994).

The impact of prior exposure to trauma has been linked to child outcomes and previous traumas may increase children's vulnerability or resilience after exposure to a traumatic event; however, the exact mechanism of how prior life experiences and preexisting mental health impact child psychopathology posttrauma is still being explored (Cox et al., 2008; Foy et al., 1996; Trickey et al., 2012). Research studies investigating the effects of preexisting psychological difficulties on PTSD symptomatology after exposure to a traumatic event are limited. Within the limited available studies it has been suggested that children with prior physical, emotional (particularly anxiety), and behavioral difficulties; and who come from disorganized, chaotic, or isolated families are at increased risk for developing PTSD (La Greca et al., 1996; Lengua, Long, Smith, & Meltzoff, 2005; Udwin et al., 2000).

Socioeconomic status (SES) within itself is considered to be a "potentiation" factor where low SES indirectly affects negative outcomes in children through the characteristics of the neighborhood in which the child resides (Foy et al., 1996). Children living in poor urban neighborhoods would most likely be exposed to high rates of community violence thereby putting them at risk for the development of PTSD symptomatology. Foy, Madvig, Pynoos, and Camilleri (1996) discussed the role of

pretrauma factors in the development of PTSD as a possible interaction effect from previous exposure to trauma, which heightens emotional reactivity to the event; and as an independent effect of increased distress from the traumatic experience.

Trauma-related factors. Aspects related to the trauma itself include objective characteristics of trauma severity and degree of exposure to the event as well as subjective characteristics of the event. Subjective characteristics consist of perceived life threat and peritraumatic emotional response (e.g., fear, helplessness, horror, guilt, shame) and dissociation (e.g., altered sense of time, “blacking out,” feeling disconnected from one’s body) (Cox et al., 2008; Keane et al., 2006; Tricky et al., 2012). Both objective and subjective trauma characteristics have consistently been associated with PTSD symptoms (Foy et al., 1996; Pine & Cohen, 2002). The correlation between level of exposure to acutely dangerous events and PTSD symptom severity (i.e., dose-effect) has been supported in studies across most types of trauma including physical and sexual abuse (Pine & Cohen, 2002). However, some researchers have questioned the appropriateness of the subjective criteria given the difficulties in assessing these symptoms in young children (Scheeringa et al., 2003). Closer proximity to the traumatic event as a risk factor for PTSD symptoms in children has also been demonstrated in several studies (e.g., Pynoos, 1993; Pynoos et al., 1987).

The involvement of a family member or close friend in the trauma is another variable that has been associated with increased child psychopathology posttrauma. Results of these studies have been mixed. For example, after the Oklahoma City bombing children who had a family member injured or killed in the bombing had higher levels of

PTSD symptoms (Pfefferbaum, Nixon, & Krug, 1999). Mirza, Bhadrinath, Goodyer, and Gilmour (1998) came to the opposite conclusion in their study with children and adolescents exposed to road traffic accidents, and family or friend involvement in the trauma had no effect on child outcomes.

Posttrauma factors. Posttrauma factors are comprised of individual child characteristics and a child's immediate psychological and social environment. The most common individual factors that have been examined as potential risk factors for PTSD are comorbid disorders, acute posttraumatic stress symptoms, and coping styles. A few studies have also investigated the effects of cognitive (Meiser-Stedman, 2002) and biological systems (De Bellis et al., 1999). No consistent patterns about these individual characteristics have been identified (Cox et al., 2008).

Social support and extrinsic factors have consistently been associated with mental health outcomes for children, especially parental support which has been shown to be one of the most important variables related to child outcome (Allwood, Bell-Dolan, & Husain, 2002; Cox et al., 2008; Pine & Cohen, 2002; Trickey et al., 2012). Parental and family functioning may moderate the impact of a traumatic event on children by serving as proximal reminders and secondary stressors of the trauma (Pynoos et al., 2007). A positive association has been found between PTSD symptoms of the child and the parent (Bryce, Walker, Ghorayeb, & Kanj, 1989; Foy et al., 1996) and parents' reactive behavior after a traumatic event may be more critical to child adjustment than direct exposure to the event (Cox et al., 2008, p. 100).

Meta-analyses. Two recent meta-analyses exploring risk factors for PTSD in children and adolescents have been completed that shed some light on the inconsistencies found in previous studies. In the first and only systematic meta-analysis with children exposed to accidental trauma, Cox and colleagues (2008) reviewed a total of 14 studies from 1980 (first formal diagnostic criteria) to 2005. The sample sizes of the studies ranged from 40-158 with children between 5-18 years old. The researchers examined the strength and predictive power of eight risk factors of which five of the variables had robust findings: female gender, pretrauma psychopathology, perceived threat to life, exposure to prior trauma, and posttrauma parental distress.

Comparisons of the risk factors indicated that pretrauma psychological problems and threat to life had the best performance and consistency across various statistical analyses. The researchers speculated that emotional and behavioral problems put children at greater risk for accidental injury and continued to negatively influence their ability to cope and recover from the traumatic event. Given the unexpected and uncontrollable nature of an accident, a child may be prone to learned helplessness thereby impairing the child's view of the world as a safe and secure place creating feelings of vulnerability and fear. In comparison, female gender had a weaker association to child outcome, but the relationship was relatively consistent.

Posttrauma parental distress on the other hand, had a relatively strong and robust relationship with child PTSD diagnosis. Cox and colleagues (2008) hypothesized that the modeling of maladaptive and avoidant coping strategies of the parent would negatively impact a child's adaptive functioning. Moreover, parents would have less effective

parenting skills and decreased ability to provide monitoring and support for the child's needs. The focus on accidental traumatic events limited the generalizability of the findings to other types of trauma and ages. Additionally, the sample size and number of risk factors assessed were small.

Trickey and colleagues (2012) conducted a more comprehensive meta-analysis with a broad range of trauma types. The researchers examined 64 studies from 1980 to 2009 with a total sample size of 32,238 participants between the ages of 6-18 years old. Twenty-five risk factors were identified as potential predictors of child PTSD in two or more previous studies; however, only six of these factors were routinely examined in 10 or more studies. Younger age was found to be non-significant to the development of PTSD indicating that overall younger age was for the most part unrelated to PTSD. Race/ethnicity was examined in five of the 25 studies and was found to have a consistent, but small effect on child psychopathology. The researchers noted that ethnicity was coded as a dichotomous variable (white vs. black or minority ethnic), which might have concealed any differences amongst minority ethnic groups. Female gender also had a consistent, but small effect predicting child PTSD symptomatology suggesting that focusing on gender differences in screening efforts may not be necessary. Other pretrauma factors of emotional and behavioral problems, life events, and parent psychological distress showed small to medium effect sizes as predictors of PTSD.

Of the trauma-related variables, trauma severity had the strongest association with child PTSD. Subjective trauma-related variables had large effects, but were assessed in only a small number of studies. There were also large effect sizes for posttrauma

individual factors of the child including comorbid disorders, distraction, PTSD at time 1, and thought suppression. External posttrauma factors varied in strength with life events and parental psychological distress showing small to medium effect sizes; and low social support, poor family functioning, and social withdrawal having medium to large effect sizes. The relationship between parental psychological distress and the development of child PTSD was more common across studies, but poor family functioning was a stronger risk factor. Trickey and colleagues (2012) concluded that PTSD in children and adolescents is primarily a result of a reaction to the specific event. The researchers suggested that resources are better invested in children's recovery environment rather than focusing on younger children at the expense of adolescents or demographic and other pretrauma factors that are only weakly linked to the development of PTSD.

Summary of risk factors. Inconsistencies across research studies examining risk factors for child PTSD and traumatic stress can be explained by a variety of factors including definition of the outcome, type and severity of the stressor, methodological issues, small and non-representative samples, demographics, the use of non-standardized measures, and length of follow-up (Pine & Cohen, 2002; Udwin et al., 2000). As a whole, it appears that posttrauma factors play a more important role in the development of child psychopathology after exposure to trauma. Living in a recovery environment that is characterized by high levels of chaos, disorganization, and disruption combined with parental/caregiver psychological distress may elevate the risk for PTSD and/or exacerbate on-going disorders (Pine & Cohen, 2002).

Interpersonal Violence

Pine and Cohen (2002) stated that the degree of trauma exposure seems to increase the risk for developing PTSD for children who are exposed to particularly high levels of trauma. Children living in environments where they are victims of and are witnesses to on-going violence in their homes and communities are exposed to extremely high levels of trauma. Compared to non-interpersonal traumatic events (e.g., natural disasters, car accidents), interpersonal trauma such as rape, torture, and abuse put children at greater risk for developing PTSD (Hunt, Martens, & Belcher, 2011). Children's exposure to multiple types and incidences of interpersonal violence is an important consideration in the risk of developing PTSD. In their review of PTSD/child witness literature, Lehman (2000) evaluated 28 studies within the time period of 1980-1999 to determine risk factors that influenced child PTSD symptomatology. The average sample size of studies was 71 with children between the ages of 8 months to 9 years. Findings from the review indicated that 85% of the children had prior histories of exposure to multiple traumatization including being physically and sexually abused, witnessing mother-assault, witnessing community violence (e.g., shootings, muggings), and being exposed to war.

A Relational Perspective of Trauma

It is well established in the literature about childhood traumatic stress that the parent-child relationship is instrumental for the social and emotional well-being of the child (e.g., Cicchetti & Toth, 1995; Gewirtz, Foratch, & Wieling, 2008; Scheeringa & Zeanah, 2001). Attachment theory (Bowlby, 1969, 1973, 1980) has been widely applied

in studies of parent and child adjustment after traumatic events (Scheeringa & Zeanah, 2001) as well as within the child maltreatment literature (Cicchetti & Toth, 1995). The basic premise of this framework is that early experiences in the quality of attachment to the primary caregiver contribute to the development of an internal working model of attachment bonds that influences the parent-child relationship as well as future intimate relationships with others. Infants are born without the ability to self-regulate their emotions and learn how to do this through the development of an attachment bond with their primary caregiver.

According to de Zulueta (2006), PTSD and other forms of trauma can be perceived as a manifestation of a disrupted attachment system. Attachment behavior is triggered by fear and most infants are predisposed to seek out an attachment figure when the infant feels threatened. The internal working model of a child develops over time, with repeated experiences with the caregiver about their physical and emotional availability during times of stress (de Zulueta, 2006). Children either have secure or insecure attachments to their primary caregiver. Securely attached relationships are characterized by caregiver accessibility and responsiveness to the child's needs, and the appropriate emotional expression of responses. Insecure attachments occur when caregiver behaviors are unresponsive during times of need. In this case, the child does not have an internal working model of responsive caregiver behavior and develops different survival strategies (de Zulueta, 2006).

Patterns of parent-child relationships. Ainsworth, Blehar, Waters, and Wall (1978) described three types of insecure attachment behaviors: anxious-ambivalent

response, avoidant response, and disorganized response. Similarities have been drawn between disrupted attachment relationships and PTSD symptomatology of hyperarousal and dissociation (de Zulueta, 2006), particularly with the disorganized attachment behavior. In situations where the child feels helpless (fear without a solution) and the flight-flight response is not possible, the child “freezes” and flees inward (i.e., dissociative response). Since infants are completely dependent upon the primary caregiver, the security of the caregiver-child attachment bond is the primary defense against traumatic stress.

Scheeringa and Zeanah (2001) created the construct *relational PTSD* to describe cases where both the parent and child are traumatized and the symptomatology of each partner exacerbates that of the other, depicting three specific patterns of parent-child relationships. In the *withdrawn/unresponsive/unavailable* pattern, the parent is emotionally and functionally unavailable to the child, occurring most often when mothers have previously suffered trauma and the child’s trauma stirs up painful memories and emotions they would rather avoid them (Appleyard & Osofsky, 2003; Scheeringa & Zeanah, 2001). The *overprotective/constricting* pattern may occur when the parent feels guilty about not protecting the child during a traumatic event, although a parent may exhibit constricting and overprotective behavior having experienced the same traumatic event as the child. In this case, the parent is preoccupied by the fear that the child may be traumatized again. In the *reenacting/endangering/frightening*, the parent may unconsciously re-traumatize the child by repeatedly asking questions or placing the child in situations where more traumas are likely to occur. Instead of avoidance, the parent

becomes preoccupied by reminders of the trauma, unable to censor statement or behaviors to protect the child.

Parent-child interactions. When violence occurs in the home there is no escape from the daily threat and reminders of previous frightening incidents and there is no safe base that the child can rely on (Margolin & Vickerman, 2007). PTSD symptoms are more likely to occur when a trusted individual causes the traumatic event and when the victim is a loved one. Therefore, the intensity of children's response to the trauma may be heightened if they are victims of threatened or actual injury by a parent/caregiver or witness violence toward the other parent or a sibling. From an attachment perspective, children are stuck in a paradoxical situation where the caregiver is a source of comfort and safety and at the same time is a source of danger and fear, which may lead to disorganized attachment of the child to the parent/caregiver.

In addition to considering the subjective experiences of the parent and child after a traumatic event, it is also important to consider the effects of the trauma on parent-child interactions. Distorted mental representations of attachment with caregivers have enduring effects throughout the child's life, also generalizing to new relationships (Cicchetti & Toth, 1995). Several researchers have recognized the importance of a multidisciplinary and multisystemic approach to assessing and treating traumatized children and families, with coordinated services at the individual parent and child level, in addition to the parent-child dyadic-level (Appleyard & Osofsky, 2003; Cicchetti & Toth, 1995). For example, interventions such as play therapy can be used to enhance parent-child interactions and help the dyad create a joint narrative of the traumatic event

together, thus altering distorted internal representational models of the parent-child relationship.

Parent-child functioning posttrauma. Most of the studies examining parent and child adaptation following traumatic stress focus on maternal factors associated with children's psychosocial adjustment (Cicchetti & Toth, 1995). For instance, Deblinger, Steer and Lippmann (1999) examined maternal distress and parenting style and their effects on child psychosocial adjustment with 100 sexually abused children aged 7-13 years who had been referred to a children's support center in New Jersey. The majority of the sample population was white (70%), with 21% blacks, 7% Hispanics, and 2% others. Mothers and children were given an assessment battery with five standardized child instruments and three standardized parent instruments. Multiple regression analyses revealed maternal factors of increased depressive symptomatology and more intrusive and controlling parenting practices were positively associated with child PTSD symptoms, which is consistent with the literature about the critical influence of parents on children's adaptive functioning after experiencing an adverse event (e.g., Cicchetti & Toth, 1995; Gewirtz et al., 2008).

Deblinger, Steer and Lippmann (1999) discussed the bidirectional influence of these findings that depressed mothers' interactions with their children may somehow produce increased child symptomatology, or their children's high levels of distress may contribute to increased distress in their mothers. With regards to parenting strategies, maternal use of guilt and anxiety-provoking parenting methods may serve to increase acting out behaviors in their children instead of reducing problem behaviors.

Alternatively, mothers may resort to guilt- or anxiety- provoking parenting strategies out of frustration from trying to manage high levels of PTSD and/or externalizing behaviors in their children.

In their review of 17 studies examining the impact of trauma on parent and child adjustment, Scheeringa and Zeanah (2001) found a significant association between parent variables and children's adaptive functioning following traumas with poorer parental and family adjustment leading to worse child outcomes. The studies included a range of traumas including acute single event traumas such as the bombing of the World Trade Center, mass trauma due to war, and chronic traumas of child maltreatment and domestic violence. In order to be included in the review, children had to have been exposed to *DSM-IV*-level trauma, the parent and child were assessed at the same time, and standardized measures were used to assess parent and child functioning.

A wide variety of assessments were used across the studies providing strong support for the finding that the parent-child relationship is of critical importance in adaptive child functioning posttrauma. Examples of parent/family variables associated with poorer child outcomes were: increased number of PTSD symptoms; more anxiety following the event; increased family chaos and less family cohesion; less supportiveness of the child; perceived as rejecting, inducing guilt and anxiety, and denial/suppression of the child's symptoms; and maternal history of mental illness (Scheeringa & Zeanah, 2001). The most specific parental variable predicting worse child outcome was maternal avoidance of symptoms.

Findings from the few studies about the quality of parent-child relationships with fathers is consistent with the literature about mothers, pointing to parental factors of avoidance and emotional numbing as the greatest predictor of poor child outcomes (Lauterbach et al., 2007). For example, Sampler, Taft, King, and King (2004) examined the relationship between PTSD and parenting satisfaction in 250 male Vietnam War veterans sampled from the National Vietnam Veterans Readjustment Study. The majority of the participants were Caucasian (78%), 32% self-defined as Latin/Hispanic, and 22% African American. Participants were given several standardized instruments to assess for the following: major depression and alcohol abuse/dependence, partner violence, PTSD symptom, and parenting satisfaction. Multiple regression analyses were conducted to determine the associations between PTSD scores and parenting satisfaction, consequently showing that avoidance and emotional numbing had the strongest relationship with parenting satisfaction. This association remained after controlling for the other variables of major depression, alcohol abuse/dependence, and partner violence.

In another more recent study with men and women, Lauterbach and colleagues (2007) assessed the impact of trauma on parent-child relationships using data from the National Comorbidity Survey of 8,098 non-institutionalized adults between the ages of 15-54 years. Only adults who met criteria for PTSD resulting from a range of traumas and also had children were included in the study, resulting in 105 men and 218 women ($n = 323$). The researchers conducted regression analyses to determine univariate predictors of the relationship between the presence or absence of PTSD and parent-child relationship quality/aggression; the relationship between support, PTSD symptoms and

quality of parent-child relationship; and the relationship between work/finances, PTSD symptoms, and quality of parent-child relationships. Somewhat inconsistent with previous studies with fathers, the researchers found that numbing was predictive of parent-child conflict, but not relationship quality. One possible explanation for this finding is the combined sample of men and women. Women reported better parent-child relationships, which may have diluted the effects for men.

Cross-Cultural Studies

Given the importance of sociocultural factors in helping to shape individuals' psychobiosocial development, it is imperative that more cross-cultural research is done to determine the similarities and differences in the etiology and consequences of trauma across culturally diverse populations (Cicchetti & Toth, 1995). The meaning and function of certain psychological symptoms may be different based on a community's ideology, beliefs, and values, therefore the presence and intensity of trauma symptomatology should be interpreted within the local context, which includes the current socio-political milieu (Moscardino, Axia, Scrimin, & Capello, 2007). Some cultures may be more permissive than others in tolerating mistreatment of vulnerable groups and the social and legal climate may affect perceptions and reporting of violence (Díaz-Olvarreita, Ellertson, Pax, Ponce de Leon, & Alarcon-Segovia, 2002).

Racial/ethnic minorities in the U.S. The majority of the studies are with Euro-American whites and the studies that have included racial/ethnic minorities have focused on group differences between African American and white children. Although findings from these studies have been mixed, more studies report lower PTSD incidence rates for

racial/minority children. For example, Graham-Bermann, DeVoe, Mattis, Lynch, and Thomas (2006) examined the association between poverty and social support and child PTSD symptomatology with 218 children ages 5-13 years and their mothers in an urban setting. About half of the children were white (52%) and the other half were primarily African American or bi-racial (44%). The prevalence of PTSD in African American children was 17% compared to 33% in white children. In the examination of group differences, white mother's depression was the strongest predictor of the child's level of traumatic stress whereas African American mother's self-esteem was most predictive of child outcome. The researchers discussed the importance of considering the cultural context for understanding the effects of potential risk and protective factors for the development of PTSD pointing to greater maternal support as well as other social support networks (e.g., friends, religion, church, other community activities).

Only one study was identified that focused solely on a non-white sample of children. Hunt, Martens, and Belcher (2011) examined the rate of PTSD symptomatology in a sample of 257 African American youth exposed to child maltreatment and community violence and received treatment at an urban mental health center between 2004-2007. The average age of participants was 11.7 years ($SD = 2.5$). Children completed the Trauma Symptoms Checklist for Children and the UCLA PTSD Index for the *DSM-IV*. Parent/caregiver reports of this instrument were also completed. Regression analyses were conducted to determine the association between PTSD and several risk factors including parent history of mental illness, parent history of substance abuse, child trauma exposure, and child/caregiver demographics of age and gender.

Findings from the study indicated that child exposure to physical abuse, domestic violence, and community violence was significantly associated with PTSD symptoms. Community violence was the only risk factor that was associated with the development of PTSD on both measures. Female gender and physical abuse were associated with increased symptomatology, but age was non-significant. Child PTSD incidence rate of 16% in this sample of African American children was lower than reported rates from other studies. The researchers speculated that African American children might employ different emotional coping strategies for managing stress than other children as a result of strong relationship bonds within their families (including extended family members) and peer group, which may act as protective factors against PTSD.

Studies in developing countries. According to Keane and colleagues (2006), only 6% of PTSD prevalence studies are conducted in developing countries. This is a major concern because these populations appear to be at increased risk for experiencing trauma. For example, de Jong and colleagues (2001) conducted an epidemiological survey with adult survivors of armed conflict, refugees, and displaced persons in four different post-conflict, low-income areas: Algeria ($N = 653$), Cambodia ($N = 201$), Ethiopia ($N = 1,200$), and Gaza ($N = 585$). An adapted version of the Life Events and Social History Questionnaire was used to assess the frequency and type of adverse events throughout the lifespan of the war survivor from birth to present. The PTSD section of the World Health Organization's Composite International Diagnostic Interview (CIDI) was used to determine PTSD prevalence. Lifetime traumatic events were categorized into seven groups: torture, youth domestic stress before age 12, death or separation within the

family before age 12), conflict-related events before and after age 12, history of psychiatric illness, health events, and current events.

The most common traumatic life events experienced by individuals were poor health, conflict after age 12 years, and poor quality of camp. PTSD prevalence rates were highest in Algeria (37%), 28 % in Cambodia, 18% in Gaza, and 16% in Ethiopia. More respondents in Ethiopia reported being exposed to torture (26%) compared to 15% in Gaza, 9.0% in Cambodia, and 8.4% in Algeria. The researchers explained the range of PTSD prevalence rates across countries as a function of the different compositions of multiple traumas experienced. Contrary to findings in the U.S. about gender differences in PTSD prevalence, females in Ethiopia had equal rates to men and less PTSD symptoms than men in Gaza. This was explained by the fact that males in both sample groups were at higher risk for exposure to trauma since many men were either former soldiers or participated in riots. Although the study did not provide nationally representative data for these countries, information gained from the study contributes to the international literature about the prevalence of trauma and PTSD in areas affected by conflict. The researchers concluded that the determinants and prevalence of PTSD varied depending on the context.

In another study with youth, Laor and colleagues (1997) conducted a follow-up study with Israeli preschoolers and their mothers under scud missile attacks during the Persian Gulf War. The researchers examined the relationship between mother response to the traumatic event and child symptoms 30-months posttrauma. The sample included 107 preschool children and their mothers from the original sample of 230, divided into two

groups of displaced ($n = 51$) where families' homes were destroyed and they moved into hotels; and a control group of non-displaced ($n = 56$) families residing in the same area as the displaced families, but their houses remained intact. Several standardized instruments were used to measure child and mother behaviors and functioning, persistent stress reaction, PTSD symptomatology, family functioning, and environmental factors.

Taken as a whole, the researchers concluded that this combination of cultural, social, physical, familial, and personal variables that help regulate stress responses make up a protective matrix for the child, of which the mother's buffering function is an integral component (Laor et al., 1997). In comparison to the non-displaced group, displaced children continued to show increased levels of stress symptomatology and reported more severe PTSD symptoms; however, the findings were not statistically significant. Displaced mothers, on the other hand, continued to display high levels of stress symptomatology. The most significant finding from the study was that child PTSD symptoms was strongly correlated with mothers' avoidant symptoms and emotional numbing, which may undermine their capacity to buffer stressful environmental stimuli for their children.

Trauma and PTSD in Mexico

Socioeconomic and sociocultural context. Poverty is pervasive throughout Mexico negatively influencing peoples' lives in many ways. Norris and colleagues (2003) identified several risk factors associated with poor countries including crowded and sub-standard housing; physically demanding and dangerous work; lack of access to medical and professional care; and enhanced power differentials between rich and poor, adults

and children, and men and women. Many Mexican women and children in particular live in impoverished conditions, which may affect their abilities to cope with traumatic stressors. Mexican females may also be at greater risk for PTSD symptomatology as a result of living in a culture that fosters traditional gender roles such that experiences with discrimination and oppression within society diminishes women's capacity to adaptively cope with trauma (Baker et al., 2005; Norris et al., 2003).

Gender role socialization might also influence sex differences in PTSD prevalence and the manifestation of symptoms. Mexican men spend more time outside of the home than women and are therefore more likely to be exposed to physically violent acts in the streets or other public places whereas women tend to experience more violence within the home. As a consequence of spending more of their time in public places, men are also more frequently exposed to trauma compared to women; however the impact of trauma seems to be more intense for women as they are more likely to be diagnosed with PTSD than men (Norris et al., 2003). A possible explanation for higher rates of PTSD in women might be related to traditional gender role socialization that promotes emotional expression in females, but inhibits it in males. Concepts such as helplessness and emotional distress may be more dissonant with Mexican men's self-concepts compared to women as well as men in the U.S. (Baker et al., 2005; Norris et al., 2003).

PTSD prevalence in Mexican adults. National data about PTSD prevalence in Mexico is minimal. Recent reports of lifetime exposure to traumatic events for the general adult population indicate a prevalence rate of 68%, which is consistent with U.S. estimates. Findings from the few known studies are inconsistent with reported PTSD

rates of 1.5% to 2.6% according to the *DSM-IV* and ICD-10 criteria, to 11.5% of the general population experiencing at least one lifetime event that met criteria for violence-related PTSD (Orozco, Borges, Benjet, Medina-Mora, & López-Carillo, 2007).

Norris and colleagues (2003) conducted one of the few large-scale epidemiological studies of trauma in Mexico in the general population. The sample consisted of 2,509 adults (1,602 women; 907 men) between the ages of 18 to 92 from four cities: Oaxaca ($n = 576$), Guadalajara ($n = 713$), Hermosillo ($n = 602$), and Mérida ($n = 602$). The Spanish PTSD module of Version 2.1 of the Composite International Diagnostic Interview developed by the World Health Organization was used to determine PTSD prevalence. The researchers found that 76% of the population experienced at least one traumatic event during their lifetime of which 70% were exposed to four or more events. The most common events were traumatic bereavement of losing of a loved one from homicide, suicide, or accident; witnessing someone injured or killed; life-threatening accidents; and physical assault. Lifetime prevalence was higher for men than women (83% and 71%, respectively).

The overall estimate of PTSD in this population was 11.2% with 7% meeting the criteria for chronic PTSD (Norris et al., 2003). This is a higher rate than the national U.S. estimate of 8%, supporting the research hypothesis that impoverished economic conditions would be associated with higher PTSD prevalence. Moreover, estimates varied in predictable ways across cities with the highest rates of PTSD in Oaxaca (17%), the poorest city from the total sample population. Women were more than twice as likely to meet criteria for PTSD as men (15% and 7%, respectively), providing support for the

hypothesis of pronounced gender differences in Mexico. However, this finding is consistent with U.S. prevalence rates for men and women making it difficult to come to any conclusions about gender differences in Mexico compared to the U.S.

In a follow-up study to the Norris and colleagues (2003) epidemiological study, Baker and colleagues (2005) solely focused on interpersonal violence within the home and community. The researchers evaluated lifetime prevalence exposure to four types of violence: sexual assault, sexual molestation, physical assault, and threatened with a weapon. The variables of recurrence (single incident or repeated), age at occurrence (childhood < 12 years, adolescence ages 12-15, adulthood > 15 years) and relationship context (stranger, intimate partner, family, friend, and acquaintances) were analyzed to determine their association with the different types of violence. Overall rates of exposure indicated that 34% of the sample reported experiencing at least one of the four types of violence during their lives and 11.5% met diagnostic criteria for PTSD.

The researchers found a similar pattern of gender differences to findings from other studies in the U.S. and Canada. Compared to women, men were more likely to experience physical assault (single-incident and recurrent); violence in adolescence and adulthood; and non-domestic violence within the community perpetuated by friends, acquaintances, and strangers (Baker et al., 2005). In contrast, only women reported exposure to intimate partner violence and were more likely to report experiences with sexual assault, violence during childhood, and family violence. Women also had higher PTSD incidence rates than men. Baker and colleagues (2005) noted that although the direction of association between gender and PTSD diagnosis for this sample was

consistent with previous studies, the rate of PTSD in Mexican women was more than five times greater than in men. Studies in U.S. and Canada have documented that women are about twice as likely as men to develop PTSD.

Díaz-Olvarreita and colleagues (2002) highlighted some common themes across studies related to exposure violence: women more frequently experience violence in the home and within families; perpetrators are typically men who have a close relationship with the woman; prior childhood abuse is associated with current abuse; and comorbidity of depression and substance abuse by either partner is common. The researchers examined these patterns within a sample of 1,780 female patients ages 15 and older being treated at outpatient clinics primarily in Mexico City. Four questionnaires were completed by study participants via mail: the Women's Health Questionnaire to determine the frequency and severity of current experiences with physical and sexual abuse; an alcohol abuse questionnaire (past and current); the Symptom Checklist-22 to assess for anxiety, depression, somatization, and low self-esteem; and a demographic questionnaire.

Current prevalence rates of physical and sexual abuse were similar to reported rates in the U.S. (8-12%) with 9% of women in this sample experiencing these types of violence. However, this estimate is lower than other studies with representative samples of Mexican women. Díaz-Olvarreita and colleagues (2002) hypothesized that this inconsistency may be accounted for by their exclusion of exposure to emotional abuse and the use of self-administered surveys, which tend to produce lower levels of reported violence compared to survey conducted by interviewing. The researchers also indicated

fear of reporting violence in severe cases of abuse as another possible explanation for lower incidence rates in the sample. Reported rates of substance abuse were 8% for the total sample and nearly twice as high for current victims of physical and/or sexual abuse (16%) and individuals with a history of violence (13%). History of abuse was also a strong predictor for current violence.

PTSD prevalence in Mexican youth. Epidemiological data about youth trauma and PTSD in Mexico is extremely limited and the few studies that exist are with adolescents. Pineda-Lucatero, Trujillo-Hernández, Millán-Guerrero, and Vásquez (2008) determined the prevalence and associated risk factors for child sexual abuse (CSA) in a sample of 1, 067 junior high school students from both urban and rural backgrounds. Two previously trained nurses administered a survey consisting of 11 questions to the adolescents during school that addressed various aspects of CSA including the relational context, single-incident versus recurrent, sexual abuse without physical contact, and sexual abuse with contact. Results from the study showed a prevalence rate of 18.7% for the total sample, which is similar to reported rates in other countries outside of the U.S. This finding may likely be higher given the tendency of underreporting of sexual abuse. Contrary to other international studies demonstrating higher incidences of CSA in females than males, there were no statistically significant gender differences in this sample. The aggressor was a relative for about one-third of the adolescents although this was slightly higher for girls than boys (37.3% and 31.7%, respectively). The majority (90%) of the experiences occurred between ages 5-10 and 75% of the cases involved direct physical contact.

Only one large-scale epidemiological study published in a U.S. scholarly journal was identified that examined the impact of PTSD on Mexican youth. Orozco, Borges, Benjet, Medina-Mora, and López-Carrillo (2007) conducted the first known representative study for adolescents in Mexico City using secondary data from the Mexican Adolescent Mental Health Survey with 3,005 youth (1,440 male; 1,565 female) aged 12-17 years residing within the metropolitan area. Prevalence rates were similar to estimates in the adult population with 69% of adolescents experiencing at least one lifetime traumatic event. In contrast, only 1.8% of the adolescents (2.4% females; 1.2% males) met criteria for PTSD, which is significantly less than U.S. estimates (6.3% females; 3.7% males).

The three most common event types within this sample were the unexpected death of a loved one, witnessing domestic violence, and being involved in a serious accident (Orozco et al., 2007). Consistent with findings from studies in the U.S. and other parts of the world, Orozco and colleagues (2007) reported rape/sexual assault as the most common traumatic event resulting in PTSD. The researchers caution that the prevalence rates are most likely underestimated since the sample included only Mexico City adolescents and was not representative of the entire country. Additionally, the youth were non-institutionalized residents and children and adolescents in government institutions may have more exposure to traumatic events.

Summary of Epidemiological Data

The majority of research about trauma and PTSD has been with adult populations in industrialized countries such as the U.S., Canada, and Europe. More studies are needed

with children and adolescents, especially with school-age children and younger children. There is great variation in reported rates of PTSD in youth across studies. This variation is accounted for by other factors aside from the traumatic event itself such as definitions of outcome, type and severity of the event, location, sample characteristics, different assessment methods, and length of time of assessment post-event (Pine & Cohen, 2002; Wickrama & Kaspar, 2007).

Economic hardship appears to be a significant ecological variable associated with negative responses to trauma and the development of PTSD. The effects of trauma in developing areas of the world is of great concern since these populations may be particularly susceptible to adverse outcomes due to poverty and lack of resources (Baker, Norris, Jones, & Murphy, 2009). Responses to traumatic stressors vary according to the type and number of events experienced. For example, in the study conducted by de Jong and colleagues (2001) more respondents in Ethiopia reported being exposed to torture (26%) compared to 15% in Gaza, 9.0% in Cambodia, and 8.4% in Algeria. Contextual factors such as socioeconomic and sociocultural conditions also influence how individuals react and respond to trauma.

More cross-cultural studies are needed in order to gain a better understanding about the nature of traumatic stress in other countries to determine the similarities and differences in the meaning and expression of trauma symptoms in different cultural contexts. Although much information can be gained from this type of comparative analysis between cultures (etic) it is equally important to gain a within-culture (emic) perspective to explore whether there is a different constellation of symptoms beyond the

traditional individually-based definition of trauma determined by the *DSM-IV* criteria for PTSD (Norris et al., 2001). This requires a multicultural, multidisciplinary, and multi-method approach using an integration of etic and emic perspectives.

Chapter III: Methods

In this study, the researcher uses data from a larger assessment protocol pilot study with the long-term vision of developing culturally informed assessment methodology and multi-component interventions that targets micro-to-macro level trauma contexts. As a whole, the assessment protocol is at different stages of piloting for cultural validation and development. The assessment battery is comprised of several quantitative measurements (for pilot and feasibility-only checks due to small *n*-size), qualitative interviews (grounded in phenomenology and ethnocultural traditions), and three structured-interaction-tasks designed to elicit psycho-socio-emotional and behavioral responses to trauma (based on observational work developed at the Oregon Social Learning Center with coercive parent-child relationships). An overview of the assessment protocol pilot and measures is provided in Appendix A.

The expected outcomes of the larger project are to develop a culturally-based, comprehensive assessment protocol that will be used as a foundation from which to inform future research in this area, and systemic interventions for traumatized populations. Results will not be complete until both the quantitative and qualitative data are analyzed. The focus of the current dissertation study is on a portion of the quantitative measurements and was not intended to stand-alone for implications for the development of systemic assessments and treatments traumatized populations.

Cross-Cultural Equivalence

Each of the quantitative instruments was examined for cross-cultural equivalence across five dimensions proposed by Flaherty et al. (1998): content, semantics, technical,

criterion, and conceptual (see Figure 1). The goal is to achieve equivalence across all five dimensions; however, the dimensions are not mutually exclusive and it is possible for a single item to be cross-culturally equivalent on some of the dimensions and not equivalent on others. It is important to note that it is rare for an instrument to have equivalency across all of these dimensions. The researchers acknowledge that this is an ideal standard of instrument development that is rarely achieved.

Figure 1. Taxonomy of issues in designing instruments for cross-cultural validation in psychiatric research. Adapted from “Developing Instruments for Cross Cultural Psychiatric Research,” by J. A. Flaherty, F. M. Gaviera, D. Pathak, T. Mitchell, R. Wintrob, J. A. Richman, and S. Birz, 1988, *The Journal of Nervous and Mental Disease*, 176(5), pp. 257-263. Copyright by J. A. Flaherty, F. M. Gaviera, D. Pathak, T. Mitchell, R. Wintrob, J. A. Richman, and S. Birz.

Focus of the Dissertation Study

In the current study, the researcher focuses on the comparative analysis of one portion of the assessment protocol, the trauma screening instruments and family violence measurements, to explore the relationship between child psychological trauma and mother-child relationships in Mexico. The sample consists of mother-child dyads where the child has a PTSD diagnosis and another sample that does not have this diagnosis. The primary purpose of this study was to gain an understanding of family (child and mother) exposure to traumatic stressors and related risk factors predicting child PTSD within a specific cultural and trauma context. Although the larger assessment protocol study used a combination of quantitative and qualitative measurements to provide both etic and emic perspectives, this dissertation study is focused on the outsider (etic) perspective.

There is a significant body of literature documenting the association between family factors (e.g., parental distress and poor functioning, ongoing family violence, disruptions in the home environment) and adverse child outcomes (Cox, Kenardy, & Hendrikz, 2008; Kearney et al., 2009; Pine & Cohen, 2002; Scheeringa & Zeanah, 2001; Trickey et al., 2012; Udwin et al. 2000). Socioeconomic and sociocultural factors such as poor housing and school conditions, high rates of crime and community violence, beliefs about appropriate parenting practices, and other values and traditions have also been linked to developing child PTSD (Baker et al., 2005; Davis & Siegel, 2000; Graham-Bermann et al., 2006; Lehmann, 2000; Norris et al., 2003; Orozco et al., 2007). Expected outcomes of this study were: (a) children whose mothers had a prior history of psychological distress and came from a disruptive and chaotic home environment would

be at greater risk for developing PTSD, and (b) high levels of repeated family violence and community violence would increase the likelihood for child PTSD.

Inclusion and exclusion criteria. To be included in the study children had to be between 7-14 years old and have a mother that qualified and agreed to go through the assessment interview. The study focused on school-aged children and the assessment battery included several self-report measures requiring the child to verbally articulate their experiences with trauma. Adult males were excluded from the study in order to make comparisons to existing child maltreatment literature, which indicates heightened vulnerability of women and children to interpersonal violence by male perpetrators (Hunt et al., 2011; Lehman, 2000). Women and children in Mexico are especially susceptible to acts of violence due to their lack of power in a male-dominated society (Baker et al., 2005; Norris et al., 2003). There were also logistical reasons for excluding men from the study. Due to the silent nature of family violence, it can be challenging to recruit study participants. Additionally, within the local context of Monterrey, men are often physically absent from the household for work related or other reasons, reducing accessibility to this population.

Mothers were first screened at CIFAC or at DCPS and were excluded from the study if they scored within the psychotic range on the Brief Symptom Inventory (BSI). The BSI was also checked for cultural equivalence with this Mexican sample before being broadly applied. Several safeguards were used to avoid coercion or obligation for participation in the study. For example, one staff person at CIFAC was trained on

recruitment procedures including a script on what to say and how to protect all records for confidentiality at CIFAC.

Sampling and recruitment. Sampling and recruitment of the participants took place from February through April 2008. Participants for this study came from two separate sources. First, a portion of the sample came from a larger epidemiological study conducted in 2007 looking at the prevalence of child maltreatment of 1,000 5th graders in the state of Nuevo León in Monterrey, Mexico. Mothers were asked whether they would be willing to be contacted for a second interview involving a more extensive battery of instruments to assess for trauma related to child maltreatment, resulting in a sub-sample of 200 mother-child dyads.

Children were evaluated for PTSD using the University of California at Los Angeles Posttraumatic Stress Disorder (UCLA PTSD) Reaction Index, Child Version (Pynoos, Rodriguez, Steinberg, Stuber, & Frederick, 1998) and divided into two lists of potential families to be invited for participation in the study; children with PTSD ($n = 21$) and children without PTSD ($n = 179$). All mother-child dyads in the PTSD group were invited to participate in the assessment protocol study and a random selection table was used to invite the No-PTSD group until a total of 30 interviews were completed in each group. Five mother-child dyads from the PTSD group and 30 from the No-PTSD group agreed to participate in the study.

The second sample source for the assessment protocol study came from families reported to the Department of Child and Protective Services (DCPS) for child maltreatment, and were referred to the trauma implementation study conducted by our

research team in partnership with DCPS. Families were given an option by DCPS staff to either undergo the usual 2-3 hour unstructured assessment or to participate in the pilot assessment protocol. Families identified from the epidemiological study were offered the same option and given a clinical referral list of resources if they wanted additional help. Criteria for inclusion in the implementation study included the child meeting a PTSD diagnosis, therefore the same protocol was relevant because it was also used for the treatment implementation study.

An additional 25 families were included in the PTSD group and 32 in the No-PTSD group for the assessment protocol pilot. There were no differences in the assessment procedures for the sample recruited from DCPS. The only notable difference was in the characteristics of the sample itself in that all of these families had a history of being reported for child maltreatment, which was not necessarily the case for the non-clinical sample recruited from the epidemiological study. Families who chose to complete the trauma assessment protocol were referred to CIFAC and the same assessment team conducted the interviews. Participation in the assessment protocol pilot did not imply the need to participate in the upcoming implementation study and there were no added risks or benefits to families who agreed or refused to participate in either the assessment protocol pilot or in the implementation study.

Participants were told that their families would not be exposed to any risk due to their involvement in the study that was greater than usual if seeking or mandated for assessment screening. The original sample for the assessment protocol pilot study was 92 mother-child dyads of which five cases were excluded for the following reasons: the

UCLA PTSD Index was not completed for three cases; the substance taking habits questionnaire was not completed for one case; and one child was older than the cut-off of 14 years. The final sample was 87 mother-child dyads divided into two groups: PTSD ($n = 36$), No-PTSD ($n = 51$).

Assessment Instruments

Local bilingual research members and staff at CIFAC and the University of Minnesota translated all of the measurements used for the assessment protocol pilot into Spanish including the questionnaires about sociodemographics and substance taking habits. Some of the instruments already had Spanish versions available; in these cases instrument items were evaluated for local dialectal differences and minor changes were made to more accurately reflect the meaning of each item. This process followed Flaherty's (1988) recommendations including the translation and back translation of the instruments by two researchers who were fluent in both Spanish and English. All of the instruments included an area for assessors to take notes about their general impressions of the child/mother, cultural issues, contextual issues, and other. For example, that the child seemed hesitant to answer questions related to sexual abuse; or perhaps the child did not want to speak negatively about their family members due to the cultural value of respect. An example of a contextual issue might be that the family's home was burned down three weeks ago and child is still very frightened.

The two trauma screening instruments and the mother exposure to intimate partner violence assessment were standardized and previous research has established satisfactory reliability and validity for the three measures. Factor analyses were not

conducted for these instruments in the current dissertation study since there was no indication that the underlying constructs would be different than previous findings. Cronbach's alpha for the total score and subscales for each instrument were given for this study sample as indicators of reliability and validity where alpha values above 0.70 are acceptable (Leech, Barrett, & Morgan, 2008).

Sociodemographics and substance taking habits. Mothers completed a sociodemographic questionnaire that asked questions about the child, the mother, current living situation of the family, and financial status (see Appendix B). Children and mothers were also given a questionnaire (individually) asking about risk-taking behaviors and exposure to violence. Only data from the first part of the questionnaire focusing on substance taking habits of the child and their family members was used in the present study (see Appendix C and Appendix D). Children and mothers were each asked to provide a yes/no response to whether or not they personally ever use alcohol, marijuana/pot, and other drugs and whether or not family members ever use these substances. Positive responses were followed up with another question about the frequency of substance use on a daily or weekly basis.

University of California (UCLA) Posttraumatic Stress Disorder Index. The child version of the UCLA PTSD Index for *DSM-IV* (Pynoos, Rodriguez, Steinberg, Stuber, & Frederick, 1998) was used in the current study to assess exposure to trauma and PTSD symptomatology with a sample of Mexican children (see Appendix E). The UCLA PTSD Index is a revised version of the Child Posttraumatic Stress Reaction Index. The instrument was not designed for formal diagnosis; rather, it was intended for

screening of posttraumatic stress symptoms and is widely used to assess preliminary diagnostic information. There are three versions: child (ages 7-12), adolescent (ages 13 or older), and parent's report, with slight variations in wording between the child and adolescent and versions (Steinberg, Brymer, Decker, & Pynoos, 2004).

Part I consists of 13 items that screen for the presence or absence of lifetime traumatic events (e.g., community violence, natural disaster, medical trauma, family violence/abuse). If children report exposure to more than one event, in item 14 they are asked to identify and describe the event that currently causes them the most distress. Part II provides a thorough evaluation of Criterion A1 and A2 (objective and subjective aspects of the traumatic exposure), measured by the presence or absence of 11 items. Criterion A must be met in order to assess PTSD symptomatology (Part III), which provides information about the frequency of symptoms over the past month using a 5-point Likert scale from 0 (none of the time) to 4 (most of the time). Seventeen of the 20 items in Part III directly correspond with *DSM-IV* subcategories B (reexperiencing), C (avoidance), and D (arousal). Two additional items (14 and 20) assess associated features of trauma-related guilt and fear of reoccurrence, respectively. The 17 items are calculated for a total PTSD severity score as well as severity scores for each of the *DSM-IV* subcategories. Children meeting criteria for all three symptom categories are scored as having a likely PTSD diagnosis of full PTSD and children meeting criteria for two subcategories are scored as partial PTSD likely. An overall severity score of 38 or higher is considered to have the greatest sensitivity and specificity for identifying PTSD (Steinberg, Brymer, Decker, & Pynoos, 2004).

The UCLA PTSD Index was selected because of its sound psychometric properties and broad application for clinical assessment, research, and post-disaster screening (Steinberg et al., 2004). It has been translated and used with various populations (e.g., different ages, types of trauma, settings, cultures) in the U.S. and around the world including post-disaster settings such as the 1999 earthquake in Turkey (Laor et al., 2002) and large-scale political violence, for instance, after the September 11th terrorist attacks in New York City (Fairbrother, Stuber, Galea, Fleischman, & Pfefferbaum, 2003). This instrument has also been used with child populations exposed to community and family violence within post-war countries such as Sri Lanka (Catani et al., 2008) and Afghanistan (Catani et al., 2009), as well as with urban youth in the U.S. (e.g., Berman, Kurtines, Silverman, & Serafini, 1996). Other translated versions include Spanish, Armenian, Bosnian, Cantonese, and Greek.

Studies over the past two decades of different versions of the UCLA PTSD Index have reported high internal consistency across versions with Cronbach's alpha falling within the range of 0.90, high test-retest reliability of 0.84, good convergent validity (0.70) in comparison with related measures, and strong sensitivity (0.93) and specificity (0.87) of detecting PTSD with a cut off score of 38 (Ellis, Lhewa, Charney, & Cabral, 2006; Roussos et al., 2005; Steinberg et al., 2004). More recently, Ellis, Lhewa, Charney, and Cabral (2006) tested the psychometric properties of the UCLA PTSD Index with a sample of 77 Somali adolescent refugees in the U.S. Results were consistent with previous studies demonstrating good internal consistency with Cronbach's alpha of 0.85 and moderate to strong convergent validity compared to other measures expected to be

related to PTSD symptomatology ($r = 0.59$ for the War Trauma Screening Scale and $r = 0.72$ for the Depression Self-Rating Scale).

Child participants in the present study completed all three parts of the UCLA PTSD Index. The instrument does not assess for Criterion F (functional impairment), therefore six items were added addressing difficulties in different areas of the child's life such as school, family life, and leisure activities. Internal consistency with this sample was similar to previous with Cronbach's alpha 0.93 for the measure and subscale estimates were 0.84 (Criterion B), 0.86 (Criterion C), and 0.83 (Criterion D).

Posttraumatic Stress Diagnostic Scale (PDS). The Posttraumatic Stress Diagnostic Scale (PDS) (Foa, 1995) was developed to assist with the diagnosis of PTSD in adults based on the *DSM-IV* criteria and was used to assess exposure to trauma and PTSD symptomatology with mother participants in the study (see Appendix F). There are four parts of this questionnaire with Parts I and II addressing *DSM-IV* Criterion A. Part I (items 1-13) is a list of stressful and traumatic events and respondents indicate any event they have witnessed or experienced. In Part II (items 14-21) respondents identify one event from Part I that bothers them the most and provides a brief description about the event. Item 15 establishes the length of time since the event occurred and items 16-21 are a series of yes/no questions asking whether the respondent or someone else was physically injured and if they thought their or someone else's life was in danger.

Part III consists of 17 items that correspond to *DSM-IV* symptom Criterion B (reexperiencing), C (avoidance), and D (arousal). This part of the instrument constituted the earlier self-report measure, the PTSD Symptom Scale (Foa, Riggs, Dancu, &

Rothbuaum, 1993) that the PDS is based on. The questions assess overall symptom severity and for each subcategory and respondents indicate frequency of exposure to the traumatic event in the past month according to a 4-point Likert scale: 0 (not at all), 1 (once a week or less), 2 (2-4 times a week) and 3 (almost always). Items 39 and 40 address the duration of symptoms. Part IV includes nine items in yes/no response format that address *DSM-IV* Criterion F (functional impairment) in different areas of life (e.g., work, friendships, family, general life satisfaction, etc.) within the past month (item 39). PTSD diagnosis is met with the fulfillment of Criterion A; a rating of “1” or higher on at least one Criterion B item, three C items, and two D items; symptom duration of at least one month; and impairment in at least one area of functioning in Criterion F. A total symptom severity score for the *DSM-IV* subcategories B, C and D can be calculated by summing the 17 items.

The reliability and validity of the PDS has been assessed in several studies in the U.S. with various adult populations across different ages (range 18-70 years), gender, race/ethnicity, and settings such as treatment and research centers, and non-residential facilities (e.g., women’s shelters, police stations) (Coffey, Dansky, Falsetti, Saladin, & Brady, 1998; Foa et al., 1993; Foa, Cashman, Jaycox, & Perry, 1997). These studies have demonstrated high internal consistency for the total score (> 0.91), and subscale reliabilities above 0.78 for symptom clusters B and C, and above 0.82 for cluster D. Comparisons of the PDS with other self-reported measures of symptomatology have shown moderate convergent validity (0.79) and concurrent validity (0.74).

Over the past decade, the PDS has been translated and validated for use with non-U.S. populations, particularly with civilian war survivors from Sarajevo (Rosner, Powell, & Butollo, 2003), Bosnia (Powell & Rosner, 2005), Iraq (Norris & Aronian, 2007), and Croatia (Jovanovic et al., 2010) to name a few. For example, Morina, Rudari, Bleichhardt, and Prigerson (2010) used an Albanian version of the PDS with 60 civilian survivors of the 1998/1999 war in Kosovo reporting an internal consistency of 0.90 for the measure. In another example, Ertl et al. (2011) validated the psychometric properties of the instrument with sample of 504 adolescents and adults from three different regions in Northern Uganda. Reported alpha coefficients for the PDS total score and symptom clusters B, C, and D ranged from 0.71 to 0.89. The researchers also reported good internal consistency for Criterion F (functional impairment) (0.86). In addition to war-affected populations, the PDS has also been validated with a sample of survivors of various types of trauma from a mental health institute in Germany (Griesel, Wessa, & Flor, 2006) and university students in Poland (Dragan, Lis-Turljeska, Popiel, Szumaila, & Dragan, 2012). In the current study in Mexico, Cronbach's alpha for the Spanish version of the instrument was 0.93 for the total score, 0.85 for Criterion B, 0.83 C, and 0.85 D.

Family Violence Checklist. Children's exposure to family violence was assessed using the domestic violence subsection from the Family Violence Checklist (Catani et al., 2008) (see Appendix G). The instrument was developed for use with children in Sri Lanka after the tsunami and the questions are categorized according to five types of family violence: physical abuse (10 items), emotional abuse (6 items), sexual abuse (6 items), neglect (4 items), and witnessing violence (5 items). Lifetime exposure to family

violence is determined by children's yes/no response to several questions about whether or not a specific event has ever occurred. Ongoing exposure to family violence is assessed by children's positive or negative (yes/no) response to whether the event occurred in the last month. In asking both of these questions, frequency of exposure to the specific type of event can be determined.

The Family Violence Checklist was originally based on two standardized measures for exploring trauma exposure in childhood: the Early Trauma Inventory (Bremner, Vermetten, & Mazure, 2000) and the Childhood Trauma Questionnaire (Bernstein et al., 1994). Items from each of the standardized instruments were selected in collaboration with local counselors and experts to determine the most relevant items for Sri Lankan culture. Some of the wording of the items was modified to fit within the local context. The sample population consisted of 296 Tamil school children (158 boys, 138 girls) from the Vadamarachi educational zone, between the ages of 9-15 years.

The psychometric properties of the instrument have not been tested, but it has been used in two studies in Sri Lanka (Elbert, Schauer, Huschka, Hirth, & Neuner, 2009; Catani et al., 2008) and one study in Afghanistan (Catani et al., 2009). An exploratory factor analysis was not conducted in the current study due to insufficient sample size ($N = 87$). A common rule of thumb to determine appropriate sample size for factor analysis is a subject-to-variable ratio of 10:1 (Cabrera-Nguyen, 2010; Costello & Osborne, 2005). The Family Violence Checklist contains 31 items, which would require a sample size of 310 participants to meet the recommended guideline. Alternatively, a sample size of 300 is generally acceptable; however, gathering larger samples is

recommended because size adequacy cannot be determined until after the data have been analyzed (Cabrera-Nguyen, 2010). There are future plans for conducting an exploratory factor analysis study combining the samples from the studies in Sri Lanka, Afghanistan, and the current study in Mexico.

Composite Abuse Scale. The 30-item version of the Composite Abuse Scale (CAS) (Hegarty, 2007) was administered to mother participants in the current study to assess exposure to intimate partner violence (see Appendix H). To date, it has been translated from English into Vietnamese, Dutch, Bengali, Russian, and Spanish. The CAS was developed to measure all types of abuse, frequency of abuse, and consequences of abuse using items selected from four different standardized assessments: the Revised Conflicts Tactics Scale (Straus, Hamby, Boney, & Sugarman, 1996), Psychological Maltreatment Women Index (Tolman, 1989), Index Spouse Abuse (Hudson & McIntosh, 1981), and Measure of Wife Abuse (Rodenberg & Fantuzzo, 1993).

The instrument addresses four dimensions of intimate partner violence: severe combined abuse (8 items), emotional abuse (11 items), physical abuse (7 items), and harassment (4 items). The response format is a 6-point Likert scale measuring the frequency of specific actions during the past 12 months: 0 (never), 1 (only once), 2 (several times), 3 (monthly), 4 (weekly), and 5 (daily). The first section of the instrument consists of background information about women's adult intimate relationships: whether or not the respondent has ever been in an adult intimate relationship, if she is currently in a relationship, if she is currently afraid of her partner, and if she has ever been afraid of

her partner. If the respondent indicates that she has never been in an adult relationship, the questionnaire is not applicable and the assessment cannot be given.

The original 1995 version consisted of 74 items and was used with a convenience sample of 427 female nurses from a large inner city Australian public teaching hospital (Hegarty, Sheehan, & Schonfeld, 1999). Multiple factor analyses were conducted resulting in a four-factor model of abuse with 51 items: severe combined abuse ($\alpha = 0.95$), emotional abuse ($\alpha = 0.92$), physical abuse ($\alpha = 0.95$), and harassment ($\alpha = 0.91$). Construct validity was established by comparing the CAS subscale items to the subscales on the Revised Conflicts Tactics Scale. Reliability estimates ranged from 0.46 to 0.80 on the different subscale dimensions.

Hegarty, Bush, and Sheehan (2005) completed a follow-up validation study of the 51-item version of the CAS with a sample of 1,896 general practice female patients and 345 emergency department patients in Australia. Factor analyses resulted in the reduction of the final scale to 30 items with similar internal consistency estimates and factor loadings as the previous study: 0.91 severe combined abuse, 0.93 emotional abuse, 0.94 physical abuse, and 0.87 harassment; corrected item-total correlations above 0.50. Cronbach's alpha coefficients of the four abuse scales in the present study were lower compared to the previous validation studies, but still in the acceptable to good range: 0.73 severe combined abuse, 0.89 emotional abuse, 0.90 physical abuse, and 0.87 harassment.

Training, Supervision and Feedback Structure

Three training sessions of the assessment protocol interview procedures were held in Mexico lasting 3-4 full days per session. Sixteen local mental health professionals

participated in the trainings: master's level couple/marriage and family therapists, and bachelor's level psychologists and social workers. Several actions were taken to facilitate the trainings including the development of a training manual (Wieling & Erolin, 2008), English and Spanish demonstration role-play videos of the entire assessment interview with research team members, and large group videotaped role-plays with the assessors/interviewers during the final training session. During the training period, the assessment protocol was tested with two mother-child dyads and minor modifications were made before implementation with study participants.

The first interview for each assessor team was videotaped in its entirety and reviewed by the Co-Principal Investigators (Co-PIs) before the assessors were allowed to complete more interviews, after which only the dyadic level tasks were videotaped. The supervision procedure included the uploading of the first interview videotape onto a secure website in Mexico to be downloaded into MediaMill, a storage and processing data software program available through the University of Minnesota. VideoAnt, an annotated software program also available through the University of Minnesota, was used for monitoring and procedural fidelity and supervision during practice role-plays and with study families. Using this software, the Co-PIs were able to provide written comments/feedback at specific places within the video segment that needed improvement. The annotated video was accessible to the assessors through a web link that was generated from the VideoAnt software. All data were encrypted and met safety standards according to Institutional Review Board guidelines.

Procedures

Eight teams of two trained assessors/interviewers gave the assessment battery to mother-child dyads at the CIFAC family therapy training facility. Since many of the mothers were illiterate and there were potential developmental delays in children, all of the instructions and instruments were administered verbally to the mother and child, one-on-one, and the assessors recorded their responses on the forms. Mothers and children were informed of the purpose of the study and potential risks and benefits of participating. Mothers signed a consent form giving permission for herself and her child to participate in the study (see Appendix I). Children also signed a separate assent form agreeing to be in the study (see Appendix J).

The entire assessment interview lasted approximately 2.5 hours, including a 15-minute break. The interview was structured into three main components: Consent/assent procedures and demographics with mother and child in same room (30 minutes), individual-level assessments with mother and child in separate rooms (60 minutes), and dyadic-level assessments with mother and child in same room (45 minutes). The dyadic-level structured interaction tasks (SITs) were videotaped. Interview appointments were scheduled by phone by a research team member at CIFAC.

It is important to note that assessors frequently checked in with the mother and child throughout the entire interview and upon completion of the interview. The assessors were instructed to end the interview prematurely if, in their clinical judgment, they believed that the mother or child was experiencing too much emotional and/or psychological discomfort. The local clinical supervisor and project Co-PI in Mexico was

available for consultation with the assessor and/or family in case of serious distress during or after the interview. None of the interviews in the current study ended prematurely. If either the mother or child was experiencing any psychological or emotional discomfort at the end of the interview the clinical supervisor was contacted. A gift card was given to the mother for participating in the study accompanied by a list of clinical resources in the community.

Data Entry and Verification

All original records were kept at CIFAC in Mexico. A data entry codebook was developed (Wieling & Erolin, 2008) and used during a two-day training in Mexico with the Mexico research team and three undergraduate psychology students hired to enter the data into SPSS version 17. Each undergraduate student entered approximately one-third of the total sample of 92 mother-child dyads. Two different students entered the data twice in order to ensure internal consistency across data entry personnel. No identifying information was included in the databases; therefore e-mail transfer of these files from Mexico to the U.S. was appropriate.

Qualitative data were entered in Spanish and translated into English by a bilingual research team member in the U.S. and checked by a Mexican researcher for verification of accuracy. Miss-entered numeric data were verified through the process of creating a new set of variables that identified cases where the original data (first data entry) did not match the re-entered data (second data entry). The output for the miss-matched numeric data were saved into word documents and reviewed for accuracy. Miss-matched data were then cross-referenced with the hard copies of the completed assessment instruments

in order to verify the accuracy of the correct response, which were then used for data analysis.

Preliminary Data Analysis

Exploratory data analysis and missing values. Statistical analyses were conducted using SPSS Version 19.0 software. Exploratory data analysis was used as a way to examine and become familiar with the data, and as a way to check for errors. Raw data for all assessment instruments and questionnaires were reviewed and cross-referenced with the data in the SPSS Data Editor. A missing value analysis was performed for all variables. Statistical assumptions for parametric and nonparametric tests were evaluated and met (e.g., independence of observations, homogeneity of variances, normality, linearity). The sociodemographic and substance taking habits questionnaire and assessment instruments were examined for incomplete, unclear, blank, or double answers. Decisions about how to handle these problems were noted on the hard copy of the questionnaires as well as a master *coding instructions* document in order to ensure consistency for all similar problems. All items requiring a yes/no response and were blank were coded as “no.” For instances where a response was unclear or incomplete and the highest frequency response for that particular item was used or an educated guess was made based upon the preceding responses.

Recoding variables. Several of the sociodemographic variables were recoded into different categorical variables with a lesser number of levels. Mother relationship status was condensed from six into three categories: 0 (single or widowed), 1 (married or cohabiting), and 2 (divorced or separated). Mother highest level of education was recoded

from 10 levels into a new variable with five categories: 0 (middle school completion or less), 1 (diploma or some high school), 2 (bachelor's or some college), 3 (master's or some graduate courses), and 4 (other). Mother work status also had 10 initial categories, which were condensed into four levels: 0 (self-employed or working for company), 1 (temporarily laid off or unemployed), 2 (full-time homemaker), and 3 (full-time student, retired, or permanently disabled). The last sociodemographic variable to be recoded was type of housing, which was reduced from 10 categories into four: 0 (rent house, apartment, or duplex), 1 (own house, apartment, or duplex), 2 (live with friend or relative), and 3 (other).

A continuous composite variable was created for *total household monthly income* that combined mother's personal monthly income with household monthly. Twelve composite variables were also added for child and mother reports of substance use for the child and family members (six variables, each). For the child, alcohol, marijuana, other drugs, and cigarettes were combined into the following composite variables: child report of intake, and mother report of child intake across three levels of frequency (lifetime/ever, weekly, and daily). Reports of substance intake for father, mother, and other family members in the household were combined into the composite variables: *child report of family intake*, and *mother report of family intake of all substances* (alcohol, marijuana, and other drugs) across the same three levels of frequency.

Several items on the Family Violence Checklist were similar in content and were combined from two items into one new variable (see Table 1). Subscale variables were created for the child and mother trauma and family violence measures. The trauma

subscales represented the *DSM-IV* criteria for PTSD diagnosis and were dichotomous (yes/no) variables: Criterion A (traumatic event), B (reexperiencing), C (avoidance), and D (arousal) for child and mother separately. Two additional continuous composite variables were created for the total number of traumatic events and overall PTSD severity. The family violence subscales were continuous composite variables for specific types of abuse for children and mothers. Child variables were: PA (physical), EA (emotional), SA (sexual), N (neglect), WV (witnessing violence), and lifetime exposure to all types of family violence. Mother variables were: SCA (severe combined abuse), EA (emotional), PA (physical), and H (harassment). Additionally, a dichotomous variable of abused/not abused was created for the mother intimate partner violence instrument.

Table 1. *Recoded Variables for Family Violence Checklist*

Old variables	New variable
Punched/kicked on body and arms or legs + punched/kicked in the face	Punched or kicked
Burned with hot water or cigarette + had someone attempt to burn or strangle or strangle you	Burned/attempted to burn or strangle
Threatened with an object or weapon + threatened to be killed	Threatened to be hurt or killed
Saw family member being punched, hit or kicked + saw family member being hit with an object	Saw family member hit, punched or kicked
Not given enough food + not given anything to drink	Not given enough food/drink

Data Analysis

Descriptive statistics. Descriptive statistics such as frequencies for categorical variables; means and standard deviations for continuous variables; histograms; and bar graphs were used to address the first research aim of identifying general characteristics of this sample of 87 mother-child dyads within a child maltreatment contact in Monterrey,

Mexico. Group and gender differences were tested using the mean comparison procedures of Pearson's chi-square tests for categorical variables and independent samples *t*-tests for continuous variables. Fischer's exact test was used to perform chi-square tests in cases where one or more of the cells had an expected frequency of five or less, providing a more accurate estimate of the expected values for small sample sizes (McDonald, 2009). Equivalency in sociodemographics, substance taking habits, trauma exposure, and exposure to interpersonal violence was determined between groups and genders. Analyses were performed separately for children and mothers.

Binary logistic regression. The second research aim was to examine potential trauma-related and posttrauma risk factors for the presence of child PTSD. This was achieved by conducting binary logistic regression to examine the relationship between the dichotomous outcome variable PTSD/No-PTSD and several continuous and dichotomous predictors. Logistic regression is similar to a generalized linear model with fewer assumptions than linear regression (Leech, Barrett, & Morgan, 2008; Steyerberg, Eijkemans, Harrell, & Habbema, 2001). The assumptions of logistic regression include independence of observations (i.e., no duplicate responses) and linearity of the independent variables to the logit (natural log of the odds ratio) of the dependent variable, multicollinearity (i.e., redundancy), and lack of strongly influential outliers were checked and met (Leech, Barret, & Morgan, 2008; Stoltzfus, 2011).

Selection of predictors. A large number candidate predictors were considered for inclusion in the logistic regression model based on past research about risk factors for child PTSD as well as clinically important variables. Sociodemographic factors such as

age, gender, and education have been widely studied as potential risk factors for child PTSD; however, findings have been mixed (Cox et al., 2008; Foy et al., 1996).

Additionally, the effects of these factors on child outcomes are small (Trickey et al., 2012); therefore they were excluded as potential predictors in the regression model. Other risk factors consistently related to child PTSD are direct exposure to interpersonal violence and witnessing violence in the home and community (e.g., Lehmann, 2000; McCloskey & Walker, 2000; Rossman & Ho, 2000, and family-level factors such as parental psychopathology, parental support, and home environment (e.g., Deblinger et al., 1999; Graham-Bermann et al., 2006; Margolin & Vickerman, 2007). Given this, all variables that addressed child or mother exposure to interpersonal violence in the home or community as well as mother PTSD diagnosis were considered for possible inclusion in the regression analysis.

Selection of model building strategy. Stepwise logistic regression is commonly used in clinical research to identify important predictors to include in regression models (Steyerberg et al., 2001); however there is disagreement about the effectiveness of this procedure as a modeling building strategy. In stepwise regression, the process of adding (forward selection) or removing (backward selection) independent variables from a model is automated based on the standard statistical criteria of $p < .05$ for inclusion, which takes advantage of random chance factors within the sample (Stolzfus, 2011). Data-dependent methods often lead to overly optimistic estimates of predictive performance, especially with small samples (Altman & Royston, 2000; Steyerberg et al., 2001). Others argue that the issue lies with the interpretation of results rather than the

procedure itself, and stepwise methods can be effective with careful consideration of the advantages and disadvantages of the procedures along with formal validation of the results (Hosmer & Lemeshow, 2000; Stolfus, 2011).

Alternative model building strategies include the direct (i.e., full, standard, or simultaneous) approach and sequential/hierarchical regression. The direct approach is recommended if no a priori assumptions are made about the relative importance of certain variables over others and all independent variables are entered into the model at the same time (Stolfus, 2011). Since assumptions were made about the importance of different independent variable to each other based on previous research, the full approach was not appropriate for the current study. In contrast, the sequential/hierarchical strategy begins with predetermined hypotheses about the relative importance of each predictor to each other and the variables are entered into the model sequentially. A complication of the hierarchical approach is the increasing complexity of different causal relationships between the independent variables and outcomes, making it difficult to draw conclusions about the data (Stolfus, 2011). The selection of a more parsimonious model is recommended in order to minimize the cost and complexity of reliably measuring a large number of predictors (Ambler, Brady, & Royston, 2002).

Choosing an appropriate model building strategy for a study is closely linked with the selection of independent variables. The number of events per variable (EPV) considered for inclusion in a regression model is important for reliability of the model. A common rule of thumb for determining the appropriate number of independent variables to include in a regression model is a minimum EPV of 10 (Altman & Royston, 2000;

Harell, Lee, & Mark, 1996) or at least 10 outcomes for each binary category (e.g., PTSD/No-PTSD). The rarer of the two binary levels should determine the maximum number of independent variables in order to avoid over-fitting of the data (Agresti, 2007). In the current study, the least common outcome was PTSD ($n=36$); therefore the regression model should be limited to four predictors in order to ensure reliability of the model. Considering the different emphasis and purpose of each of the three model building strategies, the stepwise approach seemed most appropriate for the exploratory nature of the current study to build a final model that was parsimonious and reliable.

Evaluation of model performance. A critical component of prognostic modeling is to evaluate the adequacy of a model to correctly predict the outcome for individual cases using the most parsimonious model (Sarkar & Habshah, 2010). A thorough assessment of the fit of the binary regression model requires use of a multi-faceted examination of the results in order to avoid misleading or inaccurate conclusions. The most common method for evaluating the overall fit of a model in logistic regression is the goodness-of-fit test, which assesses the improvement of fit between the predicted and observed values of the dependent variable by adding the predictor(s) to the model (Long, 1997). This is achieved by calculating the chi-square difference between the constant only (i.e., null model) and the full model with one or more predictors.

Another widely used approach is the Hosmer-Lemeshow (H-L) goodness-of-fit, which compares the predicted and observed frequencies of an outcome to calculate a Pearson chi-square (Hosmer & Lemeshow, 2000). Non-significance indicates a good overall model fit, therefore the H-L statistic should be less than $\alpha = .05$. This test is not

recommended with a sample size less than 400 since the H-L statistic assumes sampling adequacy with enough cases to ensure that 95% of cells have an expected frequency > 5.0 .

Discrimination is the ability to distinguish between groups/individuals with different outcomes predicting high probabilities for participants who have the outcome and low probabilities for those who do not (Mushkudiani et al., 2008). A commonly used measurement for assessing discrimination for dichotomous (binary) outcomes is the concordance (c) statistic, which is equivalent to the area under the receiver-operating characteristic (ROC) curve in logistic regression (Gude, Mitchell, Ausband, Sime, & Bangs, 2009). The ROC curve is a plot of the sensitivity (ability to predict an event correctly) and specificity (ability to predict a nonevent correctly) at successive cutoff points of the predicted probability of the outcome (range is from .50 to 1). A c -statistic of .50 indicates no predictive discrimination (random guessing) and a value of 1.0 indicates a perfectly discriminating model. According to Hosmer and Lemeshow (2000) a reasonable model should have $c > .70$.

Ecological Validity and Cultural Sensitivity

The larger assessment protocol pilot study used a combined approach integrating knowledge from within the culture (emic) with knowledge from outside the culture (etic) to understand and measure the impact of trauma on parent-child relationships in Mexico. The goal of the assessment protocol pilot was to take existing trauma and parenting measures as a starting point and use this emic-etic approach to culturally adapt standardized instruments for a Mexican population and develop new culturally relevant

relational measures. According to Rogler (1989), culturally sensitive research is an ongoing process where culture is considered throughout the entire research project, which is linked to *ecological validity* (Bronfenbrenner, 1977). In order for a research study to be ecology valid there must be agreement between how the research environment is experienced by the study participant and the researcher's assumptions about the environment. Using this approach, the children, mothers, and researchers in the larger assessment protocol pilot study were all part of the scientific process, creating a shared experience of the research environment.

Chapter IV: Results

The objectives for the current dissertation study were: (a) to examine individual and family characteristics between child-mother dyads that differentiate between the presence or absence of a PTSD diagnosis for children, and (b) to examine the potential trauma-related and posttrauma risk factors for the presence of child PTSD. The first study objective was achieved through the exploration of sociodemographic factors between the two groups (PTSD, No PTSD); comparisons between child and mother reports of substance taking habits for the child and family; child and mother exposure to trauma; and child exposure and mother exposure to interpersonal violence. The second aim of the study was accomplished by examining the relationship between the dichotomous variable reflecting whether or not the child met the formal *DSM-IV* criteria for PTSD and three interpersonal violence predictor variables contributing to this diagnostic status.

Characteristics of Study Sample

There were 87 children (50 boys, 37 girls) ages 7-14 years old and their mothers (ages 24-50 years) in the total sample. The average age for children was 10 years old and the mean age for mothers was 35 years old. Close to half (47.1%) of the participants lived with a friend or relative, 39.1% resided in a home that they owned (house, apartment, duplex), 12.6% rented, and 1.1% had a different living arrangement. The household size ranged widely from 1-21 adults and children, averaging 6.1 people living together in the household. There was also a large range in household monthly income from 0-15,000 Mexican pesos. The mean monthly household income for the total sample was 5,075 MXN (\$410 U.S. dollars).

The majority of mothers were either married or cohabitating with their partner (80.5%). The remaining percentage of mothers did not live with a partner and were either single/widowed (6.9%) or divorced/separated (12.6%). The highest educational level obtained by mothers was mostly middle school or less (66.7%), which is equivalent to grades 1-9. About 7% of mothers had a diploma or some high school, 10.3% had a bachelor's degree or some college, and 16.1% had obtained graduate level education. Nearly half of the mothers (46%) were self-employed or worked for a company outside of the home. A large number of mothers were full-time homemakers (39.1%). Mothers who did not have a job were full-time students, retired or permanently disabled (9.2%) or were temporarily laid off (5.7%).

The two groups, children with PTSD and children without PTSD, did not significantly differ on sociodemographic characteristics such as gender, mother variables (relationship status, educational level, work status, age), housing type, household size, and household monthly income. However, there was a difference between groups in child age and children in the PTSD group ($M = 9.69$, $SD = 2.03$) with significantly younger than children in the No-PTSD group ($M = 10.61$, $SD = 2.08$); $t(85) = 2.04$, $p = .045$. More detailed information about sociodemographic characteristics for the two groups is provided in Table 2.

Table 2. *Characteristics of PTSD and No-PTSD Groups (N=87)*

Sociodemographic variables	PTSD (<i>n</i> = 36)		No-PTSD (<i>n</i> = 51)	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Child age, years	9.69 *	2.03	10.61	2.08
Mother age, years	36.03	6.71	34.35	6.45
Household size (adults and children)	6.14	3.49	6.08	2.23
Household monthly income, MXN pesos	4880.56	2798.86	5211.96	3149.31
	<i>n</i>	%	<i>n</i>	%
Mother relationship status				
Single or widowed	3	8.3	3	5.9
Married or cohabitating	29	80.6	41	80.4
Divorced or separated	4	11.1	7	13.7
Mother highest education level				
Middle school completion or less	26	72.2	32	62.7
Diploma or some high school	3	8.3	3	5.9
Bachelor degree or some college	3	8.3	6	11.8
Other	4	11.1	10	19.6
Mother work status				
Self-employed or working for someone else	17	47.2	23	45.1
Unemployed	3	8.3	2	3.9
Full-time homemaker	12	33.3	22	43.1
Other (e.g., laid off, retired, full-time student, permanently disabled)	4	11.1	4	7.8
Type of housing				
Rent house, apartment, or duplex	5	13.9	6	11.8
Own house, apartment, or duplex	15	41.7	19	37.3
Live with friend or relative	16	44.4	25	49.0
Other	—	—	1	2.0

* $p < .05$

Substance Taking Habits

Child and mother reports of substance taking habits of alcohol, marijuana, and other drugs for the child and family (father, mother, other family members) were compared for lifetime/ever, weekly, and daily intake. Frequency of cigarette smoking was also included for child ingestion. Overall, fathers/partners had the highest rates of intake for all substances. Frequencies of substance intake for the child and for the father/partner are presented in Table 3. Comparisons between child reports and mother reports show

that children reported higher levels of their own substance intake compared to mother reports of child ingestion; however, this was reversed for father/partner substance intake with mothers reporting higher rates compared to children. The rates of child lifetime substance intake reported by children was more than double the amount reported by their mothers (12% vs. 5%), a statistically significant difference: $\chi^2 (1, N = 87) = 9.74, p = .009$. Mother reports of partner substance intake were significantly higher than child reports of their fathers across all frequency categories: lifetime/ever (87% vs. 69%), $\chi^2 (1, N = 87) = 15.17, p < .001$; weekly (55% vs. 45%), $\chi^2 (1, N = 87) = 7.90, p < .01$; and daily (22% vs. 12%), $\chi^2 (1, N = 87) = 5.25, p < .05$.

Table 3. *Child and Mother Reports of Child and Father/Partner Substance Intake*

	Child Report (%)			Mother Report (%)		
	Ever	Weekly	Daily	Ever	Weekly	Daily
Child substance intake (alcohol, marijuana, other drugs, cigarettes)	11.5**	3.4	1.1	4.6	0.0	1.1
Father/partner substance intake (alcohol, marijuana, other drugs)	69.0	44.8	11.5	87.4***	55.2**	21.8*

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

Prevalence of Exposure

Child exposure to traumatic events. Analysis of the UCLA PTSD Index data revealed that 58.6% of the children (66% boys, 48.6% girls) reported an event that met the *DSM-IV-TR*, A criterion for exposure to a traumatic event. Almost one quarter (24%) of all children experienced at least one event during their lives and 37% were exposed to multiple traumas of two or more events. The average lifetime prevalence was 1.29 events ($SD = 1.41$). None of the children reported being exposed to a big earthquake or being in

a place where there is war. Table 4 gives the frequency of child lifetime exposure to any potentially traumatic event by group. Children in the No-PTSD group had much lower rates of exposure to most of the event types compared to the PTSD group except for seeing someone being beaten, shot at or killed in town and seeing a dead body in town. The percentage of children in the No-PTSD group that reported seeing a dead body in town was actually slightly higher than what children in the PTSD group reported for this event type.

Table 4. *Percentages of Child Lifetime Exposure to Traumatic Events by Group (N = 87)*

	PTSD (n = 36)	No-PTSD (n = 51)
Being in another kind of disaster (e.g., fire, tornado, flood or hurricane)	13.9	3.9
Being in a very serious accident	11.1	3.9
Being hit, punched, or kicked very hard at home	25.0	3.9
Seeing family member being hit, punched, or kicked very hard at home	36.1	3.9
Being beaten up, shot at or threatened to be hurt badly in town	11.1	2.0
Seeing someone being beaten, shot at or killed in town	25.0	15.7
Seeing a dead body in town	16.7	17.6
Having adult touch private sexual body parts	8.3	—
Hearing about a violent death/serious injury of a loved one	22.2	3.9
Having painful or scary medical treatment in hospital	27.8	3.9

Figure 2 shows the lifetime frequencies of traumatic events for boys and girls. The three most frequent event types reported by children were: seeing someone being beaten up, shot at or killed in town (19.5%); seeing a family member being hit, punched, or kicked very hard at home (17.2%); and seeing a dead body in town (not including funerals) (17.2%). More boys than girls were affected by most of the event types except

for being beaten up, shot at or threatened to be hurt badly in town and having an adult touch private sexual body parts without permission. Boys were significantly more affected than girls by hearing about a violent death/serious injury of a loved one (18% vs. 2.7%), $\chi^2(1, N = 87) = 4.89, p = .039$ and being in a very serious accident (12% vs. 0%), $\chi^2(1, N = 87) = 4.77, p = .036$.

Figure 2. Child lifetime exposure to potentially traumatic events by gender (*indicates χ^2 comparison between boys and girls). $p < .05$

Mother exposure to traumatic events. According to the PDS data, 55.2% of the mothers reported an event that met the *DSM-IV*, A criterion for exposure to a traumatic

event. Twenty-four percent of mothers experienced at least one traumatic event throughout their lives and 47% were exposed to two or more events ($M = 1.79$, $SD = 1.86$). Mothers most frequently indicated being exposed to a natural disaster including tornado, hurricane, flood, or major earthquake (25.3%) followed by being in or witnessing a serious accident, fire, or explosion (23%). Twenty-three percent of mothers reported exposure to other traumatic events; however, many of the events overlapped with other categories such as non-sexual assault by a family member/someone known (e.g., being mugged physically attacked, shot, stabbed, or held at gunpoint), sexual assault by a family member/someone known (e.g., rape, or attempted rape), and serious accident, fire, or explosion. None of the mothers were exposed to military combat or a war zone.

Child exposure to family violence. Child exposure to violence in the home was high with 87.4% of children (92% boys, 81.1% girls) experiencing at least one type of family violence during their lifetime. On average, children were exposed to 3.85 ($SD = 3.43$) different types of events and the maximum number reported was 18 events. Children were most often exposed to emotional abuse (70.1%) and physical abuse (67.8%). About a third of the children witnessed violence of a family member (34.5%), 19.5% experienced some form of neglect, and 3.4% were exposed to sexual abuse. Continuous violence in the home was also common and 65.5% of the children (72% boys, 56.8% girls) reported being exposed to at least one event type in the past month. The average number of events occurring within the past month was 2.02 ($SD = 2.22$) and the highest reported was 10 event types. Experiences with ongoing violence followed the

same trend as lifetime exposure; emotional abuse was the most common subscale type reported (50.6%) followed by physical abuse (48.3%), witnessing violence (11.5%), neglect (9.2%), and sexual abuse (1.1%).

Group comparisons indicated that children with PTSD ($M = 5.11$, $SD = 4.10$) were exposed to significantly more types of family violence during their lifetime than children without PTSD ($M = 2.96$, $SD = 2.55$), $t(53.98) = 2.79$, $p < .01$. Table 5 gives an overview of children's lifetime exposure to different types of family violence for each group and by gender. Children in the PTSD group experienced more event types across all five family violence subscales than children in the No-PTSD group although the only statistically significant difference was for neglect (30.6% vs. 11.8%), $\chi^2(1, N = 87) = 4.74$, $p = .029$. None of the children in the No-PTSD group reported exposure to any form of sexual abuse.

Analyses of specific event types within each subscale revealed significant group differences for which children in the PTSD group experienced more lifetime exposure than children in the No-PTSD group to the following event types: verbally threatened (30.6% vs. 9.8%), $\chi^2(1, N = 87) = 6.06$, $p = .014$; told you are not good (25.0% vs. 3.9%), $\chi^2(1, N = 87) = 8.49$, $p = .006$; and saw family member threatened to be killed (13.9% vs. 0.0%), $\chi^2(1, N = 87) = 7.52$, $p = .001$. None of the children in the No-PTSD group experienced injuries from physical abuse or saw a family member threatened or being killed. Children's exposure to ongoing family violence followed a similar pattern and the PTSD group experienced more event types than the No-PTSD group with the exception of neglect, which was reversed.

Overall, boys reported more experiences with family violence than girls, but this difference was not statistically significant (M boys: 4.22, $SD = 2.68$, M girls: 3.35, $SD = 4.22$). Subscale comparisons indicated that boys' lifetime exposure to physical abuse was significantly higher than girls (86% vs. 43.2%), $\chi^2 (1, N = 87) = 17.81, p < .001$ (see Table 5). Analyses of specific event types indicated that boys reported significantly more experiences with the following event types compared to girls: hit with an object (58% vs. 32.4%), $\chi^2 (1, N = 87) = 5.58, p = .018$; slapped (58% vs. 21.6%), $\chi^2 (1, N = 87) = 11.51, p = .001$; arms twisted/pulled by hair (42% vs. 18.9%), $\chi^2 (1, N = 87) = 5.19, p = .023$; and punched or kicked (42% vs. 18.9%), $\chi^2 (1, N = 87) = 5.19, p = .023$. No boys were exposed to physical injuries or any type of sexual abuse. Similar to lifetime exposure to physical abuse, boys experienced significantly more physical abuse within the past month than girls (73% vs. 36%), $\chi^2 (1, N = 87) = 11.64, p = .001$.

Table 5. *Percentages of Child Lifetime Exposure to Family Violence (N = 87)*

Types of family violence	PTSD (n = 36)	No-PTSD (n = 51)	Boys (n = 50)	Girls (n = 37)
Physical abuse	75.0	62.7	86.0 ***	43.2
Hit with object	55.6	41.2	58.0 *	32.4
Slapped	47.2	39.2	58.0 **	21.6
Arms twisted/pulled by hair	41.7	25.5	42.0 *	18.9
Punched or kicked	33.3	31.4	42.0 *	18.9
Things being thrown at	30.6	15.7	26.0	16.2
Tied or locked up	13.9	5.9	12.0	5.4
Burned/attempted to burn or strangle	8.3	3.9	2.0	10.8
Injured	5.6	—	—	5.4
Emotional abuse	72.2	68.6	74.0	64.9
Shouted, screamed or sworn at	58.3	62.7	60.0	62.2
Verbally threatened	30.6 *	9.8	22.0	13.5
Told you are not good	25.0 **	3.9	10.0	16.2
Made fun of in front of others	22.2	11.8	16.0	16.2
Threatened to be hurt or killed	13.9	2.0	6.0	8.1
Witnessing violence	41.7	29.4	38.0	29.7
Family member hit, punched or kicked	36.1	21.6	26.0	29.7
Family member threatened to be killed	13.9 **	—	2.0	10.8
Family member injured	8.3	2.0	4.0	5.4
Neglect	30.6 *	11.8	22.0	16.2
Ignored by parents	13.9	2.0	10.0	2.7
Had to wear dirty or ragged clothes	8.3	5.9	10.0	2.7
Not given enough food or drink	11.1	5.9	6.0	10.8
Sexual abuse	8.3	—	—	8.1
Intimately touched by older person	8.3	—	—	8.1
Forced to intimately touch older person	2.8	—	—	2.7

* $p < .05$. ** $p < .01$.

Mother exposure to intimate partner violence. Mother lifetime exposure to intimate partner violence was also high with 78.2% of the mothers having experienced at least one type of violence. Mothers were exposed to an average of 14.21 ($SD = 20.38$) events during their lifetime and the greatest reported number was 108 events. Group comparisons revealed that mothers in the child PTSD group ($M = 19.42$, $SD = 26.98$) experienced more violence than mothers in the child No-PTSD group ($M = 10.53$, $SD = 13.10$) although the difference was not significant. Based on Hegarty's (2007)

recommended cutoff scores 69% of mothers from the entire sample met the criteria for the total scale *known to be abused* (cutoff score ≥ 3), of which 72.2% of the mothers had children with PTSD and 66.7% of the mothers had children who did not meet this diagnosis.

Examination of the individual subscales indicated that mothers were most frequently exposed to emotional abuse with 52.9% meeting the cutoff score ≥ 3 for this subscale (58.3% child PTSD group; 49% child No-PTSD group). Almost half (49.9%) of the mothers fulfilled the cutoff criteria ≥ 1 for both the physical abuse and severe combined abuse subscales (50% child PTSD; 49.4% child No-PTSD). The subscale with the lowest rates of exposure was harassment with 31% of the mothers satisfying the cutoff criteria ≥ 2 (33.3% child PTSD; 29.4% child No-PTSD). More mothers in the child PTSD group reported higher rates of emotional abuse and harassment, but the differences were not significant.

Table 6 provides a detailed look at mother lifetime exposure to specific event types within each abuse subscale. Compared to mothers in the child No-PTSD group, mothers in the child PTSD group had higher rates of violence across most subscales with the exception of four event types: blamed me for causing their violent behavior (50% vs. 51.0%); did not want me to socialize with female friends (30.6% vs. 39.2%); slapped me (25% vs. 31.4%); and refused to let me work outside the home (19.4% vs. 33.3%). There were significant differences between groups for two types of emotional abuse and one type of physical abuse with mothers in the child PTSD group experiencing more of

following: told that you were ugly (30.6% vs. 9.8%), $\chi^2 (1, N = 87) = 6.06, p = .014$; told that you were stupid (30.6% vs. 11.8%), $\chi^2 (1, N = 87) = 4.74, p = .029$; and was beat up (16.7% vs. 0%), $\chi^2 (1, N = 87) = 9.13, p = .004$.

Table 6. *Percentages of Mother Lifetime Exposure to Intimate Partner Violence (N = 87)*

Types of violence	Child PTSD (n = 36)	Child No-PTSD (n = 51)
Emotional abuse	75.0	72.5
Told me I wasn't good enough	41.7	23.5
Tried to turn family, friends, and children against me	27.8	21.6
Told me I was ugly	30.6 *	9.8
Tried to keep me from seeing/talking to my family	27.8	13.7
Blamed me for causing their violent behavior	50.0	51.0
Became upset if dinner/housework wasn't done	36.1	25.5
Told me I was crazy	25.0	21.6
Told me no one would ever want me	22.2	21.6
Did not want me to socialize with female friends	30.6	39.2
Tried to convince my friends, family or children I was crazy	13.9	13.7
Told me I was stupid	30.6 *	11.8
Physical abuse	50.0	49.0
Slapped me	25.0	31.4
Threw me	44.4	35.3
Shook me	33.3	27.5
Pushed, grabbed or shoved me	41.7	37.3
Hit/trying to hit me with something	33.3	15.7
Kicked, bit or hit me with a fist	25.0	13.7
Beat me up	16.7 **	—
Severe combined abuse	50.0	49.0
Kept me from medical care	22.2	11.8
Locked me in the bedroom	13.9	9.8
Raped me	13.9	3.9
Tried to rape me	11.1	5.9
Used a knife or gun or other weapon	13.9	5.9
Took my wallet and left me stranded	16.7	7.8
Put foreign objects in my vagina	2.8	--
Refused to let me work outside the home	19.4	33.3
Harassment	36.1	33.3
Followed me	25.0	17.6
Hung around outside my house	25.0	13.7
Harassed me over the phone	11.1	9.8
Harassed me at work	16.7	11.8

* $p < .05$. ** $p < .01$.

Prevalence of PTSD

Child PTSD diagnosis. From the total sample ($N = 87$), 41.4% of the children (44.4% boys, 55.6% girls) fulfilled all *DSM-IV* criteria (A, B, C, D) for full PTSD likely and 10.3% met the partial PTSD likely condition requiring the fulfillment criterion A and two of the three symptom categories B, C, or D. The maximum overall PTSD severity score possible was 68. According to recommended guidelines for severity scores, four of the children had a cutoff score above 38, which has the greatest sensitivity and specificity for detecting PTSD (Steinberg et al., 2004, p. 97). The highest PTSD severity score for the sample was 64; the greatest number of symptoms was 17 (out of 17); and the largest number of impaired functioning was four out of six possible areas. Table 7 provides an overview of severity scores, number of trauma symptoms and functional impairment for children with PTSD, which were higher for girls than boys although the differences were not statistically significant.

Table 7. *Child PTSD Prevalence Rates and Symptom Severity (n = 36)*

	PTSD		Boys ($n = 20$)		Girls ($n = 16$)	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
PTSD severity score	24.94	12.70	21.65	10.25	29.10	14.52
PTSD symptoms	11.42	3.03	10.80	2.53	12.19	3.49
Impaired areas of psychosocial functioning	1.72	1.32	1.45	1.32	2.06	1.29

Mother PTSD diagnosis. Of the total sample, 1.4% of the mothers met the diagnostic criteria for PTSD and more than half (58.3%) of these mothers also had children with PTSD. Figure 3 shows the lifetime frequencies of traumatic events for

mothers. Group comparisons made between the child PTSD and No-PTSD groups revealed no significant differences for mother exposure to various traumatic event types, except for sexual assault by a family member/someone known (9.8% vs. 33.3%), $\chi^2 (1, N = 87) = 7.43, p = .006$.

Figure 3. Mother lifetime exposure to potentially traumatic events (*indicates χ^2 comparison between child PTSD and No-PTSD groups). $p < .01$

Predicting the Development of Child PTSD

Candidate predictors. There were 24 candidate predictors (11 continuous variables and 14 dichotomous variables), which were checked for problems with multicollinearity using a Pearson correlation matrix. The presence of collinearity was determined by a correlation coefficient at .50 or above indicating that two variables contained much of the same information (Leech, Barrett, & Morgan, 2008). The intercorrelations between the dichotomous dependent variable child PTSD diagnosis (yes/no) and the candidate predictors are given in Table 8, Table 9, and Table 10. Variables 1-12 are continuous and variables 13-25 are dichotomous (yes/no). Nine of the continuous variables were excluded due to multicollinearity resulting in a total of 15 candidate predictors.

Variables related to child exposure to different types of family violence were highly correlated, therefore the variable *child lifetime exposure to all types of family violence* was retained and the other variables were removed. The exception was child exposure to sexual abuse, which was highly correlated with the specific traumatic event of *having an adult touch private sexual body parts*, therefore this more specific event type was retained. The variables of mother exposure to different types of intimate partner violence were also all highly correlated and the variable *mother lifetime exposure to all types of partner violence* was retained and the other variables were excluded. Mother exposure to physical abuse was highly correlated with the specific traumatic event of *mother sexual assault by family member/someone known* and this specific event type was retained for further analyses.

Table 8. *Intercorrelations for Child PTSD Diagnosis and Candidate Continuous Predictors (1-8)*

Variable	1	2	3	4	5	6	7	8
1. C-PTSD	—	.19	.29**	.21*	.23*	.25*	.31**	.15
2. C-physical	.19	—	.58**	.00	.30**	.34**	.89**	-.11
3. C-emotional	.29**	.58**	—	.26*	.33**	.33**	.81**	-.06
4. C-sexual	.21*	.01	.26*	—	.08	.08	.19	.02
5. C-neglect	.23*	.30**	.34**	.08	—	.23*	.50**	-.09
6. C-witness violence	.25*	.34**	.33**	.08	.23*	—	.57**	.10
7. C-all types abuse	.31**	.89**	.81**	.19	.50**	.57**	—	-.07
8. M-physical	.15	-.11	-.06	.02	-.09	.10	-.07	—
9. M-emotional	.20	-.09	-.00	-.05	-.07	.26*	-.02	.84**
10. M-harassment	.16	-.11	.03	.01	-.09	.16	-.03	.74**
11. M-severe combined	.21	-.08	.05	-.03	-.06	.27*	.02	.81**
12. M-all types abuse	.22*	-.06	.05	.04	-.02	.29**	.04	.90**
13. C-hit, punched/kicked at home	.31**	.18	.36**	-.07	.34**	.11	.29**	-.02
14. C-saw family hit, punched/kicked at home	.42**	.00	.07	-.08	.13	.19	.08	.13
15. C-beaten up, shot at, threatened in town	.19	-.05	.01	.15	.16	-.14	-.02	.06
16. C-saw someone beaten, shot, killed in town	.12	.25*	.20	-.09	.15	.35**	.30**	.00
17. C-saw dead body in town	-.01	-.09	.07	.15	.02	.11	.01	-.17
18. C-adult touched private sexual parts	.23*	-.09	.15	.70**	-.08	-.10	.01	.15
19. C-heard about violent death/injury of loved one	.28**	.15	.15	-.06	.11	-.20	.10	.00
20. M-non-sexual assault family/someone known	.02	.06	.15	-.08	-.10	.09	.08	.26
21. M-non-sexual assault stranger	.01	.13	.05	.16	-.19	.10	.07	.16
22. M-sexual assault family/someone known	.29**	-.04	.09	.25*	.10	.11	.06	.50**
23. M-sexual assault stranger	-.18	.03	-.03	-.04	-.10	.03	-.01	.08
24. M-sexual contact < age 18 with adult	.06	.13	.20	.01	-.08	.23*	.18	.20
25. M-PTSD	.14	-.05	.03	-.07	-.12	.05	-.03	.30**

Note. C = child variables. M = mother variables. * $p < .05$. ** $p < .01$.

Table 9. *Intercorrelations for Child PTSD Diagnosis and Candidate Dichotomous Predictors (9-16)*

Variable	9	10	11	12	13	14	15	16
1. C-PTSD	.20	.16	.21	.22*	.31**	.42**	.19	.12
2. C-physical	-.09	-.11	-.08	-.06	.18	.00	-.05	.25*
3. C-emotional	-.00	.03	.05	.05	.36**	.07	.01	.20
4. C-sexual	-.05	.01	-.03	.04	-.07	-.08	.15	-.09
5. C-neglect	-.07	-.01	-.06	-.02	.34**	.13	.16	.15
6. C-witness violence	.26*	.16	.27*	.29**	.11	.19	-.14	.35**
7. C-all types abuse	-.02	-.03	.02	.04	.29**	.08	-.02	.30**
8. M-physical	.84**	.73**	.81**	.90**	-.02	.13	.06	.00
9. M-emotional	—	.82**	.84**	.95**	.14	.27*	-.02	.19
10. M-harassment	.82**	—	.81**	.88**	.06	.17	-.01	.07
11. M-severe combined	.84**	.81**	—	.91**	.16	.27*	.02	.14
12. M-all types abuse	.95**	.88**	.91**	—	.09	.23*	.00	.12
13. C-hit, punched/kicked at home	.14	.06	.16	.09	—	.38**	.06	.16
14. C-saw family hit, punched/kicked at home	.26*	.17	.27*	.23*	.38**	—	.02	.08
15. C-beaten up, shot at, threatened in town	-.02	-.01	.02	.00	.06	.02	—	.13
16. C-saw someone beaten, shot, killed in town	.19	.07	.14	.12	.16	.08	.13	—
17. C-saw dead body in town	-.15	-.13	-.10	-.16	.19	-.13	.02	.08
18. C-adult touched private sexual parts	.02	.08	-.01	.05	-.07	-.09	.22*	-.09
19. C-heard about violent death/injury of loved one	.07	-.01	-.01	.02	.30**	.41**	-.09	.00
20. M-non-sexual assault family/someone known	.26*	.35**	.30**	.29**	.09	.10	-.12	.07
21. M-non-sexual assault stranger	.12	.16	.17	.15	.12	-.12	-.11	.02
22. M-sexual assault family/someone known	.48**	.47**	.48**	.51**	-.01	.16	.00	.05
23. M-sexual assault stranger	.09	.09	.09	.09	-.08	-.10	-.05	-.11
24. M-sexual contact < age 18 with adult	.22*	.25*	.17	.22*	.05	.05	-.01	.16
25. M-PTSD	.43**	.38**	.28**	.38**	.05	.17	-.10	.06

Note. C = child variables. M = mother variables. * $p < .05$. ** $p < .01$.

Table 10. *Intercorrelations for Child PTSD Diagnosis and Candidate Dichotomous Predictors (17-25)*

Variable	17	18	19	20	21	22	23	24	25
1. C-PTSD	-.01	.23*	.28**	.02	.01	.29**	-.18	.06	.14
2. C-physical	-.09	-.09	.15	.06	.13	-.04	.13	.13	-.05
3. C-emotional	.07	.15	.15	.15	.05	.09	-.03	.20	.03
4. C-sexual	.15	.70**	-.06	-.08	.16	.25*	-.04	.01	-.07
5. C-neglect	.02	-.08	.11	-.10	-.19	.10	-.10	-.08	-.12
6. C-witness violence	.11	-.10	-.20	.09	.01	.11	.03	.23*	.05
7. C-all types abuse	.01	.01	.10	.08	.07	.06	-.01	.18	-.03
8. M-physical	-.17	.15	.00	.26*	.16	.50**	.08	.20	.29**
9. M-emotional	-.15	.02	.07	.26*	.12	.48**	.09	.22*	.43**
10. M-harassment	-.13	.08	-.01	.35**	.16	.47**	.09	.25*	.40**
11. M-severe combined	-.10	-.01	-.01	.30**	.17	.48**	.09	.17	.28**
12. M-all types abuse	-.16	.05	.02	.29**	.15	.51**	.09	.22*	.40**
13. C-hit, punched/kicked at home	.19	.07	.30**	.09	.12	-.01	-.08	.05	.05
14. C-saw family hit, punched/kicked at home	-.13	-.09	.41**	.10	-.12	.16	-.10	.05	.17
15. C-beaten up, shot at, threatened in town	.02	.22*	-.09	-.12	-.11	.00	-.05	-.01	-.10
16. C-saw someone beaten, shot, killed in town	.08	-.09	.00	.07	.02	.05	-.11	.16	.06
17. C-saw dead body in town	—	.08	-.16	-.06	-.03	-.07	-.10	-.02	-.09
18. C-adult touched private sexual parts	.08	—	-.07	-.09	.09	.23*	-.04	.05	-.08
19. C-heard about violent death/injury of loved one	-.16	-.07	—	.11	.14	.10	.09	.07	.17
20. M-non-sexual assault family/ someone known	-.06	-.09	.11	—	.28**	.07	.03	.25*	.33**
21. M-non-sexual assault stranger	-.03	.09	.14	.28**	—	.18	.20	.15	.10
22. M-sexual assault family/someone known	-.07	.23*	.10	.07	.18	—	.17	.30**	.31**
23. M-sexual assault stranger	-.10	-.04	.09	.04	.20	.17	—	.02	.23*
24. M-sexual contact < age 18 with adult	-.02	.05	.07	.25*	.15	.30**	.02	—	.19
25. M-PTSD	-.09	-.08	.17	.33**	.10	.31**	.23*	.19	—

Note. C = child variables. M = mother variables. * $p < .05$. ** $p < .01$.

Stepwise selection of predictors. The stepwise backward-Likelihood Ratio (LR) procedure was used to determine which of the 15 candidate predictors significantly contributed to the regression model (standard significance of $p < .05$). Table 11, Table 12, and Table 13 give the odds ratio and confidence interval at each step starting with the step 1 (15-predictor model) and ending with step 10 (6-predictor model). The stepwise-backward procedure resulted in the elimination of one covariate at each step that did not significantly contribute to the regression model using alpha level .05. The following variables were removed at each step: (2) child saw dead body in town ($p = .94$); (3) mother non-sexual assault by stranger ($p = .88$); (4) mother lifetime exposure to all types of intimate partner violence/abuse ($p = .81$); (5) mother non-sexual assault by family member/someone known ($p = .54$); (6) child seeing someone being beaten, shot at, or killed in town ($p = .51$); (7) mother PTSD diagnosis ($p = .40$); (8) mother sexual contact when under age 18 with someone older ($p = .29$); (9) child being hit, punched, or kicked very hard at home ($p = .25$); and (10) child hearing about a violent death or serious injury of a loved one ($p = .14$). Predictors starting with the letter *C* represent child variables; an *M* denotes mother variables.

Table 11. *Stepwise-Backward LR Regression Models Predicting Child PTSD Diagnosis (N = 87): Odds Ratio and Confidence Interval for Steps 1-4*

Predictor	Step 1 (15-Predictor)	Step 2 (14-Predictor)	Step 3 (13-Predictor)	Step 4 (12-Predictor)
C-all types abuse	1.31* [1.05-1.65]	1.31* [1.05-1.65]	1.31* [1.05-1.65]	1.31* [1.05-1.64]
M-all types abuse	1.01 [0.96-1.05]	1.01 [0.96-1.05]	1.01 [0.96-1.05]	—
C-hit, punched/ kicked at home	0.32 [0.03-2.92]	0.31 [0.04-2.26]	0.30 [0.04-2.09]	0.29 [0.04-2.06]
C-saw family hit, punched/kicked at home	0.13* [0.02-0.88]	0.13* [0.02-0.86]	0.14* [0.02-0.86]	0.14* [0.02-0.85]
C-beaten up/shot at/threatened in town	0.12 [0.01-1.6]	0.12 [0.01-1.60]	0.12 [0.01-1.60]	0.13 [0.01-1.61]
C-saw someone beaten/shot/killed in town	1.91 [0.32-11.38]	1.91 [0.32-11.41]	1.91 [0.32-11.41]	1.92 [0.33-11.25]
C-saw dead body in town	0.94 [0.17-5.16]	—	—	—
C-adult touched private sexual parts	0.00 [0.00-Infinity]	0.00 [0.00-Infinity]	0.00 [0.00-Infinity]	0.00 [0.00-Infinity]
C-heard about violent death/injury of loved one	0.16 [0.01-2.12]	0.17 [0.01-2.09]	0.16 [0.01-1.96]	0.17 [0.01-2.01]
M-non-sexual assault family/ someone known	1.86 [0.28-12.33]	1.86 [0.28-12.23]	1.80 [0.29-11.24]	1.76 [0.29-10.69]
M-non-sexual assault stranger	0.86 [0.11-6.39]	0.86 [0.12-6.35]	—	—
M-sexual assault family/someone known	0.15 [0.02-1.04]	0.15 [0.02-1.03]	0.15 [0.02-1.03]	0.13* [0.02-0.82]
M-sexual assault stranger	4.57 [0.00-Infinity]	4.59 [0.00- Infinity]	4.15 [0.00-Infinity]	4.27 [0.00-Infinity]
M-sexual contact < age 18 with adult	2.54 [0.42-15.40]	2.54 [0.42-15.36]	2.54 [0.42-15.49]	2.53 [0.42-15.33]
M-PTSD	0.37 [0.04-3.87]	0.37 [0.04-3.87]	0.37 [0.04-3.80]	0.34 [0.04-2.88]
Constant	102.37 [NA]	98.14 [NA]	100.92 [NA]	126.60 [NA]

Note. CI = confidence interval for odds ratio (OR). $df = 1$. * $p < .05$.

Table 12. *Stepwise-Backward LR Regression Models Predicting Child PTSD Diagnosis (N = 87): Odds Ratio and Confidence Interval for Steps 5-7*

Predictor	Step 5 (11-Predictor)	Step 6 (10-Predictor)	Step 7 (9-Predictor)
C-all types abuse	1.29* [1.04-1.60]	1.26* [1.04-1.51]	1.24* [1.04-1.49]
C-hit, punched/ kicked at home	0.30 [0.04-2.14]	0.31 [0.04-2.25]	0.31 [0.04-2.24]
C-saw family hit, punched/kicked at home	0.13* [0.02-0.85]	0.13* [0.02-0.84]	0.12* [0.02-0.75]
C-beaten up/shot at/threatened in town	0.12 [0.01-1.52]	0.13 [0.01-1.72]	0.14 [0.01-1.78]
C-saw someone beaten/shot/killed in town	1.80 [0.31-10.43]	—	—
C-adult touched private sexual parts	0.00 [0.00-Infinity]	0.00 [0.00-Infinity]	0.00 [0.00-Infinity]
C-heard about violent death/injury of loved one	0.18 [0.01-2.13]	0.18 [0.01-2.19]	0.18 [0.02-2.15]
M-sexual assault family/someone known	0.13* [0.02-0.79]	0.13* [0.02-0.81]	0.10* [0.02-0.58]
M-sexual assault stranger	3.89 [0.00-Infinity]	3.19 [0.00-Infinity]	3.10 [0.00-Infinity]
M-sexual contact < age 18 with adult	2.75 [0.46-16.57]	2.88 [0.50-16.60]	2.59 [0.45-14.74]
M-PTSD	0.41 [0.06-3.13]	0.42 [0.05-3.22]	—
Constant	208.51 [NA]	434.30 [NA]	270.01 [NA]

Note. CI = confidence interval for odds ratio (OR). $df = 1$. * $p < .05$.

Table 13. *Stepwise-Backward LR Regression Models Predicting Child PTSD Diagnosis (N = 87): Odds Ratio and Confidence Interval for Steps 8-10*

Predictor	Step 8 (8-Predictor)	Step 9 (7-Predictor)	Step 10 (6-Predictor)
C-all types abuse	1.21* [1.02-1.43]	1.25* [1.05-1.49]	1.26* [1.05-1.51]
C-hit, punched/ kicked at home	0.32 [0.05-2.22]	0.11* [0.02-0.64]	—
C-saw family hit, punched/kicked at home	0.12* [0.02-0.75]	—	0.08* [0.02-1.51]
C-beaten up/shot at/threatened in town	0.12 [0.01-1.55]	0.13 [0.01-1.54]	0.14 [0.01-1.78]
C-adult touched private sexual parts	0.00 [0.00-Infinity]	0.00 [0.00-Infinity]	0.00 [0.00-Infinity]
C-heard about violent death/injury of loved one	0.20 [0.02-2.51]	0.16 [0.01-1.84]	—
M-sexual assault family/someone known	0.14 [0.03-0.71]	0.16* [0.33-0.80]	0.15* [0.03-0.73]
M-sexual assault stranger	2.29 [0.00-Infinity]	2.60 [0.00-Infinity]	2.64 [0.00-Infinity]
Constant	736.25 01 [NA]	220.15 [NA]	41.89 [NA]

Note. CI = confidence interval for odds ratio (OR). $df = 1$. * $p < .05$.

Final Logistic Regression Model

Binary logistic regression analysis was conducted to predict child PTSD diagnosis for 87 mother-child dyads using a 5-predictor model with the continuous variable *child lifetime exposure to all types of family violence* and the following dichotomous variables: child seeing family member being hit, punched, or kicked very hard at home; child having adult touch private sexual body parts; mother sexual assault by family member/someone known; and mother sexual assault by stranger. Multiple indicators were used in order to provide a comprehensive assessment of the results as recommended by Peng, Lee, and Ingersoll (2002), including: (a) overall model fit, (b) statistical tests of individual predictors, and (c) an assessment of the predicted probabilities. The results of the logistic regression are presented in terms of the odds of an outcome versus the probability (Brunelli & Rocco, 2006).

Overall model fit. As shown in Table 14, the 5-predictor model was statistically significant and fit the data better than the null (constant only) model in distinguishing between children with PTSD and children without PTSD, $\chi^2 (5, N = 87) = 39.65$. The Nagelkerke R^2 was 0.49 indicating that approximately half of the variance in whether children had PTSD was predicted from the linear combination of the five independent variables.

Statistical tests of individual predictors. The statistical significance of the individual regression coefficients (i.e., B s) of each predictor was tested using the Wald chi-square statistic. The variables child having adult touch private sexual body parts and mother sexual assault by stranger were not significant contributors to the regression

model. The remaining three covariates were significant predictors of child PTSD diagnosis as indicated by the odds ratios (*ORs*) in Table 14. Child lifetime exposure to all types of family violence had the least impact on the odds of a child being diagnosed with PTSD and a one-unit increase in this predictor was related to a 26% increase in the odds of child PTSD (*OR* = 1.26).

Child seeing family member being hit, punched, or kicked very hard at home had the greatest impact and every one-unit increase in this predictor was associated with a 92% decrease in the odds of child PTSD diagnosis (*OR* = 0.08). Mother sexual assault by family member/someone known also had a large effect and every one-unit increase in this predictor was related to an 82% decrease in the odds of child PTSD diagnosis (*OR* = 0.18). Additionally, the confidence intervals (*CI*s) for these three predictors did not cross the value of 1.0 suggesting that these covariates were significant contributors to child PTSD in the sample (Stoltzfus, 2011).

Table 14. *Step 11: Final 5-Predictor Logistic Regression Model Predicting Child PTSD Diagnosis (N = 87)*

Predictor	<i>B</i>	<i>SE</i>	<i>OR</i> [95% <i>CI</i>]	Wald χ^2	<i>p</i>
C-all types abuse	0.23	0.09	1.23 [1.05-1.51]	6.38	.01
C-saw family hit, punched/ kicked at home	-2.59	0.86	0.08 [0.01-0.40]	9.14	.00
C-adult touched private sexual parts	-21.37	22057.84	0.00 [0.00-Infinity]	0.00	.99
M-sexual assault family/ someone known	-1.73	0.79	0.18 [0.04-0.83]	4.85	.03
M-sexual assault stranger	21.70	17658.15	2.66 [0.00-Infinity]	0.00	.99
Constant	2.01	28255.24	7.43 [NA]	0.00	1.00

Note. *CI* = confidence interval for odds ratio (*OR*). *df* = 1.

Assessment of predictive probabilities. The predictive power of the model was evaluated according to the classification table (*c*-index), which indicates the discrimination ability of the model and how well the combination of variables predicts child PTSD (see Table 15). There was a 21.9% increase in the predictive power of the model with the five predictors compared to the null model (58.6%) and the overall percentage correctly predicted by the model was above 0.70 signifying that this was a reasonable model according to the guidelines put forth by Hosmer and Lemeshow (2000). The *c*-statistic (concordance) for sensitivity (non-event) and specificity (event) were both above the 0.50 cut off indicating positive results; however, the covariates were better at predicting children without PTSD than children with a PTSD diagnosis.

Table 15. *Observed and Predicted Frequencies for Child PTSD Diagnosis by Logistic Regression*

Observed	Predicted		% Correct
	PTSD	No-PTSD	
PTSD	24	12	66.7
No-PTSD	5	46	90.2
Overall % correct			80.5

Note. The cut value is 0.50.

Chapter V: Discussion

The overall goal of the present study was to gain a cultural and contextually-based understanding of family exposure to traumatic events and risk factors for developing child PTSD within a child maltreatment context. Given this, the findings from the study are situated within prior research in Mexico in order to provide a within culture perspective; previous studies in the U.S. are presented as a comparison of cross-cultural similarities and differences. Additionally, the majority of research focused on child maltreatment populations has been conducted in the U.S. As a whole, it appears that there are several commonalities in this sample with other traumatized populations in the U.S. and Mexico. There are also some unique characteristics of children and mothers in this study.

As expected, lifetime prevalence for exposure to traumatic events and exposure to family violence in this sample is consistent with previous literature. Trauma exposure is a common occurrence across different cultures. It was also expected that the prevalence of exposure would be more alike within a similar cultural context than cross-culturally; however, this was not always the case. A distinctive characteristic found within this sample was the extreme prevalence of family and community violence exposure compared to previous studies in Mexico. Furthermore, high levels of trauma exposure were found across the entire sample including children and mothers who did not meet diagnostic criteria for PTSD. The types of traumas that children most frequently experienced were acute, most likely as a result of the interpersonal nature of the violence as well as the chronicity of the violence. Not only were children and mothers exposed to

multiple incidences of abuse in the home, they also encountered violence on a daily basis outside of their homes.

The discussion of results from this study focuses on children and mothers separately, starting with lifetime prevalence to a variety of potentially traumatic events, exposure specific to family violence, and PTSD prevalence. Potential risk factors of child PTSD diagnosis identified in past research are discussed including sociodemographic variables of gender, age, socioeconomic status; trauma-related factors (severity of event and degree of exposure to the event); posttrauma characteristics of the child's recovery environment including parental psychopathology, distress, support, and substance use; and socioeconomic and sociocultural factors such as poverty and community violence. A discussion of the relational impact of trauma on child-mother dyads; the application of the findings within a cultural ecological framework; and implications for children, families, and communities is presented.

Lifetime Exposure

Potentially traumatic events. Contrary to what was expected, children's overall rate of exposure to any potentially traumatic event (59%) was lower than what Copeland and colleagues (2007) observed in their epidemiological study with youth in the U.S. (68%) and Orozco and colleagues (2007) in their study with Mexican adolescents aged 12-17 (69%). The frequency of trauma exposure in this sample was similar to rates documented in the aforementioned studies: 25% experienced one or more events (31%; Copeland et al.; 27% Orozco et al.) and 37% were exposed to two or more traumatic events (37%; Copeland et al.; 41%; Orozco et al.).

The overall prevalence of 55% for mother exposure to any traumatic stressor during their life was within the range of 51-69% of what has been reported for women in the U.S. (Kessler et al., 1995; Resnick et al., 1993, respectively), but was unexpectedly lower than the 71% estimate reported by Norris and colleagues (2003) with women from four cities in Mexico. The 24% frequency of single-incident trauma for mothers in this study was nearly identical to the 26% rate for U.S. women, but lower than what has previously been documented for other Mexican women (37%). Consistent with prior studies in the U.S. and Mexico, mothers in this study were most frequently exposed to a serious accident and witnessed violence.

Norris and colleagues (2003) have focused their research on disaster-related trauma primarily related to the 1999 flood in Mexico (Norris, Murphy, Baker, & Perilla, 2004; Norris, Slone, Baker, & Murphy, 2006) and Hurricane Paulina in 1998 (Norris, Perilla, & Murphy, 2001). Whereas Norris and colleagues (2003) used a community sample of survivors of various disasters, the sample in the current study is likely a clinical population because the study focuses on child maltreatment. The current study used a targeted sample of families previously identified for child maltreatment through government institutions, which may have led to underreporting of trauma exposure out of fear. Many of the families had already experienced children being removed from their homes by child protective services and may have been reluctant to report more incidences of traumatic events.

Although the reported exposure rates were lower in this sample compared to past studies, *seeing a dead body in town* was one of the most frequent types of traumatic

events that children in the present study were exposed to (not including funerals) along with *seeing someone shot at or killed in town*, for all children. In fact, children in the No-PTSD group had a slightly higher rate of exposure to seeing a dead body in town than children with PTSD. This is not necessarily surprising considering the local context of Monterrey. Exposure to these types of events would not be uncommon for populations living in communities with exceptionally high levels of crime and violence. Witnessing violence in the home (seeing a family member being hit, punched or kicked very hard at home) was also a common experience for children in the PTSD group. In the U.S. the most common traumatic events for children are hearing about the violent death of a loved one, rape, coercion, and physical assault (Copeland et al., 2007). In their study with Mexican adolescents, Orozoco and colleagues (2007) reported unexpected sudden death of a relative, witnessing domestic violence, and being involved in a serious accident as the most common life events children were exposed to. Compared to these studies it appears that children in this dissertation study sample are a particularly vulnerable population.

After the public launching of President Felipe Calderon's campaign against drug cartels in 2006 and the subsequent inability of the government to reduce the level of violence, the number of opportunistic crimes (e.g., car theft, robberies) and drug-related crimes has escalated (del Bosque, 2011; Rodriguez & Ramirez, 2012). Sadly, public executions by shooting and hanging, assault, and bodily mutilations are becoming commonplace. Although Monterrey has historically been one of the most economically advantaged cities in Mexico, the inequality between the rich and the poor is immense.

Some of the wealthiest industrialists around the world live in gated communities while countless families are barely able to survive. Many families do not have electricity or running water and many children do not attend school, leaving them with limited options for employment (del Bosque, 2011).

The drug cartels are quickly becoming a last resort out of crippling poverty as a growing number of youth look towards a future with little hope. The level of poverty is evident in this study sample by the fact that the average household size of six adults and children live on a monthly income of 5,075 Mexican pesos, which is the equivalent to \$388 U.S. dollars (based on exchange rate as of 9/10/2012). This is considerably lower than the national average monthly household income of 8,422 MXN (\$645 USD) (Gardner, 2005), indicating that children and mothers in the present study were particularly impoverished compared to the general population in Mexico.

As predicted, lifetime exposure to any type of traumatic event was higher in boys than girls (66% and 47%, respectively). Compared to girls, boys in the study reported more exposure to hearing about the violent death/serious injury of a loved one and being in a serious accident and these sex differences were significant. Surprisingly, girls reported greater exposure to being assaulted in public than boys (being beat up, shot at or threatened to be hurt badly in town). A possible explanation for this unusual finding could be that the question was open to interpretation of being exposed to any form of assault and girls may have related it to sexual assault rather than physical assault. Only three children in the entire sample reported being exposed to *having an adult touch private sexual body parts*. Past research has shown the tendency of underreporting for

sexual abuse and it is possible that children in this sample were hesitant to directly respond positively to this question out of feelings of shame and/or fear of possible repercussions from revealing a family secret.

Family violence. As expected, exposure to interpersonal violence within the family was considerably higher than exposure to other types of traumatic events for both children and mothers. Children's lifetime exposure to family violence at 87% is a great deal higher than the overall rate of 35% for youth in several industrialized countries such as the U.S., United Kingdom, Canada, and Australia (Kearney et al. 2009). This finding is not so surprising because this sample was a child maltreatment population within a developing country. It is notable that almost all of the children in the PTSD group (97%) and 80% of children in the No-PTSD group reported experiencing some type of family violence in their short lives, particularly emotional abuse and physical abuse. It is surprising that more children did not meet criteria for PTSD given the high rates of abuse experienced by these children.

It is difficult to make comparisons across different samples within Mexico in so far as there is limited prevalence data available in U.S. scholarly journals. Only one study investigating the prevalence of childhood sexual abuse among Mexican adolescents was identified reporting a lifetime exposure rate of 19% for girls (Pineda-Lucatero et al., 2008), which is significantly higher than the 3.4% reported by children in the present sample. Once again, it is very likely that children underreported when asked about their experiences either being touched or being forced to touch an older person sexually. Exposure to overall family violence in this sample is still substantially high even when

compared to the 69% exposure rate to any traumatic event reported by Orozco and colleagues (2007).

The lifetime prevalence of 78% for mother exposure to intimate partner violence (IPV) is considerably higher compared to population-based samples of women in the U.S. ranging from 7-30% (Wilt & Olson, 1996), and the 26% rate in Mexican women observed by Baker and colleagues (2005) in the same sample from the earlier epidemiological study (Norris et al., 2003). The breadth of variation in prevalence estimates was unexpected, which might be related to underreporting. The occurrence of violence in the home is most likely much greater than what is reported since women do not often share experiences with violence until they are seriously injured and are forced to seek medical treatment (Wilt & Olson, 1996).

Another possible reason for the large variation in lifetime prevalence rates to IPV could be that many previous studies have focused on sexual assault (rape) and physical violence presumably because these are the most visible and severe types of violence for which women seek treatment. All the same, incidence rates specific to sexual assault/molestation (26%) and physical abuse (50%) within this sample of mothers is still higher than U.S. prevalence rates (3-15% and 7-12%, respectively) (Acierno, Resnick, & Kilpatrick, 1997); however, the rates are similar to the 32% sexual abuse and 56% physical abuse prevalence observed by Díaz-Olavarrieta and colleagues (2002) with a different sample of Mexican women. Consistent with previous research, sexual assault was more likely to be perpetrated by a family member/someone known rather than a stranger. Mothers in this sample were most frequently exposed to emotional abuse at 53%

as well as high rates of harassment (31%), which speaks to the importance of assessing for other types of abuse in addition to sexual and physical violence.

PTSD Diagnosis

Given the wide range of child PTSD prevalence rates documented in the literature, it is difficult to make meaningful comparisons with previous studies; however studies have shown elevated rates of PTSD in children exposed to interpersonal violence. The 41% child PTSD rate in this sample was within the 3-56% range for children exposed to family violence and community violence in the U.S. (Graham-Bermann & Levendoskay, 1998; Lehman, 1997; Margolin & Vickerman, 2007), but significantly higher than the 2% prevalence in Mexican adolescents (Orozco et al., 2007). In light of previous literature about the developmental effects of psychological trauma it makes sense that children in the present study (ages 5-14) would exhibit more PTSD symptomatology compared to older youth (12-17 years) in the study by Orozco and colleagues (2007). For example, Davis and Siegel (2000) found that children who were exposed to traumatic events before age 11 were three times more likely to develop PTSD compared to older children. Consistent with U.S. studies and the adolescent study in Mexico, more girls (57%) than boys (44%) met diagnostic criteria for PTSD, had more severe symptomatology, and had more impairments in psychosocial functioning, but this difference was non-significant.

Only 2% of mothers in the study met diagnostic criteria for PTSD compared to 10% prevalence in U.S. women (Kessler et al., 1995) and 15% prevalence in a different sample of Mexican women (Norris and colleagues, 2003). A possible explanation for the

lower PTSD prevalence rate in the current mother sample could be that diagnostic assessment was based on the worst event reported by mothers across a variety of traumatic stressors rather than experiences solely with intimate partner violence. As with children, research with adults has shown higher PTSD prevalence in women exposed to intimate partner violence

Relational trauma. Only 12 mothers in the entire sample met criteria for PTSD; however, more than half (58%) of the mothers with PTSD also had children with PTSD. Additionally, mothers who had children that met PTSD diagnosis also had higher rates of exposure to intimate partner violence. From an attachment perspective, mothers' prior history with abuse may negatively influence the quality of attachment in the parent-child relationship leading to cognitive and emotional impairments in the child. Children learn early on that they cannot depend on their caregiver to help protect them from danger and they live in a constant state of fear and helplessness. The repetitive nature of exposure to family violence makes it difficult for children to recover between events because there are continual reminders of the violence (Graham-Bermann et al., 2006).

It is likely that Mexican children and mothers exhibit a relational pattern of withdrawn/unresponsive/unavailable that is common to parent-child relationships where the mother has a prior history of trauma (Sherrington & Zeanah, 2001). Seeing and hearing about the child's trauma may trigger traumatic memories in the mother, which she will try to avoid. This becomes a cycle of reoccurring trauma as the symptomatology of the child and mother exacerbates traumatic reactions in each other. This type of attachment pattern fits within the cultural context of indirect communication and conflict avoidance

that is common to many Latin cultures. As a way to illustrate the impact of relational PTSD, a specific example is provided from one of the test cases during the training phase prior to implementing the study. Children were able to share their experiences of traumatic events in their lives with their mothers as a part of the one of the structured-interaction-tasks that is a part of the multi-method assessment protocol. This was the first time that mothers had learned about many of the events in the child's life.

One child recounted an earlier memory of being in the bathroom and feeling fearful and worried when he heard the approach of male footsteps towards the door. Talking about this event was extremely emotional for both the child and mother and many tears were shed. It is possible that the task served as a treatment intervention within itself by providing a safe setting in which the child could share his traumatic experience with his mother without having her withdraw. Being able to process the event with the support of his mother who hugged and kissed him seemed to facilitate a positive coping response in the child by having her there to help soothe and regulate his emotions. This type of setting may have also provided the safety for the mother to be able to stay present and be responsive to her child's needs since it was a controlled environment and the mother could depend of the therapist for emotional support.

Comorbid substance use. The co-occurrence of patterns of substance misuse and abuse, child maltreatment, and intimate partner violence has been documented in several studies (Belsky, 1993; Lisak & Miller, 2003; Markward, Dozier, Hooks, & Markward, 2000; Stalans & Ritchie, 2008). Although not a primary focus in the present study, the finding of elevated rates of alcohol and drug use in fathers/partners in this sample

provides preliminary support for the link between substance abuse and family violence. Mother reports of their partner's regular substance use at 55% for weekly intake and 22% for daily intake are substantial and were significantly higher than what children reported for their fathers. The opposite trend was found for child substance use and child reports of their own use were higher than mother reports of child intake. It is not surprising that children's self-reports would be more accurate than mother's report of their children since it is likely that mothers in the study may not monitor their children's behaviors outside of the home. Additionally, mothers may want to think the best of their children and choose to ignore negative or risky behaviors that their child exhibits.

It also makes sense that mothers would have a more accurate perception of their partner's substance than children's perceptions since fathers/partners would be more likely to engage in these behaviors in front of the mother and hide the behaviors from his children. Fathers/partners likely use alcohol and drugs to self-medicate to alleviate unwanted feelings (e.g., stress/tension, anxieties) or as an escape from the harsh realities of life, which may lead to violent behavior towards his wife/partner and his children. The substance taking habits questionnaire did not contain enough information to really know how the findings can be interpreted; however, the transmission of patterns of dysfunctional behaviors across generations seems to be a reasonable conclusion. The questionnaire must be further developed and refined before more definitive conclusions can be made.

Examining the Findings Through a Cultural Ecological Lens

Findings from this study highlight the importance of considering multiple ecological contexts in which individuals are embedded in order to gain a comprehensive understanding about the etiology of child maltreatment. At the individual level both children and mothers were previously exposed to traumatic events; most likely lived in a chaotic and disorganized household with many people living under one roof; and lived in poor neighborhoods in the inner city. Within the immediate context of the parent-child relationship, mothers in this study were overwhelmed with multiple children to care for, working full time and frequently had more than one job for less than minimum wage, and had limited resources and social support. Parental distress has direct consequences for children, and mothers may not have been able to provide the necessary support and monitoring that their children needed.

At the broader cultural and community level, children and mothers live in a patriarchal society that fosters traditional gender roles. The daily stressors of poverty, discrimination, oppression, and community violence experienced by these children and mothers would impair their abilities to cope with additional traumatic stressors, as is indicated in both family stress and trauma theories and addressing cumulative stress and dose effect for the development of PTSD.

As a family scientist viewing these findings from a cultural ecological perspective, it is the researcher's opinion that child maltreatment is a systemic problem for everyone – children, families, the local community, and the larger global society as a whole. From a social justice perspective, family scientists have a responsibility to help

change discriminatory and oppressive practices through their scholarship. This study was undertaken in an effort to help illuminate the deleterious effects of traumatic exposure on individuals and families and more specifically, the importance of associated family-level socioeconomic and sociocultural characteristics as risk factors for the development of child PTSD. Consistent with a feminist and critical activist stance, this researcher feels a strong obligation to disseminate the findings from this study with the hope that this information will help inform policy decisions at the state and national levels to increase accessibility and provide more social support for children and families in Mexico.

Conclusions

It is evident that both children and mothers in this sample experienced high levels of traumatic stress throughout their lives and that they are exposed to appreciably greater incidences of interpersonal violence in the home versus other types of traumatic events such as disasters, war, and accidents. Findings from the present study provide support for the association of trauma-related variables and posttrauma factors in heightening the risk for PTSD in children. Interpersonal violence in particular appears to have a more negative effect on child psychopathology, along with greater exposure to ongoing direct experiences with family violence and witnessing of violence in the home. This study also provides support for the relational impact of trauma on children and their mothers and the importance of parental involvement and influence on children's cognitive and emotional processing of trauma as a part of the recovery environment. Finally, socioeconomic and sociocultural factors such as poverty and extreme levels of community violence were related to PTSD symptomatology.

Limitations

Some limitations of the study include a small non-representative sample and the inability to externally validate the results with a different community-based sample, limiting the generalizability of the findings to the larger population and clinical application in the real world. Given the nature of family violence and that secrecy that often surrounds the perpetuation of violence in the home, it can be challenging to obtain accurate and representative prevalence rates of trauma exposure and PTSD. In spite of these limitations, much can be gained from this study. A cultural ecological perspective provides a rich and more in-depth understanding of the impact of psychological trauma on children and mothers within the local context of Monterrey, Mexico.

The knowledge gained from this study may be applicable to other Mexican populations in different cities as well as immigrants in the U.S. As past research has shown, there seem to be some universal characteristics of traumatic stress and PTSD that cross all cultures. However, there are also culturally-based characteristics that may not apply to other populations and should be taken into account before making definitive conclusions. The issue of comorbid disorders was not addressed in depth because it was beyond the scope of the study. It would be important to assess for the presence of co-occurring emotional (e.g., anxiety, depression), behavioral (e.g., conduct disorder, aggression), and other risk-taking behaviors (e.g., substance abuse, suicide) in future studies as they are intricately related to PTSD symptomatology.

Implications

Findings from this study not only have implications for children and families, there are also several implications for practitioners, researchers, and social institutions within the community and government. Childhood trauma has long-term consequences impacting the psychosocial well-being and physical health of individuals throughout adulthood. The effects of trauma also greatly impact a child's interpersonal relationships with others. More family-based research is needed examining intra- and extrafamilial influences on the parent-child relationship (Cicchetti & Toth, 1995). According to Belsky (1984), parenting is one of the most proximal influences on child development. Given this, it makes sense to include both parents in the assessment and treatment of childhood traumatic stress.

Practitioners and researchers. Due to the silent nature of interpersonal violence, it would be important for physicians and mental health professionals to include screening for family violence more routinely, as a part of regular exams and therapy. The high prevalence of family violence exposure in the No-PTSD group of children highlights the importance of prevention and intervention programming to broaden their efforts to include both clinical and non-clinical populations. In terms of research, more studies need to be conducted with school age and younger children and their parents, and with more diverse populations within the U.S. and in different countries around the world. Racial/ethnic minorities in the U.S. and children and families in economically developing countries like Mexico are at increased risk for negative psychological outcomes due to poverty, more stressful life conditions, living in communities with poor social

infrastructure, exposure to high crime, language barriers, teenage pregnancy, school drop out, and discrimination (Domenenech-Rodríguez & Wieling, 2005).

Local cultural context. As demonstrated within this study, socio-political-cultural factors directly impact peoples' daily lives in Monterrey. Many people are afraid to leave their homes and when they do venture out, they check the most recent news reports in order to avoid getting caught in the middle of a gun battle. These effects were felt during the implementation of the present study. Specific measures were taken to ensure the safety of U.S. researchers each time they traveled to Monterrey. Local Mexican team members provided transportation to the family therapy clinic and other facilities, and made arrangements for lodging in areas that were considered to be safer. There were several instances during the course of the study where there were delays due to crime-related events. For example, on one occasion this researcher was unable to leave the family therapy clinic for several hours due to blockades being set up after a body was thrown out of a moving van on the expressway. As another example, the house of one of the local research team members was burglarized at two different time points during the study.

Larger sociocultural context. As an example of the potential implications of this research at the state and national levels, this study was partially funded by the Mexican government because of their interest in developing more effective ways to assess and treat trauma within their child maltreatment population. The current policy is for children whose parents have been reported for maltreatment to be removed from the home and placed in the children's state institution. An investigation of the parent(s) is conducted in

order to determine whether the parent(s) has been abusive or negligent, and if so an alternative placement within the larger family network is sought out. If no alternative placement can be found, children stay at the institution until reaching adult status.

Rather than focusing solely on the individual or family as the cause of child maltreatment, this study provides evidence for the impact of larger cultural and community factors that put children at risk for maltreatment and PTSD. More resources and efforts can be made to help reduce the amount of community violence and organized crime in Mexico, and create more job opportunities for individuals to help alleviate the number and amount of traumatic stressors people are exposed to. Additionally, findings from the study about the relational nature of trauma and child PTSD provide support for the application of systemic-level treatment models that target the parent-child relationship such as parent management skills training.

There are also implications for the U.S. as the drug war and violence continues to expand further north into Texas and other border cities between Mexico and the U.S. As more Mexican children and families cross the border and flee to safety, the U.S. will continue to see a rise in illegal and legal immigration from Mexico. It is likely that many of these immigrants will be traumatized as a result of their exposure to violence in their homes and communities. Knowledge gained from this study can help to inform best practices for use with this population and other similar populations. As this study has demonstrated, family and community violence is a not only an individual problem. It is an interrelational problem that impacts families, communities, and the larger global society as a whole.

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Appendix A

Overview of Assessment Protocol Pilot Measures

Appendix B

Sociodemographic Questionnaire

2008 Mexico Assessment Protocol

(DEMO-ENGL) Demographics 6-1-08

FAMILY ID: ____
 DATE: ____/____/____
 ASSESSOR ID: B ____

GROUP CODE: 1 2 3A 3B

FAMILY DEMOGRAPHIC QUESTIONNAIRE

Time: 10 minutes

Script: **[Say to mother]**

"The first thing we would like to do is get some information about your background. If you're ready, I will begin asking you questions and fill out this Demographic Questionnaire as we go. Are you ready?"

Personal Information

Mother name: _____ Date of birth: ____/____/____

Focus child name: _____ Date of birth: ____/____/____

Address/place of residence: _____

Telephone: (Home) _____ (Work) _____ (Cell/other) _____

Do you speak an indigenous language? ☐ Yes ☐ No If "YES", what language? _____

Cultural/ethnic identification: _____

Relational Status and Number of Children

1. What is your relational status? (Circle one)

- 1 – Single
- 2 – Married
- 3 – Widowed
- 4 – Cohabiting
- 5 – Divorced
- 6 – Separated

2. How many years have you been married/cohabiting with your current partner? _____

3. How many children do you have with your current partner, including stepchildren/other children you have helped to raise? _____

Education and Work Status

4. How many years of education have you completed? (Circle one)
- 1 – Middle school or less
 - 2 – Middle school completed
 - 3 – Some high school (no diploma)
 - 4 – High school diploma or equivalent
 - 5 – Post-high school specialized training (technical, business, clerical, or other training)
 - 6 – Some college (no Bachelor's degree): Number of years in college _____
 - 7 – Bachelor's degree
 - 8 – One or more years of graduate coursework (no degree)
 - 9 – Master's degree
 - 10 – Other _____

5. Is [child's name] attending school now? ☐ Yes ☐ No If "YES", what grade? _____

[NOTE: If child is permanently out of school (e.g., dropped out, or been permanently expelled), the answer is "NO". If child has been temporarily expelled, or, for example, is missing school because of an extended illness, the answer is "YES".]

6. What is your current work situation? (Circle one)
- 1 – Self-employed
 - 2 – Working for company/someone else
 - 3 – Temporarily laid off (maternity, sick leave, etc.)
 - 4 – Unemployed, looking for work
 - 5 – Unemployed, not looking for work
 - 6 – Take care of children in home full-time
 - 7 – Retired
 - 8 – Permanently disabled, unable to work
 - 9 – Student, not working
 - 10 – Other _____
7. Do you have employment benefits at your job (e.g., health insurance)? ☐ Yes ☐ No
If NO, do you have health benefits through another family member? ☐ Yes ☐ No
8. Do you have more than one job? ☐ Yes ☐ No
If YES, what type of work do you do in your other job? _____

Current Living Situation

9. Where do you live?
- 1 – An apartment/duplex you rent
 - 2 – An apartment /duplex you own
 - 3 – A house you rent
 - 4 – A house you own
 - 5 – A friend's apartment or house

- 6 – A relative's apartment or house
- 7 – A mission or other emergency housing
- 8 – A motel/hotel
- 9 – Homeless (group shelter, car or camping)
- 10 – Other _____

10. How many people currently live in your household (people who eat and sleep there most of the time)? (**NOTE: write who family members are if mother identifies**)

Number of Adults (18 years and older): _____

Number of Children (under 18 years): _____

11. How would you rate your housing situation on the following things:

	<u>N/A</u>	<u>Bad</u>	<u>Average</u>	<u>Good</u>	<u>Very Good</u>
a) Safety	0	1	2	3	4
b) Cleanliness	0	1	2	3	4
c) Space	0	1	2	3	4
d) Stability/permanency	0	1	2	3	4
e) Adequacy/meeting your family's needs	0	1	2	3	4

12. How would you rate your neighborhood on the following things:

	<u>N/A</u>	<u>Bad</u>	<u>Average</u>	<u>Good</u>	<u>Very Good</u>
a) Your personal safety	0	1	2	3	4
b) Your children's personal safety	0	1	2	3	4
c) Safe places for kids to play	0	1	2	3	4
d) Cleanliness	0	1	2	3	4
e) Schools	0	1	2	3	4
f) Noise level	0	1	2	3	4
g) Protection of property	0	1	2	3	4

Financial Situation and Stress

13. What is your monthly income? _____

14. What is your household monthly income? _____

Who contributes to your household income? (List all people) _____

15. What are the sources of your household income?

- 1 – Cash sales
- 2 – Wages/salary from job
- 3 – Pensions/retirement
- 4 – Gifts/stocks
- 5 – Other family members in Mexico:

Source(s) _____ Amount(s) _____

6 – Other family members in the U.S. or another country:

Source(s) _____ Amount(s) _____

7 – Other sources:

Source(s) _____ Amount(s) _____

16. How often do you NOT have enough money to pay for your family's basic needs?

	Never	Rarely	Sometimes	All of the time
a) For food	0	1	2	3
b) For housing	0	1	2	3
c) For transportation	0	1	2	3
d) For medical care	0	1	2	3
e) For children's education	0	1	2	3

17. Who do you ask for financial help for basic family needs like food, clothing, housing, transportation or medical care?

1 – Other family members

2 – Friends

3 – Neighbors

4 – Church

5 – Government agencies

6 – Non-government organizations

7 – Other (specify) _____

8 – I have no one to ask for financial help

18. How stressed do you feel RIGHT NOW about meeting your basic needs and those of your family?

<u>Not</u> <u>Stressed</u>	<u>Sometimes</u> <u>Stressed</u>	<u>Often</u> <u>Stressed</u>	<u>Overwhelmed</u>
0	1	2	3

[After completing the questionnaire, ask mother if she is ready to move onto the next activity. Tell Assessor A you are finished and ready to move onto the individual level part of the interview.]

2008 Mexico Assessment Protocol

(DEMO-SPAN) Demográfico 6-1-08

ID FAMILIA: ____
 FECHA: ____/____/____
 ID EVALUADOR: B ____

CÓDIGO: 1 2 3A 3B

CUESTIONARIO DEMOGRÁFICO FAMILIARTiempo: 10 minutosGuión: **[Decir a la madre]**

“Lo primero que nos gustaría hacer es obtener cierta información acerca de sus vidas. Si está lista, empezaré haciéndole unas preguntas y llenando un Cuestionario Demográfico conforme avanzamos. ¿Está lista?”

Información Personal

Nombre de la madre: _____

Fecha de nacimiento de la madre: ____/____/____

Nombre del hijo(a) (foco de atención): _____

Fecha de nacimiento del hijo(a): ____/____/____

Dirección/Lugar de residencia: _____

Teléfono: (Casa) _____ (Trabajo) _____ (Celular/otro) _____

¿Habla usted alguna lengua indígena? ☐ Sí ☐ No Si “Sí”, ¿cuál? _____

Identificación cultural/étnica: _____

Estado Civil y Número de Hijos1. Estado civil (circula una):

- 1 – Soltera
- 2 – Casada
- 3 – Viuda
- 4 – Unión libre
- 5 – Divorciada
- 6 – Separada

2. Número de años casada/unión libre con la pareja actual: _____

3. Número de hijo/as con la pareja actual (incluyendo hijastros/otros niño/as a los que haya criado): _____

Educación y Situación Laboral

4. Máximo años de estudios completado por la madre (Circula una):

- 1 – 2^{do} de secundaria o menos
- 2 – Secundaria completa
- 3 – Algo de preparatoria, pero no graduado
- 4 – Graduado de preparatoria o equivalente a preparatoria
- 5 – Entrenamiento especializado posterior a la preparatoria (técnico, comercio, administrativo o de oficina, otro entrenamiento)
- 6 – Algo de Universidad, pero sin título _____ (Número de años en universidad)
- 7 – Título Universitario
- 8 – Uno o más años de maestría sin titularse
- 9 – Maestría, titulada
- 10 – Otro _____

5. ¿Su hijo [*nombre del hijo(a)*] asiste a la escuela? ☐ Sí ☐ No Si "Sí", ¿en qué grado está? _____

[NOTA: Si el hijo/a está permanentemente fuera de la escuela, *por ejemplo si abandonó los estudios o fue expulsado permanentemente, la respuesta es NO. Si el hijo/a ha sido expulsado temporalmente o por ejemplo no ha ido a la escuela por una enfermedad, la respuesta es SI.]*

6. ¿Cuál es su situación laboral actual?

- 1 – Trabajador independiente
- 2 – Trabajando para compañía o empresa/para alguien más
- 3 – Temporalmente sin empleo (maternidad, incapacidad por enfermedad, etc.)
- 4 – Desempleada, buscando trabajo
- 5 – Desempleada, sin buscar trabajo
- 6 – Al cuidado de los hijo/as en casa (tiempo completo)
- 7 – Retirada
- 8 – Incapacidad permanente, incapaz de trabajar
- 9 – Estudiante, sin empleo
- 10 – Otro _____

7. ¿Tiene prestaciones en su trabajo (Ej., seguro médico)? ☐ Sí ☐ No

De ser NO, ¿tiene beneficios de salud a través de otro miembro de la familia? ☐ Sí ☐ No

8. ¿Tiene más de un empleo? ☐ Sí ☐ No

De ser SÍ, ¿qué tipo de trabajo realiza en su otro empleo? _____

Situación de vivienda actual

9. ¿Dónde vive?

- 1 – Departamento/casa de dos viviendas contiguas (duplex) de renta
- 2 – Departamento/casa de dos viviendas contiguas (duplex) propia

- 3 – Casa de renta
- 4 – Casa propia
- 5 – Departamento o casa de amigo(a)
- 6 – Departamento o casa de familiar
- 7 – Un albergue u otro refugio de emergencia
- 8 – Motel/hotel
- 9 – Sin hogar (albergue, asilo, carro o campamento)
- 10 – Otro _____

10. ¿Cuántas personas viven actualmente en su hogar (personas que comen y duermen ahí la mayoría del tiempo)? **(NOTA: escribe cuáles miembros de la familia son)**

Número de adultos (18 años o más): _____

Número de hijos (menores de 18 años): _____

11. ¿Cómo calificaría su situación de vivienda en cuanto a:

	<u>N/A</u>	<u>Mala</u>	<u>Promedio</u>	<u>Buena</u>	<u>Muy Buena</u>
a) Seguridad?	0	1	2	3	4
b) Limpieza?	0	1	2	3	4
c) Espacio?	0	1	2	3	4
d) Estabilidad/permanencia?	0	1	2	3	4
e) Adecuación/satisface necesidades de la familia?	0	1	2	3	4

12. ¿Cómo calificaría a su vecindario en cuanto a:

	<u>N/A</u>	<u>Mala</u>	<u>Promedio</u>	<u>Buena</u>	<u>Muy Buena</u>
a) Su seguridad personal?	0	1	2	3	4
b) Seguridad personal de sus hijos?	0	1	2	3	4
c) Lugares seguros de juego para sus hijos?	0	1	2	3	4
d) Limpieza?	0	1	2	3	4
e) Escuelas?	0	1	2	3	4
f) Nivel de ruido?	0	1	2	3	4
g) Protección de Propiedad?	0	1	2	3	4

Situación financiera y estrés

13. ¿Cuál es su ingreso mensual? _____

14. ¿Cuál es el ingreso mensual de su hogar? _____

¿Quién contribuye al ingreso económico de su hogar? (Enlistar a todas las personas):

15. ¿Cuáles son las fuentes de ingreso económico para su hogar?

- 1 – Ventas al contado/efectivo

- 2 – Sueldo/salario del empleo
 3 – Pensiones/retiro
 4 – Regalos/acciones/reserva o ahorro
 5 – Otros miembros de la familia en diferente estado de la República Mexicana:
 Tipo(s) _____ Cantidad(s) _____
 6 – Otros miembros de la familia en otro país:
 Tipo(s) _____ Cantidad(s) _____
 7 – Otras fuentes:
 Tipo(s) _____ Cantidad(s) _____

16. ¿Qué tan seguido no tiene el dinero suficiente para pagar las necesidades básicas de su familia?

	Nunca	Raras veces	Algunas veces	Todo el tiempo
a) Para comida	0	1	2	3
b) Para vivienda	0	1	2	3
c) Para transporte	0	1	2	3
d) Para servicio médico	0	1	2	3
e) Para educación de hijos	0	1	2	3

17. ¿A quién le solicita ayuda financiera para las necesidades básicas de su familia como alimento, vestimenta, vivienda, transporte o servicio médico?

- 1 – Otros miembros de la familia
 2 – Amigos
 3 – Vecinos
 4 – Iglesia
 5 – Agencias de Gobierno
 6 – Organizaciones no gubernamentales
 7 – Otro (especificar) _____
 8 – No tengo a quién pedir ayuda financiera

18. ¿Qué tan estresada se siente usted EN ESTE MOMENTO sobre poder alcanzar sus necesidades básicas y las de su familia?

Nada	De vez en cuando		A menudo
<u>Estresada</u>	<u>Estresada</u>	<u>Estresada</u>	<u>Abrumada</u>
0	1	2	3

[Después de completar este cuestionario, pregúntale a la madre si está lista para la próxima actividad. Dile al Evaluador A que has terminado y estás listo para comenzar la entrevista a nive.]

Appendix C

Child Report of Substance Taking Habits

2008 Mexico Assessment Protocol

(C3-ENGL) REV-Child 5-6-08

FAMILY ID: ____
 DATE: ____/____/____
 ASSESSOR ID: A ____

GROUP CODE: 1 2 3A 3B

RISK-TAKING AND EXPOSURE TO VIOLENCE[®] (CHILD VERSION)

Time: 10 minutes

Script: **[Say to child]**

"We are interested in the behaviors/activities you are engaging in or experiencing with your family and in your community. Please listen to the following list of questions and answer "YES" or "NO." Do you have any questions before we begin?" **[When child is ready, read the list to child and put an [X] in the appropriate box for each question.]**

Part 1: Drug Taking Habits

©2008 Adapted by Wieling, E., & Erolin, K.S. in collaboration with Catani, C., & Neuner, F.

1. Do you ever drink/use:
 - a) Alcohol? ☐ Yes ☐ No If YES: What type(s)? _____
 Amount/How much? _____ ☐ Daily ☐ Weekly
 - b) Marijuana/pot? ☐ Yes ☐ No If YES: What type(s)? _____
 Amount/How much? _____ ☐ Daily ☐ Weekly
 - c) Other drug/s? ☐ Yes ☐ No If YES: What type(s)? _____
 Amount/How much? _____ ☐ Daily ☐ Weekly
 - d) Cigarettes? ☐ Yes ☐ No
 If YES: Amount/How much? _____ ☐ Daily ☐ Weekly
2. Does your father/guardian ever drink/use:
 - a) Alcohol? ☐ Yes ☐ No If YES: What type(s)? _____
 Amount/How much? _____ ☐ Daily ☐ Weekly
 - b) Marijuana/pot? ☐ Yes ☐ No If YES: What type(s)? _____
 Amount/How much? _____ ☐ Daily ☐ Weekly
 - c) Other drug/s? ☐ Yes ☐ No If YES: What type(s)? _____
 Amount/How much? _____ ☐ Daily ☐ Weekly

3. Does your mother/guardian ever drink/use:

- a) Alcohol? ☐ Yes ☐ No If YES: What type(s)? _____
Amount/How much? _____ ☐ Daily ☐ Weekly
- b) Marijuana/pot? ☐ Yes ☐ No If YES: What type(s)? _____
Amount/How much? _____ ☐ Daily ☐ Weekly
- c) Other drug/s? ☐ Yes ☐ No If YES: What type(s)? _____
Amount/How much? _____ ☐ Daily ☐ Weekly

4. Do any of your other family members who live with you ever drink/use:

- a) Alcohol? ☐ Yes ☐ No If YES: What type(s)? _____
Amount/How much? _____ ☐ Daily ☐ Weekly
- b) Marijuana/pot? ☐ Yes ☐ No If YES: What type(s)? _____
Amount/How much? _____ ☐ Daily ☐ Weekly
- c) Other drug/s? ☐ Yes ☐ No If YES: What type(s)? _____
Amount/How much? _____ ☐ Daily ☐ Weekly

ID FAMILIA: ____
 FECHA: ____/____/____
 ID EVALUADOR: A ____

CÓDIGO: 1 2 3A 3B

RIESGOS Y EXPOSICIÓN A LA VIOLENCIA® (VERSIÓN INFANTIL)

Tiempo: 10 minutos

Guión: **[Decir al menor]**

“Estamos interesados en las conductas/actividades en las que estás involucrado o que experimentas con tu familia y en tu comunidad. Por favor escucha la siguiente lista de preguntas y contesta “Sí” o “NO.” ¿Tienes alguna pregunta antes de que comencemos?” **[Cuando el niño/a esté listo, lee la lista y marca una [X] en la caja adecuada de acuerdo a cada pregunta.]**

Parte 1: Hábitos de Consumo de Drogas

©2008 Adapted by Wieling, E., & Erolin, K.S. in collaboration with Catani, C., & Neuner, F.

1. ¿Alguna vez has tomado/usado:

- a) Alcohol? ☐ Sí ☐ No Si contestó Sí: Qué tipo(s)? _____
 Cantidad/Cuánto? _____ ☐ Diario ☐ Semanalmente
- b) Marihuana/mota? ☐ Sí ☐ No Si contestó Sí: Qué tipo(s)? _____
 Cantidad/Cuánto? _____ ☐ Diario ☐ Semanalmente
- c) Otra/s droga/s? ☐ Sí ☐ No Si contestó Sí: Qué tipo(s)? _____
 Cantidad/Cuánto? _____ ☐ Diario ☐ Semanalmente
- d) Cigarrillo? ☐ Sí ☐ No
 Si contestó Sí: Cantidad/Cuánto? _____ ☐ Diario ☐ Semanalmente

2. ¿Tu padre o tutor alguna vez ha tomado/usado:

- a) Alcohol? ☐ Sí ☐ No Si contestó Sí: Qué tipo(s)? _____
 Cantidad/Cuánto? _____ ☐ Diario ☐ Semanalmente
- b) Marihuana/mota? ☐ Sí ☐ No Si contestó Sí: Qué tipo(s)? _____
 Cantidad/Cuánto? _____ ☐ Diario ☐ Semanalmente
- c) Otra/s droga/s? ☐ Sí ☐ No Si contestó Sí: Qué tipo(s)? _____
 Cantidad/Cuánto? _____ ☐ Diario ☐ Semanalmente

3. ¿Tu madre o tutora alguna vez ha tomado/usado:

- a) Alcohol? ☐ Sí ☐ No Si contestó Sí: Qué tipo(s)? _____
 Cantidad/Cuánto? _____ ☐ Diario ☐ Semanalmente
- b) Marihuana/mota? ☐ Sí ☐ No Si contestó Sí: Qué tipo(s)? _____
 Cantidad/Cuánto? _____ ☐ Diario ☐ Semanalmente
- c) Otra/s droga/s? ☐ Sí ☐ No Si contestó Sí: Qué tipo(s)? _____
 Cantidad/Cuánto? _____ ☐ Diario ☐ Semanalmente

4. ¿Algún otro miembro de tu familia con el que vives ha tomado/usado:

- a) Alcohol? ☐ Sí ☐ No Si contestó Sí: Qué tipo(s)? _____
 Cantidad/Cuánto? _____ ☐ Diario ☐ Semanalmente
- b) Marihuana/mota? ☐ Sí ☐ No Si contestó Sí: Qué tipo(s)? _____
 Cantidad/Cuánto? _____ ☐ Diario ☐ Semanalmente
- c) Otra/s droga/s? ☐ Sí ☐ No Si contestó Sí: Qué tipo(s)? _____
 Cantidad/Cuánto? _____ ☐ Diario ☐ Semanalmente

Appendix D

Mother Report of Substance Taking Habits

2008 Mexico Assessment Protocol

(M3-ENGL of 7) REV-Parent 5-6-08

FAMILY ID: ____
 DATE: ____/____/____
 ASSESSOR ID: B ____

GROUP CODE: 1 2 3A 3B

RISK-TAKING AND EXPOSURE TO VIOLENCE[®] (PARENT VERSION)

Time: 10 minutesScript: **[Say to mother]**

"We are interested in the behaviors/activities you are engaging in or experiencing with your family and in your community. Please listen to the following list of questions and answer "YES" or "NO." Do you have any questions before we begin?"

Part 1: Drug Taking Habits

[®]Adapted by Wieling, E., & Erolin, K.S., 2008 in collaboration with Catani, C., & Neuner, F.

1. Do you ever drink/use:

- a) Alcohol? ☐ Yes ☐ No If YES: What type(s)? _____
 Amount/How much? _____ ☐ Daily ☐ Weekly
- b) Marijuana/pot? ☐ Yes ☐ No If YES: What type(s)? _____
 Amount/How much? _____ ☐ Daily ☐ Weekly
- c) Other drug/s? ☐ Yes ☐ No If YES: What type(s)? _____
 Amount/How much? _____ ☐ Daily ☐ Weekly

2. Does your husband/partner drink/use:

- a) Alcohol? ☐ Yes ☐ No If YES: What type(s)? _____
 Amount/How much? _____ ☐ Daily ☐ Weekly
- b) Marijuana/pot? ☐ Yes ☐ No If YES: What type(s)? _____
 Amount/How much? _____ ☐ Daily ☐ Weekly
- c) Other drug/s? ☐ Yes ☐ No If YES: What type(s)? _____
 Amount/How much? _____ ☐ Daily ☐ Weekly

3. Does [focal child name] ever drink/use:

- a) Alcohol? ☐ Yes ☐ No If YES: What type(s)? _____
 Amount/How much? _____ ☐ Daily ☐ Weekly
- b) Marijuana/pot? ☐ Yes ☐ No If YES: What type(s)? _____
 Amount/How much? _____ ☐ Daily ☐ Weekly
- c) Other drug/s? ☐ Yes ☐ No If YES: What type(s)? _____
 Amount/How much? _____ ☐ Daily ☐ Weekly
 If YES: Type(s) _____ Amount per day/week _____
- d) Cigarettes? ☐ Yes ☐ No
 If YES: Amount/How much? _____ ☐ Daily ☐ Weekly

4. Do any of your other family members who live with you ever drink/use:

- a) Alcohol? ☐ Yes ☐ No If YES: What type(s)? _____
 Amount/How much? _____ ☐ Daily ☐ Weekly
- b) Marijuana/Pot? ☐ Yes ☐ No If YES: What type(s)? _____
 Amount/How much? _____ ☐ Daily ☐ Weekly
- c) Other drug/s? ☐ Yes ☐ No If YES: What type(s)? _____
 Amount/How much? _____ ☐ Daily ☐ Weekly

ID FAMILIA: ____
 FECHA: ____/____/____
 ID EVALUADOR: B ____

CÓDIGO: 1 2 3A 3B

**RIESGOS Y EXPOSICIÓN A LA VIOLENCIA®
 (VERSIÓN DE PADRES)**

Tiempo: 10 minutos

Guión: *[Decir a la madre]*

“Estamos interesados en las conductas/actividades en las que está involucrada o que experimenta con su familia y en su comunidad. Por favor escuche la siguiente lista de preguntas y conteste “Sí” o “NO.” ¿Tiene alguna pregunta antes de que comencemos?”

Parte 1: Hábitos de Consumo de Drogas

© 2008 Adaptado por Wieling, E., y Erolin, K.S. en colaboración con Catani, C., y Neuner, F.

1. ¿Alguna vez ha tomado/usado:

- a) Alcohol? ☐ Sí ☐ No Si contestó Sí: ¿Qué tipo(s)? _____
 ¿Cantidad/Cuánto? _____ ☐ Diario ☐ Semanalmente
- b) Marihuana/mota? ☐ Sí ☐ No Si contestó Sí: ¿Qué tipo(s)? _____
 ¿Cantidad/Cuánto? _____ ☐ Diario ☐ Semanalmente
- c) Otra/s droga/s? ☐ Sí ☐ No Si contestó Sí: ¿Qué tipo(s)? _____
 ¿Cantidad/Cuánto? _____ ☐ Diario ☐ Semanalmente

2. ¿Su esposo/pareja ha tomado/usado:

- a) Alcohol? ☐ Sí ☐ No Si contestó Sí: ¿Qué tipo(s)? _____
 Cantidad/Cuánto? _____ ☐ Diario ☐ Semanalmente
- b) Marihuana/mota? ☐ Sí ☐ No Si contestó Sí: ¿Qué tipo(s)? _____
 ¿Cantidad/Cuánto? _____ ☐ Diario ☐ Semanalmente
- c) Otra/s droga/s? ☐ Sí ☐ No Si contestó Sí: ¿Qué tipo(s)? _____
 ¿Cantidad/Cuánto? _____ ☐ Diario ☐ Semanalmente

3. ¿Su hijo/a ha tomado/usado:

- a) Alcohol? ☐ Sí ☐ No Si contestó Sí: ¿Qué tipo(s)? _____
 ¿Cantidad/Cuánto? _____ ☐ Diario ☐ Semanalmente
- b) Marihuana/mota? ☐ Sí ☐ No Si contestó Sí: ¿Qué tipo(s)? _____
 ¿Cantidad/Cuánto? _____ ☐ Diario ☐ Semanalmente
- c) Otra/s droga/s? ☐ Sí ☐ No Si contestó Sí: ¿Qué tipo(s)? _____
 ¿Cantidad/Cuánto? _____ ☐ Diario ☐ Semanalmente
- d) Cigarrillo? ☐ Sí ☐ No
 Si contestó Sí: ¿Cantidad/Cuánto? _____ ☐ Diario ☐ Semanalmente

4. ¿Algún otro miembro de su familia con el que vive ha tomado/usado:

- a) Alcohol? ☐ Sí ☐ No Si contestó Sí: ¿Qué tipo(s)? _____
 ¿Cantidad/Cuánto? _____ ☐ Diario ☐ Semanalmente
- b) Marihuana/mota? ☐ Sí ☐ No Si contestó Sí: ¿Qué tipo(s)? _____
 ¿Cantidad/Cuánto? _____ ☐ Diario ☐ Semanalmente
- c) Otra/s droga/s? ☐ Sí ☐ No Si contestaste Sí: ¿Qué tipo(s)? _____
 ¿Cantidad/Cuánto? _____ ☐ Diario ☐ Semanalmente

Appendix E

UCLA PTSD Index

2008 Mexico Assessment Protocol

(C2-ENGL of 6) UCLA Child PTSD Index 7-9-08

FAMILY ID: ____
 DATE: ____/____/____
 ASSESSOR ID: A ____

GROUP CODE: 1 2 3A 3B

UCLA PTSD INDEX FOR DSM IV (Child Version, Revision 1)®

Time: 20 minutes

Script: *[Say to child]*

"This is a list of VERY SCARY, DANGEROUS OR VIOLENT things that sometimes happen to people. These are times where someone was HURT VERY BADLY OR KILLED, or could have been. Some people have had these experiences; some people have not had these experiences. Please be honest in your answer. All of your answers will be kept confidential. For each question, say "YES" or "NO" if this scary thing happened to you. Do you have any questions before we begin?" *[When child is ready, begin reading questions to child and put an [X] in the appropriate box.]*

1) Being in a big earthquake that badly damaged the building you were in.	Yes []	No []
2) Being in another kind of disaster , like a fire, tornado, flood or hurricane.	Yes []	No []
3) Being in a bad accident , like a very serious car accident.	Yes []	No []
4) Being in place where a war was going on around you.	Yes []	No []
5) Being hit, punched, or kicked very hard at home. (Do NOT include ordinary fights between brothers & sisters).	Yes []	No []
6) Seeing a family member being hit, punched or kicked very hard at home. (Do NOT include ordinary fights between brothers & sisters).	Yes []	No []
7) Being beaten up, shot at or threatened to be hurt badly in your town.	Yes []	No []
8) Seeing someone in your town being beaten up, shot at or killed .	Yes []	No []
9) Seeing a dead body in your town (do NOT include funerals).	Yes []	No []
10) Having an adult or someone much older touch your private sexual body parts when you did not want them to.	Yes []	No []
11) Hearing about the violent death or serious injury of a loved one.	Yes []	No []
12) Having painful and scary medical treatment in a hospital when you were very sick badly injured.	Yes []	No []

13)	OTHER than the situations described above, has ANYTHING ELSE ever happened to you that was really scary, dangerous, or violent ?	Yes [] No []
14)	<p>a) <i>[If the child answered "YES" to only ONE thing in the list of questions above, write the number of that item, here]:</i> _____</p> <p>b) <i>[If the child answered "YES" to MORE than one thing, ask the child to choose one thing that bothers him/her the MOST RIGHT NOW. Write the number of the item, here]:</i> _____</p> <p>c) About how long ago did this bad thing happen to you? _____</p> <p>d) Please briefly describe what happened: _____</p>	

[If the child responded "NO" to questions 1-14, STOP HERE. If the child responded "YES" to one or more of these questions, CONTINUE to question 15. The remaining questions of this instrument refer to the event that happened in question 14].

[Say to child]: "Now I'm going to ask you some questions about the bad thing you just talked about. Please answer 'YES' or 'NO' about HOW YOU FELT during or right after [bad thing/event] happened." **[As you read the questions, refer back to the bad thing frequently. You should be as specific/explicit as possible with the language you use].**

15)	Were you scared that you would die?	Yes [] No []
16)	Were you scared that you would be hurt badly?	Yes [] No []
17)	Were you hurt badly?	Yes [] No []
18)	Were you scared that someone else would die?	Yes [] No []
19)	Were you scared that someone else would be hurt badly?	Yes [] No []
20)	Was someone else hurt badly?	Yes [] No []
21)	Did someone die?	Yes [] No []
22)	Did you feel very scared, like this was one of your most scary experiences ever?	Yes [] No []
23)	Did you feel that you could not stop what was happening or that you needed someone to help?	Yes [] No []
24)	Did you feel that what you saw was disgusting or gross?	Yes [] No []
25)	Did you run around or act like you were very upset?	Yes [] No []

26) Did you feel very confused?	Yes []	No []
27) Did you feel like what was happening did not seem real in some way, like it was going on in a movie instead of real life?	Yes []	No []

[Say to child]: "Here is a list of problems people sometimes have after very bad things happen. Again, please think about the bad thing that happened to you that you talked about earlier which was [bad thing/event]. Now listen carefully, as I read each problem on the following list. As I read each problem, tell me how often this problem has happened to you in the PAST MONTH. Here is a rating sheet to help you decide how often the problem has happened in the past month [show child the frequency rating sheet]. Are you ready to begin?" **[When child is ready, read questions to child and circle the appropriate number. Be sure that child answers ALL of the questions].**

How much of the time during the PAST MONTH	None	Little	Some	Much	Most
1 _{D4} I watch out for danger or things that I am afraid of.	0	1	2	3	4
2 _{B4} When something reminds me of what happened, I get very upset, afraid or sad.	0	1	2	3	4
3 _{B1} I have upsetting thoughts, pictures, or sounds of what happened come into my mind when I do not want them to.	0	1	2	3	4
4 _{D2} I feel grouchy, angry or mad.	0	1	2	3	4
5 _{B2} I have dreams about what happened or other bad dreams.	0	1	2	3	4
6 _{B3} I feel like I am back at the time when the bad thing happened, living through it again.	0	1	2	3	4
7 _{C4} I feel like staying by myself and not being with my friends.	0	1	2	3	4
8 _{C5} I feel alone inside and not close to other people.	0	1	2	3	4
9 _{C1} I try not to talk about, think about, or have feelings about what happened.	0	1	2	3	4
10 _{C6} I have trouble feeling happiness or love.	0	1	2	3	4
11 _{C6} I have trouble feeling sadness or anger.	0	1	2	3	4
12 _{D5} I feel jumpy or startle easily, like when I hear a loud noise or when something surprises me.	0	1	2	3	4
13 _{D1} I have trouble going to sleep or I wake up often during the night.	0	1	2	3	4
14 _{Af} I think that some part of what happened is my fault.	0	1	2	3	4

How much of the time during the PAST MONTH		None	Little	Some	Much	Most
15 _{C3}	I have trouble remembering important parts of what happened.	0	1	2	3	4
16 _{D3}	I have trouble concentrating or paying attention.	0	1	2	3	4
17 _{C2}	I try to stay away from people, places, or things that make me remember what happened.	0	1	2	3	4
18 _{B5}	When something reminds me of what happened, I have strong feelings in my body, like my heart beats fast, my head aches, or my stomach aches.	0	1	2	3	4
19 _{C7}	I think that I will not live a long life.	0	1	2	3	4
20 _{AF}	I am afraid that the bad thing will happen again.	0	1	2	3	4

[Say to child]: "Please answer "YES" or "NO" to the following questions. These questions still refer to the same bad thing/event that you have been talking about, which is bad thing/event. **[Frequently remind child of what the event was and be as specific as possible.]**

Functioning

²⁰⁰⁸ Adapted by Wiering, E., & Erolin, K.S. in collaboration with Catani, C., & Neuner, F.

1. Did you ever tell a doctor, teacher, healer or priest about the problems that occurred as a result of [event]? Yes [] No []
 2. Did you take medicine more than once for the problems which occurred as a result of [event]? Yes [] No []
 3. In the past months/weeks, have you been very upset with yourself for having the problems which occurred as a result of [event]? Yes [] No []
 4. In the past months/weeks, have the problems which occurred as a result of [event] kept you from going to a ceremony, to your friends, or to a meeting? Yes [] No []
 5. In the past months/weeks, have the problems which occurred as a result of [event] kept you from playing/socializing with your friends? Yes [] No []
 6. Have these difficulties ever caused you to have problems at school or at home? Yes [] No []
- How? _____

UCLA CHILD PTSD – FREQUENCY RATING SHEET

HOW OFTEN OR HOW MUCH OF THE TIME
DURING THE PAST MONTH, THAT IS SINCE _____,
DOES THE PROBLEM HAPPEN?

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NEVER	TWO TIMES A MONTH	1-2 TIMES A WEEK	2-3 TIMES EACH WEEK	ALMOST EVERY DAY																																																																																																																																																																																																				

ID FAMILIA: ____
 FECHA: ____/____/____
 ID EVALUADOR: A ____

CÓDIGO: 1 2 3A 3B

UCLA-PTSD INDICE PARA EL DSM IV (Versión para Menor, Revisión 1) ®

Tiempo: 20 minutos

Guión: *[Decir al menor]*

"Esta es una lista de cosas muy espantosas, peligrosas o violentas que a veces les pasa a las personas/gente. Son momentos en donde alguien fue lastimado o asesinado. Algunas personas han tenido estas experiencias, otras no las han tenido. Te haré preguntas y deberás contestar SI o NO si el evento violento te sucedió o no. Por favor sé honesto/sincero/a en las respuestas. Todas las respuestas se manejarán de forma confidencial. ¿Tienes alguna pregunta antes de empezar?" *[Cuando el menor esté listo, empezar a leer las preguntas y poner una X en el cuadro adecuado.]*

1) ¿Has estado en un gran terremoto que dañó gravemente el edificio en el cual estabas?	Sí []	No []
2) ¿Has estado en otra clase de desastre , como un incendio, tornado, inundación o huracán?	Sí []	No []
3) ¿Has estado en un accidente grave , como un accidente automovilístico muy serio ?	Sí []	No []
4) ¿Has estado en un lugar donde hay una guerra ?	Sí []	No []
5) ¿Has sido golpeado(a), azotado, o pateado fuertemente en tu casa? (NO incluyas peleas ordinarias entre hermanos y hermanas).	Sí []	No []
6) ¿Has visto a un miembro de familia ser golpeado, azotado, o pateado fuertemente en tu casa? (NO incluyas peleas ordinarias entre hermanos y hermanas).	Sí []	No []
7) ¿Has recibido una paliza, un disparo o una amenaza de ser herido gravemente en el barrio, colonia o ciudad donde vives?	Sí []	No []
8) ¿Has visto donde vives alguien recibir una paliza, disparo, o ser asesinado(a) ?	Sí []	No []
9) ¿Has visto el cuerpo de un muerto ? (NO incluyas funerales).	Sí []	No []
10) ¿Algún adulto o alguien mayor que tú te ha tocado en las partes sexuales privadas del cuerpo o te ha forzado a tener relaciones sexuales?	Sí []	No []
11) ¿Has escuchado que un familiar o alguien que tú quieres, murió de forma violenta o fue herido gravemente ?	Sí []	No []
12) ¿Has sentido miedo en un hospital y recibiste tratamiento médico doloroso cuando estabas muy enfermo(a) o mal herido(a)?	Sí []	No []

13)	Además de lo que contestaste ¿te ha pasado alguna OTRA cosa espantosa, peligrosa o violenta?	Sí [☐] No [☐]
14)	a) <i>[Si contestó "SÍ" a sólo una de las preguntas anteriores, escribe el número de esa pregunta aquí]:</i> _____ b) <i>[Si contestó "SÍ" a MÁS de una pregunta, pídele que escoja la que más le molesta EN ESTE MOMENTO. Escribe el número de esa pregunta aquí]:</i> _____ c) ¿Aproximadamente hace cuánto tiempo te pasó esto? _____ d) Por favor describe brevemente lo que pasó: _____ _____	

[Si el niño/a respondió "NO" a las preguntas 1-14, TERMINA AQUI. Si el niño/a respondió "SI" a una o más de estas preguntas, CONTINUA con la pregunta 15. El resto de las preguntas del instrumento se refieren al evento que mencionó en la pregunta 14].

[Decir al menor]: "Ahora te voy a hacer algunas preguntas acerca de lo que te pasó que acabas de mencionar. Por favor contesta "SÍ" o "NO" respecto a COMO TE SENTISTE durante o inmediatamente después de que [evento/cosa negativa] te pasó." **[Al leer las preguntas, haz referencia a las cosas malas que sucedieron con frecuencia. Utiliza el lenguaje más específico y explícito posible].**

15)	¿Tenías miedo de morir?	Sí [☐] No [☐]
16)	¿Tenías miedo de que te hirieran gravemente?	Sí [☐] No [☐]
17)	¿Te hirieron gravemente?	Sí [☐] No [☐]
18)	¿Tenías miedo de que alguien pudiera morir?	Sí [☐] No [☐]
19)	¿Tenías miedo de que alguien más pudiera ser herido(a) gravemente?	Sí [☐] No [☐]
20)	¿Resultó alguien más herido gravemente?	Sí [☐] No [☐]
21)	¿Murió alguien?	Sí [☐] No [☐]
22)	¿Te sentiste muy asustado(a), como si esta fuera una de las experiencias más espantosas que has tenido?	Sí [☐] No [☐]
23)	¿Sentiste que no podías parar lo que le estaba pasando o que necesitabas que alguien te ayudara?	Sí [☐] No [☐]
24)	¿Sentiste que lo que viste fue desagradable o asqueroso?	Sí [☐] No [☐]
25)	¿Estuviste muy inquieto o actuaste como si estuvieras molesto(a)?	Sí [☐] No [☐]

26) ¿Te sentiste muy confundido(a)?	Sí []	No []
27) ¿Sentiste que lo que estaba pasando en alguna manera no parecía real, como si estuviera pasando en una película en vez de la vida real?	Sí []	No []

[Decir al menor]: "Aquí hay una lista de problemas que la gente a veces tiene después de que les suceden cosas muy malas. Por favor piensa otra vez en lo que te sucedió que me dijiste anteriormente que fue [evento/cosa mala]. Ahora escucha con atención mientras leo cada problema de la siguiente lista. Mientras voy leyendo cada problema, por favor dime qué tan seguido te ha pasado este problema en el ÚLTIMO MES. Aquí hay una hoja ilustrada que te ayuda a decidir qué tan seguido te ha pasado este problema en el último mes [muéstrale la hoja con los rangos de frecuencia] ¿Estás listo/a para empezar?" **[Cuando el niño/a esté listo/a, lee las preguntas y circula el número apropiado. POR FAVOR ASEGÚRATE DE RESPONDER A TODAS LAS PREGUNTAS].**

Cuanto Tiempo Durante EL ÚLTIMO MES	Nada	Poco	Algo	Mucho	La mayoría
1 _{D4} ¿Has estado preocupado(a) de que algo malo te pueda pasar, o por situaciones o cosas que te dan miedo?	0	1	2	3	4
2 _{B4} ¿Te sentiste asustado(a), nervioso(a) o irritado(a) porque algo te recordó lo que pasó?	0	1	2	3	4
3 _{B1} ¿Has tenido pensamientos, imágenes, o sonidos que te recuerdan lo que pasó cuando no quieres tenerlos y no puedes controlarlos?	0	1	2	3	4
4 _{D2} ¿Te sientes enojado(a) o furioso(a) y de mal humor?	0	1	2	3	4
5 _{B2} ¿Con qué frecuencia has tenido pesadillas o sueños sobre de lo que pasó?	0	1	2	3	4
6 _{B3} ¿Has sentido como si estuvieras nuevamente en esa situación, como si la vivieras otra vez?	0	1	2	3	4
7 _{C4} ¿Has preferido estar solo(a) y no estar con tus amigos(as)?	0	1	2	3	4
8 _{C5} ¿Te has sentido solo(a) y no muy cercano a la gente?	0	1	2	3	4
9 _{C1} ¿Has tratado de no hablar, pensar o sentir nada sobre lo que pasó?	0	1	2	3	4
10 _{C6} ¿Has tenido dificultad para sentirte contento(a) o feliz?	0	1	2	3	4
11 _{C6} ¿Has tenido dificultad de sentirte triste o enojado(a)?	0	1	2	3	4
12 _{D5} ¿Te has sentido nervioso(a) o te sobresaltas fácilmente cuando te sorprendes por algo o cuando escuchas un ruido fuerte?	0	1	2	3	4
13 _{D1} ¿Has batallado para dormir o te despiertas varias veces durante la noche?	0	1	2	3	4
14 _{AF} ¿Has pensado que una parte de lo que sucedió es tu culpa?	0	1	2	3	4

Cuanto Tiempo Durante EL ÚLTIMO MES		Nada	Poco	Algo	Mucho	La mayoría
15 _{C3}	¿Te ha sido difícil recordar partes importantes de lo que sucedió?	0	1	2	3	4
16 _{D3}	¿Has tenido dificultad para concentrarte o para poner atención a algo?	0	1	2	3	4
17 _{C2}	¿Has tratado de alejarte de la gente, lugares, o cosas que te recuerdan lo que pasó?	0	1	2	3	4
18 _{B5}	¿Cuando algo te recuerda lo que pasó, sientes que el corazón te late rápido, te duele la cabeza, te duele el estómago o tiembles?	0	1	2	3	4
19 _{C7}	¿Has pensado que no vas a vivir muchos años, que vas a morir joven?	0	1	2	3	4
20 _{AF}	¿Has sentido miedo de que esa experiencia desagradable te pase otra vez?	0	1	2	3	4

[Decir al menor]: "Por favor contesta "Sí" o "NO" a las siguientes preguntas. Estas preguntas todavía se refieren al mismo evento/cosa mala de la que han estado hablando, que es [cosa/evento malo]. **[Recuérdale al niño(a) frecuentemente cuál fue el evento y sé lo más específico(a) posible.]**

Funcionamiento

- ¿Alguna vez le platicaste al médico, maestro, sacerdote o curandero acerca de los problemas que se produjeron por/como resultado de [acontecimiento]? Sí [] No []
- ¿Has tomado medicina más de una vez por los problemas que se produjeron por/como resultado de [acontecimiento]? Sí [] No []
- ¿En los últimos meses/semanas, ha estado molesto(a)/transtornado(a) contigo mismo(a) por tener problemas que ocurrieron como resultado de [acontecimiento]? Sí [] No []
- ¿En los últimos meses/semanas, los problemas que ocurrieron como resultado de [acontecimiento] han hecho que evites ir a una ceremonia, ir con tus amigos, o a una reunión? Sí [] No []
- ¿En los últimos meses/semanas, los problemas que ocurrieron a consecuencia de [acontecimiento] han hecho que evites jugar/socializar con tus amigos? Sí [] No []
- ¿Estas dificultades han causado que alguna vez tengas problemas en la escuela o en casa? Sí [] No []
¿Cómo? _____

¿QUE TAN SEGUIDO, A PARTIR DE _____,
TE SUCEDE EL PROBLEMA?

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Appendix F

Posttraumatic Stress Diagnostic Scale

2008 Mexico Assessment Protocol

(M2-ENGL of 7) PDS 5-6-08

FAMILY ID: ____
 DATE: ____/____/____
 ASSESSOR ID: B ____

GROUP CODE: 1 2 3A 3B

POSTTRAUMATIC STRESS DIAGNOSTIC SCALE ®

Time: 15 minutes

Script: **[Say to mother]**

"Many people have lived through or witnessed a very stressful and traumatic event at some point in their lives. I will ask you a list of questions about traumatic events. Please tell me if any of the events have happened to you or if you have witnessed any of the events. Do you have any questions before we begin?" **[Read the list of questions to mother and mark [X] if the event has happened to her or she witnessed the event.]**

Part 1

1. ☐ Serious accident, fire, or explosion (e.g., an industrial, farm, car, plane, or boating accident)
2. ☐ Natural disaster (e.g., tornado, hurricane, flood, or major earthquake)
3. ☐ Non-sexual assault by a family member or someone you know (e.g., being mugged physically attacked, shot, stabbed, or held at gunpoint)
4. ☐ Non-sexual assault by a stranger (e.g., being mugged, physically attacked, shot, stabbed, or held at gunpoint)
5. ☐ Sexual assault by a family member or someone you know (e.g., rape, or attempted rape)
6. ☐ Sexual assault by a stranger (e.g., rape, or attempted rape)
7. ☐ Military combat or a war zone
8. ☐ Sexual contact when you were younger than 18 with someone who was 5 or more years older than you (e.g., contact with genitals, breasts)
9. ☐ Imprisonment (e.g., prison inmate, prisoner of war, hostage)
10. ☐ Torture
11. ☐ Life-threatening illness
12. ☐ Other traumatic event
13. Description of the traumatic event from question 12: _____

[If you marked ANY of the items above CONTINUE. If not, stop here.]

Part 2

14. If more than one traumatic event happened to you from Part 1, which event bothers you the MOST? ***[If there is only ONE traumatic event from Part 1, mark the SAME event below.]***

- ☐ Accident
- ☐ Disaster
- ☐ Non-sexual assault/someone you know
- ☐ Non-sexual assault/stranger
- ☐ Sexual assault/someone you know
- ☐ Sexual assault/stranger
- ☐ Combat
- ☐ Sexual contact under 18 with someone 5 or more years older
- ☐ Imprisonment
- ☐ Torture
- ☐ Life-threatening illness
- ☐ Other

Brief description of event: _____

[Questions 15-21 refer to the traumatic event described above in question 14.]

15. How long ago did the traumatic event happen? (Circle one)

- 1 – Less than one month
- 2 – 1 to 3 months
- 3 – 3 to 6 months
- 4 – 6 months to 3 years
- 5 – 3 to 5 years
- 6 – More than 6 years

[Say to mother]: "Please answer YES or NO to the following questions. *During the traumatic event...*"

16. Were you physically injured?	☐ Yes ☐ No
17. Was someone else physically injured?	☐ Yes ☐ No
18. Did you think that your life was in danger?	☐ Yes ☐ No
19. Did you think that someone else's life was in danger?	☐ Yes ☐ No
20. Did you feel helpless?	☐ Yes ☐ No
21. Did you feel terrified?	☐ Yes ☐ No

Part 3

[Say to mother]: "Many people have lived through or witnessed one or more very stressful and traumatic events at some point in their lives. I will read you a list of problems that people sometimes have after experiencing traumatic events. Please tell me how often that problem has bothered you in the PAST MONTH, using the following rating scale. Rate each problem with respect to the traumatic event that bothered you the MOST." **[Read the list to the mother and circle the appropriate response.]**

0 Not at all or only one time ever							1 Once a week or less							2 2-4 times a week							3 Almost always						
S	M	T	W	H	F	S	S	M	T	W	H	F	S	S	M	T	W	H	F	S	S	M	T	W	H	F	S
								X								X			X		X	X	X	X		X	
														X	X	X			X		X		X	X	X		X
												X				X	X	X	X			X	X	X	X	X	X
														X	X		X				X	X	X		X	X	X

	Not at all	1/week or less	2-4 times a week	Almost always
22. Having upsetting thoughts or images about the traumatic event that came into your head when you didn't want them to	0	1	2	3
23. Having bad dreams or nightmares about the traumatic event	0	1	2	3
24. Reliving the traumatic event, acting or feeling as if it was happening again	0	1	2	3
25. Feeling emotionally upset when you were reminded of the traumatic event (e.g., feeling scared, angry, sad, guilty, etc.)	0	1	2	3
26. Experiencing physical reactions when you were reminded of the traumatic event (e.g., sweating, heart beating fast)	0	1	2	3
27. Trying not to think about, talk about or have feelings about the traumatic event	0	1	2	3
28. Trying to avoid activities, people, or places that remind you of the traumatic event	0	1	2	3
29. Not being able to remember an important part of the traumatic event	0	1	2	3
30. Having much less interest or participating much less often in important activities	0	1	2	3
31. Feeling distant or cut off from people around you	0	1	2	3
32. Feeling emotionally numb (for example, being unable to cry or unable to have loving feelings)	0	1	2	3
33. Feeling as if your future plans or hopes will not come true (e.g., you not having a career, marriage, children, or a long life)	0	1	2	3

0 Not at all or only one time ever							1 Once a week or less							2 2-4 times a week							3 Almost always						
S	M	T	W	H	F	S	S	M	T	W	H	F	S	S	M	T	W	H	F	S	S	M	T	W	H	F	S
								X								X			X		X	X	X	X		X	
														X	X	X					X		X	X	X		X
												X				X	X	X	X			X	X	X	X	X	X
														X	X		X				X	X	X		X	X	X

- | | <u>Not
at all</u> | <u>1/week
or less</u> | <u>2-4 times
a week</u> | <u>Almost
always</u> |
|--|-----------------------|---------------------------|-----------------------------|--------------------------|
| 34. Having trouble falling or staying asleep | 0 | 1 | 2 | 3 |
| 35. Feeling irritable or having fits of anger | 0 | 1 | 2 | 3 |
| 36. Having trouble concentrating (e.g., drifting in and out of conversations, losing track of a story on television, forgetting what you read) | 0 | 1 | 2 | 3 |
| 37. Being overly alert (e.g., checking to see who is around you, being uncomfortable with your back to a door, etc.) | 0 | 1 | 2 | 3 |
| 38. Being jumpy or easily startled (e.g., when someone walks up behind you) | 0 | 1 | 2 | 3 |
| 39. How long have you experienced the problems that you reported above? (Circle <u>one</u>) | | | | |
| 1 – Less than 1 month | | | | |
| 2 – 1 to 2 months | | | | |
| 3 – 3 or more months | | | | |
| 40. How long after the traumatic event did these problems begin? | | | | |
| 1 – Less than 6 months after the traumatic event | | | | |
| 2 – Six or more months after the traumatic event | | | | |

[Say to mother]: “The following questions are about whether the symptoms you just rated have interfered with any of the following areas of your life during the past MONTH. Have these symptoms caused you serious problems in your...”

41. Work	☐ Yes	☐ No	☐ Have no work
42. Household chores and duties	☐ Yes	☐ No	☐ Do no household chores
43. Relationship with friends	☐ Yes	☐ No	
44. Fun and leisure activities	☐ Yes	☐ No	
45. Schoolwork	☐ Yes	☐ No	☐ Do not go to school
46. Relationship with your family	☐ Yes	☐ No	☐ Do not live with family/have no family
47. General satisfaction with life	☐ Yes	☐ No	
48. Overall functions in all areas of life	☐ Yes	☐ No	

ID FAMILIA: ____
 FECHA: ____/____/____
 ID EVALUADOR: B ____

CÓDIGO: 1 2 3A 3B

ESCALA DE DIAGNÓSTICO DE ESTRÉS POSTRAUMÁTICO ®

Tiempo: 15 minutos

Guión: **[Decir a la madre]**

“Mucha gente ha vivido o ha visto eventos muy estresantes o traumáticos en algún momento de su vida. Le voy a leer una lista de preguntas acerca de eventos traumáticos. Por favor dígame si alguno de estos eventos le ha pasado a usted o si ha sido testigo de alguno de ellos. ¿Tiene alguna pregunta antes de empezar?” **[Lee la lista de preguntas a la mamá y marca con una [X] si estos eventos le han sucedido a ella o si los ha presenciado.]**

Parte 1

1. ☐ Un accidente, incendio o explosión seria (por ejemplo un accidente industrial, de granja, en carro, avión o barco)
2. ☐ Un desastre natural (por ejemplo, tornado, huracán, inundación o terremoto mayor)
3. ☐ Una agresión no sexual por parte de algún familiar o alguien que usted conozca (por ejemplo: un asalto, ataque físico, disparo, puñalada o una amenaza con pistola)
4. ☐ Una agresión no sexual por parte de un extraño (por ejemplo un asalto, ataque físico, disparo, haber recibido una puñalada o amenazado con pistola)
5. ☐ Una agresión sexual por parte de algún familiar o alguien que usted conozca (por ejemplo: una violación o intento de violación)
6. ☐ Una agresión sexual por parte de un extraño (por ejemplo violación o intento de violación)
7. ☐ Un combate militar o una zona de guerra
8. ☐ Contacto sexual cuando era menor de 18 años con alguien que tenía 5 ó más años que usted (por ejemplo contacto con genitales, busto)
9. ☐ Un encarcelamiento (por ejemplo estar en la cárcel, prisionera de guerra, rehén)
10. ☐ Tortura
11. ☐ Enfermedad muy grave
12. ☐ Otro evento traumático
13. Descripción del evento traumático de la pregunta 12: _____

[Si marcaron CUALQUIERA de los puntos anteriores, CONTINÚA. Si no, detente aquí.]

Parte 2

14. **[Si seleccionó más de un evento traumático en la Parte 1, pregunta] "¿Cuál es el que MÁS le molesta? [Si sólo seleccionó UN evento traumático en la Parte 1, marca el MISMO evento a continuación.]**

- ☐ Accidente
- ☐ Desastre
- ☐ Agresión no sexual/alguien que usted conoce
- ☐ Agresión no sexual/extraño
- ☐ Agresión sexual/alguien que usted conoce
- ☐ Agresión sexual/extraño
- ☐ Combate
- ☐ Contacto sexual menor de 18 años con alguien 5 ó más años mayor
- ☐ Encarcelamiento
- ☐ Tortura
- ☐ Enfermedad grave
- ☐ Otro

Breve descripción del evento: _____

[Las preguntas 15-21 se refieren al evento traumático descrito en la pregunta 14]

15. ¿Hace cuánto tiempo pasó el evento traumático? (Circula una)
- 1 – Menos de un mes
 - 2 – 1 a 3 meses
 - 3 – 3 a 6 meses
 - 4 – 6 meses a 3 años
 - 5 – 3 a 5 años
 - 6 – Más de 6 años

[Decir a la madre]: "Por favor conteste SÍ o NO a las siguientes preguntas. *Durante el evento traumático...*"

16. ¿Resultó lesionada físicamente?	☐ Sí ☐ No
17. ¿Alguien más resultó lesionado físicamente?	☐ Sí ☐ No
18. ¿Pensó que peligraba su vida?	☐ Sí ☐ No
19. ¿Pensó que la vida de alguien más peligraba?	☐ Sí ☐ No
20. ¿Se sintió indefensa?	☐ Sí ☐ No
21. ¿Se sintió aterrada?	☐ Sí ☐ No

Parte 3

[Decir a la madre]: “Mucha gente ha vivido o ha visto situaciones muy estresantes o traumáticas en algún momento de su vida. Le voy a leer una lista de problemas que la gente a veces tiene después de haber vivido eventos. Por favor dígame qué tan seguido estos problemas le han molestado durante el ÚLTIMO MES, usando la siguiente escala. Califique en relación con el evento traumático que le ha molestado MÁS” **[Lee la lista a la mamá y circula la respuesta apropiada.]**

0							1							2							3						
Casi nada o solamente una vez							Una vez a la semana o menos							2-4 veces a la semana							Casi siempre						
L	M	M	J	V	S	S	L	M	M	J	V	S	S	L	M	M	J	V	S	S	L	M	M	J	V	S	S

	Casi Nada	1/sem. o menos	2-4 veces a la sem.	Casi siempre
22. Tener pensamientos o imágenes negativas sobre el evento traumático que le vienen a la mente aunque usted no quiera	0	1	2	3
23. Tener pesadillas sobre el evento traumático	0	1	2	3
24. Revivir el evento traumático, actuar o sentirse como si estuviera pasando otra vez	0	1	2	3
25. Sentirse emocionalmente mal cuando se le recuerda el evento traumático (por ejemplo sentir miedo, enojo, tristeza, culpa, etc.)	0	1	2	3
26. Tener reacciones físicas cuando se le recuerda el evento traumático (por ejemplo sudar, corazón acelerado)	0	1	2	3
27. Tratar de no pensar, hablar o tener sentimientos acerca del evento traumático	0	1	2	3
28. Tratar de evitar actividades, gente o lugares que le recuerden el evento traumático	0	1	2	3
29. No poder recordar una parte importante del evento traumático	0	1	2	3
30. Tener mucho menos interés o participar mucho menos en actividades importantes	0	1	2	3
31. Sentirse distanciada o apartada de la gente que le rodea	0	1	2	3
32. Sentirse emocionalmente adormecida (por ejemplo no ser capaz de llorar o de tener sentimientos amorosos)	0	1	2	3
33. Sentir que los planes futuros o esperanzas no se realizarán (por ejemplo que no tendrá una carrera, matrimonio, hijos o una larga vida).	0	1	2	3

0							1							2							3						
Casi nada o solamente una vez							Una vez a la semana o menos							2-4 veces a la semana							Casi siempre						
L	M	M	J	V	S	S	L	M	M	J	V	S	S	L	M	M	J	V	S	S	L	M	M	J	V	S	S
								X													X	X	X	X	X	X	
														X	X	X							X	X	X	X	X
																X	X	X	X			X	X	X	X	X	X
														X	X		X				X	X	X	X	X	X	X

	Casi Nada	1/sem. o menos	2-4 veces a la sem.	Casi siempre
34. Tener problemas para dormir o quedarse dormida	0	1	2	3
35. Sentirse irritable o tener arranques de ira	0	1	2	3
36. Tener problemas para concentrarse (por ejemplo para mantener una conversación, no poder seguir una historia en televisión, olvidar lo que leyó)	0	1	2	3
37. Estar demasiado alerta (por ejemplo vigilar quién está alrededor suyo, estar incómodo/a dando la espalda a la puerta, etc.)	0	1	2	3
38. Estar nerviosa o sobresaltarse fácilmente (por ejemplo cuando alguien camina detrás de usted)	0	1	2	3
39. ¿Hace cuánto ha experimentado los problemas reportados?				
1 – Menos de 1 mes				
2 – 1 a 2 meses				
3 – 3 o más meses				
40. ¿Cuánto tiempo después del evento traumático empezaron estos problemas?				
1 – Menos de 6 meses después del evento traumático				
2 – Seis o más meses después del evento traumático				

[Decir a la madre]: “Las siguientes preguntas son con respecto a si los síntomas que usted acaba de considerar han interferido con alguna de las siguientes áreas de su vida en el ÚLTIMO MES. ¿Durante el último mes estos problemas han afectado su...?”

41. Trabajo	☐ Sí	☐ No	☐ no tiene trabajo
42. Quehaceres y deberes del hogar	☐ Sí	☐ No	☐ no hace
43. Relación con amigos	☐ Sí	☐ No	
44. Diversión y actividades de esparcimiento	☐ Sí	☐ No	
45. Tareas escolares	☐ Sí	☐ No	☐ no va a la escuela
46. Relación con familiares	☐ Sí	☐ No	☐ vive separado de la familia o no tiene familia
47. Satisfacción general con la vida	☐ Sí	☐ No	
48. Funciones generales en todas las áreas de la vida	☐ Sí	☐ No	

Appendix G

Family Violence Checklist

2008 Mexico Assessment Protocol

(C1-ENGL of 6) DV Events List 5-6-08

FAMILY ID: ____

GROUP CODE: 1 2 3A 3B

DATE: ____/____/____

ASSESSOR ID: A ____

DOMESTIC VIOLENCE EXTENDED EVENTS LIST •

Time: 10 minutesScript: [Say to child]

"I would now like to ask you about some events that children can experience. Some things might make sense for your life and others won't. You may find some of the questions upsetting. Please remember that all answers to these questions will be kept confidential. I will ask you several questions about things you may have witnessed/experienced happening at HOME. For each question I will ask you if the event has EVER happened to you. If it has, I will ask you if the event has happened to you in the LAST MONTH. Do you have any questions before we start?" **[Read each question starting with "Have you ever..." Mark the appropriate boxes for each response. If the child did NOT experience an event, do not mark anything and move onto the next question.]**

"HAVE YOU EVER..."

	<u>Yes</u>	<u>In the last month</u>
1. Had your arms twisted or have you been pulled by the hair?	☐	☐
2. Been verbally threatened?	☐	☐
3. Been slapped on the body, arms or legs?	☐	☐
4. Been punched/kicked on body, arms or legs?	☐	☐
5. Been punched/kicked in the face?	☐	☐
6. Been hit with an object (e.g. belt, board, stick)?	☐	☐
7. Been burned with hot water or cigarette?	☐	☐
8. Had things thrown at you?	☐	☐
9. Been tied up or locked up?	☐	☐
10. Had someone attempt to strangle or burn you?	☐	☐
11. Been threatened with an object or weapon?	☐	☐
12. Been threatened to be killed?	☐	☐
13. Been injured with a weapon (gun, knife)?	☐	☐
14. Been shouted, screamed, or sworn at?	☐	☐
15. Been told that you are not good?	☐	☐
16. Been ignored by your parents/guardians?	☐	☐

"HAVE YOU <u>EVER</u>..."	<u>Yes</u>	<u>In the last month</u>
17. Been made fun of in front of others?	☐	☐
18. Had to wear dirty/ragged clothes?	☐	☐
19. <u>Not</u> been given enough food/Did you go hungry?	☐	☐
20. <u>Not</u> been given anything to drink?	☐	☐
21. Seen a family member being punched/hit/kicked?	☐	☐
22. Seen a family member being hit with an object?	☐	☐
23. Seen a family member being burned/strangled?	☐	☐
24. Seen a family member being injured with a weapon?	☐	☐
25. Seen a family member being threatened to be killed?	☐	☐
26. Been touched in your intimate/private body parts by someone much older than you?	☐	☐
27. Been forced by an adult person to insert something in any part of your body (a sexual act)?	☐	☐

[Complete questions 28-31 ONLY if child answered "YES" to question 26 or 27.]

"HAVE YOU <u>EVER</u>..."	<u>Yes</u>	<u>In the last month</u>
28. Been forced to kiss someone (<i>in a sexual way</i>)?	☐	☐
29. Been forced to touch the intimate parts of someone much older than you?	☐	☐
30. Seen someone being touched on intimate body parts against his/her will?	☐	☐
31. Been forced to watch sexual acts?	☐	☐

[Say to child]: "Please answer "YES" or "NO" for the following questions."

32. Have you experienced or witnessed any other form of violence at HOME not mentioned so far? ☐ Yes ☐ No
(Description): _____
33. Father/guardian hits/beats your mother ☐ Yes ☐ No
34. Mother hits/beats your father/guardian ☐ Yes ☐ No
35. Mother hits/beats other children in the home ☐ Yes ☐ No
36. Father/guardian hits/beats other children in the home ☐ Yes ☐ No

37. Grandparents hit/beat you and/or other children in the home ☐ Yes ☐ No
38. Older siblings hit/beat their younger siblings ☐ Yes ☐ No
39. Other _____
40. Have you ever had injuries (e.g., cuts, bruises, burns, broken bones, black eye) as the result of the sort of incidents mentioned so far? ☐ Yes ☐ No
If "YES", what type of injury? _____
41. Did you ever need medical treatment or go to a doctor/hospital because of an injury resulting from the incidents mentioned so far? ☐ Yes ☐ No
If YES, how often? _____

ID FAMILIA: ____
 FECHA: ____/____/____
 ID EVALUADOR: A ____

CÓDIGO: 1 2 3A 3B

LISTA DE CASOS EXTENDIDA ©

Tiempo: 10 minutos

Guión: *[Decir al menor]*

"Ahora me gustaría preguntarte acerca de algunos eventos que los niños pueden vivir. Algunos podrían ser aplicables a tu vida y otros no. Algunas de las preguntas podrán resultarte ofensivas. Por favor recuerda que todas las respuestas a estas preguntas serán confidenciales. Te voy a hacer varias preguntas acerca de cosas que pasaron en tu CASA y que tal vez tú hayas visto/vivido [Preguntar "alguna vez" y "en el último mes"]. "¿Tienes alguna pregunta antes de empezar?" *[Cuando el/la niño/a esté listo/a, empieza a leer las preguntas, pregunta "alguna vez" y "en el último mes". Marca una [X] en el cuadro apropiado para cada una de sus respuestas.]*

"ALGUNA VEZ TE HAN..."

	<u>Sí</u>	<u>En el último mes</u>
1. ¿Torcido el brazo/han jalado del cabello?	☐	☐
2. ¿Amenazado (verbalmente)?	☐	☐
3. ¿Dado un manazo en el cuerpo, brazos o piernas?	☐	☐
4. ¿Dado un golpe/ patada en el cuerpo, brazos o piernas?	☐	☐
5. ¿Dado un golpe/ patada en la cara?	☐	☐
6. ¿Golpeado con un objeto (ejem. cinturón, tabla, palo)?	☐	☐
7. ¿Quemado con agua caliente o cigarrillo?	☐	☐
8. ¿Aventado cosas?	☐	☐
9. ¿Atado o encerrado?	☐	☐
10. ¿Intentado estrangularte o quemarte?	☐	☐
11. ¿Amenazado con un objeto o arma?	☐	☐
12. ¿Amenazado con matarte?	☐	☐
13. ¿Herido con un arma (pistola, cuchillo)?	☐	☐
14. ¿Levantado la voz, gritado o maldecido?	☐	☐
15. ¿Dicho que no vales?	☐	☐
16. ¿Descuidado por tus padres (tutores)?	☐	☐
17. ¿Puesto en ridículo frente a otras personas?	☐	☐

“ALGUNA VEZ...”	Sí	En el último mes
18. ¿Has tenido que usar ropa sucia/ andrajosa?	☐	☐
19. ¿ <u>No</u> te han dado suficiente comida/ has padecido hambre?	☐	☐
20. ¿ <u>No</u> te han dado nada de beber?	☐	☐
21. ¿Has visto que le peguen/ golpeen/ pateen a algún familiar?	☐	☐
22. ¿Has visto que golpeen a un familiar con un objeto?	☐	☐
23. ¿Has visto que quemen o estrangulen a algún familiar?	☐	☐
24. ¿Has visto que hieran a algún familiar con un arma?	☐	☐
25. ¿Has visto que amenacen de muerte a algún familiar?	☐	☐
26. ¿Alguna persona mucho mayor que tú ha tocado tus partes íntimas?	☐	☐
27. ¿Algún adulto te ha forzado a introducir algo en cualquier parte de su cuerpo (un acto sexual)?	☐	☐

[Completa las preguntas 28-31 sólo si el menor responde “Sí” a la pregunta 26 ó 27.]

“ALGUNA VEZ...”	Sí	En el último mes
28. ¿Te han forzado a besar a alguien (<i>de manera sexual</i>)?	☐	☐
29. ¿Te han forzado a tocar las partes íntimas de alguien mucho mayor que tú?	☐	☐
30. ¿Has visto que a alguien lo toquen en sus partes íntimas en contra de su voluntad?	☐	☐
31. ¿Te han obligado a ver actos sexuales?	☐	☐

[Decir al menor]: “Por favor contesta “Sí” or “NO” a las siguientes preguntas.”

32. ¿Has vivido o sido testigo de cualquier otra forma de violencia EN CASA que no se haya mencionado hasta el momento? (Descripción): _____	☐ Sí	☐ No
33. Tu papá/tutor le pega/golpea a tu mamá	☐ Sí	☐ No
34. Tu mamá le pega/golpea a tu papá/tutor	☐ Sí	☐ No
35. Tu mamá le pega/golpea a los otros niños en la casa	☐ Sí	☐ No
36. Tu papá/tutor le pega/golpea a los otros niños en la casa	☐ Sí	☐ No
37. Tus abuelos te pegan/golpean o le pegan/golpean a los otros niños en la casa	☐ Sí	☐ No

38. Tus hermanos(as) mayores le pegan/golpean a los menores ☐ Sí ☐ No
39. Otro _____
40. ¿Alguna vez has tenido alguna lesión (cortaduras, moretones, quemaduras, ☐ Sí ☐ No
huesos fracturados, ojo morado) como resultado de alguno de los incidentes
mencionados hasta ahorita?
Sí "Sí", ¿qué tipo de lesión? _____
41. ¿Alguna vez necesitaste tratamiento médico/ fuiste al doctor/ al hospital ☐ Sí ☐ No
por alguna lesión como resultado de los incidentes que hemos mencionado hasta ahora?
Si "Sí", ¿qué tan seguido? _____

Appendix H

Composite Abuse Scale

2008 Mexico Assessment Protocol

(M1-ENGL of 7) CAS 8-12-08

FAMILY ID: ____
 DATE: ____/____/____
 ASSESSOR ID: B ____

GROUP CODE: 1 2 3A 3B

COMPOSITE ABUSE SCALE®

Time: 10 minutes

Script: **[Say to mother]**

"We are interested in finding out about your experiences in adult intimate relationships. By adult intimate relationship, we mean a husband, partner, boy/girlfriend for longer than one month. Do you have any questions before we begin?" **[Read the list of questions to mother and circle the appropriate response.]**

1. Have you ever been in an adult intimate relationship? (After you were 16 years old)
 1 – Yes
 2 – No **[If NO, this is the end of questionnaire. Do not continue.]**

2. Are you currently in a relationship?
 1 – Yes
 2 – No **[If NO, skip to question #4]**

3. Are you currently afraid of your partner?
 1 – Yes
 2 – No

4. Have you ever been afraid of any partner?
 1 – Yes
 2 – No

[Say to mother]: "Now we would like to know if you experienced any of the actions on this list, and how often it happened during the past 12 MONTHS. If you were not with a partner in the past 12 months, please answer for the last partner that you had."

Actions	How Often it Happened					
	Never	Only once	Several times	Once/month	Once/week	Daily
1. Told me that I wasn't good enough	0	1	2	3	4	5
2. Kept me from medical care	0	1	2	3	4	5
3. Followed me	0	1	2	3	4	5
4. Tried to turn my family, friends and children against me	0	1	2	3	4	5
5. Locked me in the bedroom	0	1	2	3	4	5
6. Slapped me	0	1	2	3	4	5

Actions	How Often it Happened					
	Never	Only once	Several times	Once/month	Once/week	Daily
7. Raped me	0	1	2	3	4	5
8. Told me that I was ugly	0	1	2	3	4	5
9. Tried to keep me from seeing or talking to my family	0	1	2	3	4	5
10. Threw me	0	1	2	3	4	5
11. Hung around outside my house	0	1	2	3	4	5
12. Blamed me from causing their violent behavior	0	1	2	3	4	5
13. Harassed me over the telephone	0	1	2	3	4	5
14. Shook me	0	1	2	3	4	5
15. Tried to rape me	0	1	2	3	4	5
16. Harassed me at work	0	1	2	3	4	5
17. Pushed, grabbed or shoved me	0	1	2	3	4	5
18. Used a knife or gun or other weapon	0	1	2	3	4	5
19. Became upset if dinner/housework wasn't done	0	1	2	3	4	5
20. Told me that I was crazy	0	1	2	3	4	5
21. Told me that no one would ever want me	0	1	2	3	4	5
22. Took my wallet and left me stranded	0	1	2	3	4	5
23. Hit or tried to hit me with something	0	1	2	3	4	5
24. Did not want me socialize with my female friends	0	1	2	3	4	5
25. Put foreign objects in my vagina	0	1	2	3	4	5
26. Refused to let me work outside the home	0	1	2	3	4	5
27. Kicked me, bit me or hit me with a fist	0	1	2	3	4	5
28. Tried to convince my friends, family or children that I was crazy	0	1	2	3	4	5
29. Told me that I was stupid	0	1	2	3	4	5
30. Beat me up	0	1	2	3	4	5

[After completing the assessment, ask mother if she is feeling okay and if she is ready to move onto the next activity.]

Page 3 of 3

ID FAMILIA: ____
 FECHA: ____/____/____
 ID EVALUADOR: B ____

CÓDIGO: 1 2 3A 3B

ESCALA DE ABUSO INTEGRADA®

Tiempo: 5 minutos

Guión: **[Decir a la madre]**

“Quisiéramos saber acerca de su experiencia con relaciones adultas sentimentales/íntimas. Por relaciones adultas sentimentales/íntimas nos referimos a esposo, pareja, amigo/a que ha durado más de un mes. ¿Tiene alguna pregunta antes de que empecemos?” **[Leer la lista a la madre y circula su respuesta para cada tema.]**

1. ¿Ha tenido una relación sentimental/íntima? (Después de los 16 años de edad)
 - 1 – Sí
 - 2 – No **[Si NO, este es el final del cuestionario. No continuar.]**
2. ¿Actualmente tiene una relación sentimental/íntima?
 - 1 – Sí
 - 2 – No **[Si NO, saltar a la pregunta #4]**
3. ¿Actualmente tiene miedo de su pareja?
 - 1 – Sí
 - 2 – No
4. ¿Alguna vez ha tenido miedo de alguna pareja?
 - 1 – Sí
 - 2 – No

[Decir a la madre]: “Ahora quisiéramos saber si ha experimentado/vivido alguna de las acciones descritas en esta lista y qué tan seguido ha ocurrido durante los últimos **12 MESES**. Si no tuvo una pareja los últimos 12 meses, por favor responda pensando en la última pareja que tuvo.

Acciones	Con qué frecuencia ha pasado					
	Nunca	Sólo una vez	Varias veces	Una vez/mes	Una vez/semana	Diaria mente
1. Me dijo que no era suficientemente buena	0	1	2	3	4	5
2. Me privó de cuidados médicos	0	1	2	3	4	5
3. Me siguió	0	1	2	3	4	5
4. Trató de poner a mi familia, hijos y amigos en contra mía	0	1	2	3	4	5
5. Me encerró en el cuarto	0	1	2	3	4	5

Acciones	Con qué frecuencia ha pasado					
	Nunca	Sólo una vez	Varias veces	Una vez/mes	Una vez/semana	Diariamente
6. Me cacheteó	0	1	2	3	4	5
7. Me violó	0	1	2	3	4	5
8. Me dijo que era fea	0	1	2	3	4	5
9. Trató de evitar que viera o hablara con mi familia	0	1	2	3	4	5
10. Me aventó	0	1	2	3	4	5
11. Estuvo rondando fuera de mi casa	0	1	2	3	4	5
12. Me culpó de haber provocado su conducta violenta	0	1	2	3	4	5
13. Me acosó por el teléfono	0	1	2	3	4	5
14. Me zarandéó	0	1	2	3	4	5
15. Trató de violarme	0	1	2	3	4	5
16. Me acosó en el trabajo	0	1	2	3	4	5
17. Me empujó, me estrujó, o me aventó	0	1	2	3	4	5
18. Usó un cuchillo, una pistola u otra arma	0	1	2	3	4	5
19. Se enojó si la cena no estaba lista/la casa no estaba limpia	0	1	2	3	4	5
20. Me dijo que estaba loca	0	1	2	3	4	5
21. Me dijo que nadie podría quererme	0	1	2	3	4	5
22. Me quitó la cartera y me dejó con problemas para llegar a casa	0	1	2	3	4	5
23. Me pegó o trató de pegarme con algo	0	1	2	3	4	5
24. No quiso que saliera/me reuniera con mis amigas	0	1	2	3	4	5
25. Me metió objetos en la vagina	0	1	2	3	4	5
26. Se negó a que trabajara fuera de la casa	0	1	2	3	4	5
27. Me pateó, me mordió o me golpeó con su puño	0	1	2	3	4	5
28. Trató de convencer a mis amigos, mi familia o mis hijos de que estaba loca	0	1	2	3	4	5
29. Me dijo que era estúpida	0	1	2	3	4	5
30. Me dio una paliza	0	1	2	3	4	5

[Después de completar la evaluación, pregunta a la madre si está lista para pasar a la siguiente actividad.]

0 NUNCA				1 SOLO UNA VEZ			
						X	

2 VARIAS VECES				3 UNA VEZ EN MES			
X		X		X	X	X	X
	X	X	X	X	X	X	X
X		X		X	X	X	X

4 UNA VEZ EN SEMANA				5 DIARIAMENTE															
X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

Appendix I

Consent Form

2008 Mexico Assessment Protocol

(CONS-B2-ENGL) Mother Consent-DIF 6-13-08

FAMILY ID: ____
 DATE: ____/____/____
 ASSESSOR ID: B ____

GROUP CODE: 1 2 3A 3B

MOTHER CONSENT FORM – DIF

You are invited to participate in a study that will test several assessment instruments to look at the impact of stressful and traumatic experiences on mother-child relationships. Specifically, the goals of the project are to better understand how mother-child relationships differ for families with a child that is experiencing posttraumatic stress from those with a child that is not experiencing post-traumatic stress. Posttraumatic stress can occur as a result of seeing or experiencing something horrible and scary, and can create problematic symptoms that impact individuals and their families. We also want to develop more appropriate and complete ways to capture and measure different types of parent and child interactions in these relationships. This information will help us develop treatments for parents and the entire family to help children when they have experienced traumatic events. The principal investigator of the study is Dr. Elizabeth Weling in the Department of Family Social Science at the University of Minnesota in collaboration with Dr. Elizabeth Aguilar at Centro de Investigacion Familiar A.C. (CIFAC).

You have been invited to participate in this study because you are a mother with a child between the ages of 5-14 and you have either been referred to or sought assistance from DIF NL (Desarrollo Integral de la Familia). Your collaboration on this project will provide us with knowledge on how to understand mother-child relationships in very stressful situations, including in cases where there have been reports of child maltreatment. We hope to develop preventive and clinical interventions (ways of helping parents and children) that are effective and that fit the needs and the cultural experiences of our families in this part of the country.

Procedures:

If you agree to be in this study, we will ask you to do the following things. *You and your child* (between 5 to 14 years old) will be asked to spend approximately 2 ½ hours with us answering several questions alone and completing some activities with your child. Some examples of questions your child will be asked include: *Have you ever tried to hurt yourself? Have you ever heard about the violent death or serious injury of a loved one? Have you ever been beaten up, shot at, or threatened to be hurt badly?* You and your child will first go into separate rooms and be asked to answer several paper and pencil questionnaires. I will read all of the forms to you and all you have to do is answer accordingly. After we are done with the questionnaires we will take a short break, then you and your child will return to the same room and complete three activities together. In the first activity, you and your child will talk about a positive and a negative event that happened in your child's life for five minutes each. In the second activity, you and your child will choose a topic that you may disagree about and take turns discussing each topic for five minutes. The third activity involves your child constructing a family diagram using a chess board with your help.

Potential Risks of Being in the Study:

Many of the questions that we will ask you and your child are very personal. As a result you and/or your child may feel distressed from talking about these questions. For example, as

you start to talk about these things you may start to feel overwhelmed or out of control or you might have feelings of depression or anxiety. It is very unlikely that there would be an emergency, but in the case something would happen, CIFAC clinical staff will be available to provide support or referrals to you and your family. You are welcome to review any of the instruments that will be given to your child before we begin the interview. Interviews will be videotaped for supervision and research purposes. Portions of the video will be uploaded to a secure location on the internet and transmitted to the research team abroad. No one else will have access to the data and the internet link will be de-activated within 24 hours of being sent.

Mandated Reporting:

There is also a possibility that your (or your child's) answers may provide information that would require us to break confidentiality. An example would be if you and/or your child intend to harm yourself or others. Staff will inform parents/guardians if, in the judgment of professional staff, your child (under 18) is in imminent danger of trying to kill him/herself.

Potential Benefits of Being in the Study:

There are no direct benefits to participation in the study. The overall purpose of this study is to better understand how stressful and/or traumatic events impact mother-child relationships. Accurately assessing these parent-child interactions is going to help us develop more specific and culturally appropriate ways of helping families faced with difficulties. You might also become more aware of different individual and/or relationship characteristics that help you improve your own behavior and relationship with your child.

Compensation:

You (mother) will receive a gift card for a local store in the amount of 200 Pesos to use as you like as a sign of our appreciation for your participation in the assessment protocol at completion of the interview.

Confidentiality:

The records of this study will be kept private. In any sort of report we might publish, we will not include any information that will make it possible to identify you or your child. Records will be stored securely and only researchers will have access to the records. Videotapes will be kept for the length of the study after the study is finished, in a locked and secure location in the researchers office. Protecting participants' confidentiality is priority. All identifying information will be kept in a locked file cabinet at CIFAC.

Voluntary Nature of the Study:

Your participation is voluntary and you may terminate at any time without penalty. Your decision whether or not to participate will not affect your current or future relations with CIFAC or DIF. However you will not receive the gift card for a local store. If you decide to participate, you are free to not answer any question or withdraw at any time with out affecting those relationships.

Contacts and Questions:

The researchers conducting the study are: Dr. Elizabeth Wieling at the University of Minnesota, Department of Family Social Science and Dr. Elizabeth Aguilar, Centro de

Investigacion Familiar A.C. (CIFAC). You may ask any questions you have now. If you have questions later, you may contact Dr. Wieling by phone at 00-1 (612) 625-8106 or e-mail at lwieling@umn.edu. Dr. Aguilar can be reached by phone at either 84 78 88 11 and 84 78 89 9983 87 28 0001 or by email at elizabeth.aguilar@cifac.edu.mx.

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher(s), contact the Research Subjects' Advocate Line, D528 Mayo, 420 Delaware St. Southeast, Minneapolis, Minnesota 55455; 00-1 (612) 624-1650. You may make any inquiries or report complaints about this study to the University of Minnesota's Human Subjects and Protection Board.

You will be given a copy of this information to keep for your records.

Statement of Consent:

I have read the above information. I have asked questions and have received answers. I consent to participate in the study.

Participant Signature: _____ Date: _____

Assessor Signature: _____ Date: _____

Statement of Consent for Child Participation:

I have read the above information. I have asked questions and have received answers. I consent to have my child participate in the study; however, I understand that he/she may refuse to answer any questions without any negative consequences.

Participant Signature: _____ Date: _____

Assessor Signature: _____ Date: _____

ID FAMILIA: ____
 FECHA: ____/____/____
 ID EVALUADOR: B ____

CÓDIGO: 1 2 3A 3B

FORMA DE CONSENTIMIENTO DE LA MADRE – DIF

Usted ha sido invitada para participar en un estudio en el que se van a utilizar distintos instrumentos de evaluación para conocer el impacto de experiencias traumáticas y estresantes en las relaciones madre-hijo/a. Específicamente, las metas del proyecto son entender mejor de qué manera las relaciones madre-hijo/a son diferentes en las familias que tienen un hijo/a que experimenta estrés postraumático de aquellas en las que un niño no está experimentando estrés postraumático. El estrés postraumático puede ocurrir como resultado de experimentar o ver algo horrible y aterrador y puede crear síntomas problemáticos que impactan a los individuos y sus familias. También queremos desarrollar formas más adecuadas y completas de capturar y medir diferentes tipos de interacción entre madres e hijos/as en estas relaciones. Esta información nos ayudará a desarrollar tratamientos apropiados para los padres/madres y la familia entera para ayudar a los niños/as que experimentan eventos traumáticos. La principal investigadora de este estudio es la Dra. Elizabeth Wieling en el Departamento de Ciencia Social Familiar en la Universidad de Minnesota en colaboración con la Dra. Elizabeth Aguilar en el Centro de Investigación Familiar A.C. (CIFAC).

Usted ha sido invitada a participar en este estudio porque usted es una madre con un niño entre las edades de 5-14 y le han referido o buscó ayuda en el DIF NL (Desarrollo Integral de la Familia). Su colaboración en este proyecto nos proporcionará información para entender relaciones madre-hijo/a en situaciones muy estresantes, incluyendo en los casos donde ha habido reportes de maltrato del niño. Esperamos desarrollar intervenciones preventivas y clínicas (maneras de ayudar a padres y a niños) que sean efectivas y apropiadas para las necesidades y las experiencias culturales de nuestras familias en esta parte del país.

Procedimiento:

Si acepta participar en este estudio, le vamos a pedir que haga lo siguiente. *Usted y su hijo/a (entre 5 y 14 años de edad)* van a pasar aproximadamente 2 ½ horas con nosotros, contestando diversas preguntas por separado y completando algunas actividades con su hijo/a. Algunos ejemplos de preguntas que se le harán a su hijo/a incluyen: *¿Alguna vez has intentado hacerte daño? ¿Alguna vez has escuchado sobre la muerte violenta o el daño serio a un ser querido? ¿Alguna vez te han dado una golpiza, te han disparado o te han amenazado con dañarte seriamente?* Primero, usted y su hijo/a van a estar en cuartos separados y se les va a pedir que contesten varios cuestionarios en papel y lápiz. Yo le voy a leer todas las formas con las preguntas y lo único que usted tiene que hacer es contestar de acuerdo a lo que le pregunte. Después de haber terminado con los cuestionarios, vamos a tomar un pequeño descanso y luego usted y su hijo/a van a regresar al mismo salón y van a completar tres actividades juntos.

En la primera actividad, usted y su hijo/a van a hablar sobre un evento positivo y uno negativo que hayan sucedido en la vida de su hijo/a por cinco minutos cada uno. En la segunda actividad, usted y su hijo/a van a escoger un tema en el cual puedan tener desacuerdos y tomarán turnos hablando de cada tema por cinco minutos. La tercera actividad

involucra que su hijo/a construya un diagrama familiar utilizando un ajedrez familiar con su ayuda.

Riesgos Potenciales de Participar en el Estudio:

Muchas de las preguntas que les van a hacer a usted y a su hijo/a son muy personales. Es probable que usted y/o su hijo/a puedan sentirse estresados al hablar sobre algunos temas. Por ejemplo, mientras comienza a hablar sobre estas cosas puede empezar a sentirse abrumada o fuera de control o puede sentirse triste/deprimida o ansiosa. Es poco común que haya una emergencia, pero en caso de que algo así ocurriera, el personal de la clínica de CIFAC estará disponible para asistirlo o para referirla a usted y a su familia a otro lugar. Si usted lo desea, puede revisar cualquiera de los instrumentos que se le administrarán a su hijo/a antes de que iniciemos la entrevista. Las entrevistas se grabarán en video para propósitos de supervisión e investigación. Algunas porciones del video se van a subir a un sitio seguro de internet y se transmitirán al equipo de investigadores que está en el extranjero. Nadie más tendrá acceso a los datos y el enlace de internet se desactivará después de 24 hora de haber sido enviado.

Informe de Mandato:

También existe la posibilidad de que sus respuestas (o las de su hijo/a) puedan proporcionar información que pueda requerir que nosotros rompamos la confidencialidad de este estudio. Un ejemplo sería si usted o su hijo/a tiene la intención de hacerse daño o hacerle daño a otra persona; el personal informaría a la autoridad competente basado en su juicio, si su hijo/a (menor de 18 años) corre un grave riesgo, o trata de hacerse daño.

Beneficios Potenciales de Participar en el Estudio:

No hay beneficios directos de la participación en el estudio. El objetivo general de este estudio es entender mejor cómo es que los eventos estresantes y/o traumáticos impactan las relaciones madre-hijo/a. Evaluar adecuadamente estas interacciones madre-hijo/a nos ayudará a desarrollar formas más específicas y culturalmente adecuadas de ayudar a las familias que enfrentan estos problemas. Usted también podrá estar más alerta de diferentes características individuales o de la relación que pueden ayudarle a mejorar su propia conducta y relación con su hijo/a.

Compensación:

Usted (madre) recibirá una tarjeta de regalo para una tienda local por la cantidad de 200 pesos para usarla como usted guste como muestra de nuestro aprecio por su participación en el protocolo de evaluación cuando complete la entrevista.

Confidencialidad:

Los reportes de este estudio van a guardarse en un lugar privado. Si llegamos a publicar algún reporte de este estudio, no incluiremos información que permita identificarla a usted ni a su hijo/a. Los reportes se guardarán en lugares seguros y sólo los investigadores van a tener acceso a ellos. Los videos van a conservarse mientras dure el estudio y estarán guardados bajo llave en un lugar seguro en la oficina de las investigadoras. Nuestra prioridad es proteger la confidencialidad de los participantes, por lo que toda la información que pudiera identificarla va a guardarse bajo llave en un archivero en CIFAC.

Participación Voluntaria en el Estudio:

Su participación es voluntaria y puede suspenderla en cualquier momento sin sufrir una penalización. La decisión de no participar no afectaría su relación actual o futura con CIFAC o DIF. Sin embargo, no recibiría la tarjeta de regalo. Si decide participar, es libre de no contestar a cualquier pregunta o de retirarse en cualquier momento sin que esto afecte estas relaciones.

Contactos y Preguntas:

Los investigadores que conducen este estudio son: las Dra. Elizabeth Wieling en la Universidad de Minnesota, Departamento de Ciencias Sociales de la Familia y Dra. Elizabeth Aguilar, Centro de Investigación Familiar A.C. (CIFAC). Puede hacer cualquier pregunta que tenga ahora. Si tiene más preguntas después, puede contactar a la Dra. Wieling al teléfono 00-1 (612) 625-8106 o por correo electrónico a lwieling@umn.edu. La Dra. Aguilar puede ser contactada al teléfono 84 78 88 11 y 84 78 89 99 o por correo electrónico a elizabeth.aguilar@cifac.edu.mx.

Si tiene alguna pregunta o preocupación en relación al estudio y quisiera hablar con alguien distinto al investigador(es), puede contactar al Research Subjects' Advocate Line, D528 Mayo, 420 Delaware St. Southeast, Minneapolis, Minnesota 55455; 00-1 (612) 624-1650. Puede explorar o reportar cualquier queja sobre este estudio en la Universidad de Minnesota en el Consejo de Protección a Sujetos Humanos.

Se le va a dar una copia de esta información para que la archive.

Declaración de Consentimiento:

He leído la información anterior. He hecho preguntas y he recibido respuestas. Doy mi consentimiento para participar en el estudio.

Firma del participante: _____ Fecha : _____

Firma del asesor: _____ Fecha: _____

Declaración de Consentimiento para la Participación del Hijo/a:

He leído la información anterior. He hecho preguntas y he recibido respuestas. Doy mi consentimiento para que mi hijo/a participe en el estudio; sin embargo, entiendo que él/ella puede negarse a responder a cualquier pregunta sin consecuencias negativas.

Firma del participante: _____ Fecha : _____

Firma del asesor: _____ Fecha: _____

Appendix J

Child Assent Form

2008 Mexico Assessment Protocol

(CONS-A-ENGL) Child Assent 6-13-08

FAMILY ID: ____
 DATE: ____/____/____
 ASSESSOR ID: A ____

GROUP CODE: 1 2 3A 3B

CHILD ASSENT FORM

Today we will spend time with you and your mother getting to know a little about each of you. We will ask you some questions separately from your mom about your life and what it's like to be a child in your family. We will ask you to talk about some fun things about your life and also some things that might be very hard to talk about.

We will ask you personal questions about what you might have seen or experienced yourself throughout your life. For instance, questions like: *Have you ever been scared about something bad happening to you? Have bad things happened to you? Have you ever tried to hurt yourself? Have you ever heard about the violent death or serious injury of a loved one? Have you ever been beaten up, shot at, or threatened to be hurt badly?* We will also ask you to tell us how you feel about some of the things that happen in your life with your mom and your family. You do not have to answer any questions you do not want to, and you can ask us to stop the interview at any time. No one will be upset at you if you do not want to answer and nothing bad will happen to you if you don't want to talk to us.

You and your mother will first go into separate rooms and be asked to answer several paper and pencil questionnaires. I will read all of the forms to you and all you have to do is answer accordingly. After we are done with the questionnaires we will take a short break, then you and your mother will return to the same room and complete three activities together. In the first activity, you and your mother will talk about a positive and a negative event that happened in your life for five minutes each. In the second activity, you and your mother will choose a topic that you may disagree about and take turns discussing each topic for five minutes. The third activity involves you constructing a family diagram using a chess board with your mother's help.

We want you to know that we will not tell anyone about the things that you tell us during the interview. There are only a few special times when we might have to talk to other adults about the things that you say. For example, if you told us that someone is hurting you or doing things to you that they should not be doing (like touching you in private places) then we would have to talk to other adults about it. Or if you were to tell us that you were going to hurt yourself or someone else in a very bad way, then we would also have to talk to other adults about it. These are the only times we would talk about the things that you say. The interview will be videotaped for supervision and research purposes.

It is okay for you to change your mind later and you do not have to answer our questions or do the activities. You get to decide if you want to talk with us or not and no one will be mad at you if you do not want to do this. You can also ask any questions you want at any time.

Signing here means that you have read this paper or had it read to you, you had a chance to ask any questions you want, and you are willing to talk to us today and be in this project. If you do not want to be in this project, do not sign. Remember, no one will be mad at you if you do not sign this or even if you change your mind later.

Date _____

Participant (Child) Signature _____

Assessor Signature _____

ID FAMILIA: ____
 FECHA: ____/____/____
 ID EVALUADOR: A ____

CÓDIGO: 1 2 3A 3B

FORMA DE ASENTIMIENTO DEL NIÑO

El día de hoy nos gustaría pasar algún tiempo contigo y con tu mamá, conocer un poco a cada uno de ustedes. Te vamos a hacer preguntas separado de tu mamá. Vamos a hacerte algunas preguntas sobre tí y sobre lo que es ser un niño/a en tu familia. Te vamos a pedir que hables acerca de cosas divertidas sobre tu vida y de algunas cosas que pueden ser difíciles de contar.

Te vamos a hacer preguntas personales sobre lo que has visto o experimentado a lo largo de tu vida. Por ejemplo, preguntas como: *¿Alguna vez te ha dado miedo que algo malo pueda pasarte? ¿Te ha pasado algo malo? ¿Alguna vez has intentado hacerte daño? ¿Alguna vez has escuchado sobre la muerte violenta o daño serio a un ser amado? ¿Alguna vez te han dado una golpiza, te han disparado o te han amenazado con hacerte un fuerte daño?.* Te vamos a pedir también que nos digas cómo te sientes sobre algunas cosas que pasan en tu vida con tu mamá y con tu familia. No tienes que contestar a las preguntas que no quieras contestar y puedes parar la entrevista en cualquier momento. Nadie se va a molestar contigo si no quieres contestar algo y nada malo te va a pasar si no quieres hablar con nosotros.

Primero tú y tu madre van a estar en cuartos separados y les vamos a pedir que contesten varios cuestionarios de lápiz y papel. Yo te leeré todas las formas y lo único que tienes que hacer es responderlas. Una vez que terminemos con los cuestionarios tomaremos un breve descanso, después tú y tu madre regresarán al mismo cuarto y completarán tres actividades juntos. En la primera actividad, tú y tu mamá hablarán sobre un evento positivo y uno negativo que te hayan sucedido en tu vida por cinco minutos cada uno. En la segunda actividad, tú y tu madre escogerán un tema en el que puede haber desacuerdo y tomarán turnos discutiendo cada tema por cinco minutos. La tercera actividad se trata de que tú construyas un diagrama familiar utilizando un tablero de ajedrez con la ayuda de tu madre.

También queremos que sepas que no vamos a decirle a nadie sobre las cosas que nos digas durante la entrevista. Sólo van a haber pocos momentos especiales en los que vamos a tener que hablar con otros adultos sobre lo que nos digas. Por ejemplo, si tú nos dices que alguien te está haciendo daño o que te están haciendo cosas que no deberían de hacerte (como tocarte en tus partes privadas) entonces nosotros tenemos que hablar con otros adultos sobre esto. O si nos dices que te vas a lastimar a ti mismo o alguien más de una manera muy fea, entonces tenemos que hablar con otros adultos sobre esto. Estas son las únicas veces en las que vamos a hablar sobre las cosas que nos digas. La entrevista se va a grabar en video para ser supervisada y utilizada en la investigación.

Está bien si cambias de opinión después y no tienes que contestar nuestras preguntas o hacer actividades. Tú decides si quieres hablar con nosotros o no y nadie va a estar enojado contigo si no quieres hacer esto. También puedes hacer cualquier pregunta en cualquier momento.

Si firmas aquí significa que has leído este papel o que te lo leyeron, tuviste la oportunidad de hacer cualquier pregunta que tuvieras y quieres hablar con nosotros hoy y estar en este proyecto. Si no quieres estar en este proyecto, no firmes. Recuerda, nadie va a estar enojado contigo si no firmas o aún si cambias de opinión después.

Fecha _____

Firma del (Niño/a) Participante _____

Firma del Asesor _____