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Posttraumatic Stress among Young Urban Children Exposed to Family Violence and Other Potentially Traumatic Events

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Abstract

This study examines the relationship between the number of types of traumatic events experienced by children 3 to 6 years old, parenting stress, and children's posttraumatic stress (PTS). Parents/caregivers provided data for 154 urban children admitted into community-based mental health and/or developmental services. By parent/caregiver report, children experienced an average of 4.9 different types of potentially traumatic events. Nearly one-quarter of the children evidenced clinically significant PTS. PTS was positively and significantly related to family violence and other family-related trauma exposure, nonfamily violence/trauma exposure, and parenting stress. Additionally, parenting stress partially mediated the relationship between family violence/trauma exposure and PTS. This study highlights the need for early violence/trauma exposure screening in help-seeking populations so that appropriate interventions are initiated.

Childhood exposure to violence and maltreatment negatively impacts neurobiological development and psychological and social functioning (Schechter & Willheim, 2009), and is strongly correlated with poor physical and mental health outcomes in adulthood (Anda et al., 2006). Child maltreatment (e.g., all forms of physical and/or emotional ill-treatment, sexual abuse, neglect, or negligent treatment), intimate partner violence (IPV), and household dysfunction (e.g., mental illness, alcohol/drug abuse, criminal behavior) are highly-interrelated family-based traumatic events (Dong et al., 2004) that place a child at high risk

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for exposure to other traumatic experiences (Edleson, 1999; Finkelhor, Ormrod, & Turner, 2007). The majority of maltreatment and family violence occurs during the first 5 years of life (Fantuzzo & Fusco, 2007; U.S. Department of Health and Human Services, 2007), when the developing brain is most vulnerable to the negative effects of trauma. Moreover, early childhood is a time when parental stress or psychopathology has the greatest impact on children's experience of and response to traumatic events (Schechter & Willheim, 2009). However, research on young children's exposure to family violence and other family-related traumatic events and childhood outcomes is limited, and information is needed to understand the impact of different types of trauma and potential mediating or moderating factors. This study examined the relationships between the number of types of traumatic and family violence/trauma events experienced by young children (3 to 6 years old), parenting stress, and children's posttraumatic stress (PTS).

Children under 7 years old are at increased risk for exposure to IPV (Fantuzzo, Boruch, Beriama, Atkins, & Marcus, 1997; Fantuzzo & Fusco, 2007) and have the highest rates of maltreatment victimization (U.S. Department of Health and Human Services, 2007). In a study of parent and partner violence in 453 families with children aged 7 years and younger, Smith Slep and O'Leary (2005) found that in 90%, some type of physical aggression (IPV and/or parent-to-child) had occurred in the past year. Additionally, one quarter of families reported severe partner aggression. Chronic maltreatment during infancy and through the preschool years has been linked with more maladaptive outcomes and may be more detrimental than later exposure because of the salience of attachment formation and the capacity to resolve developmental tasks during this period. Compared to maltreatment during infancy-toddlerhood or middle childhood, maltreatment during the preschool years (3 to 6 years of age) was found to be significantly related to the most severe externalizing symptoms (Manly, Kim, Rogosch, & Cicchetti, 2001).

Although experiencing one traumatic event can lead to serious consequences, research on early childhood exposure to multiple risk factors, where the likelihood of negative outcomes increases as the number of risk factors increases, suggests that exposure to multiple traumatic events may increase the severity of impact on the child. The number of risk factors a child experiences is the most relevant predictor of outcomes for young children (Appleyard, Egeland, van Dulmen, & Sroufe, 2005; Atzaba-Poria, Pike, & Deater-Deckard, 2004; Sameroff, 2000). Some studies (e.g., Greenberg, Speltz, DeKlyen, & Jones, 2001) have found a threshold effect where a significant increase in risk of developing psychopathology is found if a preschool aged child was exposed to a particular number of risk factors. Alternatively, other studies (e.g., Appleyard et al., 2005) have found a linear effect where children in early and middle childhood with higher levels of exposure to risk are more impaired. Recent research suggests that the impact of risk exposure in early childhood is highly predictive of adolescent behavioral outcomes even after controlling for risk exposure in middle childhood (Appleyard et al., 2005), suggesting the need to intervene early with young children at risk. Similar results have been found regarding the cumulative risk specific to exposure to family violence and other traumatic events. Specifically, children from early childhood through early adolescence who witnessed IPV and experienced abuse exhibited more negative behavior problems than children who witnessed only, followed by children who did not experience IPV or abuse (see Edleson, 1999 for a review). This

research highlights the importance of assessing a history of exposure to family violence and other traumatic events, and examining the rates of exposure.

Children's exposure to multiple types of family violence and other traumatic events also increases their chances of developing posttraumatic stress disorder (PTSD; Margolin & Vickerman, 2007). Exposure to family violence can result in negative social, emotional, cognitive, and behavioral outcomes for children of all ages (Fowler & Chanmugam, 2007), some of which may be measured by the posttraumatic stress construct (Briere et al., 2001). Elevated PTS symptoms have been found for school-aged children who had violent and sexual abuse histories or multiple exposures to traumatic events (Copeland, Keeler, Angold, & Costello, 2007) and for preschool children who have witnessed domestic violence (Lieberman, Van Horn, & Ozer, 2005). In early childhood, chronic exposure to family violence and other traumatic events impacts neurobiological development in ways analogous to an environmental toxin (Schechter & Willheim, 2009), with negative effects on biological processes, cognitive functioning, and emotion regulation. The PTS construct assesses symptoms of maladjustment in these areas, including arousal, avoidance, anxiety, depression, and dissociation. PTS is an important outcome to study in young children and encompasses a range of emotional and behavioral responses to family violence and trauma (Briere et al., 2001; Pollio, Glover-Orr, & Wherry, 2008).

Caregiver support and family functioning are critical mediating or moderating factors for how children 6 years old and younger respond trauma exposure (Lieberman & Knorr, 2007; Scheeringa & Zeanah, 2001) and for how trauma exposure is related to negative behavioral outcomes (English, Marshall, & Stewart, 2003; Trentacosta et al., 2008). For young children, the caregiver is an "external regulator," and is crucial for self-regulation development. Therefore, the child's ability to manage stress, such as exposure to violence or other traumatic events, is largely determined by the caregiver's response and his/her ability to help restore a sense of safety (Scheeringa & Zeanah, 2001). Mothers of young children who are involved in violent interpersonal relationships are at increased risk for stress and depression (Huth-Bocks, Levendosky, & Semel, 2001), which can impact parenting capacity. This suggests that parenting stress should be included when exploring the relationships between family violence, family-related trauma, and young children's emotional and behavioral outcomes.

Despite the documented impact of family violence and other traumatic events on young children, rates of exposure to family violence, family-related trauma, and the impact of parenting stress among this group of children and their caregivers has not been established. Research on exposure to traumatic events in young children comprises a major gap in knowledge (Scheeringa, Zeanah, Myers, & Putnam, 2003) and including young children in research may reveal important differences for how maltreatment and family violence manifests during this vulnerable period. Moreover, an examination of the impact of exposure to different types of traumatic events in early childhood could illuminate how cumulative traumatic events impact negative outcomes and posttraumatic symptoms above and beyond dichotomous classifications of children as exposed versus not exposed.

For this study, we identified exposure to family violence and other traumatic events among children 3 to 6 years old who live in an urban community, are from low socio-economic status backgrounds, and whose parents or caregivers sought mental health/developmental services to address the children's difficulties. We also examined the relationships between children's exposure to different types of traumatic events, parenting stress, and children's trauma-related symptoms. Given the distinguishing features of family-related violence and trauma (occurs in the context of ongoing important relationships among people who depend on each other or are supposed to care for or protect each other) from other forms of violence (Tolan, Gorman-Smith, & Henry, 2006), we examined the unique effect of family violence and family-related trauma versus nonfamily violence or trauma on parenting stress and children's PTS. Finally, we examined the mediating role of parenting stress between children's trauma experiences and PTS symptoms. Establishing rates of exposure to multiple traumatic events and levels of clinically significant posttraumatic distress in young children and their relationship with parenting stress is an important contribution. It is particularly important to assess young children who are brought to professionals for mental health and/or developmental services, given that this group may be especially open to intervention if recommended by a trusted provider. Furthermore, focusing promotion and prevention efforts on young children and their families increases the likelihood that problems will be addressed early, before they evolve into full blown disorders, and allows for the inclusion of protective and risk factors as targets for preventive intervention (Substance Abuse and Mental Health Services Administration, 2007).

Method

Participants

This study was conducted over a 2-year period in an impoverished and densely populated urban community in the Northeast United States. We gathered data as part of an evaluation of a community-wide, 6-year family violence initiative funded by the national Safe Start Demonstration Project of the Office of Juvenile Justice and Delinquency Prevention. Families in the study were seeking mental health, developmental screening and assessment, and/or intervention services for their children. For the 78 children (51%) with referral data, community agencies referred them most frequently for: social, emotional, and/or behavioral concerns ($n = 66, 42.9\%$), parent support/education ($n = 36, 23.4\%$), developmental issues/concerns ($n = 22, 14.3\%$), and exposure to violence and abuse ($n = 20, 13.0\%$). On average, children were referred for 2.3 reasons ($SD = 1.7$, range 0 – 8 reasons): 9.1% of children had emotional/behavioral concerns and developmental issues/concerns, 5.2% had emotional/behavioral concerns and violence exposure, 4.5% had emotional/behavioral concerns, developmental issues/concerns, and violence exposure. In most cases, biological mothers completed assessment instruments. The sample included 154 children who were predominantly male (57%) and of ethnic/racial minority status, with a mean age of 4.4 years ($SD = 0.8$). Most of the families (81.2%) were Medicaid eligible, indicating incomes less than 185% of the Federal poverty level. The sociodemographic composition of the sample, which is consistent with the racial/ethnic and income composition of the city, is shown in Table 1.

Procedure

Upon service entry, clinicians at funded programs asked all families to complete three measures. Clinicians were asked to screen all referrals for family violence exposure given the focus of the initiative. Data were collected in English or Spanish, depending on the respondent's preference and all measures were read aloud to address any literacy issues. Caregivers were informed of the evaluation procedures verbally and in writing and signed a release of information form allowing staff to share data with the researchers. The Yale University School of Medicine Institutional Review Board approved all study procedures and provided oversight in the protection of human research participants.

Measures

The Traumatic Events Screening Inventory–Parent Report Revised–Brief Version is a 24-item semi-structured interview that can be used in a variety of settings to determine the exposure history of children, ages 6 years and younger, to traumatic events (Ghosh-Ippen et al., 2002). The inventory has been validated against another measure of children's violence exposure (Berent et al., 2008). Caregivers were presented with 24 potentially traumatic events and were asked to respond (yes, no, unsure) to indicate if the child had ever experienced them. To determine children's eligibility to receive services funded by the initiative and for purposes of this study, 12 of the 24 scale items were used to assess a history of exposure to family violence or other family-related trauma (see Table 2). The different types of family and nonfamily violence and trauma events were summed to create a total score for each.

The Trauma Symptom Checklist for Young Children is a 90-item validated questionnaire that assesses trauma- and abuse-related symptoms for children ages 3 through 12 years (Briere et al., 2001). Using a 4-point scale ranging from *not at all* to *very often*, caretakers rated the frequency with which the child demonstrated behaviors/symptoms, such as temper tantrums and bad dreams, during the previous month. The checklist consists of nine clinical scales, which are summed to score the instrument, and two validity scales. The clinical subscales are scored for anxiety, depression, anger/aggression, dissociation, sexual concerns, as well as for the posttraumatic stress symptoms of intrusion, avoidance, arousal, and the posttraumatic stress–total score (the sum of the scores for intrusion, avoidance, and arousal). For the nine clinical scales, T scores at or above 70 are clinically significant, scores in the 65–69 range are subclinical but potentially problematic, and scores less than or equal to 64 are in the normal range. Inter-item reliability for the clinical subscales for the sample ranged from .71 to .92. Because of moderate skewness, the log transformation of the posttraumatic stress – total score was used for the analyses.

The Parenting Stress Index Short Form is a 36-item caregiver-report questionnaire used to assess stress in the caregiver-child relationship for children 10 years and younger (Abidin, 1995). The questionnaire consists of statements, rated on a 5-point Likert scale, ranging from *strongly disagree* to *strongly agree*. It produces a total scale score (Total Stress) and scores for three subscales: Parental Distress (distress related to the parenting role); Parent-Child Dysfunctional Interaction (disappointment in and alienation from the parent-child bond); and Difficult Child (assessment of child's difficult behaviors). The items within each

subscale are summed up to score the questionnaire. Total Stress is quantified by summing all three subscales; higher scores indicate higher levels of parenting stress. Caregivers were asked to respond to items such as, “Since having this child I feel that I am almost never able to do things that I like to do,” “My child smiles at me much less than I expected,” and “My child gets upset easily over the smallest thing.” The inter-item reliability for the full sample ranged from .51 for the Parent-Child Difficult Interaction subscale to .89 for the Difficult Child subscale. The alpha value for the total scale was .84. Because of moderate skewness, the log transformation of the total scale score was used for the analyses.

Data Analysis

Differences between genders, age and racial/ethnic groups on the Trauma Symptom Checklist for Young Children and on the Traumatic Events Screening Inventory–Parent Report Revised–Brief Version were assessed using *t* tests and ANOVAs. A path analysis was employed to test the direct relationships between the predictors (child’s age, family violence/trauma event exposure, nonfamily violence/trauma event exposure, log of total parenting stress) and the outcome variable (log of child’s posttraumatic stress total score). After examining direct relationships between the variables, a test was performed to assess the potential mediating role of parental stress within the model. Sobel tests (Sobel, 1986) were conducted to assess the statistical significance of indirect relationships between three predictors (child’s age, family violence and other family-related trauma events, and nonfamily violence/trauma events) and posttraumatic stress symptoms through the hypothesized mediator – parenting stress – based upon procedures outlined by Preacher and Hayes (2004) and MacKinnon and Lockwood (2003). The path model was analyzed using the MPlus statistical package (Muthén & Muthén, 2007), which uses Full Information Maximum Likelihood (FIML) to manage missing data.

Results

We used the Traumatic Events Screening Inventory–Parent Report Revised–Brief Version to assess rates of exposure to family violence and to other potentially traumatic events. Children were exposed to an average of 4.87 different types of potentially traumatic events in their lifetime ($SD = 2.9$; range = 0–13), independent of the child’s gender, $t < 1$ or race/ethnicity, $F(4,149) = 1.14$, *ns*. Children experienced a mean of 2.8 ($SD = 1.8$) different types of family violence and other family-related trauma events and 2.1 ($SD = 1.7$) different types of nonfamily violence/trauma events. Over 48% of the children experienced five or more potentially traumatic events, indicating that exposure to potentially traumatic events is common. A list of the types of potentially traumatic events that children’s caregivers endorsed and the prevalence of those events are displayed in Table 2.

Nearly one-quarter (23.4%) of the children had scores consistent with clinically significant PTS (T score ≥ 70), and another 16.2% scored in the subclinical but potentially problematic range. The percentage of children in the subclinical range suggests that, although their symptoms are not clinically significant, these children may still experience difficulties that warrant prevention/early intervention services. PTS scores did not differ by gender, $t < 1$ or by race/ethnicity, $F(4,146) = 1.04$, *ns*. The mean scores and frequencies for the Trauma

Symptom Checklist for Young Children subscales are shown in Table 3. Over 20% of the children were in the clinically significant range for the majority of subscales including Anger/Aggression (27.9%), Depression (22.1%), PTS Intrusion (22.1%), PTS Avoidance (21.4%), PTS Arousal (22.1%) and the PTS Total Score (23.4%).

Parenting stress was assessed using the Parenting Stress Index Short Form. Fifty-one percent of caregivers were in the clinically significant range (90th percentile) on the Total Stress scale with a mean score of 91.1 ($SD = 25.6$). Of these caregivers, nearly 20% reached the 99th percentile, indicating extremely high levels of stress in their parenting role and suggesting the need for further assessment and intervention. For the subscales, 42% were in the clinically significant range (85th percentile) on the Parental Distress subscale with a mean of 31.0 ($SD = 9.5$), 45% were in the clinically significant range on the Parent-Child Dysfunctional Interaction subscale with a mean of 25.8 ($SD = 12.1$), and 56% were in the clinically significant range on the Difficult Child subscale with a mean of 34.5 ($SD = 10.4$).

Finally, a path analysis was used to test the hypotheses that violence and trauma exposure would be positively related to posttraumatic stress and that caregiver/parenting stress would mediate the relationship between family violence and other trauma event exposure and posttraumatic stress in young children. Results of the overall path analysis are presented in Figure 1. The direct relationship between child's age and [log of] posttraumatic stress symptoms was not significant ($\beta = .08$, *ns*). However, the relationships between posttraumatic stress and family violence and other family-related trauma events ($\beta = 0.19$, $p < .05$), nonfamily violence/trauma events ($\beta = 0.18$, $p < .05$), and the parenting stress index ($\beta = 0.34$, $p < .001$) were all significant and positive. These results suggest that exposure to family and other family-related trauma and nonfamily violence/trauma events are significantly related to higher posttraumatic stress symptomatology. In addition, higher levels of parenting stress appears to be significantly related to more posttraumatic stress symptoms in the child.

The direct relationship between child's age and the [log of] Parenting Stress Index Short Form was not significant ($\beta = 0.10$, *ns*). The direct relationship between nonfamily violence/trauma events and [log of] parenting stress was also not significant ($\beta = 0.02$, *ns*). However, the direct relationship between family violence and other family-related trauma events and [log of] parenting stress was significant ($\beta = 0.20$, $p < .05$), suggesting that exposure to more family violence and family-related trauma events was related to significantly higher stress in the caregiver.

Sobel tests examined the potential mediating effect of parenting stress on the relationships between the predictors and posttraumatic stress symptoms. Results of the Sobel tests found that the indirect paths for age ($z = 1.21$, *ns*) and nonfamily violence/trauma events ($z = 0.21$, *ns*) were not significant. However, the indirect effect for family violence and other family-related trauma events was significant ($z = 2.51$, $p < .05$). There was a small to moderate effect for the relationship between family violence and trauma events and posttraumatic stress symptoms (.26) and a small effect size when parenting stress was included as a mediator between this relationship (.20). Therefore, there appears to be a moderate partial mediation for parenting stress.

Discussion

We examined the traumatic experiences and characteristics of young children, living in an urban environment with a high rate of poverty, whose caregivers sought mental health and/or developmental services. Based on caregiver reports, our results indicate that it is common for this population of young children between 3 and 6 years old to experience multiple potentially traumatic events, many of which involve family violence and family-related trauma. Over 48% of this sample experienced five or more potentially traumatic events. These findings are consistent with previous research on clinical samples, in which between 50% and 81% of maltreated children experienced multiple types of abuse (Walrath, Ybarra, Sheehan, Holden, & Burns, 2006) and higher than data from a community sample where 10.9% of children reported five or more direct exposures to violence in the past year (David Finkelhor, Turner, Ormrod, Hamby, & Kracke, 2009). The range of traumas that these young children have experienced supports previous findings that family violence and other trauma occurs in environments where multiple layers of risk might be present (Dong et al., 2004; Finkelhor et al., 2007) while the number of types of trauma experienced place these children at high risk for health and behavioral outcomes during adulthood (Felitti et al., 1998). Finally, we found that children's reactions to family violence and other family-related trauma are shaped by the level of parenting stress, suggesting that interventions for children also should address caregivers' needs.

Nearly one-quarter of the study children, independent of their gender or racial/ethnic background, experienced clinically significant posttraumatic distress, and an additional 16% suffered symptoms in the subclinical but symptomatic range. Moreover, this study found a direct relationship between the number of types of potentially traumatic events and clinically significant distress. This is consistent with recent research suggesting that the impact of multiple types of trauma exposure has an additive effect and is associated with a greater risk for negative outcomes (Edleson, 1999; Wolfe, Crooks, Lee, McIntyre-Smith, & Jaffe, 2003).

Previous research also has demonstrated that caregiver and family factors impact children's response to traumatic events (Scheeringa & Zeanah, 2001; Leiberman & Knorr, 2007). This study uniquely highlights the importance of caregiver adjustment, particularly parenting stress, as an important mechanism determining the psychological well-being of young children exposed to traumatic events.

This study supports the American Academy of Pediatrics' recommendation that health care professionals conduct family violence screenings for young children seen in pediatric settings to identify and meet the needs of these children (Holtrop et al., 2004; Siegel, Hill, Henderson, Ernst, & Boat, 1999). Given that children in this age range often attend early care and education settings, it also is vital to develop appropriate screening procedures for these settings. The findings from this study further indicate the importance of screening young children for exposure to a range of potentially traumatic events and of assessing the impact of exposure to these events and point to the need to screen for distress in both the child and the caregiver. Screening for violence/trauma exposure can alert providers to the need for specialized trauma-related services for young children and their families. Given the important role that parental stress plays in child well-being, screening of and referrals for

stressed caregivers experiencing stress in the caregiving role, especially those in violent family relationships, are an important component for intervention.

The study sample consisted of children whose caregivers were seeking mental health/developmental services for the children's emotional or behavioral symptoms. Because this was a treatment seeking population, the rates of potentially traumatic events and posttraumatic distress better represent children who present to services rather than children in the general community. Recent work by Finkelhor and colleagues (2009) provides an assessment of rates of exposure in a community sample which includes young children, however, like the current study, Finkelhor and colleagues examined the number of types of traumatic events that children were exposed to and not the frequency of these events or the proximity of the child to the perpetrator. This work is necessary to better understand the rate and intensity of violence exposure for young children.

Potential limitations of the methodology employed in this study are the restricted range of information regarding the onset and duration of posttraumatic symptoms, the limited information about the caregivers themselves, the inability to assess whether a young child perceived a given event as traumatic, the caregiver as the only source of data about children's experiences and functioning, and the caregiver reports of their own level of parenting stress. For young children only observational or parent/caregiver report of posttraumatic symptoms are feasible and appropriate. The time constrictions for program staff who had to collect evaluation/research data upon children's presentation for services prevented use of the longer version of the trauma assessment measure used in this study, which would have yielded more information about the onset, duration, impact, and other characteristics of each trauma event experienced. Time limitations also precluded use of additional measures to assess caregiver adjustment. The impact of traumatic events on the child is difficult to address, particularly among young children. For example, the traumatogenic impact of separation from a caregiver varies tremendously based on the developmental level of the child and the circumstances and length of the separation. We have attempted to account for individual differences in response to similar events by using the term "potentially traumatic events;" However, the use of child-focused research methods (child interviews, play-based assessment, etc.) may better address this concern.

In summary, exposure to family violence and other potentially traumatic events appears to be common among young children growing up in impoverished contexts who experience social, emotional, behavioral, and/or developmental challenges severe enough to seek intervention. This research demonstrates that children's reactions to family violence and trauma are shaped by the level of parenting stress and, therefore, interventions for young children should also address caregiver needs. The prevention of ongoing distress as a result of trauma exposure in young children can be addressed given that a number of empirically supported treatments are available for this age group (Cooper, Masi, Dababnah, Aratani, & Knitzer, 2007); this, as well as early identification of young children at risk for chronic difficulties, are key components for addressing the issues of this population of young children who are at risk for social/emotional, behavioral or developmental difficulties.

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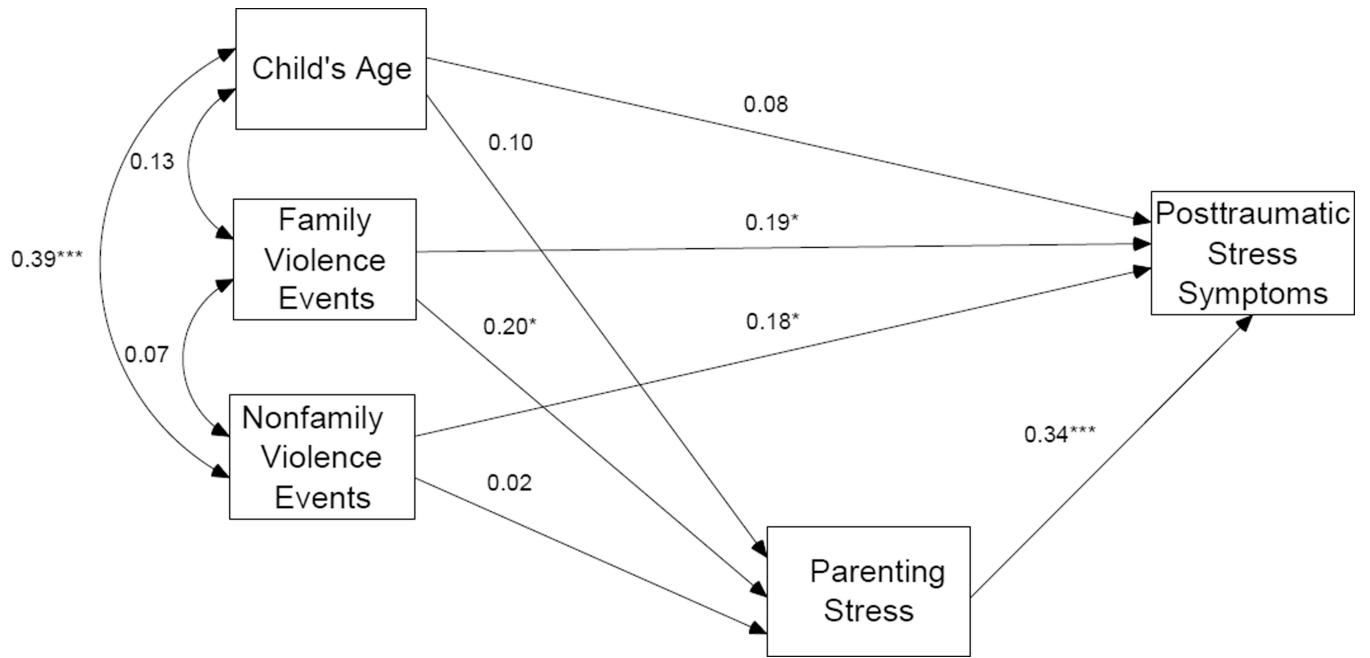


Figure 1.
 Results of Path Analysis Model including standardized coefficients.
 Note. * $p < .05$. *** $p < .001$.

Table 1

Child Characteristics (N = 154)

Characteristic	<i>n</i>	%
Sex		
Male	88	57.1
Female	66	42.9
Race/ethnicity		
White	13	8.4
Black	49	31.8
Latino/Hispanic	67	43.5
Other	7	4.5
No response	18	11.7
Age		
3 years	46	29.9
4 years	64	41.6
5 years	41	26.6
6 years	3	1.9
Medicaid receipt/eligible		
Yes	125	81.2
No	26	16.9
No response	3	1.9

Table 2

Prevalence of Children's Exposure to Potentially Traumatic Events (N = 154)

Type of exposure: Family violence/Family-related trauma events	% endorsed	n
Child has heard or seen people in the family assaulting each other	42.4	65
Child has been separated from caregiver	40.9	63
Family member arrested, jailed, or imprisoned	34.4	53
Child has seen or heard family members threaten to harm each other	28.6	44
Child has been physically assaulted or beaten	18.2	28
Child repeatedly told he/she is no good, yelled at in a scary way, or threatened with abandonment	12.3	19
Child has been without food, water, shelter, etc.	11.0	17
Someone has threatened the child with physical harm	6.5	10
Someone close to the child attempted suicide	5.8	9
Child has been forced to see or do something sexual	5.8	9
Child kidnapped or someone close to the child was kidnapped	2.6	4
Child witnessed someone else forced to engage in sexual activity	1.9	3
Type of exposure: Nonfamily violence events		
Child witnessed physical assault between nonfamily members	27.3	42
Child exposed to war or terrorism on the television or radio	24.7	38
Child experienced serious illness/medical problem	24.7	38
Severe injury or illness in someone close to the child	16.9	26
Death of someone close to the child	14.9	23
Child witnessed a serious accident	9.1	14
Child in a serious accident resulting in injury or death	7.1	11
Child attacked by dog or other animal	3.2	5
Child directly exposed to war or terrorism	2.6	4
Child present during theft or mugging	1.9	3
Child experienced natural disaster	0.6	1

Table 3

Trauma Symptom Checklist for Young Children (n = 154)

Subscale	M	(SD)	Below clinical	n	(%)	Subclinical but problematic	n	(%)	Clinical significance	n	(%)
Anger/Aggression	17.4	(6.5)	73	(47.4)	38	(24.7)	43	(27.9)			
Anxiety	13.8	(3.9)	106	(68.8)	18	(11.7)	29	(18.8)			
Depression	13.0	(3.9)	102	(66.2)	17	(11.0)	34	(22.1)			
Dissociation	11.6	(4.3)	126	(81.8)	13	(8.4)	14	(9.1)			
Sexual Concerns	9.8	(1.8)	126	(81.8)	7	(4.5)	20	(13.1)			
PTS- Intrusion	11.8	(3.6)	108	(70.1)	12	(7.8)	34	(22.1)			
PTS - Avoidance	11.4	(3.7)	107	(69.5)	13	(8.4)	33	(21.4)			
PTS - Arousal	15.2	(4.8)	98	(63.6)	21	(13.6)	34	(22.1)			
PTS - Total Score	38.6	(10.6)	91	(59.1)	25	(16.2)	36	(23.4)			