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Children who witness mother-assault: An expanded posttraumatic stress disorder conceptualization

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CHILDREN WHO WITNESS MOTHER-ASSAULT: AN EXPANDED POSTTRAUMATIC STRESS DISORDER CONCEPTUALIZATION

By

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ABSTRACT

The impact on children who witness mother-assault was conceptualized as an expanded posttraumatic stress disorder (PTSD) and an exploratory research study testing this formulation was carried out. The current conceptualization was based in part on the work of V. Wolfe and associates who utilized a model whereby a number of mediating factors were thought to determine adjustment to traumatic events. An important part of their model was the utilization of the Type I and Type II trauma typologies of Terr (1990, 1991). These typologies were used to measure the PTSD symptoms of children in response to the severity and course of mother-assault.

In this study, a Type I sequelae consisted of the PTSD responses of reexperiencing, hyperarousal, and avoidance, and was related to the severity of mother-assault and child witnessing. The Type II sequelae consisted of the PTSD symptoms in addition to the coping responses of denial, rage, dissociation, sadness, and negative attributions. The Type II typology was related to the course of mother-assault which included the frequency of assaults and the duration of witnessing. Mediators included social support family disadvantage, and family functioning. Finally, this study tested the construct validity of two new instruments related to the child witness.

The major questions posed for this exploratory research study were: a) would children who witness mother-assault exhibit Type I symptoms in response to the severity of mother-assault, b) would such children exhibit Type II symptoms in response to the course of mother-assault, and last, c) would the History Of Violence Witnessed By Child Questionnaire (HVWCQ) and the Children's Impact Of Traumatic Events Scale-Family Violence Form (CITES-FVF) be valid instruments.

Eighty-four children and their mothers volunteered to be participants. Initial findings yielded a curvilinear relationship between the Type I and II responses and the severity and course of mother-assault. Consequently, children were divided into a three group design whereby children in groups one and two reported gradual increases in symptoms. However, in the midst of the most severe mother-assault, the third group of children reported a decrease in all behaviours measuring the Type I and II PTSD typologies.

A series of two factor group X age multivariate analyses of variance (MANOVA) were carried out. Mediating variables were not significant and were not added to the MANOVA models. There was no support for the research

question that children would exhibit PTSD symptoms (Type I trauma) in response to the severity of mother-assault. Despite these findings, 56% (n=47) of the child population met the diagnostic criteria for PTSD. Also, there was no support for the research question that children would exhibit PTSD symptoms and maladaptive coping behaviours (Type II trauma) in response to the course of mother-assault. However, the PTSD responses of hyperarousal, avoidance, and assault anxiety were significant for age. As well, the only significant Type II coping responses were negative childhood attributions. Again, age not group was significant. Also, gender did not have an overall multivariate effect on Type I and Type II responses.

Finally, two series of principal components factor analyses were conducted on the CITES-FVF and the HVWCQ. The first series of analyses did not support the research question that the CITES-FVF would be a valid measure. There were, however, similarities in the underlying structures of both instruments. The second series of factor analyses supported the question that the HVWCQ would be a valid instrument. At the same time reservations were raised given one of the factors had only a single variable.

This exploratory study suggested a number of implications with respect to theory, clinical practice, and policy development. Primarily, it was argued that the current expanded PTSD conceptualization has some merit with respect to the child witness to mother-assault, and that furthermore, a broadened PTSD may also have some theoretical potential. In addition, the ramifications for group, individual, and family therapies were considered. Finally, policy developments by way of written protocols for shelter staff were highlighted.

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Chapter One

Introduction

The Prevailing Problem

The issue of violent assaults against women by their husbands or partners coupled with the effects on their witnessing children is no longer treated as a private family matter. Instead, public awareness of family violence has emerged as an issue of primary concern in society.

The 1980's marked an important decade of research, policy, treatment, and prevention programs aimed at assaulted women and their children (Jaffe, Sudermann, & Reitzel, 1992). These developments have further underscored the seriousness and extent of violence in families. For example, in the United States, it has been estimated that approximately 3 to 4 million households with female partners experience a significant degree of violence on a yearly basis (Gelles & Straus, 1988). In Canada, figures suggest that approximately 500,000 Canadian households with female partners experience similar degrees of violence on a yearly basis (MacLeod, 1987). Researchers have also confirmed that at least 95% of the violence against women is perpetrated by men (Kurz, 1989). These assaults range from threats to beatings to homicides and are accompanied by varying degrees of psychological abuse intended to degrade and belittle (Wiebe, 1985).

The incidence of assaults against women in relationships paints a compelling picture of an event which

may tragically affect many children. At present no large-scale studies exist documenting the exact numbers of children who have witnessed their mothers being assaulted. However, sufficient numbers of small surveys and observational reports from shelters exist to highlight the serious nature of this problem. For example, the London Ontario Co-ordinating Committee To End Woman Abuse (1990) surveyed 50 social service agencies and 196 schools in London and Middlesex counties to determine the number of children exposed to mother-assault. Seventy-eight percent (n=39) of the social service agencies responded to the survey. These agencies reported that 50% of their child clients had witnessed mother-assault. Schools reported that 14.3% (n=app. 7,000) of their student population had been exposed to mother-assault, with 1/3 of the schools not reporting a percentage, or indicating they had no way to estimate a number.

Other estimates are also striking. For instance, a project in Toronto, Ontario investigating statistics on child witnesses indicated that 68% of 2,910 wife assault cases had children present (Leighton, 1989). The above study reflected the earlier accounts of Kincaid (1982) who estimated that as many as 133,000 children in Ontario may witness mother-assault on a yearly basis.

Surveys on the numbers of child witnesses in the United States and Britain would suggest that children there manage no better. In the United States, Carlson (1984) has

estimated (based on an average of two children in 55% of abusive relationships) that on a yearly basis, 3.3 million children are at risk of witnessing the violent assault of their mothers. Similarly, Pagelow (1982) reported that 76% (n=233) of 306 assaulted women said at least one child was present during the beatings. Surprisingly, in this same study, 51% (n=158) of the mothers said all their children were usual observers.

Finally, in Britain, Dobash and Dobash (1979) interviewed 109 assaulted women in shelters about the last assault they experienced. The authors found that 75% (N=81) of the mothers said that at least one child had been present. In another report, Dobash (1977) found that of 1,014 witnesses called to testify against perpetrators, 46% (N=464) were child witnesses.

Studies on shelters for battered women have also identified the high rates of child witnesses. MacLeod (1987) found that at least 70% of all women coming to shelters brought children, while 17% of the women brought three or more children. In another study, Layzer et al. (1985) reported on findings from six shelter-based research projects. At the time of the study, many of the children in the shelters exhibited acute health and behaviour problems. Finally, McKay (1987) surveyed staff members of shelters and found that 86% of children who came to the shelters exhibited numerous emotional and behaviourial problems.

The surveys and shelter observations reported above have identified a large population of children who may be at risk. At the same time, a number of the above studies may have been speculative given the differing modes of calculations, definitions of the research terms, and timing of the research. This seems to highlight a difficulty of assessing trends within the family violence field (Gorlick, 1994). However, it has still been possible to study how witnessing mother-assault may have serious, negative consequences.

Background To The Present Study

Within the last decade, a number of research teams have determined that children of all ages who witness mother-assault constitute a clinical population exhibiting a host of adjustment problems. Here, descriptive and empirical studies of shelter and non-shelter children have concentrated on observing internalizing, externalizing, and subtle symptoms.

Descriptive studies (e.g. Carlson, 1990, 1991; Hughes, 1982; Layzer, Goodson, & deLange, 1985; Pfouts, Schopler & Henley, 1981) have generally included case and observational data, whereas empirical studies (e.g. Jaffe, Wolfe, & Wilson, 1990; Jaffe, Wolfe, Wilson, & Slusczarek, 1986; Wolfe, Jaffe, Wilson, & Zak, 1986; Wolfe, Zak, Wilson, & Jaffe, 1986; Rossman & Rosenberg, 1992; Hughes & Barad, 1983; Hughes, 1988) have used standardized measures and

control groups in determining the effects of witnessing mother-assault. Both types of studies have evidenced a range of highly consistent behaviours. That is, children who witness their mother's assault exhibit global adjustment problems, including internalizing behaviours (withdrawn, fearful, depression, somatization, anxiety), externalizing behaviours (running away, aggression, tantrums, cruelty to animals), and deficits in social competence (poor school performance, no friends). The global adjustment problems of this population have also been delineated along age and gender lines (for a review see Fantuzzi et al., 1991; Jaffe, Sudermann & Reitzel, 1993; Jaffe et al., 1990).

Research teams have also determined that adjustment problems among child witnesses are cumulative when multiple victimization occurs. Research has shown that children who had witnessed mother-assault and been physically abused exhibited greater rates of behaviourial and emotional adjustment deficits compared to children who were only witnesses (Wolfe et al., 1985). In another study, child witness/physical abuse victims exhibited internalizing and externalizing scores which were found to be within the range requiring immediate clinical intervention (Hughes, Parkinson, & Vargo, 1989).

An additional adjustment difficulty for some child witnesses has come from the clinical observation of subtle symptoms in child witnesses. Subtle symptoms have been classified into three areas, including responses and

attitudes about conflict resolution, responsibility for the violence, and knowledge about how to be safe. In their review of this area, Jaffe et al. (1990) suggested that many children have deficits in all three domains. Furthermore, the authors felt that such problems were evident but often not attended to simply because questions were not asked.

The preceding literature has documented how children may be seriously affected by witnessing their mothers' assaults. This has provided important links in developing an understanding of the psychological needs of this specific population. At the same time, there has been a growing recognition that witnessing mother-assault may be an overwhelming traumatic life stressor deserving consideration. To emphasize this point, Jaffe et al. (1993, suggested:

> some children's reactions to witnessing family violence may satisfy the criteria for posttraumatic stress disorder (PTSD) as outlined in the Diagnostic and Statistical Manual of Mental Disorders by The American Psychiatric Association (p.321).

The ideas of Jaffe et al. (1993) have been part of a growing trend in the child witness literature indicating that exposure to the threat of physical harm or witnessing acts of violence is a traumatic event which could result in symptoms of posttraumatic stress disorder (PTSD) (Jaffe et

al. 1990, 1992, 1993; Jaffe, Hurley, & Wolfe, 1991; Rossman & Rosenberg, 1990; 1990; Wolfe & Jaffe, 1991).

Purpose And Rationale Of The Present Study

Given the increasing interest in the child witness to mother-assault and posttraumatic stress disorder, this dissertation will attempt to determine whether a group of children who have witnessed mother-assault over a period of time will exhibit symptoms of PTSD. The rationale for investigating PTSD responses in the child witness originates in a number of important sources. These include: a) a need to examine PTSD and the current child trauma field as it relates to the child witness, b) to develop an empirical study which might better describe trauma-specific responses in the child witness, and c) to consider an alternative PTSD conceptualization which includes the child witness. Each source is outlined below.

A primary basis for pursuing the current research comes from the field of children and posttraumatic stress. Although this field appears to be developing into an advanced area of study, a growing sub-speciality may be found primarily in children who have witnessed mother-assault but are not residents of shelters for battered women. To date, a handful of clinical-descriptive (e.g. Black, Kaplan, & Harris Hendricks, 1993; Malmquist, 1986; Pynoos & Eth, 1985; Silvern & Kaersvang, 1989) and empirical (e.g. Martinez & Richters, 1993; Osofsky, Wewers, Hann, &

Fick, 1993) studies have documented PTSD or PTSD-like behaviours in children who have either witnessed their mothers' rape, murder or suicide in addition to any number of related traumatic events. Considering the numbers of children exposed to mother-assault, there is a need to continue to identify the presence or absence of PTSD in the large numbers of children who witness dangerous, yet less extreme, forms of violence.

Consequently, a second rationale for the proposed study comes from a need to empirically determine whether a group of children who have witnessed mother-assault exhibit PTSD symptoms. This question has been asked in other forums. In their book Children Of Battered Women, Jaffe et al, (1990) speculated:

> clinical and empirical data presented throughout this volume suggest that children exposed to wife abuse may be similar to those children described as suffering from posttraumatic stress disorder (PTSD). (p.72)

In response to the developing interest in the child witness and PTSD, the present study will examine two new measurement instruments entitled the Childrens Impact of Traumatic Events Scale-Family Violence Form (CITES-FVF) (Wolfe & Lehmann, 1992) and the History of Violence Witnessed By Child Questionnaire (HVWCQ) (Lehmann & Wolfe,

1992). The CITES-FVF intends to measure the impact of witnessing mother-assault by identifying PTSD symptoms as well as the attributional style of the child, while the HVWCQ measures the severity and course of violence the child has witnessed.

A number of benefits may be derived from the use of an instrument such as the CITES-FVF (Wolfe & Lehmann, 1992) and the HVWCQ (Lehmann & Wolfe, 1992). First, the instruments may help identify a pattern of assault-specific symptoms characteristic of the traumatic experience of witnessing mother-assault. Thus, a database identifying the direct effects of witnessing mother-assault could be developed over and above the instruments measuring general dysfunction. In this vein, such measures need not be discarded. Instead, more global instruments and an instrument such as the CITES-FVF (Wolfe & Lehmann, 1992) could be used in combination to develop more comprehensive assessment and intervention strategies.

Second, using an instrument such as the CITES-FVF (Wolfe & Lehmann, 1992) and the HVWCQ (Lehmann & Wolfe, 1992) might help clinicians diagnose post-assault witnessing symptoms more accurately rather than strictly relying on subjective-based therapist interviews. Consequently, the CITES-WAF (Wolfe & Lehmann, 1992) and HVWCQ (Lehmann & Wolfe, 1992) could have the benefit of sensitizing interviewers to assault-specific sequelae.

Third, by developing instruments with specific reference to mother-assault, researchers may become more adept at determining the links between independent and dependent variables associated with this traumatic event. This link could assist future researchers in differentiating between the type, intensity, and frequency of abusive experiences (McGee, Wolfe, & Yuen, 1991).

A final rationale for the proposed study lies in developing an expanded PTSD conceptualizations of the child witness. Currently, a psychodynamic/cognitive model of traumatic processing has tended to dominate the child-trauma field (Pynoos & Eth, 1884 1985a,b; Silvern & Kaersvang, 1989). Although this model has been helpful in articulating how children process traumatic symptoms, this dissertation seeks to begin a discussion whereby an expanded PTSD conceptualization might be considered. The purpose of such a notion might be to accommodate a number of additional coping responses seen in traumatized children, including the child witness (e.g. anxiety, dissociation, depression, anger). This dissertation will attempt to assess some of the above coping responses in children who have witnessed mother-assault over a long period of time. This goal will be accomplished by referring to the Type I and Type II trauma responses of Terr (1990, 1991).

Relevance Of The Present Study

Clinicians who treat children are likely to hear about the effects of witnessing mother-assault on a daily basis. Therefore, this study is a timely and necessary contribution to our understanding of the seriousness of this social problem and should benefit the child witness field in two ways. First, the present study presents an opportunity to validate two new instruments and help determine, if in fact, the instruments do identify and/or measure PTSD responses. If predictions are supported by the data, the present study may identify the existence of PTSD assault-specific behaviours that could be addressed in assessment and therapy.

Last, this study may lead to future alternative conceptual perspectives in understanding the traumatic responses of the child witness. In light of the current interest in PTSD and the child witness, an expanded PTSD conceptualization could complement and add to the existing model.

Research Questions For The Present Study

At present some children may exhibit PTSD symptoms as a consequence of witnessing mother assault. Consequently, the purpose of this study is to determine if a sample of children who have witnessed mother-assault over time exhibit symptoms of PTSD. Therefore, the research questions in the present study include the following:

1. Will children who witness mother-assault exhibit PTSD symptoms?

2. Will children who witness mother-assault exhibit additional coping responses?

3. Will the HVWCQ (Lehmann & Wolfe, 1992) be a valid self-report instrument in determining the severity and course of mother assault that a child has witnessed?

4. Will the CITES-FVF (Wolfe & Lehmann, 1992) be a valid self-report instrument in measuring PTSD symptoms in children who have witnessed mother-assault?

Chapter Two

Selective Review Of The Literature

Introduction

Although much of the research and literature concerning posttraumatic stress disorder (PTSD) has addressed adults, within the last fifteen years an increasing amount of attention has been paid to traumatized children. This chapter begins with a review of the PTSD criteria and is followed by an overview of two features which have assisted researchers in identifying PTSD characteristics in children. A brief examination of the current child trauma literature is also considered. Next, a specific investigation of PTSD and the child witness to mother-assault literature is highlighted. In addition, an expanded PTSD conceptual framework which forms the basis of the present study is considered. The chapter concludes with a discussion of the variables, research questions, and hypotheses.

Children and PTSD: Criteria & Literature Review

The present section highlights PTSD criteria as defined by the DSM III-R (APA, 1987). Characteristics of traumatic stressors and current available assessment techniques are detailed followed by a brief literature review of children and PTSD. A summary discussion is included.

PTSD Criteria

Beginning in the 1980's a number of studies (Pynoos & Eth, 1984; 1985a,b; Terr, 1979, 1981) reported on children

who had experienced a number of life-threatening events. These events included a group of children who had been kidnapped as well as children who had witnessed their mother's rape, suicide, or murder. The importance of these studies rested in their discussions and observations of posttraumatic responses as a consequence of what had occurred. Furthermore, the significance of these studies helped bring about the incorporation of child-specific features of PTSD into the Diagnostic and Statistical Manual of Mental Disorders 3rd ed., rev. (DSM III-R (APA, 1987).

For the purposes of this dissertation, the concept of trauma is derived from the DSM III-R (APA, 1987) and may be seen and defined as:

> an event that is outside the range of usual human experience and that would be markedly distressing to almost anyone. (p.247).

A summary of the criteria along with the range of accompanying symptoms are highlighted below in Table 1. The four criteria include: 1)reexperiencing the traumatic event; and 2)avoidant responses associated with the traumatic event; 3)persistent symptoms of increased arousal and 4)duration of the disturbance.

Table 1 Diagnostic Criteria for PTSD (DSM III-R, 1987)

1)re-experiencing the trauma by at least one of the following:

-recurrent and intrusive recollections (in young children, repetitive play in which themes of the trauma are expressed)

-recurrent dreams

-sudden acting or feeling as if the traumatic event were recurring because of an association with sensory experiences (illusions, flashbacks, dissociations)

-distress at exposure to events that symbolize traumatic events

2)avoiding of stimuli associated with the trauma or numbing/denying of responsiveness by at least three of the following:

-avoiding thoughts or feelings associated with the trauma

-inability to recall an important aspect of the trauma

-diminished interest in important activities (in children loss of developmental skills such as toilet training or language skills)

-feeling detached from others

-loss of affect

-sense of a foreshortened future

3)increased arousal of at least two of the following:

-difficulty falling or staying asleep

-irritability or outbursts of anger

-difficulty concentrating

-hypervigilance

-exaggerated startle response

-physiologic reactivity to events that symbolize or resemble an aspect of the traumatic event (APA, 1987 pp.247-250).

4)duration of the disturbance (symptoms in 1, 2, and 3) of at least one month.

The recognition of PTSD sequelae as a diagnostic entity marked the beginning whereby systematic studies could directly examine children's responses to any number of

traumatic events. This has resulted in a large body of written knowledge within the child trauma field (e.g. Dawes, 1992; Figley, 1989; Lipovsky, 1991; Lyons, 1987; Mowbray, 1988; McNally, 1991, 1993; Peterson, Prout, & Schwarz, 1991; Pynoos, 1990; Terr, 1990; Van der Kolk, 1987).

Much of the above literature has been written in a way illustrating how children respond to traumatic experiences and exhibit PTSD criteria characteristics. Two common features specific to children have assisted this process and are frequently found in the literature. These include identifying stressors that may produce PTSD in children and assessment techniques that attempt to verify a DSM III-R diagnosis and/or description of PTSD. Each are considered below.

Traumatic Stressors

According to DSM III-R criteria (APA, 1987), PTSD is partly defined by an external event that is outside of the child. Examples of such stressors are thought to include a serious physical threat to self or others, the destruction of one's home or community, seeing another person killed or injured. In discussing the specific characteristics of traumatic events, Lipovsky (1991) has documented a number of characteristics that could be associated with the development of PTSD in children. These include: a)the degree to which the child thought she/he might be killed or injured, b)the level of exposure to frightening events, c)the degree the child thought significant others to be in

danger, d)the objective level of threat, and e)the response of significant others.

Fear, terror, and helplessness have also been emphasized in understanding the extreme nature of the stressor. Terr (1991) has argued that children may exhibit fear and terror in response to prolonged anticipation of oncoming events. Here, the author suggests that exposure to repeated and chronic traumatic events may help break down a child's coping behaviours. Likewise, Van der Kolk (1987) stated childhood trauma is significant because traumatic events create "uncontrollable, terrifying experiences which may have their most profound effects when the central nervous system and cognitive functions have not fully matured" (p.xii). Furthermore, Eth & Pynoos, (1985a,b) and Pynoos, (1990) have emphasized that the sheer nature of an overwhelming event can leave a child feeling helpless, and anxious in the face of unbearable danger.

Another key point associated with the traumatic nature of the stressor lies in the area of personal impact or dose-response effect. That is, the more closely the child is interpersonally affected through family or friendship ties by what she/he has seen, heard, or experienced, the more likely there will be a traumatic response. Consequently, some authors (Figley 1989; March, 1990; McNally, 1993; Pynoos, 1990) suggest that children respond more severely and their PTSD symptoms last longer if the traumatic event is associated with human accountability as compared to

natural disasters. In this context, there is also agreement that childhood PTSD is triggered most consistently by exposure to violence.

Furthermore, it has been suggested that children need not be physically present to develop PTSD. Generally, such cases of PTSD in children occur when a child strongly identifies with an individual (family member or friend) who may have been traumatized (Lyons, 1987).

A final area that considers the nature of the stressor lies with individual perception. Dawes (1992) and Richman (1993) emphasized the importance of understanding how children make sense of their experience of trauma, and what it means to them. Similarly, other authors have discussed the role cognition plays via children processing the traumatic event (Pynoos & Eth, 1984, 1985a,b). Understanding the role of perception and of processing traumatic events are crucial as many authors have suggested children often under-report their symptoms (Lyons, 1987, Pynoos, 1990). Thus it seems vital not to overlook the importance a child places on the traumatic event.

Current Assessment Techniques

The second feature which addresses the DSM III-R criteria of PTSD in children may be found in the numerous assessment methods currently available. The literature has identified a number of these procedures including structured interviews with parents/children as well as PTSD-specific assessment scales.

There are several interview methodologies currently in use. The Diagnostic Interview For Children and Adolescents (DICA & DICA-Revised) (Herjanic & Reich, 1982; Welner et al., 1987) are structured interviews given to parents and children to assess PTSD. The child Post-Traumatic Stress Disorder Inventory: Parent Interview (Nader & Pynoos, 1989) asks parents to report on their children's PTSD symptoms. In addition, Richters and Martinez (1990) designed the Survey of Children's Stress Symptoms-Parents report in response to childrens exposure to community violence. Much of the current trend in structured interviewing can be traced to the early work of Terr (1979, 1981) and Pynoos and associates (Pynoos & Eth, 1984, 1985a,b, 1986) who developed structured interviews for children and their parents following life-threatening events.

At the same time, a number of assessment scales have been developed to isolate PTSD-specific sequelae. Currently, the Posttraumatic Stress Reaction Index-Revised (PTSDRI) (Frederick, Pynoos, & Nader, 1992) is the most commonly used measure of children's PTSD responses. The PTSDRI covers 20 items of traumatic responses based from the DSM III-R criteria (APA, 1987). The PTSDRI evolved from the first version of the Reaction Index which covered 15 items based from the DSM III criteria (APA, 1980). Both scales have been used to measure PTSD in children who have survived disasters (e.g. Vogel & Vernberg, 1993) and community violence (e.g. Pynoos et al., 1987).

The Impact of Events Scale (IES) (Horowitz, Wilner, & Alvarez, 1979) has also been used as a measure of PTSD. Although designed for use with adults, the IES assessed for PTSD sequelae in children who had survived disasters (Yule & Udwin, 1991; Yule, Udwin, & Murdoch, 1990).

Saigh (1989a,b) has developed the Children's Posttraumatic Stress Disorder Inventory (CPTSDI), a structured interview for diagnosing DSM-III PTSD with children who have survived war-time experiences. In addition, Sack et al., (1986) used a modified version of the Global Assessment Scale (CGAS) to identify PTSD symptoms in Cambodian children who were prisoners of war.

A number of scales have been devised to measure PTSD in sexually abused children. Recently, Wolfe et al., (1991) evaluated the Children's Impact of Traumatic Events Scale-Revised (CITES-R) with a similar sample of children. This instrument has 78 items, and measures PTSD responses as well as children's social support and attributions regarding their abuse. Furthermore, a number of authors (Deblinger et al., 1990; Kiser et al., 1988, 1991; McLeer et al., 1988, 1992) developed self-report PTSD instruments based on DSM III-R criteria to assess sequelae. Finally, a number of authors have used more general assessment instruments and adapted interpretation of scales with regard to PTSD or items representing PTSD (Holaday et al., 1992; Koverla et al. (1990); Wolfe, Gentile, & Wolfe, 1989).

Measuring PTSD in child survivors of community violence has also been developed. Richters and Martinez (1990) devised the Checklist of Child Distress Symptoms (CCDS). The CCSD is a 30 item scale which has been adapted for structured interviews with young (6-7) and middle-aged (8-11) children. Furthermore, Fitzpatrick and Boldizar (1993) used an adapted version of the Purdue Posttraumatic Stress Scale (Figley, 1989), a 15 item questionnaire, in their examination of inner city children in Chicago.

While the above studies have led to a body of empirical evidence in favour of a PTSD formulation, some overall methodological and statistical issues are worthy of noting. The majority of studies were not able to use comparison or control groups, thus limiting between-group differences. As well, some instruments were specifically designed for adults (Holaday et al., 1992; Yule & Udwin, 1990; Yule et al., 1991) and it is unknown how applicable the results might have been to children. Finally, a number of studies developed self-report instruments specifically for the study reported. It is therefore unknown how valid and reliable the instruments might be. In this case, a number of authors (Armsworth & Holaday, 1992; Udwin, 1993; Vogel & Vernberg, 1993) have been critical of the child trauma research field as many instruments have not undergone proper psychometric testing, thus providing findings that were not comparable.

Children And PTSD: An Overview Of The Literature

Perhaps the most studied area of childrens' PTSD responses comes from children who have survived natural disasters, including hurricanes, tornadoes, bush fires, floods, landslides, nuclear accidents, and boating accidents. Comprehensive reviews have been included in the work of Green et al., (1991), Gordon and Wraith (1993) and Vogel & Vernberg (1993).

Community violence has also been associated with the disaster reviews. However, because of its human origins, this area deserves separate attention. Currently, this literature has examined PTSD responses in children who have been exposed to community violence including gang-related violence (Applebaum & Burns, 1991), sniper shootings (Pynoos & Nader, 1988; Pynoos et al., 1987; Nader et al., 1990; Schwartz & Kowalski, 1991), the violence of inner cities (Fitzpatrick & Boldizar, 1993; Green, 1993; Lorion & Saltzman, 1993; Martinez & Richters, 1993; Richters & Martinez, 1993; Shakoor & Chalmers, 1991) and kidnapping (Terr, 1979, 1981, 1990).

Another important group of studies has come from the child sexual abuse field. Authors including Kendall-Tackett, Williams, and Finkelhor (1993), Rowan and Foy (1993), Perrin and Wurtele (1990), Green (1993) and Wolfe and Birt (in press) have summarized the current empirical literature involving child survivors of sexual abuse and

PTSD. At the same time, Green (1993) has detailed efforts to examine PTSD and child physical abuse.

The issue of war has also been examined in response to the PTSD sequelae found in children. Macksoud, Dyregrov, and Raundalen (1993) have summarized the empirical studies in this area.

Finally, there has been some interest in children, PTSD, and illness. Nir (1985) has studied children and cancer, Stoddard et al., diagnosed PTSD in children with severe burns, and last, Nader, Stuber, and Pynoos (1991) and Stuber et al., (1991) discussed the traumatic impact of children undergoing bone marrow transplants.

Children And PTSD: A Summary and Discussion

A number of important issues may be indicated as a result of the discussion above, thereby adding to the current interest in children and PTSD. First among the issues is the notion of criteria consistency. The literature presented above seems to show that a number of childhood stressors meet the criteria for trauma as outlined by the DSM III-R (APA, 1987), and that a substantial number of child survivors show trauma-specific symptoms in most domains as defined by the DSM III-R (APA, 1987).

Second, despite the applicability of the DSM III-R criteria (APA, 1987) to adults and children, the studies seem to suggest some general fundamental differences (Peterson et al., 1991). Children over the age of 3 or 4 do

not become amnesic; that is, they tend not to employ a denial of reality; posttraumatic play of the trauma is more frequent with children; children will often display a time distortion in re-counting events; children and adolescents will often have a foreshortened view of their future; school work may suffer for short periods of time following the trauma compared to the long-term work problems of adults, and finally, children rarely have flashbacks of their experiences but instead have singular images of what occurred (Peterson et al., 1991).

Third, a number of child researchers of PTSD (Armsworth & Holoday, 1993; Green et al., 1991; Udwin, 1993; Vogel & Vernberg, 1993; Wolfe & Birt, in press) have called for the disorder to be examined more closely and possibly broadened to accommodate other behaviours commonly found in traumatized youth. Essentially, the common concern noted relates to the belief that many of the PTSD symptoms as defined in the DSM III-R may not constitute an exhaustive list or even be all essential to the disorder. Some additional behaviours seen as needing consideration have included depression, self-abuse, anxiety, poor academic achievement, and abnormal sexual behaviour among children who have experienced sexual abuse.

The fourth issue concerns some methodological problems raised by a number of authors. Armsworth and Holaday (1993) and Udwin (1993) have argued that the literature lacks a standardized definition of stress and trauma for children.

The authors feel some definitions may fail to account for existing behaviours. They suggest that an effort should be made to standardize instruments and methods of obtaining data (e.g. self-report, parent-report) in order to improve response rates and ultimately be able to differentiate risk factors. On another point, Lansen (1992) has argued that the mental health field has begun to put too much weight on PTSD as an exclusive measure of distress. It may be important for the child research field to continue using non-trauma measures since an absence of PTSD may not necessarily mean an absence of distress. McNally (1991) has also argued that subtypes of PTSD (acute vs chronic forms) need further clarification rather than assuming both will display similar symptomatology. Finally, Armsworth and Anett (1990) suggested qualitative methods of research might be useful in understanding which aspects of the trauma create the most distress or what characteristics of the child predispose her/him to greater risk.

The fifth and final issue concerns the outcome of a child's PTSD responses. In this context a number of authors have urged the child trauma field to learn more about what risk (Udwin, 1993) or mediating (Green et al., 1991; van der Kolk, 1987) factors make children vulnerable to PTSD. Some of the reported risk/mediating factors found in the literature have included the degree of exposure to and source (human vs natural) of the traumatic event (Pynoos, 1990); a child's attributional style (Wolfe et al., 1989)

and cognitive appraisal of the event (Pynoos & Eth, 1985); lack of family supports (Pynoos, 1990; Terr, 1983; Van der Kolk, 1987), parental traumatization (Udwin, 1993), prior trauma to the child (Krugman, 1987; Terr, 1991; Van der Kolk, 1987), as well as bereavement (Vogel & Vernberg, 1993). Other factors may also influence a child's reaction to a potentially traumatizing event such as age, sex (Green et al., 1991; Mowbray, 1988) and race (Lonigan, 1991).

The present discussion has provided a review of the current literature on children and PTSD. The findings seem to indicate that PTSD sequelae can be measured and observed in any number of child trauma survivors. As shown below, studies have also reported on trauma-specific responses in the child witness to mother-assault.

PTSD And The Child Witness To Mother Assault: A Review Of The Literature

In addition to speculations from the child witness to mother-assault field that children may exhibit PTSD symptoms, child-trauma researchers have already begun to document similar responses in this population. Two on-line data bases, PSYLIT II and SWAB (Social Work Abstracts), were used to locate relevant articles beginning in 1980 and ending in 1994. An outline of recent empirical and clinical/descriptive studies documenting PTSD symptoms in the child witness to mother-assault are highlighted in Table 2.

Publications were selected for the current review if they met the following criteria: a)reference to mother-assault/family violence, b)reference to child witnesses, and c)reference to PTSD. In sum, 16 articles were chosen for review. Nine additional conceptual papers which contained references to the child witness were also included (Armsworth & Holaday, 1993; Eth & Pynoos, 1985; Pynoos & Eth, 1984, 1985, 1986; Pynoos & Nader, 1990, 1993; Pynoos, 1990, 1994). A summary of the literature review is highlighted according to the presence of PTSD in the child witness, specific PTSD symptoms found in the child witness, and mediating/risk factors influencing traumatic responses.

Table 2
Studies Of The Child Witness and PTSD

Author/Year	Traumatic Event	N	Age	Informant	Assessment Measure	Findings
Pynoos & Eth (1984)	Child witness to mother's murder by a parent	40	pre school-adolescent	child	clinical interview	using a 3 phase interview, 80% of the witnessing children met the PTSD criteria
Pynoos & Eth (1985)	Child witness to mother's rape, murder or suicide	100	pre-school-adolescent	child	clinical interview	80% of the sample displayed symptoms characteristic of PTSD
Pynoos & Eth (1986)	Child witness to mother's rape, murder or suicide	200	3-16	child/ referral sc.	clinical interview	no specific percentages except to say all children elicited PTSD symptoms from all domains of the criteria

Table 2 (Continued)
Studies Of The Child Witness and PTSD

Author/Year	Traumatic Event	N	Age	Informant	Assessment Measure	Findings
Malmquist (1986)	Child witness to mother's murder	16	5-10	child	IES++	PTSD was evident in 100% of the children
Black & Kaplan (1988)	Child witness to mother's murder	28	18 mo.-14	caretaker notes	review of cases	no final statistics; authors caution PTSD will be present given the extreme nature of the stressor
Pynoos & Nader (1988)	Child witness to parental rape	10	5-17	child	PTSDRI+	90% diagnosed with severe PTSD, 10% with moderate PTSD
Silvern & Kaersvang (1989)	Child witness to mother assault	1	8	child/ parent	clinical interview & play observation	PTSD evident through post traumatic play
Famularo et al. (1991)	Physical/ sexual abuse/ & witnessing mother assault	19	7-14	child/ parent	DICA-R++	36.8% received a DSM III-R PTSD diagnosis
Dyson (1991)	Child witness to mother's murder<u>or</u> violence among var[illegible] family members	6	12-14	child	clinical interview	no final statistics however author notes all children exhibited PTSD stress responses
Holaday et al. (1992)	witnessing mother assault, physical/ sexual assault <u>or</u> survived war	63	7-17	child	Rorschach	no final statistics of PTSD however when compared to controls, traumatized group displayed higher emotional & behavioural problems

Table 2 (continued)
Studies of the child witness and PTSD

Author/Year	Traumatic Event	N	Age	Informant	Assessment Measure	Findings
Black et al., (1992)	child witness to parental murder	76	---	child/ caretaker	clinical interview	app. 50% of children who were direct witnesses had significant PTSD; those who did not exhibit PTSD generally had other psychiatric problems
Martinez & Richters (1993)	child witness to community violence & mother assault	165	7-11	child/ parent	CDS+	high distress symptoms in young and old children were related to witnessing violence in community & at home
Osofsky et al. (1993)	child witness to community violence & mother assault	53	10	mother	SCSS+++	witnessing mother assault & community violence led led to largest R's of PTSD symptoms
Fitzpatrick & Boldizar (1993)	child witness to community violence & mother assault	221	7-18	child	Purdue PTSD Scale@	27.1 % of youth met PTSD criteria
Black et al., (1993)	child witness to parental murder	46	8 mo.-15	referring therapist	survey study assessing problem level	26% of the sample were thought to have PTSD, with most having a combination of emotional and behavioural problems
Duncan & Allen-Meares (1994)	child witness to mother assault & homicide	2	6-10	referring therapist	observation in assessment	assessment indicated children exhibited PTSD in all three domains

@Purdue PTSD Scale (Figley, 1989)
+Checklist of Child Distress Symptoms (Martinez & Richters, 1990a)
++Impact of Events Scale (Horowitz, Alvarez, & Wilner, 1979)
+++Survey of Children's Stress Symptoms-Parent Report (Richters, 1990)
++Diagnostic Interview For Children and Adolescents-Revised (Reich & Welner, 1990)
#Posttraumatic Stress Disorder Reaction Index (Frederick, 1985)

The Presence of PTSD In The Child Witness

The use of methodologies to determine PTSD varied. The PTSDRI (Frederick, 1985) and the DICA-R (Reich & Welner, 1990) were the only measures standardized for children, while the remaining scales were adapted for use because of their specificity to adult populations. Further, there did not seem to be much difference in the instruments' ability to determine a PTSD diagnosis. That is, standardized instruments as well as interview methodologies seemed equally capable of measuring traumatic sequelae. For example, 90% of children who had witnessed their mother's rape (Pynoos & Nader, 1988) were diagnosed with severe PTSD using the PTSDRI, compared to 80% of the sample who had witnessed their mother's murder and interviewed by way of a three phase interview (Pynoos & Eth, 1984, 1985).

As well, some studies did not use the measures to make actual clinical diagnoses of PTSD, but to highlight the clusters of symptoms in surviving children. Fitzpatrick and Boldizar (1993) found that while 27.1% of their sample met all three PTSD criteria, 34.2% met 2 criteria, and 27.1% met only 1 criteria. Likewise, other studies (Holoday et al., 1992; Osofsky et at., 1993; Richters & Martinez, 1993) noted similar sentiments, indicating the usefulness of PTSD domains of reexperiencing, avoidance, and hyperarousal to demonstrate the disturbance among this population.

The remaining clinical-descriptive studies were also able to delineate the PTSD responses in children (Burman &

Allen-Meares, 1994; Black & Kaplan, 1988; Black et al., 1992, 1993; Dyson, 1991; Pynoos & Eth, 1984, 1985, 1986; Silvern & Kaersvang, 1989). Here, the 3 phase interview approach of Pynoos and associates seemed to be the most frequent methodology in assessing PTSD symptoms. By way of a structured interview process, Pynoos and Eth (1984) identified clusters of symptoms (paralleling the DSM III criteria, APA, 1980) in pre-schooler, school-age, and adolescent subjects by observing behaviours and asking questions about the crimes children had witnessed.

Specific PTSD Symptoms Found In The Child Witness

There are a number of PTSD symptoms related specifically to the child witness and found in the current review which warrant further discussion. Each are detailed below.

Repetitive Play

Repetitive play has been coined post-traumatic play in that the play of the child compulsively repeats themes and aspects of the trauma (Terr, 1991). Such play is contrasted from normal play in that normal play is an activity the child feels he or she enjoys, alone or in a group (Terr, 1981). At the same time, post-traumatic play is seen to reflect either a useful part of recovery or a hindrance in that it continues to be an unwanted reminder of the experience (Pynoos, 1990; Pynoos & Nader, 1993). Examples of post-traumatic play were commonly found in younger

children who played shooting games (Pynoos & Nader, 1988), dead games (Malmquist, 1986; Pynoos & Eth, 1984, 1985), superhero (Silvern & Kaersvang, 1989) and games representing acts of community violence (Osofsky et al., 1993).

Trauma-specific Fears

As a consequence of witnessing mother-assault, children developed a number of fears. These included a fear of guns and drugs (Martinez & Richters, 1993), fear of the assailant returning and harming the child (Black et al., 1993; Eth & Pynoos, 1985; Pynoos & Eth, 1984, 1985), and fears associated with the dark and sleeping alone (Burman & Allen-Meares, 1994). Other children developed fears beyond events directly related to the trauma (Pynoos & Nader, 1988). A number of studies also reported on childrens' fears of losing control because of their wish to retaliate against the violent perpetrator (Eth & Pynoos, 1985; Pynoos & Eth, 1984, 1985, 1986; Pynoos & Nader, 1988).

One study, however, found the exact opposite responses. Older boys who were rated as most anxious by their mothers denied these symptoms and tended to brag about their experiences (Martinez & Richters, 1993). Although this bravado was seen as a developmental shift, the authors had concerns about such behaviours given the violent conditions under which these children lived.

Somatic Complaints

Somatic complaints are psychophysiological stress responses which occur as a consequence of the traumatic

event. Somatic complaints such as headaches, stomach aches, recurring asthma, dizziness, nausea, diarrhoea, etc. were reported in 100% of the studies listed in Table 2. The occurrence of such problems cut across all stages of development.

Sleep Problems

Sleep disturbances including dreams and nightmares, are thought to occur with great frequency (Pynoos, 1990). Consequently, problems with sleeping were reported in a number of studies. Pynoos and Nader (1988) reported that 60% of the children who had witnessed their mother's rape had sleep disturbances. These mothers also reported their children as being chronically fatigued. Similarly, Fitzpatrick and Boldizar (1993) found that 37.2% of their sample reported sleep-related difficulties. In another study, Martinez & Richters (1993) reported that 70% of the children had sleep-related problems compared to parent-reports of twenty-seven percent.

School Performance

Problems in school were seen as related to fatigue and lack of sleep (Pynoos & Nader, 1990). Other studies also found that school performance was due to the dislocation of some children who had witnessed their mother's murder (Black & Kaplan, 1988). Finally, Dyson (1991), Burman and Allen-Meares (1994) and Pynoos and Eth (1984) reported that 100% of their school-age children showed declines in concentrating and ability to learn. These problems were

seen as a consequence of recurring, intrusive thoughts of a parent's or family member's death as well as the stress of the situation.

Memory Distortions

It has been suggested that children may demonstrate a number of memory distortions. For example, Pynoos, (1990, 1994) reported the younger the child, the more the child might omit moments of extreme threat or distort their proximity to the violence. This was found with a younger group of children who tried to sleep while their mother was being raped (Pynoos & Nader, 1988). The authors felt these type of memory distortions insulated the child from the tremendous anxiety experienced. On the other hand, Pynoos and Eth (1985a, 1986) found that adolescents could give accounts of events but were more interested in scrutinizing their overall participation with that of the victim and perpetrator. Finally, Peterson et al. (1991) wrote that the traumatized child does not disbelieve what has occurred; that is, children do not have amnesia associated with the event, and can provide details of their experiences. Peterson et al's (1991) point was confirmed in many of the descriptive studies (Black et al., 1992, 1993; Black & Kaplan, 1988, 1993; Pynoos & Eth, 1984; Pynoos & Eth, 1985a) of children who had witnessed their parent's murder.

Foreshortened Future

A sense of foreshortened future has been reported in a number of studies. For example, Fitzpatrick and Boldizar

(1993) found that 50.8% of their sample reported feelings of a bleak future. Likewise, Martinez and Richters (1993) reported that children felt more hopeless about their future compared to the perceptions of their mothers. Also, Pynoos and Nader (1988) found that younger and older children were preoccupied with their future life and relationships following the rape of their mothers. Finally, Pynoos and Eth (1984) reported that the majority of their school-age children and adolescents had little hope they would live to be old.

Emotional Responses

Armsworth and Holaday (1993) concluded that traumatized children are likely to show a heightened sense of emotional vulnerability due to reminders or intrusive thoughts of the traumatic event. The accuracy of Armsworth and Holaday's point was confirmed by one hundred percent of the studies in Table 2. Witnessing children exhibited a host of negative emotional responses. These included reduced self-esteem (Dyson, 1991; Holaday et al., 1992; Silvern & Kaersvang, 1989), and lost trust in others (Pynoos & Eth, 1984; 1985a). Other emotional responses found included depression and feelings of helplessness (Dyson, 1991; Black & Kaplan, 1988; Black et al., 1992, 1993; Famularo et al., 1991; Martinez & Richters, 1993; Pynoos, 1994); and guilt about not intervening (Black et al., 1993; Pynoos & Nader, 1988; Pynoos & Eth, 1984).

Behaviourial Responses

A number of behaviourial responses have also been identified among child witnesses. These have included social and emotional withdrawal from family and friends (Osofsky et al., 1993; Martinez & Richters, 1993; Pynoos & Nader, 1988), anxious clinging (Osofsky et al., 1993; Pynoos & Eth, 1984; Pynoos & Nader, 1988), aggression and acting out in school (Burman & Allen-Meares; Black et al., 1992; Dyson, 1991; Malmquist, 1986), regression in the form of enuresis (Burman & Allen-Meares, 1994; Malmquist, 1986), and reduced friendships due to inappropriate behaviours (Dyson, 1991; Pynoos & Nader, 1988).

The clinical/descriptive and empirical studies reviewed above have generally assessed and found PTSD symptoms in children after they have witnessed mother-assault as well as experienced a number of other traumatic events. At the same time, the same literature has attempted to articulate what factors might mediate some of the traumatic responses. These factors are considered below.

Risk/Mediating Factors Influencing Traumatic Responses

A number of risk/mediating factors from the studies found in Table 2 may influence the responses and adaptation of the child witness to mother-assault. The factor sub-headings below have been adapted from the work of Korol (cited in Green et al., 1991) and Vogel and Vernberg (1993) in their summaries of children and disasters.

Characteristics Of The Stressor

Characteristics of the stressor include historical factors, exposure to the particular traumatic event, and bereavement. Virtually 100% of the cases reviewed in Table 2 involved circumstances in which children were multiply victimized. For example, in their review of children who had witnessed their mother's murder, Black et al., (1993) calculated that at least 60% of the sample children had been exposed to previous violence in their homes. Famularo et al., (1991) found that 80% of their referrals had histories of previous traumatization including physical and/or sexual abuse. Similarly, authors who studied community violence (Osofsky et al., 1993; Richters & Martinez, 1993; Fitzpatrick & Boldizar, 1993) found that multiple traumas, such as witnessing shootings, muggings, and mother-assault, led to increases in symptoms of distress.

Direct exposure to the traumatic event also seemed to have a negative impact on children. Black et al., (1992, 1993) concluded that children who directly witnessed their mothers murder would likely show more PTSD responses than those not exposed. Osofsky et al., (1993) found that direct exposure to violence at home and on the street as well as hearing about violence were the biggest predictors of PTSD symptoms.

When bereavement is associated with exposure to violence, PTSD reactions complicate the bereavement process (Pynoos & Eth 1985a; Pynoos & Nader, 1993). This is due to

the fact that traumatic and grief reactions are dual demands which can stress the internal resources of the child. Similar views were raised by Black et al., (1992, 1993) in studies of children who witnessed their mother's murder. The authors found that normal mourning was inhibited by the child's sudden loss, coupled with disruptions in their homes and schools. Furthermore, in a case study, Dyson (1991) found that multiple family deaths due to violence coupled with rage and revenge fantasies prevented an adolescent from beginning to come to terms with his mother's death.

Characteristics Of Processing The Event

Currently, one main conceptual model appears to account for how a child processes traumatic event(s). Pynoos and Eth (1984, 1985a,b) have detailed a psychodynamic/cognitive model of traumatic processing. Essentially the authors have followed Freud's definition of psychic trauma whereby an overwhelming event results in a state of helplessness in the face of danger, arousal, and instinctual arousal. The model is also cognitive in that coping with the traumatic event is a cognitive process involving an ongoing tension between defense against and any experiential repetition of memories of the trauma. The role of childhood development has helped define this model, and consequently, has been divided according to the cognitive changes of infancy, toddlerhood, pre-school, school-age, and adolescent.

Some of the studies reviewed in Table 2 utilized the psychodynamic/cognitive model. For example, in their review

of children who had witnessed their mother's murder, Black et al., (1993) believed that infants and toddlers were protected from the full impact of the event due to their development and cognitive immaturity. As well, pre-school children exhibited a number of denial fantasies or attributed superhuman powers to themselves for self-protection (Pynoos & Eth, 1985b; Pynoos & Nader, 1993). Furthermore, pre-school children appeared to have difficulty processing the traumatic event and displayed a great deal of confusion, anxiety, and an over-all sense of helplessness and passivity (Pynoos & Eth, 1985a,b, 1986; Pynoos & Nader, 1988, 1993).

School-age children presented problems related to processing their anger, difficulty learning in school, and failed peer relationships (Pynoos & Eth, 1985a,b,; Pynoos & Nader, 1993; Dyson, 1991). Children also detailed revenge-like fantasies in which they would intervene (Pynoos & Eth, 1986; Pynoos & Nader, 1993). Adolescents, on the other hand, showed more posttraumtic acting out, desires for revenge, and made radical shifts in how they view their future (Pynoos & Eth, 1985b; Pynoos & Nader, 1993).

The Role of Age

Age was reported as an important mediators. In some studies there was a trend towards younger children exhibiting more distress. Black et al., (1993) found that 58% of the school-age children compared to 10% of their adolescent sample were seen as having more emotional

problems. Martinez and Richters (1993) also found that a combination of viewing drugs and guns in the home as well as witnessing violence resulted in higher distress symptoms for younger children than their counterparts. Similarly, Fitzpatrick and Boldizar (1993) reported that younger children showed higher levels of distress than older children when fathers and stable female caretakers were absent. Finally, Pynoos and Nader (1988) found that younger children had more difficulty processing their mother's rape than older children.

In the current review, there was no consistent pattern suggesting that one gender exhibited more symptoms than the other. These findings are somewhat similar to Udwin's (1993) contention that in general, child trauma studies differentiating gender have been conflictual and inconsistent in terms of one gender being more at risk.

Characteristics Of The Environment

The final mediating factor addresses characteristics of the environment. Table 2 has reported that 53% of the studies were those in which the most extreme form of mother-assault occurred; that is, a mother was murdered. Although none of the studies provided detailed histories of these families, enough information was provided to suggest that all the families were chaotic, dysfunctional, and suffering extreme stress prior to the murder. This may be compounded by the fact that most of the children had been multiply traumatized.

A number of other points have been made regarding the posttraumatic environment. Pynoos and Nader (1988) found that family conflicts between children and parents increased. Black et al., (1988) provided details suggesting post-death placement was difficult for surviving children, particularly when they were not given details of the incidents. Legal issues around adoption, and custody and access also tended to stress the children who had survived.

Family support, too, seemed a crucial characteristic. Fitzpatrick and Boldizar (1993) found that 70% of their sample reported not having a male role model within the home. This led the authors to question the impact such circumstances could have on a child's support network in terms of positive male relationships. In another study Martinez and Richters (1993) implied that lack of parent monitoring and supervision may have contributed to children self-reporting more distress symptoms than their parents did of them. Further, the authors found that parents from the most violent homes were significantly less likely to agree with their children about their children's distress symptoms. As well, in the same study, Martinez and Richters (1993) found that exposure to violence and distress symptoms was strongly related to less-educated parents. The above point in combination with the remainder of the study prompted the authors to suggest children living in violent environments could be at risk for developing maladaptive responses.

The Child Witness: A Summary And Discussion

Despite the limited number of published studies, some important issues may be raised. Primarily, the literature listed in Table 2 considered PTSD in non-shelter children who had witnessed a continuum of violence directed against their mothers, ranging from assaults to homicide. The studies also placed most of the children in varying victimizing contexts such as sexual abuse, community violence, etc. Overall, the empirical and clinical-descriptive studies would seem to suggest that children who have witnessed their mother's assault exhibit symptoms of PTSD consistent with the DSM III-R criteria (1987). These findings could suggest that the PTSD model may be a viable concept when considering the direct effects of witnessing mother-assault.

Second, there seems to be some consistency between the reported findings in Table 2 and certain risk or mediating factors found in the above review. That is, there appeared to be a number of factors including previous traumatization, developmental processing, age, and dysfunctional family environment which may have mediated the development of PTSD symptoms.

Another important issue concerns the use of assessment instruments. The studies addressed in Table 2 would seem to indicate that the empirically-based measures as well as the interview-based assessments are equally capable of determining any number of PTSD responses of the child

witness. In terms of methodological considerations, it may be helpful for future studies to use more standardized measures, use control groups, and develop longitudinal studies to determine the after-effects of witnessing mother-assault.

The fourth issue relates to broadening the disorder to accommodate additional symptoms. For example, virtually 100% of the studies listed in Table 2 suggested children who witnessed mother-assault as well as experienced other traumatic events all exhibited increased anxiety. While this is an area that requires further study, empirical confirmation may verify what is being reported widely among clinicians.

The fifth and final issue relates to the development of conceptual models. As stated above, one model (Pynoos & Eth, 1984, 1985a,b) seems to reflect much of the conceptual thinking underlying traumatic processing. However, inspection of Table 2 revealed that many of the clinical-descriptive and empirical studies failed or provided little identification of a conceptual framework (e.g. Dyson, 1991; Famularo et al., 1991 Malmquist, 1986). Consequently, in places there was minimal rationale for a conceptual model. These findings coincide with the contention of some authors (e.g. Udwin, 1993; Vogel & Vernberg, 1993; D. Wolfe & Jaffe, 1991; V. Wolfe & Birt, in press) that current PTSD conceptualizations need continuing development and empirical

verification and that current PTSD models do not account for all forms of posttraumatic sequelae.

One option to address these concerns may be the development of an expanded conceptual model along with concurrent instruments which could measure the direct effects of witnessing mother-assault. Such instruments might begin to account for the assault-specific symptoms that are characteristic of PTSD and help clarify the diversity of problems observed. Finally, an expanded model may address the growing desire for a broadening of current PTSD criteria. In this context, an expanded PTSD model for studying the child witness to mother-assault may be found by considering the recent work of V. Wolfe and associates.

The Present Study: An Expanded PTSD Conceptual Framework

The current section includes a conceptual framework as a basis for the present study. Here, an expanded PTSD conceptualization with respect to the child witness is presented and is partly based on a theoretical and empirical model of child sexual abuse adjustment developed by V. Wolfe and her associates.

The major premise of the Wolfe and associates model (V. Wolfe & Wolfe, 1988) is that children's responses to sexual abuse will be varied reflecting a number of mediating factors. Therefore, in order to understand and predict a child's particular responses, one would need to consider a number of these mediating factors. Such factors could

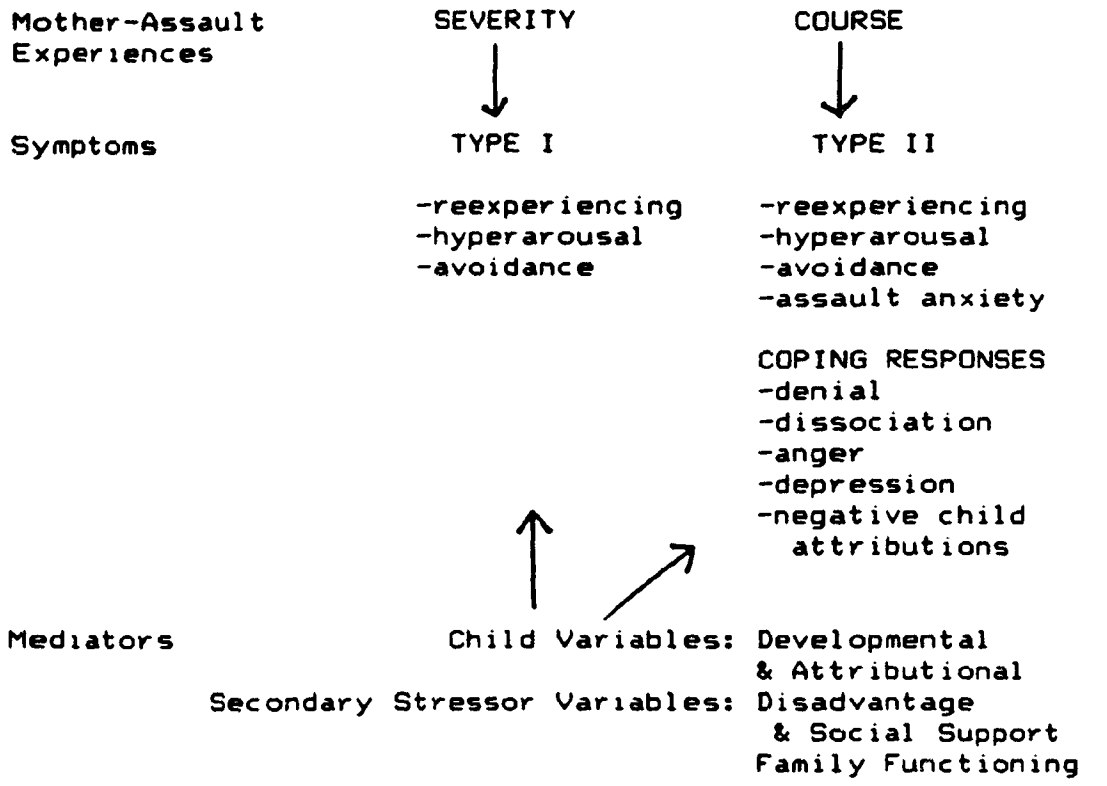
include the nature of the abuse, the child's responses including trauma-specific and negative coping sequelae, the child's current development, as well as family and community supports and resources. The importance of each of the above factors will differ depending upon the point at which the child presented. In this case, presentation of the child could vary from predisclosure, to disclosure, to recovery and adjustment.

An additional element of the V. Wolfe and associates model (Wolfe & Birt, in press) has been their investigation of childhood sexual abusive experiences (severity vs course) as part of the Type I and Type II PTSD typologies of Terr (1987, 1990, 1991). For example, in studies of sexually abused children, the the role of severity vs course (Gentile, 1988; Wolfe & Gentile, 1992) were found to be important indicators in differentiating short versus long-term responses. In addition, symptom variables including depression (V. Wolfe, 1990), PTSD and anxiety (V. Wolfe et al., 1991) were investigated. Furthermore, the authors suggested that long-term global adjustment problems including anxiety and chronic behaviour problems (V. Wolfe & Gentile, 1992) and dissociation (V. Wolfe & Birt, in press) were also part of the typologies. Essentially, the findings of V. Wolfe and her associates paralleled some of the ideas of Terr.

Figure one provides a visual overview of an expanded PTSD conceptualization for the child witness to mother-

assault. As figure 1 indicates, the current expanded conceptualization is partly based on two aspects of assault experiences (severity & course) as well as the Type I and Type II PTSD symptom and coping variables of Lenore Terr (1990, 1991). Therefore, the Type I and Type II typologies are discussed first. Next, a number of child and secondary stressor variables will be considered as mediating the potential outcome of Type I and Type II responses. Child variables will include a developmental framework plus an attributional style (V. Wolfe & Wolfe, 1988), while secondary stressor variables will include social support and family disadvantage.

Figure 1
A Pictoral Overview Of An Expanded PTSD Conceptualization



Conceptual Framework: The Type I and Type II Responses of Terr

Lenore Terr is considered a pioneer in the study of PTSD and children. Her work and contributions to the clinical and research field have had a direct impact on the inclusion of symptoms of PTSD in the DSM III-R. One of the earliest and most important work recognizing PTSD in children came from Terr's (1981, 1983a, 1984) follow-up accounts of twenty five school children who had been kidnapped in a school bus. Other important topics have also included posttraumatic play and child development (Terr,

1981), parental kidnapping (1983), the early formation of memories and PTSD (Terr, 1983, 1988), children traumatized in small groups (Terr, 1985), children as court witnesses (1986), children's nightmares in response to trauma (Terr,1987), and treating disaster survivors through marathon group work (Terr, 1992a).

The present discussion will focus on Terr's (1990, 1991, 1992c) theories of how children cope with short and long-term repeated trauma. In essence, Terr (1990, 1991, 1992a,b) may have begun to broaden the scope of analyzing PTSD in children in the aftermath of traumatic events.

Type I Trauma

In order to account for a child's coping strategies in the presence of short and long-term chronic trauma, Terr (1991) has suggested a dual classification for individuals suffering from trauma-related life events. Type I trauma is the result of one sudden, unexpected blow to the child, such as being in a car accident, going to the hospital, a non-violent family death, etc., and includes the core PTSD symptoms of intrusive memories, avoidant behaviours, and hyperarousal. Additionally, Terr (1990, 1991, 1992b) suggested that a number of internal changes occur from single blows which may also be present in Type I trauma. These include the full-detailed memories of the traumatic event, the development of omens or signs which predicted the trauma, and visual-like misperceptions or hallucinations of the traumatic event.

Type II Trauma

As indicated above, some children experience a limited number of traumatic episodes. At the same time, many children are also exposed to a continuous and chronic pattern of traumatic events (e.g. physical, sexual abuse, witnessing mother's assault, rape, or murder) aggravated by occasional bouts of extreme life-threatening behaviours. Terr (1990, 1991) has referred to this form of trauma as Type II.

According to Terr's conceptualization, children who experience a type II trauma develop similar PTSD core symptoms as a type I trauma (reexperiencing, avoidance, hyperarousal). Terr (1990, 1991) has suggested that individuals exposed to repeated traumatic events develop additional abnormal internal coping strategies which persist and become dysfunctional in situations outside the trauma domain.

Terr (1990, 1991, 1992b) has argued that there are four universal coping responses associated with Type II trauma. The first response includes denial and emotional numbing behaviours. In contrast to the brief denial and numbing which can occur in a Type I trauma, the denial and emotional numbing of Type II is more extreme. Terr (1990) states:

> children begin to develop the ability to deny reality once disasters start piling up. Because second, third, and fourth ordeals can no longer

> surprise, a battle-weary child finds himself bracing for shocks. He prepares. In an attempt to see no evil, hear no evil, speak no evil, and feel nothing, the youngster starts ignoring what is at hand. His senses go numb and he guards against thinking. (p.79)

Children do not talk about themselves and may not talk about their ordeal for years. Some children may forget whole segments of their childhood, be indifferent to their own and others' feelings, or even forget that they have developed symptoms. In effect, Terr (1990, 1991) writes that numbing behaviours are a response to long lasting and repeated trauma.

Children also develop a second coping response of self-hypnosis or dissociating when they come to expect the trauma to be repeated. Terr (1990) suggests children do not forget who they are, such as in psychogenic fugue. Rather, children develop the ability to feel detached from their minds and bodies. They acquire the ability to disengage from the traumatic event by narrowing sensory and perceptual inputs, and increasing distortive cognitive inputs. For example, a child may pretend she/he can become invisible or can escape his/her body during the traumatic event.

The third coping response in children is the presentation of a prolonged sense of rage. Again, rage is brought on by long standing traumas and is often seen

through acting out behaviours (Terr, 1991). Terr (1990) also states rage often takes three separate forms: first, the child may identify with the aggressor, often leading to cruel and abusive behaviour; second, the child retreats into passivity; and third, the child may fly into wild rages and self-destructive behaviour whenever frustration hits.

A final coping response that is often associated with Type II trauma is a deep sense of sadness. Terr (1990, 1991) implies that such unremitting sadness often accompanies grieving children who have faced death or some permanent catastrophe such as loss of limbs or facial disfigurement. However, the author also states that depression often accompanies long standing and repeated traumas.

Some support for Terr's (1990, 1991) conceptualization may be found in the work of Wolfe and associates. In a factor analysis of the History of Victimization Form (Wolfe, Gentile, & Bourdeau, 1986), Gentile (1988) found two factors: "seriousness of sexual abuse" (severity of sexual abuse acts, severity of coercion/force employed, and number of perpetrators); and "course of abuse" (frequency and duration of the sexual abuse, as well as the relationship of the child to the perpetrator). In line with Gentile's analysis, Wolfe (November, 1990) found that PTSD symptoms (intrusive thoughts and abuse-related fears of the abuse) assessed fairly soon after disclosure were primarily related to the seriousness of abuse factor, whereas course of abuse

related primarily to depressive symptoms at a nine month follow-up assessment. In a further study, V. Wolfe et al., (1991) found that anxiety and discomfort with sex was related to the seriousness of abuse. Consequently, V. Wolfe & Gentile (1992) and V. Wolfe and Birt (in press) have suggested that the abuse-related factors have different effects at different points in time. Thus, the "severity of abuse" factor is seen to reflect the more short-term Type I trauma (core PTSD symptoms) response while the "course of abuse" is seen to reflect the more long-term Type II trauma (core PTSD symptoms plus negative coping and attribution styles) response.

There has been other empirical support for Terr's typologies. Recently, Kiser et al. (1991) found evidence for Type II trauma in a sample (n=89) of children with histories of physical and/or sexual abuse. Her analysis revealed that chronically abused children were more depressed, somatic, hyperactive, and displayed a wider range of symptoms than their counterparts who had experienced only one event of physical and/or sexual abuse. In addition, Malinosky-Rummell and Hoier (cited in Wolfe & Gentile, in press) found that child and caregiver-reported dissociative symptoms were higher for sexually abused children than for a control sample. As well, dissociative strategies were most common among children who had experienced more frequent abuse.

Additional evidence of Terr's type II responses may also be found in the early work of Famularo, Kinsherff, and Fenton (1989) although it had yet to be defined as such. Using DSM III PTSD criteria, sexually abused children were diagnosed with either acute or chronic PTSD. The chronic group displayed histories of repeated trauma as well as a greater sense of detachment from others, sadness, restricted affect, pessimism about life, and dissociative periods.

The Type I and Type II responses of Terr (1990, 1991) may have particular applicability to the child witness. First, they may be able to differentiate short from long-term symptoms in some children. That is, children presenting with either typology are likely to exhibit different symptoms patterns. For example, children who witness relatively brief incidents of mother-assault may exhibit PTSD sequelae while those children exposed to chronic forms of mother assault may exhibit a host of traumatic sequelae in additional to any number of coping responses. Finally, from a conceptual perspective, the typologies provides an assessment opportunity to consider assault-specific symptoms that may be functionally related to witnessing mother-assault. Here, an opportunity exists to assess children beyond identifying global symptoms. Ultimately, a more precise database might be established.

The Role of Mediators Following The Witnessing Of Mother-Assault

Following on the ideas of Wolfe and associates, a number of mediators may influence how the child responds to Type I or Type II trauma. A discussion of some child and secondary stressor variables follows below.

Child Variables: A Developmental Perspective

The impact of child sexual abuse on development has been raised by V. Wolfe and her associates in a number of papers. This has included reviews of global and abuse-specific symptoms (V. Wolfe & Wolfe, 1988; V. Wolfe & Birt in press) as well as an overview of developmental theories (V. Wolfe & Gentile, 1992; V. Wolfe & Birt, in press) and their importance to sexual abuse. Consequently, the role of child development in mediating trauma-related symptoms has relevance to this study for three reasons. First, a child's development is likely to effect the ability to recall and express the events of mother-assault. Second, a child's understanding of and ability to put the violent nature of mother-assault into perspective will be mediated by development. Third, and last, the stage of development at which the child experiences mother-assault is likely to affect her/his personal and social growth. The importance of a developmental perspective as a child variable is addressed by way of the psychopathological model of Dante Cicchetti and associates. Finally, the role of childhood attributions, as a child variable is also considered.

Developmental psychopathology is one of the most well-supported theoretical and empirical fields studying the observable effects of child maltreatment such as childhood physical (Cicchetti & Howes, 1991; Cicchetti & Lynch, 1993; Cicchetti & Olson, 1990; Wolfe, 1987) and sexual abuse (Cole & Putnam, 1992). Further, the domain of developmental psychopathology has been based on the notion that a developmental approach can be applied to any unit of behaviour in normal as well as atypical populations (Cicchetti, 1990). Developmental psychopathologists also argue that one can learn more about normal functioning by studying how developmental pathways go awry and become pathological and, similarly, that one can enhance one's knowledge of pathology by understanding normal development (Cicchetti, 1984; Rutter, 1986).

Developmental psychopathology employs a multi-disciplinary perspective, suggesting that multiple domains of development such as the attachment process, emotional regulation, language development, and socio-emotional growth can be observed and ultimately studied (Cicchetti, 1990). According to this perspective, child development is more than a series of unfolding age and stage appropriate tasks which decrease in importance relative to newly emerging tasks. Instead, development continues to be integrated and changes with the emerging competencies of further life tasks (Cicchetti, Cummings, Greenberg, & Marvin, 1990). For example, while attachment is critical in the first year of

life, it continues to be an important part of one's integration in adult life. Thus, a developmental psychopathological view suggests that when there are pronounced disturbances at a particular stage of development, the child may become vulnerable to maladaptation with subsequent developmental tasks. The child takes incompetencies of one stage (e.g failure to attach) into later stages (e.g. poor peer relations and/or parenting, negative view of self).

In a recent review of childhood traumatic stress, Pynoos (1994) has argued for the consideration of a developmental psychopathological model when assessing PTSD. In doing so Pynoos (1994, p.89) states that "a developmental psychopathology model of PTSD underscores the complex impact on developmental progression and personality of serial or sequential traumatization". Pynoos (1994) has offered a developmental psychopathological template in which PTSD sequelae (reexperiencing, avoidance, hyperarousal) of pre-school, childhood, and adolescence can vary according to the developmental tasks of cognitive and emotional development, autonomy, self-efficacy, moral development, and peer relations. As an example, fear of emotional intensity (avoidance) may interfere with the preschool task of developing a variety of emotional responses. On the other hand, adolescents may or may not be able to develop a greater sophisticated understanding of the origin and consequences of negative emotions.

A developmental psychopathological perspective may be applicable to children who witness their mother's assault. For example, numerous reviews of the child witness literature have suggested that preschoolers who witness mother assault exhibit poor health, poor sleeping habits, and excessive screaming while older preschoolers have also shown difficulty in relating socially to their peers (see Fantuzzo and Lindquist, 1988; Jaffe et al., 1990, 1992, 1993). These reviews have also shown how school-age children exhibit elevated levels of internalizing and externalizing behaviours. A number of school-related problems have been detected as well, including erratic attendance, poor achievement, poor concentration, and school phobias. Finally, adolescents have demonstrated difficulties including hostility, aggression, running away, anxious behaviours, somatic complaints, and withdrawn and suicidal behaviours.

Child Variables: Childhood Attributions

The study of Developmental psychopathology has relied heavily on observable behaviour to account for changes in children who have been maltreated. However, there has also been concern about some of the psychological processes underlying child sexual abuse since authors have found that adult survivors often have a lingering negative view of themselves and their world (Gold, 1986; Silver, Boon, & Stones, 1983; Seidner & Calhoun, 1984). In this context, V. Wolfe and Wolfe (1988) questioned whether such abusive

experiences might affect children's developing view of the world and themselves. Here, the authors speculated on the development of childhood attributions as a response to sexual abuse. Consequently, a second view of child development comes from the notion of causal attributions.

The use of causal attributions to explain various responses of individuals to trauma has been based on the belief that actual environmental events are less important than the way individuals perceive those events and the meanings they attach to them (Veronen & Kilpatrick, 1983). Here, the authors state:

> any attempt to understand human behaviour must deal with the attributions, or explanations, people ascribe to events...it becomes important to examine not just what happens to a person per se but also why they think it happened, and what they think it means. (Vernon & Kilpatrick, 1983, p.117)

In assigning causality to events and struggling with issues such as responsibility for the violence and self-blame, the questions of attributions is raised. It seems possible, therefore, that some understanding of children's attributional processes may contribute to how coping takes place. Within the field of child sexual abuse, V. Wolfe and Wolfe (1988) turned to the reformulated learned helplessness

(Abraham, Seligman, & Teasdale, 1978) model in attempting to answer some of these questions.

The Reformulated Learned Helplessness Model (Abramson, Seligman, & Teasdale, 1978) evolved from the learned helplessness model (Maier & Seligman, 1976; Seligman, 1972) which first examined the responses of animals (e.g. rats, dogs, & cats) to uncontrollable events such as electric shocks. Essentially, the model proposed that repeated exposure to uncontrollable events resulted in passive, unresponsive, and helpless behaviours. When applied to humans, the model suggested that persons develop universal helplessness when making attributions between their acts and its outcomes. Symptoms of helplessness (depressed affect, behavioural helplessness) were seen as a consequence of the persons's expectancy that future responses would be futile in obtaining a different outcome.

At the same time, the initial conceptual development with respect to human subjects was found to be limited on two fronts (Abramson, Seligman, & Teasdale, 1978). First, the authors suggested that the model could not distinguish between attributions to events that were naturally uncontrollable and events that were uncontrollable because of skill deficits. Second, the authors stated that the model did not specify where and when a person who expects outcomes to be uncontrollable would show deficits.

In response to the original conceptual criticisms, the authors devised a three dimensional taxonomy to explain

individual and/or pervasive differences for the cause(s) of uncontrolled events. These dimensions include and are defined as:

1) internal-external factors- attributing the cause of helplessness to something internally (in me) as opposed to attributing the cause externally (out of me);

2) stable-unstable factors- stable causal factors are thought of as long lived or recurrent, whereas unstable causal factors are short-lived or intermittent;

3) global-specific factors- global causal attribution implies that helplessness will occur across situations, whereas a specific causal attribution implies helplessness only in the original situation (Abramson, Seligman, & Teasdale, 1978, pp.54-55).

The new reformulated model also attempts to address poor self-esteem that frequently accompanies helpless and negative behaviours (Wolfe & Wolfe, 1988). For example, if an event is attributed to internal as opposed to external factors, the individual is vulnerable to negative self-esteem. If the person perceives the event to be stable as

opposed to unstable, chronic helplessness may occur. Finally, if the event is perceived as global as opposed to specific, widespread deficits may occur.

The work of V. Wolfe and associates has had an impact of understanding how the role of childhood attributions may have particular applicability to traumatic responding. For example, the development of the Children's Impact Traumatic Events Scale (V. Wolfe, Wolfe, & LaRose, 1986) and its revised version (CITES-R) V. Wolfe, Wolfe, Gentile, & La Rose 1987) was partly based on the notion that attributional style might mediate the impact of child sexual abuse. In one study using the CITES-R (Wolfe et al., 1989), a negative attributional style was related to negative affect (e.g. anxiety and depression) as well as to symptoms specific to sexual abuse (e.g. guilt, feelings of betrayal). Furthermore, the same authors (V. Wolfe et al., 1989) found that the PTSD symptoms of intrusive thoughts appeared to relate to stable and global attribution factors.

Other authors have also reported on the importance of childhood attributions. D. Wolfe and McGee (1991) suggested that childhood sexual abuse is a stressful event that elicits attributional responses influencing a child's coping behaviours. In one study, D. Wolfe et al., (1994) found that a sample of sexually abused children who met some of the PTSD criteria had more self-blame and guilt symptoms than a group who did not meet some of the PTSD criteria. As well, Shapiro (1989) noted a number of benefits in using an

attributional framework with child sexual abuse survivors. Finally, Cicchetti, Toth, & Bush (1988) further contended that maltreatment experiences interfered with children's development of self-success, such as the degree of control they perceived regarding their actions.

Although the study of child attributions has yet to develop in the child witness field, authors (Jaffe et al., 1990; D. Wolfe & Jaffe, 1991) have speculated that some childhood attributions (e.g. feeling guilty about and responsible for the assaults, a negative view of oneself) in the child witness may be operative. Recurring traumatic events, such as witnessing mother-assault, may change a child's world view so that over time the world is seen as fearful and filled with misfortune (global attributions). Furthermore, as the child is unable to control the events in her/his life, she/he may begin to believe she/he deserves to be treated in this way (e.g. internal attributions). Finally, over time, the child may begin to blame herself/himself for the mother-assault, thus supporting a negative self-concept (stable attributions). It seems probable that the increase of negative attributions over a period of time could increase the probability of developing long-term adjustment problems. Problems such as depression, aggression-related behaviours, and interpersonal relationship difficulties might in turn become resistant to change.

Secondary Stressor Variables: The Role Of Family Disadvantage And Social Support

D. Wolfe & Jaffe (1991) see secondary stressors as the indirect effects of mother assault. Secondary stressors such as economic disadvantage, parental separation, changes in residence, sibling and parental distress, and so forth may act as variables in mediating child witness responses.

One secondary stressor variable of mother-assault which is of concern to the present study is the notion of family disadvantage. A number of authors (Jaffe et al., 1990; Schechter & Gary, 1988) have argued that economic and social factors is a form of victimization against women which directly disempowers women. D. Wolfe et al., (1988) found that family disadvantage such as living below the poverty line, number of children, multiple moves and child witness to multiple violence perpetrators predicted negative child behaviour problems as well as childrens' social competence.

Given the negative impact of violence against women on the self as well as on parenting capacities (Dutton, 1992; Jaffe et al., 1990, 1992, 1993), it is suggested family disadvantage may be an important pathway to understanding the process of caretaking and family functioning. The effect of being assaulted may prevent a mother from attending to her child's needs. Moreover, children who witness mother-assault live in environments which are stressful, unpredictable, and uncontrollable. In the absence of a supportive family context where these

experiences might be moderated, children may be vulnerable to developing long-term traumatic coping resources (Type II responses), however inadequate. Long-term coping responses may interfere with the development of age appropriate tasks such as regulating emotions, developing peer relationships, and doing well in school. Tragically, these events may be negatively internalized by witnessing children, ultimately moulding their attitudes, affect, and their overall sense of themselves (Cicchetti & Lynch, 1993).

A final secondary stressor variable of mother-assault which is of concern to the present study is the notion of social support. Social support is defined as "the existence or availability of people on whom we can rely, people who let us know that they care about, value, and love us" (Sarason, Levine, Basham, & Sarason, 1983, p.127). Since social isolation is a commonly used tactic on the part of the assaultive perpetrator, mothers may not have the social support from others such as friends or family. Mothers may be physically isolated from friends and family as well as deprived emotionally from loved ones.

A secondary stressor such as a lack of social support may be several steps removed from the original traumatic event. Despite this fact, it may be critical when considering the adjustment of child witnesses. For example, PTSD sequelae coupled with the fall-out of a lack of social support may give rise to a chronic, stress-filled environment for the child that makes extinction from the

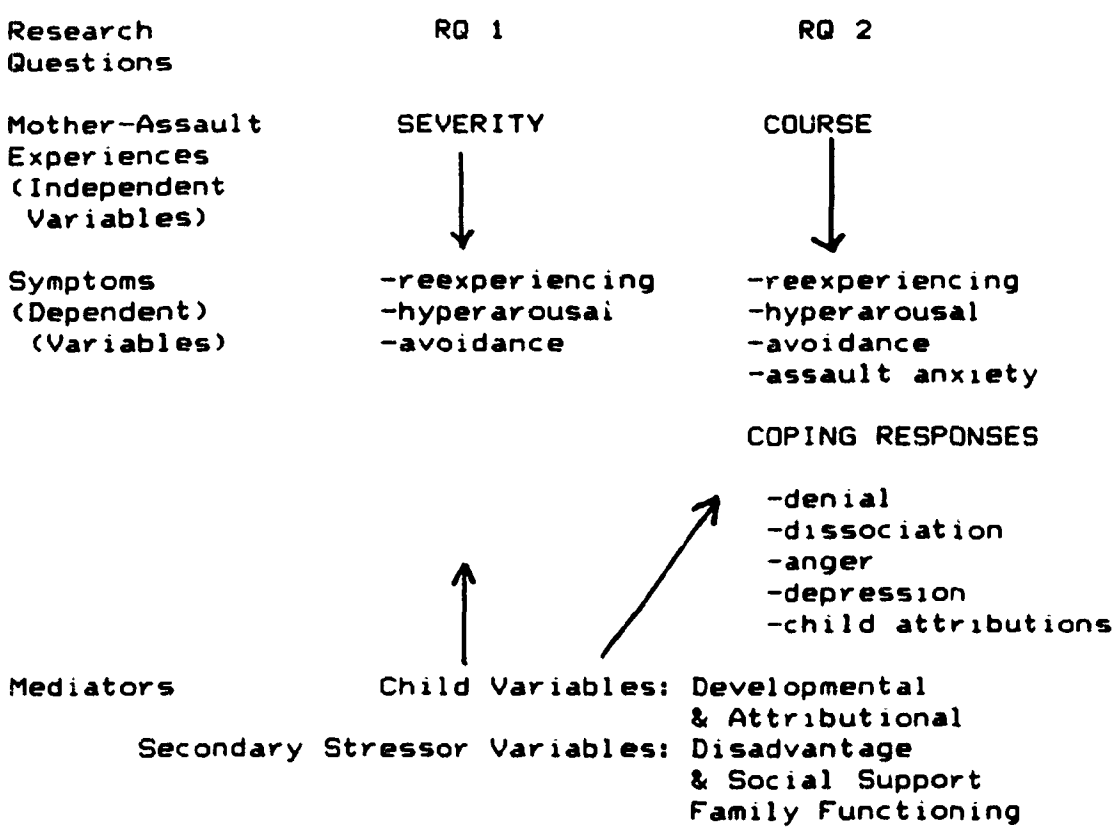
original stressor more difficult. In this case, it may also be harder for the parent to provide the child with either protection from further assaults, emotional support, or appropriate modelling of behaviour.

In this section of chapter two, an alternative PTSD conceptualization has been proposed. This proposal has included a Type I and Type II trauma typology mediated and/or influenced by a potential number of child and secondary stressor variables.

The Present Study: Variables, Research Questions, And Hypotheses

Building on the proposed conceptual framework, Figure 2 presents a visual overview of research questions one and two. In addition, this exploratory study will evaluate two assessment instruments (research questions three and four) intended to document some PTSD assault-specific patterns. The Children's Impact of Traumatic Events Scale-Family Violence Form (CITES-FVF) (V. Wolfe & Lehmann, 1992) documents PTSD responses in children who have witnessed mother assault. As well, The History Of Violence Witnessed By Child Questionnaire (HVWCQ) (Lehmann & V. Wolfe, 1992) documents the severity and course of the assault the child has witnessed.

Figure 2
An Overview Of An Expanded PTSD Conceptualization Including Research Questions 1 And 2



Variables, And Research Questions

The independent variable includes the severity and course of mother-assault witnessed by the child (as measured by the HVWCQ) (Lehmann & V. Wolfe, 1992).

The dependent variables include the following:

1)sum PTSD scores of intrusion, avoidance and hyperarousal as measured by the CITES-FVF

2)composite scores of the attributional sub-scales of the CITES-FVF including self blame/guilt, personal

vulnerability, dangerous world and empowerment as measured by the CITES-FVF

3)composite scores of the social reactions sub-scales of the CITES-FVF including negative reactions by others and social support

4)general attributional style of internal/external, stable/unstable and global/specific factors as measured by the Attributional Style Questionnaire-CASQ) (Kaslow, Tannenbaum & Seligman, 1978)

5)sum score of childhood dissociation (as measured by the Childhood Dissociative Checklist-CDC) (Putnam & Helmers 1993)

6)sum score of child's coping with anger (as measured by the Anger Control Inventory) (Nelson & Finch, 1978)

7)sum score of child's intensity of anger (as measured by the Anger Response Inventory) (Hoshmand & Austin, 1987)

8)sum score of childhood depression (as measured by the Childhood Depression Inventory, (Kovacs, 1983)

The mediating variables for the study are to include:

1)sum score of perceived parental support (as measured by the Social Support Questionnaire-SSQ (Sarason et al., 1983)

2)sum score of family functioning (as measured by the Family Adaptability and Cohesion Scale III-Faces III) (Olson et al., 1985)

3)sum score of family disadvantage (as measured by the Family Disadvantage Index) (Dumas & Wahler, 1983)

Finally, the specific research questions of this exploratory study include:

1) Do children who witness mother-assault exhibit symptoms of PTSD? It is anticipated that there will be a positive relationship between the Severity of Mother-Assault and high intensity of childrens scores on Type I responses (reexperiencing, avoidance, hyperarousal).

2) Do children who witness mother-assault on a long-term basis exhibit symptoms of PTSD as well as maladaptive coping strategies? It is expected that there will be a positive relationship between the Course of Mother-Assault and high intensity of children scores on Type II responses including core PTSD symptoms (intrusion, avoidance, hyperarousal, assault anxiety) as well as maladaptive coping variables (anger, dissociation, depression) and negative attribution styles.

3)Is the CITES-FVF (V. Wolfe & Lehmann, 1992) a valid instrument in assessing PTSD symptom patterns in children who witness mother-assault? It is expected that a factor

analysis of the CITES-FVF (V. Wolfe & Lehmann, 1992) will reveal a factor structure similar to that of the CITES-R (V. Wolfe et al., 1991) scales for sexually abused children. These scales are to include reexperiencing, avoidance, hyperarousal, negative reactions by others, social support, self/blame guilt, personal vulnerability, dangerous world, and empowerment.

4)Is the History of Violence Witnessed By Child Questionnaire (HVWCQ) (Lehmann & V. Wolfe, 1992) a valid instrument for assessing the course and seriousness of witnessing mother-assault? It is anticipated that a factor analysis of the History of Violence Witnessed By Child Questionnaire (HVWCQ) (Lehmann & V. Wolfe, 1992) will reveal a factor structure similar to that of the History of Victimization Form (V. Wolfe, Gentile, & Bourdeau, 1986) for sexually abused children. These scales are to include Seriousness of Mother-Assault and Course of Mother-Assault.

Chapter Three

Research Design And Methodology

Introduction

This chapter outlines the research design and methodological considerations for the present study. The purpose of this study was twofold; first, this study attempted to learn more about the posttraumatic stress disorder (PTSD) responses in children who had witnessed mother-assault. Second, this study attempted to determine the validity of two self-report instruments specifically designed for the current study. To accomplish these objectives, this study relied on a sample of referred children and their mothers from shelters for battered women, child protection agencies, and a second stage housing project for battered women.

Design

The research design selected for this study was exploratory (Rubin & Babbie, 1989, p. 86) as its intent was to "provide a beginning familiarity with the topic." In the case of the child witness, the empirical and conceptual knowledge level within the child witness/PTSD field is relatively new. This study therefore, followed Grinnell & Stothers (1988, p.225) prior notions to "not come up with statistically sound data ...only to build a foundation of general ideas and tentative theories which could be explored

later with more precise and more complex designs and methodologies."

The exploratory design chosen was the one group posttest only design (Grinnell & Williams, 1990). This particular design is also known as a cross-sectional design as it examines a phenomenon by taking a cross-section of it at one point in time (Rubin & Babbie, 1989).

The one group posttest only design was chosen for two reasons. First, the one group posttest only design seemed the most feasible considering the research conditions. Families who experience mother-assault and are residing in shelters for battered women can be highly transient, returning to their homes or finding new living accommodations. There was no guarantee participating families would be available for any follow-up interviews. Thus, more sophisticated experimental testing was not indicated. Second, this research project had a time deadline and was not funded by any external sources. Consequently, it was important to gain a maximum amount of information within a reasonable time frame.

Participants

A total sample size of 84 voluntary male and female children and their mothers were recruited for the present study, beginning in August, 1992 and completed in August, 1993. The study sample were also selected from non-clinic agencies for a two reasons. First, an attempt was sought to

find the broadest and most representative group of children who had witnessed mother-assault. It was thought clinic samples of children might have characterized the most severe referrals. Finally, it was reasoned that a non-clinic sample might reveal greater within-group differences.

The sample children ranged from 9 to 15 years of age. Initial screening of mothers and children by shelter staff determined that all 84 children who took part in the study were child witnesses to mother-assault. To complete the sample of 84, children who had developmental delays were excluded from the study. In addition, children who did not consent to sharing questionnaire information with mothers when requested were not included.

The initial sample population came from eight shelters for battered women and their families across southwestern Ontario and Michigan. These included:

1)Hiatus House, Windsor
2)D.A.R.E.S., Pt. Huron, Michigan
3)Womens Interval Home, Sarnia
4)Womens Rural Resource Centre, Strathroy
5)YMCA Womens Shelter, St. Thomas
6)Womens Community House, London
7)Optimist Place, Stratford
8)Womens Emergency Shelter, Woodstock

In December 1992, only 20% of the sample had been collected. A review of this figure with all the shelters revealed that fewer families with children in the desired age range were available for the study. Therefore, it was decided to expand the referral base to a second group of

non-clinic settings who serviced assaulted women and their families.

In January 1993, The Children's Aid Society (C.A.S.) of London, The Children's Aid Societies of Oxford and Elgin County, as well as the London Second Stage Housing Corporation were approached and agreed to become involved in the study. The C.A.S.s' of London, Oxford, and Elgin counties are child protective agencies servicing children and their families. The London Second Stage Housing Corporation is a long-term alternative housing development for separated and/or divorced assaulted women and their families. In total, 12 non-clinic agencies were used in the study.

Procedure

A number of steps were undertaken to recruit agencies and staff, mothers and children in this exploratory study. These steps are outlined below.

Engaging Agencies And Staff

There was some diversity between the two groups of agencies and consequently, two separate approaches to recruiting and testing children and their mothers were undertaken. These approaches involved the use of child advocates to administer the questionnaires and for the primary researcher to be the sole data gatherer.

In the early stages of planning this study with shelter directors, it was felt that child advocates should play a

part in gathering data. The shelter directors believed that the children would be more comfortable with the child advocates considering the researcher was male and a stranger. In addition, shelter directors believed that the child advocates could gain more clinical experience by participating in the study. Finally, it was felt that the process of doing the study together would strengthen the therapeutic relationship between the child advocates and the children.

The primary researcher met with the child advocates prior to the beginning of the study to explain the purpose of the research and discuss the related questionnaires. Five shelters agreed to have their child advocates view a data-gathering interview between a child and the primary researcher. The remaining three shelters agreed to begin the study on their own.

As the study proceeded, a lack of time, staff changeovers, and increased workloads prevented many child advocates from completing the questionnaires with the children. Given these demands, approximately 30% of the sample study were completed by the child advocates. The remaining 70% of the sample were completed by the primary researcher.

The second group of agencies (CAS and London Second Stage Housing) required an alternative method of recruiting participants and procedures to carry out the study. Compared to the shelters, the overall concern of the second

group of agencies were the expectations required of staff. The four agencies comprising the second group were in full support of the study, however, the prospective agencies felt their staff's time was at a premium. Additional requests on their individual caseworkers time was seen as unreasonable. Consequently, both agencies requested that their staff not administer any of the questionnaires.

In the case of the three childrens aid agencies, individual caseworkers informed families of the study and forwarded interested parties to the primary researcher. Each family was telephoned and an appointment was set up to meet and explain the research. After the consent forms to participate were signed, mothers and children were interviewed in their own homes or in a room provided by the agency.

The London Second Stage Housing Authority is a secure building. Therefore, at pre-arranged times the primary researcher gained entrance into the facility to meet the interested families. All interviews between the primary researcher and family members took place in a common room of the apartment complex.

Engaging Mothers In The Shelters

The child advocates approached mothers one to two weeks after admission to the shelters. Mothers were told a volunteer research study was underway at the shelter looking at the effects of witnessing mother-assault on children. Each mother was asked to consider participating in this

study. Interested mothers were given a letter of support for the research study from the director (Appendix A) as well as a letter introducing the primary researcher and the purposes of the study (Appendix B). Children were also told of the research study and asked if they would like to be volunteers (Appendix C). Each parent and child were given the option of calling the primary researcher with questions or concerns.

Initial meetings with the participating mothers involved answering questions about the study. A number of issues were raised for discussion including confidentiality, relevance of the study, and the impact of witnessing mother-assault on children. This was followed by mothers signing consent forms to participate. The mothers in this study were also given the option of filling in questionnaires on their own or with assistance from the child advocates or the primary researcher. A written and/or verbal summary of the childrens participation was also offered to the mothers. Finally, all families were paid $25 for their participation.

Engaging Children

A number of efforts were made to ensure that the process of taking part in the study would not be overly intrusive to the children. As already indicated, a number of children were tested by the shelter child advocate, and this experience was felt to be the least intrusive.

Whenever possible, children met the primary researcher along with a parent and child advocate. Information on the

purpose of the study was shared and children were encouraged to ask questions or ask for clarification. Prior to testing, child-consent forms were signed (Appendix D). All children were given the option of completing the study with a parent or child advocate present.

The timing of administering the questionnaires was important. To ensure privacy and minimize any feelings of intrusion, interviews occurred at the discretion of the children. This led to a number of after school, week-end, and after supper interviews between the primary researcher and the children. All shelters provided a quiet room for the subsequent interviews. Children who were part of the non-shelter sample completed the questionnaires with the primary researcher in their homes.

The questionnaires of this study were administered through an interview format. The primary researcher/child advocates read the questions, and the children responded accordingly. Since a number of instruments were used, children were always given the option of taking a break or stopping the interview process entirely in order to begin at a later date. In addition, children were encouraged to ask for clarification on questions they did not understand. After the interviews were completed, the primary researcher made every effort to support children for their participation. Children had the option of talking about what it was like to meet with the researcher and discuss their experiences.

Both groups of agencies used similar questionnaires with the samples of children and mothers. For children these included The Children's Impact of Traumatic Events Scale-Family Violence Form (CITES-FVF) (Appendix E), The History Of Violence Witnessed By Child Questionnaire (HVWCQ) (Appendix F), The Attributional Style Questionnaire For Children (Appendix G), The Childhood Depression Inventory (Appendix H), The Children's Inventory of Anger- Short Form (Appendix I), The Anger Control Inventory-Response Scales (Appendix J), and The Childhood Dissociative Checklist-Child Form (Appendix K). The mothers completed questionnaires including FACES III (Appendix L), Child Dissociative Checklist-Mother Form, (Appendix M), Family Disadvantage Checklist (Appendix N), and the Social Support Questionnaire (Appendix O). Each measure is detailed below.

Assessment Measures

The Children's Impact of Traumatic Events Scale-Family Violence Form (CITES-FVF)

The CITES-FVF (Wolfe & Lehmann, 1992) was designed for the child witness to mother-assault and is a self-report instrument administered in a structured interview format. The questionnaire asked children a series of assault-specific questions that related to the presence of any PTSD symptoms. In addition, children were asked about their perceptions and attributions as a consequence of the assaults.

The CITES-FVF (Wolfe & Lehmann, 1992) includes 80 statements that are specific to mother-assault. For example, item 1 states " I believe I will not experience family violence in my home again, whereas item 10 reads "I have dreams or nightmares about the violence". Children have the option by responding "very true", "somewhat true", or "not true" to each item.

The 80 statements of the CITES-FVF (Wolfe & Lehmann, 1992) falls under three main categories that contain 10 subscales. The categories and their subscales include PTSD (Intrusive Thoughts, Avoidance, Hyperarousal, and Assault Anxiety) Attributions About The Abuse (Self Blame/Guilt, Personal Vulnerability, Dangerous World, and Empowerment) and Social Reactions (Negative Reactions by Others and Social Support).

The CITES-FVF was adapted for the present study from the Children's Impact of Traumatic Events Scale-Revised (CITES-R) (Wolfe et al., 1992). The CITES-R was designed to measure post sexual-abuse PTSD symptoms in children and is a 78 item scale covering three similar categories and 10 subscales as the CITES-FVF. The CITES-R has one additional category and subscale entitled Eroticism. Eroticism was not conceptually relevant to the present study, and therefore, was not included.

The CITES-R (Wolfe et al., 1991) has been subjected to psychometric testing. A principal components factor analysis was carried out on the CITES-R revealing 12 factors

which accounted for 62.2% of the variance. Using the results of the factor analysis as well as some refinements in the conceptual basis underlying the scales, four main categories along with 11 subscales were developed. Alpha values for internal consistency were also found to be high. The alpha value for the entire scale was .89, while the alpha values for the four categories were .88 for PTSD, .87, for Social Reactions, .78, for Attributions, and .57 for Eroticism.

The History of Violence Witnessed By Child Questionnaire (HVWCQ)

The History of Violence Witnessed By Child Questionnaire (HVWCQ) (Lehmann & Wolfe, 1992) was also designed for the current study. The HVWCQ is a 14 item self-report questionnaire filled out by the mother. The HVWCQ asked the mother to report on the extent of the assaults she had experienced by severity and course.

In this study, the severity of mother-assault included a scaled score of the severity of violence mothers experienced (Question B) as well as a score for the types of witnessing on the part of the child (Question B). In order to determine the severity of the violent assaults, the 12 items making up the assaults were scored in a way which would correspond with their severity. For example, being yelled, swore at, or insulted received a minimum score of 1 while being threatened with a gun or knife or being shot and

or cut with a knife recieved a maximum score of 9. Table 3 provides an overview of the scoring procedure with respect to the 12 assault items.

Table 3
An Overview Of Scoring Procedures With Respect To Assault Items on The HVWCQ

Assault ItemsBy Groups Ranging in Severity	Scoring Value per Assault Groupings
-yelled, swore, or insulted you -threw, smashed, or -kicked something at you	1
-tried to hit you with something	2
-slapped you -kicked, or hit you with a fist	3
-destroyed personal property	4
-hurt a family pet	5
-physically hurt you	6
-threatened with a gun or knife	7
-sexually assaulted you	8
-used a gun or knife	9

The severity of witnessing mother-assault was also scored similarily on each of the 12 items. Children who heard the assault were given a minimum score of 1, seeing the violence received a score of 2 while attempting to directly intervene received a maximum of 3. Finally, a composite score of the

severity of mother-assault was determined by adding up the two factors.

The course of mother-assault included the frequency of assaultive experiences (Question B); that is, mothers reported on the total number of acts of violence against them by responding to 12 assaultive behaviours on the HVWCQ. The range of violent acts varied from 0 (did not occur) to 6 (this act of violence occurred more than 20 times). The course of mother-assault also included the duration of time their child had witnessed mother-assault. Here, duration of time ranged from a low of 1 (< 1 month) to a high of 7 (witnessed greater than 4 years. A composite score of the course of mother-assault was determined by adding up the two factors. Finally, it should be noted that the particular coding structure undertaken with respect to scoring severity and course was in part a subjective decision made by the researcher.

Some of the items of the HVWCQ were modified for the present study from the History of Victimization Form (HVF) (Wolfe, Gentile, & Bourdeau, 1986) which, in turn, was adapted in part from the Conflict Tactics Scale (Straus, 1979). The HVF is a checklist for estimating the frequency and duration of child sexual abuse as well as the relationship to the perpetrator and the type of force or coercion that was used.

In a factor analysis of the sexual abuse subscale of the History of Victimization Form, Gentile (1988) found that

two factors emerged allowing the author to divide the sample into two groups. The course of abuse factor included duration and frequency of abuse, as well as the relationship of the child to the perpetrator. The seriousness of abuse factor encompassed the following variables: type of sexual acts, force or coercion and the number of perpetrators. In a later study, a multivariate analysis of the abuse factors using multiple regression (Wolfe et al., 1989), revealed that the anxiety of sexually abused children could be predicted by the course and seriousness variables, with an R of .54.

Attributional Styles

The Children's Attributional Style Questionnaire (CASQ)

The CASQ Children's Attributional Style Questionnaire (Kaslow, Tannenbaum, & Seligman, 1978) was used to assess the way children attributed causality for good and bad events. The CASQ consists of 48 items that assesses the child's tendency to attribute positive events to internal, global and stable factors and negative events to external, specific, and unstable factors. Each item includes a situation ("you get good grades") and two possible attributions why the situation occurred ("I am a hard worker" vs "school work is simple"). Children are asked to choose the situation which best describes them.

A child's overall attributional style score was obtained by subtracting the composite negative score from

the composite positive score. In the present study, the lower the overall attributional style score, the more the child witness might explain negative events such as mother assault in terms of external, unstable, and specific causes.

The reliability of the CASQ was determined in study of children (n=96) (Seligman et al., 1984). It was predicted that children with depressive symptoms would endorse a negative attributional style. The authors found that test-retest reliability on attributions for good events ranged from alpha .32 to .55, while attributions for negative events ranged from .13 to .56. Higher reliabilities were obtained by combining the subscales to form a composite. The CASQ scores were fairly consistent over a six month interval (r= .71, .66, ps <.001) showing attributional style to be a somewhat stable individual difference among children. The predictive power of the CASQ has also been corroborated in other studies of depression and children (Kaslow, Rehm, Pollack, & Siegel, 1984; Kaslow, Rehm, & Siegel, 1984; Nolen-Hoiksema, Seligman, & Girgus, 1986, 1992).

The Childhood Depression Inventory (CDI)

The Childhood Depression Inventory (Kovacs, 1983; Kovacs & Beck, 1977) was used to measure current levels of self-reported depression. The inventory contains 27 "depressive" items. Each item contains three statements

(e.g. "I hate myself", "I do not like myself", "I like myself") graded in severity from 0 to 2. Children will be asked to endorse the item which best represents them for the past two weeks. The composite score was obtained by adding all the items together with a higher score representing more self-reported depression. The test-retest reliability of the CDI is reported to range from r= .43 to .83 (Kovacs, 1983). Similar reliability figures have been substantiated by Finch and Eastman (1983), and Saylor Benson, and Einhaus (1985).

The Children's Inventory of Anger (CIA)-Short Form

The Children's Inventory of Anger-Short Form (Nelson & Finch, 1978) is a self-report instrument containing 21 items. The CIA was used to assess the sample childrens' anger. Each item (e.g. "Somebody calls you a chicken") is rated on a four point scale (e.g."I don't care," "that bothers me but I'm not too mad," "I'm really mad but I think I can control myself," "I'm furious, I feel like hurting or killing that person"). Children were asked to imagine the situation was happening to them and asked to decide how angry they might get.

The CIA-short form is a reduced version of the CIA which has 71 items. The present 21 items picked for the short form version represented those items which correlated most highly with the full scale items. Psychometric

evaluation has not been completed on the short form, thus limiting the scale's reliability and validity.

The Anger Response Inventory-Response Scales

The Anger Control Inventory-Response Scales (Hoshmand & Austin, 1987) is a self-report instrument containing 68 items. The present child version was used to measure the anger responses in the sample of child witnesses. Items (e.g. "When I am angry, I stomp my feet or storm out of places") are rated on a four point scale ("Never," "Sometimes," "Often," "Almost Always"). Child witnesses were asked how they respond when angry.

The Anger Control Inventory-Response Scales was used to measure the intensity of anger responses in the child witness. The Anger Response Inventory-Response Scales (Hoshmand & Austin, 1987) has six subscales making up the 68 items. These subscales are called maladaptive behaviour, arousal intensity, arousal duration, maladaptive cognition, behaviourial skill deficit, and cognitive skill deficit. The current instrument has demonstrated moderate to high item-total correlations (range =.57 to .71) and high internal consistency (alpha range =.54 to .81) on a clinical and normal sample of 236 adults. Finally, test-retest over a 1 month interval on a randomly selected normal sample of 49 showed high correlations of .73 to .83 (Hoshmand & Austin, 1987).

The Childhood Dissociative Checklist-Mother Form (CDC)

The Childhood Dissociative Checklist (Putnam & Helmers, & Trickett, 1993) is a 20 item instrument used by parents for assessing dissociative behaviours in their children and adolescents. The sample mothers were asked to read a behaviour (e.g. "Child does not remember or denies traumatic or painful experiences that are known to have occurred") and to rate their child ("very true," "somewhat true," or "not true"). The CDC was found to have a one year test-retest reliability coefficient of rho .69 , ($p = .001$) in a sample of normal and sexually abused girls ($n = 73$). Partial construct validity of the scale was also determined. Coefficients ranged between rho = .59 to rho = .79 with a median coefficient of .73.

The Childhood Dissociative Checklist-Child Form (CDC-CF)

The Childhood Dissociative Checklist-Child Form was adapted for the present study from the Childhood Dissociative Checklist (Putnam, 1991). The CDC-CF was altered for children aged 9 to 15 to become a self-report instrument assessing for dissociative symptoms. The CDC-CF contains 22 items. The sample children read a list of sentences (e.g. I know I have had very scary, or painful experiences but I cannot remember some things about them) and rated them according to "not true," "somewhat true," or "very true."

Family Functioning/Social Support

Family Adaptability and Cohesion Scale III (FACES-III)

The FACES III (Olsen, Portner, & Lavee, 1985) is a 20 item self-report and was administered to the mothers of children who had witnessed mother-assault. The FACES III (Olsen et al., 1985) measures perception of their families adaptability and cohesion. Adaptability is defined as the family's capacity to change its rules, roles, and power structure in response to stress while cohesion is defined as emotional bonding between family members (Edman, Cole, & Howard, 1990). Each item (e.g. "Family members ask each other for help") is rated on a 5 point scale ranging from "almost never" to "almost always."

The reliability of the FACES III has also been demonstrated by Olson (1985). In a nation-wide study of 1,000 families, the author found moderate levels of internal consistency in cohesion (alpha =.77) and adaptability (alpha =.62). Test-retest correlations at 4-5 weeks were r =.83 for cohesion and r =.80 for adaptability. In a later test of 121 couples, both convergent and discriminant validity were demonstrated (Edman, Cole, & Howard, 1990).

The Family Disadvantage Index

The Family Disadvantage Index (Dumas & Wahler, 1983) was used to obtain an estimate of family disadvantage. Seven sociodemographic variables (e.g "Have you lived in three or more homes since the birth of your oldest child?")

are combined in a linear fashion with the mother answering a "yes" or "no" to each question. A disadvantage score of 1 is assigned to each of the seven variables. Current psychometric properties of the FDI are not available.

The Social Support Questionnaire

The Social Support Questionnaire (Sarason, Levine, Basham, & Sarason, 1983) was used to measure the perceived social support of mothers. The SSQ has 27 items. Questions (e.g. "Whose lives do you feel you are an important part of?") asked mothers about the number of people in their environment who provided help or support. Responses to questions will be filled in by initialling that support person and who they were (e.g. P.L. father). Mothers will be able to include a maximum of 8 support persons' per questions. Each question also has the option of answering "no one" as a support. Finally, following each question, mothers rated (e.g. a 7 point scale ranging from very satisfied-very dissatisfied) the supports to that particular question.

The SSQ (Sarason et al., 1983) has also been psychometrically evaluated. Using a sample of 602 university graduates, the inter-item correlations ranged from .35 to .71, with a mean inter-item correlation of .54. The alpha coefficient of internal reliability was .97. Separate factor analyses were performed for the N (number of supports) and S (satisfaction scores). Each of these

factors showed a strong first factor. The first factor accounted for 82% of the common variance for the N score. The comparable figure for the S score was 72%. All factor loadings exceeded .60 for the N score and .30 for the S score. Finally, test-retest correlations with 105 students at 4 week intervals yielded .90 for N and .83 for S variables respectively.

Data Analysis

The S.P.S.S. PC+ (SPSS, 1988) statistical package was used to analyze the data. Descriptive statistics, including frequencies and percentages were used to report the results obtained from the questionnaires.

In order to evaluate research questions one and two, a series of multivariate analyses of variance (MANOVA) were carried out. The purpose of MANOVA is to analyze a set of dependent variables in an analysis of variance design as a set, as opposed to each dependent variable separately (Gardner, 1992). In effect, MANOVA asks whether there is at least one way of combining the dependent variables to see whether the combination differs as a function of the treatment or independent variable.

Gardner (1992) has highlighted a number of advantages in using MANOVA over ANOVA which may be relevant to the present hypothesis. First, when using MANOVA, one is likely to be protected against Type I error. That is, if the null hypothesis is true, the test statistic would likely exceed a

specified value less than a given percentage of the time on the basis of chance. Since this study chose a significance vale of .05, there was a 5% chance of rejecting the null hypothesis when it was true. A second advantage of MANOVA is to capitalize on the power associated with considering a set of dependent variables. In this study, a number of dependent variables were considered to assess the coping responses of the child witness.

Prior to conducting the analyses, correlations between the dependent variables and the mediating variables including social support, family functioning, and family disadvantage were computed in order to determine to what extent they might also predict child adjustment. Meaningful correlations were used as covariates for the MANOVA.

To complete the MANOVA, the course of mother-assault (independent variable) was entered into the analyses followed by the dependent variables. A number of analyses were computed to determine which dependent variables might predict Type II (long-standing witnessing of mother assault) trauma.

Finally, the examination of research questions three and four related to the issue of test validity. Validity is concerned with a test measuring what is purports to measure (Allen & Yen, 1979). Furthermore, questions three and four were assessed through construct validity in which instruments measure the theoretical construct or trait that it was designed to measure (Allen & Yen, 1979). In this

case, construct validity of the CITES-FVF (Wolfe & Lehmann, 1991) and the HVWCQ (Wolfe & Lehmann, 1991) were carried out by factor analyses.

As a form of construct validity, factor analysis represents a procedure for analyzing the interrelationships among a set of variables and for explaining these interrelationships in terms of a reduced number of variables called factors (Allen & Yen, 1979). A factor is a hypothetical variable which influences scores on one or more observed variables (Allen & Yen, 1979).

To test for the validity of the above assessment instruments, a number of principal component factor analyses of the CITES-WAF and HVWCQ were completed. Using an eigenvalue of 1.00 as the criterion for retaining a factor, separate factor analyses using varimax rotations were conducted (Allen & Yen, 1979). A varimax rotation is a statistical procedure which attempts to mark the factors which have more of a significant relationship from those factors that do not (Tabachnick & Fidell, 1989). Once the factor analysis for each instrument was completed, alpha values for each of the scales were examined to determine the factor structures (Cronbach, 1959). Next, the subscales and factor structures found in the CITES-FVF (ten factors) and HVWCQ (two factors) were compared with the factor structures found in the History of Victimization Form (two factors) and the CITES-R (ten factors). In the event that either instrument (CITES-FVF & HVWCQ) exhibited separate factor

structures, further factor analyses were to be carried out. This reflected a need to examine different conceptual underpinnings of the instruments because some rotated items might not be consistent with the original scales (CITES-R & History of Victimization Form).

Ethical Issues

This exploratory research study was reviewed by the Wilfrid Laurier University Ethics Review Committee. A number of revisions were subsequently made to the format of the study. The study proposal was also screened by research committees/boards of directors of various shelters (Hiatus House, Windsor, Womens Community House, London, YMCA Womens Shelter, St. Thomas, & Womens Interval Home, Sarnia) and non shelters (London Second Stage Housing). Initial screening for the Children's Aid Societies' participation was made at the provincial level in Toronto by a manager at the Ontario Association of Children's Aid Societies. Discretion for involvement in the study was then left with individual agency directors.

Parents (Appendix D) and children (Appendix D) filled in separate consent forms. While it was acknowledged the child consent forms held no legal ground, the act of signing one's name provided a message to the children that they had some control over what was about to be undertaken. All parties were told they could stop being a participant at any

time during the interviews. Finally, codes names were used for those who requested their natural names not be used.

Limitations Of The Research

The present research is exploratory with a one group posttest only or cross-sectional design. Given its exploratory nature, there may be some limitations to the current study. The first limitation may lie in the psychometric values of the CITES-FVF and the HVWCQ. In this study, there was no psychometric pretesting of the CITES-FVF and HVWCQ. Consequently, the validity of these questionnaires may be suspect.

Another limitation of the present study may be selection bias. This refers to unequivalent groups in the sample. In this case, three different types of agencies were used. Although none were clinic agencies, the participating agencies had substantial differences among them which could not be controlled for. For example, living in one's own home (CAS sample) might have contributed to having access to more personal resources, social supports, and/or overall well-being than living in a shelter. Furthermore, the level of stress of all family members was thought to be considerably higher in shelters compared to one's own home. This too, could influence the respondent's answers.

A final limitation of the present study may relate to the notion of statistical power. Statistical power is the ability of the selected statistical test(s) to correctly

reject the null hypothesis when the null hypothesis is indeed false (Craft, 1990). In this case, Rubin and Babbie (1989) suggested earlier that a minimum sample of 10 was required for each variable when using multivariate data analysis and that a correlation coefficient of .30 or greater could suggest a medium size effect between variables. However, given that only an n = 84 was attained instead of the minimum of 100, any minor or moderate effect may still need to be questioned.

Chapter Four

Findings And Analysis

Introduction

This chapter presents the findings of the current study and is divided into five sections. First, characteristics of the children and their mothers are highlighted in section one. Sections two and three discuss exploratory questions one and two. The first two questions are primarily evaluated by a series of multivariate analyses of variance (MANOVA). Finally, sections four and five discuss the results of exploratory questions three and four. In this case, the factoral validity of two scales are evaluated.

Characteristics The Current Sample

Section one presents the demographic data of the current study. The agencies who referred the participants came from a variety of sources. Twelve agencies volunteered to be a part of this study with 66.6% (n=8) coming from shelters for battered women, 8.3 % (n=1) from a second stage housing agency, and 25% (n=3) from three local children's aid societies.

In total, 84 children and 67 mothers participated in the study. The circumstances of the mothers varied. Mothers ages ranged from 25 to 42 with a mean age of 33 (sd 4.12). Of the total group of mothers, 53.6% (n=45) stated they were single parents at the time of the study. Furthermore, 77.4% (n=65) of the mothers reported having an income of less than

$25,940. This income represents the cut-off for families living below the poverty line (Health & Welfare Canada, 1990). In addition, 59.3% (n=40) of the mothers reported that they had three or more children in their current care. At the same time, 69% (n=46) of the mothers reported receiving two or more different kinds of social services within the past year. Typical services included mother's allowance, personal, and/or family counselling. Finally, 82.1% (n=55) of the mothers had moved three or more times since the birth of their oldest child.

Of the 84 children in the current study 57.1% (n=48) were males and 42.9% (36) were females. The average age of children was 11 (sd 1.96). In addition, the sample children were divided into two groups according to their median age. In this study the median age of the children was also eleven years. Therefore, a young and old group was created. The young group ranged from ages nine through eleven, while the older group ranged in age from twelve through fifteen. Fifty four point eight percent (n=46) of the children made up the young group (9-11), while 45.2% (n=38) of the children made up the older group (12-15).

In responding to questions about children being exposed to mother-assault, mothers reported 61.2% (n=52) of the children had experienced more than one male abusive role model. Mothers also indicated that 70.3% (n=59) of their children had witnessed the last act of violence anywhere between one week and three months prior, while 29.7% (n=25)

of the children witnessed their last assault between four months and longer than one year prior.

The Relationship Between Severity of Mother-Assault And Type I Trauma Responses

Section two considers the first exploratory question. That is, the first question anticipated in this study was that there:

> would be a positive relationship between the severity of mother-assault and high intensity of childrens scores on Type I responses- (reexperiencing avoidance, hyperarousal).

This section begins with a review of the descriptive data of the severity of mother-assault and Type I responses including reexperiencing, avoidance, and hyperarousal. Next, a curvilinear relationship between the severity of mother-assault and Type I responses is reported. In addition, a two factor group X age multivariate analyses of variance (MANOVA) is carried out in order to examine the relationship between the criterion variables --the Type I responses and the predictor variable -- the severity of mother-assault, age and gender. As well, the omnibus test statistic (Pillais Trace, F ration statistic $p < .05$) will be used to measure any multivariate test of significance. A significant F indicates that the collection of dependent means differ among the treatment condition (Gardner, 1992).

The Severity Of Mother-Assault

The severity of mother-assault was determined from items found in the HVWCQ (Lehmann & Wolfe, 1992). A composite score of the severity of mother-assault was determined by adding up the seriousness of assaults as well as the seriousness of witnessing. The range of severity of mother-assault scores went from a low of 4 to a high of 72, with a mean score of 28.84 (sd 13.87).

Type I PTSD Responses of Child Witnesses

The Type I PTSD responses was determined from items found in the CITES-FVF (Wolfe & Lehmann, 1992). Here, children responsed to 25 items covering the PTSD subscales of reexperiencing, avoidance, and hyperarousal as well as assault anxiety. Reliability analyses were conducted on the PTSD subscales as well as for the entire scales. The alpha values for the PTSD subscales were Reexperiencing, .82; Avoidance, .63; and Hyperarousal, .68. The alpha value for the entire scale was .88.

The child participants endorsed endorsed PTSD items along a continuum of 1 (not true), 2 (somewhat true), and 3 (very true). The mean endorsement of items per scale was approximately 1.96 (sd .72). Thus, on average, children who witnessed their mothers assaults reported some PTSD symptoms per scale.

Table 3 highlights the number and percentages of children endorsing PTSD symptoms. The percentages represent

positive endorsement of the items by the participants. A majority of the youth said that they were bothered by intrusive thoughts of the past violence, avoided reminders of the past and often exhibited a number of hyperarousal symptoms such as feeling irritable or being easily startled. As a whole, there seemed to be a trend whereby fewer respondants exhibited reexperiencing sequelae compared to the avoidance, and hyperarousal domains. T-tests comparing the younger (9-11) and older sample (12-15) found that the reexperiencing subscale scores were not significantly different for the two age groups $t(1,82) = 1.98$, ns. However, the younger sample reported significantly more responses on the hyperactivity, $t(1,82) = 2.35$, $p < .02$, avoidance $t(1,82) = 2.10$ $p < .03$, subscales than their older counterparts. Chi-square tabulations carried out on gender and subscale scores were all non significant.

Table 4 also examined assault anxiety responses of the child witnesses. Although assault anxiety is not a part of PTSD criteria and therefore not used in research question one, these responses were included in an attempt to consider a broader range of symptoms. Overall, respondants reported being upset the most when having to thinking about the violence.

To further elaborate on the possible clinical significance of the symptom reporting, the 25 items were combined into the three DSM III-R criteria domains for PTSD (APA, 1987). Table 5 highlights the percentage of cases

showing the minimum criteria for each PTSD domain. As well, the minimum percentage of children which may have met the clinical diagnosis for PTSD is presented. Depending on the criteria chosen from the DSM III-R specifications reported in Table 1, Table 5 suggested that a minimum of 44% (n=37) and a maximum of 68% (n=57) of the child participants exhibited symptoms consistent with the criteria for PTSD. Based on the findings, the CITES-FVF suggested that on average, 56% (n=47) of the child sample met the criteria for PTSD.

Table 4
Number and Percentage of Child Witnesses Reporting PTSD Symptoms By Responding "Very True" or "Somewhat True" (N=84)

Reexperiencing By Item		%	N
10	Nightmares/dreams.	40.5%	34
16.	Can't stop thinking about it.	67.9%	57
19.	Pictures come to mind when I don't expect them to.	60.7%	51
29.	I think about the violence when I don't want to.	64.3%	54
33.	Play out the violence	20.2%	17
43.	I sometimes want to cry when I think of the violence.	76.2%	64
49.	Many things remind me of the violence.	58.3%	49

Avoidance By Item		%	N
3.	I stay away from reminders.	90.4%	76
27.	I try not to think about violence.	90.7%	77
31.	I avoid places that remind me.	63.1%	53
47.	Reduced interest in activities.	46.5%	39
50.	Reminders make me think of other.	89.3%	75
58.	I have tried to foget about violence.	95.2%	80
63.	I won't live to be very old.	30.9%	26
64.	I don't tell anyone my feelings.	57.1%	48
67.	Pretend violence was a dream.	69.0%	58
69.	Convince myself violence not bad.	51.2%	43
71.	Hard to get close to others.	46.5%	39

Table 4 (continued)
Number and Percentage of Child Witnesses Reporting PTSD Symptoms By Responding "Very True" or "Somewhat True" (N=84)

Hyperarousal By Item		%	N
5.	I often feel irritable.	82.2%	69
6.	I have trouble sleeping.	51.2%	43
11.	Trouble concentrating.	64.3%	54
15.	Easily startled.	76.2%	64
20.	Restless or jumpy.	70.2%	59
25.	Easily annoyed.	73.8%	63
40.	Reminders scare me.	59.5%	50

Assault Anxiety By Item		%	N
35.	Thinking about it upsets me.	85.8%	72
39.	I have more angry feelings.	73.8%	62
56.	Angry people make me nervous.	67.9%	57
61.	Don't want to think about it.	95.2%	80
80.	I get scared thinking about it.	70.3%	59

Table 5
Minimum Criteria Per PTSD Subscale Domains Plus Range Of Diagnoses For PTSD In Child Participants (N=84)

	# Symptoms Per Domain	%	N
Reexperiencing	1	20.2	17
Avoidance	3	44.83	37
Hyperarousal	2	55.35	57
Minimum Diagnosis For PTSD		44.23	37
Maximum Diagnosis For PTSD		68.9	57

A Curvilinear Relationship between Mother-Assault and Child Type I PTSD Responses

Prior to dividing the children into groups on the basis of a median split and comparing responses with the seriousness of mothers' assaults, correlations between mother-assault and child PTSD responses were examined. Table 5 highlights correlation coefficients between the

experience of mothers' assaults and childrens' PTSD responses. The data suggested no correlation between

Table 6
Correlation Coefficients between Severity Of Violence And Childrens Type I PTSD Responses

	r
Severity of Violence	
Reexperiencing	-.03
Hyperarousal	.10
Avoidance	-.03

mothers responses of assault and and childrens responses on any of the PTSD subscales. Consequently, a nonlinear regression analysis was carried out to investigate whether a curvilinear relationship existed between the mothers responses to severity of assault and childrens' responses on the Type I PTSD and PTSD sub-scales (Cohen, 1978). Following on Cohens's formulation, the independent variable was squared and entered into the regression equation to determine curvilinearity. The result of the non-linear regression found in Table 7 was significant revealing a curvilinear relationship between the amount of violence experienced childrens' traumatic responses.

Table 7
Non-Linear Regression Analysis: A Curvilinear Finding Of Children's PTSD Responses As A Function Of The Severity Of Mother-Assault

Independent Variables	R	R2	Adjusted R2	Regression Co-efficient B	F Of Inclusion	df
Severity	.065	.004	-.007	1.28	3.77	1,82
Severity Multiplied	.390	.152	.131	-1.28	-3.76*	1,81

*p <.001

Given the curvilinear findings, a decision was made to divide the groups into a three group design. To accomplish this, the sample was divided into groups which came as close as possible to the ideal number of 28. Therefore, group two had an additional n of 29 compared to a group three n of 27.

There were two reasons for a three group design. First, the median split dividing the high from low severity of mother assault could be seen as less representative of the population from which the sample was drawn, and second, dividing the groups into three instead of two may have reflected the frequency distribution of the mothers and childrens responses more fairly.

Table 8 reports on the cell counts of the curvilinear findings of childrens' responses based on the severity factor. Inspection of Table 8 suggested that the Type I PTSD sub-scale responses of children tended to increase as the severity of mother-assault increased. However, all the subscale responses consistently dipped in the third group despite the increased severity of assaults. That is, as mothers reported more assaults, childrens' subscale responses increased to the middle group, and then fell in the third group.

Table 8
Cell Counts Indicating A Curvilinear Relationship Among Type I PTSD Responses including Reexperiencing, Avoidance, Hyperactivity, & Assault In Response To The Severity Of Mother-Assault

	Gp1 (n=28)		Gp2 (n=29)		Gp3 (n=27)	
	$\bar{x}$	(sd)	$\bar{x}$	(sd)	$\bar{x}$	(sd)
Re-experiencing	11.62	3.01	13.39	4.09	12.83	4.16
Avoidance	21.33	3.24	23.45	4.07	22.10	3.45
Hyper-arousal	12.48	3.03	15.21	3.31	14.7	3.53

Next, in order to examine differences among the three groups with respect to the Type I PTSD sub-scale responses as a function of the seriousness of mother-assault, a two factor group X age multivariate analyses of variance (MANOVA) was carried out. Results are illustrated in Table 9. The current analysis yielded a non significant main effect for group (Pillais = .172) approximate F(8,152) = 1.79, p ns and age (Pillais = .087) approximate F(4,75) = 1.79, p ns. There was no significant group X age interaction effect. MANOVA results indicated children's PTSD responses were not significantly related to group or age. However, it appeared that group three may have minimized their symptoms in the face of having witnessed the most assaults.

Table 9
Summary Table For Two Factor Manova Results of Type I PTSD Responses Including Group And Age Means

	Severity Groups						
	Gp 1 (n=28)		Gp 2 (n=29)		Gp 3 (n=27)		F Ratio
Type I Responses	$\bar{X}$	(sd)	$\bar{X}$	(sd)	$\bar{X}$	(sd)	1.79 (ns)
Reexperiencing	11.60	2.98	13.34	4.3	13.02	4.09	
Avoidance	21.31	3.26	23.43	4.41	22.42	3	
Hyperarousal	12.44	2.45	15.20	3.98	15.02	3.4	
Age							1.79 (ns)
	9-11 (n=46)		12-15 (n=38)				
	$\bar{X}$	(sd)	$\bar{X}$	(sd)			
Reexperiencing	13.32	3.66	11.98	3.91			
Avoidance	23.19	3.02	21.59	4.09			
Hyperarousal	15.16	3.08	13.28	3.24			

*MANOVA of Type I Response clusters for Group and Age.
Note: Higher means represent more negative symptoms.

To complete question one, an additional series of group X gender multivariate analysis of variance (MANOVA) were carried out. A summary table highlighting the MANOVA results for gender are previewed in Appendix P. Results were not significant at the 5% level, indicating gender did not have a multivariate effect. Also, there was no significant group X gender interaction effect. Finally, a series of multivariate analyses of variance (MANCOVA) was carried out across Type I subscales with age, sex, and the severity variables as covariates. In effect the influences of age, sex, and the severity variables were removed to determine if there would be significant differences among the three groups of children. The results yielded a non significant main effect across all of the Type I subscales suggesting that the MANCOVA testing did not yield any significant group

differences. Adjusted main effect means and levels of covariate significance are highlighted in Appendix Q and R.

In conclusion, exploratory question one was not supported. A curvilinear relationship was found whereby two of the three groups of children reported increased Type I PTSD sequelae as the severity of mother-assault intensified. However, MANOVA results did not support significant group or age differences in response to the severity of mother-assault. Finally, gender did not have a multivariate effect.

The Relationship Between The Course Of Mother-Assault And Type II Responses

Section three considers the second exploratory question of this research study. That is, the second question raised in this study suggests that:

> there will be a positive relationship between the course of mother-assault and high intensity of children scores on Type II responses including core PTSD symptoms as well as coping variables (anger, dissociation, depression) and negative attribution styles.

This section begins with a review of the descriptive data of the course of mother-assault. Next, a curvilinear relationship between the criterion and predictor variables are reported followed by a series of two factor group X age multivariate analysis of variance (MANOVA). As well, the omnibus test statistic (Pillais Trace, F ratio statistic $p < .05$) will be used to measure any multivariate test of

significance. Further, a significant F indicates that the collection of dependent means differ among the treatment condition (Gardner, 1992). Finally, the results of the multivariate analyses of variance (F ratio values) are verified through univariate analyses comparing the groups.

The Course of Mother-Assault

The course of mother-assault was determined by items found in the HVWCQ (Lehmann & Wolfe, 1992). In this study the course of mother-assault included the frequency of assaultive experiences (question B); that is, mothers reported on the total number of acts of violence against them. The course of mother-assault also included the duration of witnessing mother-assault (question C) ; that is, mothers reported on the total number of years mothers felt her child/children had witnessed mother-assault.

Mothers reported on the frequency of their assaultive experiences by responding to 12 items on the HVWCQ scale. With a range of scores from 0 (did not occur) to 6 (this act of violence occurred more than 20 times), the sum scores ranged from a low of 0 to a high of 78. Table 10 shows the means, standard deviations, and approximate numbers of assaults for each item. The mean score on the HVWCQ was 32.89 (sd 15.33). Based on an average of 2.5 acts of violence (over 13 items), the mean score suggested that mothers in the current sample experienced an average of 82 acts of violence perpetrated against them by their

partner(s). Mothers also indicated the length or duration of time their child had witnessed mother assault. Here, duration of time ranged from a low of 1 or < one month to a high of 7 or > 4 years. The mean score for the length of witnessing was 6.41 (sd .97) or between 3 and 4 years. Further observation of this variable indicated that on average, 95.2% (n=80) of the children in the present sample had witnessed mother-assault between three and four years.

Table 10

Means, Standard Deviations, and Approximate Number of Assaults Experienced By Mothers

Type Of Assault	Mean	SD	App. # OF Assaults
1. yelled, swore & insulted	5.73	.73	between 11 & 20
2. threw, smashed or kicked at	3.96	2.14	between 3 & 5
3. pushed, grabbed or shoved	3.94	2.42	between 3 & 5
4. slapped	2.82	2.42	twice
5. destroyed personal property	2.13	2.29	between 3 & 5
6. hurt a family pet	1.50	1.97	once
7. hit with an object	1.50	2.07	once
8. kicked or hit with fist	1.32	2.^	twice
9. broken bones, or drew blood	1.82	2.32	once
10. sexually assaulted	2.27	2.25	twice
11. threatened with a gun or knife	1.14	1.56	once
12. used a gun or knife	.61	1.32	once

A composite score of the course of mother-assault was determined by adding the frequency of assaults reported with the duration of witnessing. The range of mother-

assault scores went for a low of 11 to a high of 70 with a mean of 39.31 (sd 15.68).

Finally, Table 11 provides an overview of the means, standard deviations, and range of responses of the dependent and mediating measures. In order to determine whether any of the mediating variables would be added to the MANOVA, correlation coefficients were calculated between mediating and dependent measures. The results were all non significant. Consequently, none of the mediating variables were added to the MANOVA.

Table 11
Means, Standard Deviations, And Range Of Responses of Dependent and Mediating Measures

Dependent Measures	Mean	SD	Range
PTSD CITES-FVF	49.25	9.79	29-72
Social Reactions (CITES-FVF)	29.13	3.48	22-41
Assault Anxiety (CITES-FVF)	11.27	2.35	5-15
Attributions (CITES-FVF)	67.86	9.38	46-92
Child Depression Iventory	8.23	6.35	0-33
Child Dissociative Checklist-Child Form	14.90	7.62	0-38
CASQ	4.52	4.08	-7 -14
Children's Inventory Of Anger	56	12.85	27-56
Anger Control Inventory	148.84	24.84	96-136

Mediating Measures	Mean	SD	Range
Family Disadvantage Index	4.51	1.69	0-7
FACES III Cohesion	34.33	8.31	18-48
Adaptability	24.13	6.47	12-44
SSQ-Number of Supports	69.1	49.63	0-182
SSQ-Satisfaction	119.28	40.07	0-162
Child Dissociative Checklist-Parent	8.46	5.92	0-25

A Curvilinear Relationship Between Course of Mother-Assault Type II Responses

Similar to question one, correlation coefficents between the course of mother assault and Type II responses were all non-significant. Consequently, a non-linear multiple regression was conducted to determine if a curvilinear relationship existed between the mothers' responses to the course of assault and childrens' responses on the Type II PTSD responses and coping variables (Cohen, 1978). The result of the non-linear regression found in Table 12 was significant revealing a curvilinear relationship between the course of mother-assault and the PTSD and coping variables.

Table 12
Non-Linear Regression Analysis: A Curvilinear Finding Of Children's PTSD And Type II Coping Responses As A Function Of The Course Of Mother-Assault

Independent Variable	R	R2	Adjusted R2	Regression Co-efficient B	F Of Inclusion	df
Course	.05	.003	-.009	1.46	2.68	1,82
Course Multiplied	.286	.081	.059	-1.43	-.63*	2,81

*p <.01

As in question one, a three group design was considered to reflect the curvilinear nature of the non linear multiple regression. Further, the sample was divided into groups which came as close to the ideal of 28 participants per group.

Two Factor Group X Age Multivariate Analysis of Variance (MANOVA) Results

A total of 5 multivariate models were tested to examine group differences with respect to the Type II measures. The models examined the multivariate effects across the general measures as well as specific measures including sub-scales. Again, conventional statistical significance levels ($p < .05$) were used for the MANOVA models.

The Course Of Mother-Assault And General Measures

Two two factor group X age multivariate (MANOVA) models were conducted with respect to Type II responses. The first model reflected the course of mother-assault Type II coping responses including childrens PTSD full scale scores (CITES-FVF), childhood depression (CDI), dissociation (CDC-Child Form), and anger (Anger Control Inventory & Childrens Inventory of Anger) . Table 13 summarizes the means, and F ratio statistics for the multivariate comparisons among the three groups of children. The results yielded a non significant main effect for group Type II responses (Pillais = .106) approximate $F(10,150) = .847$, p ns, and a significant main effect for age Type II responses (Pillais = .173) approximate $F(5,74) = 3.09$, $p < .05$. Younger children (9-11) reported significantly more overall Type II PTSD symptoms than their counterparts (12-15). There was no group X age interaction effect.

Table 13
Summary Table For Two Factor MANOVA Results Of Type II Responses Including Childrens PTSD, Childhood Depression, Dissociation, And Anger

	Course Groups						
	Gp 1 (n=29)		Gp.2 (n=27)		Gp.3 (n=28)		F Ratio
Group Type II Coping responses	$\bar{X}$	(sd)	$\bar{X}$	(sd)	$\bar{X}$	(sd)	.847 (ns)
CITES-FVF PTSD	46.27	8.17	51.02	10.46	49.56	9.48	
CDI	7.10	7.1	10.29	6.47	7.1	7.1	
Dissociation	13.19	6.66	16.98	8.33	14.36	7.96	
ACI (Anger)	140.17	20.72	159.16	23.65	148.27	26.3	
CIA (Anger)	52.63	12.11	59.47	11.96	56.41	14.14	
Age							3.098
	9-11 (n=46)		12-15 (n=38)				
	$\bar{X}$	(sd)	$\bar{X}$	(sd)			
CITES-FVF PTSD	51.61	8.95	46.29	9.78			.017*
CDI	8.94	5.22	7.34	5.65			.249
Dissociation	15.89	7.51	13.79	7.79			.234
ACI (Anger)	149.59	24.99	148.82	22.12			.879
CIA (Anger)	57.2	13.34	55.15	11.92			.490

*MANOVA of Type II clusters for group and age
Significance of F; * p < .05
Note: Higher means indicate higher negative endorsement of items

The second model reflected the Type II coping responses of child attributions including the CITES-FVF attributions and the CASQ. Table 14 summarizes the means and F ratio statistics for the multivariate comparisons among the three groups of children. The second model also yielded a non significant main effect for group Type II attributional responses (Pillais = .061), approximate $F(4,156) = 1.24$, p ns; and a significant main effect for age Type II attributional responses (Pillais = 1.24), approximate $F(4,75) = 3.57$, $p < .05$. Younger children (9-11) reported a

greater negative attributional style than their counterparts (12-15). There was no age X group interaction effect.

Table 14
Summary Table For Two Factor MANOVA Results Of Type II Childhood Attributional Responses

	Course Groups						
	Gp 1 (n=29)		Gp 2 (n=27)		Gp 3 (n=28)		F Ratio
Group Type II Coping Attributional Responses@	$\bar{X}$	(sd)	$\bar{X}$	(sd)	$\bar{X}$	(sd)	1.24 (ns)
CITES-FVF	65.31	7.6	69.34	9.3	68.66	9.14	
CASQ	5.34	4.41	3.53	3.68	5.12	3.77	
Age							3.57@
	9-11 (n=46)		12-15 (n=38)				
	$\bar{X}$	(sd)	$\bar{X}$	(sd)			
CITES-FVF	70.54	8.43	64.99	8.97			.014@
CASQ	4.75		4.57	4.08			.851

@MANOVA of Type II clusters for group and age
Significance of F; @ p < .05

The Course Of Mother-Assault And Specific Measures

In order to further examine differences among the three groups of children with respect to the Type II measures, three additional two factor group X age multivariate analysis of variance models (MANOVA) were carried out. The first model reflected the Type II CITES-FVF PTSD responses of reexperiencing, hyperarousal, avoidance, and assault anxiety. Table 15 reports on the means and F ratio statistics for the multivariate comparisons among the three groups of children. The results yielded a non significant main effect for group CITES-FVF PTSD responses (Pillais = .067), approximate F(8,152)) = .663, p ns; and a significant

main effect for age CITES-FVF PTSD responses (Pillais = 1.24). Younger children (9-11) reported overall more hyperarousal, avoidance, and assault anxiety symptoms than the older child (12-15) sample.

Table 15
Summary Table For Two Factor MANOVA Results Of Type II CITES-FVF PTSD Responses

	Course Groups						
	Gp. 1 (n=29)		Gp. 2 (n=27)		Gp. 3 (n=28)		F Ratio
Group Type II CITES-FVF PTSD Responses	$\bar{X}$	(sd)	$\bar{X}$	(sd)	$\bar{X}$	(sd)	.663 (ns)
Reexperiencing	11.89	3.16	13.38	3.84	12.5	4.23	
Hyperarousal	12.78	3.22	14.88	4.08	14.44	3.65	
Avoidance	21.59	3.05	22.75	3.65	22.61	2.88	
Assault Anxiety	10.41	2.32	11.34	1.95	11.72	2.35	
Age							2.66@
	9-11 (n=46)		12-15 (=38)				
	$\bar{X}$	(sd)	$\bar{X}$	(sd)			
Reexperiencing	13.29	3.82	11.89	2.98			.119
Hyperarousal	15.09	2.5	12.98	3.4			.034@
Avoidance	23.23	3.1	21.40	3.76			.007$
Assault Anxiety	11.87	2.87	10.48	3.99			.007$

* MANOVA cluster of Type II responses for group and age
Significance of F; @ p < .05; $ p < .01
Note; Higher means represent more negative symptoms

The second model reflected the Type II CITES-FVF attributional responses of dangerous world, self-blame/guilt, personal vulnerability, and empowerment. Table 16 highlights the means and F ratio statistics for the multivariate comparisons among the three groups of children. A non significant main effect for group CITES-FVF attributional responses (Pillais = .110), approximate $F(8, 152) = 1.10$, p ns was reported, as well as a significant main effect for age CITES-FVF attributional responses

(Pillais = .118), approximate F(4,75) = 2.51, p < .05. Thus, the results suggested younger children (9-11) reported more dangerous world and personal vulnerability symptoms than their older (12-15) counterparts.

Table 16
Summary Table For Two Factor MANOVA Results Of Type II CITES-FVF Attributional Responses

	Course Groups						
	Gp.1 (n=29)		Gp.2 (n=27)		Gp.3 (n=28)		F Ratio
Group Type II Coping CITES-FVF Attributions	$\bar{X}$	(sd)	$\bar{X}$	(sd)	$\bar{X}$	(sd)	1.10 (ns)
Dangerous World	17.37	2.94	17.87	3.11	18.79	2.69	
Self-Blame Guilt	11.90	3.3	12.59	2.9	11.54	3.1	
Empowerment	14.04	1.76	13.36	1.93	14.68	2.1	
Personal Vulnerability	23.92	3.31	27.54	4.5	25.29	4.11	
Age							2.51#
	9-11 (n=46)		12-15 (n=38)				
	$\bar{X}$	(sd)	$\bar{X}$	(sd)			
Dangerous World	18.88	2.79	17.14	3.04			.014#
Self-Blame Guilt	12.37	3.03	11.64	3.19			.293
Empowerment	14.19	1.68	13.87	2.18			.495
Personal Vulnerability	26.99	4.09	24.18	3.85			.004$

* MANOVA clusters of Type II responses for group and age
Significance of F; # p < .05, $ p < .01
Note; Higher means indicate more negative symptoms

The third and final model reflected the Type II anger responses of the Anger Control Inventory. Table 17 features the means and F ratio statistics for the multivariate comparisons among the three groups of children. The results indicated a non significant main effect for group Type II Anger (Pillais = .130), approximate F(12,148) = .863, p ns; as well as a non significant main effect for age Type II

Anger (Pillais = .110) approximate F(6,73) = .836, p ns. Thus, there were no significant group or age differences using the Anger Control Inventory. Finally, there was no group X age interaction.

Table 17
Summary Table For Two Factor MANOVA Results Of Type II Anger Responses

	Course Groups						F Ratio
	Gp. 1 (n=29)		Gp.2 (n=27)		Gp. 3 (n=28)		
Group Type II Coping Anger Control Inventory	$\bar{X}$	(sd)	$\bar{X}$	(sd)	$\bar{X}$	(sd)	.863 (ns)
Intensity of Arousal	24.43	6.25	28.24	7.58	26.79	8.75	
Arousal Duration	9.41	2.86	11.65	4.41	10.35	3.56	
Maladaptive Cognitions	27.08	8.62	33.77	9.07	28.72	8.28	
Maladaptive Behaviours	19.7	4.51	23.27	4.31	21.8	5.22	
Cognitive Deficits	38.67	4.82	39.66	7.2	38.91	7.44	
Behaviour Deficits	20.86	6.25	22.54	7.58	21.69	8.75	
Age							.836 (ns)
	9-11 (n=46)		12-15 (n=38)				
	$\bar{X}$	(sd)	$\bar{X}$	(sd)			
Intensity of Arousal	26.9	8.37	26.07	6.68			
Arousal Duration	10.8	3.73	10.14	3.49			
Maladaptive Cognitions	29.18	8.67	30.53	8.64			
Maladaptive Behaviours	22.04	5.87	21.13	3.48			
Cognitive Deficits	38.44	7.25	39.72	5.72			
Behaviour Deficits	21.44	4.64	21.95	4.24			

* MANOVA clusters of Type II responses for group and age
Note; Higher means represent more negative symptoms

An additional series of two factor group X gender multivariate analyses of variance (MANOVA) were carried out with the general and specific Type II measures. Results were all non significant at the 5% level, indicating gender did not have a multivariate effect. A summary table highlighting MANOVA results for gender are presented in

Appendix S. As well, there was no significant group X gender interaction effect.

In order to complete question two, a series of five multivariate analyses of covariance (MANCOVA) was carried out. The purpose of the MANCOVA was to examine group effects across all Type II measures with age, sex, and the severity variables as covariates. In effect, the influence of age, sex and the severity of mother-assault were removed in the analyses. The results yielded a non significant main effect across all of the Type II measures indicating that the MANCOVA testing did not yield any group differences among any of the Type II measures. Adjusted main effect means and levels of covariate significance are highlighted in Appendix T and U.

In summary, exploratory question two was not supported. in that there were no group differences in relation to the course of mother-assault. However, age predicted a number of differences in the Type II coping responses. As a group, younger children (9-11) reported significantly more PTSD symptoms (Table 13) than their older counterparts (12-15). This same younger group reported an overall greater negative attribution style (Table 14). As well, the younger group of children reported more hyperarousal, avoidance, and assault anxiety symptoms than the older group (Table 15). Also, the younger group reported significantly more specific attributional (Dangerous World & Personal Vulnerability) symptoms than the older group (Table 16). At the same time,

it should be noted that there was no relationship between the course of mother-assault and the Type II coping responses of anger, dissociation, and depression. Finally, gender did not predict any Type II differences.

Factoral Validity of CITES-FVF

The fourth section includes a discussion of the third question. That is, the third exploratory question raised in the current study anticipated that:

> a factor analysis of the CITES-FVF (Wolfe & Lehmann, 1992) would reveal a factor structure similar to that of the CITES-R (Wolfe & Gentile, 1991) scales for sexually abused children. These factors are to include reexperiencing, assault anxiety, negative reactions from others, social support, self blame/guilt, vulnerability/self/blame, guilt, personal vulnerability, dangerous world, and empowerment.

A series of factor analyses were completed on the CITES-FVF in order to compare its factor structure with the factor structure of the CITES-R. A principal component factor analysis using a varimax rotation of factors with values of 1.0 or higher specified for extraction was used to reduce the data for each factor of the CITES-FVF. Further, item factor loadings of .3 or higher were used to define all the variables in each obtained factors (Tabachnick & Fidell, 1989). Cronbach's (1951) coefficient alpha formula was also used to estimate the internal consistency for the obtained factors.

The first principal component factor analysis of the CITES-FVF was limited to 10 factors to investigate whether

there was a similar factor structure as the CITES-R. Results of the first analysis yielded a 10 factor structure accounting for 56.8% of the variance with a coefficient alpha reliability estimate (Cronbach, 1951) of .68. This was somewhat similar to the CITES-R which accounted for approximately 59.5% (this study did not include eroticism which had a total variance of 2.7%) of the variance with a coefficient alpha reliability estimate of approximately .89. However, the rotated solutions of the CITES-FVF differed considerably from the CITES-R as the factor structure of the CITES-FVF did not have any clear conceptual underpinnings. For example, intrusive thought and social support items had similar loadings yet were grouped under the same factor. There were also factors which yielded loadings above .3 but investigation of the items revealed they represented a mixture of the 10 factors (e.g. intrusive thoughts, assault anxiety, child attributions). Overall, the first factor analysis seemed to suggest that the conceptual and content base of the CITES-FVF may be different than the CITES-R. As well, a visual inspection of the scree plot in which the eigenvalues were graphed (Cattell, 1966) suggested that a 3 factor solution might be more appropriate. Here, the percentage of variance explained was reduced after the third factor (6.4% to 4.3%). Consequently, another factor analysis examin the relationship of the variables seemed in order.

A second principal components factor analysis was conducted using a three factor solution. A varimax rotation of factors (80 items) revealed 3 factors with a variance accounting for 33.2%. However, observations suggested that 35 items on the CITES-FVF did not exceed the .3 loading cut-off. Consequently, the 35 items were eliminated and a third principal components factor analysis was conducted with the remaining 45 items. Table 18 shows the results of the varimax rotation of factors specifiying a 3 factor solution. As well, Table 19 includes a comparison of the factor and reliability analysis of the CITES-R (Wolfe et al., 1992). Table 18 provides an overview of the third factor analysis and includes the coefficient alpha estimates for each factor along with individual item loadings. The underlying concepts of each factor are also noted.

Table 18
Varimax Factor Loadings and Reliability Estimates Comparing The CITES-R (Wolfe et al., 1992) And The CITES-FVF (Wolfe & Lehmann, 1992)

Scale	Items	Factors	Subscales	% Variance	α For Combined Scales
CITES-R	78	11	11	62.2	.89
CITES-FVF	45	3	10	36.4	.901

α = Cronbach's Alpha

Table 19
Varimax Factor Loadings, Variance, and Coefficient Alpha Estimates For the CITES-FVF (Wolfe & Lehmann, 1992)

Factor	Underlying Concept	Items By Number	Loadings	% Variance	∝
1	The presence of	6	.620	23.4	.891
	of posttraumatic	10	.596		
	stress disorder	16	.609		
	symptoms (PTSD)	19	.573		
	coupled with	29	.576		
	Assault Anxiety	43	.675		
		49	.619		
		3	.619		
		27	.402		
		31	.560		
		58	.392		
		67	.411		
		5	.575		
		11	.671		
		40	.654		
		35	.580		
		39	.328		
		56	.500		
		61	.354		
		80	.700		

Factor	Underlying Concept	Items By Numbers	Loadings	% Variance	∝
2	Social factors	2	.535	6.7	.446
	mediating the	37	.555		
	responses of the	44	.712		
	child [illegible]ness	28	-.379		
		55	-.609		
		62	-.523		
		68	-.464		
		70	-.345		

Table 19 (Continued)

Varimax Factor Loading, Variance, And Coefficient Alpha Estimates For The CITES-FVF (Wolfe & Lehmann, 1992)

3	The child attaches individual meanings (attributions) to witnessing mother assault	32	.407	6.4	.825
		34	.412		
		36	.391		
		54	.309		
		57	.482		
		65	.384		
		66	.429		
		72	.433		
		73	.381		
		75	.435		
		59	.556		
		74	.306		
		78	.371		
		7	.554		
		42	.674		
		46	.640		
		26	.517		

Minimum Loadings = 0.3
α = Cronbach's Alpha
α For Combined Scales = .901

Further inspection of Table 20 suggested that each factor may be broken into subscales that best describe the underlying concept. These subscales are derived from the factor/subscales articulated by Wolfe et al., (1991) in their discussion of the CITES-R. However, it should be noted that there was a difference between factors and subscales (Table 18) when the CITES-R and the CITES-FVF were compared. To clarify this difference, the CITES-R subscales were the factors representing a refinement of the factor analysis which isolated the 10 factors (not including eroticism). In contrast, the subcales of the CITES-FVF were not factors. Instead, the subscales represented the makeup of the final 3 factors and their respective variances. For

example, factor 1 of the CITES-FVF isolated four subscales identified as reexperiencing, avoidance, hyperarousal, & assault anxiety. Given the favorable loadings of factor 1, the variables (items listed) measured something in common with the factor. Consequently, factor 1 was called Posttraumatic stress disorder (PTSD). Factor 2 is entitled Social Reactions. Its subscales of Negative Reactions From Others and Social Support were also subscales (factors) found in the CITES-R. Finally, factor 3 in the CITES-FVF is called Attributions. The subscales identifying the attribution factor were similar to the subscales (factors) found in the CITES-R. Table 20 provides an illustration of the subscales by factors. Overall, the combined coefficient alpha of the CITES-FVF was within the desireable range for scale reliability articulated by Nunnally (1978).

Table 20
Factors and Respective Subscales For The CITES-FVF (Wolfe & Lehmann, 1992)

Factor	Per Factor	Subscales and Individual Items	Per Subscale
1. PTSD	.891	Reexperiencing (10 16, 19,29,43,49)	.84
		Avoidance (3,27,31,58,67)	.64
		Hyperarousal (5,6,11,40)	.71
		Assault Anxiety (35,39,56, 61,80)	.65
2. Social Reactions	.446	Negative Reactions (2,37,44) From Others	.85
		Social Support (28,55,62,68,70)	.52
3. Attributions	.825	Self Blame/Guilt (32,34,36)	.59
		Personal Vulnerability (54,57,65, 66,72,73,75)	.74
		Dangerous World (59,74,78)	.51
		Empowerment (7,42,46)	.66

An inspection of the data contained in Tables 19 and 20 suggested that the three extracted factors and their subscales seemed to describe the validated structure of the CITES-FVF (Wolfe & Lehmann, 1994). A summary discussion is outlined below.

Factor 1
The underlying dimension for this factor is the presence of posttraumatic stress disorder (PTSD) symptoms including reexperiencing, avoidance, and hyperarousal. A fourth subscale articulates individual assault anxiety.

The first factor entitled PTSD accounts for the largest percentage of the total variance, 23.4%. This factor included the largest number of items (20) and had the largest coefficient alpha value (.89). There were also four subscales which represented the first factor.

Reexperiencing

The reexperiencing subscale included six items (item loadings provided in paranthesis): I have dreams or nightmares about the violence (.596); I think about the violence even when I don't want to (.609); Pictures of the violence often pop into my mind when I don't expect them to (.573); I think about the violence and what happened to my family even when I don't want to (.576); I sometimes want to cry when I think of the violence (.675); and last, Many things remind me of the violence (.619).

Avoidance

The second subscale of avoidance had five items: I try to stay away from things that remind me of the violence (.619); I try not to think about the violence (.402); I avoid places or things on purpose that remind me of the violence (.560); I have tried to forget about the violence (.392); I sometimes pretend the violence never happened or that it was a bad dream (.411).

Hyperarousal

The hyperarousal subscale had four items: I have trouble falling asleep (.620); I often feel irritable for no reason (.535); I have difficulty concentrating because I often think about the violence and what happened to my family (.671); and last, When someone reminds me of the violence, I get scared (.654).

Assault Anxiety

Assault anxiety was the final subscale making up the PTSD factor had five items: Thinking about the violence upsets me (.580); I have more angry feelings than my friends (.328); I get nervous when I see people get angry (.500); I hope I never have to think about violence again (.354); and finally, I get scared when I think about the violence (.700).

The fifteen items that describe PTSD above sequelae have also been articulated by Wolfe and Gentile (1991) in their validation study of the CITES-R as well as an earlier report using the CITES-R with sexually abused children

(Wolfe, Gentile, & Wolfe, 1980). Further observation suggested that the 15 items were similar to the diagnostic criteria domains (intrusive thoughts, avoidance, & hyperarousal) for PTSD as outlined by the APA, (1987). The final five items related to the anxiety a child might experience as a consequence of witnessing mother-assault.

Factor 2

The second dimension is entitled Social Reactions. The underlying trait of this factor suggests there are social factors which may mediate the responses of the child witness.

The second factor entitled Social Reactions accounted for 6.7% of the total variance. This factor had the lowest number of items (8) with the lowest coefficient alpha (.44). Two subscales represented the second factor.

Negative Reactions From Others

The negative reactions from others subscale had three items: Some people believe I did something to cause the violence (.535); Some people blame me for the violence (.555), and Some people think I was to blame for the violence (.712).

Social Support

There were five items in this final subscale: Most people listen carefully to me when I talk about the violence (-.379); I have someone who I can talk to about the violence (-.609); I feel good how mom helped me cope with the violence (-.523); I feel my mom will protect me from ever seeing violence again (-.464), and social workers,

counsellors, and/or the police have helped me and my family (-.345).

Inspection of the data in factor 2 suggested children may have perceived others as blaming them for their mother being assaulted. In addition, the data seemed to suggest an inverse relationship existed between negative reactions from others and social support; that is, the more children felt troubled by the negative responses from others, the more likely they may have felt they had fewer social supports.

Factor 3
The final dimension is entitled attributions. The underlying trait for this factor are the individual meanings the child attaches to witnessing mother assualt.

The final factor entitled attributions had 17 items and the lowest total variance (6.4%). The coefficient alpha of this factor was .87. Four subscales made up the conceptual underpinnings.

Self Blame/Guilt

The self blame/guilt subscale had four items: I am embarassed when I see people who know about the violence (.407); Children who behave better than me have not experienced family violence (.412); Violence in my family happened because I am unlucky (.391), and Violence in my family happened because I was not smart enough to stop it from happening (.517).

Personal Vulnerability

Seven items made up the personal vulnerability subscale: I often worry that someone will beat me up in the future (.309); I feel different from other kids my age because I have witnessed family violence (.482); I feel I have to know people a long time before I can trust them (.384); Sometimes my anger scares me (.429); Bad things happen to me all the time (.433); I worry that my dad will do something awful to my mom (.381), and I worry that my dad will take me away from my mom (.435).

Dangerous World

The dangerous world subscale had three items: Most kids my age should not trust men because they can be violent (.556); I have to be careful with people I don't know because anyone could become physically violent (.306), and If my mom finds a boyfriend or gets married, I fear that person will hurt her too (.371).

Empowerment

The final subscale of empowerment also had three items: If family violence happens in my home again, I can protect myself (.554); If violence happens in my home again, I can stop it (.674), and If violence happens in my home again, I know what to do to stop it (.640).

The attribution factor items represent a relatively new construct in describing the experiences of child witnesses of mother-assault. The current factor attempted to understand how children in this sample interpreted and

attached meaning to past violent experiences by asking attribution-specific questions. An inspection of the items suggested that children seemed to feel some internal sense of responsibility for the violence. They also appeared to come away from their experiences feeling unprotected and lacking in confidence of being safe in the future. Finally, the sample children appeared to take some of the blame for the assaults. Again, the issue of personal responsibility may have accounted for the responses.

The quality of the 3 factor scale was examined through the use of the Kaiser-Meyer-Olkin (KMO) measure of sample adequacy (Kaiser, 1974). The KMO is an index for comparing the magnitude of the observed correlation coefficients to the magnitudes of the partial correlation coefficients of the variables (Norusis, 1988). In effect, the strength of the relationship among the variables were examined. This procedure produced a value of .6667. Kaiser (1974) described results in the .6 to .7 range as mediocre to middling, suggesting minimal strength among the variables. At the same time, the results seemed to indicate that there were sufficient pairs of positive correlations between variables in the CITES-FVF to warrant a factor analysis and that the results could be meaningful. Also, the application of Bartlett's test of sphericity produced a value of 188.961 ($p < .0000$). The low level of significance seemed to suggest that the three factor model was appropriate and that the

data from children in the current sample may have been representative of a multivariate normal population.

Finally, the multi-trait validity of the three factor scale was also considered (Campbell & Fiske, 1959). Multi-trait validity attempts to determine the internal validity of a scale by looking at the commonality of the theoretical constructs. A view of Table 21 below confirmed that the 3 factor scale found in the CITES-FVF had reasonable to high correlations between the variables (factors). Based on Guilford's (1950) recommendations, the intercorrelations obtained for the combined CITES-FVF scale and for the 3 factors (range .254 to .926) represented a statistically significant and acceptable correlation between the variables.

Table 21
Means, Standard Deviations, Coefficient Alphas And Intercorrelations of Factors In The Final Varimax Factor Rotation Procedure For The CITES-FVF (Wolfe & Lehmann, 1992)

Variable	M	S.D.	1	2	3	4
1. Combined Scales (A)	91.1190	15.1827	(.901)	.926**	.474**	.857**
2. PTSD	42.1071	8.9793		(.891)	.368**	.631**
3. Social Reactions	17.0238	2.1620			(.446)	.254*
4. Attributions	31.9881	6.8045				(.825)

*p < .01
**p < .001
Primary diagonal shows coefficient alpha (α).
(A) = measured as the sum of the three factor scores.

In summary, exploratory question three was not supported. The results of the varimax factor loadings outlined in Table 15 suggested that the CITES-FVF (Wolfe & Lehmann, 1992) and the CITES-R (Wolfe et al., 1991) had dissimialar factor structures. Results of the third

principal components factor analysis of the CITES-FVF suggested three factors with a total variance of thirty-six point four percent. This is contrasted with the principal components factor analysis of the CITES-R which yielded eleven factors with a total variance of sixty-two point two percent. The construct validity of the CITES-FVF therefore, was not supported.

It should also be noted however, that some of the conceptual underpinnings of both scales seemed to have similarities. The CITES-FVF had three factors which were identical to the three dimensions (reexperiencing, avoidance, & hyperarousal) articulated in the CITES-R. In addition, alpha values in the CITES-FVF and the CITES-R were very similar. For example, alpha values for combined PTSD scales were .90 and .89 for the CITES-FVF and CITES-R respectively; for PTSD, .88 and .89; and for Attributions, .82 and .78 respectively. Given the obtained results, it is suggested that the three factor scale shows some future potential of developing into a reliable and valid measure of the traumatic impact of mother-assault on a child. Specifically, it would appear that the PTSD and Attribution domains may have some construct validity (Allen & Yen, 1979); that is, the two factors seemed to measure the theoretical constructs they were designed to measure. At the same, the Social Reaction construct results suggested that the current items may not have been the best meaure of this trait. More work on this factor seems indicated.

Factoral Validity Of The HVWCQ

The fifth and final section deals with the last exploratory question of the current study. That is, question four expected:

> a factor analysis of the History of Violence Witnessed By Child Questionnaire (HVWCQ) (Lehmann & Wolfe, 1992) would reveal a factor structure similar to that of the History of Victimization Form (HVF) (Wolfe, Gentile, & Bourdeau, 1987) for sexually abused children. These scales are to include Severity of Mother-Assault and Course of Mother-Assault.

In order to carry out a principal component factor analysis, similar procedures were used as those outlined in question three. The analysis was limited to 2 factors to investigate whether there was a similar factor structure as found with the History of Victimization Form. Results of this analysis yielded a two factor structure accounting for 80.7% of the variance with a coefficient alpha reliability estimate of .77. Table 22 compares the results of the factor analysis of the History of Victimization Form with the HVWCQ.

Table 22
Varimax Factor Loadings and Reliability Estimates Comparing The History Of Victimization Form (HVF) (Wolfe, Bourdeau, & Gentile, 1986) And The HVWCQ (Lehmann & Wolfe, 1992).

Scale	Variables	Factors	% Variance	~For Combined Scale
HVF	6	2	65	----
HVWCQ	4	2	80.7	.764

Table 23 also provides an overview of the two factors along with their respective loadings, variances, and alpha estimates.

Table 23
Varimax Factor Loadings, Variance, and Coefficient Alpha Estimates For The HVWCQ (Lehmann & Wolfe, 1992)

Factor	Underlying Concept	Variables	Loadings	% Variance	α
1	The severity of mother-assault	degree of severity	.691	59.8	.814
		frequency of reported assaults	.900		
		type of witnessing	.892		
2	The course of mother assault	duration of witnessing mother assault	.965	20.9	----

A summary discussion is outlined below.

Factor 1
The underlying dimension for this factor is the severity of mother-assault which includes the degree of severity of mother-assault, the frequency of reported assaults, and the type of child-witnessing.

The first factor entitled severity of mother-assault accounted for the largest percentage of the total variance, 59.8%. This factor included three of the four variables and had a coefficient alpha of .814. Four variables are included in this factor (item loadings provided in paranthesis): the degree of severity of mother-assault (.691); the frequency of reported assaults (.900); and the type of child witnessing (.892).

Factor 2
The second dimension is entitled course of mother-assault. The underlying trait of this factor is the duration of witnessing of mother-assault.

The final factor entitled course of mother-assault accounted for 20.9% of the total variance. This factor had one

variable and therefore, alpha estimates were not calculated. The variable loading was estimated to be .965.

The quality of the two factor scale was examined through the use of the Kaiser-Meyer-Olkin (KMO) measure of sample adequacy (Kaiser, 1974). This procedure produced a value of .6861. The results seemed to indicate sufficient pairs of positive correlations between the variables in the HVWCQ. Also, the application of Bartlett's test of sphericity produced a value of 109.938 ($p < .0000$). The low level of significance seemed to suggest that the two factor model was appropriate and that the data from the mothers may have been representative of a multivariate normal population.

Finally, the multi-trait validity of the two factor scale was also considered (Campbell & Fiske, 1959). A view of Table 24 confirmed the two factor scale found in the HVWCQ had reasonable to high correlations between the variables (factors).

Table 24
Means, Standard Deviations, Coefficient Alphas And Intercorrelations Of Factors In The Final Varimax Factor Rotation Procedure For The HVWCQ (Lehmann & Wolfe, 1992)

Variables	Mean	S.D.	1	2	3	4
Factor One			(.814)			
1. Degree Of Severity	7.71	2.07		.604**	.452**	.346**
2. Frequency Of Assaults	32.89	15.33			.726**	.327*
3. Type Of Witnessing	21.13	12.81				.229
Factor Two			(.965)			
4. Duration of Witnessing	6.41	.97				

*p < .01
**p < .001
Paranthesis shows coefficient alpha

In summary, exploratory question four was partially supported. The varimax factor loading outlined in Table 21 suggested that the HVWCQ (Lehmann & Wolfe, 1992) and the HVF (Wolfe, Bourdeau, & Gentile, 1986) had similar factor structures. However, it should also be noted that the items making up the factors in both scales differed. The HVF (Wolfe et al., 1986) determined that the frequency, duration, and relationship of the child to the perpetrator made up the course factor, while the severity factor was made up of severity, number of perpetrators, and severity of the force/coercion. The varimax rotation of factors found in Table 23 revealed that the severity factor made up three of the four variables, while the course factor consisted of one variable. Thus, is would seem the construct validity of both scales were somewhat different.

Conclusion

The findings of this chapter have produced a number of results in relation to the exploratory questions. The initial characteristics of the sample suggested mothers reported an average of eighty-two acts of mother-assault at the hands of their partners. This was compounded by various stressors including living below the poverty line, having three or more children in their care, and multiple family moves. Children on the other hand, responded positively to approximately 63% of all the PTSD sequelae including the assault anxiety subscale on the CITES-FVF (Wolfe & Lehmann, 1992).

Exploratory question one was not supported. Despite the curvilinear findings, there were no statistical significant differences between Type I PTSD responses and groups, age, or gender.

Exploratory question two was not supported. There was were no statistical significant differences between Type II PTSD responses and group or gender. However, the variable of age of the children was important; that is, younger children (9-11) reported significantly more Type II responses including composite PTSD and negative attributional styles, sub-scale PTSD responses including hyperarousal, avoidance, and assault anxiety and finally sub-scale attributional sumptoms including dangerous world and personal vulnerabiltiy than older children (12-15). At the same time, the role of gender was not significant.

Exploratory question three was not supported. The results of the principal components factor analyses suggested that the CITES-FVF (Wolfe & Lehmann, 1992) and the CITES-R (Wolfe, V. et al., 1991) had different factor structures. In other words, the construct validity (Allen & Yen, 1979) of question three was not supported. More work seems indicated on this measure as some of the items did not appear to accurately measure the underlying theoretical constructs.

Finally, exploratory question four was partially supported by the data. The results of the principal components factor analysis suggested that the HVWCQ (Lehmann & Wolfe, 1992) and the HVF (Wolfe et al., 1986) had similar factor structures.

Chapter Five

Discussion And Conclusion

Introduction

This exploratory study was designed to learn more about the posttraumatic stress disorder (PTSD) responses in a sample of children who had witnessed mother-assault. The construct validity of two self-report instruments related to PTSD assault-specific sequelae and the extent of mother-assault were also examined through a series of factor analyses. This chapter presents a discussion of the results of this study in an order representing the most prominent findings. The primary finding of PTSD symptoms in the child witnesses that are associated with the course of mother-assault (Type II trauma) are presented first. A summary of the findings specific to the remaining research questions follows. The chapter concludes with a discussion of the limitations of this study, the implications for practice, and suggestions for future research.

PTSD And The Child Witness To Mother-Assault

The primary findings of this study related to the clinical significance of a PTSD diagnosis in the child sample in addition to the self-reports of PTSD subscale symptoms in the child witness sample. The data presented in Table five, suggested that approximately 56% (n=47) of the child witness sample met the criteria for PTSD. The percentage above is lower than the results found by Eth and

associates in samples of children who had witnessed their mother's rape, murder, or suicide (see Table 2). Despite this, the figures of the present study suggested that witnessing of mother-assault was distressing enough for a number of children to meet the diagnostic criteria for PTSD.

Preliminary data also indicated that approximately 63% (n=53) of the child sample positively endorsed all the trauma items within the criteria domains. A discussion of these findings follows.

Reexperiencing Symptoms

The reexperiencing domain received the lowest endorsement from the child sample. Approximately 55% (n=44) responded positively to items including recurring nightmares, intrusive thoughts and reminders of the event, as well as play-acting out the assaults. Although reexperiencing symptoms were shown to increase in response to the course of mother-assault, the MANOVA results in Table 11 indicated that the symptoms failed to reach the .05 level of significance. The results of these findings suggested that there was no association between the reexperiencing symptoms of the three group child sample and the course of mother-assault.

Despite the failure of the reexperiencing domain to reach a level of significance, some studies from Table 2 have reported similar percentage findings as those above. Boldizar and Fitzpatrick (1982) found that 68% of a sample of children who had been exposed to community violence

reported reexperiencing symptoms of intrusive thoughts, nightmares, and frequent reliving of the event. Similarly, Pynoos and Nader (1988) found that 66% of their sample of children who had witnessed their mother's rape reported reexperiencing symptoms anywhere between at least once every other day and at least once per week. Other clinical-descriptive studies also reported the presence of reexperiencing symptoms in the child witness (Pynoos & Eth, 1985; Black et al., 1992, 1993; Dyson, 1991).

Hyperarousal

In this study, approximately 68.2% (n=57) of the children positively endorsed all the hyperarousal items while significant differences were found for age. Hyperarousal symptoms included feeling irritable, difficulty with sleep and concentration, restlessness, being annoyed, and fear of reminders.

Two empirical studies in Table 2 also reported similar statistics for the hyperarousal domain as those reported above. Fitzpatrick and Boldizar (1993) found that approximately 47% of a sample of children who had witnessed community violence and mother-assault exhibited a high rate of hyperarousal symptoms. Similarly, Pynoos and Nader (1988) reported that approximately 70% of their sample of traumatized children reported hyperarousal symptoms. In addition, a number of clinical-descriptive studies in Table 2 reported ongoing hyperarousal symptoms in children (Black

et al., 1993; Burman & Allen-Meares, 1994; Dyson, 1991; Malmquist, 1986; Osofsky et al., 1993; Pynoos & Eth, 1984).

The prominence of hyperarousal symptoms in this study is not surprising given that witnessing mother-assault is a highly charged traumatic event leaving children emotionally vulnerable. The unpredictability and continued expectation of mother-assault by a trusted adult figure may have left the sample children in a continued state of arousal. In addition, hyperactivity symptoms may have been high considering that approximately 70% (n=59) of the sample children had witnessed their last assault between one week and three months prior to the study. Children may have continued to be physically and psychologically "on alert" for danger even in the shelter. Finally, being interviewed by a strange male could also have acted as an arousal stimulus. Given the power difference between the children and the adult male interviewer, talking about mother-assault may have made some children feel they were being re-victimized.

Another possible interpretation for the increased reports of irritation, restlessness, and aggression in the hyperarousal domain comes from Kiser et al. (1991) in their work with physically and sexually abused children. The authors noted that the hyperarousal symptoms in their clinical sample may have been representative of the reexperiencing domain; that is, intrusive reminders may have been driven by the intense anxiety associated with abusive

experiences. In the current study, the combination of tension associated with being in an assaultive family, the continuing threat of violence, as well as the presence of any reexperiencing symptoms could have resulted in the coping response of hyperarousal. It may also be speculated that the intense anxiety associated with witnessing mother-assault may have overshadowed the children's responses to the reexperiencing symptoms.

Avoidance

Approximately 66% (n=55) of the children in the current sample also reported elevated avoidance symptoms, including avoiding thoughts associated with mother-assault, a loss of interest in activities, a feeling of estrangement from others, and a sense of a foreshortened future. Significant age differences were also found among the child sample.

A number of reasons may have accounted for the presence of avoidance symptoms. The presence of avoidance symptoms may have been a direct attempt on the part of the children to suppress thoughts or any kind of visual, kinaesthetic, or olfactory associations connected with mother-assault. Similar views were implied in other studies (Table 2) of children who had witnessed community violence and mother-assault (Martinez & Richters, 1993; Osofsky et al., 1993) as well as the rape of their mothers (Pynoos & Nader, 1988).

The presence of avoidance symptoms has also been associated with protecting one's self against intense feelings of helplessness (Pynoos, 1990; van der Kolk, 1987,

Terr, 1990). Similarly, in this study, the intensity of avoidance displayed by the sample children may have been indicative of underlying feelings of helplessness. Since the act of mother-assault was an event the children had no control over, some child observers may have felt responsible for the assault. It is also possible that the cumulative effect of years of witnessing mother-assault may have put these children into a state of believing nothing made a difference, and that significant relationships would not protect them from harm. In this context, it is important to remember that at the time of the interviews approximately 95% (n=80) of the sample had reportedly witnessed mother-assault between two and four years.

Assault Anxiety

In the face of heightened arousal, children also reported assault anxiety symptoms such as being upset, nervous, or being scared as measured by the Assault Anxiety sub-scale of the CITES-FVF. Approximately 78% (n=65) of the child sample endorsed the above items. There were also significant age differences. Anxiety of this type was considered a common response in most of the children's postdisaster responses as seen in the review of Table 2. It may be that frightening thoughts of the traumatic event elicited feelings of anxiety in the child sample. Given that reexperiencing events can be uncontrollable (Pynoos, 1990), the combination of intrusive thoughts/memories and

living in an assaultive environment could have predisposed children towards anxious feelings.

The presence of anxiety in child victims of trauma has also been reported elsewhere. Lonigan et al., (1991) found significantly higher anxiety scores and more PTSD symptoms in children who reported more severe exposure to a hurricane. Likewise, Yule and Udwin (1991) found that the most severe reactions following a disaster (the sinking of a ship) were high levels of PTSD, depression, and anxiety. Finally, in a study of sexually abused children, Wolfe, D., et al., (1994) found that children who met the PTSD diagnostic criteria, reported significantly more anxiety than children who did not meet the PTSD criteria. Although anxiety is not considered a characteristic of the current PTSD criteria, it has been shown to be evident in any number of life events experienced by children.

In summary, there was some preliminary endorsement in this study for the prediction of a positive association between PTSD symptoms and the child witness to mother-assault. In addition, the findings seemed to point in the direction of supporting the speculations of authors (e.g. Jaffe et al., 1990, 1992, 1993; Wolfe & Jaffe, 1991; Rossman & Rosenberg, 1990) as well as the literature review outlined in Table 2 that children who witness mother-assault will exhibit some PTSD symptoms. Based on the required PTSD criteria and the endorsement of the trauma items, there was also a case for a "probable diagnosis of PTSD" in some of

the children. At the same time, the findings cannot be generalized since no previous study on shelter-related children has documented PTSD symptoms.

The Role of Age And Gender

The second prominent finding concerned the relationship between age and gender of the children and traumatic responses. There seemed to be a tentative relationship between age and the course of mother-assault whereby younger children reported overall more PTSD symptoms than the older child sample. There also appeared to be a significant relationship between age and the PTSD sub-scales of hyperarousal, avoidance, assault anxiety, and negative child attributions. Thus it would appear that as the course of mother-assault increased so did the younger children's PTSD and attributional responses relative to the older sample. The younger sample, therefore, may have been most vulnerable to witnessing mother-assault and developing PTSD symptoms as well as negative child attributions. The results found in this study are similar to the age trend reported in Table 2. Three studies (Black et al., 1993; Martinez & Richters, 1993; Pynoos & Nader, 1988) reported younger children displaying more traumatic distress. Similar support for the above findings have been found in younger sexually abused children (Wolfe, V. et al., 1991; Wolfe & Birt, in press; Wolfe, D. et al., 1994) as well as children who have survived disasters (Vogel & Vernberg, 1993).

Given the findings with respect to age, there could be a number of possible reasons why age mattered in the current sample. Age represents a developmental marker differentiating how children respond to stress (Green et al., 1991; Pynoos & Eth, 1985; Pynoos, 1990; Van der Kolk, 1987). Consequently, it could be possible that the younger children may have had greater difficulty interpreting and understanding the assaults and the stress of the situation. The older sample may have been more aware of the dangers and deliberately avoided potential violence by leaving the situation or by spending more time with peers.

Further, there are developmental changes with age in children's attributions about determining the control over events (Carey, 1985; Connell, 1988). Younger children may be more susceptible to "magical" beliefs that something they did caused the assaults. Without some kind of protection by family or friends, the child may be negatively impacted. Conversely, the adolescent has the capacity for abstract understanding of persons motivations and actions, and capable of knowing how the trauma may affect their lives. Some of the sample adolescents, then, may have developed their own coping and resilience capacities through decreased family involvement and increased involvement with community, peers, and/or school.

The differences in age responses may have also been related to the duration with which the sample witnessed mother-assault. Given that mother-assault occurs over a

long period of time and increases in intensity (Sinclair, 1985), it is reasonable to suggest that adolescents in this sample may have witnessed their mothers assaults over a longer period of time than the younger sample. Consequently, the notion of mother-assault as a "secret of the family" (Elbow, 1982; Jaffe et al., 1990; Lehmann et al., 1994) may have been reinforced consistently over the years so that minimizing symptoms on the part of adolescents may have been a purposeful and natural choice to make.

Another reason for age differences may be related to family supports. Although the study found no relationship among family variables (FACES III & SSQ) and PTSD responses, mothers did respond to a number of events which could have potentially left younger children feeling unsupported. For example, 59.3% (n=40) of the mothers indicated they had three or more children in their present care. In addition, 77.4% (n=65) of the mothers reported living below the poverty line of $25,940. The data above relates indirectly to the potential health needs of women and would be consistent with the literature which has found many assaulted women have numerous stress and health related problems (Haber & Ross, 1985; Jaffe et al., 1986; Keronac, Taggart, Lescop, & Fortin, 1986; Thoenes & Cini, 1994). In this context of violence, it seems reasonable to suggest that the task of multiple child care plus increased financial hardship would produce a maximum amount of physical and emotional stress on mothers. Since younger

children are more dependent on adults for their care, this particular group may have perceived themselves as having fewer social supports from mothers and consequently, been more stressed.

A final point considers why age was not significant when contrasting the severity and course of mother-assault. In this case, different variables were used to define the construct of severity compared to the course of mother-assault, which too had different variables. It may be that the severity variables were poorly constructed and unable to statistically distinguish age groups.

The gender of the sample children did not seem to have an effect on traumatic responding. Consequently, it is unknown whether girls or boys in this study were equally or unequally affected by their exposure to mother-assault. Further, these findings may be inconclusive for two reasons. First, this study lacked measures which might have differentiated female/male responses. For example, a number of studies measuring stress and children used instruments that have helped divide gender into internalizing (more typical of girls) & externalizing sequelae (more typical of boys) (Kiser et al., 1988; Milgram et al., 1989; Steinglass & Getty, 1990). Second, identifying gender differences in this study may not have been identified because of the small sample (n=84). In their review of disasters and children, Vogel & Vernberg (1983) concluded that gender differences emerged in large samples.

The Dissimilar Findings Between Severity And Course Of Mother-Assault

The third prominent finding related to the dissimilar outcomes between the PTSD responses of children and the HVWCQ when taking the severity and the course of mother-assault into account. The severity of mother-assault measured mothers reports of the types of assaults and child witnessing, while the course of mother-assault considered the frequency of assaults, plus the child's life experience or duration of witnessing. The results of this study indicated that the severity of mother-assault did not predict any positive group or age association with PTSD responses, whereas the course of mother-assault predicted an overall positive association with age on the PTSD response subscales of hyperactivity, avoidance, assault anxiety, as well as attributional differences (Tables 11 & 12).

The above findings which suggested that the course of mother-assault could predict a number of PTSD responses seems to parallel some existing conceptual formulations and empirical studies of children and PTSD. For example, a number of authors (Pynoos & Nader, 1990; Pynoos, 1990 Terr, 1990; van der Kolk, 1987) have all argued that the duration of exposure to a traumatic event is an important mediator in determining PTSD responses. In particular, these same authors have suggested that the duration and PTSD responses found in children are likely to be most damaging when the perpetrator of the traumatic event is a family member.

Empirical studies have also made similar propositions. Earls et al. (1988) found that children with a pre-existing psychiatric history and or disorder were at greater risk of developing PTSD symptoms following a flood disaster. Bradburn (1991) came to similar conclusions in a study of children following an earthquake. As well, D. Wolfe et al. (1994) found that children who had been sexually abused over a year experienced more PTSD symptoms than non-PTSD children who had been sporadically abused. Finally, it may be reasonable to conclude that many of the studies listed in Table 2 were children who had been exposed to parental violence over an extended period of time which may, in part, help account for the traumatic sequelae. At the same time, questions may be raised as to why there were dissimilar findings in this study when taking the course and severity of mother-assault into account. Some reasons may be considered. One reason for the differences may be related to the construct of severity. Terr (1991) proposed that the symptoms associated with trauma varies according to the frequency and duration of the trauma. Essentially, Terr's notion of frequency is analogous to the Type I typology (PTSD sequelae) which measures exposure to a single traumatic event compared to multiple traumatic events of the Type II typology (PTSD sequelae plus coping responses). In this study it was not possible to measure the severity of mother-assault as no child in the sample experienced one singular exposure to mother-assault.

Another reason for some of the differences may be that the current study did not use the same variables to differentiate severity from course as found in the Wolfe et al. (1989) study. For example, the sample did not include sexually abused children and consequently the variables used to determine severity were changed. Also, the current study relied on different respondents (parents versus social workers) than the Wolfe et al. (1989) study. Therefore, it is reasonable to suggest that some of the above differences would have led to different outcomes.

One final reason for the differences may be related to measurement issues. The severity and course of mother-assault were derived from the HVWCQ (Lehmann & Wolfe, 1992). Proper psychometric evaluation of the instrument was not carried out prior to the beginning of the study. Therefore, adequate reliability and validity of the instrument was missing. Consequently, the author was unable to determine whether course or severity were acceptable constructs.

In conclusion, some dissimilar findings were reported when taking the severity and course of mother-assault into account. Although the differences in this study may have been due to statistical and/or methodological procedures, more study seems indicated.

The Role Of Type II Coping Responses

The fourth major finding of the current study concerned the role of Type II coping responses. To review, Terr (1990, 1991) suggested Type II coping responses resulted

from long-standing, chronic exposure to stressful circumstances and included the behaviours of denial, rage, dissociation, and depression. As discussed in the preceding results section, this study found no support for the notion of a positive relationship between the course of mother-assault and the Type II trauma responses.

There may be a number of reasons for the lack of findings as stated above. First, no measure was used to identify the construct of denial. Consequently, it is uncertain as to whether or not any of the child sample exhibited symptoms of denial. Second, the Anger Control Inventory (Hoshmand & Austin, 1987) measuring rage was originally designed for adults. Therefore, it is unknown how applicable the items might have been to the present sample. Third, a number of instruments including the Children's Inventory of Anger (Nelson, & Finch, 1978) and the Childhood Depression Inventory (Kovacs, 1983) made no mention of witnessing mother-assault or trauma. In this vein, Elliott & Briere (1991) have argued that without reference to abuse or assault, measurement instruments may be less sensitive to abuse-specific symptoms.

One final reason for the lack of group or age differences in the coping responses may be related to the use of multivariate analyses of variance MANOVA models. In this context, Briere (1992) has argued that the use of MANOVA models may be inappropriate when encompassing a collection of unrelated measures as opposed to a set of

measures whose interrelationship is likely to be significant. It could be argued that the constructs making up the Type II coping responses may be clinically related, but unrelated statistically. Unfortunately no current study measuring the same Type II responses has used a similar MANOVA model to determine coping behaviours. Instead, studies referring to Type II outcomes have generally used a number of alternative procedures including clinical impressions (Kiser et al., 1988; Terr, 1990, 1991), univariate analyses of variance ANOVA (Kiser et al., 1991), multiple regression (Wolfe et al., 1989) and nonparametric techniques (Famularo et al., 1987).

In conclusion, this study was unable to statistically differentiate any Type II coping responses among the child sample of witnesses to mother-assault. Although Type II coping responses seem to be clinically relevant, further statistical development of this construct seems indicated.

The Role Of Childhood Attributions

The fifth major finding concerned childhood attributions and mother-assault. In this study, there was some preliminary support for research question two suggesting a positive association between the course of mother-assault and negative childhood attributions as measured by the attribution subscales of the CITES-FVF. Specifically, age seemed to be a factor in determining negative attributions. Younger children appeared to feel more personally vulnerable than the older sample. For

example, younger children reported more negative responses to such statements as "family violence might happen in my home again" and "I worry that my dad might do something awful to my mom". Furthermore, younger children reported more negative endorsements of the dangerous world attribution subscale. These included such items as "Family violence happens often" or "Men often abuse women". It may be argued that the developmental factor of age plus repeated exposure to mother-assault resulted in the children learning that they could do little to prevent what had happened. These negative experiences could provide the context for future generalized beliefs about how the world and relationships might be viewed. The younger children in this study might also be considerably more vulnerable since it has been argued that negative attributions become resistant to change the longer they are a part of one's life (Wolfe, 1987). Without the developmental or social resources to eliminate such attributions, it is conceivable child witnesses could show more helpless deficits over time.

The current study seems to parallel other researchers who have concluded that one's attributional style may impact coping styles to traumatic events. For example, a number of studies found that attributional style mediated sexual abuse symptoms (Gold, 1986; Wolfe, V. et al., 1989; Wolfe, D. et al., 1994). In their concluding comments on the role of attributions, Wolfe & Birt (in press) suggested coping with

trauma may increase negative attributional styles leading to the possibility of developing long-term adjustment problems.

The present formulation addressing attributions in the child witness is a relatively new area of research. At the same time, the findings of this study are important for assessing how children make sense of their experiences of mother-assault and what the events mean to them (Dawes, 1992; Richman, 1993). However, the current study on child attributions only looked at the "child's self-directed attributions" (Wolfe & McGee, 1991, p.266) and for this reason the results should be seen as tentative. Following on the thinking of Wolfe & McGee (1991), the present findings on attributions were unable to take into account to what extent the underlying reciprocal tension associated with mother-assault affected the child's responses. More specifically, the present study was unable to determine whether the child made her/his own assessment of the perpetrator's behaviour and motivations prior to responding to the attributions scales. Here, it has been suggested that different forms of attributions including cause, responsibility, intent, and blame may play a role in children's responses. (Shaver, 1985; Shaver & Drown, 1986). For example, it might be argued that a child who attributed a parent's violence as intentional because that parent was mean might fare worse than a child who attributed the intentional violence to the loss of a job.

In conclusion, there seems to be some preliminary evidence indicating that the current child sample exhibited a negative attributional style. Younger children reported an increased number of responses to feeling vulnerable, and living in a dangerous world compared to their older counterparts.

The Validity Of The CITES-FVF

The sixth major finding concerned the validity of the CITES-FVF (Wolfe & Lehmann, 1992). The data presented in Chapter V did not support the research question that the CITES-FVF (Wolfe & Lehmann, 1992) and the CITES-R (Wolfe et al., 1991) would have similar factor structures. However, it should be noted that the underlying structure between the two instruments were quite similar. That is, factor analyses of both instruments seemed able to delineate the PTSD, attributional, and social support items into their respective dimensions. These same analyses revealed that in both instruments, the PTSD subscales of reexperiencing, avoidance, and hyperarousal had similar factor and subscale correlations. Further, the internal reliability of both instruments were alike, found in their similarity of alpha values.

At the same time, the differences between the final factor structures may have been due to a number of reasons. In their methodological discussion of factor analysis, Tabachnick and Fidell (1989) suggested that a sample size of between 100 and 200 was sufficient for most purposes.

Consequently, a reason for the differences between the dissimilar factor structures of the CITES-R (Wolfe et al., 1991) and the CITES-FVF (Wolfe & Lehmann, 1992) may be related to the number of children found in the respective samples. The V. Wolfe et al (1991) sample had a total of 137 subjects, which was well within the range suggested by Tabachnick and Fidell (1989). The current sample had only 84 children suggesting that the statistical power was not adequate in determining the necessary factor structure (Craft, 1990).

Tabachnick and Fidell (1989) have also noted that criterion differences (e.g. socio-economic factors, single parent family versus two-parent family, in treatment versus no treatment) with respect to groups may also result in the extraction of different factors. In other words, while the two sample groups (CITES-R & CITES-FVF) shared the experience of being traumatized, there may have been some factors which made them different. As an example, children in the CITES-R sample were not in a shelter setting, whereas the majority of the CITES-FVF sample were. Children in the CITES-R sample came from a variety of homes, whereas approximately 54% (n=45) of the CITES-FVF sample were children of single parents. Essentially, the criterion differences may be endless without exactly duplicating each group.

A final reason that accounted for the differences in factor structures may have been related to the use of

complex versus pure variables. Tabachnick and Fidell (1989) argued that a pure variable is usually correlated with only one factor while a complex variable is correlated with several. In effect, it may be argued that the CITES-R findings reflected more "purity" between the variables in that the variables (in the CITES-R) correlated more efficiently, resulting in the final eleven factors. On the other hand, it may be suggested that the variables making up the CITES-FVF reflected more complexity. For example, items on the attribution subscales clustered together under one factor instead of four separate factors as found in the CITES-R. The fact that the items were clustered together may have been because of their complexity (e.g. items being too vague, wording hard to understand) and not because there was some underlying process guiding them. Consequently, it may be that the attribution variables chosen for use may not have been the most appropriate variables to measure attributions in the child witness.

In conclusion, the current research question anticipating similar factor structures between the CITES-R (Wolfe et al., 1991) and the CITES-FVF (Lehmann & Wolfe, 1992) was not supported. A series of principal component factor analyses resulted in different factor structure for the CITES-FVF as compared to the CITES-R. Given the scale differences, further research seems warranted.

The Validity Of The HVWCQ

The seventh and final prominent finding of the current research concerned the validity of the HVWCQ (Lehmann & Wolfe, 1992). The results of Chapter four supported the research question that the HVWCQ (Lehmann & Wolfe, 1991) and the History of Victimization Form (HVF) (Wolfe, V., et al., 1987) would have similar factor structures identified as course and severity. Again, the construct validity of the HVWCQ was partially supported. That is, the results of the principal components factor analysis of the HVWCQ yielded a two factor structure with a variance of 71.9%.

Although the research question was supported, firm conclusions about the instrument's usefulness and/or construct validity should be guarded particularly given the second factor was made up of only one item. In this context, Tabachnick and Fidell (1989) have suggested that any interpretation of factors made up of one or two variables should be considered cautiously. Further, the HVWCQ and the HVF were constructed differently. The HVF was a complete and detailed checklist that asked social workers specific questions as to the severity and course of children's abusive experiences. In contrast, the HVWCQ asked mothers about their children's, their own, and their children's experiences and hinged on three areas: severity of the assault, the type of child witnessing, and the duration of witnessing mother assault. Given these minimal areas, it seems reasonable that a similar factor extraction

was unlikely. Additionally, since the respondents filling in the HVF and HVWCQ were different, it is unknown whether mothers or social workers might have been biased in their answers.

In summary, the current research question which expected similar factor structures between the HVWCQ and the HVF was only partially supported. Preliminary analysis would suggest test re-construction and additional analyses are needed.

Limitations Of This Study

The preceding section reviewed the prominent findings of the current study. At the same time, this study has a number of limitations that restrict the generalizability of the findings. These limitations are reviewed below.

Primarily, this study sample was not a true representative of the population of children who witness mother-assault. Currently, there are no other PTSD studies on children in shelters for battered women. Furthermore, this study focused on one portion of the witnessing population including children in shelters and a second stage housing project, and children referred from children's aid agencies. Since it has been estimated that in the city of London a minimum of 7,000 children annually witness the violent assaults of their mothers (London Co-ordinating Committee To End Woman Abuse, 1991), it is highly unlikely a representative segment of the population was included.

Another limitation related to the use of a cross-sectional (one shot) design. Here, Briere (1991) has stated that cross-sectional research is rarely helpful in discriminating abuse-specific from abuse-antecedent events. Consequently, it is unknown whether the self-reports of the child sample reflected their present state of functioning or to what extent any number of background factors (e.g. prewitnessing functioning of children, other forms of maltreatment, social factors) may have entered into the present results. In this context, Fredrich and Reams (1987) implied that abuse symptomatology can vary in type, intensity, and duration across the developmental life span.

This study was further limited in its generalizability by having studied the effects of witnessing mother-assault without investigating whether children in the sample were also victims of physical, sexual, and/or psychological abuse. This is important as virtually 100% of the studies reviewed in Table 2 reported on children being multiply victimized in some form. The current findings of Table 2 are similar to other studies of child maltreatment where multiple victimization was found (for a review see Belsky, 1993).

Another limitation of the current study was the failure of any of Terr's (1991) Type II coping responses to be differentiated by group or age. This is somewhat surprising since much of the clinical-descriptive and empirical literature in Table 2 listed at least one or two of the Type

II coping responses being present in children. For example, many of the studies identified any number of coping responses including depression, dissociation, and/or anger in their reviews.

Further, an additional limitation of the current study involved the measurement instruments. With the exception of the CITES-FVF (Wolfe & Lehmann, 1992), the remaining instruments including the mediating variables measured general dysfunction. This is important as most of the instruments and their items made no reference to abuse or trauma. Thus, it seems probable that the instruments were less sensitive to abuse-specific symptoms and therefore, more significant relationships between the variables may not have been detected. Currently, there is a trend towards using more abuse-specific instruments with adult (Briere & Runtz, 1989, 1990) and child (V. Wolfe, et al., 1989; D. Wolfe, et al., 1994) with victims of abuse.

A related issue involving the measurement instruments was their focus on pathology. In effect, the bulk of the instruments stressed deficits and not strengths or resources. Consequently, the instruments may have acted as restraints in empowering women and children by not focusing on those areas of their lives (e.g. parenting, self-care, occupations) in which they were functioning adequately.

A final limitation of this study related to instrument use. Here, a number of the scales including the CDC-Child Form, Family Disadvantage Index, Anger Control Inventory,

CITES-FVF, HVWCQ) lacked proper psychometric testing (e.g. adequate reliability and validity). Thus, it is unknown whether the instruments were appropriate for use with children. In some respects, these instruments too, may have also been insensitive to trauma-specific symptoms.

Implications Of This Study

The preliminary findings of this study represent a possible foundation upon which the examination of posttraumatic sequelae in the child witness to mother-assault can be further developed. These findings, therefore, have implications for theory, clinical practice, and policy development, as is examined below.

Theory

The current study provides some tentative support for the notion that witnessing mother-assault is a traumatic stressor (Lipovsky, 1991) and that a posttraumatic stress disorder conceptualization has some merit in understanding the adaptation of the child witness. Evidence to support this perspective came from the data on self-reports of PTSD symptoms (reexperiencing, hyperarousal, avoidance) in the current sample. Based on the findings of this study, there seems little doubt that what the children witnessed left them feeling in danger, threatened, terrorized, and filled with a bleak view of the world. In effect, it may also be argued that the use of the terms "trauma" or "traumatized" to clarify the experiences of the children in this sample has not been misapplied. This is important in light of the

fact that a substantial number of children met the diagnostic criteria for PTSD. What the children experienced was real and there is every indication they were deeply affected by what they saw.

This study also opens some possible discussion for considering a broadened PTSD conceptualization. The current PTSD criteria constituting the disorder takes into account three clusters of behaviours (APA, 1987) and each of the clusters of behaviours were reported by the current sample of children. However, based on the expanded PTSD conceptual framework, this study examined an additional number of features which seemed to be essential to traumatic responding. The presence of assault anxiety symptoms as well as negative child attributions were found to be important mediators to traumatic responding. Furthermore, some of the Type II trauma responses including denial and emotional numbing, rage, and dissociation seemed to provide some beginning data of the clinical descriptive trauma typologies articulated by Terr (1987,1990, 1991) and considered by V. Wolfe and associates. It may be suggested therefore, that the findings continue to lend some support to the recent argument made by Udwin (1993, p.124) that "the features (PTSD sequelae) may not constitute an exhaustive list".

A final implication of this study is that the current expanded PTSD conceptualization appears to link symptoms to theory more clearly. The important connection here is that

the responses found in the CITES-FVF (Wolfe & Lehmann, 1992) represent symptoms specific to the nature of mother-assault rather than symptoms of general child pathology (Briere, 1992; V. Wolfe, et al., 1991). Given these circumstances, it may be argued that the results could lead to greater diagnostic specificity in this particular population than might occur when using general measures of PTSD. Diagnostic specificity may also help address the criticism that the DSM III-R criteria are overly broad and therefore unable to determine which traumatic event has more impact (Richman, 1993). Ultimately, the linking of symptoms to theory may create an opportunity to permit more concise interpretation of new data of the child witness to mother-assault.

Clinical Practice

There are some general and specific implications with respect to clinical practice. The main general implication for this study would suggest that an expanded PTSD conceptualization can guide one's clinical practice. In this context it is furthermore suggested that any practice intervention must take into account how adjustment to witnessing mother-assault is mediated by a number of child, family, and larger societal factors. Consequently, understanding the factors which could mediate a child witness's responses are potentially complex and it may be helpful for clinicians to reconsider the model of V. Wolfe and Wolfe (1988).

The model of V. Wolfe and Wolfe (1988) is grid-like with four main mediator headings moving in a horizontal fashion across the page. These mediator headings include the nature of the abuse, child characteristics, family characteristics, and community attitudes and resources. Under each of the headings any number of characteristics may be added in a vertical fashion. Table 21 provides a visual hypothetical overview of factors and their characteristics impacting all family members who experience mother-assault. The grid-like features found in Table 21 may also be considered a prototype model in assisting the therapist in her/his clinical practices.

Table 21
Visual Hypothetical Overview of Factors Influencing The Child Witness's Symptoms

Nature of Abuse	Child Characteristics	Family Characteristics	Community Attitudes & Resources
Time frame since violence stopped	Presentation of PTSD symptoms	Secondary stressors resulting from assault	Legal aid & support
Reason for child disclosing mother-assault	Presence of Type II coping responses	Sole parent or re-uniting parent	Community aids to help c/p
Risk factors for further witnessing	Child's understanding & knowledge of violence	Changes in family interaction	Ethno-culture barriers
Any physical symptoms	Age and stage of development	Sources of social support	Gender-awareness of helper
Duration/frequency of witnessing	Gender of child	Extended family support	Safety issues
	Presentation of global symptoms	Stress and health of parent	Protocols for treat-ment
	Positive coping resources	Positive coping resources	
	Safety Issues	Safety Issues	

Specific implications are also related to clinical practices with group, individual, and family therapy modalities. Child group therapy seems to be the most current methodology when treating the child witness to mother-assault (e.g. Frey-Angel, 1989; Ragg & Webb, 1992; Wilson, Cameron, Jaffe, & Wolfe, 1990). The primary focus of the above groups are psycho-educational in which children learn various strategies for dealing with such issues as anger, self-esteem, and peer relationships. The findings of this study with respect to both PTSD and attributional indicators may highlight the need to include alternative treatment strategies. For example, it may be argued that questions about PTSD sequelae could be crucial to some children. An alternative possibility for group leaders may be to consider anger as a startle response to reminders instead of behaviour which is modeled. The presence of negative attributions in this study may also need to be an additional component in working with self-esteem. Ultimately, this study may stimulate "new" (e.g. attributional) questions to ask that may be fundamental to the child.

Another implication of this study is associated with the practice of individual therapy with the child witness. While reports of individual therapy with the child witness in the literature are scarce (e.g. Burman & Allen-Meares, 1984; Davies, 1991; Silvern & Kaersvang, 1989), this study argues that the role of individual therapy for child

witnesses deserves further attention. Possible attention might be focused on children in the third group (n=28) who consistently reported fewer symptoms in the face of the most severe mother-assault. Such children may be the most psychologically at risk and deserving of intensive individual treatment.

As an example, this study noted some elevated responses to anger among the sample children. While anger responses are commonly found in the child witness literature (e.g. see Jaffe & associates) the consistent decrease of anger responses are worth noting. If one were to consider the impact of mother-assault on the third group, it may be that long-standing, repeated exposure to mother-assault taught the child that her/his experiences were outside the realm of shareable experiences with significant others including mothers and fathers. Ultimately the child may have become ill-equipped to deal with any of her or his anger and learned to deny and/or disavow feelings. In this context it might be argued that individual therapy may be a valuable format to help the child express her/his feelings and come to terms with what happened.

There are some benefits to individual therapy which may be crucial for a certain number of children who have witnessed mother-assault. Pynoss and Nader (1993) have noted a number of these benefits in their work with traumatized children who have experienced any number of life-threatening events. These include counteracting

traumatic hindrances to normal functioning and development, to identify the child's ongoing processing of traumatic aspects of the event, to monitor and address the various traumatic symptoms, to restore the capacity for normal play, and to address additional stresses subsequent to the trauma.

There has also been some attempt to consider a family therapy approach with traumatized families (Catherall, 1992; Figley, 1989; Hurley & Jaffe, 1991; Lehmann et al., 1994), although such approaches have been criticized on a number of fronts. In particular, the assumptions of family therapy have been seen as biased against women and children. Consequently, there have been a number of negative treatment implications including blaming mothers and idealizing fathers (Bograd, 1984, 1990), reinforcing stereotyped roles of men and women (Myers Avis, 1986, 1988), ignoring the economic realities of women (McDonald, 1989), and neglecting the psychological and intrapsychic functioning of women and children (Walker, 1989).

The implications for the current study are that family therapy can be a method of practice that includes multiple treatment approaches for dealing with safety, traumatic symptoms, family relationships, and some of the cultural norms which disempower women. It is argued that under certain prescribed conditions family therapy provides an opportunity for the family to restore a sense of security and safety in children, to address the traumatic after-

affects of mother-assault, to work with the larger community, and to re-build family relationships.

Policy Development

This section of the chapter also considers the implications for policy development. This study took place in shelters for battered women as well as through children's aid agencies. Each of these agencies had child-directed programs which focused exclusively on the child witness. However, none of the existing shelter programs appeared to have treatment strategies for dealing directly with PTSD sequelae. Further, there seemed to be some confusion amongst workers as to what exactly were the most common symptoms of PTSD.

The results of this study would suggest that policies through written protocols be developed when dealing with traumatized children. Protocols could include steps for asking about traumatic stressors and teaching children how to cope with symptoms. Protocols should also be developed for dealing with possible ethical and confidential issues. For example, should a mother be told of her child's symptoms even if the child would like her/his confidentiality respected? Does the presence of PTSD symptoms suggest that the child may be in need of protection, particularly if the family is re-uniting with the batterer or the mother minimizes her child's distress? How much information should outside resources have regarding the child's distress?

With the exception of Willbach (1989) and Lehmann (1992), very little has been written on the ethical issues surrounding mother-assault. Since ethical issues are concerned with the well-being of persons', some major guidelines may be indicated in terms of policy development.

The effect of mother-assault on children and mothers is complex, involving any number of health, safety, and clinical isssues for survivors and treatment providers. Consequently, policy makers in shelters might consider not what the right ethical decision might be, but what is the best decision given the circumstances (Lehmann, 1992). In this case, Lehmann (1992) highlighted a model of ethical justification involving three tiers of inquiries in clarifying ethical decision-making. Decisions then, might involve breaking the confidentiality of the child in light of symptom presentation and possible risk to emotional health. It might also involve making enquiries to child welfare authorities if children and their mothers return to homes where the likelyhood of violence is high. Here, justification for such decisions attempt to sort out clincial and ethical dilemmas which might have not been possible through ordinary case planning or consultation.

Further, Willbach (1989) has suggested that ending the violence should be the goal of each worker. Consequently, this involves each worker examining their personal beliefs and biases around violence in families. Willbach (1989) argues that ethical decisions should be made by resorting to

moral judgment about clinical situations. For example, confusion about treating violence might be reduced if one takes the moral position that the man is totally responsibility for his violence. Further, shelters may need to examine their own existing policies in regard to mother-assault. Ultimately, this may mean taking a moral stand against violence at any cost, even at the price of the worker/family relationship. Shelters may find themselves needing to take political decisions which could also create tensions between existing agencies.

Finally, the presence of PTSD symptoms in this sample suggests policies need to be directed towards staff development. Staff need to have training on the characteristics of PTSD symptomatology, the course of the disorder, what the long-term implications of repeated traumatization might be, and finally, how to intervene when a child reports PTSD symptoms. Mothers also need training in what to look out for and how to help their child cope. Through information sharing mothers can serve as a buffers between the child and the stressor and act as models to demonstrate that trauma is surmountable.

Suggestions For Future Research

The findings of this study along with its limitations suggests a number of directions for future research efforts.

One important aspect of this research was the development of the CITES-FVF (Wolfe & Lehmann, 1992). This scale holds promise for identifying assault-specific PTSD

symptoms and attributions in the child witness to mother-assault. The significance of this scale could be enhanced if a new study were undertaken where the final 45 items of the principal components factor analysis in exploratory question two were used to measure the assault-specific symptoms in another sample of shelter children. Since the 45 items had the highest correlations specific to witnessing children, further analyses might improve the construct validity of the CITES-FVF (Wolfe & Lehmann, 1992). A second might also determine if a PTSD diagnosis could be determined with greater precision.

The severity and course of mother-assault variables are important concepts deserving further attention. It might be valuable to reconstruct the HVWCQ with items similar to the History Of Victimization Form (Wolfe, V. et al., 1987) or those found in the found in the Family Disadvantage Index (Dumas & Wahler, 1983). Future studies using additional items than those used in the HVWCQ might be able to differentiate the assault variables in another sample of child witnesses with greater precision. Here, it might be possible to discriminate whether, for example, variables such as duration of the abuse, relationship with the perpetrator, type of witnessing, and so forth are related to the immediate or more long-term impact on the child. More specifically and following on the work of V. Wolfe and associates, ongoing work might determine whether the assault

variables have different effects at different points in time for child witnesses to mother-assault.

Future studies might also consider whether the Type I syndrome can be defined with greater clarity. In this context future studies might consider an expansion of Type I criteria as it seems unlikely that most children witness mother-assault as a one-time traumatic experience (Terr, 1987, 1990, 1991). Enlarging Type I criteria could have the benefit of being able to discriminate between chronic and less than chronic witnessing children. The impact of such work might be felt most in treatment interventions.

The findings of this study are specific to shelter children. It would be also interesting to compare these results with those obtained from children in other settings. Children's mental health settings would provide another alternative sample. An interesting project might be to compare traumatic sequelae in two samples. The use of multiple settings might also determine the existence of any further curvilinear relationships among child witnesses.

The literature review of the child witness to mother-assault discussed above (Table 2) indicated that family and social support were important variables in determining child posttraumatic responding. This study, however, was unable to determine to what extent family factors such as family cohesion and adaptation or mother's sources of social support mediated children's PTSD responses. Since the role of family variables are important, it may be helpful to

review previous trauma studies with children where family variables accounted for some of the childrens responses and use those variables in further studies.

Another recommendation for future studies might be to explore what other risk/mediating factors exist which might make the child witness more vulnerable to developing PTSD. It might be useful to examine whether multiple maltreatment (e.g. physical, sexual, and/or psychological abuse) occurred among child witnesses and how such maltreatment might covary with PTSD. Other factors to consider might include pre-trauma characteristics and coping styles of children and mothers, as well as the impact of ethnicity, race, and socioeconomic factors on traumatic responding (Table 21).

Although the child trauma field is still relatively new, there were no longitudinal reviews of the child witness to mother-assault listed in Table 2. It might be useful, therefore, to follow the lead of the child sexual abuse field that reported on the adjustment of children between 12 months and 5 years after their abuse disclosures (for a summary see Kendall-Tackett et al., 1993). Three questions might begin to explore the long-term outcome for the child witness; What was the course of PTSD symptomatology over time, what contributed to recovery, and will longitudinal studies contribute to further theory development?

The final area for future research concerns alternative research methods. In a review of political violence and childhood trauma, Dawes (1992) implied that quantitative

methods of data gathering could be mechanistic and impersonal. Alternatively, the author argued for understanding the meanings children place on the events that befell them. From a quantitative perspective, this study could be interpreted as one where meaningful dialogue with those in pain was minimal, forfeited in the service of being overly objective. Future research with children who witness mother-assault, therefore, might pursue a qualitative approach to answering research questions.

Rubin and Babbie (1989) have suggested qualitative research is concerned with subjectively understanding the deeper meanings of the human experience. In this context future studies with child witnesses to mother-assault might use open-ended, probing interviews to generate answers about how children cope with their experiences. What are their coping strategies? What does their future look like? Who do they trust and why? Have they ever experienced the Type I trauma characteristics such as omens or misperceptions (Terr, 1990, 1991)? Similar qualitative questions could answer the ways in which mothers perceive how their family functions, who are their sources of support, and how their role of parent affects their children's functioning.

One final question which qualitative research could address is whether the impact of witnessing mother-assault might be better understood by using a female versus male interviewing process. Here, mothers and children might be given the choice of who they would rather be interviewed by

and why. Essentially, qualitative studies answering the above questions would be similar to those clinical-descriptive studies found in Table Two.

There is also room for future research studies that mix quantitative and qualitative methodologies. Perhaps the field of anthroplogy may be one area of study which child researchers could look to. Pelto and Pelto (1978) have contrasted two perspectives for researchers. The emic approach is essentially quantitative in that the child and/or family behaviour is studied in order to describe patterns according to observer-defined criteria. By contrast, etic approaches use the process of an interview whereby persons are questioned according to the personal interpretations and meanings which are ascribed to events in their lives. The emic approach then organizes information around family members' personal and historical narratives of their experiences.

While an etic and emic methodology may be found in the field of family therapy (Barlow et al., 1987; Epston, 1986) and family systems medicine (Griffith & Griffith, 1994), such practices have yet to be found with the child witness. One possible future area of study might be to use assault-specific instruments such as the CITES-FVF (V. Wolfe & Lehmann, 1992) followed by interviews which probed the personal impact of PTSD sequelae as well as the influence of mediators such as family characteristics and community attitudes. Another study might involve interviewing

children similar to the process advocated by Pynoos (1986) followed by the administration of general instruments of child coping.

A mix of the two methodologies might also enlighten the nature of any possible curvilinear relationships in future studies. For example, should findings be similar to the third group of the current study, the nature and/or significance of the curvilinear phenomenon could be examined in much more detail by administering assault-specific and/or general instruments. This could be followed by open-ended questioning that surveyed the relationships of mothers and children. It might be possible to determine if any curvilinear findings were due to child/parent interactions, child fears, or denial. As Terr (1990) alluded to earlier, once traumas build up, the child guards against thinking, developing the ability to block out thoughts and feelings.

Finally, it might be very useful to study the different forms of attributions a child might make regarding the assaults she/he may have witnessed (e.g. Shaver, 1985; Shaver & Drown, 1986). This could involve the use of instruments such as the CITES-FVF attributional subscales followed by questions related to the child's personal appraisal of what occurred. In this case it would not be necessary to solely rely on statistical inference.

Conclusion

The research of childhood PTSD is growing quickly. New ideas on traumatic stressors, child development, and measurement instruments are radically changing how we conceptualize trauma. The intent of this exploratory research study was essentially to expand on information that already existed about PTSD, children, and mother-assault in families. Here, an expanded model of PTSD was developed, partly based on the ideas of V. Wolfe and her associates. Consequently, this study found that the children who witnessed mother-assault exhibited a number of assault-specific PTSD sequelae in addition to negative child attributions. Age was also found to be the most prominent mediating factor with younger children exhibiting more traumatic responses than older children. Additionally, some beginning data suggested that the Type I and Type II typologies of Lenore Terr merit future evaluation and study. Finally, it is hoped that the results of this study plus the conceptual, clinical, and policy implications will provide clinicians and researchers with greater clarity in understanding and treating the child witness to mother-assault.

APPENDIX A: LETTER OF SUPPORT FROM AGENCY DIRECTORS TO MOTHERS

WOMEN'S EMERGENCY CENTRE

WOODSTOCK INC.

975 James St., P.O. Box 1207, Woodstock, Ontario N4S 8P6 Telephone: 539-4811 1-800-265-1938 Fax: 539-1163

Dear Mother:

Our shelter has been invited to participate in a research study by Peter Lenmann, a doctoral candidate in social work at Wilfrid Laurier University, Waterloo, Ontario. Peter considers it important to determine how your child may or may not have been effected by the violence she/he has seen or heard in the past. This research study would involve asking your child to fill in some questionnaires. As well, Peter would be asking you to fill in some questionnaires. Peter has said that the total time he would be asking of you and your child will not be more than 90 minutes. You will be reimbursed $25 for your time and expenses.

While this shelter supports Peter's research, you should know this study is completely voluntary for you and your child. It is your decision. Your decision <u>will not</u> effect you or your child's stay in this shelter.

If you would like to know a little more about this study, the child advocate or primary worker will give you an introductory letter. If you decide to participate in this study, the child advocate will contact Peter and arrangements will be made to meet you and your child.

Sincerely,

Executive Director

APPENDIX B: LETTER TO MOTHERS INTRODUCING THE PRIMARY RESEARCHER AND THE PURPOSES OF THE STUDY

Wilfrid Laurier
University

Founded 1911

Dear Mother;

My name is Peter Lehmann. I am a doctoral candidate in social work at Wilfrid Laurier University, Waterloo, Ontario. At the present time, I am conducting a research study with mothers and children who are residents of a women's shelter. The woman's shelter has given me permission to contact you.

I would like to invite your and your child's participation in my study. The purpose of my study is to determine how children may or may not have been effected by the abuse they have seen and heard. In meeting with your child, this research study aims to determine the extent to which your child remains troubled by any unpleasant memories or feelings.

In addition, mothers like yourself will be asked how long your child may have witnessed any abuse, what your child may have seen and/or heard, and what your sources of social support might be.

This research study could benefit your child in a number of ways. First, your child might have an opportunity to tell about some of her/his feelings about what has happened. Second, answering some of these questions might help children become more comfortable in openly asking about other things that may have been on their minds. Finally, this study and your child's participation will help influence more helpful therapies for children now and in the future for those who have witnessed their mother's abuse.

There will be no physical or safety risks to you and your child in participating in this study. If your child becomes upset during this study I will stop immediately. You will be informed and you, your child, the child advocate and I will decide together if your child can finish this study. Following the study, the child advocate and/or I will spend as much time as necessary in answering your child's questions or helping discuss her or his feelings about what we have done together.

This study will take place in the shelter and should take approximately 90 minutes of your and your child's time. You and your child will be reimbursed $25 dollars for your time and expenses.

Faculty of Social Work
Wilfrid Laurier University, Waterloo, Ontario, Canada N2L 3C5 (519) 884-1970 Fax: (519) 747-9129

Wilfrid Laurier
University

Founded 1911

All information from you and your child will be handled in a confidential manner, and kept locked in my office at home. No one but myself will be able to see what you and your child have answered. As well, if you do not wish to use your real name, we

can choose a code name for you to go under. After my doctoral work is completed, all information on you and your child will be destroyed.

Finally, if you would like to know the conclusions of this research project, I will provide you with a general summary. Also, at your request and with your child's permission, I would be prepared to share with you your child's responses. Your child will know this may happen before the research study begins.

If you are willing to be included in this study, please let the child advocate or your primary worker know. She will contact me and make an appointment for us to meet where I will outline with you and your child what I would like to do. If you have any questions you may contact me at (519) 439-4484 or my research supervisor, Dr. Robert Basso at (519) 884-1970, ext. 2031. I hope you and your child will want to participate in this study and look forward to hearing from you.

Sincerely,

Peter Lehmann

Faculty of Social Work
Wilfrid Laurier University, Waterloo, Ontario, Canada N2L 3C5 (519) 884-1970 Fax: (519) 747-9129

APPENDIX C: LETTER TO THE CHILDREN INTRODUCING THE STUDY

Wilfrid Laurier University

Founded 1911

Child Consent To Participate

You are being invited to take part in answering some questions that I have about abuse in families. Often, girls and boys ask "just what does abuse in families mean?" Here is what I think it means. When kids see abuse in families, it usually means that kids see their moms being hurt in different ways by dad or by mom's boyfriend. Usually, kids who stay at shelters also see lots of different abuse and violence. This might include seeing mom hit or slapped, swore at or called bad names, or seeing plates or furniture being broken. I am a social worker who is trying to find out how kids feel about this. What I learn from you may help social workers like me in our work with other children in shelters.

If you decide to spend some time with me answering these questions we will meet at the shelter. You will be able to quit answering the questions any time you want. This means you will not be forced by me, your mom, or the shelter staff to answer any questions you do not want to talk about.

If you have any questions, I will do my best to answer them for you. If you would like to talk with my boss about what I am doing, I will arrange for you to phone him. His name is Dr. Robert Basso, and he works in Waterloo, Ontario.

When we are finished, your mom may want to know how you are feeling. With your permission, I will spend some time with her telling her about your feelings.

---

1. I agree to answer the questions as explained by Peter Lehmann.

_____ _____

(name of child) (date)

_____

(witness)

2. I do____ do not_____ give permission for my mother to be told about my answers to these questions.

_____ _____

(name of child) (date)

_____

(witness)

Faculty of Social Work
Wilfrid Laurier University, Waterloo, Ontario, Canada N2L 3C5 (519) 884-1970 Fax: (519) 747-9129

APPENDIX D: CONSENT FORMS FOR MOTHERS AND CHILDREN

Wilfrid Laurier University

Founded 1911

Parent Consent To Participate

If you agree to participate in the research study by Peter Lehmann on the effects of children who witness abuse in their homes, please sign your name below. You may withdraw your participation at any time. If you have any concerns or complaints about this research, you may contact Peter Lehmann at (519) 439-4484 or the research supervisor, Dr. Robert Basso at (519) 884-1970. Dr. Basso is with the Faculty of Social Work, Wilfrid Laurier University, Waterloo, Ontario.

I agree to participate in the study as explained in the letter from Peter Lehmann.

Name of participant (print)	Signature
Witness	Date

Faculty of Social Work
Wilfrid Laurier University, Waterloo, Ontario, Canada N2L 3C5 (519) 884-1970 Fax: (519) 747-9129

University

Founded 1911

Child Consent To Participate

You are being invited to take part in answering some questions that I have about abuse in families. Often, girls and boys ask "just what does abuse in families mean?" Here is what I think it means. When kids see abuse in families, it usually means that kids see their moms being hurt in different ways by dad or by mom's boyfriend. Usually, kids who stay at shelters also see lots of different abuse and violence. This might include seeing mom hit or slapped, swore at or called bad names, or seeing plates or furniture being broken. I am a social worker who is trying to find out how kids feel about this. What I learn from you may help social workers like me in our work with other children in shelters.

If you decide to spend some time with me answering these questions we will meet at the shelter. You will be able to quit answering the questions any time you want. This means you will not be forced by me, your mom, or the shelter staff to answer any questions you do not want to talk about.

If you have any questions, I will do my best to answer them for you. If you would like to talk with my boss about what I am doing, I will arrange for you to phone him. His name is Dr. Robert Basso, and he works in Waterloo, Ontario.

When we are finished, your mom may want to know how you are feeling. With your permission, I will spend some time with her telling her about your feelings.

---

1. I agree to answer the questions as explained by Peter Lehmann.

_____ _____

(name of child) (date)

_____

(witness)

2. I do____ do not_____ give permission for my mother to be told about my answers to these questions.

_____ _____

(name of child) (date)

_____

(witness)

Faculty of Social Work
Wilfrid Laurier University, Waterloo, Ontario, Canada N2L 3C5 (519) 884-1970 Fax: (519) 747-9129

APPENDIX E: THE CHILDREN'S IMPACT OF TRAUMATIC EVENTS SCALE-FAMILY VIOLENCE FORM (CITES-FVF)

NAME_____ AGE____ DATE OF BIRTH_____ I.D.#____

Boy or Girl (circle)

CHILDREN'S IMPACT OF TRAUMATIC EVENTS SCALE-FVF (FAMILY VIOLENCE FORM)*

Vicky Veitch Wolfe, Ph.D. (The University of Western Ontario)

Peter Lehmann, M.S.W. (Madame Vanier Children's Service, London, Ontario)

TO INTERVIEWER: The questionnaire below may be recorded individually or together with the child. Many of the questions refer to "dad". One may need to substitute "dad" for "boyfriend, friend, etc" depending on the perpetrator.

Prior to presenting the questionnaire, read the following instructions to the child.

"I am going to ask you several questions about the violence you witnessed in your family. I am not going to ask you to describe what happened, instead, I want to know your thoughts and feelings about what happened. I will read a sentence and you can tell me whether or not it is very true, somewhat true, or not true. I want you to know there are no right or wrong answers to the questions I will be asking. If I ask you a question and you feel uncomfortable, please tell me and I will move on to another question".

SCALES:

PTSD

IT--Intrusive thoughts

AV--Avoidance

HAR--Hyperarousal

Attributions about the violence

SBG--Self Blame/Guilt

PV--Personal Vulnerability

DW--Dangerous World

EMP--Empowerment

Social Reactions

NRO--Negative Reactions by others

SS--Social Support

*This instrument is based upon The Children's Impact Of Traumatic Events Scale-Revised (CITES) (Vicky Veitch Wolfe and Carol Gentile, 1989).

CHILDRENS IMPACT OF TRAUMATIC EVENTS SCALE

	VERY TRUE	SOMEWHAT TRUE	NOT TRUE	
1. I believe I will not experience family violence in my home again.	___	___	___	(EMP)
2. Some people believe that I did something to cause the violence.	___	___	___	(NRO)
3. I try to stay away from things that remind me of the violence.	___	___	___	(AV)
4. People who know about the violence say bad things about me and my family.	___	___	___	(NRO)
5. I often feel irritable for no reason.	___	___	___	(HAR)
6. I have trouble falling asleep because pictures or thoughts of the violence keep popping into my head.	___	___	___	(IT)
7. If family violence happens in my home again, I can protect myself.	___	___	___	(EMP)
8. I dislike or feel uncomfortable when someone expresses anger.	___	___	___	(PV)
9. Family violence happens often.	___	___	___	(DW)
10. I have dreams or nightmares about the violence.	___	___	___	(IT)
11. I have difficulty concentrating because I often think about the violence and what happened to my family.	___	___	___	(HAR)
12. After people learned about the violence in my family, they no longer wanted to spend time with me.	___	___	___	(NRO)
13. Family violence might happen in my family again.	___	___	___	(PV)
14. Men often abuse women.	___	___	___	(DW)
15. I am easily startled or surprised.	___	___	___	(HAR)
16. I think about the violence even when I don't want to.	___	___	___	(IT)
17. I was not to blame for the violence.	___	___	___	(SGB) (REVERSE)
18. Sometimes I worry about what life will be like in the future.	___	___	___	(DW)
19. Pictures of the violence often pop into my mind when I don't expect them to.	___	___	___	(IT)
20. I often feel restless or jumpy.	___	___	___	(HYR)
21. Things in my life will get better.	___	___	___	(EMP)
22. Some kids at school make fun of me because they know about the violence and the trouble my family has had.	___	___	___	(NRO)

23. Most people who know about the violence are nice and understanding.	___	___	___	(SS)
24. Sometimes I feel I have done something wrong because I have talked about a family secret.	___	___	___	(SBG)
25. I am easily annoyed by others.	___	___	___	(HYR)
26. Violence in my family happened because I was not smart enough to stop it from happening.	___	___	___	(SBG)
27. I try not to think about the violence.	___	___	___	(AV)
28. Most people listen carefully to me when I talk about the violence.	___	___	___	(SS)
29. I think about the violence and what happened to my family even when I don't want to.	___	___	___	(IT)
30. Violence in my family happened because I did something bad.	___	___	___	(SBG)
31. I avoid places or things on purpose that remind me of the violence.	___	___	___	(AV)
32. I am embarrassed when I see people who know about the violence.	___	___	___	(SBG)
33. Sometimes when playing I act out what happened during the violence.	___	___	___	(IT)
34. Children who behave better than me have not experienced family violence.	___	___	___	(SBG)
35. Thinking about the violence upsets me.	___	___	___	(SXA)
36. Violence in my family happened because I am unlucky.	___	___	___	(SBG)
37. Some people blame me for the violence.	___	___	___	(NRO)
38. As a result of the violence and my family troubles, people who used to care about me no longer do.	___	___	___	(NRO)
39. I have more angry feelings than my friends.	___	___	___	(SXA)
40. When someone reminds me of the violence, I get scared.	___	___	___	(HYA)
41. _____ is to blame for the violence.	___	___	___	(SBR-REV)
42. If violence happens in my home again, I can stop it.	___	___	___	(EMP)
43. I sometimes want to cry when I think of the violence.	___	___	___	(IT)
44. Some people think that I was to blame for the violence.	___	___	___	(NRO)
45. No matter what I do, I can't stop family violence.	___	___	___	(PV)
46. If violence happens in my home again, I know what to do to stop it.	___	___	___	(EMP)

47. I am not as interested in some things I used to like (hobbies, sports, friendships) since the violence happened.	___	___	___	(AV)
48. People who I trusted let me down.	___	___	___	(HRO)
49. Many things remind me of the violence.	___	___	___	(IT)
50. When I'm reminded of the violence, I try to think of something else.	___	___	___	(AV)
51. I worry that other children will experience family violence.	___	___	___	(DW)
52. Very few children see their families fight.	___	___	___	(PV-REV)
53. My mother knows enough abou' family violence that she can protect me in the future.	___	___	___	(EMP)
54. I often worry that someone will beat me up in the future.	___	___	___	(PV)
55. I have someone who I can talk to about the violence.	___	___	___	(SS)
56. I get nervous when I see people get angry.	___	___	___	(SXA)
57. I feel different from other kids my age because I have witnessed family violence.	___	___	___	(PV)
58. I have tried to forget about the violence.	___	___	___	(AV)
59. Most kids my age should not trust men because they can be violent.	___	___	___	(DW)
60. In the future my mother will prevent violence from happening again.	___	___	___	(SS)
61. I hope I never have to think about violence again.	___	___	___	(SXA)
62. I feel good about how my mother helped me cope with the family violence.	___	___	___	(SS)
63. I don't think I will live to be very old.	___	___	___	(AV)
64. I don't tell anyone about my feelings.	___	___	___	(AV)
65. I feel I have to know people a long time before I can trust them.	___	___	___	(PV)
66. Sometimes my anger scares me.	___	___	___	(PV)
67. I sometimes pretend the violence never happened or that it was a dream.	___	___	___	(AV)
68. I feel my mom will protect me from ever seeing family violence again.	___	___	___	(SS)
69. Sometimes I can convince myself that the violence I saw was not so bad.	___	___	___	(AV)
70. Social workers, counsellors, and/or the police have helped me and my family.	___	___	___	(SS)

71. Because of the violence, it is more difficult for me to love or get close to people. ___ ___ ___ (AV)

72. Bad things happen to me all the time. ___ ___ ___ (PV)

73. I worry that my dad will do something awful to my mom. ___ ___ ___ (PV)

74. I have to be careful with people I don't know because anyone could become physically violent. ___ ___ ___ (DW)

75. I worry that my dad will take me away from my mom. ___ ___ ___ (PV)

76. Sometimes I worry that I'll never see my dad again. ___ ___ ___ (PV)

77. Seeing my family fight has made me more sad than other children. ___ ___ ___ (PV)

78. If my mom finds a boyfriend or gets married, I fear that person will hurt her too. ___ ___ ___ (DW)

79. Many children grow up in violent homes. ___ ___ ___ (DW)

80. I get scared when I think about the violence. ___ ___ ___ (SXA)

APPENDIX F: THE HISTORY OF VIOLENCE WITNESSED BY CHILD QUESTIONNAIRE (HVWCQ)

History of Violence Witnessed By Child Questionnaire (HVWCQ)

*Vicky Veitch Wolfe, Ph.D. (UWO), Peter Lehmann, M.S.W. (Mae. Vanier Children's Service)

Below are two questions plus a checklist which look at the number of times your child may have witnessed different types of violence. Please answer them to the best of your memory.

A. Has your child ever witnessed an assault against you by your partner? __yes __no If yes, when was the last time? __less than one week ago___ between 1 & 2 weeks ago___ between two & four weeks ago__ between 1 & 3 months ago__ between 3 & 6 months ago__between 6 & 9 months ago __between 9 & 12 months ago __more than 1 year ago

B. Question B deals with the different kinds of violence you experienced and the number of times your child may have been a witness. More than one check can be made if needed.

Types of violence and number of times your child was a witness.	1=once 2=twice 3=3-5 times 4=6-10 times 5=11-20 times 6=more than 20 times	this assault occurred but my child did not hear or see what happened	How did your child witness the violence? She/He... heard what happened	saw what happened	tried to stop the violence by stepping in
1. yelled, swore or insulted you	1 2 3 4 5 6	____	___	____	____
2. threw, smashed, or kicked something at you	1 2 3 4 5 6	___	___	___	____
3. pushed, grabbed, or shoved you	1 2 3 4 5 6	___	___	____	___
4. slapped you	1 2 3 4 5 6	___	___	____	____
5. kicked, or hit you with a fist	1 2 3 4 5 6	____	___	_____	___
6. tried to hit you with something (e.g. bat, car, pot or pan)	1 2 3 4 5 6	___	___	____	____
7. physically hurt you (e.g. drew blood, black eye, broken bone)	1 2 3 4 5 6	____	___	___	____
8. threatened with a gun or knife	1 2 3 4 5 6	____	___	____	____
9. used a gun or knife	1 2 3 4 5 6	___	___	____	____
10. sexually assaulted you (e.g. forced sex against your will)	1 2 3 4 5 6	___	___	____	____
11. destroyed your personal property	1 2 3 4 5 6	___	___	___	___
12. hurt a family pet	1 2 3 4 5 6	___	___	___	___
13. any other acts your child may have witnessed_____	1 2 3 4 5 6	___	___	___	___

C) Over the span of your child's life, how long (weeks, months, years) do you believe she/he has witnessed violence against you? __less than 1 month___ between 1 & 6 months ___ between 6 & 12 months___ between 1 & 2 years___ between 2 & 3 years__ between 3 & 4 years___more than 4 years

APPENDIX G: THE ATTRIBUTIONAL STYLE QUESTIONNAIRE FOR CHILDREN

Child 2

KASTAN
Instructions

UH/2/80
Hand scored

I am going to read you some situations and I want you to try really hard to imagine that they have just happened to you. Then, I want you to choose the most likely reason to explain why the situation happened to you.

First I will read you the situation, and then I will read you two possible reasons for the situation and I want you to choose the one that seems most true to you. Sometimes both of the reasons may sound true, and sometimes both may sound false, and, you may never have been in some of these situations. But even so, I want you to pick the reason that seems to explain why the situation happened to you.

There are no right answers and no wrong answers, so always pick the reason that seems the most likely to you.

Circle either "A" or "B" for each question.

KASTAN-REVISED CHILDREN'S ATTRIBUTIONAL STYLE QUESTIONNAIRE (KASTAN-R CASQ

1. YOU GET AN "A" ON A TEST.

   A. I AM SMART.
   B. I AM GOOD IN THE SUBJECT THAT THE TEST WAS IN.

2. YOU PLAY A GAME WITH SOME FRIENDS AND YOU WIN.

   A. NO ONE I KNOW PLAYS THAT GAME WELL.
   B. I PLAY THAT GAME WELL.

3. YOU SPEND A NIGHT AT A FRIEND'S HOUSE AND YOU HAVE A GOOD TIME.

   A. MY FRIEND WAS IN A FRIENDLY MOOD THAT NIGHT.
   B. EVERYONE IN MY FRIEND'S FAMILY WAS IN A FRIENDLY MOOD THAT NIG

4. YOU GO ON A VACATION WITH A GROUP OF PEOPLE AND YOU HAVE FUN.

   A. I WAS IN A GOOD MOOD.
   B. THE PEOPLE I WAS WITH WERE IN GOOD MOODS.

5. ALL OF YOUR FRIENDS CATCH A COLD EXCEPT YOU.

   A. I HAVE BEEN HEALTHY LATELY.
   B. I AM A HEALTHY PERSON.

6. YOUR PET GETS RUN OVER BY A CAR.

   A. I DON'T TAKE GOOD CARE OF MY PETS.
   B. DRIVERS ARE NOT CAUTIOUS ENOUGH.

7. SOME KIDS THAT YOU KNOW SAY THAT THEY DO NOT LIKE YOU.

   A. ONCE IN A WHILE PEOPLE ARE MEAN TO ME.
   B. ONCE IN A WHILE I AM MEAN TO OTHER PEOPLE.

8. YOU GET VERY GOOD GRADES.

   A. SCHOOL WORK IS SIMPLE.
   B. I AM A HARD WORKER.

9. YOUR FRIEND TELLS YOU THAT YOU LOOK NICE.

   A. MY FRIEND LIKED THE WAY I LOOKED THAT DAY.
   B. MY FRIEND LIKES THE WAY I LOOK.

10. A GOOD FRIEND TELLS YOU THAT HE HATES YOU.

    A. MY FRIEND WAS IN A BAD MOOD THAT DAY.
    B. I WASN'T NICE TO MY FRIEND THAT DAY.

11. YOU TELL A JOKE AND NO ONE LAUGHS.

    A. I DO NOT TELL JOKES WELL.
    B. THE JOKE IS SO WELL KNOWN THAT IT IS NO LONGER FUNNY.

12. YOUR TEACHER GIVES A LESSON AND YOU DO NOT UNDERSTAND IT.

    A. I DIDN'T PAY ATTENTION TO ANYTHING THAT DAY.
    B. I DIDN'T PAY ATTENTION WHEN MY TEACHER WAS TALKING.

13. YOU FAIL A TEST.

    A. TEACHERS MAKE HARD TESTS.
    B. SOMETIMES TEACHERS MAKE HARD TESTS.

14. YOU GAIN A LOT OF WEIGHT AND START TO LOOK FAT.

    A. THE FOOD THAT I HAVE TO EAT IS FATTENING.
    B. I LIKE FATTENING FOODS.

15. A PERSON STEALS MONEY FROM YOU.

    A. THAT PERSON IS DISHONEST.
    B. PEOPLE ARE DISHONEST.

16. YOUR PARENTS PRAISE SOMETHING THAT YOU MAKE.

    A. I AM GOOD AT MAKING SOME THINGS.
    B. MY PARENTS LIKE SOME THINGS I MAKE.

17. YOU PLAY A GAME AND YOU WIN MONEY.

    A. I AM A LUCKY PERSON.
    B. I AM LUCKY WHEN I PLAY GAMES.

18. YOU BREAK A GLASS.

    A. I AM NOT CAREFUL ENOUGH.
    B. SOMETIMES I AM NOT CAREFUL ENOUGH.

19. YOU ARE INVITED TO A LOT OF PARTIES.

A. A LOT OF PEOPLE HAVE BEEN ACTING FRIENDLY TOWARD ME LATELY.
B. I HAVE BEEN ACTING FRIENDLY TOWARD A LOT OF PEOPLE LATELY.

20. A GROWNUP YELLS AT YOU.

A. THAT PERSON YELLED AT THE FIRST PERSON HE SAW.
B. THAT PERSON YELLED AT A LOT OF PEOPLE HE SAW THAT DAY.

21. YOU DO A PROJECT WITH A GROUP OF KIDS AND IT TURNS OUT BADLY.

A. I DON'T WORK WELL WITH THE PEOPLE IN THE GROUP.
B. I NEVER WORK WELL WITH A GROUP.

22. YOU MAKE A NEW FRIEND.

A. I AM A NICE PERSON.
B. THE PEOPLE THAT I MEET ARE NICE.

23. YOU HAVE BEEN GETTING ALONG WELL WITH YOUR FAMILY.

A. I AM EASY TO GET ALONG WITH WHEN I AM WITH MY FAMILY.
B. ONCE IN AWHILE I AM EASY TO GET ALONG WITH WHEN I AM WITH MY FAMILY.

24. YOU TRY TO SELL CANDY, BUT NO ONE WILL BUY ANY.

A. LATELY A LOT OF CHILDREN ARE SELLING THINGS, SO PEOPLE DON'T WANT TO BUY ANYTHING ELSE FROM CHILDREN.
B. PEOPLE DON'T LIKE TO BUY THINGS FROM CHILDREN.

25. YOU PUT A HARD PUZZLE TOGETHER.

A. SOMETIMES I AM GOOD AT PUTTING PUZZLES TOGETHER.
B. SOMETIMES I AM GOOD AT PUTTING THINGS TOGETHER.

26. YOU GET A BAD GRADE IN SCHOOL.

A. I AM STUPID.
B. TEACHERS ARE UNFAIR GRADERS.

27. YOU WALK INTO A DOOR AND YOU GET A BLOODY NOSE.

A. I WASN'T LOOKING WHERE I WAS GOING.
B. I HAVE BEEN CARELESS LATELY.

28. YOU HAVE A MESSY ROOM.

A. I DID NOT CLEAN MY ROOM THAT DAY.
B. I USUALLY DO NOT CLEAN MY ROOM.

29. YOU TWIST YOUR ANKLE IN GYM CLASS.

A. THE PAST FEW WEEKS THE SPORTS WE PLAYED IN GYM CLASS HAVE BEEN DANGEROUS.
B. THE PAST FEW WEEKS I HAVE BEEN CLUMSY IN GYM CLASS.

30. YOUR PARENTS TAKE YOU TO THE BEACH AND YOU HAVE A GOOD TIME.

A. EVERYTHING AT THE BEACH WAS NICE THAT DAY.
B. THE WEATHER AT THE BEACH WAS NICE THAT DAY.

31. YOU TAKE A TRAIN WHICH ARRIVES SO LATE THAT YOU MISS A MOVIE.

A. THE PAST FEW DAYS THERE HAVE BEEN PROBLEMS WITH THE TRAIN BEING ON TIME.
B. THE TRAINS ARE ALMOST NEVER ON TIME.

32. YOUR MOTHER MAKES YOU YOUR FAVORITE DINNER.

A. THERE ARE A FEW THINGS THAT MY MOTHER WILL DO TO PLEASE ME.
B. MY MOTHER LIKES TO PLEASE ME.

33. A TEAM THAT YOU ARE ON LOSES A GAME.

A. THE TEAM MEMBERS DON'T PLAY WELL TOGETHER.
B. THAT DAY THE TEAM MEMBERS DIDN'T PLAY WELL TOGETHER.

34. YOU FINISH YOUR HOMEWORK QUICKLY.

A. LATELY I HAVE BEEN DOING EVERYTHING QUICKLY.
B. LATELY I HAVE BEEN DOING SCHOOLWORK QUICKLY.

35. YOUR TEACHER ASKS YOU A QUESTION AND YOU GIVE THE WRONG ANSWER.

A. I GET NERVOUS WHEN I HAVE TO ANSWER QUESTIONS.
B. THAT DAY I GOT NERVOUS WHEN I HAD TO ANSWER QUESTIONS.

36. YOU DO NOT GET YOUR CHORES DONE AT HOME.

A. I WAS LAZY THAT DAY.
B. MANY DAYS I AM LAZY.

37. YOU GO TO AN AMUSEMENT PART AND YOU HAVE A GOOD TIME.

A. I USUALLY ENJOY MYSELF AT AMUSEMENT PARKS.
B. I USUALLY ENJOY MYSELF.

38. YOU HAVE A FIGHT WITH A FRIEND.

A. I WAS IN A BAD MOOD THAT DAY.
B. MY FRIEND WAS IN A BAD MOOD THAT DAY.

39. YOU GET ALL THE TOYS YOU WANT ON YOUR BIRTHDAY.

A. PEOPLE ALWAYS GUESS WHAT TOYS TO BUY ME FOR MY BIRTHDAY.
B. THIS BIRTHDAY PEOPLE GUESSED RIGHT AS TO WHAT TOYS I WANTED.

40. YOU GO TO A FRIEND'S PARTY AND YOU HAVE FUN.

A. YOUR FRIEND GIVES GOOD PARTIES.
B. YOUR FRIEND GAVE A GOOD PARTY THAT DAY.

41. YOUR NEIGHBORS ASK YOU OVER FOR DINNER.

A. SOMETIMES PEOPLE ARE IN KIND MOODS.
B. PEOPLE ARE KIND.

42. YOU HAVE A SUBSTITUTE TEACHER AND SHE LIKES YOU.

A. I WAS WELL BEHAVED DURING CLASS THAT DAY.
B. I AM ALMOST ALWAYS WELL BEHAVED DURING CLASS.

43. YOU MAKE YOUR FRIENDS HAPPY.

A. I AM A FUN PERSON TO BE WITH.
B. SOMETIMES I AM A FUN PERSON TO BE WITH.

44. YOU GET A FREE ICE-CREAM CONE.

A. I WAS FRIENDLY TO THE ICE-CREAM MAN THAT DAY.
B. THE ICE-CREAM MAN WAS FEELING FRIENDLY THAT DAY.

45. AT YOUR FRIEND'S PARTY THE MAGICIAN ASKS YOU TO HELP HIM OUT.

A. IT WAS JUST LUCK THAT I GOT PICKED.
B. I LOOKED REALLY INTERESTED IN WHAT WAS GOING ON.

46. YOU TRY TO CONVINCE A KID TO GO TO THE MOVIES WITH YOU, BUT HE WON'T G

A. THAT DAY HE DID NOT FEEL LIKE DOING ANYTHING.
B. THAT DAY HE DID NOT FEEL LIKE GOING TO THE MOVIES.

47. YOUR PARENTS HAVE A BIG FIGHT.

A. IT IS HARD FOR PEOPLE TO GET ALONG WELL.
B. IT IS HARD FOR PEOPLE WHO ARE MARRIED TO GET ALONG WELL.

48. YOU HAVE BEEN TRYING TO GET INTO A CLUB AND YOU DO NOT GET IN.

A. THERE ARE A LOT OF THINGS THAT I AM NOT GOOD AT.
B. I AM NOT GOOD AT THE THINGS THAT PEOPLE IN THE CLUB DO.

APPENDIX H: THE CHILDREN'S DEPRESSION INVENTORY (CDI)

CD INVENTORY

NAME: _____

DATE: _____

KIDS SOMETIMES HAVE DIFFERENT FEELINGS AND IDEAS.

THIS FORM LISTS THE FEELINGS AND IDEAS IN GROUPS. FROM EACH GROUP, PICK ONE SENTENCE THAT DESCRIBES YOU BEST FOR THE PAST TWO WEEKS. AFTER YOU PICK A SENTENCE FROM THE FIRST GROUP, GO ON TO THE NEXT GROUP.

THERE IS NO RIGHT ANSWER OR WRONG ANSWER. JUST PICK THE SENTENCE THAT BEST DESCRIBES THE WAY YOU HAVE BEEN RECENTLY. PUT A MARK LIKE THIS X NEXT TO YOUR ANSWER. PUT THE MARK IN THE BOX NEXT TO THE SENTENCE THAT YOU PICK.

HERE IS AN EXAMPLE OF HOW THIS FORM WORKS. TRY IT. PUT A MARK NEXT TO THE SENTENCE THAT DESCRIBES YOU BEST.

EXAMPLE:

- [ ] I READ BOOKS ALL THE TIME
- [ ] I READ BOOKS ONCE IN A WHILE
- [ ] I NEVER READ BOOKS

REMEMBER, PICK OUT THE SENTENCES THAT DESCRIBE YOUR FEELINGS AND IDEAS IN THE PAST TWO WEEKS.

1. ☐ I AM SAD ONCE IN A WHILE
   ☐ I AM SAD MANY TIMES
   ☐ I AM SAD ALL THE TIME

2. ☐ NOTHING WILL EVER WORK OUT FOR ME
   ☐ I AM NOT SURE IF THINGS WILL WORK OUT FOR ME
   ☐ THINGS WILL WORK OUT FOR ME O.K.

3. ☐ I DO MOST THINGS O.K.
   ☐ I DO MANY THINGS WRONG
   ☐ I DO EVERYTHING WRONG

4. ☐ I HAVE FUN IN MANY THINGS
   ☐ I HAVE FUN IN SOME THINGS
   ☐ NOTHING IS FUN AT ALL

5. ☐ I AM BAD ALL THE TIME
   ☐ I AM BAD MANY TIMES
   ☐ I AM BAD ONCE IN A WHILE

6. ☐ I THINK ABOUT BAD THINGS HAPPENING TO ME ONCE IN A WHILE
   ☐ I WORRY THAT BAD THINGS WILL HAPPEN TO ME
   ☐ I AM SURE THAT TERRIBLE THINGS WILL HAPPEN TO ME

7. ☐ I HATE MYSELF
   ☐ I DO NOT LIKE MYSELF
   ☐ I LIKE MYSELF

8. ☐ ALL BAD THINGS ARE MY FAULT

☐ MANY BAD THINGS ARE MY FAULT

☐ BAD THINGS ARE NOT USUALLY MY FAULT

9. ☐ I DO NOT THINK ABOUT KILLING MYSELF

☐ I THINK ABOUT KILLING MYSELF BUT I WOULD NOT DO IT

☐ I WANT TO KILL MYSELF

10. ☐ I FEEL LIKE CRYING EVERYDAY

☐ I FEEL LIKE CRYING MANY DAYS

☐ I FEEL LIKE CRYING ONCE IN A WHILE

11. ☐ THINGS BOTHER ME ALL THE TIME

☐ THINGS BOTHER ME MANY TIMES

☐ THINGS BOTHER ME ONCE IN A WHILE

12. ☐ I LIKE BEING WITH PEOPLE

☐ I DO NOT LIKE BEING WITH PEOPLE MANY TIMES

☐ I DO NOT WANT TO BE WITH PEOPLE AT ALL

13. ☐ I CANNOT MAKE UP MY MIND ABOUT THINGS

☐ IT IS HARD TO MAKE UP MY MIND ABOUT THINGS

☐ I MAKE UP MY MIND ABOUT THINGS EASILY

14. ☐ I LOOK O.K.

☐ THERE ARE SOME BAD THINGS ABOUT MY LOOKS

☐ I LOOK UGLY

15. ☐ I HAVE TO PUSH MYSELF ALL THE TIME TO DO MY SCHOOLWORK

☐ I HAVE TO PUSH MYSELF MANY TIMES TO DO MY SCHOOLWORK

☐ DOING SCHOOLWORK IS NOT A BIG PROBLEM

REMEMBER, DESCRIBE HOW YOU HAVE BEEN IN THE PAST TWO WEEKS.

16. ☐ I HAVE TROUBLE SLEEPING EVERY NIGHT
☐ I HAVE TROUBLE SLEEPING MANY NIGHTS
☐ I SLEEP PRETTY WELL

17. ☐ I AM TIRED ONCE IN A WHILE
☐ I AM TIRED MANY DAYS
☐ I AM TIRED ALL THE TIME

18. ☐ MOST DAYS I DO NOT FEEL LIKE EATING
☐ MANY DAYS I DO NOT FEEL LIKE EATING
☐ I EAT PRETTY WELL

19. ☐ I DO NOT WORRY ABOUT ACHES AND PAINS
☐ I WORRY ABOUT ACHES AND PAINS MANY TIMES
☐ I WORRY ABOUT ACHES AND PAINS ALL THE TIME

20. ☐ I DO NOT FEEL ALONE
☐ I FEEL ALONE MANY TIMES
☐ I FEEL ALONE ALL THE TIME

21. ☐ I NEVER HAVE FUN AT SCHOOL
☐ I HAVE FUN AT SCHOOL ONLY ONCE IN A WHILE
☐ I HAVE FUN AT SCHOOL MANY TIMES

22. ☐ I HAVE PLENTY OF FRIENDS
☐ I HAVE SOME FRIENDS BUT I WISH I HAD MORE
☐ I DO NOT HAVE ANY FRIENDS

23. ☐ MY SCHOOLWORK IS ALRIGHT

☐ MY SCHOOLWORK IS NOT AS GOOD AS BEFORE

☐ I DO VERY BADLY IN SUBJECTS I USED TO BE GOOD IN

24. ☐ I CAN NEVER BE AS GOOD AS OTHER KIDS

☐ I CAN BE AS GOOD AS OTHER KIDS IF I WANT TO

☐ I AM JUST AS GOOD AS OTHER KIDS

25. ☐ NOBODY REALLY LOVES ME

☐ I AM NOT SURE IF ANYBODY LOVES ME

☐ I AM SURE THAT SOMEBODY LOVES ME

26. ☐ I USUALLY DO WHAT I AM TOLD

☐ I DO NOT DO WHAT I AM TOLD MOST TIMES

☐ I NEVER DO WHAT I AM TOLD

27. ☐ I GET ALONG WITH PEOPLE

☐ I GET INTO FIGHTS MANY TIMES

☐ I GET INTO FIGHTS ALL THE TIME

THE END

THANK YOU FOR FILLING OUT THIS FORM

SUM: _____

APPENDIX I: THE CHILDREN'S INVENTORY OF ANGER-SHORT FORM

Children's Inventory of Anger*

These are some general situations that sometimes make boys and girls angry (mad). Read (listen to) each statement carefully and try to imagine that it's actually happening to you. Then decide how angry (mad) you would get in that particular setting. The following are examples of responses to the situations.

1 = **I DON'T CARE.** That situation doesn't bother me. I don't know why that would make anyone angry (mad).

2 = **THAT BOTHERS ME BUT I'M NOT TOO ANGRY (MAD) ABOUT IT.** I'll just forget it.

3 = **I'M REALLY ANGRY (MAD), BUT I THINK I CAN CONTROL MYSELF.**

4 = **I CAN'T STAND THAT! I'M FURIOUS!** I feel like hurting or killing that person; or destroying that thing!

1	2	3	4	1.	Somebody calls you a "chicken".
1	2	3	4	2.	Someone cuts in front of you in lunch line.
1	2	3	4	3.	Your friends say that they are going to come Saturday and they do not come.
1	2	3	4	4.	You want to go somewhere with a friend but your mom says no without any reason.
1	2	3	4	5.	You are playing a game and someone on the other side tries to cheat.
1	2	3	4	6.	You are trying to do your work in school and someone bumps your desk on purpose and you mess up.
1	2	3	4	7.	You are watching T.V. and someone turns it to another station.
1	2	3	4	8.	Your brother or sister wears your clothes that you told them not to.
1	2	3	4	9.	Your mom or dad promises you something and you don't get it.
1	2	3	4	10.	Your friends are playing a game but won't let you play too.

1	2	3	4	11.	You do something special for a friend and later they won't do something for you.
1	2	3	4	12.	You tell the truth about something but your parents don't believe you.
1	2	3	4	13.	You tell your mom that you don't have any homework but she makes you study anyway.
1	2	3	4	14.	The bus driver takes your name for acting up on the bus, but everybody else was acting up too.
1	2	3	4	15.	You have to go to bed at 9:30 even in the summertime and your friends get to stay up until 10:30 or 11:00.
1	2	3	4	16.	You get lost at the shopping center and when you finally find your parents scream at you.
1	2	3	4	17.	At lunch, you select a piece of pie and the kid behind you knocks it out of your hand.
1	2	3	4	18.	At school, two bigger kids come and take your basketball away from you and play "keep away" from you.
1	2	3	4	19.	You didn't notice that someone put gum on your seat on the bus and you sit on it.
1	2	3	4	20.	People won't be quiet when you are trying to watch your favorite T.V. show.
1	2	3	4	21.	Someone in your class tells the teacher on you for doing something.

* This version of the CIA includes only the items which correlate most highly with the full scale score.

APPENDIX J: THE ANGER CONTROL INVENTORY-RESPONSE SCALES

ANGER RESPONSE INVENTORY *

(Hoshmand & Austin, 1987)

Tell what you do when you are angry by checking the appropriate column,

	Never	Some-times	Often	Almost Always
1. When I am angry, I stomp my feet or storm out of places.	( )	( )	( )	( )
2. When I am angry, I can listen to the other person before I do something.	( )	( )	( )	( )
3. When I am angry, I call people names or shout at them.	( )	( )	( )	( )
4. When I am angry, I sulk or pout in front of others.	( )	( )	( )	( )
5. When I am angry, I break things.	( )	( )	( )	( )
6. When I am angry, I speak calmly and say how I feel.	( )	( )	( )	( )
7. When I am angry, I try to talk things over calmly and work things out.	( )	( )	( )	( )
8. When I am angry, I threaten to hurt the person who is making me angry.	( )	( )	( )	( )
9. When I am angry, I tell people I understand how they feel.	( )	( )	( )	( )
10. When I am angry, I try to hurt myself.	( )	( )	( )	( )
11. When I am angry, I hit other people.	( )	( )	( )	( )
12. When I am angry, I can admit that I am upset.	( )	( )	( )	( )

	Never	Some-times	Often	Almost Always
13. When I am angry, I throw things or pound the wall.	( )	( )	( )	( )
14. When I am angry, I walk away and try to forget about it.	( )	( )	( )	( )
15. When I am angry, I try to understand the other person's side of things.	( )	( )	( )	( )
16. When I am angry, I try to get back at people by being mean or hurtful.	( )	( )	( )	( )
17. When I am angry, I eat lots of junk food.	( )	( )	( )	( )
18. When I am angry, I ask people to give me time to calm down before I talk.	( )	( )	( )	( )
19. When I am angry, I take it out on people who have nothing to do with making me angry.	( )	( )	( )	( )
20. When I am angry, I explain the reasons for my anger calmly.	( )	( )	( )	( )
21. When I am angry, I get all choked up.	( )	( )	( )	( )
22. When I am angry, I feel choked up for a long time.	( )	( )	( )	( )
23. When I am angry, I feel like crying.	( )	( )	( )	( )
24. When I am angry, I have a hard time breathing.	( )	( )	( )	( )
25. When I am angry, my chest feels very tight.	( )	( )	( )	( )
26. When I am angry, I get hot feelings all over my body.	( )	( )	( )	( )
27. When I am angry, my body shakes.	( )	( )	( )	( )

	Never	Some-times	Often	Almost Always
28. When I am angry, I feel uptight?	( )	( )	( )	( )
29. When I am angry, my body stays tense for a long time.	( )	( )	( )	( )
30. When I am angry, my voice becomes shaky.	( )	( )	( )	( )
31. When I am angry, my heart pounds.	( )	( )	( )	( )
32. When I am angry, I clench my fists.	( )	( )	( )	( )
33. When I am angry, I feel tightness in my arms for a long time.	( )	( )	( )	( )
34. When I am angry, my head spins.	( )	( )	( )	( )
35. When I am angry, I get a headache.	( )	( )	( )	( )
36. When I am angry, I grind my teeth.	( )	( )	( )	( )
37. When I am angry, I find it hard to stay still.	( )	( )	( )	( )
38. When I am angry, I feel numb.	( )	( )	( )	( )
39. When I am angry, I get a stomachache.	( )	( )	( )	( )
40. When I am angry, my mouth gets dry for a long time.	( )	( )	( )	( )
41. When I am angry, I say to myself, "Here we go again ..... I have to be the one to lose out".	( )	( )	( )	( )
42. When I am angry, I say to myself, "This person upset me on purpose".	( )	( )	( )	( )
43. When I am angry, I tell myself, "Don't do anything that will get me in trouble".	( )	( )	( )	( )

	Never	Some-times	Often	Almost Always
44. When I am angry, I tell myself, "Keep calm and cool".	( )	( )	( )	( )
45. When I am angry, I say to myself, "It is no use talking to some people".	( )	( )	( )	( )
46. When I am angry, I tell myself, "Don't take this situation personally".	( )	( )	( )	( )
47. When I am angry, I tell myself, "I must show people that I am really tough".	( )	( )	( )	( )
48. When I am angry, I tell myself, "Count to 10 before doing anything".	( )	( )	( )	( )
49. When I am angry, I tell myself, "Don't do anything to make things worse".	( )	( )	( )	( )
50. When I am angry, I say to myself, "It's not fair".	( )	( )	( )	( )
51. When I am angry, I say to myself, "Maybe the other person does not mean it".	( )	( )	( )	( )
52. When I am angry, I tell myself, "I am going to get even".	( )	( )	( )	( )
53. When I am angry, I tell myself, "Don't lose your temper".	( )	( )	( )	( )
54. When I am angry, I say to myself, "People never treat me fairly".	( )	( )	( )	( )
55. When I am angry, I tell myself, "I'd better be careful how I handle this situation".	( )	( )	( )	( )
56. When I am angry, I say to myself, "Sometimes people can't help what they do, even though it bothers me".	( )	( )	( )	( )

	Never	Some-times	Often	Almost Always
57. When I am angry, I say to myself, "People always think that they can take advantage of me".	( )	( )	( )	( )
58. When I am angry, I tell myself, "If I can think straight, I'll be able to tell my side of things better".	( )	( )	( )	( )
59. When I am angry, I say to myself, "People don't care how I feel".	( )	( )	( )	( )
60. When I am angry, I see a fight coming.	( )	( )	( )	( )
61. When I am angry, I picture myself getting upset just like in the past.	( )	( )	( )	( )
62. When I am angry, I picture myself staying calm and in control.	( )	( )	( )	( )
63. When I am angry, I picture myself losing control just like in the past.	( )	( )	( )	( )
64. When I am angry, I picture myself talking calmly with the person who made me angry.	( )	( )	( )	( )
65. When I am angry, I feel as if I am hearing the same unpleasant words I have heard before.	( )	( )	( )	( )
66. When I am angry, I can almost hear people call me a baby if I don't stand up to the person who made me angry.	( )	( )	( )	( )
67. When I am angry, I can almost hear a pleasant and calm voice telling me to keep calm.	( )	( )	( )	( )
68. When I am angry, I feel as if I am hearing the same voice that bothered me before.	( )	( )	( )	( )

APPENDIX K: THE CHILDHOOD DISSOCIATIVE CHECKLIST-CHILD FORM

CHILD DISSOCIATIVE CHECKLIST *

Frank W. Putnam, M.D.

Date: Age: Sex: Name:

Below is a list of behaviors that describe children. For each item that describes you **NOW** or **WITHIN THE PAST 12 MONTHS**, please circle 2 if the item is VERY **TRUE** of you. Circle **1** if the item if **SOMEWHAT** or **SOMETIMES TRUE** of you. If the item is **NOT TRUE** of you, circle **)**.

0 1 2 1. I know I have had very scary, painful or traumatic experience but I can not remember some things about them.

0 1 2 2. Others have said that I appear to be in a daze or "spaced out". Teachers say that I "daydream" frequently in school.

0 1 2 3. I act very differently from time to time. I can go from being shy to being outgoing, from acting like a boy to acting like a girl, or from being fearful to being aggressive.

0 1 2 4. I forget or become confused about things that I should know, e.g., I forget the names of friends, teachers, or other important people; I lose my possessions; or get lost easily.

0 1 2 5. At times, I lose track of time. (e.g., I may think that it is morning, when it is actually afternoon; I may get confused about what day it is; or I may become confused about when something happened.

0 1 2 6. The things that I can do or the things that I like change from day-to-day or even hour-to-hour (e.g., my handwriting may change or I won't be able to remember things that I had previously known like spelling or multiplication tables.

0 1 2 7. I act alot younger than my age for no reason.

0 1 2 8. I have difficulty learning from past mistakes. Discipline or punishment does not seem to change the way I act.

0 1 2 9. Others have said that they know that I have done something wrong but I didn't remember doing it.

0 1 2 10. At times, I want to be called by names different than my own.

0 1 2 11. People have told me that I have done things that I believe someone else did.

0 1 2 12. I get headaches or stomachaches which come and go quickly.

0 1 2 13. I act in a sexual way towards other children or adults.

0 1 2 14. I have attempted to hurt myself on purpose.

0 1 2 15. I have had injuries at times that I could not explain.

0 1 2 16. I have heard voices talking to me. The voices may be friendly or angry and may come from imaginary companions or sound like voices of parents, friends, or teachers.

0 1 2 17. I have one or more imaginary companion(s) who has/have done things that others thought I did.

0 1 2 18. I get very angry at times and become very strong.

0 1 2 19. People have told me that I walk in my sleep.

0 1 2 20. I have strange nighttime experiences (e.g., I see "ghosts"; things happen at night that I can't explain like getting hurt or breaking toys).

0 1 2 21. I talk or argue with myself at times and use a different voice.

0 1 2 22. At times, I feel like I have two or more people inside me that take control over my actions.

* Altered to involve self-report by the child.

APPENDIX L: FACES III

YOUR NAME: _____

FACES III

David H. Olson, Joyce Portner, and Yoav Lavee

1	2	3	4	5
ALMOST NEVER	ONCE IN A WHILE	SOMETIMES	FREQUENTLY	ALMOST ALWAYS

DESCRIBE YOUR FAMILY NOW:-

_____ 1. Family members ask each other for help.

_____ 2. In solving problems, the children's suggestions are followed.

_____ 3. We approve of each other's friends.

_____ 4. Children have a say in their discipline.

_____ 5. We like to do things with just our immediate family.

_____ 6. Different persons act as leaders in our family.

_____ 7. Family members feel closer to other family members than to people outside the family.

_____ 8. Our family changes its way of handling tasks.

_____ 9. Family members like to spend free time with each other.

_____10. Parent(s) and children discuss punishment together.

_____11. Family members feel very close to each other.

_____12. The children make the decisions in our family.

_____13. When our family gets together for activities, everybody is present.

_____14. Rules change in our family.

_____15. We can easily think of things to do together as a family.

_____16. We shift household responsibilities from person to person.

_____17. Family members consult other family members on their decisions.

_____18. It is hard to identify the leader(s) in our family.

_____19. Family togetherness is very important.

_____20. It is hard to tell who does which household chores.

APPENDIX M: THE CHILDHOOD DISSOCIATIVE CHECKLIST-MOTHER FORM

CHILD DISSOCIATIVE CHECKLIST

(V 3.0 -- 2/90)

Frank W. Putnam, M.D.
Unit on Dissociative Disorders, LDP, NIMH

Date:_____ Age: ____ Sex: M F Identification: _____

Below is a list of behaviors that describe children. For each item that describes your child **NOW** or **WITHIN THE PAST 12 MONTHS**, please circle **2** if the item is **VERY TRUE** of your child. Circle **1** if the item is **SOMEWHAT** or **SOMETIMES TRUE** of your child. If the item is **NOT TRUE** of your child, circle **0**.

0 1 2 1. Child does not remember or denies traumatic or painful experiences that are known to have occurred.

0 1 2 2. Child goes into a daze or trance-like state at times or often appears "spaced-out". Teachers may report that he or she 'daydreams' frequently in school.

0 1 2 3. Child shows rapid changes in personality. He or she may go from being shy to being outgoing, from feminine to masculine, from timid to aggressive.

0 1 2 4. Child is unusually forgetful or confused about things that he or she should know, e.g. may forget the names of friends, teachers or other important people, loses possessions or gets lost easily.

0 1 2 5. Child has a very poor sense of time. He or she loses track of time, may think that it is morning when it is actually afternoon, gets confused about what day it is, or becomes confused about when something happened.

0 1 2 6. Child shows marked day-to-day or even hour-to-hour variations in his or her skills, knowledge, food preferences, athletic abilities, e.g. changes in handwriting, memory for previously learned information such as multiplication tables, spelling, use of tools or artistic ability.

0 1 2 7. Child shows rapid regressions in age-level of behavior, e.g. a twelve year-old starts to use baby-talk, sucks thumb or draw like a four year-old.

0 1 2 8. Child has a difficult time learning from experience, e.g. explanations, normal discipline or punishment do not change his or her behavior.

0 1 2 9. Child continues to lie or deny misbehavior even when the evidence is obvious.

0 1 2 10. Child refers to him or herself in the third person (e.g. as she or her) when talking about self, or at times insists on being called by a different name. He or she may also claim that things that he or she did actually happened to another person.

0 1 2 11. Child has rapidly changing physical complaints such as headache or upset stomach. For example, he or she may complain of a headache one minute and seem to forget all about it the next.

0 1 2 12. Child is unusually sexually precocious and may attempt age-inappropriate sexual behavior with other children or adults.

0 1 2 13. Child suffers from unexplained injuries or may even deliberately injure self at times.

0 1 2 14. Child reports hearing voices that talk to him or her. The voices may be friendly or angry and may come from 'imaginary companions' or sound like the voices of parents, friends or teachers.

0 1 2 15. Child has a vivid imaginary companion or companions. Child may insist that the imaginary companion(s) is responsible for things that he or she has done.

0 1 2 16. Child has intense outbursts of anger, often without apparent cause and may display unusual physical strength during these episodes.

0 1 2 17. Child sleepwalks frequently.

0 1 2 18. Child has unusual nighttime experiences, e.g. may report seeing "ghosts" or that things happen at night that he or she can't account for (e.g. broken toys, unexplained injuries).

0 1 2 19. Child frequently talks to him or herself, may use a different voice or argue with self at times.

0 1 2 20. Child has two or more distinct and separate personalities that take control over the child's behavior.

APPENDIX N: THE FAMILY DISADVANTAGE INDEX

INFORMATION FORM

Name of Child_____ Sex_____ Age___

Name of Mother (Real or Code)_____
Age_____

Are there three or more children living with you at the present time? yes____ no___

Have you lived in three or more homes since the birth of your oldest child? yes___ no___

Have you experienced at least one legal as well as non-legal marital/common-law separation within the last two years?
yes___ no___

Is your income less than $25,920 on a yearly basis? yes___
no___

Has your family received two or more community services (e.g. counselling, mother's allowance) in the past?
yes___ no___

Has your child/children lived with one or more aggressive male role model(s) for more than six months? yes___ no___

APPENDIX O: SOCIAL SUPPORT QUESTIONNAIRE

SSQ

Name: _____

_____

Date: ___

INSTRUCTIONS:

The following questions ask about people in your environment who provide you with help or support. Each question has two parts. For the first part, list all the people you know, excluding yourself, whom you can count on for help or support in the manner described. Give the person's initials and their relationship to you (see example). Do not list more than one person next to each of the letters beneath the question.

For the second part, circle how satisfied you are with the overall support you have.

If you have no support for a question, check the words "No one," but still rate your level of satisfaction. Do not list more than nine persons per question.

Please answer all questions as best you can. All your responses will be kept confidential.

EXAMPLE:

Who do you know whom you can trust with information that could get you in trouble?

No one	1)	T.N. (brother)	4)	T.N. (father)	7)
	2)	L.M. (friend)	5)	L.M. (employer)	8)
	3)	R.S. (friend)	6)		9)

How satisfied?

6-very satisfied	5-fairly satisfied	4-a little satisfied	3-a little dissatisfied	2-fairly dissatisfied	1-very dissatisfied

1. Whom can you really count on to listen to you when you need to talk?

No one	1)	4)	7)
	2)	5)	8)
	3)	6)	9)

How satisfied?

6-very satisfied	5-fairly satisfied	4-a little satisfied	3-a little dissatisfied	2-fairly dissatisfied	1-very dissatisfied

2. Whom could you really count on to help you if a person whom you thought was a good friend insulted you and told you that he/she didn't want to see you again?

No one	1)	4)	7)
	2)	5)	8)
	3)	6)	9)

How satisfied?

6-very satisfied	5-fairly satisfied	4-a little satisfied	3-a little dissatisfied	2-fairly dissatisfied	1-very dissatisfied

3. Whose lives do you feel that you are an important part of?

No one	1)	4)	7)
	2)	5)	8)
	3)	6)	9)

How satisfied?

6-very satisfied	5-fairly satisfied	4-a little satisfied	3-a little dissatisfied	2-fairly dissatisfied	1-very dissatisfied

4. Whom do you feel would help you if you were married and had just separated from your spouse?

No one	1)	4)	7)
	2)	5)	8)
	3)	6)	9)

How satisfied?

6-very satisfied	5-fairly satisfied	4-a little satisfied	3-a little dissatisfied	2-fairly dissatisfied	1-very dissatisfied

5. Whom could you really count on to help you out in a crisis situation, even though they would have to go out of their way to do so?

No one	1)	4)	7)
	2)	5)	8)
	3)	6)	9)

How satisfied?

6-very satisfied	5-fairly satisfied	4-a little satisfied	3-a little dissatisfied	2-fairly dissatisfied	1-very dissatisfied

6. Whom can you talk with frankly, without having to watch what you say?

No one	1)	4)	7)
	2)	5)	8)
	3)	6)	9)

How satisfied?

6-very satisfied	5-fairly satisfied	4-a little satisfied	3-a little dissatisfied	2-fairly dissatisfied	1-very dissatisfied

7. Who helps you feel that you truly have something positive to contribute to others?

No one	1)	4)	7)
	2)	5)	8)
	3)	6)	9)

How satisfied?

6-very satisfied	5-fairly satisfied	4-a little satisfied	3-a little dissatisfied	2-fairly dissatisfied	1-very dissatisfied

8. Whom can you really count on to distract you from your worries when you feel under stress?

No one	1)	4)	7)
	2)	5)	8)
	3)	6)	9)

How satisfied?

6-very satisfied	5-fairly satisfied	4-a little satisfied	3-a little dissatisfied	2-fairly dissatisfied	1-very dissatisfied

9. Whom can you really count on to be dependable when you need help?

No one	1)	4)	7)
	2)	5)	8)
	3)	6)	9)

How satisfied?

6-very satisfied	5-fairly satisfied	4-a little satisfied	3-a little dissatisfied	2-fairly dissatisfied	1-very dissatisfied

10. Whom could you really count on to help you out if you had just been fired from your job or expelled from school?

No one	1)	4)	7)
	2)	5)	8)
	3)	6)	9)

How satisfied?

6-very satisfied	5-fairly satisfied	4-a little satisfied	3-a little dissatisfied	2-fairly dissatisfied	1-very dissatisfied

11. With whom can you totally be yourself?

No one	1)	4)	7)
	2)	5)	8)
	3)	6)	9)

How satisfied?

6-very satisfied	5-fairly satisfied	4-a little satisfied	3-a little dissatisfied	2-fairly dissatisfied	1-very dissatisfied

12. Whom do you feel really appreciates you as a person?

No one	1)	4)	7)
	2)	5)	8)
	3)	6)	9)

How satisfied?

6-very satisfied	5-fairly satisfied	4-a little satisfied	3-a little dissatisfied	2-fairly dissatisfied	1-very dissatisfied

13. Whom can you really count on to give you useful suggestions that help you to avoid making mistakes?

No one	1)	4)	7)
	2)	5)	8)
	3)	6)	9)

How satisfied?

6-very satisfied	5-fairly satisfied	4-a little satisfied	3-a little dissatisfied	2-fairly dissatisfied	1-very dissatisfied

14. Whom can you count on to listen openly and uncritically to your innermost feelings?

No one	1)	4)	7)
	2)	5)	8)
	3)	6)	9)

How satisfied?

6-very satisfied	5-fairly satisfied	4-a little satisfied	3-a little dissatisfied	2-fairly dissatisfied	1-very dissatisfied

15. Who will comfort you when you need it by holding you in their arms?

No one	1)	4)	7)
	2)	5)	8)
	3)	6)	9)

How satisfied?

6-very satisfied	5-fairly satisfied	4-a little satisfied	3-a little dissatisfied	2-fairly dissatisfied	1-very dissatisfied

16. Whom do you feel would help if a good friend of yours had been in a car accident and was hospitalized in serious condition?

No one	1)	4)	7)
	2)	5)	8)
	3)	6)	9)

How satisfied?

6-very satisfied	5-fairly satisfied	4-a little satisfied	3-a little dissatisfied	2-fairly dissatisfied	1-very dissatisfied

17. Whom can you really count on to help you feel more relaxed when you are under pressure or tense?

No one	1)	4)	7)
	2)	5)	8)
	3)	6)	9)

How satisfied?

6-very satisfied	5-fairly satisfied	4-a little satisfied	3-a little dissatisfied	2-fairly dissatisfied	1-very dissatisfied

18. Whom do you feel would help if a family member very close to you died?

No one	1)	4)	7)
	2)	5)	8)
	3)	6)	9)

How satisfied?

6-very satisfied	5-fairly satisfied	4-a little satisfied	3-a little dissatisfied	2-fairly dissatisfied	1-very dissatisfied

19. Who accepts you totally, including both your worst and your best points?

No one	1)	4)	7)
	2)	5)	8)
	3)	6)	9)

How satisfied?

6-very satisfied	5-fairly satisfied	4-a little satisfied	3-a little dissatisfied	2-fairly dissatisfied	1-very dissatisfied

20. Whom can you really count on to care about you, regardless of what is happening to you?

No one	1)	4)	7)
	2)	5)	8)
	3)	6)	9)

How satisfied?

6-very satisfied	5-fairly satisfied	4-a little satisfied	3-a little dissatisfied	2-fairly dissatisfied	1-very dissatisfied

21. Whom can you really count on to listen to you when you are very angry at someone else?

No one	1)	4)	7)
	2)	5)	8)
	3)	6)	9)

How satisfied?

6-very satisfied	5-fairly satisfied	4-a little satisfied	3-a little dissatisfied	2-fairly dissatisfied	1-very dissatisfied

22. Whom can you really count on to tell you, in a thoughtful manner, when you need to improve in some way?

No one	1)	4)	7)
	2)	5)	8)
	3)	6)	9)

How satisfied?

6-very satisfied	5-fairly satisfied	4-a little satisfied	3-a little dissatisfied	2-fairly dissatisfied	1-very dissatisfied

23. Whom can you really count on to help you feel better when you are feeling generally down-in-the-dumps?

No one	1)	4)	7)
	2)	5)	8)
	3)	6)	9)

How satisfied?

6-very satisfied	5-fairly satisfied	4-a little satisfied	3-a little dissatisfied	2-fairly dissatisfied	1-very dissatisfied

24. Whom do you feel truly loves you deeply?

No one	1)	4)	7)
	2)	5)	8)
	3)	6)	9)

How satisfied?

6-very satisfied	5-fairly satisfied	4-a little satisfied	3-a little dissatisfied	2-fairly dissatisfied	1-very dissatisfied

25. Whom can you count on to console you when you are very upset?

No one	1)	4)	7)
	2)	5)	8)
	3)	6)	9)

How satisfied?

6-very satisfied	5-fairly satisfied	4-a little satisfied	3-a little dissatisfied	2-fairly dissatisfied	1-very dissatisfied

26. Whom can you really count on to support you in major decisions you make?

No one	1)	4)	7)
	2)	5)	8)
	3)	6)	9)

How satisfied?

6-very satisfied	5-fairly satisfied	4-a little satisfied	3-a little dissatisfied	2-fairly dissatisfied	1-very dissatisfied

27. Whom can you really count on to help you feel better when you are very irritable, ready to get angry at almost anything?

No one	1)	4)	7)
	2)	5)	8)
	3)	6)	9)

How satisfied?

6-very satisfied	5-fairly satisfied	4-a little satisfied	3-a little dissatisfied	2-fairly dissatisfied	1-very dissatisfied

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TO SCORE SSQ:

1. Add total number of people for all 27 items. (Max. score is 243). This gives you SSQ Number Score, or SSQN.
2. Total Satisfaction scores for all 27 items (Max. = 162). This gives you SSQ Satisfaction score or SSQS.
3. You can also add up total number of people that are family members and that can give the SSQ Family score.

Reference for reliability and validity of SSQ in addition to 1983 Sarason, Levine, Basham, and Sarason article:

Heitzmann, C.A. and Kaplan, R.M. (1988). Assessment of methods for measuring social support. Health Psychology, 1(1), 75-109.

Appendix P
Summary Table For Two Factor MANOVA Of Gender With Type I Mean PTSD Responses

Type I Responses*	Male (n=48)		Female (n=36)		F Ratio
	$\bar{X}$	(sd)	$\bar{X}$	(sd)	
Reexperiencing	12.99	2.1	11.92	3.3	.743(ns)
Avoidance	22.60	3.2	21.99	3.9	
Hyperactive	14.35	4.	13.58	4.9	

* MANOVA clusters for of Type I responses for gender

Appendix Q
Summary Table For MANCOVAs on Type I Responses

	Adjusted Main Effect Means						Covariate Significance		
	Gp.1		Gp.2		Gp.3		F Ratio	Age	Course
Type I Responses	$\bar{X}$	(sd)	$\bar{X}$	(sd)	$\bar{X}$	(sd)	.331(ns)		
Reexperiencing	11.24	2.56	13.26	2.76	13.35	2.51		ns	ns
Avoidance	21.26	3.87	23.25	2.99	22.29	2.65		ns	ns
Hyperarousal	12.21	2.76	15.02	3.87	15.16	2.88		ns	ns

Appendix R
Summary Table For MANCOVAs On Type I Responses

	Adjusted Main Effect Means						Covariate Significance		
	Gp.1		Gp.2		Gp.3		F Ratio	Sex	Course
Type I Responses	$\bar{X}$	(sd)	$\bar{X}$	(sd)	$\bar{X}$	(sd)			
Reexperiencing	11.03	3.88	13.52	3.22	13.28	2.65	.218(ns)	ns	ns
Avoidance	20.98	3.33	23.55	2.8	22.37	2.87		ns	ns
Hyperarousal	11.92	2.19	15.30	2.78	15.16	1.98		ns	ns

Appendix S
Summary Table For Two Factor MANOVA Of Gender With Mean Type II Responses

	Male (n=48)		Female (n=36)		F Ratio
Gender Type II PTSD Responses*	$\bar{X}$	(sd)	$\bar{X}$	(sd)	.743(ns)
Reexperiencing	12.99	3.8	11.92	4.4	
Avoidance	22.60	3.3	21.99	3.3	
Hyperarousal	14.38	2.7	13.58	2.2	
Assault Anxiety	11.38	3.3	11.09	4.6	
Gender Type II Coping Responses*					.803(ns)
	$\bar{X}$	(sd)	$\bar{X}$	(sd)	
CITES-FVF PTSD	50.08	2.3	48.10	3.4	
CDI	8.96	4.3	7.20	3.3	
Dissociation	15.3	2.2	14.41	3.1	
ACI (Anger)	150.14	2.4	147.32	3.8	
CDI (Anger)	55.87	3.3	56.23	2.1	
Gender Type II Coping Attribution Responses*					.363(ns)
	$\bar{X}$	(sd)	$\bar{X}$	(sd)	
CITES-FVF (Attributions)	69.18	5.2	66.15	4.8	
CASQ	4.45	3.5	4.66	4.6	
Gender Type II Coping Anger Control Inventory*					.751(ns)
	$\bar{X}$	(sd)	$\bar{X}$	(sd)	
Intensity of Arousal	26.84	4.6	26.33	4.6	
Arousal Duration	10.46	3.4	10.7	4.1	
Maladaptive Cognition	29.94	2.9	30.08	3.3	
Maladaptive Behaviours	21.66	4.5	21.74	3.5	
Cognitive Deficits	39.43	4.5	37.57	3.6	
Behaviour Deficits	21.78	3.9	20.86	2.9	
Gender Type II Coping CITES-FVF Attributions*					.383(ns)
	$\bar{X}$	(sd)	$\bar{X}$	(sd)	
Self-Blame/Guilt	12.1	4.9	11.92	5.	
Dangerous World	18.55	6.9	17.46	6.2	
Personal Vulnerability	26.39	8.	24.73	7.8	
Empowerment	13.94	4.8	13.89	6.	

* MANOVA clusters of Type II responses for gender

Appendix T
Summary Table For MANCOVAs on Type II Responses

	Adjusted Main Effect Means						Covariate Significance		
	Gp.1		Gp.2		Gp.3		F Ratio	Age	Severity
Type II Responses	$\bar{X}$	(sd)	$\bar{X}$	(sd)	$\bar{X}$	(sd)	1.04 (ns)		
CITES-FVF PTSD	47.66	9.4	59.0	9.3	49.27	8.4		.01*	ns
CDI	8.79	2.1	9.71	2.2	6.71	3.3		ns	ns
Dissociation	12.69	3.5	17.12	4.5	15.01	4.2		ns	ns
ACI	142.97	14.9	158.37	16.7	145.81	14.9		ns	ns
CIA	51.83	10.	59.77	12.5	56.77	10.5		ns	ns
Type II Attributional Responses							1.49 (ns)		
	$\bar{X}$	(sd)	$\bar{X}$	(sd)	$\bar{X}$	(sd)			
CITES-FVF Attributions	65.17	7.8	69.77	8.8	68.77	7.8		.02*	
CASQ	4.26	2.3	3.40	3.2	5.83	3.1		ns	ns
Type II CITES-FVF PTSD Responses							.928 (ns)		
	$\bar{X}$	(sd)	$\bar{X}$	(sd)	$\bar{X}$	(sd)			
Reexperiencing	12.26	4.4	13.32	5.12	12.43	4.5		ns	ns
Avoidance	22.7	4.7	22.69	7.8	22.7	6.7		.03*	ns
Hyperarousal	13.36	4.9	14.88	6.8	14.37	5.7		.01*	ns
Assault Anxiety	10.66	5.7	11.29	5.8	11.86	4.6		.02*	ns
Type IICITES-FVF Attributional Responses							2.03 (ns)		
	$\bar{X}$	(sd)	$\bar{X}$	(sd)	$\bar{X}$	(sd)			
Dangerous World	17.46	6.7	18.03	7.4	18.76	6.7		.03*	ns
Self Blame/Guilt	11.94	5.6	12.7	6.11	11.59	5.66		ns	ns
Empowerment	13.59	5.6	13.55	6.5	14.59	5.77		ns	ns
Personal Vulnerability	24.48	7.8	27.51	7.88	24.75	7.53		.01	ns
Type II Anger Control Inventory							.942 (ns)		
	$\bar{X}$	(sd)	$\bar{X}$	(sd)	$\bar{X}$	(sd)			
Intensity of Arousal	25.35	13.22	28.04	14.3	25.95	1.8		ns	ns
Arousal Duration	10.19	3.66	11.57	5.5	9.94	3.33		ns	ns
Cognitive Deficits	38.01	5.4	39.36	6.77	38.7	3.21		ns	ns
Behaviour Deficits	20.31	4.38	22.35	5.87	21.5	3.21		ns	ns
Maladaptive Cognitions	27.84	5.11	33.8	5.	28.59	2.98		ns	ns
Maladaptive Behaviours	20.75	3.25	23.24	4.5	21.11	4.21		ns	ns

Appendix U
Summary Table For MANCOVAs on Type II Responses

	Adjusted Main Effect Means						Covariate Significance		
	Gp. 1		Gp.2		Gp.3		F Ratio	Sex	Sever.
Type II Responses							.491(ns)		
	$\bar{X}$	(sd)	$\bar{X}$	(sd)	$\bar{X}$	(sd)			
CITES-FVF PTSD	50.42	4.33	50.62	4.2	46.75	3.86		ns	ns
COI	8.97	2.33	9.57	3.21	6.24	3.67		ns	ns
Dissociation	14.15	3.98	17.05	3.87	13.62	2.98		ns	ns
ACI	147.32	13.87	157.44	14.87	142.39	12.65		ns	.03*
CIA	53.36	8.54	59.41	7.65	55.45	6.87		ns	ns
Type II Attributional Responses							.226(ns)		
	$\bar{X}$	(sd)	$\bar{X}$	(sd)	$\bar{X}$	(sd)			
CITES-FVF Attributions	68.18	3.65	69.53	4.98	66.	3.44		ns	ns
CASQ	4.09	1.8	3.56	1.22	5.84	2.10		ns	.01*
Type II CITES-FVF PTSD Responses							.419(ns)		
	$\bar{X}$	(sd)	$\bar{X}$	(sd)	$\bar{X}$	(sd)			
Reexperiencing	13.16	3.45	13.23	3.76	11.63	2.88		ns	ns
Avoidance	22.69	4.5	22.64	3.45	22.70	3.98		ns	ns
Hyperarousal	14.61	2.91	14.73	3.11	13.26	2.98		ns	.01*
Assault Anxiety	11.26	2.65	11.26	1.98	11.29	2.61		ns	ns
Type II CITES-FVF Attributional Responses							.118(ns)		
	$\bar{X}$	(sd)	$\bar{X}$	(sd)	$\bar{X}$	(sd)			
Dangerous World	18.6	4.8	17.91	3.8	17.74	4.8		ns	ns
Self Blame/Guilt	12.50	3.9	12.63	2.18	11.09	2.7		ns	.01*
Empowerment	13.56	2.76	13.57	3.87	14.61	2.91		ns	ns
Personal Vulnerability	25.40	1.34	27.46	2.80	24.25	3.18		ns	ns
Type II Anger Control Inventory							.758(ns)		
	$\bar{X}$	(sd)	$\bar{X}$	(sd)	$\bar{X}$	(sd)			
Intensity of Arousal	27.17	2.87	27.76	2.80	24.25	2.82		ns	ns
Arousal Duration	10.99	3.87	11.40	2.86	9.30	3.98		ns	ns
Cognitive Deficits	38.11	2.81	39.37	2.74	38.58	3.84		ns	ns
Behaviour Deficits	19.94	2.	22.44	3.12	21.78	2.99		ns	ns
Maladaptive Cognitions	29.48	3.99	33.43	2.77	27.32	3.11		ns	ns
Maladaptive Behaviours	21.60	3.76	23.02	3.66	20.47	2.87		ns	.02*

*p <.05

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