FITT

Family-Informed
Trauma Treatment Center

A PARTNER IN NCTSN
The National Child Traumatic Stress Network

Understanding the impact of trauma and urban poverty on family systems: Risks, resilience and interventions

This project was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), US Department of Health and Human Services (HHS). The views, policies, and opinions expressed are those of the authors and do not necessarily reflect those of SAMHSA or HHS.

A PARTNER IN NCTSN The National Child Traumatic Stress Network

F I T T
Family-Informed Trauma Treatment Center

Executive Summary:
Understanding the Impact of Trauma and Urban Poverty on Family Systems: Risks, Resilience, and Interventions

Purpose: This white paper reviews the clinical and research literatures on the impact of trauma in the context of urban poverty on the family system including the individual child or adult, adult intimate partnership, parent-child, siblings and intergenerational relationships, as well as the family as a whole. The purpose is to widen the trauma-informed care lens by focusing on familial responses to trauma and by building the foundational knowledge needed to design family centered, trauma-specific interventions that strengthen the family's ability to adapt, cope and heal.

Findings: Families living in urban poverty often encounter multiple traumas over many years. Further, they are less likely than families living in more affluent communities to have access to the resources that may facilitate the successful negotiation of their traumatic experiences. Thus, many families have difficulty adapting.

Repeated exposures can lead to severe and chronic reactions in multiple family members with effects that ripple throughout the family system and, ultimately, society. Research demonstrates that all levels of the family system are impacted:

- **Individual** distress can range from transient symptoms to Posttraumatic Stress Disorder (PTSD) to more complex trauma-related disorders, with the potential to disrupt functioning across multiple domains.
- Though some research indicates that supportive **adult intimate relationships** can be a source of strength in coping with a traumatic experience or dealing with the stress of poverty, the majority focuses on difficulties faced by couples who have experienced trauma, such as problems with communication, difficulty expressing emotion, struggles with sexual intimacy, and high rates of hostility, aggression and interpersonal violence.
- Within the **parent-child relationship**, compromised attachment and mistrust may stem from parental withdrawal/worry and re-enactment of abandonment/betrayal themes.
- Though trauma may not affect the **parenting** practices of all parents, the experiences of chronic trauma and the stress associated with urban poverty have been associated with decreased parental effectiveness, less warmth, limited understanding of child development and needs, increased use of corporal punishment and harsh discipline, high incidents of neglect, and an overall strategy of reactive parenting.
- **Sibling relationships** may become negative and conflictual depending on the quality of individual parent-child relationships, differential treatment of siblings by parents, parental management of sibling conflict, individual children's behavior and emotional regulation and coping skills, and family norms regarding aggression and fairness.
- Research on **intergenerational** trauma and urban poverty has demonstrated that adults with histories of childhood abuse and exposure to family violence have problems with emotional regulation, aggression, social competence, and interpersonal relationships, leading to functional impairments in parenting which transmit to the next generation.

- The **family as a whole** is also impacted by chronic conditions of high stress and exposure to multiple traumas and families often experience chaotic, disorganized lifestyles, inconsistent and/or conflicted relationships, and crisis-oriented coping.

Risk factors contributing to negative outcomes, such as developing trauma-related symptoms or becoming a trauma-organized family system, generally include prior individual or family psychiatric history, history of other previous traumas or adverse childhood experiences, pile up of life stressors, severity/chronicity of traumatic experiences, conflictual or violent family interactions, and lack of social support.

At each subsystem level and at the family system level, the ability to cope adaptively with extremely difficult circumstances is also documented although less emphasized. Some adults and adolescents grow stronger, develop a new appreciation for relationships, and their "why me" questions produce meaningful answers about their life purpose. Adult intimate partners, siblings, and families as a whole often join together around traumatic events, supporting one another and collaborating to deal with adversity and survive or thrive. The literature identifies the following factors as potentially protective including emotional and behavioral regulation, problem-solving skills, resource seeking, sense of efficacy, and spirituality.

Assessment: There are no instruments designed to assess the influence of trauma and urban poverty on families. For this reason, an assessment of family subsystems is recommended using multiple tools that have adequate reliability and validity for measuring specific subsystem impacts.

Interventions: Trauma-specific Cognitive Behavioral Therapy (CBT) for individual family members and for intimate partners has demonstrated efficacy for reducing symptoms of PTSD and depression. In addition, trauma-specific and trauma-adapted treatments targeting parenting practices and parent-child relations have proven efficacy at improving parent-child interactions, communication, trust, and decreasing harshness. There are few well-developed, standardized and empirically supported family therapies for treating family systems impacted by trauma.

Conclusions: Families exposed to urban poverty face a disproportionate risk of exposure to trauma and of becoming trauma-organized systems. Factors associated with urban poverty such as low neighborhood safety, daily hassles, and racial discrimination have been shown to increase the risk that trauma will negatively impact family functioning. The erosion in family functioning jeopardizes the ability of families to make effective use of structured treatment approaches and limits the success of treatments that require family support. Family treatments that are sensitive to the traumatic context of urban poverty, that include engagement strategies that incorporate alliances with primary and extended family systems, that build family coping skills, and that acknowledge cultural variations in family roles and functions are needed to adequately address the needs of this population. Additional treatment development research is needed to advance the child trauma field in its understanding and delivery of trauma-informed services to these families.

Suggested citation: Collins, K., Connors, K., Donohue, A., Gardner, S., Goldblatt, E., Hayward, A., Kiser, L., Strieder, F. Thompson, E. (2010). *Understanding the impact of trauma and urban poverty on family systems: Risks, resilience, and interventions.* Baltimore, MD*:* Family Informed Trauma Treatment Center**.** http://nctsn.org/nccts/nav.do?pid=ctr_rsch_prod_ar or http://fittcenter.umaryland.edu/WhitePaper.aspx

Understanding the Impact of Trauma and Urban Poverty on Family Systems: Risks, Resilience, and Interventions

Authors: Kathryn Collins, Ph.D., MSW,[1] Kay Connors, MSW,[2] April Donohue, MA,[2] Sarah Gardner, MSW,[3] Erica Goldblatt, MSW,[2] Anna Hayward, MSW,[1] Laurel Kiser, Ph.D., M.B.A.,[2] Fred Strieder, Ph.D., MSSA,[1] Elizabeth Thompson, Ph.D.[3]

Affiliations: The Family-Informed Trauma Treatment (FITT) Center: [1]University of Maryland School of Social Work; [2]University of Maryland School of Medicine; [3]The Family Center at Kennedy Krieger Institute

The Family-Informed Trauma Treatment (FITT) Center is a partner of the National Child Traumatic Stress Network (NCTSN), which chose the FITT Center to serve as a national expert on the role of the family in the lives of children impacted by chronic trauma and stress.

The goal of the FITT Center is to develop, implement, evaluate, and disseminate theoretically sound, family-based interventions to improve outcomes for children in urban and military families who have experienced trauma.

Established by Congress in 2000, the NCTSN is a unique collaboration of academic and community-based service centers whose mission is to raise the standard of care and increase access to services for traumatized children and their families across the United States.

For more information, visit www.nctsn.org and http://fittcenter.umaryland.edu

Suggested citation: Collins, K., Connors, K., Donohue, A., Gardner, S., Goldblatt, E., Hayward, A., Kiser, L., Strieder, F. Thompson, E. (2010). *Understanding the impact of trauma and urban poverty on family systems: Risks, resilience, and interventions.* Baltimore, MD: Family Informed Trauma Treatment Center. http://nctsn.org/nccts/nav.do?pid=ctr_rsch_prod_ar or http://fittcenter.umaryland.edu/WhitePaper.aspx

This project was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), US Department of Health and Human Services (HHS). The views, policies, and opinions expressed are those of the authors and do not necessarily reflect those of SAMHSA or HHS.

TABLE OF CONTENTS

1. Introduction to Understanding the Impact of Trauma and Urban Poverty on Family Systems
2. Impact of Trauma and Urban Poverty on Children and Adolescents
3. Impact of Trauma and Urban Poverty on Adult Family Members
4. Impact of Trauma and Urban Poverty on the Family as a Whole
5. Impact of Trauma and Urban Poverty on Intergenerational Relationships
6. Impact of Trauma and Urban Poverty on Parent-Child Relationships
7. Impact of Trauma and Urban Poverty on Parenting Practices
8. Impact of Trauma and Urban Poverty on Intimate Partner Relationships
9. Impact of Trauma and Urban Poverty on Sibling Relationships
10. Conclusion

Appendix A: FITT Assessment Table
Appendix B: Additional assessments found in the literature
Appendix C: List of tables

Chapter 1

Introduction to Understanding the Impact of Trauma and Urban Poverty on Family Systems

It has long been understood that a family and its individual members, especially its children, are interdependent (Minuchin, 1985). Each member and family subsystem perform vital roles and functions within the context of multifaceted family relationships. Families can be negatively affected by chronic exposure to trauma, including the trauma and stressful conditions associated with living in urban poverty. For this reason, it is important to understand how trauma and urban poverty affect these familial relationships and functions in order to address trauma's full effect on children and their families. This White Paper presents the current status of knowledge in the field.

Optimal family functioning can be negatively impacted when families experience chronic exposure to trauma(s) and environmental stressors associated with urban poverty (Kaysen, Resick, & Wise, 2003). Urban poverty increases the number of trauma exposures, as well as distress associated with the high burden and hassles of daily living. When coping resources are depleted family relations can suffer and vital functions, such as protection from harm, provision of basic needs, and capacity to adapt and develop, are threatened, often resulting in perpetual cycles of crises (Brody & Flor, 1997; Clark, et al., 2000; Hill, 1958) Although it is widely accepted that parental response and family functioning are powerful mediators between trauma and its impact on children, including treatment outcomes (Repetti, et al.,2002; Cohen & Mannarino, 1996; Cohen, & Mannarino, 2000; Deblinger &. Heflin, 1996; Pfefferbaum, 1997; Whittlesey, et al., 1999; Banyard, et al., 2001; Laor, et al., 2001) more research is needed to understand how all levels of the family system promote resiliency and adaptation or present risks to positive outcomes.

This paper updates and expands on the findings reported by Kiser & Black (2005) in "Family processes in the midst of urban poverty: What does the trauma literature tell us?" By reviewing reports published between 2000 to 2008, we now examine the impact of chronic trauma in the context of urban poverty on all levels of the family system: individual children and adults, the family as a whole, intergenerational transmission of trauma, parent-child, adult intimate partner, and sibling relationships. This paper presents key research findings, risk and protective factors associated with each family subsystem, and available clinical tools and interventions. To further understand the mechanisms that promote or interfere with healthy parent-child relationships, a chapter on trauma's effects on parenting practices is included. By synthesizing this information, we aim to widen the trauma-focused care lens to the entire family and to the contextual risks of urban poverty and to build foundational knowledge needed to design family-informed trauma interventions that strengthen the family's innate ability to adapt, cope and heal in the aftermath of trauma.

Scope of Need: Research indicates that families living in urban poverty encounter multifaceted risks associated with the hardship of depleted resources, burdens of high stress and incivilities, and exposure to multiple traumas (Ackerman, et al., 1999; Repetti, Taylor, & Seeman, 2002; Kiser & Black, 2005). Because ethnic groups are overrepresented, there can be additional suffering secondary to racist attitudes and negative social perceptions of people living in poverty. The following statistics indicate the prevalence of trauma and poverty in American cities (Emery and Laumann-Billings 1998; Groves, 2002; Sherman & Arloc, 2006; Edelson, 1999; NCCP, 2007; NCCP, 2008):

- *49% of American children in urban areas (9.7 million) live in low-income families.*
- *Families of color are disproportionally represented in impoverished urban neighborhoods.*
- *Black and Latino families with children are more than twice as likely as white families with children to experience economic hardships.*
- *Families constitute two-fifths of the U.S. homeless population, which increases the risk of trauma exposure and intense anxiety and uncertainty.*
- *83% of inner city youth report experiencing one or more traumatic events.*
- *1 out of 10 children under the age of six living in a major American city report witnessing a shooting or stabbing.*
- *59% - 91% of children and youth in the community mental health system report trauma exposure.*
- *60% - 90% of youth in juvenile justice have experienced traumas.*
- *Urban males experience higher levels of exposure to trauma, especially violence related incidents, while females are four times more likely to develop Post-Traumatic Stress Disorder (PTSD) following exposure to traumatic events.*

Trauma and contextual stress can negatively impact children and adults' functioning, often undermines parenting efforts, family relationships, and family functioning, and can increase risk of family violence (Jaffe and Wolfe 1986; McCubbin & McCubbin, 1993; Appleyard & Osofsky, 2003; Scheeringa & Zeanah, 2001; Green, et al., 1991). Although the majority of family violence occurs between intimate partners and parent-children, multiple family subsystems can be affected or involved. Statistics reveal the prevalence of family violence in the United States (Emery and Laumann-Billings 1998; U.S. Department of Justice 2005; Kaufman and Zigler 1987):

- *27% of all violent crimes occur among family members.*
- *Between 3.3 and 10 million children witness domestic violence yearly.*
- *Almost 20% of adult women have been physically abused by a male partner.*
- *22% of women and 7.5% of men reported that they were raped and/or physically assaulted by an intimate partner (e.g., spouse, partner, or date) at some time in their lifetime.*
- *Over 1,500 women were murdered in 1995 by their husband or boyfriend. More than 60% of femicides in 2004 were committed by a spouse or intimate partner.*
- *2.5 million reports of child abuse are made each year.*
- *In the United States, almost 900,000 cases of neglect and abuse are substantiated yearly, with more than 300,000 youth placed in out-of-home care.*
- *Each year, 20–35% of abused children suffer a serious injury and between 1,200 and 1,500 die as a result of abuse.*
- *One-third of individuals who were abused as children will become perpetrators of abuse in adulthood.*
- *African American (82%) and American Indian/Alaskan Native (42%) children are disproportionally represented in the child welfare system.*

Families raising children in low-income, urban neighborhoods are exposed to multiple on-going traumas, from potential to severe threats, all of which increase the likelihood of negative outcomes (Evans &. English, 2002; Esposito, 1999). In fact, the consequences of community and family violence are well documented, and while direct victims are at greatest risk of harm, effects are systemic (Emery and Laumann-Billings 1998, p. 128). Understanding the effects of trauma and poverty on different family members and among familial relationships, as well as understanding the full range of family members' responses to trauma and poverty, is critical to improving outcomes.

Theories and Proposed Model: Multiple theories help to explain how contextual risk and traumatic experiences impact the individuals, dyads and groups within families. The authors identify nine common theories to explain the complex mechanisms and mediators that impede or support family processes in the face of trauma and urban poverty: 1) family systems theory, 2) family resiliency theory, 3) McMaster model of family functioning, 4) ecodevelopmental theory, 5) attachment theory, 6) trauma theory, 7) social learning theory, 8) family stress theory, and 9) conservation of resources theory.

Building on general systems theory, **family systems** and **family resiliency theories** seek to explain the interconnectedness of individual family members and family subsystems to better understand how their shared history, familial bonds and collaborative coping strategies support the family's functioning, as well as how family-level risk and protective factors impede or support their ability to perform essential family functions, such as nurturance, protection, stability and cohesion (Brodsky, 1999; Patterson, 1991).

Another key model influencing development of family intervention is the **McMaster model of family functioning (MMFF).** It assumes that the primary function of the family unit is to support each member's development while maintaining an optimal level of functioning as demonstrated by effective problem solving, communication, role performance, affective responsiveness, affective involvement, and behavior control (Bishop, et al., 1980).

Ecodevelopmental and **attachment theories** explain the complex relationships and multidirectional interactions that influence child development (Bronfenbrenner, 1979), and how the secure-base and emotional closeness provided by parents to their child provides a framework for the child to regulate emotions and behaviors and mediates the effects of trauma (Cicchetti et al., 2006; Toth et al, 2002).

Trauma and **social learning theories** are fundamental to the development of current trauma treatments. **Trauma theory** explains the neurobiological and psychological consequences of overwhelming and threatening life experiences, while **social learning theory** helps to explain how learning to recognize, correct and cope with trauma-related thoughts and to regulate emotional and behavioral responses are critical to effectiveness of trauma recovery models (Bandura 1989, Pynoos, et al., 1999; Cahill & Foa, 2007; Monson & Friedman, 2006).

Finally, several models and theories advance understanding of the impact of poverty on family functioning. One, the **family stress model of economic hardship**, examines how poverty affects families' financial resources and influences emotions, behaviors, or relationships of family members (Conger et al, 2002; McCubbin & McCubbin, 1993; McCubbin, 1995). The **conservation of resources (COR) theory** highlights how families conserve resources to strengthen coping and prevent loss of future resources (Johnson, et al., 2007; Hobfoll, et al., 1992).

Together, these theories help explain the complex, multidirectional relationships and transactions in family systems and also set the stage for understanding the importance of nonlinear, ecological, systematic interventions.

Proposed Model: The Family-Informed Trauma Treatment Model

Aspects of these nine theories have been used to develop the **family-informed trauma treatment (FITT) model**, which recognizes that families living in under-resourced and dangerous communities are exposed to multiple traumas, including current dangers and traumatic reminders, while trying to manage daily responsibilities. Families in these communities report frequent exposure to illegal drug activities and community violence, safety concerns such as potential for house fires and rat

infestations, difficulty finding a safe way to get children to and from school, and multiple daily hassles due to inadequate access to resources and opportunities. (Figure 1)

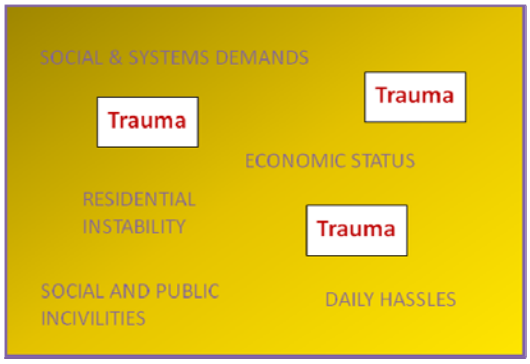

Figure 1: The traumatic context of urban poverty includes increased risks of discrete traumas, such as violence and crime, as well as difficulties that exacerbate trauma's effects.

The traumatic context of urban poverty has pervasive effects that slowly erode parent and family function and affect outcomes. Contextual risks of urban poverty (meager resources, crowded conditions, trauma, etc.) affect everyone exposed, but effects on children are exaggerated by reduced parental well-being and family functioning (Kiser, 2006). This is critical to understanding and mediating the effects of trauma and poverty because parental and family functioning affect risk for development of emotional and/or behavior problems in children.

The FITT Model provides an ecological, family systems approach to reduce symptoms of trauma-related distress and to promote safety and recovery for all family members. In particular, it considers the full spectrum of effects of trauma and poverty on individuals, familial relationships, and family functioning, which reveals a complex interplay of both direct and downstream effects of trauma on the family. (Figure 2)

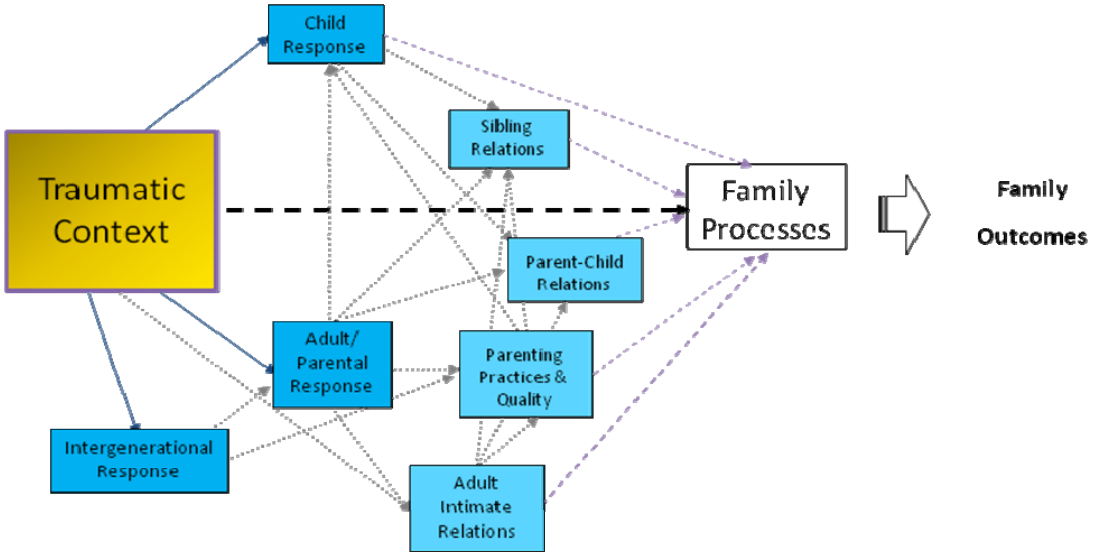

Figure 2: Individuals and familial relationships are affected by trauma and poverty and, in turn, influence effects of trauma and poverty, creating a complex interplay of cause and effect. Solid lines

represent effects of exposure to chronic trauma on *individual family members*. Dotted lines represent effects of chronic trauma and individual responses to trauma on *dyadic family subsystems*. Dashed lines represent effects of responses to and effects of chronic trauma on *family processes*. The bold, dashed line indicates a direct causal relationship of trauma, family functioning and outcomes. (Adapted from Kiser & Black, 2005)

In this paper, we highlight the salient risk and protective factors for individuals and familial relationships that impact coping resources and adaptation to living and thriving in harsh, traumatic conditions. Risk factors are conditions that predispose individuals to trauma-related disorders while protective and resilience factors increase chances of positive adaptation. Some aspects of the family system, such as child, adult and parent-child relations and parenting practices, have been widely studied and have well established clinical tools and interventions available, while research and interventions in other areas, particularly intergenerational relationships, sibling relationships, and family as a whole, are limited. We have applied available findings from studies of trauma and family systems to the growing understanding of how the combination of contextual risks and traumas impact families' life cycles and recovery and report on assessment tools normed for and interventions conducted with African-American families living in urban settings, when available. However, other relevant tools and treatments are also presented for this comprehensive examination of an emerging area of research.

Favorable outcomes for families affected by trauma and urban poverty are highly dependent upon the availability of and access to assessment and treatment practices that are trauma-specific, family-centered, and target all levels of the system impacted by trauma. Our review of key clinical and research findings points to the need for further research on the impact of trauma and urban poverty on families and for the development of interventions that address family systems' issues and integrate them into a trauma-informed, family-centered system of care.

References

Ackerman, B. P., Kogos, J., Youngstrom, E., Schoff, K., & Izard, C. (1999). Family instability and the problem behaviors of children from economically disadvantaged families. *Developmental Psychology, 35*, 258-268.

Appleyard, K., & Osofsky, J. D. (2003). Parenting after trauma: Supporting parents and caregivers in the treatment of children impacted by violence. *Infant Mental Health Journal, 24*(2), 111-125.

Bandura, A. (1989). Regulation of cognitive processes through perceived self-efficacy. *Developmental Psychology, 25*, 729-735.

Banyard, V. L., Rozelle, D., & Englund, D. W. (2001). Parenting the traumatized child: Attending to the needs of nonoffending caregivers of traumatized children. *Psychotherapy*, *38*(1), 74-87.

Bishop, D. S., Epstein, N. B., & Baldwin, L. M. (1980) .Structuring a Family Assessment Interview. *Can Fam Physican, Nov* (26), 1534-1537.

Brody, G. H. & Flor, D. L. (1997). Maternal psychological functioning, family processes, and child adjustment in rural, single-parent, African American families. *Developmental Psychology, 33*(6): 1000-1011.

Brody, G. H., Ge, X., Kim, S. Y., Murry, V. M., Simons, R. L., Gibbons, F. X., Gerrard, M., & Conger, R. (2003). Neighborhood disadvantage moderates associations of parenting and older sibling problem attitudes and behavior with conduct disorders in African American children. *Journal of Consulting & Clinical Psychology*, *71*(2), 211-222.

Bronfenbrenner, U. (1979). *The ecology of human development*. Cambridge, MA: Harvard University Press.

Brodsky, A. E. (1999). "Making It": The components and process of resilience among urban, African-American, single mothers. *American Journal of Orthopsychiatry, 69*(2), 148-160.

Cahill, S. P., & Foa, E. B. (2007). Psychological theories of PTSD. In M. J. Friedman, T. M. Keane, & P. A. Resick (Eds.), *Handbook of PTSD: Science and practice* (pp. 55-77). New York: The Guilford Press.

Cicchetti, D., Rogosch, F. A., & Toth, S. L. (2006). Fostering secure attachment in infants in maltreating families through preventive interventions. *Developmental Psychopathology 18*, 623-650.

Clark, A. F., Barrett, L., & Kolvin, I. (2000). Inner city disadvantage and family functioning. *European Child & Adolescent Psychiatry*, *9*(2), 77-83.

Cohen, J. A., & Mannarino, A .P. (1996). Factors that mediate treatment outcome in sexually abused preschool children. *Journal of the American Academy of Child & Adolescent Psychiatry, 35*, 1402-1410.

Cohen, J.A., & Mannarino, A.P. (2000). *Predictors of treatment outcome in sexually abused children. Child Abuse & Neglect*, *24*, 983-994.

Conger, R. D., Wallace, L. E., Sun, Y., Simons, R. L., McLoyd, V., & Brody, G. H. (2002). Economic pressure in African American families: A replication and extension of the family stress model. *Developmental Psychology, 38*, 179-193.

Deblinger, E., & Heflin, A.H. (1996). *Treating sexually abused children and their non-offending parents: A cognitive-behavioral approach.* Thousand Oaks, CA: Sage Books.

Edelson, J.L. (1999). The Overlap Between Child Maltreatment and Woman Battering. *Violence Against Women*. 5:134-154.

Emery, R. E., & Laumann-Billings, L. (1998). An overview of the nature, causes, and consequences of abusive family relationships. *American Psychologist, 53*(2) 121-135.

Esposito, C. (1999). Learning in urban blight: School climate and its effect on the school performance of urban, minority, low-income children. *School Psychology Review, 28,* 365-377.

Evans, G.W., & English, K. (2002). The environment of poverty: Multiple stressor exposure, psychophysiological stress, and socioemotional adjustment. *Child Development*, *73*(4), 1238-1248.

Green, B.L., Korol, M., Grace, M. C., Vary, M. G., Leonard, A. C., Gleser, G. C. & Smitson-Cohen, S. (1991). Children and disaster: age, gender, and parental effects on PTSD symptoms. *American Academy of Child and Adolescent Psychiatry*, *30*(6), 945-951.

Groves, B. M. (2002). Children who see too much: Lessons from the Child Witness to Violence Project. Boston, Beacon Press.

Hill, R. (1958). Generic features of families under stress. *Social Casework*, *49,* 139-150.

Hobfoll, S. E., Lilly, R. S., & Jackson, A. P. (1992). Conservation of social resources and the self. In H. O. F. Veiel & U. Baumann (Eds.), *The meaning and measurement of social support* (pp. 125-141). Washington, DC: Hemisphere.

Jaffe, P., & Wolfe, D. (1986). Similarities in behavioral and social maladjustment among child victims and witnesses to family violence. *American Journal of Orthopsychiatry, 56*(1), 142-146.

Johnson, D. M., Palmieri, P. A., Jackson, A. P., & Hobfoll, S. E. (2007). Emotional numbing weakens abused inner-city women's resiliency resources. *Journal of Traumatic Stress, 20*(2), 197-206.

Kaufman, J., & Zigler, E. (1987). Do abused children become abusive parents? *American Journal of Orthopsychiatry, 37*, 186-192.

Kaysen, D., Resick, P. A., & Wise, D. (2003). Living in danger: the impact of chronic traumatization and the traumatic context on posttraumatic stress disorder. *Trauma Violence & Abuse*, *4*(3), 247-264.

Kiser, L. J. (2006). Protecting children from the dangers of urban poverty. *Clinical Psychology Review*, *27*(2), 211-225.

Kiser, L. J., & Black, M. A. (2005). Family processes in the midst of urban poverty. *Aggression and Violent Behavior*, *10*(6), 715-750.

Kiser, L. J., Ostoja, E., Pruitt, D. B. (1998) Dealing with stress and trauma in families. *Stress in Children. Child and Adolescent Psychiatric Clinics of North America, 7*(1), 87-104.

Laor, N., Wolmer, L. & Cohen, D. J. (2001). Mothers' functioning and children's symptoms five years after a SCUD missile attack. *American Journal of Psychiatry*, *158*, 1020-1026.

McCloskey, L., Figuerdo, A. J., & Koss, M. P. (1995). The effects of systematic family violence on children's mental health. *Child Development, 66*(5), 1239-1261.

McCubbin, M. A., & McCubbin, H. I. (1993). *Families coping with illness: The resiliency model of family stress, adjustment, and adaptation*. St. Louis, MO: Mosby Year Book, Inc. (p. 21-63).

McCubbin, M. (1995). The typology model of adjustment and adaptation: A family stress model. *Guidance & Counseling*, *10*(4), 1-27.

Minuchin, P. (1985). Families and Individual Development: Provocations from the field of family therapy. *Child Development, 56 (2), 289-302.*

Monson, C. M., & Friedman, M. J. (2006). Back to the future of understanding trauma: Implications for cognitive-behavioral therapies for trauma. In V. M. Follette & J. I. Ruzek (Eds.), *Cognitive behavioral therapies for trauma* (pp. 1-13). New York: The Guilford Press.

National Center Against Domestic Violence. Domestic Violence Facts Available at: http://www.ncadv.org/files/DomesticViolenceFactSheet(National).pdf

National Center for Children in Poverty. Basic Facts about Low-Income Children Birth to Age 18, October 2008. Available at: http://www.nccp.org/publications/pub_845.html

National Center for Children in Poverty. Strengthening Policies to Support Children, Youth, and Families Who Experience Trauma, July 2007. Available at: http://www.nccp.org/publications/pdf/text_737.pdf

National Center for Children in Poverty, Who are America's Poor Children? The Official Story, October 2008. Available at: http://www.nccp.org/publications/pub_843.html

Patterson, J. M. (1991). A family systems perspective for working with youth with disability. *Pediatrician, 18*(2), 129-41.

Pfefferbaum, B. (1997). Posttraumatic stress disorder in children: A review of the past 10 years. *Journal of the American Academy of Child and Adolescent Psychiatry*, *36*(11), 1503-1511.

Pynoos, R. S., Steinberg, A. M., & Piacentini, J. C. (1999). A developmental psychopathology model of childhood traumatic stress and intersection with anxiety disorders. *Biological Psychiatry*, *46*, 1542-1554.

Repetti, R. L., Taylor, S. E., & Seeman, T. E. (2002). Risky families: Family social environments and the mental and physical health of offspring. *Psychological Bulletin, 128*, 330-366.

Scheeringa, M. S., & Zeanah, C. H. (2001). *A relational perspective on PTSD in early childhood. Journal of Traumatic Stress*, *14*(4), 799-815.

Sherman, A. 2006. African American and Latino Families Face High Rates of Hardship. Washington, DC: Center on Budget and Policy Priorities. Available at http://www.cbpp.org/cms/?fa=view&id=850.

Toth, S. L., Maughan, A., Manly, J. T., Spagnola, M. & Cicchetti, D. (2002). The relative efficacy of two interventions in altering maltreated preschool children's representational models: Implications for attachment theory. *Developmental Psychopathology, 14*, 877-908.

U.S. Department of Justice, Bureau of Justice Statistics: Family Violence Statistics, June 2005. Available at: http://www.ojp.usdoj.gov/bjs/abstract/fvs.htm. Accessed October 27, 2008.

Whittlesey, S. W., Allen, J. R., Bell, B. D., Lindsey, E. D.,. Speed, L. F., Lucas, A. F., (1999). Avoidance in trauma: Conscious and unconscious defense, pathology, and health. *Psychiatry*, *62*, 303-312.

Chapter 2

Impact of Trauma and Urban Poverty on Children and Adolescents

Mounting evidence suggests that children and adolescents growing up in urban poverty are more likely than those growing up in other contexts to experience multiple traumas and significant adverse life events, and to thus develop complex symptoms of traumatic distress at disproportionate rates. Repeated exposure creates a complicated set of reactions that occur before, during, and after traumatic events and carry long-term developmental risks. Although exposure to and effects of chronic trauma in children from low-income, urban environments have been labeled a public health concern, there is still limited treatment effectiveness or practice research available to guide the delivery of services to this highly impacted, underserved population.

Theory

Efforts to explain the severity and chronicity of reactions to repeated traumas traditionally focus on the cumulative effects of multiple traumatic episodes. Yet circumstances that create persistent feelings of not being safe and of being unable to control situations cause children to anticipate further events even as they deal with the effects of one trauma (Pynoos, Steinberg, & Goenjian, 1996; Kiser et al., 1993; Overstreet & Braun, 2000; Schwab-Stone et al., 1999). Thus, according to this view, it is the combination of experience and anticipation of traumatic events that leads to the long-term functional changes in multiple systems that is characteristic of complex posttraumatic stress disorder (PTSD). In fact, anticipatory anxiety results in a spectrum of symptoms similar to PTSD, including fears, preoccupations, nightmares, vigilance, avoidance, and enactments, and it may contribute to the development of some symptoms, coping mechanisms, and general expectancies commonly associated with complex PTSD (Kiser et al., 1993; McCarroll, Ursano, Fullerton, Liu, & Lundy, 1995).

Key Research Findings

Studies of children living in poor inner-city neighborhoods document extremely high rates of exposure to trauma (70-100%) (Dempsey, Overstreet, & Moely, 2000; Fitzpatrick & Boldizar, 1993; Macy, Barry, & Noam, 2003). In addition to normal childhood stresses, children in these circumstances are often exposed to violent crime in their neighborhood or school; gang and drug activity; house fires; victimization, incarceration, or death of a family member; family violence; and maltreatment (Black & Krishnakumar, 1998; Buckner, Bassuk, Weinreb, & Brooks, 1999; Coulton, Korbin, & Su, 1999; Dempsey, 2002; Dubow, Edwards, & Ippolito, 1997). This rate of exposure raises public health concerns (Cooley-Quille, Turner, & Beidel, 1995; Margolin & Gordis, 2000).

Because feeling safe and secure is a prerequisite for healthy emotional development and general welfare (Hirsch et al., 2000; Stevenson, 1998), many children growing up in urban poverty exhibit distress. Their reactions to trauma include increased monitoring of their environment for dangers, anxiety when separated from trusted adults, irritability and aggression, or increased need for affection, support, and reassurance. In the short term, such reactions may signal appropriate upset and serve as strategies for successful adaptation. However, persistence of the reactions or interference with functioning may be labeled posttraumatic stress symptoms (PTSS), which progress

to PTSD in 24-34% of children exposed to urban community violence (Wethington et al., 2008). Co-morbidity with other mental health problems also is likely.

Unfortunately, current diagnostic criteria for PTSD may be insufficient to describe the disorders resulting from exposure to multiple traumas. Children growing up in urban poverty often display symptoms of complex PTSD (Briere, 2002; Cummings & Davies, 2002; Herman, 1992; Terr, 1985 & 1991), also referred to as Type II trauma disorder (Terr, 1983 & 1985) or Developmental Trauma Disorder (van der Kolk, 2005). Complex trauma is a varied and multifaceted phenomenon, frequently embedded in a matrix of other psychosocial problems (e.g., neglect, marital discord, and domestic violence) that carry ongoing threat. The symptom presentation of children exposed to prolonged, repeated trauma is best described by affective and physiological dysregulations; attachment disorders and disturbed relatedness; changes in consciousness and self-perception; cognitive distortions regarding trauma and perpetrator; and changes in systems of personal meaning (Cook, Blaustein, Spinazzola, & van der Kolk, 2003).

Developmental processes are also at risk. In relation to the symptoms affecting attention, concentration, and memory, these children often experience disruptions in academic learning and skill development. Their hypervigilance, heightened sense of alert, and posttraumatic play may set them apart from peers, restrict the normalcy of their social interactions, and place them at risk for delays in social competence. Childhood victims of chronic trauma risk development of a lack of basic trust in the ability of others to protect them, a view of the world as threatening, a lack of self-confidence, and a dysregulated nervous system (Macy, Barry, & Noam, 2003; Perry & Pollard, 1998; Pfefferbaum, 1997; Pynoos et al., 1996; Warren, Emde, & Sroufe, 2000). Finally, lowered future expectations are often formed as children with chronic trauma histories experience ongoing functional impairments, including substance abuse, delinquency, suicidality, acts of self-destruction, chronic anger, unstable relationships, and dissociation (Davies & Flannery, 1998; Pynoos, Steinberg, & Piacentini, 1999).

There is a small but growing literature on the potential for positive outcomes following exposure to trauma. Some adolescents demonstrate both outward and intrapersonal growth through their struggle to deal with the bad things that happen to them (Levine, Laufer, Hamama-Raz, Stein, & Solomon, 2008).

Risk and Protective Factors

Epidemiological and social science research is beginning to document the extent and cost of youth traumatization. Both risk and protective factors for development of trauma-related disorders exist at multiple levels—individuals, families, schools, neighborhoods, and society. Risk factors are the conditions in these settings that predispose children and adolescents to trauma-related disorders. Protective and resilience factors increase chances of positive adaptation. (Table 2.1)

Given that characteristics of the traumatic event, such as frequency and duration, greatly influence a victim's reaction, the epidemiology of trauma experienced by children growing up in poor urban settings is not directly comparable to trauma induced by single events or child sexual abuse (Kiser, Millsap, & Heston, 1992; Graham-Bermann & Levendosky, 1998; Pynoos et al., 1996). The context of urban poverty along with multiple individual, family, school, and community risk factors not only increases the likelihood of trauma exposure, but also heightens vulnerability to traumatic distress after exposure (Whittlesey et al., 1999; Levendosky & Graham-Bermann, 1998; Erel & Burman, 1995). For children and adolescents, individual vulnerability (female gender, genetic predisposition), characteristics of the trauma (loss, proximity, etc.), and parental distress combine to increase the risk of maladaptation.

Although exposure to the social ecology of urban poverty carries significant risk, most children continue to function well and do not develop PTSD (Wethington et al., 2008). Through supportive relationships with family and friends, these children learn and use coping and problem-solving skills that encourage positive adaptation.

Table 2.1: Risk and Protective Factors for Children and Adolescents

Risk Factors	Protective Factors
Psychiatric history	Socioeconomic advantage
Other previous trauma	Easygoing temperament
Other adverse childhood experience	High intellectual ability
Trauma severity	Problem-solving skills
Peritraumatic psychological processes (high emotion and dissociative)	Coping skills (self-regulation)
Time since trauma	Caring and support
Biological and genetic predisposition	
Parents' degree of distress	
Female gender	
Poor parent-child and family attachment	

Assessment Instruments

There is no "gold standard" for assessing childhood complex traumatic stress disorders; instruments are slowly being evaluated psychometrically and specific measures are being developed to address effects of multiple exposures. Some best-practice guidelines include the need to gather information from multiple sources, especially from both child and caregiver. It is also important to measure symptoms in all three clusters (reexperiencing, avoidance, and hyperarousal) plus indicators of complex trauma such as futurelessness, shame, guilt, and changes in self-esteem and systems of meaning. See Appendix A for a list of frequently used measures for assessing traumatic exposure and responses in children and adolescents.

Interventions

Cognitive-behavioral therapy (CBT), both individual and group models, is the single intervention model with empirical support in children and adolescents. Although both individual and group CBT therapies have demonstrated efficacy, additional study of their effectiveness with minority populations living in urban poverty is needed (Wethington et al., 2008). There is inadequate evidence of effectiveness for other psychosocial treatments and for psychopharmacology.

Empirical evidence and clinical support are lacking for current models of treatment for children who have experienced chronic trauma. There is general consensus that, in addition to treating the symptoms of PTSD, treatment of disorders related to chronic trauma exposure must *also* address the

following: improving the child's sense of safety; using problem-solving techniques for minimizing additional stresses; diminishing dysregulations; and promoting resilience by clearing up maladaptive beliefs, rebuilding a sense of mastery, restoring trust in self and others, renewing a sense of positive meaning, and making connections to appropriate supports (Banyard, Rozelle, & Englund, 2001; Cohen, Berliner, & Mannarino, 2000; Davies & Flannery, 1998; Herman, 1992; Miller, 1999; Temple, 1997).

Numerous detailed descriptions of CBT approaches with traumatized children exist (Parson, 1997; Cohen, Mannarino, Berliner, & Deblinger, 2000). One CBT model, Trauma Focused-Cognitive Behavioral Therapy (TF-CBT), has been studied in numerous randomized, controlled clinical trials, and multiple published reports have supported its effectiveness (Cohen, Deblinger, Mannarino, & Steer, 2004; Cohen & Mannarino, 1996a; Cohen & Mannarino, 1996b; Cohen & Mannarino, 1997; Cohen, Mannarino, & Knudsen, 2005; Deblinger, Steer, & Lippman, 1999). In general, the treatment manualization, control design, training of clinicians, fidelity checks, and follow-up in these studies were exemplary.

These trials' samples included children between the ages of 8-17 years (one study focused on 3-7-year-olds). All of the children experienced sexual abuse; one sample included 229 multiply traumatized children with sexual abuse-related PTSD symptoms. The racial composition of the samples was mixed but predominantly Caucasian. Non-offending parents/primary caretakers participated in all of the trials.

These trials compared TF-CBT for 12 weeks with nondirective supportive therapy (NST), consisting of play therapy for children and supportive therapy for parents; child-centered supportive therapy (CCT); and community treatment as usual (TAU). One of these trials compared multiple formats of TF-CBT including treatment with child only, mother only, and both child and mother. Results indicated that TF-CBT was significantly better than NST, CCT, and TAU for improving children's PTSD, internalizing, externalizing, and sexual problems. Differences were sustained for up to 24 months. Furthermore, TF-CBT for child and parent was superior to TF-CBT for either parent or child alone.

Overall, the evidence suggests that TF-CBT is more effective than no treatment or treatment that is not designed to address trauma. This research also generally affirms the effectiveness of TF-CBT that includes orientation and psychoeducation, coping skill development, direct exploration of the traumatic experience coupled with exposure/contingency reinforcement programs, evaluation and reframing of cognitions regarding the event, and parent/caregiver support (Cohen, 1998; Cohen, Mannarino, Berliner, & Deblinger, 2000; Perrin, Smith, & Yule, 2000). Given the positive findings across multiple well designed trials conducted by several research groups, TF-CBT has been labeled an evidence-based practice (Chadwick Center for Children and Families, 2004; Substance Abuse & Mental Health Services Administration, 2005; Bisson, 2005; Saunders, Berliner, & Hanson, 2004).

Cognitive Behavioral Intervention for Trauma in Schools (CBITS) has been disseminated nationwide (Ngo et al., 2008), and in culturally diverse settings (Morsette et al., 2009). Designed to be implemented in school settings, CBITS is a group intervention with the potential for increasing access to needed services in the actual communities where children are exposed to trauma and violence. CBITS is a SAMHSA model program and listed as a proven practice on the Promising Practices Network.

Structured Psychotherapy or Adolescents Responding to Chronic Stress (SPARCS), another group therapy modality, was designed to treat chronically traumatized children/adolescents who continue to live in stressful situations.

Table 2.2: Interventions: Child and Adolescent

Treatment Name	Developer(s)	Essential Elements	Research Evidence & Outcomes
Trauma Focused Cognitive Behavioral Therapy (TF-CBT)	Cohen, Mannarino , Berliner, & Deblinger (2000)	Psychoeducation and parenting skills; relaxation techniques; Affective Expression and Regulation; Cognitive Coping and Processing; Trauma Narrative; In vivo Exposure, Conjoint parent/child sessions, Enhancing Personal Safety and Future Growth.	Effectiveness of TF-CBT has been well established in several randomized, controlled clinical trials. Studies have indicated TF-CBT reduces targeted internalizing symptoms (e.g., PTSD, depression, anxiety, self-blame) as well as sexualized and other externalizing behaviors (e.g., defiance, oppositionality).
Cognitive Behavioral Intervention for Trauma in Schools (CBITS)	RAND Corporation, the Los Angeles Unified School District, and UCLA (Jaycox, Stein, Wong, Kataoka) (2003)	Education about reactions to trauma; relaxation training; cognitive therapy, real life exposure, stress or trauma exposure; social problem-solving.	Two published studies (Ngo et al., 2008; Morsette et al., 2009)
Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)	DeRosa, Habib, Pelcovitz, Rathus, Sonnenklar, Ford, et al (2006)	Mindfulness, Problem-solving, Meaning Making, Relationship-building/Communication skills, distress tolerance, psycho-education on stress and trauma.	Pilot data and case studies suggest that it is a promising practice.

Conclusion and Comment

Children and adolescents growing up in urban poverty face increased risks for exposure to trauma. Ongoing stressors may include violent crime, family violence, death of a family member, maltreatment, and many others. Such harsh environments and poor living conditions often result in high levels of distress and posttraumatic stress symptoms. Although children and adolescents are at risk for numerous negative outcomes, there is also the potential for resilience and growth following traumatic experiences. Researchers have worked to identify those factors which can either put youth at a higher risk for future difficulties or help shield them from negative outcomes.

Despite progress in better understanding the effects of trauma on children and adolescents, more work remains in developing empirically-supported, developmentally appropriate assessment tools and interventions, especially for children exposed to multiple or chronic trauma. As current assessment tools continue to be studied and empirical support for them obtained, it is important for

treatment providers to consult multiple sources and to thoroughly evaluate the child's or adolescent's symptoms. When treating youth with PTSD, TF-CBT remains the gold standard. For youth displaying other symptoms related to on-going risk and chronic stressors, several promising treatment approaches are emerging. Research with children and adolescents living in urban poverty has shown that youth are resilient, and with help, can learn to survive and emerge stronger from even the most challenging environments. However, the possibility of resilience does not reduce the public health need to improve challenging environments and the services available to individuals living in poverty.

References

Ambrosini, P. J. (2000). Historical development and present status of the schedule for affective disorders and schizophrenia for school-age children (K-SADS). *Journal of the American Academy of Child & Adolescent Psychiatry, 39,* 49-58.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th Ed.). Washington, DC: Author.

Banyard, V. L., Rozelle, D., & Englund, D. W. (2001). Parenting the traumatized child: Attending to the needs of nonoffending caregivers of traumatized children*. Psychotherapy*, *38*(1), 74-87.

Bisson, J. A. M. (2005). *Psychological treatment of post-traumatic stress disorder (PTSD) (Review)*. John Wiley & Sons, Ltd.

Black, M. M., & Krishnakumar, A. (1998). Children in low-income, urban settings: Interventions to promote mental health and well-being*. American Psychologist, 53*, 635-646.

Briere, J. (2002). *Advances in treating complex psychological trauma and PTSD*. Baltimore, MD.

Briere, J., & Spinazzola, J. (2005). Phenomenology and psychological assessment of complex posttraumatic states. *Journal of Traumatic Stress, 18,* 401-412.

Buckner, J. C., Bassuk, E. L., Weinreb, L. F., & Brooks, M. G. (1999). Homelessness and its relation to the mental health and behavior of low-income, school-age children*. Developmental Psychology, 35*, 246-257.

Carrion, V. G., Weems, C. F., Ray, R., & Reiss, A. L. (2002). Toward an empirical definition of pediatric PTSD: The phenomenology or PTSD symptoms in youth. Journal of American Academy of Child and Adolescent Psychiatry, 41, 166-173.

Chadwick Center for Children and Families. (2004). *Closing the quality chasm in child abuse treatment: identifying and disseminating best practices*. San Diego, CA: Author.

Cohen, J. A. (1998). *Practice parameters for the assessment and treatment of children and adolescents with posttraumatic stress disorder. Journal of the American Academy of Child & Adolescent Psychiatry, 37*), 4S-26S.

Cohen, J. A., Berliner, L., & Mannarino, A. P. (2000). Treating traumatized children: A research review and synthesis*. Trauma, Violence, & Abuse*, 1, 29-46.

Cohen, J. A., Deblinger E., Mannarino, A. P., & Steer, R. (2004). A multisite, randomized controlled trial for children with sexual abuse-related PTSD symptoms. *Journal of the American Academy of Child & Adolescent Psychiatry, 43*, 393-402.

Cohen, J. A., Deblinger, E., Mannarino, A. P., & Steer, R. (2009). *Measuring treatment outcomes with the trauma symptom checklist in sexually abused children with multiple trauma histories*. Manuscript submitted for publication.

Cohen, J. A., Mannarino, A. P., & Knudsen, K. (2005). Treating sexually abused children: One year follow-up of a randomized controlled trial. *Child Abuse & Neglect*, 29, 135-145.

Cohen, J. A., Mannarino, A. P., Berliner, L., & Deblinger, E. (2000) Trauma-focused cognitive behavioral therapy for children and adolescents: An empirical update. *Journal of Interpersonal Violence, 15,* 1203-1223.

Cohen, J. A., & Mannarino, A. P. (1996a). A treatment outcome study for sexually abused preschool children: Initial findings. *Journal of the American Academy of Child & Adolescent Psychiatry*, *35*, 42-50.

Cohen, J. A., & Mannarino, A. P. (1996b). Factors that mediate treatment outcome in sexually abused preschool children. *Journal of the American Academy of Child & Adolescent Psychiatry*, *35,* 1402-1410.

Cohen, J. A., & Mannarino, A. P. (1997). A treatment study of sexually abused preschoolers: Outcome during one year follow-up. *Journal of the American Academy of Child & Adolescent Psychiatry*, *26*, 1228-1235.

Cooley-Quille, M. R., Turner, S. M., & Beidel, D. C. (1995). Emotional impact of children's exposure to community violence: A preliminary study. *Journal of the American Academy of Child & Adolescent Psychiatry*, *34,* 1362-1368.

Cook, A., Blaustein, M., Spinazzola, J., & van der Kolk, B. (2003). *Complex trauma in children and adolescents: White paper from the National Child Traumatic Stress Network Complex Trauma Task Force*. Los Angeles: National Child Traumatic Stress Network.

Coulton, C. J., Korbin, J. E., & Su, M. (1999). Neighborhoods and child maltreatment: A multi-level study. *Child Abuse & Neglect, 23*, 1019-1040.

Cummings, E., & Davies, P. T. (2002). Effects of marital conflict on children: Recent advances and emerging themes in process-oriented research. *Journal of Child Psychology & Psychiatry & Allied Disciplines*, *43*, 31-63.

Davies, W. H., & Flannery, D. J. (1998). Post-traumatic stress disorder in children and adolescents exposed to violence. *Pediatric Clinics of North America*, *2*, 341-353.

Deblinger, E., Steer, R. A., & Lippman, J. (1999). Two-year follow-up study of cognitive behavioral therapy for sexually abused children suffering post-traumatic stress symptoms. *Child Abuse & Neglect*, *23*, 1371-1378.

Dempsey, M., Overstreet, S. & Moely, B. (2000). *"Approach" and "avoidance" coping and PTSD symptoms in inner-city youth. Current Psychology, 19*, 28-46.

Dempsey, M. (2002). Negative coping as mediator in the relation between violence and outcomes: Inner-city African American youth. *American Journal of Orthopsychiatry*, *72*, 102-109.

Dubow, E. F., Edwards, S., & Ippolito, M. F. (1997). Life stressors, neighborhood disadvantage, and resources: A focus on inner-city children's adjustment. *Journal of Clinical Child Psychology*, *26*, 130-144.

Erel, O., & Burman, B. (1995). Interrelatedness of marital relations and parent-child relations: A meta-analytic review. *Psychological Bulletin*, *118*, 108-132.

Fitzpatrick, K. M. & Boldizar, J. (1993). *The prevalence and consequences of exposure to violence among African-American youth. Journal of the American Academy of Child & Adolescent Psychiatry, 32*, 424-430.

Graham-Bermann, S. A., & Levendosky, A. A. (1998). Traumatic stress symptoms in children of battered women. *Journal of Interpersonal Violence*, *13*, 111-128.

Herman, J. (1992). *Trauma and recovery*. New York: Basic Books.

Hirsch, B. J., Roffman, J., Deutsch, N., Flynn, C., Loder, T., & Pagano, M. (2000). Inner-city youth development organizations: Strengthening programs for adolescent girls. *Journal of Early Adolescence*, *20*, 210-230.

Kendall, P. C., Marrs-Garcia, A., Nath, S. R., & Sheldrick, R. C. (1999). Normative comparisons for the evaluation of clinical significance. *Journal of Consulting & Clinical Psychology, 67*, 285-99.

Kiser, L. J., Millsap, P. A., & Heston, J. D. (1992). Clinical description of victims of physical and sexual abuse in a day treatment population. *International Journal of Partial Hospitalization*, *8*, 89-96.

Kiser, L. J., Heston, J. D., Hickerson, S., Millsap, P. A., Nunn, W., & Pruitt D. B. (1993). Anticipatory stress in children and adolescents. *American Journal of Psychiatry, 150,* 87-92.

Levendosky, A. A., & Graham-Bermann, S. A. (1998). The moderating effects of parenting stress on children's adjustment in woman-abusing families. *Journal of Interpersonal Violence*, *13*, 363-397.

Levine, S. Z., Laufer, A., Hamama-Raz, Y., Stein, E., & Solomon, Z. (2008). Posttraumatic growth in adolescence: Examining its components and relationship with PTSD. *Journal of Traumatic Stress, 21,* 492-496.

Macy, R. D., Barry, S., & Noam, G. G. (2003). Threat and trauma: An overview. In R.D. Macy, S. Barry, & G.G. Noam (Eds.), *New directions for youth development: Youth facing threat and terror: Supporting preparedness and resilience* (pp. 11-28). San Francisco, CA: Jossey-Bass.

Margolin, G., & Gordis, E. B. (2000). The effects of family and community violence on children. *Annual Review of Psychology*, *51*, 445-479.

McCarroll, J. E., Ursano, R. J., Fullerton, C. S., Liu, X., & Lundy, A. (1995). Anticipatory stress of handling human remains from the Persian Gulf War: Predictors of intrusion and avoidance. *Journal of Nervous & Mental Disease*, *183*, 698-703.

Miller, L. (1999). Treating posttraumatic stress disorder in children and families: Basic principles and clinical considerations. *The American Journal of Family Therapy*, *27*, 21-34.

Mirza, K. A., Bhadrinath, B. R., Goodyer, I. M., & Gilmour, C. (1998). Post-traumatic stress disorder in children and adolescents following road traffic accidents. *British Journal of Psychiatry, 172,* 443-7.

Morsette, A., Swaney, G., Stolle, D., Schuldberg, D., van den Pol, R., & Young, M. (2009). Cognitive behavior intervention for trauma in schools (CBITS): School based treatment on a rural American Indian reservation. *Journal of Behavior Therapy and Experimental Psychiatry, 40*, 169-178.

Ngo, V., Langley, A., Kataoka, S. H., Nadeem, E., Escudero, P., & Stein, B. D. (2008). Providing evidence based practice to ethnically diverse youth; Examples from the Cognitive Behavioral Intervention for Trauma in Schools (CBITS) program. *Journal of the American Academy of Child and Adolescent Psychiatry, 47*, 858-862.

Overstreet, S., & Braun, S. (2000). Exposure to community violence and post-traumatic stress symptoms: Mediating factors. *American Journal of Orthopsychiatry, 70*, 263-271.

Parson, E.R. (1997). Posttraumatic child therapy (P-TCT). *Journal of Interpersonal Violence*, *12*, 172-195.

Perrin, S., Smith, P., & Yule, W. (2000). Practitioner review: The assessment and treatment of Post-traumatic Stress Disorder in children and adolescents. *Journal of Child Psychology and Psychiatry, 41*, 277-289.

Perry, B. D., & Pollard, R. (1998). Homeostasis, stress, trauma, and adaptation: A neurodevelopmental view of childhood trauma. *Child and Adolescent Clinics of North America*, *7*, 33-51.

Pfefferbaum, B. (1997). Posttraumatic stress disorder in children: A review of the past 10 years. *Journal of the American Academy of Child and Adolescent Psychiatry*, *36*, 1503-1511.

Pynoos, R. S., Steinberg, A. M., & Piacentini, J. C. (1999). A developmental psychopathology model of childhood traumatic stress and intersection with anxiety disorders. *Biological Psychiatry*, *46*, 1542-1554.

Pynoos, R. S., Steinberg, A. M., & Goenjian, A. (1996). Traumatic stress in childhood and adolescence: Recent developments and current controversies. In B.A. van der Kolk, A.C. McFarlane, & L. Weisaeth (Eds.), *Traumatic stress: The effects of overwhelming experience on mind, body, and society* (pp. 331-358). New York: Guilford Press.

Saunders, B. E., Berliner, L., & Hanson, R. F. (2004). *Child physical and sexual abuse: Guidelines for treatment (revised report)*. Charleston, SC: National Crime Victims Research and Treatment Center.

Schwab-Stone, M., Chen, C., Greenberger, E., Silver D., Lichtman, J., & Voyce, C. (1999). No safe haven II: The effects of violence exposure on urban youth. *Journal of the American Academy of Child & Adolescent Psychiatry*, *38*, 359-367.

Stallard, P., Velleman, R., & Baldwin, S. (1999). Psychological screening of children for post-traumatic stress disorder. Journal of Child Psychology and Psychiatry, 40, 1075-1082.

Stevenson, H.C. (1998). Raising safe villages: Cultural-ecological factors that influence the emotional adjustment of adolescents. *Journal of Black Psychology*, *24*, 44-59.

Stover, C. S., & Berkowitz, S. J. (2005). Assessing violence exposure and trauma symptoms in young children: A critical review of measures. *Journal of Traumatic Stress*, *18*, 707-717.

Substance Abuse and Mental Health Services Administration. (2005). *National registry of evidence-based programs and practices database*. Washington, DC.

Temple, S. (1997). Treating inner-city families of homicide victims: A contextually oriented approach. *Family Process*, *36*, 133-149.

Terr, L. C. (1991). Childhood traumas: An outline and overview. *American Journal of Psychiatry*, *148*, 10-20.

Terr, L. C. (1985). Psychic trauma in children and adolescents. *Psychiatric Clinics of North America*, *8*, 815-835.

Terr, L. C. (1983). Chowchilla revisited: The effects of psychic trauma 4 years after a school bus kidnapping. *American Journal of Psychiatry*, *140*, 1543-1550.

van der Kolk, B. A. (2005). Developmental Trauma Disorder: Toward a rational diagnosis for children with complex trauma histories. *Psychiatric Annals*, *35*, 401-408.

Vila, G., Porche, L. M., & Mouren-Simeoni, M. C. (1999). An 18-month longitudinal study of posttraumatic disorders in children who were taken hostage in their school. *Psychosomatic Medicine, 61,* 746-754.

Warren, S. L., Emde, R. N., & Sroufe, L. A. (2000). Internal representations: Predicting anxiety from children's play narratives. *Journal of the American Academy of Child and Adolescent Psychiatry*, *39*, 100-107.

Wethington, H. R., Hahn, R. A., Fuqua-Whitley, D. S., Sipe, T. A., Crosby, A. E., Johnson, R. L., et al. (2008). The effectiveness of interventions to reduce psychological harm from traumatic events among children and adolescents: a systematic review. *American Journal of Preventive Medicine, 35*, *287-313.*

Whittlesey, S. W., Allen, J. R., Bell, B. D., Lindsey, E. D., Speed, L. F., Lucas, A. F, Ware, M.M., Allen, S.F. & Pfefferbaum, B. (1999). Avoidance in trauma: Conscious and unconscious defense, pathology, and health. *Psychiatry*, *62*, 303-312.

Chapter 3

Impact of Trauma and Urban Poverty on Adult Family Members

The impact of trauma on adults is well documented for a variety of trauma types and populations, including, to some degree, in the context of urban poverty. Although much of the research focuses on the characteristics of posttraumatic stress disorder (PTSD) and factors that contribute to its development, increasing attention is being paid to reactions to trauma beyond the symptomatology of PTSD, especially in the case of complex trauma involving chronic or multiple traumatic experiences.

Theory

Cahill and Foa (2007) presented an overview of the theoretical perspectives used to account for the development of PTSD. These included the following six theoretical groupings: (1) conditioning theories such as Mowrer's two-factor learning theory of fear and anxiety; (2) schema theories, which are rooted in theories of personality and social psychology; (3) emotional processing theory, which led to the development of a comprehensive theory of PTSD centered on the concept that individuals with PTSD possess "pathological fear structures" in their memory; (4) classical cognitive theory, which led to Ehlers and Clark's (2000) model of PTSD organized around the concept of the traumatic memory; (5) dual representation theory, which is connected to contemporary cognitive neuroscience; and (6) the SPAARS model, with its four levels or formats of mental representation (schematic, propositional, analogue, and associative representational systems) (Cahill & Foa, 2007). Other theoretical perspectives represented within the literature include: attachment theory (Scheeringa & Zeeanah, 2001), family systems theory (Punamaki, Qouta, El Sarraj, & Montgomery, 2006), conservation of resources theory (Walter & Hobfoll, 2009), stress response theory (Kira, 2001), the self-trauma model (Briere & Scott, 2006), and general cognitive and behavioral theories (Monson & Friedman, 2007). Discussions within the literature around the traumatic nature of poverty and trauma within the context of poverty are rooted in the family stress model and the context of stress model (Wadsworth & Santiago, 2008).

Key Research Findings

There is a plethora of conceptual and empirical findings on the impact of chronic trauma and economic deprivation on adults' functioning, health, and well-being. It is well established from national epidemiological studies of PTSD that approximately 50% to 90% of adults in the United States have experienced one or more traumatic events; and 10% to 20% of those exposed will develop all of the symptoms necessary to establish a diagnosis of PTSD. Furthermore, a much higher percentage, up to 68%, will develop some symptoms of PTSD (Norris & Slone, 2007). Adults surviving the stress of urban poverty are not only more likely to experience multiple traumatic events; they are also more likely to develop trauma-related symptoms that impact their functioning, health, and well-being (Breslau, Chilcoat, Kessler, Peterson, & Lucia, 1999; Cooper-Patrick et al., 1999; Kessler et al., 1999). Research by Switzer et al. (1999) showed that 42% of adult urban residents exposed to trauma met diagnostic criteria for PTSD at 12 months and as many as 69% met the criteria at some point in their lifetime.

The symptoms of PTSD include feelings of intense fear, helplessness, or horror; reexperiencing of a traumatic event through dreams, flashbacks, or dissociative experiences; avoiding reminders of the trauma (concrete triggers such as people and places, as well as thoughts and feelings), which can

lead to feelings of detachment and emotional numbing; and increased anxiety and other symptoms of hyperarousal such as sleep disturbances, irritability, or concentration difficulties (American Psychiatric Association, 2000). These symptoms will impact, to varying degrees, an individual's ability to function in professional, social and familial contexts (Breslau, 2002).

Much of the research on trauma is now moving beyond the conceptualization of PTSD to address symptoms exhibited by individuals who have experienced complex trauma, which involves chronic or multiple traumatic events and is often interpersonal in nature. The experience of chronic trauma has been connected to a host of symptoms not captured in the PTSD diagnosis, including: altered self-capacities, such as dysfunctions in the areas of identity, affect regulation, and interpersonal relatedness; cognitive disturbance, such as low self-esteem, self-blame, helplessness, hopelessness, and expectations of rejection and loss; mood disturbance, such as anxiety, depression, anger and aggression; and overdeveloped avoidance responses, such as dissociation, substance abuse and tension-reducing behaviors such as compulsive sexual behavior, binging and purging, and self-mutilation (Briere & Spinazzola, 2005). Furthermore, experiencing childhood abuse, neglect or other traumatic stressors, known as adverse childhood experiences, increases the individual's risk for a variety of health problems as an adult, including alcoholism, heart disease, obesity, drug use, liver disease, and depression, among others (Felitti et al., 1998).

Research into the characteristic effects of experiencing specific types of trauma is also widely available, specifically addressing the impacts of medical trauma (Santacroce, 2003), interpersonal violence (Helfrich, Fujiura, & Rutkowski-Kmitt, 2008), and military combat (Matsakis, 2007). Not only does the impact of trauma depend on the nature and severity of the traumatic incident, research also shows that the impact may differ depending on the cultural background of the individual (Jobson & O'Kearney, 2008). The oppressive experience of racism in and of itself can be considered a form of traumatic stress (Bryant-Davis, 2007). Poverty can also be considered a form of trauma (Kira, 2001). Constant worry about hunger, violence, illness and accidents, economic strain, and discrimination experienced by those dealing with poverty-related stress has been tied to reduced physical and mental health such as depression and anxiety (Wadsworth & Santiago, 2007).

On the other end of the spectrum, some research suggests that successful negotiation of a traumatic event can lead to positive outcomes. This is known as posttraumatic growth and may include improved relationships with others, openness to new possibilities, greater appreciation of life, enhanced personal strength, and spiritual development (Peterson, Park, Pole, D'Andrea, & Seligman, 2008). However, individuals struggling with both trauma and poverty are less likely to have access to resources that may facilitate successful negotiation of a traumatic event and the resulting positive outcomes. Walter and Hobfoll (2009) found that inner-city women with PTSD who were able to limit the loss of material, energy, and familial interpersonal resources demonstrated significant traumatic symptom reduction over a 6-month period.

Risk and Protective Factors

Information about risk and protective factors for adults is abundant within the literature. A meta-analysis by Brewin, Andrews, and Valentine (2000) helped sort out which factors are stronger predictors of the development of PTSD and which seem to be predictors only within certain populations. Gender, age at trauma, and race only predicted PTSD in some populations: for example, the gender effect (PTSD being more likely to develop in women than men) was not seen in combat veterans, and race was a weak predictor in almost all populations. While education, previous trauma, and general childhood adversity were more dependable predictors of PTSD, they still varied based on the population studied. The strongest predictors were psychiatric history, reported childhood abuse, and family psychiatric history (Brewin et al., 2000). Risk factors that occurred during or after the

traumatic event, such as trauma severity, lack of social support, and additional life stress, had a stronger impact than factors in existence prior to the trauma (Brewin et al., 2000).

Another meta-analysis, conducted by Ozer, Best, Lipsey, and Weiss (2003), found that peritraumatic psychological processes, such as high emotion or dissociative experiences immediately before and/or after the traumatic incident, were the strongest predictors of the development of PTSD. Also, biological factors, such as allostatic load and predisposing genetic factors, may increase an individual's vulnerability to the development of PTSD (Layne, Warren, Watson, & Shaleve, 2007). Some of the protective factors identified include: an easygoing temperament, high intellectual ability, positive family environment, internal locus of control, socioeconomic advantage, coping skills, social support, self-concept, self-efficacy, and self-regulation (Layne et al., 2007). A qualitative study with parents of murdered children identified the following six resources as possible protective factors: personal qualities, spirituality, continuing bond with the victim, social support, previous coping experience, and self-care (Parappully, Rosenbaum, van den Daele, & Nzewi, 2002).

Table 3.1: Risk and Protective Factors for Adult Family Members

Risk Factors	Protective Factors
Psychiatric history	Easygoing temperament
Childhood abuse	High intellectual ability
Family psychiatric history	Positive family environment
Low socioeconomic status	Internal locus of control
Lack of education	Socioeconomic advantage
Low intelligence	Coping skills
Other previous trauma	Social support
Other adverse childhood experience	Self-concept
Trauma severity	Self-efficacy
Lack of social support	Self-regulation
Life stress	Spirituality
Female gender	Self-care
Younger age	
Race (minority status)	
Peritraumatic psychological processes (high emotion & dissociative) experiences)	
Biological and genetic predisposition	

Assessment Instruments

Two of the most consistently used instruments to assess adult responses to trauma are the PTSD Checklist (PCL) (Weathers et al., 1993) and the Structured Clinical Interview for DSM-IV, PTSD module (SCID-PTSD). The PCL consists of 17 self-report items and has shown test-retest reliability and validity in both veteran and civilian populations, with military (PCL-M) and civilian (PCL-C) versions available for use. The scoring allows for the measurement of both symptom severity and diagnostic status (Keane, Brief, Pratt, & Miller, 2007). The SCID-PTSD must be administered by a clinician, who rates the presence of PTSD symptoms based on the individual's response to prompts and follow-up questions pertaining to the diagnostic criteria for PTSD (Keane et al., 2007).

Keane et al. (2007) included the following assessment instruments in their overview of the best evidence-based measures of responses to trauma: the Clinician Administered PTSD Scale (CAPS) (Blake et al., 1990), PTSD Symptom Scale Interview (PSS-I) (Foa, Riggs, Dancu, & Rothbaum, 1993), Structured Interview for PTSD (SIP) (Davidson, Smith, & Kudler, 1989; Davidson et al., 1997), and Posttraumatic Diagnostic Scale (PDS) (Foa et al., 1997). For a complete list of other assessment instruments appearing in the literature, see Appendices A and B.

Interventions

A variety of interventions have been designed to assist adults struggling to recover after trauma. Some have been evaluated and empirically proven effective; however, even in the most successful programs, 50% of individuals who finish treatment continue to experience symptoms that warrant an ongoing diagnosis of PTSD (Monson & Friedman, 2006). Friedman, Resick, and Keane (2007) observed that "all clinical practice guidelines for PTSD recommend cognitive behavior therapy (CBT) as the treatment of choice" and noted that the most successful treatment modalities are prolonged exposure (Foa, Hembree, & Rothbaum, 2007), cognitive therapy, cognitive processing therapy, and stress inoculation therapy, all of which may be considered CBT approaches (Friedman, Resick, & Keane, 2007, p. 9). Similarly, a recent meta-analysis of different treatment methods for PTSD found that three methods — Trauma-Focused CBT (TF-CBT) and Eye Movement Desensitization and Reprocessing (EMDR), stress management, and group CBT — each improved PTSD symptoms more than placement on a waiting list or usual care methods. TF-CBT or EMDR were superior to all other interventions (Bisson et al., 2007). Other interventions, such as supportive therapy/nondirective counseling, psychodynamic therapies, and hypnotherapy, demonstrated inconclusive or unsuccessful results (Bisson et al., 2007). A meta-analysis by Davidson and Parker (2001) also highlighted the effectiveness of CBT and EMDR for dealing with trauma, but it questioned the necessity of the eye movement stimulation aspect of EMDR treatment.

Critical incident stress debriefing (CISD), which consists of brief treatment immediately following a traumatic incident, showed little promise in reducing post-traumatic stress symptoms in a meta-analysis conducted by van Emmerik, Kamphuis, Hulsbosch, and Emmelkamp (2002). Other new intervention strategies, such as the "comprehensive, integrated, trauma-informed, and consumer-involved services" provided through the Women, Co-occurring Disorder and Violence Study (WCDVS) (Substance Abuse and Mental Health Services Administration, 2000), show the potential to reduce both posttraumatic stress symptoms and severity of drug use (Cocozza et al., 2005).

Table 3.2: Interventions: Adult

Treatment Name	Developer(s)	Essential Elements	Research Evidence & Outcomes
Cognitive-Behavioral Therapy (Prolonged Exposure Therapy)	Edna Foa, Hembree & Rothbaum (2007)	3 components: psychoeducation, imaginal exposure (recounting the trauma and emotional reliving of the trauma); in vivo exposure (gradually approaching reminders of the trauma)	Empirical studies demonstrate positive results for exposure therapy in treating PTSD in a variety of populations including Vietnam Veterans, sexual assault survivors and mixed trauma survivors.
Cognitive Processing Therapy (CPT)	Patricia Resick & Monica Schnicke (1992)	Includes both cognitive and exposure components. Manualized to be conducted over 12 sessions, individual or group format	Developed for use with sexual assault survivors, successful in reducing PTSD symptoms and trauma-related guilt
Eye Movement Desensitization and Reprocessing (EMDR)	Francine Shapiro (1993)	8 phases of treatment combining aspects of exposure therapy, cognitive therapy, psychodynamic therapy and eye movement stimulation.	Meta-analysis of studies evaluating CBT & EMDR highlights the effectiveness of CBT and EMDR for dealing with trauma, but questions the necessity of the eye movement stimulation aspect of EMDR.
Stress Inoculation Training	Donald Meichenbaum (1985)	3 phases of treatment: conceptualization phase (includes psychoeducation & goal setting); coping skills acquisition and rehearsal (relaxation training); application and follow through (may include in vivo and imaginal exposure)	2 studies demonstrated effectiveness in treating PTSD with SIT in female sexual assault survivors
"comprehensive, integrated, trauma-informed, and consumer-involved services"	Women, Co-occurring Disorder and Violence Study (WCDVS); Substance Abuse and Mental Health Services Administration (SAMHSA) (2000)	Designed for women experiencing mental health and substance use disorders who have a history of physical and/or sexual abuse	9 sites are currently implementing these services, early results indicate potential to reduce both posttraumatic stress symptoms and severity of drug use

Conclusion and Comment

Risk and protective factors associated with the development of PTSD in response to single incident trauma exposures among adults have included education level, minority status, previous trauma, social support, socioeconomic status, degree of life stress and coping experience (Layne et al., 2007;Parapully et al., 2002; Brewin et al., 2000). Adults that live within the context of urban poverty are not only more likely to be at risk for multiple traumatic experiences but are also more likely to be susceptible to the very risk factors associated with the development of PTSD. This increased risk is, in turn, associated with the development of trauma-related symptoms that can impact functioning, health and well-being (Breslau, Chilcoat, Kessler, Peterson & Lucia, 1999; Cooper-Patrick et al., 1999; Kessler et al., 1999). Moreover, specific factors related to poverty-related stress such as violence, discrimination and economic strain have been associated with negative physical and mental health outcomes (Wadsworth & Santiago, 2007), making recovery from trauma exposures more difficult. Because up to 50% of individuals who finish treatment continue to experience symptoms that qualify them for an ongoing diagnosis of PTSD (Monson & Friedman, 2006), it is important to continue research in this area as well as to further develop interventions that will address the complex and specific needs of adults who live in urban poverty and experience multiple traumatic events in order to achieve the goal of improving long term outcomes.

References

American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.

Bisson, J. I., Ehlers, A., Matthews, R., Pilling, S. Richards, D., & Turner, S. (2007). Psychological treatments for chronic post-traumatic stress disorder: Systematic review and meta-analysis. *British Journal of Psychiatry*, *190*, 97-104.

Blake, D. D., Weathers, F.W., Nagy, L.M., Kaoupek, D.G., Klauminzer, G., Charney, D. S., Keane, T. M., (1990). A clinician rating scale for assessing current and lifetime PTSD: The CAPS-1. *Behavior Therapist, 13*, 187-188.

Breslau, N. (2002). Epidemiologic studies of trauma, posttraumatic stress disorder, and other psychiatric disorders. *Canadian Journal of Psychiatry, 47*(10), 923-929.

Breslau, N., Chilcoat, H. D., Kessler, R. C., Peterson, E. L., & Lucia, V. C. (1999). Vulnerability to assaultive violence: Further specification of the sex difference in posttraumatic stress disorder. *Psychological Medicine, 29*, 813-821.

Brewin, C. R., Andrews, B., & Valentine, J. D. (2000). Meta-analysis of risk factors for posttraumatic stress disorder in trauma-exposed adults. *Journal of Consulting and Clinical Psychology, 68*(5), 748-766.

Briere, J., & Scott, C. (2006). *Principles of trauma therapy*. Thousand Oaks, CA: Sage Publications.

Briere, J., & Spinazzola, J. (2005). Phenomenology and psychological assessment of complex posttraumatic states. *Journal of Traumatic Stress, 18*(5), 401-412.

Bryant-Davis, T. (2007). Healing requires recognition: The case for race-based traumatic stress. *The Counseling Psychologist, 35*(1), 135-143.

Cahill, S. P., & Foa, E. B. (2007). Psychological theories of PTSD. In M. J. Friedman, T. M. Keane, & P. A. Resick (Eds.), *Handbook of PTSD: Science and practice* (pp. 55-77). New York: The Guilford Press.

Cocozza, J. J., Jackson, E. W., Hennigan, K., Morrissey, J. P., Glover Reed, B., & Banks, S. (2005). Outcomes for women with co-occurring disorders and trauma: Program-level effects. *Journal of Substance Abuse Treatment*, *28*, 109-119.

Cooper-Patrick, L., Gallo, J. J., Powe, N. K., Steinwachs, D. M., Easton, W. W., & Ford, D. E. (1999). Mental health service utilization by African Americans and Whites: The Baltimore epidemiologic catchment area follow-up. *Medical Care, 37*, 1034-1045.

Davidson, J.R.T., Book, S.W., Colket, J.T., Tupler, L.A., Roth, S., David, D., Hertzberg, M., Mellman, T., Beckham, J.C., Smith, R.D., Davison, R.M., Katz, R., & Feldman, M.E. (1997). Assessment of a new self-rating scale for posttraumatic stress disorder. *Psychological Medicine*, 27, 153-160.

Davidson, J. R., Malik, M.A., & Travers, J. (1997). Structured interview for PTSD (SIP): psychometric validation for DSM-IV criteria. *Depression and Anxiety,* 5, 127-129.

Davidson, J. R., Smith, R. D., & Kudler, H. S. (1989). Validity and reliability of the DSM-III criteria for PTSD: experience with a structured interview. *Journal of Nervous and Mental Disease*, 176, 568-572.

Davidson, P. R., & Parker, K. C. (2001). Eye movement desensitization and reprocessing (EMDR): A meta-analysis. *Journal of Consulting and Clinical Psychology*, *69*(2), 305-316.

Ehlers, A., & Clark, D. M. (2000). A cognitive model of posttraumatic stress disorder. *Behavior Research and Therapy,* 38(4), 319-345.

Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V., et al. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) study. *American Journal of Preventive Medicine, 14*(4), 245-258.

Foa, E. B., Cashman, L., Jaycox, L. H., Perry, K. J. (1997). The validation of a self-report measure of posttraumatic stress disorder: the Posttraumatic Diagnostic Scale. *Psychological Assessment, 9*(4), 445-451.

Foa, E. B., Hembree, E. A., Rothbaum, B. O. (2007). Prolonged Exposure Therapy for PTSD: Therapist guide. New York: Oxford University Press.

Foa, E. B., Riggs, D. S., Dancu, C. V., Rothbaum, B. O. (1993). Reliability and validity of a brief instrument for assessing posttraumatic stress disorder. *Journal of Traumatic Stress*, *6*, 459-473.

Friedman, M. J., Resick, P. A., & Keane, T. M. (2007). PTSD: Twenty-five years of progress and challenges. In M. J. Friedman, T. M. Keane, & P. A. Resick, P. A. (Eds.), *Handbook of PTSD: Science and practice* (pp. 3-18). New York: The Guilford Press.

Helfrich, C. A., Fujiura, G. T., & Rutkowski-Kmitt, V. (2008). Mental health disorders and functioning of women in domestic violence shelters. *Journal of Interpersonal Violence, 23*(4), 437-453.

Jobson, L. & O'Kearney, R. (2008). Cultural differences in personal identity in post-traumatic stress disorder. *British Journal of Clinical Psychology, 47*, 95-109.

Keane, T. M., Brief, D. J., Pratt, E. M., & Miller, M. W. (2007). Assessment of PTSD and its comorbidities in adults. In M. J. Friedman, T. M. Keane, & P. A. Resick (Eds.), *Handbook of PTSD: Science and practice* (pp. 279-305). New York: The Guilford Press.

Kessler, R. C., Zhao, S., Katz, S. J., Kouzis, A. C., Frank, R. G., Edlund, M., et al. (1999). Past year use of outpatient services for psychiatric problems in the national comorbidity survey. *American Journal of Psychiatry, 156*, 115-123.

Kira, I. A. (2001). Taxonomy of trauma and trauma assessment. *Traumatology, 7*(2), 73-86.

Layne, C. M., Warren, J. S., Watson, P. J., & Shaleve, A. Y. (2007). Risk, vulnerability, resistance and resilience: Toward an integrative conceptualization of posttraumatic adaptation. In M. J. Friedman, T. M. Keane, & P. A. Resick (Eds.), *Handbook of PTSD: Science and practice* (pp. 497-520). New York: The Guilford Press.

Matsakis, A. (2007). *Back from the front: combat trauma, love, and the family.* Baltimore: The Sidran Press.

Meichenbaum, D. (1985). Stress inoculation training. New York: Pergamon Press.

Monson, C. M., & Friedman, M. J. (2006). Back to the future of understanding trauma: Implications for cognitive-behavioral therapies for trauma. In V. M. Follette & J. I. Ruzek (Eds.), *Cognitive behavioral therapies for trauma* (pp. 1-13). New York: The Guilford Press.

Norris, F. H., & Slone, L. B. The epidemiology of trauma and PTSD. In M. J. Friedman, T. M. Keane, & P. A. Resick (Eds.), *Handbook of PTSD: Science and practice* (pp. 78-98). New York: The Guilford Press.

Ozer, E.J., Best, S. R., Lipsey, T. L. & Weiss, D. (*2003*). Predictors of posttraumatic stress disorder and symptoms in adults: A meta-analysis. *Psychological Bulletin, 129*(1), 52-73.

Parappully, J., Rosenbaum, R., van den Daele, L., & Nzewi, E. (2002). Thriving after trauma: The experience of parents of murdered children. *Journal of Humanistic Psychology 42*(1), 33-70.

Peterson, C., Park, N., Pole, N., D'Andrea, W., & Seligman, M. E. (2008). Strengths of character and posttraumatic growth. *Journal of Traumatic Stress, 21*(2), 214-217.

Punamaki, R., Qouta, S., El Sarraj, E., & Montgomery, E. (2006). Psychological distress and resources among siblings and parents exposed to traumatic events. *International Journal of Behavioral Development, 30*(5), 385-397.

Resick, P. A., & Schnicke, M. K. (1992). Cognitive processing therapy for sexual assault victims. *Journal of Consulting and Clinical Psychology, 60*(5), 784-756.

Santacroce, S. J. (2003). Parental uncertainty and posttraumatic stress in serious childhood illness. *Journal of Nursing Scholarship, 35*(1), 45-51.

Scheeringa, M. S., & Zeeanah, C. H. (2001). A relational perspective on PTSD in early childhood. *Journal of Traumatic Stress, 14*(4), 799-815.

Shapiro, F. (1993). Eye movement desensitization and reprocessing (EMDR) in 1992. *Journal of Traumatic Stress*, *6*(3), 417-421.

Substance Abuse and Mental Health Services Administration (SAMHSA). (2000). Cooperative Agreement To Study Women With Alcohol, Drug Abuse and Mental Health (ADM) Disorders Who Have Histories of Violence, (No. TI 00-003) Rockville, MD: US Department of Health and Human Services.

Switzer, G. E., Dew, M. A. Thompson, K., Goycoolea, J. M., Derricott, T., & Mullins, S. D. (1999). Posttraumatic stress disorder and service utilization among urban mental health center clients. *Journal of Traumatic Stress*, *12*(1), 25-39.

van Emmerik, A. A., Kamphuis, J. H., Hulsbosch, A. M., & Emmelkamp, P. M. (2002). Single session debriefing after psychological trauma: A meta-analysis. *The Lancet*, *360*, 766-772.

Wadsworth, M. E., & Santiago, C. D. (2008). Risk and resiliency processes in ethnically diverse families in poverty. *Journal of Family Psychology, 22*(3), 399-410.

Walter, K. H., & Hobfoll, S. E. (2009). Resource loss and naturalistic reduction of PTSD among inner-city women. *Journal of Interpersonal Violence, 24*(3), 482-498.

Weathers, F. W., Litz, B. T., Herman, D. S., Huska, J. A., Keane, T. M., (1993). The PTSD Checklist (PCL): Reliability, validity, and diagnositic utility. Paper presented at the annual meeting of the International Society for Traumatic Stress Studies, San Antonio.

Chapter 4

Impact of Trauma and Urban Poverty on the Family as a Whole

Families exposed to urban poverty face a disproportionate risk of exposure to trauma and of becoming trauma-organized systems. Families living in urban poverty often encounter multiple traumas over many years. Repeated exposures can lead to severe and chronic reactions in multiple family members with effects that ripple throughout the family system and, ultimately, society. Although some families show resilience, many families living under chronically harsh, traumatic circumstances have difficulties adapting. These families struggle to maintain healthy structure, relationships, and coping. The erosion of family processes jeopardizes the ability of families to make effective use of structured treatment approaches and limits the success of treatments that require family support.

Theory

Systems theory is the dominant theory relevant to understanding the impact of trauma on families living in urban poverty (Shochet & Dadds, 1997; Patterson, 1991; Gelles & Maynard, 1987; Howes, Cicchetti, Toth, & Rogosch, 2000; Bronfenbrenner, 1979). Two central tenets of systems theory are important: 1) when an event occurs that affects one member of the family, the entire family system is affected; and 2) all systems strive to maintain balance or homeostasis, and when thrown out of balance by threats or traumas, try to regain balance as quickly as possible.

Trauma can impact the family system through several distinct pathways: simultaneous exposure when all members of the family are exposed to the same event; vicarious traumatization or contagion of trauma from an exposed family member to others in the family; intrafamilial trauma when one family member is the perpetrator of the trauma; and secondary stress when traumatic distress symptoms disrupt family functioning (Figley, 1988).

Other theories have been used to explain family reactions to the pressures and stresses of urban poverty, including ecodevelopmental theories (Hill, Fonagy, Safier, & Sargent, 2003; Kazak, 1989; Meyers, Varkey, & Aguirre, 2002); family stress theory (Patterson, 2002; Hammack, Robinson, Crawford, & Li, 2004; Conger et al., 2002; McCubbin, 1995); family resilience theories (Patterson, 2002; Carver, 1998; Delage, 2002; Greeff & Human, 2004; Harvey & Hill, 2004; Hernandez, Gangsei, & Engstrom, 2007); and resource theories (Thornton, 1998; Johnson, Palmieri, Jackson, & Hobfoll, 2007).

Key Research Findings

Families living in urban poverty face any number of major family stressors, such as family conflict, violence and dissolution, victimization/incarceration or death of a family member, and more neglect and maltreatment than families living in more affluent communities. They are also prone to experiencing financial hardship, residential instability, homelessness, and racial discrimination. Parental mental illness, substance abuse, or both are prevalent (Coulton, Korbin, & Su, 1999; Buckner, Bassuk, Weinreb, & Brooks, 1999; Esposito, 1999; Elliott et al., 1996; Furstenberg & Hughes, 1997). Worry over the physical safety and well-being of family members is a frequent concern for families living in impoverished, urban environments. Often these circumstances are not short-term, but ongoing, multigenerational patterns of existence (Putnam & Trickett, 1993).

Strong empirical evidence demonstrates the impact of chronic trauma on individual family members and, in turn, on multiple family subsystems. Additionally, there is evidence that living under chronically harsh, traumatic circumstances slowly erodes the critical family processes of structure, relationships, and coping (Kiser & Black, 2005). Well-designed studies using large, diverse, multiethnic samples and a wide variety of methods indicate that negative changes in family functioning are often associated with conditions of high stress, trauma, and grief or loss.

Structure

Families living in urban poverty struggle with the most fundamental family functions required to provide for basic needs and safety. Because uncontrollable stresses make it difficult to sustain a stable and predictable daily schedule, many families become chaotic and disorganized (Brody & Flor, 1997; Clark, Barrett, & Kolvin, 2000; Hill & Herman-Stahl, 2002; Kiser, Medoff, & Black, 2009; Evans, Maxwell, & Hart, 1999; Ackerman, Kogos, Youngstrom, Schoff, & Izard, 1999; Figley, 1988; Meyers et al., 2002; Wheaton, 1997). High rates of parental distress, psychopathology, and substance abuse mean that parents are often unavailable to organize family life.

Relationships

Urban poverty may also have a pervasive influence on family relationships. When significant adults are consistently unable to provide protection and control over the environment, relational models become characterized by mistrust (Ackerman et al., 1999). Frequent changes in family membership create inconsistency and increase the risk for family conflict and violence. Families exposed to chronic trauma experience sudden, unpredictable, or violent losses at a higher rate, making members vulnerable to traumatic grief reactions (Burgress, 1975). Finally, families living in urban poverty often have fewer social support resources and more difficulty mobilizing them for coping and problem solving.

Coping

Trauma and the context of urban poverty (high-burden, uncontrollable, unpredictable, and recurring conditions) dictate the choice of family coping responses. Many families find that their coping resources are depleted and their efforts to plan, solve problems, and follow through are futile. Based on the ABCX family crisis model (Hill, 1958), the combination of depleted coping resources and reactive coping styles suggests that families will repeatedly move through one crisis after another (Repetti, Taylor, & Seeman, 2002; Kiser, Ostoja, & Pruitt, 1998).

The literature also reflects that some families faced with difficult environments and multiple stressors show resilience, adaptation, and positive outcomes. Indeed, certain families experience posttraumatic growth and begin to cope in more productive ways following traumatic events (Calhoun & Tedeschi, 1998). Burton and Jarrett (2000) note that families showing resilience make deliberate accommodations to cope with the unpredictable, dangerous contexts of urban poverty. Resilient families structure their routines to accomplish daily tasks safely. They stress the importance of frequent communication when apart. They adopt relatively strict rules and limits to maintain control of what they can control (Gaudin, Polansky, Kilpatrick, & Shilton, 1996), and they also pull together, support each other, and believe that they can overcome their difficulties (Greeff & Human, 2004; Lauterbach, Koch, & Porter, 2007; McCubbin & McCubbin, 1993; Patterson, 2002). Resilient families often rely on a collective value and belief system that helps them in understanding what is important to the family and in explaining and justifying the positive and negative events in their lives (Evans, Boustead, & Owens, 2008; Haight, 1998).

Risk and Protective Factors

Studies of families impacted by trauma related to urban poverty have delineated some consistent risk and protective factors. The strongest of these may be parental characteristics, and parental adjustment and support following trauma have been related to favorable family responses. The caregiving subsystem is typically responsible for structuring daily routines and for setting the tone for family interactions. When caregivers experience high stress and significant trauma, their availability to function in this role may be compromised. Parental responses to trauma directly affect family functioning, including emotional expression and problem solving, and can lead to an increased risk of family violence (Davidson & Mellor, 2001; Margolin, Christensen, & John, 1996).

While parental functioning is both a risk and protective factor for adjustment to trauma, other important contributors to family response are preexisting family characteristics. Unclear leadership, decreased organization and verbal expression, negative affect expression, increased isolation, unresolved conflict, and increased chaos appear more prominently among neglectful than non-neglectful families (Gaudin et al., 1996). In addition, low family income and isolation increase the risk for multiple forms of family violence, including intimate partner violence and child abuse. Davies, Myers, Cummings, and Heindel (1999) found that family physical violence resulted from poor interpersonal interactions in the family and contributed to avoidance of conflict and to hopelessness about the future.

Protective factors in families include preexisting intrafamilial assistance and support from family and friends, in addition to positive physical affection, cohesion, adaptability and involvement in a religious community (Greeff & Human, 2004; Higgins & McCabe, 2003). Family self-efficacy, along with a survivor mentality (as opposed to a victimization mentality), also are related to better outcomes (Chaitin, 2003).

Table 4.1: Risk and Protective Factors for Families

Risk Factors	Protective Factors
Economic deprivation	Birth spacing
Stress and trauma pileup	Sufficient caretakers
Family conflict and discord	No history of violence in family of origin
Divorce	High expectations
Lack of support network	Beliefs in family efficacy
Inadequate family problem-solving skills	Spiritual orientation
History of alcohol and drug abuse and/or mental health problems in parents	Caring and support
Poor communication patterns among family members	Warm and positive interactions
Poor supervision of the child	Ability to manage unpredictable stressors

Risk Factors	Protective Factors
Poor parent-child relationships	Ability to manage conflict effectively
Family chaos and stress	Adaptability of family roles
Exposure to community violence	Maintenance of routines and rituals
	Community involvement

Assessment Instruments

A variety of accepted assessment measures for measuring family functioning have been described. The Family Empowerment Scale is an instrument used widely in studies of family engagement and participation in treatment (Koren, DeChillo, Friesen, 1992). Two other measures of family functioning have been used widely in research on the impact of trauma and economic hardship. The Family Adaptability and Cohesion Evaluation Scales (FACES) were employed in multiple studies to assess family interaction, adjustment, adaptability, and cohesion across a variety of traumatic circumstances (Ackerman et al., 1999; Barakat et al., 1997; Higgins & McCabe, 2003; Jordan, 1991; Northam, Anderson, Adler, Werther, & Warne, 1996). The Family Assessment Device (FAD) also appeared frequently in studies addressing poverty, war trauma, and natural disaster (Clark et al., 2000; Davidson & Mellor, 2001; Kilic, Ozguven, & Sayil, 2003). In addition, the Family APGAR (Adaptability, Partnership, Growth, Affection, and Resolve) is a popular measure due to its brevity (Smilkstein, 1978), and Family Processes is a specific measure to examine family functioning in ethnic minority families living in urban poverty (Smith, Prinz, Dumas, & Laughlin, 2001). A summary of these assessment measures appears in Appendices A and B.

Interventions

There are few well-developed, standardized, and empirically supported family therapies for treating trauma, but the available literature on family trauma therapy does provide a framework for family intervention. Specific areas for trauma work with families include assuring that the child is safe from further trauma and feels safe; rapidly stabilizing family and child functioning with normal behavioral expectations; understanding trauma-related symptoms; working through trauma(s); developing a shared sense of meaning; using problem-solving techniques for minimizing additional stresses; and connecting family members to appropriate supports (Cohen, Goodman, Brown, & Mannarino, 2004; MacDonald, Chamberlain, Long, & Flett, 1999; Cozza, 2006; Cicchetti, Rogosch, & Toth, 2006; Lieberman, Van Horn, & Ghosh Ippen, 2005; Lieberman, Van Horn, & Ghosh Ippen, 2006; Toth, Maughan, Manly, Spagnola, & Cicchetti, 2002; Chaffin, et al., 2004; Taylor & Chemtob, 2004; Neimeyer, 1998). Traumatic grief research points to shared meaning making and cognitive appraisal as curative factors (Taylor & Chemtob, 2004; Neimeyer, 1998).

Descriptions of several family-level interventions appear in the literature. Some are in early stages of efficacy testing, but none have been studied rigorously.

Table 4.2 Interventions: Family

Treatment Name	Developer(s)	Essential Elements	Research Evidence & Outcomes
Family Resolution Therapy (FRT)	Saunders & Meinig (2000)	Follows a series of procedures designed for intervention to create strong family relationships in spite of long-term traumatic impact. Focuses on creating or rebuilding safe family structures that can continue to function following professional involvement.	A promising treatment; no controlled studies of efficacy.
Intensive Family Preservation Services (IFPS)	Tracy, Haapala, Kinney, & Pecora (1991)	Family-focused and community-based crisis intervention services that strive to maintain family unity and prevent the removal of children from the home. Hallmarks include small caseloads for clinicians, who provide short lengths of service; 24-hour staff availability; and provision of services directly in the home.	Kirk (2001) retrospective study: IFPS reduced or delayed number of placements of children in welfare system. Highest-risk families experienced improved family functioning.
Multisystemic Therapy for Maltreated Children and their Families (MST)	Swenson, Henggeler, Taylor, & Addison (2005)	Provision of multiple treatment interventions that target key factors within the family's social system that create dissidence and problems.	Brunk, Henggeler, & Whelan (1987): comparison of MST and parent training in brief treatment of child abuse and neglect.
Physical Abuse-Informed Family Therapy	Kolko & Swenson (2002)	Seeks to reduce domestic violence and improve positive family outcomes through promoting cooperation, development of new understandings about the value of violence-free interactions, and skill building.	No data available
Community Family Therapy (CFT)	Rojano (2004)	Developed specifically for low-income urban families, CFT combines many systems and theories in order to engage clients. Therapy requires specific commitments of both family and therapist: families commit to change by accessing community resources and civil action; and therapists seek personal growth, collaboration within the community, and provision of volunteer services.	No data available

Treatment Name	Developer(s)	Essential Elements	Research Evidence & Outcomes
Contextual Family Therapy	Boszormenyi -Nagy (1987)	Based on the psychodynamic model, this process accentuates the need for trust, loyalty, and mutual support to hold families together. Dysfunction is believed to result from the breakdown of the above elements, which leads to the loss of a sense of fairness. Fairness can be regained through guided discussion of previously avoided emotional conflicts.	Bernal, Flores-Ortiz, & Sorensen (1990): although little empirical attention has been paid to this therapy, development of an action index for this form of therapy is helpful in discerning which areas a therapist should focus on in treatment.
Project FOCUS	Saltzman, Lester, Beardslee,& Pynoos (2008)	A resilience-based program centered on opening lines of communication between parents and children. In eight sessions, families learn to communicate feelings about difficult life events and acknowledge the uniqueness of each member's experience.	A promising treatment; no controlled studies of efficacy.
Attachment Focused Family Therapy	Hughes (2007)	Works on developing behaviors between children and parents that provide physical and psychological safety for the child. This is achieved through coaching of parents on communication and play and the creation of a safe haven and secure base from which the child can explore the world.	No data available.
Strengthening Family Coping Resources (SFCR)	Kiser (2006)	Uses family ritual and routine to increase the family's sense of safety, stability, and ability to cope with crises. Intended to help families regulate their emotions and behaviors and improve family communication about and understanding of the traumas they have experienced. Consists of a 15-week multifamily group process that includes work on storytelling and creation of a family trauma narrative.	A promising treatment; no controlled studies of efficacy.

Conclusion and Comment

Families living in urban poverty are at high risk for exposure to chronic, recurrent trauma. The impact of such trauma is felt by all members of the family and can affect the family system through multiple pathways (Figley, 1988). The gradual erosion of healthy family processes due to living with trauma exposures in a high-stress context that includes on-going danger has been well documented. As coping resources are depleted over time, families struggle to maintain healthy and trusting family relationships, a positive present and future family identity, and stability and structure both within the family system and in their day-to-day lives. However, despite the struggles faced by many families living in harsh conditions, resilient families exist who are not only able to adapt following difficult times, but can even grow stronger as a family unit. Knowledge gained from both the distressed and highly adaptive families can aid development of appropriate interventions to address safety concerns, stabilize the family unit, connect the family with resources, and work through the trauma to alleviate associated symptoms. By working with the family as a whole to address the impact of trauma, the family unit can grow stronger and move forward, together.

References

Ackerman, B. P., Kogos, J., Youngstrom, E., Schoff, K., & Izard, C. (1999). Family instability and the problem behaviors of children from economically disadvantaged families. *Developmental Psychology, 35*, 258-268.

Barakat, L. P., Kazak, A. E., Meadows, A. E., Casey, R., Meeske, K., & Stuber, M. L. (1997). Families surviving childhood cancer: A comparison of posttraumatic tress symptoms with families of healthy children. *Journal of Pediatric Psychology, 22*, 843-859.

Bernal, G., Flores-Ortiz, Y., & Sorensen, J. L. (1990). A Contextual Therapy action index. *Journal of Family Psychology, 23,* 119-149.

Boszormenyi-Nagy, I. (1987). Foundations of contextual therapy: Collected papers of Ivan Boszormenyi, M.D. Philadelphia, PA: Brunner/Mazel.

Brody, G. H., & Flor, D. L. (1997). Maternal psychological functioning, family processes, and child adjustment in rural, single-parent, African American families. *Developmental Psychology, 33*, 1000-1011.

Brunk, M. A., Henggeler, S. W., & Whelan, J. P. (1987). Comparison of multisystemic therapy and parent training in the brief treatment of child abuse and neglect. *Journal of Consulting and Clinical Psychology, 55,* 171-178.

Buckner, J. C., Bassuk, E. L., Weinreb, L. F., & Brooks, M. G. (1999). Homelessness and its relation to the mental health and behavior of low-income school-age children. *Developmental Psychology, 35,* 246-257.

Burgress, A. (1975). Family reaction to homicide. *American Journal of Orthopsychiatry*, *45,* 391-398.

Burton, L. M., & Jarrett, R. L. (2000). In the mix, yet on the margins: The place of families in urban neighborhood and child development research. *Journal of Marriage & the Family, 62*, 1114-1135.

Bronfenbrenner, U. (1979). *The ecology of human development*. Cambridge, MA: Harvard University Press.

Calhoun, L., & Tedeschi, R. (1998). Beyond recovery from trauma: Implications for clinical practice and research. *Journal of Social Issues, 54*, 357-371.

Carver, C. S. (1998). Resilience and thriving: Issues, models, and linkages. *Journal of Social Issues, 54*, 245-266.

Chaffin, M., Silovsky, J. F., Funderburk, B., Valle, L. A., Brestan, E. V., Balachova, T., et al. (2004). Parent-Child Interaction Therapy with physically abusive parents: Efficacy for reducing future abuse reports. *Journal of Consulting & Clinical Psychology, 72,* 500-510.

Chaitin, J. (2003). "Living with" the past: Coping and patterns in families of Holocaust survivors. *Family Process, 42*, 305-322.

Cicchetti, D., Rogosch, F. A., & Toth, S. L. (2006). Fostering secure attachment in infants in maltreating families through preventive interventions. *Development and Psychopathology, 18,* 623-650.

Clark, A. F., Barrett, L., & Kolvin, I. (2000). Inner city disadvantage and family functioning. *European Child & Adolescent Psychiatry, 9*, 77-83.

Cohen, J. A., Goodman, R. F., Brown, E. J., & Mannarino, A. (2004). Treatment of childhood traumatic grief: Contributing to a new emerging condition in the wake of community trauma. *Harvard Review of Psychiatry, 12,* 213-216.

Conger, R. D., Wallace, L. E., Sun, Y., Simons, R. L., McLoyd, V. C., & Brody, G. H. (2002). Economic pressure in African American families: A replication and extension of the family stress model. *Developmental Psychology, 38*, 179-193.

Coulton, C. J., Korbin, J. E., & Su, M. (1999). Neighborhoods and child maltreatment: A multi-level study. *Child Abuse & Neglect, 23,* 1019-1040.

Cozza, S. J. (2006). *The children and families of combat injured service members*. All Network Meeting-National Child Traumatic Stress Network.

Davidson, A. C., & Mellor, D. J. (2001). The adjustment of children of Australian Vietnam veterans: is there evidence for the transgenerational transmission of the effects of war-related trauma? *Australian and New Zealand Journal of Psychiatry, 35*, 345-351.

Davies, P. T., Myers, R. L., Cummings, E., & Heindel, S. (1999). Adult conflict history and children's subsequent responses to conflict: An experimental test. *Journal of Family Psychology, 13*, 610-628.

Delage, M. (2002). Strengthening family resilience in traumatic situations. *Therapie Familiale, 23*, 269-287.

Elliott, D. S., Wilson, W. J., Huizinga, D., Sampson, R. J., Elliott, A., & Rankin, B. (1996). The effects of neighborhood disadvantage on adolescent development. *Journal of Research on Crime and Delinquency, 33,* 389-426.

Esposito, C. (1999). Learning in urban blight: School climate and its effect on the school performance of urban, minority, low-income children. *School Psychology Review, 28,* 365-377.

Evans, C. J., Boustead, R. S., & Owens, C. (2008). Expressions of spirituality in parents with at-risk children. *Families in Society, 89,* 245-252.

Evans, G. W., Maxwell, L. E., & Hart, B. (1999). Parental language and verbal responsiveness to children in crowded homes*. Developmental Psychology, 35*, 1020-1023.

Figley, C. R. (1988). Post-traumatic family therapy. In F. M. Ochberg (Ed.), *Post-traumatic therapy and victims of violence* (pp. 83-109). New York: Bruner/Mazel.

Furstenberg, F. & Hughes, M. (1997). The influence of neighborhoods on children's development: A theoretical perspective and a research agenda. In J. Brooks-Gunn, G. Duncan, & J. Aber (eds.). *Neighbourhood Poverty Volume 2: Policy Implications in Studying Neighborhoods.* New York: Russell Sage Foundation.

Gaudin, J. M., Polansky, N. A., Kilpatrick, A. C., & Shilton, P. (1996). Family functioning in neglectful families. *Child Abuse & Neglect, 20*, 363-377.

Gelles, R. J., & Maynard, P. E. (1987). A structural family systems approach to intervention in cases of family violence. *Family Relations, 38*, 270-275.

Greeff, A. P., & Human, B. (2004). Resilience in families in which a parent has died. *American Journal of Family Therapy, 32*, 27-42.

Haight, W. (1998). "Gathering the spirit" at First Baptist Church: Spirituality as a protective factor in the lives of African American children. *Social Work, 43*, 213-221.

Hammack, P. L., Robinson, W. L., Crawford, I., & Li, S. T. (2004). Poverty and depressed mood among urban African-American adolescents: A family stress perspective. *Journal of Child and Family Studies, 13*, 309-323.

Harvey, A. R., & Hill, R. B. (2004). Africentric youth and family rites of passage program: Promoting resilience among at-risk African American youths. *Social Work, 49*, 65-74.

Hernandez, P., Gangsei, D., & Engstrom, D. (2007). Vicarious resilience: A new concept in work with those who survive trauma. *Family Process, 46*, 229-241.

Higgins, D. J., & McCabe, M. P. (2003). Maltreatment and family dysfunction in childhood and the subsequent adjustment of children and adults. *Journal of Family Violence, 18*, 107-120.

Hill, R. (1958). Generic features of families under stress*. Social Casework, 49*, 139-150.

Hill, N. E., & Herman-Stahl, M. A. (2002). Neighborhood safety and social involvement: Associations with parenting behaviors and depressive symptoms among African-American and Euro-American mothers. *Journal of Family Psychology, 16*, 209-219.

Hill, J., Fonagy, P., Safier, E., & Sargent, J. (2003). The ecology of attachment in the family. *Family Process, 42*, 205-221.

Howes, P. W., Cicchetti, D., Toth, S. L., & Rogosch, F. A. (2000). Affective, organizational, and relational characteristics of maltreating families: A systems perspective. *Journal of Family Psychology, 14*, 95-110.

Hughes, D. A. (2007). *Attachment-focused family therapy.* New York, NY: W. W. Norton & Co.

Johnson, D. M., Palmieri, P. A., Jackson, A. P., & Hobfoll, S. E. (2007). Emotional numbing weakens abused inner-city women's resiliency resources. *Journal of Traumatic Stress, 20*, 197-206.

Jordan, J. R. (1991). Cumulative loss, current stress, and the family: A pilot investigation of individual and systemic effects. *Omega: Journal of Death & Dying, 24*, 309-332.

Kazak, A. E. (1989). Families of chronically ill children: A systems and social-ecological model of adaptation and challenge. *Journal of Consulting and Clinical Psychology, 57*, 25-30.

Kilic, E. Z., Ozguven, H. D., & Sayil, I. (2003). The psychological effects of parental mental health on children experiencing disaster: The experience of Bolu earthquake in Turkey. *Family Process, 42*, 485-495.

Kiser, L. J. (2006). *Strengthening family coping resources: Multi-family group for families affected by trauma.* Baltimore.

Kiser, L. J., & Black, M. A. (2005). Family processes in the midst of urban poverty. *Aggression and Violent Behavior, 10*, 715-750.

Kiser, L. J., Medoff, D., & Black, M. M. (2009). *Urban poverty, childhood traumatic stress, and family processes.* Manuscript submitted for publication.

Kiser, L. J., Ostoja, E., & Pruitt, D. B. (1998). Dealing with stress and trauma in families. *Stress in Children. Child and Adolescent Psychiatric Clinics of North America, 7*, 87-104.

Kirk, R. S. (2001). *Tailoring Intensive Family Preservation Services for Family Reunification Cases: Field Testing and Validation of the North Carolina Family Assessment Scale for Reunification.* Interim project report to the National Family Preservation Network and the David and Lucile Packard Foundation. Available at: <http://www.nfpn.org>

Kolko, D. J. & Swenson, C. C. (2002). *Assessing and treating physically abused children and their families: A Cognitive-behavioral approach*. Thousand Oaks, CA: Sage Publications.

Koren, P. E., DeChillo, N., & Friesen, B. J. (1992). Measuring empowerment in families whose children have emotional disabilities. *Rehabilitation Psychology, 37*, 305-321.

Lauterbach, D., Koch, E. I., & Porter, K. (2007). The relationship between childhood support and later emergence of PTSD. *Journal of Traumatic Stress, 20*, 857-867.

Lieberman, A. F., Van Horn, P., & Ghosh Ippen, C. (2005). Toward evidence based treatment: Child-Parent Psychotherapy with preschoolers exposed to marital violence. *Journal of the American Academy of Child & Adolescent Psychiatry, 44,* 1241-1248.

Lieberman, A. F., Van Horn, P., & Ghosh Ippen, C. (2006). Child-Parent Psychotherapy: 6-Month follow-up of a randomized control trial. *Journal of the American Academy of Child & Adolescent Psychiatry, 45,* 913-918.

Margolin, G., Christensen, A., & John, R. S. (1996). The continuance and spillover of everyday tensions in distressed and nondistressed families. *Journal of Family Psychology, 10*, 304-321.

McCubbin, M. (1995). The typology model of adjustment and adaptation: A family stress model. *Guidance & Counseling, 10*, 1-27.

McCubbin, M. A., & McCubbin, H. I. (1993). *Families coping with illness: The resiliency model of family stress, adjustment, and adaptation*. St. Louis, MO: Mosby Year Book.

MacDonald, C., Chamberlain, K., Long, N., & Flett, R. (1999). Posttraumatic stress disorder and interpersonal functioning in Vietnam War Veterans: A mediational model. *Journal of Traumatic Stress, 12,* 701-707.

Meyers, S. A., Varkey, S., & Aguirre, A. M. (2002). Ecological correlates of family functioning. *American Journal of Family Therapy, 30*, 257-273.

Neimeyer, R. A. (1998). *Lessons of Loss: A Guide to Coping*. New York: McGraw-Hill.

Northam, E., Anderson, P., Adler, R., Werther, G., & Warne, G. (1996). Psychosocial and family functioning in children with insulin-dependent diabetes at diagnosis and one year later. *Journal of Pediatric Psychology, 21*, 699-717.

Patterson, J. M. (1991). A family systems perspective for working with youth with disability. *Pediatrician, 18*, 129-141.

Patterson, J. M. (2002). Integrating family resilience and family stress theory. *Journal of Marriage and the Family, 64*, 349-360.

Putnam, F. W. & Trickett, P. K. (1993). Child sexual abuse: A model of chronic trauma. *Psychiatry: Interpersonal and Biological Processes, 56,* 82-95.

Repetti, R. L., Taylor, S. E., & Seeman, T. E. (2002). Risky families: Family social environments and the mental and physical health of offspring. *Psychological Bulletin, 128*, 330-366.

Rojano., R. (2004). The practice of Community Family Therapy. *Family Processes, 43,* 59-77.

Saltzman, W., Lester, P., Beardslee, W., & Pynoos, R. (2008). *FOCUS project for military families training manual*.

Saunders, B.E., & Meinig, M.B. (2000). *Family Resolution Therapy in cases of child abuse.* Charleston, SC: Authors.

Shochet, I., & Dadds, M. (1997). When individual child psychotherapy exacerbates family systems problems in child abuse cases: A clinical analysis. *Clinical Child Psychology & Psychiatry, 2*, 239-249.

Smilkstein, G. (1978). The Family APGAR: A proposal for family function test and its use by physicians. *Journal of Family Practice, 6*, 1231-1239.

Smith, E. P., Prinz, R. J., Dumas, J. E., & Laughlin, J. (2001). Latent models of family processes in African American families: Relationships to child competence, achievement, and problem behavior. *Journal of Marriage & the Family, 63,* 967-980.

Swenson, C. C., Henggeler, S. W., Taylor, I. S., & Addison, O. W. (2005). Multisystemic therapy and neighborhood partnerships: Reducing adolescent violence and substance abuse. New York, NY: Guilford Press.

Taylor, T. L. & Chemtob, C. M. (2004). Efficacy of treatment for child and adolescent traumatic stress. *Archives of Pediatric Adolescent Medicine, 158,* 786-791.

Thornton, M. C. (1998). Indigenous resources and strategies of resistance: Informal caregiving and racial socialization in black communities. In H. I. McCubbin, E. A. Thompson, A. I. Thompson, & J. A. Futrell (Eds.), R*esiliency in African-American families: Resiliency in families serie*s (Vol. 3, pp. 49-66). Thousand Oaks, CA: SAGE Publications, Inc.

Toth, S. L., Maughan, A., Manly, J. T., Spagnola, M., & Cicchetti, D. (2002). The relative efficacy of two interventions in altering maltreated preschool children's representational models: Implications for attachment theory. *Developmental Psychopathology, 14,* 877-908.

Tracy, E. M., Haapala, D. A., Kinney, J., & Pecora, P. J. (Eds.). (1991). *Intensive Family Preservation Services: An instructional sourcebook..* Cleveland, OH: Mandel School of Applied Social Sciences, Case Western Reserve University.

Wheaton, B. (1997), The nature of chronic stress. In B. H. Gottlieb (Ed.), *Coping with chronic stress. The Plenum series on stress and coping* (pp. 43-73). New York: Plenum Press.

Chapter 5

Impact of Trauma and Urban Poverty on Intergenerational Relationships

Although scant, the literature that specifically addresses the interplay of risk and protective factors related to trauma exposures and their effects across generations – from grandparents to parents and onto their children raises some important issues. As a reference point, information can be gleaned from the literature on Holocaust survivors and their children, studies of family-of-origin violence, literature on indigenous peoples and studies of complex trauma and its effects on adult functioning and infant mental health, as well as through research on risk and protective factors associated with posttraumatic stress disorder (PTSD) in adults and children. There is much more to understand about the complex mechanics of intergenerational transmission of risk and protective factors in the context of urban poverty and the interventions that may positively affect outcomes.

Theory

Several authors have attempted to organize the literature regarding the mechanisms of transmission of intergenerational trauma effects into models or frameworks. Weingarten (2004) groups these mechanisms into four categories: *biological*, based on studies showing a second generational vulnerability to PTSD possibly caused by lower cortisol levels; *psychological*, including attachment disturbances and projection; and *familial* and *societal*, which both center around issues of silence. Ancharoff, Munroe, & Fisher (1998) developed a working model of what they refer to as secondary trauma, in which a parent's "traumatized worldview" is learned through the parent-child relationship. They identify four primary mechanisms for this transmission: silence, overdisclosure, identification, and reenactment. Bowen (1978) contributed to contemporary understanding of intergenerational transmission of trauma by articulating the transmission of emotional processes from one generation to the next. He notes that the current family system and functioning difficulties, including experiences with and impacts of trauma, are often influenced by previous generations of the family. Kira (2001) put forward a complex classification of trauma types and transmission mechanisms. This system views poverty as a form of trauma that acts through a "collective cross-generational transmission" and "community violence as survival trauma." Further, it classifies intrafamilial physical abuse/incest as "generational family trauma" because interpersonal insults experienced by the victim generation produce attachment-style problems and distorted internal working models of relationships that go on to negatively affect the next generation.

In their review of the literature on influence of family-of-origin violence on later involvement in violent relationships, Delso & Margolin (2004) identify the main theoretical perspectives used both in this specific context and more generally regarding intergenerational effects of trauma. These are attachment theory (Bar-On et al., 1998), social learning theory (Margolin, Gordis, Median, & Oliver, 2003; Kwong, Bartholomew, Henderson, & Rinke, 2003), family systems theory (Margolin et al., 2003), continuity of antisocial behavior, and genetics and heritability.

It is well established in the trauma literature that adults with histories of childhood maltreatment have noted problems with modulating feelings states (van der Kolk, B.A., McFarlane, A.C., & Weisaeth, L., 1996), anger management (Briere, 1988), and social competence (Shipman, Zeman, Penza-Clyve & Champion, 2000). These difficulties produce functional impairments in parenting patterns that affect their children's outcomes. While women who suffer a traumatic experience in adulthood often have functional impairments related to PTSD symptoms, women with unresolved childhood abuse histories demonstrate impairments in emotional regulation and interpersonal

relationships that exceed those explained by PTSD symptoms (Cloitre, M., Miranda, R., Stovall-McClough, K. C., & Han, H., 2005).

Extending attachment theory to an exploration of how parents with trauma histories transmit elements of that history to their children through the parent child relationship, Grienenberger, Kelley, and Slade (2005) found that mothers who were able to accurately reflect on their children's affect and intentions were better able to provide integrated responses to their children in times of distress. However, maternal reflective functioning requires the mother to set aside her own affective experience and reflect on the child's subjective intention in the moment. Parents with histories of complex trauma have difficulty with emotional regulation and interpersonal relationships that may persist even after PTSD symptoms resolve. Those difficulties make the task of responding to the strong negative affect states of their children especially difficult. Children won't feel safe or contained if their adult caregivers fall apart or react harshly or punitively when the child expresses fear, anger or sadness.

Key Research Findings

The original research regarding the intergenerational transmission of trauma effects grew out of studies done with survivors of the Holocaust and their children. Researchers offer basically two perspectives. The first is **the resilience perspective**, which maintains that children of survivors who were able to cope with their traumatic experiences will have increased resilience in the face of future trauma. The second is **the vulnerability perspective**, which contends that the "permanent psychic damage" of trauma leaves children of survivors more vulnerable to future negative impacts of trauma (Danieli, 1998). Summarizing a variety of studies, Felsen (1998) described the presence of a "common constellation of personality characteristics" in children of Holocaust survivors that fall into the vulnerable range of psychological functioning, including higher tendency to depressive experiences, mistrustfulness, elevated anxiety, difficulties in expressing emotions, difficulties in the regulation of aggression, higher feelings of guilt and self-criticism, and a higher incidence of psychosomatic complaints. Children of Holocaust survivors also seem to experience greater difficulty in the area of psychological separation-individuation (Felsen, 1998), which has been related to parental overprotection and the parentification of children in this population (Bar-On et al., 1998). A prominent theme throughout these studies is the *conspiracy of silence*, which describes how survivors were not listened to and not believed immediately following the Holocaust, silencing the voices of some survivors (Danieli, 1998). Studies have shown that the survivors who had difficulties communicating their traumatic experiences to their families had children with more adverse effects, with female children showing greater adverse effects than male children.

Although a history of childhood exposure to family violence increases the risk for adult marital violence, it is not predictive and can be interrupted at various stages. Delsol and Margolin (2004) compiled the results of nine relevant studies and found that approximately 60% of maritally violent men report family-of-origin violence compared to approximately 20% of non-maritally violent men. Kwong et al. (2003) noted that all types of family-of-origin violence can be correlated to future relationship abuse, regardless of the role or gender of the victims and perpetrators. For example, a male child raised in a family with father-to-mother violence is not necessarily more likely to become a perpetrator, and a female child raised in a family with father-to-mother violence is not necessarily more likely to become a victim. However, both male and female children raised in families with father-to-mother violence have significantly higher rates of involvement in abusive relationships of some sort, whether intimate or parent-child (Kwong et al., 2003). Family-of-origin violence has been linked to higher rates of future child abuse, with co-occurrence rates ranging from 6% to 14% (Margolin et al., 2003).

Finally, several studies have looked at the role of parental trauma exposures on various elements of the child's experience and functioning. One study found that the children of caregivers with unresolved loss histories have increased behavior problems (Zajac & Kobak, 2009). Cohen, Hien, & Batchelder (2008) found that cumulative maternal trauma predicted child abuse potential, punitiveness, substance abuse, and depression. In a study of African-American women with PTSD, the researchers found that women who had high levels of social support, self esteem and religious coping were less likely to have experienced intimate partner violence and child maltreatment (Bradley, Schwartz & Kaslow 2005). Parenting stress has been shown to be affected by social support, self-efficacy, family risk, and income (Raikes and Thompson, 2005). In a study of traumatized inner-city mothers, higher levels of reflective function, regardless of the severity of PTSD symptoms, were associated with balanced classifications of their children on the Working Model of the Child Interview (WMCI) (Zeanah & Benoit, 1995). The study suggested that good reflective function may inhibit trauma-associated dysregulation (Schechter, D.S., Coots, T., Zeanah, C.H., Davies, M., Coates, S.W., Trabka, K.A., Marshall, R.D., Liebowitz, M.R., & Myers, M.M., 2005).

Risk and Protective Factors for Intergenerational Transmission of Trauma Effects

Risk and protective factors related to intergenerational transmission of trauma effects can be found in the family violence literature, where they are categorized as personal characteristics or contextual factors. Risk factors for men with violent families of origin include the following personal characteristics: psychopathology and psychological distress; antisocial personality traits; hostility; approval of marital violence and attitudes condoning violence against women; patriarchal attitudes and nonegalitarian marital role expectations; and substance abuse (Delsol & Margolin, 2004). Studies have found inconsistent results in examining risk factors at the contextual level. Delsol and Margolin (2004) found that the contextual factors of marital problems and life stress, which are often stronger predictors of domestic violence than is family-of-origin violence per se, "do not appear to play a role in the intergenerational transmission of violence" (Delsol & Margolin, 2004, p. 115). However, Choice et al. (1995) found that marital problems were a partial mediator between family-of-origin violence and marital violence. At the same time, research has shown that socioeconomic factors and cultural mores are also important contextual components in the intergenerational transmission of trauma (Waller 2001).

Research shows that "extreme or chronic" poverty multiplies risks to children's safety (i.e. exposure to toxins, pollution, and community violence) and reduces opportunities and resources needed for parents to moderate the negative impact of poverty (Knitzer, & Perry, 2009).
Exposure to violence is a major "breach in safety" that leaves the young child to manage their fear and anxiety alone; without the needed relational support to modulate their neurobiological stress responses (Schechter, & Willheim, 2009). Chronic lack of resources and compromised early parent relationships interfere with the child's ability regulate their social emotional needs. Early exposure to community violence can compromise parent-child relations and result in long term patterns of negative parent-child interactions (Scheeringa, & Zeanah, 2001).

Protective factors that limit the potential intergenerational transmission of violence include strong social bonds, attitudes about the inappropriateness of violence, strong sense of culture and racial identity and disengagement from family-of-origin trauma (Delsol & Margolin, 2004; Goodman & Olatunji 2008; Waller 2001). For violence-exposed children raised in urban poverty contexts, positive relationships with parents and community members, as well as a high self-reliance are protective factors (Vazsonyi, Pickering, & Bolland, 2006; Goodman and Olatunji 2008).

Table 5.1: Risk and Protective Factors for Intergenerational Transmission of Trauma Effects

Risk Factors	Protective Factors
Psychopathology and psychological distress	Strong social bonds
Antisocial personality traits	Disengagement from family-of-origin trauma
Hostility	Attitudes about the inappropriateness of violence
Approval of marital violence and attitudes condoning violence against women	Reflective functioning
Patriarchal attitudes and nonegalitarian marital role expectations	Strong sense of racial and cultural identity
Substance abuse	
Contextual factors	

Assessment Instruments

Due to the paucity of standardized assessment instruments measuring trauma within the family of origin, use of qualitative open-ended questions is suggested. Many of the studies described here score family-of-origin trauma dichotomously along variables such as father-to-mother aggression, mother-to-father aggression, father-to-self aggression, and mother-to-self aggression (Kwong et al., 2003). Examples of possible qualitative questions include: "When you think back to your childhood, what sorts of traumatic events did your parent(s), grandparent(s), or primary caregiver(s) experience? Please explain each person's experience with a traumatic event;" and "How did your parent(s), grandparent(s), or primary caregiver(s) respond, deal with or manage their feelings regarding the traumatic event?"

The Family History Research Diagnostic Criteria (FHRDC) (Andreasen, Endicott, Spitzer, & Winokur, 1977) is designed to collect family psychiatric information by interviewing a single family member (i.e., the study participant). The instrument includes diagnostic criteria for 12 psychiatric disorders and has been used in studies examining the impact of trauma within one's family of origin.

In addition to the adult and child measures for PTSD and mood/behavior problems, studies have used the Adult Attachment Interview, the Parenting Stress Index, the Child Abuse Potential Inventory and the Lifetime Trauma Interview. The Working Model of the Child Interview (WMCI) is a 1-hour semi-structured interview that assesses caregivers' mental representations of their children and their current relationships with their children (Zeanah & Benoit, 1995). The WMCI was developed for use in connection with the Adult Attachment Interview. Narrative responses are coded for content and quality into three categories: balanced, disengaged, and distorted.

The Parent Development Interview-Revised (PDI-R) is a 45-item semi-structured interview that assesses "parents' representations of their children, themselves as parents, and their relationships with their children" (Slade, A., Aber, J. L., Berger, B., Bresgi, I., & Kaplan, M. 2002; Slade, A., Aber, J. L., Bresgi, I., Berger, B., & Kaplan, M., 2004, p. 276). Researchers have coded the maternal narrative on the WMCI and combined this with the PDI-R to get a current rating of parental reflective function.

Interventions

Although no evaluations were found in the literature regarding interventions to address trauma within the parent's family of origin, several authors offer guidelines and recommendations to clinicians regarding intergenerational transmission of trauma. Danieli (2007) suggested that examining the former generation's trauma exposure will offer a more complete assessment of an individual's posttraumatic status. Weingarten (2004) stressed the need for clinicians to be aware of mechanisms of intergenerational transmission of trauma and offered suggestions to help foster awareness and empowerment around trauma within the family of origin.

The Clinician Assisted Videofeedback Exposure Session (CAVES) is a research assessment measure and experimental intervention that uses video to engage mothers with trauma histories in rating their interactions with their toddlers at key developmental points. It uses questions from the WMCI to probe the nature of the interaction and was found to be effective at reducing negative attributions (Schechter, D. S., Myers, M. M., Brunelli, S. A., Coates, S. W., Zeanah, C. H., Davies, M., Grienenberger, J.F., Marshall, R.D., McCaw, J.E., Trabka, K.A., & Liebowitz, M.R., 2006).

There are very few family intervention strategies geared to urban poverty. SURVIVE (Supporting Urban Residents to be Violence-Free in a Violent Environment) is a promising family-based intervention for urban youth and parents with a focus on family and community violence (DeVoe, Dean, Traube, & McKay, 2005). It incorporates 12-week, multi-family group sessions that include psychoeducation about trauma and its effects, coping skills, self care and problem solving; safety planning; risk assessment; and harm reduction.

Engagement strategies that incorporate alliances with primary and extended family systems are essential to trauma interventions in urban poverty contexts. With the overrepresentation of ethnic groups in urban poverty populations, intervention strategies will be most effective if they build on cultural variations in family roles and functions. Finally, given what the trauma literature tells us about survivors' enduring difficulties with interpersonal relationships and affect management, engagement strategies that incorporate a high level of sensitivity and affect containment will be most effective.

Table 5.2: Interventions: Intergenerational Trauma Effects

Treatment Name	Developer(s)	Essential Elements
Clinician Assisted Videofeedback Exposure Session (CAVES)	Schechter, Myers, Brunelli, Coates, Zeanah, Davies, Grienenberger, Marshall, McCaw Trabka, & Liebowitz (2006)	Video session with mother and child to review interactions; used in conjunction with WMCI
"Supporting Urban Residents to be Violence-Free in a Violent Environment" (SURVIVE)	DeVoe, Dean, Traube & McKay (2005)	Family-based intervention for urban youth; 12 week program with family group format. Includes psychoeducation, safety planning, risk identification, and harm reduction

Conclusion and Comment

Research shows that when parents have experienced traumatic events during childhood, especially within their familial relationships, their children may experience secondary effects of these exposures through complex and overlapping relationship processes. Risk factors for increased likelihood of transmission of trauma effects include the "conspiracy of silence," witnessing violence in the family of origin, poor attachment with caregivers, functional impairments in parenting, certain personality characteristics and contextual factors. Protective factors that limit intergenerational transmission include strong social bonds, attitudes about the inappropriateness of violence, and disengagement from the parent's family-of-origin trauma. In urban poverty contexts, positive relationships with parents and high self-reliance are protective factors that limit transmission of violence. Interventions for reducing transmission of trauma effects include addressing the prior generation's trauma exposure with current clients, increased clinician awareness of intergenerational trauma effects, video assisted interviews with parents and their children, and family-based models that address community violence. Although studies to date mainly inform understanding of intergenerational dynamics of family violence, the literature suggests that interventions geared to addressing trauma effects in families living in urban poverty should emphasize primary and extended family systems, build on an understanding of cultural variations in family roles and functions, and incorporate strategies that promote affect management.

References

Ancharoff, M. R., Munroe, J. F., & Fisher, L. M. (1998). The legacy of combat trauma: Clinical implications of intergenerational transmission. In Y. Danieli (Ed.), *International handbook of multigenerational legacies of trauma* (pp. 257-276). New York: Plenum Press.

Andreasen, N. C., Endicott, J., Spitzer, R. L., & Winokur, G. (1977). The family history method using diagnostic criteria. *Archives of General Psychiatry*, *34*, 1229-1235.

Bar-On, D., Eland, J., Kleber, R. J., Krell, R., Moore, Y., Sagi, A., et al. (1998). Multigenerational perspectives on coping with the Holocaust experience: An attachment perspective for understanding the developmental sequelae of trauma across generations. *International Journal of Behavioral Development*, *22*(2), 315-338.

Bowen, M. (1978). Family theory in Clinical Practice. New York: Jason Aronson.

Bradley, R., Schwartz, A. C., & Kaslow, N. J. (2005). Posttraumatic stress disorder symptoms among low-income, African American women with a history of intimate partner violence and suicidal behaviors: Self-esteem, social support, and religious coping. *Journal of Traumatic Stress*, *18*(6), 685-696.

Briere, J. (1988). The long-term clinical correlates of childhood sexual victimization. *Annals of the New York Academy of Sciences*, *528*, 327-334.

Choice, P., Lamke, L. K., & Pittman, J. F. (1995). Conflict resolution strategies and marital distress as mediating factors in the link between witnessing interparental violence and wife battering. Violence and Victims, 10, 107–119

Cloitre, M., Miranda, R., Stovall-McClough, K. C., & Han, H. (2005) Beyond PTSD: Emotion regulation and interpersonal problems as predictors of functional impairment in survivors of childhood abuse. *Behavior Therapy*, *36*(2), 119-124.

Cohen, L. R., Hien, D. A., & Batchelder, S. (2008). The impact of cumulative maternal trauma and diagnosis on parenting behavior. *Child Maltreatment*, *13*(1), 27-38.

Danieli, Y. (2007). Assessing trauma across cultures from a multigenerational perspective. In J. P. Wilson & C. S. Tang (Eds.), *Cross-cultural assessment of psychological trauma and PTSD* (pp. 65-89). New York: Springer.

Danieli, Y. (1998). Introduction: History and conceptual foundations. In Y. Danieli (Ed.), *International handbook of multigenerational legacies of trauma* (pp. 1-17). New York: Plenum Press.

Delsol, C., & Margolin, G. (2004). The role of family-of-origin violence in men's marital violence perpetration. *Clinical Psychology Review*, *24*(1), 99-122.

DeVoe, E. R., Dean, K., Traube, D., & McKay, M. M. (2005). The SURVIVE community project: A family-based intervention to reduce the impact of violence exposures in urban youth. *Journal of Aggression, Maltreatment & Trauma, 11*(4), 95-116.

Felsen, I. (1998). Transgenerational transmission of effects of the Holocaust: The North American research perspective. In Y. Danieli (Ed.), *International handbook of multigenerational legacies of trauma* (pp. 1-17). New York: Plenum Press.

Goodman, R. D. & Olatunji, C. A. (2008). Transgenerational trauma and resilience: improving mental health counseling for survivors of Hurricane Katrina. Journal of Mental Health Counseling 30 (2) 121-136

Grienenberger, J., Kelly, K., & Slade, A. (2005). Maternal reflective functioning, mother–infant affective communication, and infant attachment: Exploring the link between mental states and observed caregiving behavior in the intergenerational transmission of attachment. *Attachment & Human Development, 7*(3), 299–311.

Harpaz-Rotem, I., Murphy, R. A., Berkowitz, S., Marans, S., & Rosenheck, R. A. (2007). Clinical epidemiology of urban violence: Responding to children exposed to violence in ten communities. *Journal of Interpersonal Violence*, 22(11), 1479-190.

Kira, I. (2001). Taxonomy of trauma and trauma assessment. *Traumatology,* 7, 2.

Knitzer, J., & Perry, D. (2009) Poverty and Infant and Toddler Development: Facing the Complex Challenges. In C. H. Zeanah (Ed.), Handbook of Infant Mental Health: Third edition (pp.133-152). New York: The Guilford Press

Kwong, M. J., Bartholomew, K., Henderson, A. J., & Rinke, S. J. (2003). The intergenerational transmission of relationship violence. *Journal of Family Psychology, 17*(3), 288-301.

Margolin, G., Gordis, E. G., Median, A. M., & Oliver, P. H. (2003). The co-occurrence of husband-to-wife aggression, family-of-origin aggression and child abuse potential in a community sample. *Journal of Interpersonal Violence, 18*(4), 413-440.

McKay, M. M., Lynn, C. J., & Bannon, W. M. (2005). Understanding inner city child mental health needs and trauma exposure: Implications for preparing urban service providers. *American Journal of Orthopsychiatry, 75*(2), 201-210.

Middlemiss, W. (2003). Brief report: Poverty, stress and support: Patterns of parenting behaviour among lower income black and lower income white mothers. *Infant and Child Development, 12*(3), 293-300.

Raikes, H. A., & Thompson, R. A. (2005). Efficacy and social support as predictors of parenting stress among families in poverty. *Infant Mental Health Journal*, *26*(3), 177-190.

Scaramella, L. V., Neppl, T. K., Ontai, L. L., & Conger, R. D. (2008). Consequences of socioeconomic disadvantage across three generations: Parenting behavior and child externalizing problems. *Journal of Family Psychology*, *22*(5), 725-733.

Schechter, D.S., Coots, T., Zeanah, C.H., Davies, M., Coates, S.W., Trabka, K.A., Marshall, R.D., Liebowitz, M.R., & Myers, M.M. (2005). Maternal mental representations of the childin an inner-city clinical sample: Violence-related posttraumatic stress and reflective functioning. *Attachment and Human Development,* 7(3) 313-331.

Schechter, D. S., Myers, M. M., Brunelli, S. A., Coates, S. W., Zeanah, C. H., Davies, M., Grienenberger, J.F., Marshall, R.D., McCaw, J.E., Trabka, K.A., & Liebowitz, M.R. (2006). Traumatized mothers can change their minds about their toddlers: Understanding how a novel use of videofeedback supports positive change of maternal attributions. *Infant Mental Health Journal, 27*(5), 429-447.

Schechter, D. S., Willheim, E. (2009) The Effects of Violent Experiences on Infants and Young Children. In C. H. Zeanah (Ed.), Handbook of Infant Mental Health: Third edition (pp.196-213). New York: The Guilford Press.

Scheeringa, M. S. & Zeanah, C.H. (2001) A relational perspective on PTSD in early childhood. Journal of Traumatic Stress, 14 (4), 799-815.

Schwartz, A. C., Bradley, R. L., Sexton, M., Sherry, A., & Ressler, K. J. (2005). Posttraumatic Stress Disorder among African Americans in an inner city mental health clinic. *Psychiatric Services, 56*(2), 212-215.

Self-Brown, S. R. (2005). Effects of family violence and parental psychopathology on the psychological outcome of urban adolescents exposed to community violence. *Dissertation Abstracts International: Section B: The Sciences and Engineering*, *65*(7-B), 3724.Shipman, K.L., & Zeman, J. (1999). Emotional understanding: A comparison of physically maltreating and nonmaltreating mother-child dyads. *Journal of Clinical Child Psychology, 28,* 407-417.

Shipman, K. L., Zeman, J., Penza-Clyve, S., & Champion, K. (2000). Emotion management skills in sexually maltreated and nonmaltreated girls: A developmental psychopathology perspective. *Development and Psychopathology, 12,* 47-62.

Slade, A. (2005). Parental reflective functioning: An introduction. *Attachment & Human Development, 7*(3): 269-281.

Slade, A., Aber, J. L., Berger, B., Bresgi, I., & Kaplan, M. (2002). *The Parent Development Interview—Revised*. Unpublished manuscript, Yale Child Study Center, New Haven, Connecticut.

Slade, A., Aber, J. L., Bresgi, I., Berger, B., & Kaplan (2004). *The Parent Development Interview – Revised*. Unpublished protocol. The City University of New York.

Slee, P. T., & Murray-Harvey, R. (2007). Disadvantaged children's physical, developmental and behavioral health problems in an urban environment. *Journal of Social Service Research*, *33*(4), 57-69.

van der Kolk, B.A., McFarlane, A.C., & Weisaeth, L. (Eds.), (1996). *Traumatic stress: the effects of overwhelming experience on mind, body, and society*. New York: Guilford Press.

Vazsonyi, A., Pickering, L., & Bolland, J. (2006). Growing up in a dangerous developmental milieu: The effects of parenting process on adjustment in inner city African American adolescents. *Journal of Community Psychology, 34*, 47-73.

Wadsworth, M .E., Raviv, T., Reinhard, Wolff, B., Santiago, C. D., & Einhorn, L. (2008). An indirect effects model of the association between poverty and child functioning: The role of children's poverty-related stress. *Journal of Loss & Trauma, 13*(2-3), 156-185.

Waller, M.A. (2001). Resilience in ecosystemic context: Evolution of the concept. American Journal of Orthopsychiatry, 71, 290-297.

Weingarten, K. (2004). Witnessing the effects of political violence in families: Mechanisms of intergenerational transmission and clinical interventions. *Journal of Marital and Family Therapy*, *30*(1), 45–59.

Zajac, K., & Kobak, R. (2009). Caregiver unresolved loss and abuse and child behavior problems: Intergenerational effects in a high-risk sample. *Development and Psychopathology*, *21*, 173-187.

Zeanah C. H., & Benoit, D. (1995). Clinical applications of a parent perception interview in infant mental health. *Child and Adolescent Clinics of North America*, *4*, 539-554.

Chapter 6

Impact of Trauma and Urban Poverty on Parent-Child Relationships

Trauma, urban poverty, and parent-child relational variables interact in complex ways to affect child and family mental health outcomes. Generally speaking, research indicates that the *quality* of the parent-child relationship is negatively impacted when a parent (mother) has experienced a traumatic event or events and when the child being parented experiences an event or events. Relational variables reported in the literature include compromised attachment, parental withdrawal/worry, and reenactment of abandonment themes. Factors associated with urban poverty such as racial discrimination, economic hardship, and chronic stress increase the likelihood of a negative impact of trauma on the parent-child relationship. Moreover, trauma in a setting of poverty has been found to be more detrimental to the parent-child relationship than poverty alone.

Theory

Two well-known theories that provide a framework for examining impact of trauma on the parent-child relationship are attachment theory (Bar-On et al., 1998; Lewin & Bergin, 2001; Magnus, Cowen, Wyman, Fagen, & Work, 1999) and family systems theory (Dalla, 2003; Dickstein et al., 1998). The family stress model of economic hardship (Conger, Wallace, Sun, Simons, McLoyd & Brody, 2000) and the mundane extreme environmental stress model (Peters & Massey, 1983) provide additional perspective for understanding this impact in an urban poverty context. In a study that expanded the original family stress model of economic hardship, Conger et al. (2002) concluded that economic hardship was associated with caregiver emotional stress, which was associated with disruption in the caregiver-child relationship. Using the mundane extreme environmental stress model to explore the relationship between emotional distress and parent-child relationship quality, Murray (2001) concluded that experience of racial discrimination worsens the two variables' negative effects.

Key Research Findings

Most research examines the parent-child relationship by assessing the impact of the parent's trauma experience on the relationship. For example, reduced quality of the parent-child relationship has been attributed to the following: mothers' compromised ability to attach to her offspring due to her own trauma history (Bar-On et al., 1998); reenactment of parental abandonment themes (Dalla, 2003); and parental withdrawal and parent-child relationship conflict stemming from parental psychological symptoms such as depression (Conger et al., 2002). In a nationally representative sample of men and women with a diagnosis of posttraumatic stress disorder (PTSD, non-military), numbing was found to predict increased parent-child aggression (Lauterbach et al., 2007). Parental worry partially explained the association between parental depression and the development of posttraumatic symptoms in children being treated for assault or accident (Meiser-Stedman, Yule, Dalgleish, & Smith, 2006). In a study examining the parent-child relationship subsequent to the child's traumatic experience, mothers of child sexual abuse victims showed increased depression, anxiety, and decreased attachment behaviors when compared to mothers of non-abused children (Dickstein et al., 1998). In another study, mothers' depressive symptoms were found to be linked to their concerns about safety in the neighborhood, but maternal displays of affection and warmth were not (Hill & Herman-Stahl, 2002).

Risk and Protective Factors

The literature has suggested numerous maternal factors that increase the likelihood of negative impacts of trauma and stress on parent-child relationships. These risk factors include depression (Conger et al., 2002; Dickstein et al., 1998; Lewin & Bergin, 2001; Meiser-Stedman et al., 2006; Hill & Herman-Stahl, 2002); history of parental abandonment (Dalla, 2003); alcohol/drug abuse (Dalla, 2003); and insecure attachment to the child (Bar-On et al., 1998). Maternal factors noted to be protective were reflective functioning (Schechter et al., 2005) and secure attachment (Lewin & Bergin, 2001). Positive parental mental health and emotional responsiveness predicted resilience in a group of 7-to-9-year-olds living in high-risk urban environments (Wyman et al., 1999).
Richards et al. (2004) found that for children, unstructured and unmonitored free time with peers was a risk factor for exposure to community violence. Child protective factors were spending time with family and structured activity (Richards et al., 2004).

Contextual risk factors included racial discrimination (Meiser-Stedman et al., 2006); economic hardship (Dalla, 2003; Lauterbach et al., 2007); work-related stress (Lauterbach et al., 2007); chronic stress; and current domestic violence (Dalla, 2003). Lauterbach et al. (2007) found that social support buffered the negative effects of PTSD on parent-child relationships. Meiser-Stedman et al. (2006) concluded that a stable marital relationship buffered the negative effects of racial discrimination.

Table 6.1: Risk and Protective Factors for Parent-Child Relationships

Risk Factors	Protective Factors
Insecure Attachment	Secure attachment
History of parental abandonment	Reflective functioning
Alcohol/drug abuse	Social support
Economic hardship	Time spent with family and structured activity
Maternal (parental) depression	Stable and satisfying marital relationship
Work-related stress	Emotionally responsive parenting attitudes
Racial discrimination	Positive mental health
Unstructured and unmonitored free time with peers	
Current domestic violence	
Chronic stress	

Assessment Instruments

Though not specifically designed to do so, two measures may have potential for evaluating the parent-child subsystem in the context of traumatic experience. The Parent-Child Conflict Tactic Scales (CTS PC) (Straus, Hamby, Finkelhor, Moore, & Runyan, 1998) and Parental Acceptance-Rejection Questionnaire – Child Version (PARQ-Child) (Rohner, Saavedra, & Granum, 1980).

Interventions

Several interventions that target parent-child relationships have evidence supporting their effectiveness when used with traumatized children and their families: These include:

- Parent-Child Interaction Therapy (PCIT), which combines elements of attachment and learning theories, systems theory, and behavior modification. PCIT was developed for the treatment of young children with significant behavior problems. With a focus on balancing positive parent-child interaction and consistent limit setting, treatment involves direct practice and coaching skills in sessions and establishes daily positive interaction time in the home. It has been empirically validated in more than 80 studies.
- Child-Parent Psychotherapy (CPP), which was specifically designed to treat children under the age of 6 years with domestic violence exposures. Theoretical underpinnings include attachment, social learning, cognitive behavioral, developmental traumatology, and psychodynamic theories. A key component of CPP is a focus on improving the caregiver-child relationship. Several randomized controlled trials have demonstrated the effectiveness of CPP (Lieberman, Van Horn & Gosh Ippen, 2005; Toth, Maughan, Manly, Spagnola & Cicchetti, 2002; Cicchetti, Rogosch, & Toth, 2006).
- Abuse-Focused Cognitive Behavioral Therapy for Child Physical Abuse (AF-CBT), designed to treat physically abusive families (including the offending caregiver). Theoretical underpinnings include family systems, cognitive behavioral, and developmental traumatology theories. Parent-child- or family system-directed components include communication and pro-social problem-solving skills training. A randomized controlled trial demonstrated the effectiveness of AF-CBT (Kolko, 1996).
- Combined Parent-Child Cognitive Behavioral Approach for Children and Families at Risk for Child Physical Abuse (CPC-CBT), which integrates several CBT models and was developed to treat families with a history of harsh discipline strategies and/or physical abuse (Runyon, Ryan, Kolar & Deblinger, 2004).

Table 6.2: Interventions: Parent-Child Relationships

Treatment Name	Developer(s)	Essential Elements	Research Evidence & Outcomes
Parent Child Interaction Therapy (PCIT)	Eyberg (2003)	Relationship enhancement & child behavior management	Empirically validated in over 80 studies, with findings including decrease in parental distress; decrease in maternal depressive symptoms; generalization to untreated siblings; positive changes in parents' interaction style; and maintenance of gains up to 6 years.

Treatment Name	Developer(s)	Essential Elements	Research Evidence & Outcomes
Child Parent Psychotherapy (CPP)	Lieberman & Van Horn (2005)	Safety, affect regulation, improving child-caregiver relationship, normalization of trauma-related response, joint construction of trauma narrative	Reduction in negative child behaviors and trauma symptoms, reduction in maternal avoidance, reduction in maternal distress and PTSD symptoms, improved self-representation, enhanced attachment classification.
Abuse-Focused Cognitive Behavioral Therapy for Child Physical Abuse (AF-CBT)	Kolko (1996)	Child-directed components; caregiver-directed components; parent-child- or family system-directed components	When compared with routine community service, treatment group had better outcomes in the following: parent-child aggression, child externalizing behavior, family conflict, and family cohesion.
Combined Parent-Child Cognitive Behavioral Approach for Children and Families at Risk for Child Physical Abuse (CPC-CBT)	NJ Cares Institute (2005)	Child Intervention; Parent Intervention; Parent-Child Intervention	Preliminary data suggest improvements in child internalizing and externalizing behaviors, and positive parenting behaviors.

Conclusion and Comment

The parent-child dyad is one of the units within a family that can be negatively impacted by exposure to traumatic events. Parental emotional symptoms and behaviors associated with relationship impairment stem from responses to current and historical trauma exposures, and can be exacerbated by additional stress of minority status and living in urban poverty. Risk factors include racial discrimination, economic hardship, maternal depression and history of parental abandonment. Protective factors include secure attachment, reflective functioning, stable and satisfying marital relationship, emotionally responsive parenting attitudes and social support. The two assessment measures of general parent-child relationship (the Parent-Child Conflict Tactic Scales and Parental Acceptance-Rejection Questionnaire – Child Version) should be evaluated for their utility and feasibility in evaluation and treatment planning with traumatized families. Evidence-supported trauma-specific interventions that target the parent-child relationship demonstrate improvements in dyadic interaction, child positive behavior, attachment and reduction in parental distress.

References

Bar-On, D., Eland, J., Kleber, R. J., Krell, R., Moore, Y., Sagi, A., Soriano, E., Suedfeld, P., Van de Valen, P.G. & Ijzendoorn, M.H. (1998). Multigenerational perspectives on coping with the Holocaust experience: An attachment perspective for understanding the developmental sequelae of trauma across generations. *International Journal of Behavioral Development*, *22*(2), 315-338.

Cicchetti, D., Rogosch, F. A. & Toth, S. L. (2006). Fostering secure attachment in infants in maltreating families through preventive interventions. *Development and Psychopathology, 18,* 623-650.

Conger, R. D., Wallace, L. E., Sun, Y., Simons, R. L., McLoyd, V. C., & Brody, G. H. (2002). Economic pressure in African American families: A replication and extension of the family stress model. *Developmental Psychology*, *38*(2), 179-93.

Dalla, R. L. (2003). When the bough breaks…: Examining intergenerational parent-child relational patterns among street-level sex workers and their parents and children. *Applied Developmental Science*, *7*(4), 216-228.

Dickstein, S., Seifer, R., Hayden, L. C., Schiller, M., Sameroff, A. J., Keitner, G., et al. (1998). Levels of family assessment: II. Impact of maternal psychopathology on family functioning. *Journal of Family Psychology*, *12*(1), 23-40.

Hill, N. E., & Herman-Stahl, M. A. (2002). Neighborhood safety and social involvement: Associations with parenting behaviors and depressive symptoms among African American and Euro-American mothers. *Journal of Family Psychology*, *16*(2), 209-219.

Kolko, D.J. (1996). Individual cognitive-behavioral treatment and family therapy for physically abused children and their offending parents: A comparison of clinical outcomes. *Child Maltreatment, 1*, 322-342.

Lauterbach, D., Bak, C., Reiland, S., Mason, S., Lute, R. L., & Earls, L. (2007). Quality of parental relationships among persons with a lifetime history of posttraumatic stress disorder. *Journal of Traumatic Stress*, *20*(2), 161-172.

Lewin, L., & Bergin, C. (2001). Attachment behaviors, depression, and anxiety in nonoffending mothers of child sexual abuse victims. *Child Maltreatment*, *6*(4), 365-375.

Lieberman, A.F., Van Horn, P. & Gosh Ippen, C. (2005. Toward evidence-based treatment: Child Parent Psychotherapy with preschoolers exposed to marital violence. *Journal of the American Academy of Child and Adolescent Psychiatry*, *44*(12), 1241–1248.

Magnus, K. B., Cowen, E. L., Wyman, P. A., Fagen, D. B., & Work, W. C. (1999). Parent-child relationship qualities and child adjustment in highly stressed urban black and white families. *Journal of Community Psychology*, *27*(1), 55-71.

Meiser-Stedman, R. A., Yule, W., Dalgleish, T., & Smith, P. A. (2006). The role of the family in child and adolescent posttraumatic stress following attendance at an emergency department. *Journal of Pediatric Psychology*, *31*(4), 397-402.

Murry V. M., Brown, P. A., Brody, G. H., Cutrona, C. E., & Simons, R. L. (2001). Racial discrimination as a moderator of the links among stress, maternal psychological functioning, and family relationships. *Journal of Marriage and the Family*, *63*(4), 911–914.

Peters, M. F., & Massey, G. C. (1983). Mundane extreme environmental stress in family stress theories: The case of Black families in White America. *Marriage and Family Review*, *6*, 193-218.

Richards, M. H., Larson, R., Miller, B. V., Luo, Z., Sims, B., Parrella, D.P., et al. (2004). Risky and protective contexts and exposure to violence in urban African American young adolescents. *Journal of Clinical Child and Adolescent Psychology*, *33*(1), 138-148.

Rohner, R.P., Saavedra, J.M., & Granum, E.O., 1980. Parental Acceptance-Rejection Questionnaire test manual in R.P. Rohner (Ed.) Handbook for the study of parental acceptance-rejection, University of Connecticut: Storrs, CT, p. 58-104.

Runyon, M. K., Ryan, E., Kolar, R., & Deblinger, E. (2004). An overview of child physical abuse: Developing an integrated parent-child cognitive-behavioral treatment approach. *Trauma, Violence, & Abuse: A Review Journal, 5*, 65-85.

Schechter, D. S, Coots, T., Zeanah, C. H., Davies, M., Coates, S.W., Trabka, K. A., et al. (2005). Maternal mental representations of the child in an inner-city clinical sample: Violence-related posttraumatic stress and reflective functioning. *Attachment and Human Development*, *7*(3), 313-331.

Straus, M.A., Hamby, S. L., Finkelhor, D., Moore, D. W., & Runyan, D. K. (1998). Identification of child maltreatment with the parent-child conflict tactics scale: Development and psychometric data for a national sample of American parents. *Child Abuse and Neglect*, 22, 249-270.

Toth, S. L., Maughan, A., Manly, J. T., Spagnola, M. & Cicchetti D. (2002). The relative efficacy of two interventions in altering maltreated preschool children's representational models: Implications for attachment theory. *Developmental Psychopathology*, *14*, 877-908.

Wyman, P. A., Cowen, E. L., Work, W. C., Hoyt-Meyers, L., Magnus, K. B., & Fagen, D. B. (1999). Caregiving and developmental factors differentiating young at-risk urban children showing resilient versus stress-affected outcomes: A replication and extension. *Child Development*, *70*(3), 645-659.

Chapter 7

Impact of Trauma and Urban Poverty on Parenting Practices

Research has firmly demonstrated both that parenting practices have a direct effect on children's behaviors and outcomes, and that trauma and the stress of urban poverty may impact an individual's ability to function in a variety of circumstances, including an individual's ability to be a parent. Here we provide an overview of the ways in which trauma and poverty affect parenting practices and the interventions designed to ameliorate these effects.

Theory

Literature on impact of trauma on parenting practices and intervention strategies is rooted in a variety of theoretical perspectives: attachment theory (Appleyard & Osofsky, 2003; Banyard, Williams, & Siegel, 2003; DiLillo & Damashek, 2003; Newcomb & Locke, 2001); social learning theory (Banyard et al., 2003; DiLillo & Damashek, 2003); developmental perspective (Marcenko, Kemp, & Larson, 2000); trauma theory (Levendosky & Graham-Bermann, 2001; Elliott, Bjelajac, Fallot, Markoff, & Reed, 2005); empowerment theory and relational theory (Elliott et al., 2005); stages of change model and solution-focused approach (Van deMark, Brown, Bornemann, & Williams, 2004); cognitive behavioral approach (Van deMark et al., 2004); ecological perspective (Levendosky & Graham-Bermann, 2001; Pinderhughes, Nix, Foster, & Jones, 2001); observational learning (Locke & Newcombe, 2004); developmental lifespan model of child sexual victimization (Manion et al., 1996); parental acceptance-rejection theory (Newcomb & Locke, 2001); and Bowen family systems theory (Harris & Topham, 2004).

Key Research Findings

As with all adults, parents may react to trauma in different ways; thus, while parenting practices of some will not be affected by trauma, parental functioning of others may be diminished. Parental practices are especially dependent upon the parents' ability to manage stress reactions (Appleyard & Osofsky, 2003). Decreased parental effectiveness, less warmth, and a lack of ability to appropriately control children's behaviors have all been connected to parental experiences with trauma (Levendosky & Graham-Bermann, 2001). Parents dealing with trauma may lack an understanding of child development and age-appropriate needs, practice corporal punishment as a means of control, and express a firm belief in obedience and suppression of feelings (Green, Miranda, Daroowalla, & Siddique, 2005). Parents may hold unrealistic expectations and misattributions about the causes of their children's behavior due to traumatic experiences (Kolko & Swenson, 2002).

One of the primary mediating factors between the stress of living in poverty and poor child outcomes is the role of poor parenting practices (National Institute of Child Health and Development [NICHD], 2005; McLoyd, 1998). Living in a stressful environment with high levels of community violence and trauma, as seen in the context of urban poverty, can be linked to less positive perceptions of one's children, the use of harsh discipline, an overall strategy of reactive parenting (Pinderhughes, Dodge, Bates, Pettit, & Zelli, 2000), and decreased ability to monitor one's children (Spano, Rivera, Vazsonyi, & Bolland, 2008). Early-age parenthood is associated with harsh parenting practices, and living in chronic poverty, specifically during one's adolescence, is correlated with a much greater likelihood of early parenthood (Scaramella, Neppl, Ontai, & Conger, 2008). Raikes and Thompson

(2005) explored the connections between parenting stress, income, and "family risk", which included experiencing trauma. They learned that whereas lower-income mothers exhibited greater parenting stress, this association became less evident for mothers with higher ratings of self-efficacy (although family risk strongly predicted parenting stress). Some researchers suggest that the effects of chronic poverty on children appear to follow different pathways among different racial-ethnic groups, with parenting practices, maternal depression, and neighborhood context all playing different roles in African-American, Latino and white families (Pachter, Auinger, Palmer, & Weitzman, 2006).

Recent research shows that parents who are able to maintain effective parenting practices in the face of the stress of living in an inner-city environment have the potential to protect their adolescent sons from the negative health consequences and violent behaviors associated with that environment (Vazsonyi, Pickering, & Boland, 2006; Spano et al., 2009). Specifically, some suggest that non-coercive restrictive parenting that is consistent can shield children from the negative consequences of the stress of living in poverty (Bhandari & Barnett, 2007).

The impact of childhood sexual abuse (CSA) is one of the most widely researched forms of trauma in terms of the trauma's impact on parenting practices. One review of this body of research found three studies demonstrating a connection between maternal CSA and difficulty establishing appropriate hierarchical boundaries with children; five studies that connected a history of CSA to utilization of excessively harsh discipline; three studies demonstrating a tendency for mothers with a history of CSA to become more permissive parents; and two studies indicating that maternal CSA may lead to increased stress about one's performance as a parent (DiLillo & Damashek, 2003). Other parenting practices associated with a history of CSA include negative views of oneself as a parent, the use of physical discipline and violence towards children, neglectful behaviors, and less satisfaction with parenting (Banyard, 1997; Banyard et al., 2003; Manion et al., 1996; Schuetze & Eiden, 2005).

Risk and Protective Factors

Risk factors that increase parents' vulnerability to trauma's potential impact on parenting practices include: parental history of childhood abuse, low marital relationship quality, low income, large family size, and mother's young age (Banyard et al., 2003); parental alcoholism and/or substance use (DiLillo & Damashek, 2003; Locke & Newcombe, 2004; Marcenko et al., 2000); living in an impoverished neighborhood (Pinderhughes et al., 2001; Ceballo & McLoyd, 2002); high levels of symptoms related to posttraumatic stress disorder (PTSD), particularly emotional numbing and avoidance (Lauterbach et al., 2007); allowing children excessive unstructured and unmonitored free time (Richards et al., 2004); maternal depression and current partner violence (Schuetze & Eiden, 2005); maternal mental illness (Dickstein et al., 1998); use of avoidant coping mechanisms (Wright, Fopma-Loy, & Fischer, 2005); and racial discrimination (Murry, Brown, Brody, Cutrona, & Simons, 2001).

Protective factors that increase a parent's resilience in the face of trauma and lessen its potential to impact parenting practices include: problem-solving abilities, positive coping and self-care skills, self-esteem, spirituality, and connections to friends and other social supports (Banyard et al., 2003); spending time with family and providing structured activities for adolescents (Richards et al., 2004); spousal/partner support (Wright et al., 2005); social support networks (Burchinal, Follmer, & Bryant, 1996; Ceballo & McLoyd, 2002); family cohesion and involvement (Anderson, 2008) and maternal awareness of and communication about children's exposure to violence (Ceballo, Dahl, Aretakis, & Ramirez, 2001).

Table 7.1: Risk and Protective Factors for Parenting Practices

Risk Factors	Protective Factors
Parental history of childhood abuse	Problem-solving abilities
Low marital relationship quality and current partner violence	Positive coping and self-care skills
Low income	Time with family
Large family size	Spousal/partner support
Mother's young age	Social support networks
Parental alcoholism and/or substance use	Maternal awareness of children's exposure to violence and parent-child communication about community violence
Living in an impoverished neighborhood; low neighborhood safety	Family cohesion and involvement
High levels of PTSD-related symptoms, particularly emotional numbing and use of avoidant coping mechanisms	
Maternal depression and/or mental illness	
Racial discrimination	

Assessment Instruments

In the literature on the impact of trauma on parenting, two measures appear repeatedly as assessments of parenting practices. The first is the Parenting Stress Index (PSI) (Abidin, 1995), a self-report measure that includes 36 items that assess caregiver stress and inappropriate parenting. This measure provides for scoring in the following three areas: parental distress (contributing parental factors), difficult child (contributing child factors), and parent-child dysfunction interaction. The PSI has been demonstrated to be an appropriate measure of parenting practices in a context of urban poverty (Reitman, Currier, & Stickle, 2002). The second is Parent Sense of Competence Scale (PSOC) (Gibaud-Wallston & Wandersman, 1978), a strengths-based measure of parenting attitudes that includes 17 self-report items divided into parent satisfaction and parent self-efficacy subscales. Other assessment instruments to measure the impact of trauma on parenting practices are provided in Appendices A and B.

Interventions

Although a wide variety of interventions have been designed to support development of effective parenting practices, few of them explicitly address trauma and its impacts on parenting behaviors. A recent meta-analysis of 77 evaluations of parent training programs, by Kaminski, Valle, Filene, &

Boyle (2008), helps illustrate which components of parenting programs in general are connected to greater improvements in both parenting behavior and child externalizing behavior. The most important components were "parent training in creating positive interactions with their child" and "requiring parents to practice new skills with their own child during sessions" (Kaminski et al., p. 581). Although not labeled as trauma-informed practices, some programs included in this meta-analysis have been used successfully with populations dealing with trauma: *filial therapy* helped to increase parents' attitudes of acceptance and empathic behavior towards their children (Landreth & Lobaugh, 1998); *cognitive-ecological preventive intervention* for children living in inner-city and other urban poor communities showed success in preventing adolescent aggression at greater rates when it included a parenting component (Metropolitan Area Child Study Research Group, 2002); use of the *Keys to Interactive Parenting Scale* assessment and intervention has been shown to increase parenting outcomes (Comfort & Gordon, 2009); participation in the *STAR Parenting Program* led to decreased levels of verbal and corporal punishment, anger, stress, and child behavior problems (Nicholson, Anderson, Fox, & Brener, 2002); and *PARTNERS Parent Training Groups* demonstrated effectiveness with the use of less harsh discipline and an increase in positive parenting by families involved in Head Start (Webster-Stratton, 1998).

Another resource for trauma-related parenting programs is the literature surrounding parent training programs that have been established as evidence-based or promising practices when used in cases of child abuse and neglect. Some of these programs have been evaluated with families living in the context of urban poverty (Johnson et al., 2008; Barth et al., 2005). Several trauma-informed comprehensive service programs addressing issues such as domestic violence and substance abuse include components on parenting practices (Elliott et al., 2005; Sullivan, Egan, & Gooch, 2004; Van deMark et al., 2004). There is also the potential to mediate the impact of trauma on children by creating interventions aimed at supporting and encouraging positive parenting practices immediately following traumatic experiences (Gerwitz, Forgatch, & Wieling, 2008).

Table 7.2: Interventions: Parenting Practices

Treatment Name	Developer (s)	Essential Elements	Research Evidence & Outcomes
1-2-3 Magic	Bradley et al. (2003)	Group format, geared to parents with children between the ages of 2-12. Three steps: control negative behavior, encourage good behavior, strengthen relationships.	Parents receiving intervention demonstrated improved parenting practices and reported reduced negative child behaviors compared to a control group.

Treatment Name	Developer (s)	Essential Elements	Research Evidence & Outcomes
ADVANCE	Lovell & Richey (1997)	Social support skill training (SSST) intervention; training for parents on appropriate use of consequences, positive reinforcement, and ignoring; weekly parent discussion group on child development; daily living skills for parents. 17-session SSST groups on: creation of metaphor for friendship, the Relationships Road Map, strengths and gaps in personal networks, positive and negative indicators of potential network members, and conversational and assertiveness skills.	Participants reported significantly higher proportions of contacts with formal service providers and people from known organizations, and more conversations about finances and fewer about housework than control. Though nonsignificant, participants also reported increases in "quick contacts," self-initiated interactions, and child-related topics.
Cognitive–ecological preventive intervention	Metropoli-tan Area Child Study Research Group (2002)	Includes a classroom intervention, small group, and family intervention. Geared to children living in inner-city and other urban poor communities	Showed success preventing adolescent aggression at greater rates when intervention included a parenting component.
Family Connections	DePanfilis & DuBowitz (2005)	Community-based intervention that focuses on: emergency assistance/concrete services; home-based family intervention (e.g., family assessment, outcome-driven service plans, individual and family counseling); service coordination with referrals targeted toward risk (e.g., substance abuse treatment) and protective factors (e.g., mentoring program); and multifamily supportive recreational activities.	Positive changes in protective factors (parenting attitudes, parenting competence, and social support); diminished risk factors (depressive symptoms, parenting stress, life stress); improved safety (physical and psychological care of children); and improved behavior (decreased internalizing and externalizing).
Filial therapy	Landreth & Lobaugh (1998)	10-week filial therapy parent training group for incarcerated fathers, utilizes play therapy techniques, teaches parents to take on the therapeutic role.	Helped to increase parents' attitudes of acceptance and empathic behavior towards their children; reduced stress related to parenting.

Treatment Name	Developer (s)	Essential Elements	Research Evidence & Outcomes
Incredible Years	Webster-Stratton & Reid (2003)	Focuses on strengthening the core parenting competencies of monitoring, positive discipline, and confidence. Encourages parental involvement with children's scholastic experiences. Program divided based on child's age: 0-3, 3-6, 6-12, 4-12 years. Group based, utilizes videos and role playing.	Demonstrated success with parents with a history of child maltreatment, with improvements in parental positive affect; nurturing/supportive parenting practices and discipline competence; and the reduced use of critical statements and commands.
Keys To Interactive Parenting Scale (KIPS)	Comfort & Gordon (2006)	Assesses parenting behaviors through observation, including: "sensitivity of responses, supports emotions, physical interaction, involvement in child's activities, open to child's agenda, engagement in language experiences, reasonable expectations, adapts strategies to child, limits & consequences, supportive directions, encouragement, promotes exploration & curiosity"	Tested reliably for children ages zero through five; thoroughly tested for validity, reliability; tested with diverse populations. "Parenting outcomes assessed using increase significantly with intervention" (2009).
Multisystemic Therapy (MST)	Borduin et al. (1995)	Present-focused and action-oriented. Directly addresses intrapersonal (e.g., cognitive) and systemic (family, peer, school) factors. Individualized and highly flexible to client's needs. Most sessions held in the family's home at a convenient time or in community locations. Treatment time-limited. Goal is to empower parents to handle challenges themselves.	MST has demonstrated an increase in supportiveness and decrease in conflict-hostility in families. It has also shown decreased symptomatology in parents (self-report) and decreased behavior problems in youth (parental report). Further, participant youth have a lower rate of recidivism, drug and alcohol use, and peer aggression.
Nurturing Parent Programs	Bavolek (2002)	May be home-based (for children preschool age and below) or group-based. An empowerment-based program, the Nurturing Parent Program teaches parents what to expect from children at each developmental stage, helps parents develop nurturing, nonviolent discipline strategies, and increases effective, nurturing communication.	Parents who demonstrated maladaptive parenting practices prior to this intervention demonstrated nurturing parent attitudes after completion.

Treatment Name	Developer (s)	Essential Elements	Research Evidence & Outcomes
Parent Child Interaction Therapy (PCIT)	Eyberg (2003)	Therapists observe and coach parents during parent-child interactions. Most appropriate for children ages 2-7. Two major components, *relationship enhancement* to teach parents to decrease negative aspects of their relationship and develop supportive communication; and *strategies for compliance* to teach effective discipline and child management skills.	Program shown to be effective in reducing child behavior problems and maternal stress and increasing the number of positive parent-child interactions.
Parenting Through Change	Forgatch & DeGarmo (1999)	Series of 14-16 weekly parent group meetings (group size 6-16) in office setting with child care, meals, and transportation provided. Manualized sessions with instruction in non-coercive discipline, contingent encouragement, monitoring, and problem solving. Homework assignments, charts, and parent manual.	Reduced coercive parenting practices, prevented decay in positive parenting, improved effective parenting practices.
PARTNERS Parent Training Groups	Webster-Stratton (1998)	Group format, parents watch video vignettes of positive parenting interactions followed by discussion and teaching of positive discipline strategies.	Evaluated with families involved in Head Start programs, who demonstrated the use of less harsh discipline and an increase in positive parenting following this intervention.
Project 12-Ways	Lutzker & Rice (1984)	Project 12-Ways uses behavioral methods and focuses on various targets in the ecology of multi-problem families entering the system for child neglect. Parents are taught skills in safety, bonding, and health care.	Improved assertion skills, job skills, and home management
Project Safe Care	Taban & Lutzker (2001)	15-session training program focused on home safety, infant and child health care, and bonding and stimulation. Interventions included verbal instructions, discussions, reading materials, modeling, role-play and practice, and feedback administered via research assistants, videotapes, and, in few cases, a nurse or a caseworker.	Parents felt more confident about their knowledge and ability regarding their children's health and safety. Showed improvement in their interaction with their children, and reported enjoying being with their children more.

Treatment Name	Developer (s)	Essential Elements	Research Evidence & Outcomes
Project SelfCare	Fraser, Armstrong, Morris, & Dadds (2000)	Project SelfCare uses a treatment team of pediatricians, nurses, and social workers to encourage utilization of community services. Promotes social support systems and informal resources, and enhances skills and confidence to access resources. Services guided by individual need and offered in home.	Showed a relationship between maternal, family and environmental factors in the immediate postnatal period and adjustment to the parenting role.
Relational Psychotherapy Mother's Group/ Enhanced Behavioral Family Intervention (EBFI)	Sanders et al. (2004)	Enhanced group behavioral family intervention focuses on parents' negative attributions regarding their child's and their own behavior, and parents' anger-control deficits. Parent workbook, and sessions to teach 17 core child-management strategies, Planned Activities Training; plus 4 sessions addressing risk factors associated with child abuse and neglect. Parents were also taught anger management techniques, and cognitive techniques that challenged their attributions.	Control and EBFI showed reduced dysfunctional attributions, with EBFI showing a significantly greater reduction in the potential for child abuse and unrealistic expectations. Both groups showed decreased anger experience and expression. EBFI showed a significantly greater reduction in negative attributions than control.
STAR Parenting Program	Nicholson, Anderson, Fox & Brenner (2002)	STAR strategy (Stop, Think, Ask, Respond) utilizes cognitive behavioral and anger management techniques to help parents develop a more "thoughtful" parenting style.	Research indicates decreased levels of verbal and corporal punishment, anger, stress, and child behavior problems following this intervention.
Steps Towards Effective Enjoyable Parenting (STEEP)	Egeland & Erickson Farrell (2004)	Rooted in attachment theory and the ecological perspective, STEEP uses home visits, small group format, and videotaped interaction and review, with goal of teaching parents about child development and problem solving to increase positive parenting. Developed for use with parents of young children.	Participants demonstrated better understanding of child development and life management skills, and fewer depressive symptoms and repeat pregnancies (within two years of the birth of their baby), and increased sensitivity to their child's cues and signals.
Systematic Training for Effective Parenting (STEP) Program	Wilczak & Markstrom (1999)	Utilizes a parent study group format to educate parents regarding child development. Teaches parents the four goals of misbehavior (attention, power, revenge, inadequacy) and how to develop effective discipline that is firm and kind.	Increased fathers' knowledge about effective parenting practices and feelings of efficacy as parents

Treatment Name	Developer (s)	Essential Elements	Research Evidence & Outcomes
Triple P-Positive Parenting Program	Sanders et al. (2004)	Behavioral based parenting intervention provided at the individual level, group level, or in a self-directed format. Provides parents with tip sheets on child development for each age group and promotes self-efficacy, self-management, and problem solving skills.	Evaluation research demonstrates a reduction in children's disruptive behaviors and dysfunctional parenting practices.

Conclusion and Comments

When parents experience trauma, research shows it can affect their parenting abilities in various ways. Risk factors include pre-existing poor parenting practices, poor parental mental health, parental PTSD symptoms, parental substance use/abuse, low family income, living in an impoverished neighborhood, mother's young age, current intimate partner violence, parental history of childhood abuse, large family size, and racial discrimination. Parents who maintain effective parenting practices despite these risks have good problem solving abilities, good coping skills and self-care skills, spend time with family, have partner and social support, have strong family cohesion and involvement and are likely to benefit from these protective factors. Another protective mechanism is parents' awareness of child exposure to violence and discussion of it with their children. The most effective interventions include parental training to create positive interactions with their child, and the use of parental practice of these skills in session with the child. Specific programs that have shown improved parenting practices among families exposed to trauma include filial therapy, cognitive-ecological preventive intervention, the STAR parenting program, and PARTNERS parent training groups. Supportive parenting practice training immediately following trauma has been shown to mediate some of trauma's effects and should be studied further.

References

Abidin, R. R. (1995). *Parenting Stress Index (3rd ed.).* Odessa, FL: Psychological Assessment Resources, Inc.

Anderson, L. S. (2008). Predictors of parenting stress in a diverse sample of parents of early adolescents in high-risk communities. *Nursing Research*, *57*(5), 340-350.

Appleyard, K., & Osofsky, J. D. (2003). Parenting after trauma: Supporting parents and caregivers in the treatment of children impacted by violence. *Infant Mental Health Journal*, *24*(2), 111-125.

Banyard, V. L. (1997). The impact of childhood sexual abuse and family functioning on four dimensions of women's later parenting. *Child Abuse and Neglect*, *21*(11), 1095-1107.

Banyard, V. L., Williams, L. M., & Siegel, J. A. (2003). The impact of complex trauma and depression on parenting: An exploration of mediating risk and protective factors. *Child Maltreatment*, *8*(4), 334-349.

Barth, R. P., Landsverk, J., Chamberlain, P., Reid, J. B., Rolls, J. A., Hurlburt, M. S., et al. (2005). Parent-training programs in child welfare services: Planning for a more evidence-based approach to serving biological parents. *Research on Social Work Practice*, *15*(5), 353-371.

Bavolek, S. J. (2002). *Research and validation report of the nurturing parenting programs.* Retrieved April 6, 2009, from http://www.nurturingparenting.com/research_validation/.

Bhandari, R. P., & Barnett, D. (2007). Restrictive parenting buffers Head Start students from stress. *Infants & Young Children*, *20*(1), 55-63.

Borduin, C. M., Mann, B. J., Cone, L. T., Henggeler, S. W., Fucci, B. R., Blaske, D. M., et al. (1995). Multisystemic treatment of serious juvenile offenders: Long-term prevention of criminality and violence. *Journal of Consulting & Clinical Psychology, 63*, 569-578.

Bradley, S. J., Jadaa, D., Broudy, J., Landy, S., Tallett, S. E., Watson, W., et al. (2003). Brief psychoeducational parenting program: An evaluation and 1-year follow-up. *Journal of the American Academy of Child and Adolescent Psychiatry*, *42*(10), 1171-1178.

Burchinal, M. R., Follmer, A., & Bryant, D. M. (1996). The relations of maternal social support and family structure with maternal responsiveness and child outcomes among African American families. *Developmental Psychology*, *32*(6), 1073-1083.

Ceballo, R., & McLoyd, V. C. (2002). Social support and parenting in poor, dangerous neighborhoods. *Child Development*, *73*(4), 1310-1321.

Ceballo, R. Dahl, T. A., Aretakis, M. T., & Ramirez, C. (2001). Inner-city children's exposure to community violence: How much do Parents Know? *Journal of Marriage and the Family*, *63*, 927-940.

Chaffin, M., Silovsky, J., Funderburk, B., Valle, L. A., Brestan, E. V., Balachova, T., et al. (2004). Parent-child interaction therapy with physically abusive parents: Efficacy for reducing future abuse reports. *Journal of Consulting and Clinical Psychology*, *72*, 491-499.

Comfort, M., Gordon, P., & Unger, D.G. (2006). Keys to Interactive Parenting Scale: A Window Into Many Facets of Parenting. *Journal of Zero to Three*, *26*(5), 37-44.

Comfort, M. & Gordon, P. (2004-2009). *KIPS Fast Facts: A Brief Overview,* and *KIPS Snapshot: purpose and background*. Accessed online at http://www.comfortconsults.com/KIPSSnapshot022109.pdf.

Cowen, P.S. (2001) Effectiveness of a parent education intervention for at-risk families. *Journal of the Society for Pediatric Nursing*, *6*(2), 73-82.

DePanfilis, D., & Dubowitz, H. (2005), Family Connections: A program for preventing child neglect*. Child Maltreatment, 10*(2), 108-123*.*

Dickstein, S., Seifer, R., Hayden, L. C., Schiller, M., Sameroff, A. J., Keitner, G., et al. (1998). Levels of family assessment: II. Impact of maternal psychopathology on family functioning. *Journal of Family Psychology*, *12*(1), 23-40.

DiLillo, D. K., & Damashek, A. (2003). Parenting characteristics of women reporting a history of childhood sexual abuse. *Child Maltreatment*, *8*(4), 319-333.

Egeland, B., & Erickson M. F. (2004). Linking theory and research to practice: The Minnesota Longitudinal Study of Parents and Children and the STEEPTM program. *Clinical Psychologist, 8*(1), 5-9.

Egeland, B. & Erickson, M.F. (2003). Lessons from STEEP™: Linking theory, research and practice for the well-being of infants and parents. In A. Sameroff, S. McDonough & K. Rosenblum (Eds.). *Treating parent-infant relationship problems: Strategies for intervention.* New York: Guilford Press.

Elliott, D. E., Bjelajac, P., Fallot, R. D., Markoff, L. S., & Reed, B. G. (2005). Trauma-informed or trauma-denied: Principles and implementation of trauma-informed services for women. *Journal of Community Psychology*, *33*(4), 461-477.

Eyberg, S. M. (2003). Parent-child interaction therapy. In T.H. Ollendick & C.S. Schroeder (Eds.) *Encyclopedia of Clinical child and Pediatric Psychology*. New York: Plenum.

Fraser, J. A., Armstrong, K. L., Morris, J. P., & Dadds, M. R. (2000). Home visiting intervention for vulnerable families with newborns: Follow-up results of a randomized controlled trial. *Child Abuse & Neglect, 24*(11), 1399-1429.

Forgatch, M. S., & DeGarmo, S. S. (1999). Parenting through change: An effective prevention program for single mothers. *Journal of Consulting and Clinical Psychology*, *67*(5), 711-724.

Gerwitz, A., Forgatch, M., & Wieling, E. (2008). Parenting practices as potential mechanisms for child adjustment following mass trauma. *Journal of Marital and Family Therapy, 34*(2), 177-192.

Gibaud-Wallston, J., & Wandersman, L. (1978). *Development and utility of the Parenting Sense of Competence Scale*. Paper presented at the meeting of the American Psychological Association, Toronto.

Green, B. L., Miranda, J., Daroowalla, A., & Siddique, J. (2005). Trauma exposure, mental health functioning, and program needs of women in jail. *Crime and Delinquency*, *51*(1), 133-151.

Harris, S. M., & Topham, G. L. (2004). Assessment and treatment of trauma from a Bowen family systems perspective. In D. R. Catherall (Ed.), *Handbook of stress, trauma and the family* (pp. 283-306). New York: Taylor & Francis Books.

Johnson, M. A., Stone, S., Lou, C., Ling, J., Ciassen, J., & Austin, M. J. (2008). Assessing parent education programs for families involved with child welfare. *Journal of Evidence-Based Social Work*, *5*(1), 191-236.

Kaminski, J. W., Valle, L. A., Filene, J. H., & Boyle, C. L. (2008). A meta-analytic review of components associated with parent training program effectiveness. *Journal of Abnormal Child Psychology*, *36*, 567-589.

Kolko D. J., & Swenson C. C. (2002). *Assessing and treating physically abused children and their families: A cognitive behavioral approach*. Thousand Oaks, CA: Sage Publications.

Landreth, G. L., & Lobaugh, A. F. (1998). Filial therapy with incarcerated fathers: Effects on parental acceptance of child, parental stress, and child adjustment. *Journal of Counseling and Development*, *76*, 157-165.

Lauterbach, D., Bak, C., Reiland, S., Mason, S., Lute, M. R., & Earls, L. (2007). Quality of parental relationships among persons with a lifetime history of posttraumatic stress disorder. *Journal of Traumatic Stress*, *20*(2), 161-172.

Levendosky, A. A., & Graham-Bermann, S. A. (2001). Parenting in battered women: The effects of domestic violence on women and their children. *Journal of Family Violence*, *16*(2), 171-192.

Locke, T. F., & Newcomb, M. (2004). Child maltreatment, parent alcohol- and drug-related problems, polydrug problems, and parenting practices: A test of gender differences and four theoretical perspectives. *Journal of Family Psychology*, *18*(1), 120-134.

Lovell, M. L., & Richey, C. A. (1997). The impact of social support skill training on daily interactions among parents at risk for child maltreatment. *Children and Youth Services Review, 19*(4), 221-251.

Lutzker, J. R., & Rice, J. M. (1984). Project 12-Ways: Measuring outcome of a large in-home service for treatment and prevention of child abuse and neglect. *Child Abuse and Neglect, 8,* 519-524.

Manion, I. G., McIntyre, J., Firestone, P., Ligezinska, M., Ensom, R., & Wells, G. (1996). Secondary traumatization in parents following the disclosure of extrafamilial child sexual abuse: Initial effects. *Child Abuse and Neglect*, *20*(11), 1095-1109.

Marcenko, M. O., Kemp, S. P., & Larson, N. C. (2000). Childhood experiences of abuse, later substance use, and parenting outcomes among low-income mothers. *American Journal of Orthopsychiatry*, *70*(3), 316-326.

McLoyd, V. C. (1998). Socioeconomic disadvantage and child development. *American Psychologist*, *53*(2), 185-204.

Metropolitan Area Child Study Research Group. (2002). A cognitive-ecological approach to preventing aggression in urban settings: Initial outcomes for high-risk children. *Journal of Consulting and Clinical Psychology*, *70*, 179-294.

Murry, V. M., Brown, P. A., Brody, G. H., Cutrona, C. E., & Simons, R. L. (2001). Racial discrimination as a moderator of the links among stress, maternal psychological functioning, and family relationships. *Journal of Marriage and the Family*, *63*(4), 911-914.

National Institute of Child Health and Human Development Early Child Care Research Network (2005). Duration and developmental timing of poverty and children's cognitive and social development from birth through third grade. *Child Development*, *76*(4), 795-810.

Newcomb, M. D., & Locke, T. F. (2001). Intergenerational cycle of maltreatment: A popular concept obscured by methodological limitations. *Child Abuse and Neglect*, *25*(9), 1219-1240.

Nicholson, B., Anderson, M., Fox, R., & Brenner, V. (2002). One family at a time: A prevention program for at-risk parents. *Journal of Counseling and Development*, *80*, 362-371.

Pachter, L. M., Auigner, P., Palmer, R., & Weitzman, M. (2006). Do parenting and the home environment, maternal depression, neighborhood, and chronic poverty affect child behavioral problems differently in different racial-ethnic groups? *Pediatrics*, *117*(4), 1329-1338.

Pinderhughes, E. E., Nix, R., Foster, E. M., & Jones, D. (2001). Parenting in context: Impact of neighborhood poverty, residential stability, public services, social networks, and danger on parental behaviors. *Journal of Marriage and the Family*, *63*(4), 941-953.

Pinderhughes, E. E., Dodge, K. A., Bates, J. E., Pettit, G. S., & Zelli, A. (2000). Discipline responses: Influences of parents' socioeconomic status, ethnicity, beliefs about parenting, stress, and cognitive-emotional processes. *Journal of Family Psychology*, *14*(3), 380-400.

Raikes, H. A., & Thompson, R. A. (2005). Efficacy and social support as predictors of parenting stress among families in poverty. *Infant Mental Health Journal*, *26*(3), 177-190.

Reitman, D., Currier, R. O., & Stickle, T. R. (2002). A Critical evaluation of the Parenting Stress Index-Short Form (PSI-SF) in a Head Start population. *Journal of Clinical Child and Adolescent Psychology*, *31*(3), 384-392.

Richards, M. H., Larson, R., Miller, B. V., Luo, Z., Sims, B., Parrella, D.P., et al. (2004). Risky and protective contexts and exposure to violence in urban African American young adolescents. *Journal of Clinical Child and Adolescent Psychology, 33*(1), 138.

Sanders, M. R., Pidgeon, A. M., Gravestock, F., Connors, M. D., Brown, S., & Young, R. W. (2004). Does parental attributional retraining and anger management enhance the effects of the Triple P-Positive Parenting Program with parents at risk of child maltreatment? *Behavior Therapy*, *35*(3), 513-535.

Scaramella, L. V., Neppl, T. K., Ontai, L. L., & Conger, R. (2008). Consequences of socioeconomic disadvantage across three generations: Parenting behavior and child externalizing problems. Journal of Family Psychology, *22*(5), 725-733.

Schuetze, P., & Eiden, R. D. (2005). The relationship between sexual abuse during childhood and parenting outcomes: Modeling direct and indirect pathways. *Child Abuse and Neglect*, *29*(6), 645-659.

Spano, R., Vazsonyi, A. T., & Bolland, J. (2009). Does parenting mediate the effects of exposure to violence on violent behavior? An ecological-transactional model of community violence. *Journal of Adolescence, 32*(5), 1-21.

Sullivan, M., Egan, M., & Gooch, M. (2004). Conjoint Interventions for Adult Victims and Children of Domestic Violence: A Program Evaluation. *Research on social work practice, 14*(3), 163-170.

Taban, N., & Lutzker, J. R. (2001). Consumer evaluation of an ecobehavioral program for prevention and intervention of child maltreatment. *Journal of Family Violence, 16*(3), 323-330.

Thomas, D., Leicht, C., Hughes, C., Madigan, A., Dowell, K. (2003). *Emerging Practices in the prevention of child abuse and neglect*. Retrieved April 6, 2009 from http://www.childwelfare.gov/preventing/programs/whatworks/report/emergingb.cfm .

Van deMark, N. R., Brown, E., Bornemann, A., & Williams, S. (2004). New directions for families: A family-oriented intervention for women affected by alcoholism and other drug abuse, mental illness and trauma. *Alcoholism Treatment Quarterly*, *22*(3), 141-160.

Vazsonyi, A. T., Pickering, L. E., & Bolland, J. M. (2006). Growing up in a dangerous developmental milieu: The effects of parenting processes on adjustment in inner-city African American adolescents. *Journal of Community Psychology, 34*, 47-73.

Webster-Stratton, C. (1998). Preventing conduct problems in Head Start children: Strengthening parenting competencies. *Journal of Consulting and Clinical Psychology*, *66*, 715-730.

Webster-Stratton, C., & Reid, M. J. (2003). The Incredible Years parents, teachers and children training series: A multifaceted treatment approach for young children with conduct problems. In A.E. Kazdin (Ed.), *Evidence-based psychotherapies for children and adolescents* (pp. 224-240). New York: Guilford Press.

Wilczak, G. L., & Markstrom, C. A. (1999). The effects of parent education on parental locus of control and satisfaction of incarcerated fathers. *International Journal of Offender Therapy and Comparative Criminology*, *43*, 90-102.

Wright, M. O., Fopma-Loy, J., & Fischer, S. (2005). Multidimensional assessment of resilience in mothers who are child sexual abuse survivors. *Child Abuse and Neglect*, *29*, 1173-1193.

Chapter 8

Impact of Trauma and Urban Poverty on Intimate Partner Relationships

Combined traumas (past or present) and urban poverty can cause undue burden on intimate adult partner relationships. Individually, each partner must manage their personal responses to traumatic stress and burdens associated with lack of resources and opportunities for personal and familial mobility. Within their relationship, the couple negotiates acceptable levels of closeness, communication and collaboration, tolerance of each other's stress responses as well as safe ways to manage conflict and distress. Although there is limited research on the effects of trauma and urban poverty on couples, the following summary outlines theories, research findings, and intervention tools.

Theory

The literature regarding the impact of trauma on adult intimate relationships is rooted in a variety of theoretical perspectives, including attachment theory (Liang, Williams, & Siegel, 2006; Johnson, 2002; Nelson Goff & Smith, 2005; Whiffen & Oliver, 2004); object relations theory (Mazor, 2004); behavior theory and cognitive theory (Glynn et al., 1999; Leonard, Follette, & Compton, 2006; Monson, Schnurr, Stevens, & Guthrie, 2004; Monson, Stevens, & Schnurr, 2005); family systems theory (Nelson Goff et al., 2006; Nelson & Wampler, 2000); secondary traumatic stress theory (Nelson Goff et al., 2006; Nelson Goff & Smith, 2005; Nelson, Wangsgaard, Yorgason, Kessler, & Carter-Vassol, 2002); traumatic stress theory (Nelson et al., 2002); the family stress model (Conger et al., 2002); and chaos theory (Remer, 2004).

Nelson Goff and Smith (2005) used secondary traumatic stress theory and the empirical literature regarding the impact of trauma on adult intimate relationships to create the couple adaptation to traumatic stress (CATS) model, which identifies the "primary and secondary trauma effects in individuals, as well as the interpersonal effects within the couple system" (Nelson Goff & Smith, 2005, p. 148). Although no research studies have been able to empirically prove the mechanisms through which a trauma history for one partner affects the intimate relationship, Nelson Goff and Smith (2005) suggest the following processes of transmission: chronic stress, attachment, identification and empathy, projective identification, and conflict and physiological responses.

Key Research Findings

Varying perspectives exist regarding the conceptualization of poverty as trauma or poverty as an example of stress (Cassiman, 2005; Wadsworth & Santiago, 2005). Although most studies regarding the impact of stress on intimate partner relationships is from white, middle-class families, two help shed light on other populations. A study by Cutorna, Russella, Abrahama, Gardnera, Melbya, Bryanta, and Congera (2003) examined the impact of stress from neighborhood-level disadvantage and financial strain on rural and suburban African-American couples. This study found an unanticipated association between living in an economically disadvantaged neighborhood and higher marital quality, which the authors attributed to the results of "social comparison processes and degree of exposure to racially based discrimination" (Cutrona et al., 2003, p. 389). As anticipated, however, family financial strain appears to predict lower levels of perceived marital quality (Cutrona et al., 2003). Another examination of African-American families, including from rural and smaller

urban contexts, demonstrated a connection between economic hardship and the experience of economic pressure, which in turn contributed to emotional distress and problems within the intimate partner relationship (Conger, et al., 2002). Distress and problems within the caregiving relationship then negatively influence child outcomes (Cummings and Davies, 2002), demonstrating the potential for couples' experiences of poverty-related stress to negatively influence the children's health and well-being (Conger et al., 2002).

The majority of studies looking at the impact of trauma on intimate relationships use samples where at least one partner has experienced trauma in connection with military combat, political violence, chronic illness, or childhood abuse, with the majority of studies using samples of veterans and their partners (Monson & Taft, 2005). A variety of studies and reviews have highlighted the following difficulties in couples where one or both partners have a trauma history: problems with communication, expressing emotion, self-disclosure, sexual intimacy, family cohesion, hostility, aggression, and interpersonal violence (Calhoun & Wampler, 2002; Monson & Taft, 2005; Cook, Riggs, Thompson, Coyne, & Sheikh, 2004). Couples dealing with trauma also express greater levels of marital distress and are three to six times more likely to separate or divorce than couples without a history of trauma (Monson & Taft, 2005). However, Whiffen and Oliver (2004) point out that supportive adult intimate relationships can be a source of strength in recovering from traumatic experiences and identify three qualitative and two empirical studies that demonstrate this point.

Some studies have demonstrated the effects of specific types of trauma on intimate relationships. For instance, female childhood sexual abuse survivors may avoid intimate relationships as adults (Whiffen & Oliver, 2004) or in the context of intimate relationships express higher rates of conflict with and fear of their partners as well as difficulties with sexual intimacy (Follette & Pistorello, 1995). Whisman (2006) examined the effects of seven types of childhood trauma on two specific marital outcomes, finding that childhood experiences of physical abuse, rape, or serious assault were all associated with a greater probability of marital disruption, while childhood experiences of rape and sexual molestation were associated with lower levels of marital satisfaction. For adult women who have survived a sexual assault, the event may disrupt an intimate relationship; however, there is research showing that the ability to communicate openly about the traumatic incident with an intimate partner can minimize its long-term effects (Whiffen & Oliver, 2004). In Oliver's 1999 study on the effects of a child's death on couples, one third of couples who have experienced a shared trauma, the death of a child, experience a significant disruption to their relationship; however, qualitative research shows that the quality of the relationship prior to the traumatic incident can determine the trauma's potential impact (Oliver, 1999; Whiffen & Oliver, 2004).

A discussion of trauma's impact on intimate relationships must differentiate between the effects of interpersonal violence within the couple relationship and the effects of one or both partner's individual experiences of trauma on the couple relationship. While a sizable body of research examines interpersonal violence in the context of urban poverty, research on trauma and stress on the couple system focuses almost exclusively on white, middle-class families (Fein & Ooms, 2006; Conway & Hutson, 2008). Not only is living in an impoverished neighborhood associated with higher rates of interpersonal violence (Cunradi, 2000), but low-income women of color disproportionately experience more severe interpersonal violence (Benson & Fox, 2004; West, 2004). Intimate partner relationships in the context of urban poverty are thus doubly at risk of traumatization due to greater risk of trauma within the relationship and greater risk that an individual in the couple will experience trauma that in turn impacts the relationship.

Qualitative studies have helped identify the themes prevalent among intimate partners dealing with trauma, which include "increased communication, decreased communication, increased cohesion/connection, increased understanding, decreased understanding, sexual intimacy

problems, symptoms of relationship distress, support from partner and relationship resources" (Nelson Goff et al., 2006). Some qualitative research has indicated that there may be different patterns of relating between single-trauma couples (in which only one partner has a history of trauma), and dual-trauma couples (in which both do) (Nelson et al., 2002).

Risk and Protective Factors

Little of the research in this area has examined risk and protective factors that make couples more vulnerable or more resilient in the face of traumatic experiences. Nelson Goff and Smith (2005) applied the general trauma literature to couples and identified the following risk factors: multiple traumatic experiences, mental illness, poor coping responses, and severe trauma. The protective factors include positive coping strategies, high self-esteem, social support, and good physical health (Nelson Goff & Smith, 2005).

Table 8.1: Risk and Protective Factors for Intimate Partner Relationships

Risk Factors	Protective Factors
Multiple traumatic experiences	Social support
History of mental illness	High self-esteem
Poor coping responses	Positive coping strategies
Trauma-specific characteristics (severity, age at time of trauma, etc.)	Good physical and mental health
Low relationship quality	Couple resources such as cohesion, adaptability, and shared power

Assessment Instruments

The most frequently used assessment instrument measuring the impact of trauma within adult intimate relationships is the Dyadic Adjustment Scale (DAS) (Spanier, 1976). Studies have also used a variety of measures of relationship satisfaction and standardized instruments (See Appendices A and B).

Interventions

A variety of therapeutic interventions geared toward the couple subsystem within a family have been designed specifically to address issues of trauma. Although the following interventions have not yet been studied empirically, case studies indicate their potential positive impact: 1) emotionally focused couple therapy with trauma survivors, which is rooted in attachment theory (Johnson, 2002); 2) relational couple therapy for child survivors of trauma, which is based on object relations theory (Mazor, 2004); 3) critical interaction therapy, a nine-step therapy process developed for use with Vietnam veterans (Johnson, Feldman, & Lubin, 1995); and 4) a framework for couple therapy guided by the three clusters of posttraumatic stress disorder (PTSD) symptoms (re-experiencing, avoidance, and arousal) (Sherman, Zanotti, & Jones, 2005).

Two types of couple-level interventions have been tested empirically. Directed therapeutic exposure (DTE) for couples was found to reduce some symptoms of PTSD, such as hypersensitivity and hyperarousal, although addition of behavioral family therapy did not further reduce these or other

symptoms in comparison to a control group (Glynn et al., 1999). In addition, a small empirical study showed the positive impact of cognitive behavioral couples therapy (CBCT) in cases where one partner is diagnosed with PTSD (Monson et al., 2004).

Table 8.2: Interventions: Intimate Partner Relationships

Treatment Name	Developer(s)	Essential Elements	Research Evidence & Outcomes
A framework for couples therapy developed for use with Vietnam veterans guided by the three clusters of PTSD symptoms: re-experiencing, avoidance and arousal	Sherman et al. (2005)	Describes how each cluster of PTSD impacts the relationships and then offers guidelines for intervention. *Re-experiencing*: to assist the veteran in teaching his partner how to support him during episodes, teach the couple a debriefing process to help deescalate the situation, and promote learning from the episode. *Avoidance*: to empower the couple to risk trust and openness with each other and negotiate how much of the trauma is shared in the relationship; encourage the pursuit of enjoyable activities, teaching interpersonal problem-solving skills. *Increased arousal*: to assist the couple in coping effectively with irritability and/or expressions of anger, teach conflict disengagement strategies, and educate the couple about anxiety management strategies and sleep hygiene tips.	Case studies demonstrated reduction of traumatic stress symptoms and improved relationship quality.
Cognitive Behavioral Couples Therapy (CBCT)	Monson et al. (2004)	CBCT for PTSD includes 15 sessions with 3 phases of treatment: (1) treatment orientation and psychoeducation about PTSD and its related intimate relationship problems; (2) behavioral communication skills training; and (3) cognitive interventions.	Clinician and partner reports showed significant improvements in PTSD symptoms, while veterans denied reduction in PTSD symptoms but reported decreased depression and anxiety. Partners reported improved relationship satisfaction, while veteran reports remained the same.

Treatment Name	Developer(s)	Essential Elements	Research Evidence & Outcomes
Critical Interaction Therapy	Johnson, Feldman, & Lubin (1995)	Nine-step therapy process: (1) free discussion; (2) emergence of the critical interaction; (3) identifying the traumatic memory; (4) establishing the physical connection; (5) reporting the traumatic story; (6) linking trauma with current conflict; (7) checking in with spouse; (8) reviewing the critical interaction sequence; and (9) offering directives.	Through case reports, the developers found once the nascent mutuality of perspective within the couple was established, the couples could support each other in the relationship and family system, thereby reducing the trauma symptomatology or symptom formation within the family system.
Directed Therapeutic Exposure (DTE) for couples	Boudewyns & Shipley (1983)	18 twice-weekly sessions in 3 stages: (1) introduction and data gathering (2 sessions); re-exposure-cognitive restructuring (13-14 sessions); and (3) generalization training and termination (1-2 sessions).	Sample included 42 Vietnam veterans with PTSD and a family member (89% participated with their spouse or an intimate partner). DTE resulted in improvement of positive symptoms (such as hypersensitivity and hyperarousal), but no significant change in negative symptoms (such as avoidance and numbing).
Emotionally Focused Couple Therapy (EFT)	Johnson & Greenberg (1988)	EFT for trauma survivors follows 3 stages: (1) creation of stability and de-escalation of trauma symptoms and relationship distress; (2) restructuring of interactions to create the secure bonding that fosters relationship healing; and (3) integration of these changes into the life of the couple.	Meta-analysis of studies of EFT with "maritally distressed couples" (not necessarily trauma survivors) showed an effect size of 1.3, meaning that almost 90% of treated couples rated themselves better than controls following this intervention (Johnson et al., 1999). Although case studies indicate success with trauma survivors, no empirical studies reported.

Treatment Name	Developer(s)	Essential Elements	Research Evidence & Outcomes
Relational Couple Therapy	Mazor (2004)	Based upon object relations theory, designed for use with couples with one partner who survived the Holocaust. Three phases of intervention: (1) developing a "containing therapeutic environment" to establish a sense of trust and secure relations with the therapist and, later on, within the couple bond; (2) relating each partner's life/trauma story, increasing empathy, reducing automatic projections and fears of each other; (3) creating new responses and behaviors in the couple "that may extend the couple's emotional system."	Qualitative case studies indicate potential success of this intervention, but no empirical research has been reported.

Conclusion and Comment

Cunradi et al. (2000) demonstrated that socio-environmental characteristics including poverty are associated with intimate partner violence. Other studies have shown the impact of trauma and poverty on intimate partner relationships can affect communication, understanding of one another, cohesion, sexual intimacy, partner support, and resources in the relationship (Nelson Goff et al., 2006). Patrick Calhoun and Tim Wampler (2002) note that in couples in which one partner is diagnosed with PTSD, the other partner often experiences stressors such as "crisis management, symptom management, social isolation, financial problems, strain on the family system and adjustment to the course of PTSD" (p. 17). These vicarious trauma effects are serious and well-documented for veterans, but not as well researched in other populations. Further, protective factors such as positive coping strategies and social support may help the couple strengthen resilience and build cohesive partner relationships within the context of poverty and trauma exposure. Empirically tested interventions include directed therapeutic exposure and cognitive behavior couples therapy. Interventions with potential include emotionally focused couple therapy, relational couple therapy, critical interaction therapy, and a framework for couple therapy focused on three PTSD symptoms. In sum, the experience of trauma in couples is often affected by socio-environmental (e.g., poverty, income, age, substance use, etc.) factors making some couples more vulnerable, and mediating the effects for others. The need for more empirically tested and effective interventions geared toward intimate partners is evident, as research demonstrates that trauma not only affects the family as a whole, but also its subsystems.

References

Benson, M. L., & Fox, G. L. (2004). When violence hits home: How economics and neighborhood play a role. Research in Brief. Washington, DC: U.S. Department of Justice.

Boudewyns, P., & Shipley, R. (1983). *Flooding and Implosive Therapy*. New York: Plenum Press.

Calhoun, P. S., & Wampler, T. P. (2002). Reducing caregiver burden and psychological distress in partners of veterans with PTSD. *National Center for PTSD Clinical Quarterly*, *11*(2), 17, 19–22.

Cassiman, S. A. (2005). Toward a more inclusive poverty knowledge: Traumatological contributions to the poverty discourse. *The Social Policy Journal*, *4*(3/4), 93-106.

Conger, R. D., McLoyd, V. C., Wallace, L. E., Sun, Y., Simons, R. L., & Brody, G. H. (2002). Economic pressure in African American Families: A replication and extension of the family stress model. *Developmental Psychology*, *38*(2), 179-193.

Conway, T., & Hutson, R. Q. (2008). Healthy marriage and the legacy of child maltreatment: A child welfare perspective. *Couples and Marriage Policy Brief Series*, 12. Accessed April 1, 2009. http://clasp.org/publications/marriage_brief_12.pdf

Cook, J. M., Riggs, D. S., Thompson, R., Coyne, J. C., & Sheikh, J. I. (2004). Posttraumatic stress disorder and current relationship functioning among World War II ex-prisoners of war. *Journal of Family Psychology*, *18*(1), 36–45.

Cummings, E., & Davies, P. T. (2002). Effects of marital conflict on children: Recent advances and emerging themes in process-oriented research. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, *43*(1), 31–63.

Cunradi, C.B., Caetano, R., Clark, C., & Schafer, J. (2000). Neighborhood Poverty as a Predictor of Intimate Partner Violence Among White, Black, and Hispanic Couples in the United States: A Multilevel Analysis. *Annals of Epidemiology*, *10*(5), 297-308.

Cutorna, C.E., Russella, D.W., Abrahama, W.T., Gardnera, K.A., Melbya, J.N., Bryanta, C., & Congera, R.D. (2003). Neighborhood Context and Financial Strain as Predictors of Marital Interaction and Marital Quality in African American Couples. *Personal Relationships*, *10*(3): 389-409.

Fein, D., & Ooms, T. (2006). What do we know about couples and marriage in disadvantaged populations? Revised version of a paper presented at the annual research conference of the Association for Public Policy Analysis and Management, Washington, DC, November 3-5, 2005. Accessed at http://clasp.org/publications/couples_marriage_disadvantaged.pdf, April 1, 2009.

Follette, V. M., & Pistorello, J. (1995). The role of couples therapy in the treatment of sexual abuse survivors. In C. Classen & I. D. Yalom (Eds.), *Treating women molested in childhood* (pp. 129-162). San Francisco: Jossey-Bass.

Glynn, S. M., Eth, S., Randolph, E. T., Foy, D. W., Urbaitis, M., Boxer, L., et al. (1999). A test of behavioral family therapy to augment exposure for combat-related posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology*, *67*(2), 243-251.

Johnson, S. M. (2002). *Emotionally focused couple therapy with trauma survivors: Strengthening attachment bonds*. New York: Guilford Press.

Johnson, D.R., Feldman, S., & Lubin, H. (1995). Critical Interaction Therapy: Couples Therapy in Combat-Related Posttraumatic Stress Disorder. *Family Process*, *34*(4), 401-412.

Greenberg, L., & Johnson, S. (1988). *Emotionally focused couples therapy.* New York: Guilford Press.

Leonard, L. M., Follette, V. M., & Compton, J. S. (2006). A principle-based intervention for couples affected by trauma. In V.M. Follette & J. I. Ruzek (Eds.), *Cognitive-behavioral therapies for trauma* (2nd ed., pp. 362-387). New York: Guilford Press.

Liang, B., Williams, L. M., & Siegel, J. A. (2006). Relational outcomes of childhood sexual trauma in female survivors: A Longitudinal study. *Journal of Interpersonal Violence*, *21*(1), 42-57.

Mazor, A. (2004). Relational couple therapy with post-traumatic survivors: Links between post-traumatic self and contemporary intimate relationships. *Contemporary Family Therapy: An International Journal*, *26*(1), 3-21.

Monson, C. M., & Taft, C. E. (2005). PTSD and intimate relationships. *PTSD Research Quarterly*, *16*(4), 1-7.

Monson, C. M., Schnurr, P. P., Stevens, S. P., & Guthrie, K. A. (2004). Cognitive-behavioral couple's treatment for posttraumatic stress disorder: Initial findings. *Journal of Traumatic Stress*, *17*(4), 341-344.

Monson, C. M, Stevens, S. P., & Schnurr, P. P. (2005). Cognitive behavioral couple's treatment for posttraumatic stress disorder. In A. A. Corales (Ed.), *Focus on posttraumatic stress disorder research* (pp. 245-274). New York: Noca Science Publishers.

Nelson Goff, B. S., Reisbig, A. M., Bole, A., Scheer, T., Hayes, E. H., Archuleta, K. L., et al. (2006). The effects of trauma on intimate relationships: A qualitative study with clinical couples. *American Journal of Orthopsychiatry, 76*(4), 451-460.

Nelson Goff, B. S., & Smith, D. (2005). Systemic traumatic stress: The Couple Adaptation to Traumatic Stress Model. *Journal of Marital and Family Therapy*, *31*, 145–157.

Nelson, B. S., & Wampler, K. (2000). Systemic effects of trauma in clinic couples: An exploratory study of secondary trauma resulting from childhood abuse. *Journal of Marital and Family Therapy, 26,* 171-184.

Nelson, B. S., Wangsgaard, S., Yorgason, J., Kessler, M. H., & Carter-Vassol, E. I. (2002). Single- and dual-trauma couples: Clinical observations of relational characteristics and dynamics. *American Journal of Orthopsychiatry*, *72*(1), 58-69.

Oliver, L. (1999). Effects of a child's death on the marital relationship: A review. Omega Journal of Death and Dying, 39, 197-227.

Remer, R. (2004). The partner's experience: learning to cope with *chaos.* In Donald R. Catherall (Ed.), *Handbook of stress, trauma, and the family*. (pp. 51-68) New York: Brunner-Routledge.

Sherman, M. D., Zanotti, D. K., & Jones, D. E. (2005). Key elements in couples therapy with veterans with combat-related posttraumatic stress disorder. *Professional Psychology: Research and Practice*, *36*(6), 626-633.

Spanier, G. B. (1976). Measuring dyadic adjustment: New scales for assessing the quality of marriage and similar dyads. *Journal of Marriage and the Family*, *38*(1), 15-28.

Wadsworth, M. E., & Santiago, C. D. (2008). Risk and resiliency processes in ethnically diverse families in poverty. *Journal of Family Psychology*, *22*(3), 399-410.

West, C. (2004). Black women and intimate partner violence: New directions for research. *Journal of Interpersonal Violence*, *19*, 1487-1493.

Whiffen, V. & Oliver, L. (2004). The Relationship Between Traumatic Stress and Marital Intimacy. In Donald Roy Catherall (Ed.), *Handbook of stress, trauma, and the family,* (pp. 139-160). New York: Brunner-Routeledge.

Whisman, M. A. (2006). Childhood trauma and marital outcomes in adulthood. *Personal Relationships*, *13*(4), 375-386

Chapter 9

Impact of Trauma and Urban Poverty on Sibling Relationships

Outside of the parent-child relationship, siblings may represent a child's most important and long-term relationships. Siblings may provide a protective function when parenting is compromised or when a child suffers a significant adverse life event. For families surviving poverty and chronic stressful situations, siblings may develop deep bonds of support centered on shared traumatic experiences. The strong sibling bond can also present opportunities for further trauma, for example, through effects of trauma experienced by one or more siblings (Alderfer, Labay, & Kazak, 2003). Traumatic loss of a sibling can be particularly difficult for children and result in higher rates of posttraumatic stress disorder (PTSD) as well as other problems (Applebaum & Burns, 1991).

Theory

Several theoretical models have been used to explain the importance of sibling relationships, including psychoanalytic theory, family systems theory, family role theory, and social learning theory (Bank & Kahn, 1982). Brody (1998) explored the relationship between family experiences and sibling relationship quality and developed a model that included the following influential components: parent-child relationship quality; differential treatment of siblings by parents; parental management of sibling conflict; children's individual behaviors and emotional regulation and coping skills; and family norms regarding aggression and fairness. Sibling relationships can also be understood in a theoretical model that places the early attachment to siblings in an object relations framework (Bank & Kahn, 1982). Within this framework, younger siblings may develop sibling attachments as strong and intense as those with parent figures. These attachments may result in positive outcomes from strong and supportive relationships with older siblings, or negative outcomes if older siblings are ambivalent, inconsistent, or abusive.

Key Research Findings

The influence of siblings on children's behavior and development is just beginning to be understood. Research has yet to identify specific pathways for this influence above and beyond that of parenting. Deviant attitudes and behaviors in older siblings, when coupled with high levels of harsh-inconsistent and low levels of nurturing-involved parenting, were associated with conduct problems in younger siblings. This effect was stronger in children residing in disadvantaged neighborhoods (Brody et al., 2003). In another study, children who demonstrated good relationships with a friend or a sibling were less likely to demonstrate aggressive or disruptive behavior (McElwain & Volling, 2005).

Limited research exists on siblings who experience trauma, although some studies have explored the effect of family violence and conflict on sibling relationships. Graham-Bermann (1996) found that in families experiencing domestic violence, children expressed a heightened level of worry about family members including siblings. The presence of family stressors increased the risk of maltreatment to other siblings in families where abuse and maltreatment were reported. In the majority of these families, either the index child was scapegoated and no other children were maltreated, or all of the children were maltreated (Hamilton-Giachritsis & Browne, 2005). Maternal hostility was a mediating factor between marital conflict and sibling warmth and conflict, while paternal hostility was a mediating factor between marital conflict and sibling conflict/rivalry and problematic peer relationships (Stocker & Youngblade, 1999).

Additional studies highlight the impact of a sibling's medical illness, injury or sudden death. A review of studies of siblings of children with a chronic illness found that the majority (60%) of studies reported an increased risk of negative outcomes for siblings; 30% found no increased risk; and 10% found both positive and negative outcomes (Williams, 1997). A study of adolescents grieving the sudden, violent death of a sibling demonstrated various grief reactions and changes in behavior up to 2 years after a sibling's death (Lohan & Murphy, 2001). Furthermore, a study of siblings of burn victims showed better psychological adjustment for these siblings than the normative group, except in the area of social competence. Such findings show the possible benefits of coping with the experience of medical trauma in the family (Mancuso, Bishop, Blakeney, Robert, & Gaa, 2003).

Risk and Protective Factors

Affectionate or positive sibling relationships can mediate the effect of stressful life events on children. For example, affectionate sibling relationships mediated the effect of stressful life events on a child's internalizing behavior even after controlling for mother-child relationship quality, although, sibling relationships were not predictive of internalizing behavior in the absence of stressful life events (Gass, Jenkins, & Dunn, 2007). Pike, Coldwell, and Dunn (2005) also found that the link between sibling relationship quality and children's adjustment is not entirely mediated by the parent-child relationship. Sibling relationship quality was found to be linked to older (but not younger) siblings' adjustment, and positive sibling relationships were linked to better individual adjustment, while negative sibling relationships were not linked to problem behaviors (Pike, Coldwell & Dunn, 2005). In addition, an older sibling's behavioral willingness to use substances has been associated with a younger sibling's future substance use (Pomery et al., 2005).

Table 9.1: Risk and Protective Factors for Sibling Relationships

Risk Factors	Protective Factors
Living in a high-risk neighborhood	Affectionate relationship with an older sibling
Harsh-inconsistent parenting	Positive parent-child relationships
Additional family stressors or marital conflict	Positive parenting practices
Lack of family cohesion and expressiveness	Good marital adjustment
Parental depression	

Assessment Instruments

Instruments used to assess sibling relationships noted in the literature include: Sibling Relationship Inventory (Stocker & McHale, 1992); Sibling Injury Questionnaire; Maternal Interview of Sibling Relationships (adapted); Sibling Relationship Questionnaire (child report) (Buhrmester & Furman, 1990); coding team assessments of videotaped interactions between siblings (free play and sharing tasks) on measures of individual behavior and dyadic interactions; and the Berkeley Puppet Interview to obtain child report of sibling and parent-child relationships (Ablow & Measelle, 1993).

Two child self-report measures of sibling relationships are commonly used in research: the Sibling Relationship Inventory (SRI) and the Sibling Relationship Questionnaire (SRQ). The SRI is a 17-item measure structured in a standardized interview format to capture three dimensions: reflecting affection, hostility, and rivalry. The SRQ is a 48-item measure of a child's relationship with one identified sibling. A parallel parent version is also used, and a shorter, 39-item version is also available. The instrument consists of 15 subscales: pro-social, maternal partiality, nurturance of sibling, nurturance by sibling, dominance of sibling, dominance by sibling, paternal partiality, affection, companionship, antagonism, similarity, intimacy, competition, admiration of sibling, admiration by sibling, and quarrelling. These scales can be used to derive four factors: warmth/closeness, relative status/power, conflict, and rivalry.

Interventions

Few interventions have been developed specifically to assist the siblings of individuals who have experienced trauma or to help heal sibling relationships affected by trauma. The majority of existing interventions focus specifically on medical trauma and have been developed to provide services and support to siblings of children with chronic illnesses. The Surviving Cancer Competently Intervention Program (SCCIP), developed by Kazak, Alderfer, Streisand, Simms, Rourke, Barakat,and others (2004), is one such intervention and consists of a 1-day, four-session intervention combining cognitive behavioral and family therapy approaches for family members, including siblings, of childhood cancer patients. Evaluations of this program showed no reduction in PTSD symptoms for siblings upon completion of the intervention, although fathers and adolescent cancer survivor showed some benefits (Kazak et al, 2004). Another example is Camp Okizu, developed by Packman, Fine, Chesterman, VanZutphen, Golan, and Amylon (2004), which offers siblings of children with cancer the chance to participate in week-long camp sessions that combine traditional camp activities with interventions aimed at building confidence and self-esteem in the face of serious illness in the family. Siblings who completed this intervention exhibited decreased anxiety, decreased PTSD symptoms, and increased self-esteem (Packman et al., 2004).

One study compared sibling play group therapy to filial therapy used in domestic violence shelters to assist child witnesses of domestic violence. Filial therapy was more effective than sibling play therapy in reducing behavioral problems and increasing in self-concept among child witnesses of domestic violence, as well as higher attitudes of acceptance and empathic behavior among mothers (Smith & Landreth, 2003). Sibling therapy has also been used in the inpatient setting to help rebuild a sibling relationship that was severely damaged by extreme physical and emotional abuse at the hands of the biological mother (McGarvey & Haen, 2005). In this study, therapy helped with issues of survivor guilt, self-worth and sibling relationship quality.

Table 9.2: Interventions: Sibling Relationships

Treatment Name	Developer(s)	Essential Elements	Research Evidence & Outcomes
Surviving Cancer Competently Program (SCCIP)	Kazak et al. (2004)	For children of siblings with cancer. One-day, 4 session intervention using cognitive behavioral and family therapy approaches.	No reduction in PTS symptoms for siblings although some positive results for other family members (Kazak et al., 2004)

Treatment Name	Developer(s)	Essential Elements	Research Evidence & Outcomes
Camp Okizu	Packman et al. (2004)	Week-long day camp for siblings of children with cancer that also offers traditional camp activities. Goal is to provide these siblings with "peer interaction to validate their feelings as normal in the context of serious illness in the family and to bolster their self-confidence and esteem".	Statistically significant differences found for all sibling self-report measures. No significant group differences on demographic variables (sibling age, grade, ethnicity, mother or father education, or income).

Conclusion and Comment

The effect of the relationship between siblings is complicated by the relationship itself, whether the siblings experience it as strong and supportive or ambivalent, inconsistent, or abusive. Furthermore, the sibling relationship, its effects, and the siblings' experience of it are affected by the birth order, relationship with parent(s), conflict, individual behavior, emotion regulation and coping skills, and trauma. While there is little research on the relationship of siblings and trauma exposure, we can conclude that family violence and conflict and serious illness or death of a sibling are each associated with an increased risk of negative outcomes. Some siblings experience positive outcomes following trauma exposure. Risk factors include living in a high-risk neighborhood, harsh/inconsistent parenting, family stress, marital conflict, lack of cohesion and expressiveness and parental depression. Affectionate relationship with sibling, positive relationship with parent(s), positive parenting practices, and good marital adjustment can mediate trauma's effect on sibling relationships. Developed interventions for siblings who have faced trauma focus on medical traumas. Among therapies used to treat children exposed to trauma, filial therapy and sibling play therapy demonstrate an ability to increase positive behaviors, coping and adjustment.

References

Ablow, J.C. & Measelle, J.R. (1993). Berkley Puppet Interview. Unpublished instrument. University of California, Berkley.

Alderfer, M. A., Labay, L. E., & Kazak, A. E. (2003). Brief report: Does posttraumatic stress apply to siblings of childhood cancer survivors? *Journal of Pediatric Psychology, 28*(4), 281-286.

Applebaum, D. R., & Burns, G. L. (1991). Unexpected Childhood Death: Posttraumatic Stress Disorder in Surviving Siblings and Parents. *Journal of Clinical Child Psychology*, *20*(2), 114-121.

Bank, S., & Kahn, M. D. (1982). *The Sibling Bond*. Basic Books: New York.

Brody, G. H. (1998). Sibling relationship quality: Its causes and consequences. *Annual Review of Psychology, 49*, 1-24.

Brody, G. H., Ge, X., Kim, S. Y., Murry, V. M., Simons, R. L., Gibbons, F. X., et al (2003). Neighborhood disadvantage moderates associations of parenting and older sibling problem attitudes and

behavior with conduct disorders in African American children. *Journal of Consulting & Clinical Psychology, 71*(2), 211-222.

Furman, W., & Buhrmester, D. (1985). Children's perceptions of the qualities of sibling relationships. *Child Development*, *56*(2), 448-461.

Gass, K., Jenkins, J., & Dunn, J. (2007). Are sibling relationships protective? A longitudinal study. *Journal of Child Psychology and Psychiatry, 48*, 167-175.

Graham-Bermann, S. A. (1996). Family worries: Assessment of interpersonal anxiety in children from violent and nonviolent families. *Journal of Clinical Child Psychology, 25*(3), 280-287.

Hamilton-Giachritsis, C., & Browne, K. (2005). A retrospective study of risk to siblings in abusing families. *Journal of Family Psychology*, *19*(4), 619-624.

Kazak, A. E., Alderfer, M. A., Streisand, R., Simms, S., Rourke, M. T., Barakat, L. P., et al. (2004). Treatment of posttraumatic stress symptoms in adolescent survivors of childhood cancer and their families: A randomized clinical trial. *Journal of Family Psychology, 18*(3), 493-504.

Lohan, J. A., & Murphy, S. A. (2001). Parents' perceptions of adolescent sibling grief responses after an adolescent or young adult child's sudden, violent death. *Omega Journal of Death & Dying, 44*(1), 77-95.

McElwain, N., & Volling, B. (2005). Preschool children's interactions with friends and older siblings: Relationship specificity and joint contributions to problem behavior. *Journal of Family Psychology*, *19*(4), 486-496.

McGarvey, T. P., & Haen, C. (2005). Intervention strategies for treating traumatized siblings on a pediatric inpatient unit. *American Journal of Orthopsychiatry, 75*(3), 395-408.

Mancuso, M. G., Bishop, S., Blakeney, P., Robert, R., & Gaa, J. (2003). Impact on the family: Psychosocial adjustment of siblings of children who survive serious burns. *Journal of Burn Care & Rehabilitation, 24*(2), 110-118.

Packman, W. L., Fine, J., Chesterman, B., VanZutphen, K., Golan, R., & Amylon, M. D. (2004). Camp Okizu: Preliminary investigation of a psychosocial intervention for siblings of pediatric cancer patients. *Children's Health Care, 33*(3), 201-215.

Pike, A., Coldwell, J., & Dunn, J. (2005). Sibling relationships in early/middle childhood: Links with individual adjustment. *Journal of Family Psychology*, *19*(4), 523-532.

Pomery, E., Gibbons, F., Gerrard, M., Cleveland, M., Brody, G., & Wills, T. (2005). Families and risk: Prospective analyses of familial and social influences on adolescent substance use. *Journal of Family Psychology*, *19*(4), 560-570.

Smith, N., & Landreth, G. (2003). Intensive filial therapy with child witnesses of domestic violence: A comparison with individual and sibling group play therapy. *International Journal of Play Therapy, 12*(1), 67-88.

Stocker, C. M., & Youngblade, L. (1999). Marital conflict and parental hostility: Links with children's sibling and peer relationships. *Journal of Family Psychology, 13*(4), 598-609.

Stocker, C., & McHale, S. (1992). Linkages between sibling and parent-child relationships in early adolescence. *Journal of Social and Personal Relationships*, *9*, 179-195.

Williams, P. (1997). Siblings and pediatric chronic illness: A review of the literature. *International Journal of Nursing Studies, 34*(4), 312-323.

Chapter 10

Conclusion

Families living in urban poverty encounter multiple traumas. Access to resources, including mental health intervention, is critical for recovery, stability and growth. Families living in urban poverty are less likely than families living in more affluent communities to have access to the services and capital resources that may facilitate successful negotiation of their traumatic experiences, but they often utilize relational resources within the family and community to provide essential protection and support needed for recovery from posttraumatic stress. Nurturing, protective and supportive relationships between parents, intimate partners, siblings and extended family members as well as with neighbors and faith-based groups increase the safety and stability of family functioning needed for recovery and growth. Risk factors contributing to family instability generally include prior individual or family psychiatric history, history of other previous traumas or adverse childhood experiences, pile-up of life stressors, severity/chronicity of traumatic experiences, conflictual or violent family interactions, and lack of social support. When families face significant risks, including limited resources, their ability to adapt is comprised and they are at risk of becoming trauma-organized systems.

Research demonstrates that all levels of the family system are impacted the risks associated with chronic exposure to trauma and stressors:

- **Individual** distress can range from transient symptoms to Posttraumatic Stress Disorder (PTSD) to more complex trauma-related disorders, with the potential to disrupt functioning across multiple domains.
- The **family as a whole** is impacted by chronic conditions of high stress and exposure to multiple traumas and families often experience chaotic, disorganized lifestyles, inconsistent and/or conflicted relationships, and crisis-oriented coping.
- Research on **intergenerational trauma** and urban poverty has demonstrated that adults with histories of childhood abuse and exposure to family violence have problems with emotional regulation, aggression, social competence, and interpersonal relationships, leading to functional impairments in parenting which transmit to the next generation.
- Within the **parent-child relationship**, compromised attachment and mistrust may stem from parental withdrawal/worry and re-enactment of abandonment/betrayal themes.
- Though trauma may not affect the **parenting practices** of all parents, the experiences of chronic trauma and the stress associated with urban poverty have been associated with decreased parental effectiveness, less warmth, limited understanding of child development and needs, increased use of corporal punishment and harsh discipline, high incidents of neglect, and an overall strategy of reactive parenting.
- Some research indicates that supportive **intimate partner relationships** can be a source of strength in coping with a traumatic experience or dealing with the stress of poverty, but the majority focuses on difficulties faced by couples who have experienced trauma, such as problems with communication, difficulty expressing emotion, struggles with sexual intimacy, and high rates of hostility, aggression and interpersonal violence.
- **Sibling relationships** may become negative and conflictual depending on the quality of individual parent-child relationships, differential treatment of siblings by parents, parental management of sibling conflict, individual children's behavior and emotional regulation and coping skills, and family norms regarding aggression and fairness.

Repeated exposures can lead to severe and chronic reactions in multiple family members with effects that ripple throughout the family system and, ultimately, society.

In summary, living under chronically harsh, traumatic circumstances erodes parental functioning, parent-child relationships and family processes. This erosion jeopardizes families' ability to make use of structured treatment approaches and limits success of treatments that require family support. Availability of trauma-specific assessments varies across the family system, and there are no instruments designed specifically to assess the influence of trauma and urban poverty on families. For this reason, an assessment of family subsystems is recommended using multiple tools that have adequate reliability and validity for measuring specific subsystem impacts. Family treatments sensitive to the traumatic context of urban poverty, inclusive of engagement strategies that incorporate alliances with primary and extended family systems and that build family coping skills and acknowledge cultural variations in family roles and functions, are needed to adequately address the needs of families living in urban poverty experiencing chronic trauma. More research is needed to better understand how to design and deliver family-centered trauma treatments that engage families in change processes that effect positive outcomes for all their members.

Assessment of Impact on the Child

Name of Instru	Author(s)	Domains Assessed	Age Range	Source/Form (self report, lab, observation, other)	Where to obtain	Psycho-metric Properties
Traumatic Events Screening Inventory for Children – Brief Form (TESI-C-Brief) & Parent Report (TESI-PR)	Ribbe, 1996; Ford et al., 2000	A measure of experiencing and witnessing of traumatic events for children. TESI-C-Brief covers 16 categories of events arranged hierarchically.	3-18 years	Interview format or as self-report; parent-report	Link to PDF at NCPTSD: http://www.ncptsd.va.gov/ncmain/ncdocs/assmnts/traumatic_events_screening_inventory_tesi.html Cost: Free	Some evidence for reliability and validity
Trauma Exposure Screening Inventory-Parent Report Revised (TESI-PRR)	Ghosh et al., 2002	A measure of experiencing and witnessing of traumatic events for young children. Includes traumas more frequently occurring to young children (i.e., animal attacks, prolonged or sudden separations and intense family conflict).	0-6 years	Interview format or parent-report	Request from: Chandra.ghosh@ucsf.edu Cost: Free	Not reported
Violence Exposure Scale for Children-Preschool Version (VEX-PV)	Fox & Leavitt, 1995	A measure of experiencing and witnessing of traumatic events for young children.	4-10 years	Interview format with children	Request from: Ariana Shahinfar, Ph.D.; Department of Psychology; University of North Carolina - Charlotte; 9201 University City Blvd.; Charlotte, NC 28223 Cost: Free	Some evidence for reliability and validity

Name of Instru	Author(s)	Domains Assessed	Age Range	Source/Form (self report, lab, observation, other)	Where to obtain	Psycho-metric Properties
Violence Exposure Scale for Children-Preschool Version-Revised Parent Report (VEX-RPR)	Fox & Leavitt, 1995	This measure asks questions related to violence exposure.	4-6 years	Interview format with parents	Request from: Ariana Shahinfar, Ph.D.; Department of Psychology; University of North Carolina - Charlotte; 9201 University City Blvd.; Charlotte, NC 28223 Cost: Free	Not reported
Clinician Administered PTSD Scale for Children (CAPS-CA)	Nader et al., 1994	A measure of DSM IV diagnostic criteria for PTSD that determines exposure to events meeting DSM-IV criterion, frequency and intensity for the 17 symptoms in criteria B, C, and D, and criterion E, the 1-month duration requirement.	8-15 years	Semi-structured interview	Request from National Center for PTSD: http://www.ncptsd.va.gov/ncmain/assessment/assessmt_request_form.html OR Purchase from Western Psychological Services Cost: Informal version free from NCPTSD. From publisher: $104.50 initial kit. $3.80/ interview booklet (pkgs of 10)	Strong evidence for reliability and validity
Schedule for Affective Disorders and Schizophrenia for School Age Children – Present (K-SADS-P/L)	Kaufman, Birmaher, Brent, Rao, Ryan, 1995	Diagnostic interview keyed to DSM-IV.	6-18 years	Semi-structured interview	Varies by version, but the following link provides information for access: http:\\www.wpic.pitt.edu\Ksads Cost: Free for research and not-for-profit clinical use.	Some evidence for reliability and validity (as specifically related to PTSD diagnoses)

Name of Instru	Author(s)	Domains Assessed	Age Range	Source/Form (self report, lab, observation, other)	Where to obtain	Psycho-metric Properties
UCLA PTSD Index for DSM-IV	Pynoos et al., 1998	Instrument keyed to DSM-IV PTSD symptoms for youth who report traumatic stress experiences.	7-12 years	Self-report or interview format; parent report version also exists.	Request from: UCLA PTSD Index for DSM-IV: UCLA Trauma Psychiatry Service; 300 Medical Plaza; Los Angeles, CA 90095-6968. Phone: (310) 206-8973 Email: HFinley@mednet.ucla.edu Cost: Free	Strong evidence for reliability and validity
Trauma Symptom Checklist for Children (TSCC)	Briere, 1996	A measure of PTSD and related symptoms, including those related to complex trauma disorders [41]. TSCC comprises 2 validity scales and 6 clinical subscales (Anxiety, Depression, Anger, Posttraumatic Stress, Sexual Concerns, Dissociation).	8-16 years	Self-report	Psychological Assessment Resources Cost: $158 initial kit (manual, 25 booklets, 50 profile forms). $2.36 /test booklet (pkgs of 25). $1.24/profile form (pkgs of 25)	Strong evidence for reliability and validity
Trauma Symptom Checklist for Young Children (TSCYC)	Briere, 2000	The instrument contains eight clinical scales: Posttraumatic Stress-Intrusion (PTSI), Posttraumatic Stress-Avoidance (PTS-AV), Posttraumatic Stress-Arousal (PTS-AR), Sexual Concerns (SC), Dissociation (DIS), Anxiety (ANX), Depression (DEP), and Anger/Aggression (ANG).	3-12 years	Caregiver report	Psychological Assessment Resources Cost: $200 initial kit (manual, 25 interview booklets, 25 profile forms, 25 answer sheets per age range). $1.28/booklet, $1.76/answer sheets, $1.28/ profile forms (all pkgs of 25 each).	Strong evidence for reliability and validity

Name of Instru	Author(s)	Domains Assessed	Age Range	Source/Form (self report, lab, observation, other)	Where to obtain	Psycho-metric Properties
Posttraumatic Stress Disorder Semi-Structured Interview and Observational Record	Scheeringa & Zeanah, 1994	Interview and observation of the primary caretaker and the child, includes interview for caregiver's own PTSD symptoms. Symptoms measured by the interview include those similar to the Diagnostic Classification of Mental and Developmental Disorders in Infancy and Early Childhood (DC: 0–3). Includes 18 DSM-IV criteria.	0-7 years	Parent administered interviews by highly trained clinician	Contact author: Michael Scheeringa 1440 Canal Street, TB52 Tidewater Building, 10th Floor New Orleans, LA 70112 OR mscheer@tulane.edu Cost: Free with permission	Some evidence for reliability and validity.
Child and Adolescent Needs and Strengths - Trauma Exposure and Adaptation Version (CANS-TEA)	Lyons, 2009	Assesses 12 areas: Trauma History, Traumatic Stress Symptoms, Regulation of Emotions, Regulation of Behavior, Other Behavioral Health Concerns, Attachment Difficulties, Problem Modifiers, Stability of Social Environment, Child Strengths, Functioning, Acculturation.	4-18 years	Clinician administered interview	Contact: Melanie Buddin Lyons; phone: 847-501-5113; fax: 847-501-5291; email: Mlyons405@aol.com Cost: Free	Some evidence for reliability and validity.
Child Behavior Checklist (CBCL)	Achenbach & Edelbrock, 1991	The instrument measures 8-9 subscales that can be collapsed into Internalizing, Externalizing, and a Total Problem Score.	6-18 years; 1.5 - 5 year forms also available	Primary caregiver report	ASEBA Cost: $0.50/response form (pkgs of 50); $295 initial electronic scoring kit and data management software, includes manual	Well validated

Name of Instru	Author(s)	Domains Assessed	Age Range	Source/Form (self report, lab, observation, other)	Where to obtain	Psycho-metric Properties
Global Appraisal of Individual Needs - Short Screener (GAIN-SS)	Dennis, Feeney, Stevens, & Bedoya, 2006	The GAIN-SS is designed to screen general populations to quickly and accurately identify adolescents & adults as having 1+ behavioral health disorders and a need for referral to some part of the behavioral health treatment system. It also serves as an easy-to-use quality assurance tool across diverse field-assessment systems for staff with minimal training or direct supervision. Can serve as a periodic measure of change over time in behavioral health.	Teens & adults	Self or staff administration with paper and pen, on a computer, or on the web.	Available from: http://www.chestnut.org/LI/gain/GAIN_SS/index.html Cost: Free	Some evidence for reliability and stability
Juvenile Inventory for Functioning	Hodges, 2003	Assesses 10 domains of functioning (school/job, feelings, home life, dealing with bad feelings, family life, alcohol and drugs, friends, thinking, neighborhood, health)	Teens & parents	Computer self-administered interview	Unable to locate	Unable to locate

Name of Instru	Author(s)	Domains Assessed	Age Range	Source/Form (self report, lab, observation, other)	Where to obtain	Psycho-metric Properties
Behavior Assessment System for Children - Second Edition (BASC-2)	Reynolds & Kamphaus, 2004	Behaviors, thoughts, emotions; also adaptive & maladaptive behaviors in home, school, and community settings	2 years - 21 years, 11 mo	Self-report, teacher rating, parent rating, structured developmental history, classroom observation	Pearson Assessment Cost: $91.75 for manual; $1.15/computer entry form; $1.38/hand score forms (25 per pkg). Computer scoring programs range from $267 - $906	Strong evidence for reliability and validity
Structured Interview for Disorders of Extreme Stress	Pelcovitz, van der Kolk, Roth, Mandel, Kaplan, & Resick, 1997	Complex PTSD may not be fully normed: regulation of affect and impulses, attention or consciousness, self-perception, perception of the perpetrator, relations with others, somatization, systems of meaning	Teens & adults	Structured interview, self report version also available	The Trauma Center at JRI: http://www.traumacenter.org/products/instruments.php Cost: $50 for assessment packet (includes 2 other measures) and $50 for scoring program. $90 for both.	Some evidence for reliability and validity
Child Dissociative Checklist	Putnam, Helmers, Horowitz, & Trickett, 1993	Dissociative amnesia, rapid shifts in demeanor & abilities, spontaneous trance states, hallucinations, identity alterations, aggression/sexualized behaviors. A score higher than 12 is evidence of pathological dissociation.	Child	Parent report	Available from: http://www.traumaawareness.org/id34.html Cost: Free	Strong evidence for reliability and validity

Assessment of Impact on the Adult Family Members

Name of Instrument	Author(s)	Domains Assessed	Age Range	Source/Form (self report, observation, lab, other)	Where to obtain	Psychometric Properties

Name of Instrument	Author(s)	Domains Assessed	Age Range	Source/Form (self report, observation, lab, other)	Where to obtain	Psychometric Properties
Clinician Administered PTSD Scale (CAPS)	Blake, Weathers, Nagy, Kaloupek, Charney, & Keane, 1995	Diagnostic criteria for PTSD	Adult	Structured diagnostic interview	Request from National Center for PTSD: http://www.ncptsd.va.gov/ncmain/assessment/assessmt_request_form.html OR Western Psychological Services Cost: Informal version free. From publisher: $104.50 initial kit. $3.80/ interview booklet	Well validated
Structured Clinical Interview for DSM-IV, PTSD module (SCID-PTSD)	First, Spitzer, Gibbon, & Williams, 1996	Diagnostic criteria for PTSD	Adult	Structured diagnostic interview	The Clinician Version of the SCID-I (SCID-CV), and the SCID-II, may be purchased from American Psychiatric Press (800-368-5777). Cost: Clinician's version, $167 initial kit (administration booklet, 5 score sheets, user's guide). $13.20/ score sheet (pkg of 5)	Strong evidence for reliability and validity (as specifically related to diagnoses of PTSD)
PTSD Checklist (PCL)	Weathers et al., 1993	Diagnostic criteria for PTSD	Adult	Self-report	Request from National Center for PTSD: http://www.ncptsd.va.gov/ncmain/assessment/assessmt_request_form.html Cost: Free	Strong evidence for reliability and validity

Name of Instrument	Author(s)	Domains Assessed	Age Range	Source/Form (self report, observation, lab, other)	Where to obtain	Psychometric Properties
Childhood Trauma Questionnaire (CTQ)	Bernstein & Fink, 1998	Caregiver history of abuse/neglect during childhood. The scale assesses three types of abuse (Emotional, Physical, Sexual), two types of neglect (Emotional, Physical), plus 2 validity scales.	12 and over	Self-report	Pearson Assessment Cost: $149 for kit (manual, 25 forms). $2.36/form (pkgs of 25).	Strong evidence for reliability and validity
Trauma Symptom Inventory (TSI)	Briere, 1995	Measure of trauma symptoms. The TSI comprises 3 validity scales and 9 clinical scales (anxious arousal, depression, anger/ irritability, intrusive experiences, defensive avoidance, dissociation, sexual concerns, dysfunctional sexual behavior, impaired self-reference, tension reduction behavior).	Adults (18 years+)	Self-report	Psychological Assessment Resources 800.331.8378 Cost: $210 for introductory kit. $2.10/ answer sheet (pkgs of 25). $1.52/ profile forms (pkgs of 25.)	Strong evidence for reliability and validity
Life Stressor Checklist-Revised	Wolfe, Kimerling, Brown, Chrestman, & Levin, 2003	Questionnaire about stressful life events. Covers disasters, accidents, incarceration, foster/adoption, parental divorce, financial problems, physical or mental illnesses, victim of crimes, child abuse, neglect, miscarriage or abortion, separation from your child, grief, etc.	Adult	Self-report	Write to: Rachel Kimerling, PhD; Education Division National Center for PTSD; VA Palo Alto Health Care System; Building 334-PTSD; 795 Willow Road; Menlo Park, CA 94025 Cost: Free	Strong evidence for reliability and validity

Name of Instrument	Author(s)	Domains Assessed	Age Range	Source/Form (self report, observation, lab, other)	Where to obtain	Psychometric Properties
Posttraumatic Stress Diagnostic Scale (PDS)	Foa, Cashman, Jaycox, & Perry, 1997	PTSD diagnosis, symptom severity score, symptom severity rating, level of impairment in functioning	Adult	Self-report	Pearson Assessment Cost: $64 starter kit (manual, 1 booklet, 10 answer sheets, 10 worksheets). Reorder kit $150 (50 answer sheets, 50 worksheets).	Strong evidence for reliability and validity
Brief Symptom Inventory (BSI)	Derogatis, 1993	Inventory of psychological symptoms. The BSI yields three global indices of distress, Global Severity Index (GSI) and nine subscales including Anxiety, Depression, Hostility, Obsessive-Compulsive, Somatization, Interpersonal Sensitivity, Phobic Anxiety, Paranoid Ideation, Psychoticism.	13 and over	Self-report	Pearson Assessment Cost: $109 initial kit (manual, 50 answer sheets, 50 profile forms). $1.15/ answer sheet (pkg of 50). $0.53/profile form (pkg of 50).	Strong evidence for reliability and validity
CAGE	Ewing, 1984	Measures problems related to alcohol or drug abuse.	Adult	Self-report	Available in the public domain (Can access via online search engine by entering "CAGE and Ewing.") Cost: Free	Strong evidence for reliability and validity (in terms of identifying problematic drinking)

Name of Instrument	Author(s)	Domains Assessed	Age Range	Source/Form (self report, observation, lab, other)	Where to obtain	Psychometric Properties
Beck Depression Inventory II (BDI-II)	Beck, Steer, & Brown, 1996	Depression severity, 4 point scale, multiple symptoms: sadness, pessimism, past failure, loss of pleasure, guilty feelings, punishing feelings, self-dislike, self-criticism, suicidal thoughts, crying, agitation, loss of interest, indecisiveness, worthlessness, loss of energy, changes in sleep, irritability, changes in appetite, concentration, tiredness or fatigue	13 and over	Self-report	Pearson Assessment Cost: $109 initial kit (manual, 25 forms). $1.96/ form (pkgs of 25).	Strong evidence for reliability and validity
Beck Anxiety Inventory	Beck & Steer, 1993	Severity of Anxiety, 4 point scale: cognitive and physiological symptoms	Adult	Self-report	Pearson Assessment Cost: $109 initial kit (manual, 25 forms). $1.96/ form (pkgs of 25).	Strong evidence for reliability and validity
Pittsburg Sleep Quality Index	Buysse, Reynolds III, Monk, Berman, & Kupfer, 2000	Sleep quality during the previous month; distinguish between good and poor sleepers. Domains include subjective sleep quality, sleep latency, sleep duration, habitual sleep efficiency, sleep disturbances, use of sleep medications and daytime dysfunction.	Adult	Self-Report and Partner Report	Link - University of Pittsburgh Sleep Medicine Institute: http://www.sleep.pitt.edu/content.asp?id=1484&subid=2316 Cost: Free, with permission for use	Strong evidence for reliability and validity

Name of Instrument	Author(s)	Domains Assessed	Age Range	Source/Form (self report, observation, lab, other)	Where to obtain	Psychometric Properties
Addiction Severity Index	McLellan, Luborski, Cacciola, Griffith, McGrahan, O'Brien, 1979	History, frequency, and consequences of drug and alcohol use. 5 other domains: medical, legal, employment, social/family, and psychological functioning. Rating scale of 0-4	Adult	Face-to-face structured interview	Download from: http://www.tresearch.org/resources/instruments.htm#top Cost: Free	Strong evidence for reliability and validity
Dissociative Experiences Scale, II	Bernstein-Carlson, & Putnam, 1993	Help patients identify psychopathology and quantify dissociative experiences: memory, identity, cognition, feelings of derealization, depersonalization, absorption, imaginative involvement. Ranges from never (0%) to always (100%).	Adult	Self-report	Order from Sidran Institute: http://www.sidran.org/ Cost: $12, unlimited use	Strong evidence for reliability and validity (as a screener)

Assessment of Impact on the Family as a Whole

Name of Instrument	Author(s)	Domains Assessed	Age Range	Source/Form (self report, lab, observation, other)	Where to obtain	Psychometric Properties
Family Empowerment Scale	Koren, DeChillo, & Friesen, 1992	Assesses parent and caregiver beliefs regarding their roles and responsibilities in addition to how they provide advocacy for their child.	18 and up	Caregiver report	Portland State University Link: www.rtc.pdx.edu Search publications for "Family Empowerment Scale" Cost: Free	Some evidence for reliability and validity

Name of Instrument	Author(s)	Domains Assessed	Age Range	Source/Form (self report, lab, observation, other)	Where to obtain	Psychometric Properties
Family Adaptability and Cohesion Scale (FACES IV)	Olson, Gorall, & Tiesel, 2007	Based on the Circumplex model. Revised version includes six subscales: two assess the mid-ranges of adaptability and cohesion, and four assess the extremes (rigid, chaotic, disengaged, and enmeshed).	12 and up	Self-administered instrument, each family member can complete	Life Innovations Link: http://www.facesiv.com/ Cost: $95 FACES IV package with unlimited use	Strong evidence for reliability and validity
Family Assessment Device (FAD)	Epstein, Baldwin, &Bishop, 1983	Designed to measure family functioning based upon the McMaster Model. The instrument provides scores for 7 scales, including problem-solving, communication, roles, affective responsiveness, affective involvement, behavior control, and overall functioning.	12 and up	Self-administered instrument	Brown University/Butler Hospital Family Research Program. Email: familyresearch@lifespan.org Cost: $41.95 for book, *Evaluating and Treating Families*, which includes permission to make copies of measure	Strong evidence for reliability and validity
Family Processes	Smith, Prinz, Dumas, & Laughlin, 2001	Cohesion, Structure, Beliefs, Defiant Beliefs	Adult	Self-administered instrument	Unable to locate	Some evidence for reliability and validity
APGAR	Smilkstein, 1978	Measure assesses a family member's perception of satisfaction with family relationships including five dimensions: Adaptability, Partnership, Growth, Affection, and Resolve.	Adult	Self-administered instrument	Available in the public domain. Also included in the original reference. Cost: Free	Strong evidence for reliability and validity

Name of Instrument	Author(s)	Domains Assessed	Age Range	Source/Form (self report, lab, observation, other)	Where to obtain	Psychometric Properties
Family Advocacy and Support Tool (FAST)	Lyons, 2005	The Family Assessment and Support Tool (FAST) is the family version of the Child and Adolescent Needs and Strengths (CANS) for family of planning and outcome management tools. It has 4 domains: Family Together, Caregiver's Status, Youth's Status, and Advocacy Status.	Adult	Clinician administrated	Available from the Buddin Praed Foundation. Direct link to measure: http://www.praedfoundation.org/About%20the%20FAST.html Cost: Free	New or promising measure
Family Environment Scale	Moos & Moos, 1994	Perception of actual environments, perception of ideal family environments, and expectations of what family environments will be like under anticipated family changes. Subscales of cohesion, expressiveness, and conflict, independence, achievement orientation, intellectual-cultural orientation, active-recreational orientation, and moral-religious emphasis, organization/control, and system maintenance.	Family members age 11 through adult	Self-administered	Mind Garden Link: http://www.mindgarden.com/products/fescs.htm Cost: $40 manual & sampler set. $1 per form, or less if purchased in quantities greater than 100.	Strong evidence for reliability and validity
Family Crisis Oriented Personal Evaluation Scales (F-COPES)	McCubbin, Olson, & Larsen, 1991	Five subscales: obtaining social support, redefinition of the problem, seeking spiritual support, mobilization of the family to obtain and accept formal support, passive appraisal of the crisis.	Family members age 12+	Self-administered	Unable to locate	Strong evidence for reliability and validity

Name of Instrument	Author(s)	Domains Assessed	Age Range	Source/Form (self report, lab, observation, other)	Where to obtain	Psychometric Properties
California Inventory for Family Assessment	Werner & Green, 1996	Assesses cohesion-enmeshment domain of family functioning re: intrusiveness (blurring or violation of boundaries) and closeness-caregiving (relationship-enhancing behaviors such as warmth and nurturance). Assesses dyadic relationship behavior (e.g., wife-husband; brother-sister) rather than behavior at the level of the family as a whole.	Family members	Self administered	Link to access manual: http://sites.google.com/site/californiainventoryforfamilyassessment/ Cost: Free	Strong evidence for reliability and validity

Assessment of Impact on Intergenerational Relationships

Name of Instrument	Author(s)	Domains Assessed	Age Range	Source/Form (self report, lab, observation, other)	Where to obtain	Psychometric Properties

Name of Instrument	Author(s)	Domains Assessed	Age Range	Source/Form (self report, lab, observation, other)	Where to obtain	Psychometric Properties
Qualitative questions	N/A	Examples of possible qualitative questions include: "When you think back to your childhood, what sorts of traumatic events did your parent(s), grandparent(s), or primary caregiver(s) experience? Please explain each person's experience with a traumatic event" and "How did your parents(s), grandparent(s), or primary caregiver(s) respond, deal with or manage their feelings regarding the traumatic event?"	N/A	N/A	N/A	N/A
Adult Attachment Interview	George, Kaplan, & Main, 1985	Adult strategies for identifying, preventing, and protecting the self from perceived dangers, particularly those associated with intimate relationships	Adult	Interview	Stony Brook Attachment Lab; Link: http://www.psychology.sunysb.edu/attachment/measures/measures_index.html Cost: Free access to measure, but approx. $1500 for training costs	Strong evidence for reliability and validity
Traumatic Stress Schedule (TSS)	Norris, 1990	For use with general population and measures essential information about potentially traumatic events. Excludes emotional abuse and neglect.	Adult	Brief interview	Embedded within original reference (Norris, 1990). Also, can contact author directly: Fran.Norris@dartmouth.edu Cost: Free	Strong evidence for reliability and validity

Name of Instrument	Author(s)	Domains Assessed	Age Range	Source/Form (self report, lab, observation, other)	Where to obtain	Psychometric Properties
Working model of the child	Zeanah & Benoit, 1995	Assesses parents' perceptions of their infant's characteristics. Results in 1 of 3 classifications of representations: balanced, disengaged, distorted.	Parents of 0 to 48 month olds	Structured Interview	Link to copy of measure: http://www.oaimh.org/newsFiles/Working_Model_of_the_Child_Interview.pdf Cost: Free access to measure, but approx. $1500 for training costs	Strong evidence for reliability and validity

Assessment of Impact on Parent Child Relationships

Name of Instrument	Author(s)	Domains Assessed	Age Range	Source/Form (self report, lab, observation, other)	Where to obtain	Psychometric Properties
Parent-Child Conflict Tactic Scales (CTSPC-CA)	Straus, Hamby, Finkelhor, Moore, Runyan, 1995	Measures the frequency of parents' behavior related to discipline, aggression, assault, neglect, and sexual abuse and the extent to which parents carried out specific acts of physical or psychological aggression, regardless of whether or not the child is injured.	Rec. for children 11 and younger, but can be used with teens	Child respondent, interviewer administered for pre-teens, self-report for older teens	Copyrighted, permission required for use. Information link: http://pubpages.unh.edu/~mas2/CTS24D.pdf Cost: Free, with permission	Some evidence for reliability and validity
Parent-Child Conflict Tactic Scales (CTS PC)	Straus, Hamby, Finkelhor, Moore, Runyan, 1998	Areas assessed: Nonviolent discipline, physical assault, neglect, psychological aggression, weekly discipline, & sexual abuse. Focuses on parent's experiences with their child, but also asks about parent's own experiences as a child.	Parent	Parent self-report or interview	Western Psychological Services Cost: $54.50 for the handbook; $1.70 per form (pkgs of 25)	Strong evidence for reliability and validity
Parental Acceptance-Rejection Questionnaire – Child Version (PARQ – child)	Rohner, Saaredra, & Granum, 1979	Designed to measure the way their mothers treat them in terms of 4 scales: warmth and affection; hostility and aggression; indifference and neglect; undifferentiated rejection.	Child age 6 - 15	Child self-report	Rohner Research Publications Cost: $35 for Handbook (which includes measure), $100 (Handbook, computer scoring software, copyright waiver)	Strong evidence for reliability and validity

Parenting Relationship Questionnaire	Kamphaus & Reynolds, 2006	Indices: Attachment, Communication, Discipline Practices, Involvement, Parenting Confidence, Satisfaction with School, Relational Frustration. Also has a faking good scale.	Age 2:0 - 18:11	Primary caregiver self-report	Pearson Assessment Cost: $132.85 initial kit (manual, 25 forms each of preschool, school-age, & parent feedback forms). $1.28/hand-scored forms (25 per pkg)	Not reported. More detailed information may be available in manual.
Parent Infant Relationship Global Assessment Scale (PIRGAS)	Zero to three, 1994	Clinician judgment of parent infant relationship, 90 point scale	Infant and Caregiver	Clinician	Washington Institute; Link: http://depts.washington.edu/washinst/Resources/CGAS/PIRGAS%20Index.htm Cost: Free	Not reported

Assessment of Impact on Parenting Practices

Name of Instrument	Author(s)	Domains Assessed	Age Range	Source/Form (self report, lab, observation, other)	Where to obtain	Psychometric Properties
Parenting Stress Index (PSI)	Abidin, 1990	Parental distress (contributing parental factors), difficult child (contributing child factors), parent-child dysfunction interaction	Parents of children 1 mo to 12 yr	Self-report	Psychological Assessment Resources Cost: Full: $175 initial kit (manual, 10 reusable booklets, 25 forms); Short: $122 initial kit (manual, 25 forms); $2.72/form (25 per pkg)	Strong evidence for reliability and validity
Parenting Sense of Competence Scale (PSOC)	Gibaud-Wallston & Wandersman, 1978; Johnston & Mash, 1989	Measure covers two factors: parent satisfaction & parental self-efficacy	Parents of children of all ages	Self-report	Available in the public domain. Can also contact first author Charlotte Johnston: cjohnston@psych.ubc.ca Cost: Free	Strong evidence for reliability and validity
Children's Report of Parenting Behavior Inventory (CRPBI-30)	Schludermann & Schludermann, 1988	Measures 3 dimensions of parenting Acceptance, Psychological Control, and Firm Control/Discipline.	For older children and teens	Self-report	Available in the public domain. Can also contact first author Eduard Schludermann: schlude@ms.umanitoba.ca Cost: Free	Strong evidence for reliability and validity
Child Abuse Potential Inventory	Milner, 1980	Purpose is to screen for suspected physical child abuse cases. Possesses 6 factor scales: distress, rigidity, unhappiness, problems w/child & self, problems w/family, and problems w/others. It also contains 3 validity scales: Lie, random response, & inconsistency.	Parent	Self-report	Psychological Assessment Resources Cost: $180 initial kit (manuals, 10 booklets and various scoring sheets); $2.80/booklet and $0.50 scoring sheets (10 per pkg)	Strong evidence for reliability and validity

Name of Instrument	Author(s)	Domains Assessed	Age Range	Source/Form (self report, lab, observation, other)	Where to obtain	Psychometric Properties
Parent Practices Scale	Strayhorn & Weidman, 1988	Measure favorable and unfavorable parenting such as how much approval and disapproval the parent gives the child, how and when the child is punished, etc. Three scales, positive and negative parenting practices, total score.	Parent	Self-report	Link (includes different versions): http://www.psyskills.com/parpractices.htm Cost: Free	Some evidence for reliability and validity
Parenting Dimensions Inventory-Short Version (PDI-S)	Power, 2002	Measure of parenting style. Eight dimensions are measured resulting in two scales: warmth and strictness.	Parents of children age 3-12	Self-report	Contact first author: tompower@wsu.edu Cost: Free	Some evidence for reliability and validity
Alabama Parenting Questionnaire	Frick, 1991	Assesses: Positive involvement w/kids, Monitoring/Supervision, Use of positive discipline techniques, Consistency of discipline, Use of Corporal Punishment, Other Discipline Practices	Child and Parent	Child Form, Child Telephone Interview, Parent Form, Parent Telephone Interview	Link: http://fs.uno.edu/pfrick/APQ.html Cost: Free	Strong evidence for reliability and validity
Parent Locus of Control Scale	Campis, Lyman, & Prentice-Dunn, 1986	Parental efficacy, responsibility, child control of parent's life, parental belief in fate/chance, parental control of child's behavior	Parent	Self-Report	Available in the public domain Cost: Free	Strong evidence for reliability and validity

Name of Instrument	Author(s)	Domains Assessed	Age Range	Source/Form (self report, lab, observation, other)	Where to obtain	Psychometric Properties
Adult Adolescent Parenting Inventory - Second Edition (AAPI-2)	Bavolek, S.J., 1984	Assesses: Innappropriate expectations of children, parental lack of empathy, strong belief in the use of corporal punishment, reversing parent-child roles, oppressing children's power & independence.	Adult and teen parent and non-parent	Self-Report	Family Development Resources; Link to online access: http://www.aapionline.com/index.php?page=assess Cost: Minimum purchase of 10 administrations: $10 per administration. Cost per admin decreases as number of admin purchased increases.	Strong evidence for reliability and validity

Assessment of Impact on Intimate Partner Relationships

Name of Instrument	Author(s)	Domains Assessed	Age Range	Source/Form (self report, lab, observation, other)	Where to obtain	Psychometric Properties
Dyadic Adjustment Scale (DAS)	Spanier, 1976	Measure of intimate partner relationships. It assesses four areas: Dyadic consensus, Dyadic satisfaction, Dyadic cohesion, and Affectional expression.	Adult	Self report	Multi-Health Systems Cost: $35 (manual); $2.25 per Quikscore form (pkgs of 20). Computer scoring also available for $3 per profile report.	Well validated
Revised Conflict Tactics Scales (CTS2)	Strauss, Hamby, Boney-McCoy, & Sugarman, 1996	Scales measuring the physical and psychological attacks on a partner in a marital, cohabiting, or dating relationship. Also looks at use of reasoning or negotiation to deal with conflicts. Scales include: physical assault, psychological aggression, negotiation, and injury & sexual coercion.	Adult	Self-report	Western Psychological Services Cost: $54.50 for the handbook; $1.70 per form (pkgs of 25)	Well validated

Name of Instrument	Author(s)	Domains Assessed	Age Range	Source/Form (self report, lab, observation, other)	Where to obtain	Psychometric Properties
Family Assessment Form (FAF)	McCroskey, Nishimoto & Subramanian, 1991	Assesses 6 domains: living conditions, financial conditions, interactions between adult caregivers, interactions between caregivers & children, support available to family, and developmental stimulation available to children	Adult	Observation, clinical assessment, & self-report	CWLA website: http://www.familyassessmentform.com/index.html Cost: $14.95 for paper booklet (unlimited copies permitted). $495 computer administered program w/50 assessments; $4 per additional assessment.	Some evidence for reliability and validity
Partner Violence Inventory (PVI)	Bernstein, 1998	Assesses physical, sexual, & emotional assault, partner drug & alcohol abuse, mutual physical fights, warmth & affection, and minimization of problems	Adult	Self-report	Unable to locate	New or promising measure

Assessment of Impact on Sibling Relationships

Name of Instrument	Author(s)	Domains Assessed	Age Range	Source/Form (self report, lab, observation, other)	Where to obtain	Psychometric Properties
Sibling Relationship Questionnaire	Buhrmester & Furman, 1990	Measure includes 16 scales that represent four factors: warmth/closeness; status/power; conflict; and rivalry.	6-18 years	Self-report by child about one identified sibling; Parent report also available	Contact first author, Wyndol Furman: wfurman@du.edu Cost: Free, with permission	Strong evidence for reliability and validity

Name of Instrument	Author(s)	Domains Assessed	Age Range	Source/Form (self report, lab, observation, other)	Where to obtain	Psychometric Properties
Sibling Relationship Inventory	Stocker & McHale, 1992	Three factor structure: affection, hostility, and rivalry.	6-18 years	Interview	Contact first author, Clare Stocker: cstocker@du.edu Cost: Free	Some evidence for reliability and validity
Conflict Tactic Scales - SP	Strauss, Hamby, Finkelhor, Boney-McCoy, & Sugarman, 1995	For use with children to describe conflict tactics with a sibling. Half items relate to respondents behavior towards sibling, half relate to siblings behavior towards respondent.	Children and teens	Self-report or interview format	Copyrighted, permission required for use. Information link: http://pubpages.unh.edu/~mas2/CTS24D.pdf Cost: Free, with permission	Some evidence for reliability and validity

Appendix B: Additional assessments found in the literature

Adult Assessment Instruments

- Anxiety Disorders Interview Schedule-Revised (Di Nardo, P.A. & Barlow D.H., 1988)
- Automatic Thoughts Questionnaire (Hollon, S.D. & Kendall, P.C., 1980)
- Changes in Religious Beliefs Scale (Falsetti, 1992)
- Childhood Sexual Abuse Questionnaire (Aalsma, M.C., Zimet, G.D., Fortenberry, J.D., Blythe, M., & Orr, D.P., 2002)
- Davidson Trauma Scale (Davidson, J.R.T., Book, S.W., Colket, J.T., Tupler, L.A., Roth, S., David, D., et al., 1997)
- Distressing Event Questionnaire (Kubany, E.S., Leisen, M.B., & Kaplan, A.S., 2000)
- Family Experiences Scale (The National Research Consortium of Counseling and Psychological Services in Higher Education; Johnson, C.V. & Hayes, J.A., 2003)
- Generalized Self-Efficacy Scale (Schwarzer, R. & Jerusalem, M., (1995)
- Impact of Event Scale-Revised (Horowitz, M., Wilner, N., & Alvarez, W., 1979)
- Keane PTSD Scale of the MMPI Form R (Keane, T.M., Malloy, P.F., & Fairbank, J.A., 1984)
- Life Orientation Test-Revised (Scheier, M.R., Carver, C.S., & Bridges, M.W., 1994)
- List of Threatening Experiences (Brugha, T., Bebbington, P., Tennant, C., & Hurry, J., 1985)
- Rosenberg Self-Esteem Scale (Rosenberg, 1965)
- Mississippi Scale for Combat-Related PTSD (Keane, T.M., Caddell, J.M., & Taylor, K.L., 1988)
- Multidimensional Scale of Perceived Social Support (Zimet, G.D., Dahlem, N.W., Zimet, S.G., & Farley, G.K., 1988)
- Parent-Child Conflict Tactics Scales-Adult Recall Version (Straus, M., Hamby, S.L., Finkelhor, D., Moore, D.W., & Runyan, D., 1998)
- Part II of the Hopkins Symptom Checklist (Derogatis, L.R., Lipman, R.S., Rickels, K., Uhlenhuth, E.H., & Covi, L., 1974)
- Posttraumatic Cognitions Inventory (Foa, E.D., Ehlers, A., Clark, D.M., Tolin, D. F., & Orsillo, S.M., 1999)
- Potential Stressful Events Interview (Falsetti, S. A., Resnick, H. S., Kilpatrick, D. G., & Freedy, J. R., 1994)
- Resiliency Attitudes Scale (Biscoe, B. & Harris, B. 1994)
- Revised Conflict Tactics Scale (Straus, M.A., Hamby, S.L., Boney-McCoy, S., & Sugarman, D.B., 1996)
- Satisfaction with Life (caregiver) (Diener, E., Emmons, R.A., Larsen, R.J., & Griffon, S., 1985)
- Self-harm Behavior Questionnaire (Gutierrez, P.M., Osman, A., Barrios, F.X., Kopper, B.A., 2001)
- Sexual Risk Behavior Questionnaire-Revised (Gilbert, L., El-Bassel, N., Schilling, R.F., Wada, T., & Bennet, B., 2000)
- Social & Occupational Functioning Assessment Scale (Goldman, H.H., Skodal, A.E.,& Lave, T.R., 1992)
- Trauma History Questionnaire (Green, B.L., 1996)
- Twenty Statement Test (Kuhn, M.H. & McPartland, T.S., 1954)
- UCLA PTSD Reaction Index (Pynoos, R.S., Rodriguez, N., Steinberg, A.S., Stuber, M. & Frederick, C. 1998)
- University of Rhode Island Change Assessment (DiClemente, C. C., & Hughes, S. O., 1990)
- Working Alliance Inventory (Horvath, A. O. & Greenberg, L. S., 1989)
- Schema Questionnaire (Young, J., 1990)

References

Aalsma, M.C., Zimet, G.D., Fortenberry, J.D., Blythe, M., & Orr, D.P. (2002). Reports of childhood sexual abuse by adolescents and young adults: stability over time. *The Journal of Sex Research*, 39(4), 259-263.

Biscoe, B. & Harris, B. (1994). *Resiliency attitudes scale*. Oklahoma City: Sage.

Brugha, T., Bebbington, P., Tennant, C., & Hurry, J. (1985). The List of Threatening Experiences: a subset of 12 life event categories with considerable long-term contextual threat. *Psychological Medicine*, 15, 189-194.

Davidson, J.R.T., Book, S.W., Colket, J.T., Tupler, L.A., Roth, S., David, D., Hertzberg, M., Mellman, T., Beckham, J.C., Smith, R.D., Davison, R.M., Katz, R., & Feldman, M.E. (1997). Assessment of a new self-rating scale for posttraumatic stress disorder. *Psychological Medicine*, 27, 153-160.

Derogatis, L.R., Lipman, R.S., Rickels, K., Uhlenhuth, E.H., & Covi, L. (1974). The Hopkins Symptom Checklist (HSCL): A self-report symptom inventory. Behavioral Science, 19(1), 1-15.

DiClemente, C. C., & Hughes, S. O. (1990). Stages of change profiles in outpatient alcoholism treatment. *Journal of Substance Abuse*, 2, 217–235.

Diener, E., Emmons, R.A., Larsen, R.J., & Griffon, S. (1985). The Satisfaction with Life Scale. *Journal of Personality Assessment*, 49(1), 71-75.

Di Nardo PA, Barlow DH. *Anxiety Disorders Interview Schedule-Revised (ADIS-R)*. Albany, NY: Phobia and Anxiety Disorders Clinic; 1988.

Falsetti, S. A. (1992). *Changes in Religious Beliefs Scale*. Unpublished scale, National Crime Victims Research and Treatment Center, Medical University of South Carolina, Charleston, SC.

Falsetti, S. A., Resnick, H. S., Kilpatrick, D. G., & Freedy, J. R. (1994). A review of the Potential Stressful Events Interview: A comprehensive assessment instrument of high and low magnitude stressors. *The Behavior Therapist*, *17*, 66–67.

Family Experiences Scale, designed by: The National Research Consortium of Counseling Centers in Higher Education at the University of Texas Counseling and Mental Health Center. Accessed online at http://www.cmhc.utexas.edu/researchconsortium.html.

Foa, E.D., Ehlers, A., Clark, D.M., Tolin, D. F., & Orsillo, S.M. (1999). The Posttraumatic Cognitions Inventory (PTCI): Development and Validation. *Psychological Assessment*, 11(3), 303-314.

Gilbert, L., El-Bassel, N., Schilling, R.F., Wada, T., & Bennet, B. (2000). Partner Violence and Sexual HIV Risk Behaviors Among Women in Methadone Treatment. AIDS and Behaviors, 4(3), 261-269.

Goldman, H.H., Skodal, A.E., & Lave, T.R. (1992). Revising axis V for DSM-IV: a review of measures of social functioning. *American Journal of Psychiatry,* 149, pp. 1148–1156.

Green, B.L. (1996). Trauma History Questionnaire. In B.H. Stamm (Eds.), *Measurement of Stress, Trauma and Adaptation*. Lutherville, MD: Sidran, pp. 366–369.

Gutierrez, P.M., Osman, A., Barrios, F.X., Kopper, B.A. (2001). Development and Initial Validation of the Self-Harm Behavior Questionnaire. *Journal of Personality Assessment*, 77(3), 475-490.

Hollon, S.D. & Kendall, P. C. (1980). Cognitive self-statements in depression: Development of an automatic thoughts questionnaire. *Cognitive Therapy and Research*, 4(4), Dec 1980, 383-395.

Horowiz, M., Wilner, N., & Alvarez, W. (1979). Impact of Event Scale: A measure of subjective stress. Psychosomatic Medicine, 41(3), 209-218.

Horvath, A. O. & Greenberg, L. S. (1989). Development and Validation of the Working Alliance Inventory. *Journal of Counseling Psychology*, 36(2), 223-233.

Johnson, C.V. & Hayes, J.A. (2003). Troubled Spirits: Prevalence and Predictors of Religious and Spiritual Concerns Among University Students and Counseling Center Clients. Journal of Counseling Psychology, 50(4), 409-419.

Keane, T.M., Malloy, P.F., & Fairbank, J.A. (1984). Empirical development of an MMPI subscale for the assessment of combat-related posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology*, 52, 85-90.

Keane, T.M., Caddell, J.M., & Taylor, K.L.. (1988). Mississippi Scale for Combat-Related Posttraumatic Stress Disorder: three studies in reliability and validity. *Journal of Consulting Clinical Psychology*, 56, 85-90.

Kubany, E.S., Leisen, M.B., & Kaplan, A.S. (2000). Validation of a Brief Measure of Posttraumatic Stress Disorder: The Distressing Event Questionnaire (DEQ). *Psychological Assessment*, 12(2), 197-209.

Kuhn, M.H. & McPartland, T.S. (1954). An empirical investigation of self attitudes. *American Sociological Review*, 19, 68-76.

Pynoos, R. S., Rodriquez, N. Steinberg, A. S., Stuber, M., & Frederick, C. (1998). *The UCLA PTSD Reaction Index for DSM IV (Revision 1).* Los Angeles: UCLA Trauma Psychiatry Program.

Rosenberg, M. (1965). *Society and the adolescent self-image*. Princeton, NJ: Princeton University Press.

Scheier, M.R., Carver, C.S., & Bridges, M.W. (1994). Distinguishing optimism from neuroticism: A reevaluation of the life orientation test. *Journal of Personality and Social Psychology*, 5, 1063-1078.

Schwarzer, R., & Jerusalem. M. (1995). Generalized Self-Efficacy Scale. In J. Weinman, S. Wright, & M. Johnston (Eds.). *Measures in health psychology: A user's portfolio. Causal and control beliefs* (pp. 35-37). Windsor. England: NFER-NELSON.

Straus, M.A., Hamby, S.L., Boney-McCoy, S., & Sugarman, D.B. (1996). The Revised Conflict Tactics Scales (CTS2). *Journal of Family Issues*, 17(3), 283-316.

Straus, M., Hamby, S.L., Finkelhor, D., Moore, D.W., & Runyan, D. (1998). Identification of Child Maltreatment With the Parent-Child Conflict Tactics Scales: Development and psychometric data for a national sample of American parents. *Child Abuse & Neglect*, 22(4), 249–270.

Young, J. (1990). *Cognitive therapy for personality disorders: A schema-focused approach*. Sarasota, FL: Professional Resource Exchange, Inc.

Zimet, G.D., Dahlem, N.W., Zimet, S.G., Farley, G.K. (1988). The Multidimensional Scale of Perceived Social Support. *Journal of Personality Assessment*, 52(1), 30-41.

Family as a Whole Assessment Instruments

- Assessment of Strategies in Families—Effectiveness (Friedemann, 1998; Friedemann & Smith, 1997)
- Beavers' Self Report Family Inventory (SFI; Beavers & Hampson, 1990)
- Beavers Timberlawn Family Evaluation Scale (Lewis, Beavers, Gossett, & Phillips, 1976)
- Family Adaptation Checklist (McCubbin, Thompson, & McCubbin, 1996)
- Family Crisis-oriented Personal Evaluation Scales (FCOPES; McCubbin, Olson, & Larsen, 1991)
- Family Expressiveness Questionnaire (FEQ; Halberstadt, 1986)
- Family Environment Scale (Moos & Moos, 1994)
- Family Functioning Questionnaire (Linder-Pelz, Levy, Tamir, Spenser, & Epstein, 1984)
- Family Hardiness Index (FHI; McCubbin, 1991)
- Family History Questionnaire (Qureshi, et al., 2005)
- Family History-research Diagnostic Criteria (Andreasen, Endicott, Spitzer, & Winokur, 1977)
- Family Inventory of Life Events and Changes (FILE; McCubbin, 1991)
- Family Member Well-being Index (McCubbin, Thompson, & McCubbin, 1996)
- Family Messages Measure (Lux, 1989)
- Family Relations Scale (Barbarin, 1992)
- Family Sense of Coherence Scale (Antonovsky & Sourani, 1988)
- Family Worries Scale (Graham-Bermann, 1996)

References

Andreasen, N. C., Endicott, J., Spitzer, R. L., & Winokur, G. (1977). The family history method using diagnostic criteria; reliability and validity. *Archives of General Psychiatry*, *34*, 1229–1235.

Antonovsky, A., & Sourani, T. (1988). Family sense of coherence and family adaptation. *Journal of Marriage and the Family, 50*, 79–92.

Barbarin, O. A. (1992). Manual: Family Relations Scale. Michigan: University Centre for the Child and Family.

Graham-Bermann, S. A. (1996). Family worries: Assessment of interpersonal anxiety in children from violent and nonviolent families. *Journal of Clinical Child Psychology, 25,*

280-287.

Beavers, W.R. & Hampson, R.B. (1990) *Successful Families: Assessment and Intervention.* New York: W.W. Norton.

Friedemann, M. L. (1998). *1998 testing of the ASF-E*. Unpublished manuscript, Florida International University, Miami.

Friedemann, M. L., & Smith, A. A. (1997). A triangulation approach to testing a family instrument. *Western Journal of Nursing Research*, *19*, 364-378.,

Halberstadt, A. G. (1986). Family socialization of emotional expression and nonverbal communication styles and skills. *Journal of Personality and Social Psychology, 51,* 827-836.

Lewis, J. M., Beavers, W. R., Gossett, J. T, & Phillips, V. A. (1976). *No single thread: Psychological health in family systems.* New York:Brunner/Mazel.

Linder-Pelz, S., Levy, S., Tamir, A., Spenser, T., & Epstein, L. M. (1984). A measure of family functioning for health care practice and research in Israel. *Journal of Comparative Family Studies, 15,* 211-230.

Lux, M. G. (1989). *Family messages and depression in children.* Unpublished doctoral dissertation, University of Texas at Austin.

McCubbin, H. I. (1991). Family index of regenerativity and adaptation. In H.I. McCubbin & A.I. Thompson (Eds.), Family assessment: Inventories for research and practice (pp. 292-312). Madison, WI: University of Wisconsin.

McCubbin, H. I., Olson, D. H., Larsen, A. S., Corcoran, K., & Fischer, J. (2000). Measures for clinical practice: A sourcebook. 3rd Ed. (2vols.). NY, Free Pr. V. 1, Pg. 294-297.

McCubbin, H., Thompson, A., & McCubbin, M. (1996). Family assessment: Resiliency, coping and adaptation. Inventories for research and practice. Madison, WI: University of Wisconsin Publishers.

Moos, R. & Moos, B. (1994). *Family Environment Scale Manual: Development, Applications, Research - Third Edition*. Palo Alto, CA: Consulting Psychologist Press.

Qureshi, N., Bethea, J., Modell, B., Brennan, P., Papageorgiou, A., Raeburn, S., et al. (2005). Collecting genetic information in primary care: Evaluating a new family history tool. *Family Practice, 22,* 663-669.

Parenting Practices Assessment Instruments

- Family Adaptability and Cohesion Evaluation Scales IV (FACES IV; Olson, Tiesel, & Gorall, 2007)
- Interaction Ratings Scale (Crnic & Greenberg, 1990)
- Keys to Interactive Parenting Scale (KIPS; Comfort, Gordon, & Unger, 2006)
- Parental Acceptance and Rejection Questionnaire (PARQ ; Rohner, 1991)

- Parent-Child Rating Scale–Revised (PCRS-R; Hightower, 1994)
- Parenting Style Survey (PSS; Sameroff et al., 1989)

References

Comfort, M., Gordon, P., & Unger, D.G. (2006). Keys to Interactive Parenting Scale: A Window Into Many Facets of Parenting. *Journal of Zero to Three*, 26(5), 37-44.

Crnic, K. and Greenberg, M. (1990). *Minor parenting stresses with young children*. Child Development, 61, 1628-1637.

Hightower. A.D. (1994). Parent-Child Rating Scale. Rochester, NY: Primary Mental Health Project, 1994.

Olson, D. H., Gorall, D. M., & Tiesel, J. W. (2007) *FACES IV Manual*. Minneapolis, MN: Life Innovations.

Rohner, R.P. (1991). *Handbook for the study of parental acceptance and rejection*. Center for the Study of Parental Acceptance and Rejection, University of Connecticut at Storrs.

Sameroff, A. J., Thomas, S. L., & Barrett, L. (1989). *Parental style survey*. Providence, RI: Bradley Hospital.

Intimate Partner Relationships Assessment Instruments

- Personal Assessment of Intimacy in Relationships (Schaeffer & Olsen, 1981)
- Communications Pattern Questionnaire-Short Form (Christensen, 1987)
- Social Adjustment Scale–Self-Report (Weissman & Bothwell, 1976)
- Social Problem Solving Inventory (D'Zurilla & Nexu, 1990)
- Family Adaptability and Cohesion Scale (Olson, Gorall, & Tiesel, 2007)

References

Christensen, A. (1987). Detection of conflict patterns in couples. In K. Hahlweg & M. J. Goldstein (Eds.), Understanding major mental disorder: The contribution of family interaction research (pp. 250-265). New York: Family Process Press.

D'Zurilla, T.J., & Nezu, A.M. (1990). Development and preliminary evaluation of the Social Problem-Solving Inventory. *Psychological Assessment: A Journal of Consulting and Clinical Psychology.* 2(2), Jun 1990, pp. 156-163.

Olson, D. H., Gorall, D. M., & Tiesel, J. W. (2007) *FACES IV Manual*. Minneapolis, MN: Life Innovations.

Schaeffer, M.T., & Olsen, D.H. (1981). Assessing Intimacy: The PAIR inventory. *Journal of Marital & Family Therapy,*7(1), Jan 1981, pp. 47-60.

Weissman, M.M. & Bothwell, S. (1976). Assessment of social adjustment by patient self-report. *Archives of General Psychiatry,* 33(9), Sep 1976, 1111-1115.

Appendix C: List of tables

Table 2.1: Risk and Protective Factors for Children and Adolescents
Table 2.2: Interventions: Child and Adolescent
Table 3.1: Risk and Protective Factors for Adult Family Members
Table 3.2: Interventions: Adult
Table 4.1: Risk and Protective Factors for Families
Table 4.2: Interventions: Family
Table 5.1: Risk and Protective Factors for Intergenerational Transmission of Trauma Effects
Table 5.2: Interventions: Intergenerational Trauma Effects
Table 6.1: Risk and Protective Factors for Parent-Child Relationships
Table 6.2: Interventions: Parent-Child Relationships
Table 7.1: Risk and Protective Factors for Parenting Practices
Table 7.2: Interventions: Parenting Practices
Table 8.1: Risk and Protective Factors for Intimate Partner Relationships
Table 8.2: Interventions: Intimate Partner Relationships
Table 9.1: Risk and Protective Factors for Sibling Relationships
Table 9.2: Interventions: Sibling Relationships