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RISK, RESILIENCE, AND INDICATORS OF EMOTIONAL, SOCIAL AND INTELLECTUAL FUNCTIONING IN CHILDREN (0-6) EXPOSED TO VIOLENCE[1]

In the following pages we present general information that has been gleaned from available literature reviews focusing on the impact of exposure to violence among children, aged 0 to 6. It is important to note that there is a paucity of literature and empirical research in which young children (0 to 6) are the focus of study. For the most part, available information focuses upon school-aged children (age 5 and older).

Risk and Resilience Factors for Children Exposed to Violence	
Protective/Resilience Factors	**Risk Factors**
▪ Good caretaking by either a parent or other significant adults ▪ Institutional supports for child's own intellectual abilities and interpersonal skills	▪ Proximity to violence – what the child actually saw or heard ▪ Age ▪ Child's temperament ▪ Availability of supports that can emotionally protect or sustain the child ▪ Frequency of exposure to violence ▪ Presence of co-occurring factors such as substance abuse and child maltreatment

These factors suggest that interventions should focus upon

- improving parents care-taking skills;
- improving child's own conflict resolution skills;
- improving child's ability to self-regulate emotions/reactions to conflict;
- decreasing child's exposure to co-occurring factors;
- providing compensatory activities for children that build upon their intellectual and interpersonal skills;
- proving family-centered approach that involves competent/caring family members or other adults that can serve as supports for the child and family; and
- developing age-appropriate strategies (not a one-size fits all approach).

[1] The information presented in this document was derived from the following references unless otherwise noted:

Geffner, R.A., Jaffe, P.G., and Sudermann, M. (Eds.) (2000). Children exposed to domestic violence: Current issues in research, intervention, prevention, and policy development. The Haworth Press, Inc.: New York.

Holden, G.W., Geffner, R., and Jouriles, E.N. (Eds.) (1998). Children Exposed to marital violence: theory, research, and applied issues. American Psychological Association: Washington, D.C.

Symptoms and Effects in Children Exposed to Violence	
Infants, toddlers, and preschoolers	**Young, school-aged children (5-6)**
▪ Irritability ▪ Sleep disturbance ▪ Exaggerated startle response ▪ Fears of being alone ▪ Regression in toileting and language ▪ Inhibited exploratory behavior/autonomy ▪ Show limited range of emotion in their play ▪ Generalized fears ▪ Anxiety ▪ Fear of loss of parent ▪ Fear of death ▪ Sense of responsibility for the violence ▪ Anxious attachment ▪ View of world as unpredictable, hostile, and threatening ▪ Helplessness ▪ Negative impact on school-readiness ▪ Negative impact on physical health (failure to thrive, increased frequency of illness and doctor visits)	▪ Anxiety ▪ Nightmares ▪ Withdrawal from peers, teachers, and other caregivers ▪ Aggressiveness ▪ Effects on school performance ▪ Difficulties paying attention ▪ Self define as “jumpy” or “scared” ▪ Increased incidence of temper “tantrums” ▪ Lower interpersonal problem-solving skills ▪ Lower levels of empathy ▪ Sense of foreshortened future ▪ Lack of interest in play ▪ Repetition of violent event in play

No single measure or clinical scale specific to post-traumatic stress disorder (PTSD) associated with exposure to violence is available. A diagnoses involves obtaining a thorough history from multiple sources, documenting exposure to the trauma, evidence of persistent reexperiencing of the trauma, avoidance and numbing of responsiveness and increased physiologic arousal. Parent (or caregiver) and teacher reports are useful to assess external symptoms and changes in behavior. Family interviews may detect related symptoms among those related to the child. A clinical interview with the child in conjunction with a general anxiety scale such as the Revised Children’s Manifest Anxiety Scale is essential in assessing internal symptoms such as cognitive and affective anxiety.

Dean, X. Parmelle, Child and Adolescent Psychiatry, p. 108

Assessment Tools for use with Children Exposed to Family Violence

The instruments described in this section were chosen because they met the following criteria:

1. Easily administered by layperson;
2. Contain relatively few items (less than 30 wherever possible);
3. Have a history of use in research on children exposed to violence;
4. Have widely approved psychometric properties (reliability and validity); and
5. Results can be easily interpreted by laypersons.

Domain	Instrument Name	Respondent	Age Range	Description
Child Anxiety	*The Revised Child Manifest Anxiety Scale (RCMAS)* Reynolds, C.R., & Richmond, B.O. (1978). Factor Structure and Construct Validity of "What I think and Feel": The Revised Child Manifest Anxiety Scale. Journal of Personality Assessment, 43, 281-283.		5 and older	The RCMAS is the most commonly used self-report scale for assessing the presence of anxiety in children. It should be used to complement other sources of information about the child's behavior.

Child Mental Health	*Diagnostic Classification of Mental Health and Developmental Disorders in Infancy and Early Childhood.* Zero To Three: National Center for Infants, Toddlers, and Families. May be ordered directly from the Zero to Three website at: http://www.zerotothree.org		0 - 5	This publication does not include specific measures or assessment instruments. However, it provides clear criteria for identifying and diagnosing trauma and other mental health disorders in infants and young children. For sites that plan to develop their own assessment tools, this may be a good source for the identification and development of age-appropriate instrument items.
Child Mental Health	***The Child Dissociation Checklist (CDC)*** Putnam, F. W., Helmers, K., & Trickett, P. K. (1993). Development, reliability, and validity of a child dissociation scale. *Child Abuse & Neglect, 17*, 731-741.	Parent, guardian, teacher, etc.	Adult	This 20-item observer report instrument asks an adult familiar with the child's behavior (e.g., parent, foster parent, teacher, etc.) to describe the child's behavior over the past 12-month period. The instrument was derived from prior multiple personality disorder predictor lists developed by Putnam and is intended as a clinical screening instrument and as a research measure; not as a diagnostic instrument.
Child Mental Health	… McLeer, S. V., Callaghan, M., Henry, D., & Wallen, J. (1994). Psychiatric disorders in sexually abused children. *Journal of American Academy of Child and Adolescent Psychiatry, 27*, 650-654.	Parent/Guardian and Child		This study was designed to compare the prevalence of psychiatric disorders in sexually abused children. The study used the Schedule for Affective Disorders and Schizophrenia for School-Age Children—Epidemiological Version (S-ADSSC-E) instrument to interview first parents/guardians and then children.

Child Mental Health	***The Child Dissociation Checklist (CDC)*** Putnam, F. W., Helmers, K., & Trickett, P. K. (1993). Development, reliability, and validity of a child dissociation scale. *Child Abuse & Neglect, 17*, 731-741.	Parent, guardian, teacher, etc.		This 20-item observer report instrument asks an adult familiar with the child's behavior (e.g., parent, foster parent, teacher, etc.) to describe the child's behavior over the past 12-month period. The instrument was derived from prior multiple personality disorder predictor lists developed by Putnam and is intended as a clinical screening instrument and as a research measure; not as a diagnostic instrument.
Mental Health	**Beck Depression Inventory** (Beck et al., 1988)			The Beck Depression Inventory (BDI) is a widely used self-report inventory regarding severity of depressive symptoms. The BDI consists of 21 items, or sets of statements, answered on a 0 to 3 point scale. Test-retest reliability from a large number of studies is high with non-clinical samples. Internal consistency is reported over 0.85 in both clinical and non-clinical samples.
Mental Health	**Spielberger State-Trait Anxiety Scale** (STAI, Spielberger et al., 1970)			The Spielberger State/Trait Anxiety Inventory is based on a theoretical distinction between state anxiety, a transient condition of perceived anxiety, and trait anxiety, a more stable condition of a tendency toward anxiety. The STAI consists of 40 items. Twenty-items ask individuals to rate how they feel "right now" (state) and another 20 ask "how you generally feel" (trait). Test-retest reliabilities are typically lower for state than for trait with the latter on average greater than 0.75.

Child Development	**Ages and Stages Questionnaire --2nd edition (ASQ);** Bricker & Squires, 1999 Brookes Publishing Co.	Parent	0 to 60 months	This questionnaire uses Communication, Gross Motor, Fine Motor, Problem solving, Personal-Social scales to measure developmental progress. Totals for each area that are compared to cut-points; scores below cut-points are indicative of further evaluation
Child Development	**Child Development Inventory (CDI)**; Ireton, Behavior Science Systems, 1992	Parent	3 to 6 years	This inventory is a revision of the Minnesota Child Development Inventory. It includes a General Development section with Language Comprehension, Expressive Language, Fine and Gross Motor, Self-Help, and Personal-Social scales and a Behavioral Symptoms/ Possible Problems section. Scores are generated in eight developmental areas and in General Development and are compared to cut-score (score obtained by child 25% younger). Mental Measurements reviews (Kirnan & Crespo, 1998; Stein, 1998) of the CDI are less than favorable, particularly for use with children > 4 years. Reviewers cite lack of nationally representative norms and inadequate psychometric characteristics in the older age groups. Best use is as a rough screen.
Child Development	Mullen Scales of Early Learning (Mullen, 1985)	child	birth-68 months	These scales can be used to evaluate children's developmental age. The Mullen is a test used to assess a child's development in the areas of gross and fine motor, visual reception (nonverbal problem-solving), and receptive and expressive language. An overall developmental score is also provided. The Mullen subscales and overall composite score possess good to excellent reliability in terms of internal, test-retest, and

				inter-rater reliability and sound concurrent validity when compared to other measures of similar developmental competence. Overall, the Mullen is considered one of the better Multidomain developmental assessment tools for young children (Gilliam and Mayes, 2000). Only well trained research technicians with acceptable levels of demonstrated inter-rater reliability (typically, at least 90% accuracy as compared to a criterion) will be used to collect this data. The Mullen also provides information regarding social and language development.
Child Development	*The Vineland Adaptive Behavior Scales* Sparrow, S. S., Balla, D.A., Cicchetti, D.V. (1984). Circle Pines, Minn.	Parents and Teachers	0 - 18	The Vineland Adaptive Behavior Scales (VABS) are the most commonly used adaptive behavior scales in studies of cognitive ability in children. It is a measure of personal and social sufficiency administered in a semi-structured interview format. The Vineland yields norm-referenced assessments of communication, daily living, and socialization skills which are combined into the Adaptive Behavior composite, an assessment of overall adaptive behavior. An additional motor skills dimension is obtained for younger children. As a measure of adaptive behavior, the Vineland allows assessment of capacities defined by their performance by the individual rather than an assumption of underlying potential or ability. As such, the Vineland provides an important overview of the daily functioning of respondents and represents the most widely used instrument of its type.

Social Competence	**Social Competence and Behavior Evaluation Scale (SCBE)**; LaFrenier & Dumas, 1995 *Western Psychological Services*	Teacher	30 to 76 months	This scale measures according to 8 basic scales: depressive-joyful; anxious-secure; angry-tolerant; isolated-integrated; aggressive-calm; egotistical-prosocial; oppositional-cooperative; and dependent-autonomous These scales help determine social competence, tendency to externalize versus internalize problems and general adaptation. There are separate norms for boys and girls. Madle (2001) considers the SCBE to be promising though finds the development of the measure incomplete; he recommends it as a supplemental scale. Poteat (2001) considers it to be well-developed scale but cautions use with 3 year olds and with children from higher SES backgrounds.
Social Competence	**Social Skills Rating System,** *Gresham and Elliott, 1990, American Guidance Service*	Parents, Teachers, Students (≥ 7 grade)	3-0 to 4-11; Grades K-6; Grades 7-12	The Parent Form contains a Social Skills Scale with sub scale measures of cooperation, assertiveness, responsibility, and self-control as well as a Problem Behaviors Scale with externalizing and internalizing sub scales. The Teacher Form has the same elements as the Parent Form but also includes an Academic Competence Scale. Among others, Furlong and Karno (1995) recommend the SSRS as the most comprehensive rating scale for assessing social skills.

Social Competence	Child and Adolescent Functional Assessment Scale (CAFAS, Hodges, 1995)	Parent/Guardian and Clinicians	Age group	This scale will be completed by clinicians in conjunction with primary caregivers to determine the level of psychosocial impairment of the child in terms of role performance, overt behavior impairment, mood disorder, substance use, and quality of thinking and problem solving. Adaptive psychosocial functioning represents an important and distinct assessment beyond behavioral symptomatology as it allows quantification of levels of impairment across five psychosocial areas of role performance: behavior toward others, mood, substance use, and cognitive processing. The CAFAS represented the primary assessment of psychosocial functioning in the Fort Bragg study of children's systems of mental health care (Bickman et al., 1995) and represents the most widely used assessment of its kind.

Behavior	**Child Behavior Checklist (CBCL 4-18)** Achenbach, 1992 University Associates in Psychiatry; Burlington, VT	Parent	4-18 years	This Checklist contains 9 Syndrome scales that include withdrawn, somatic complaints, anxious/depressed, social problems, thought problems, attention problems, delinquent behavior, aggressive behavior, and sex problems. It also includes social competence scales that address activities, social, and school. Administering this checklist also produces results on 3 problem scales including Internalizing (I), Externalizing (E), & Total Problems (TP) scales. Furlong & Wood (1998) consider it to be the most well established measure of parent reported emotional and behavioral problems, but find that the CBCL scales lack sufficient breadth in assessing social competence. Both syndrome scales and social competence scales have discriminated between different childhood problem groups and their respective comparison groups.
Behavior s	**Caregiver-Teacher Report Form for Ages 2-5 (C-TRF/2-5);** Achenbach, 1997	Child care provider/pres chool teacher	2 to 5 years	This report form measures according to 7 syndrome scales including Anxious/Obsessive, Depressed/ Withdrawn, Fears, Somatic Problems, Immature, Attention Problems, and Aggressive Behavior. Scores also scale Internalizing (I), Externalizing (E), and Total Problems (TP).

Behavior	**Teachers Report Form (TRF)**; Achenbach, 1991	Teacher	5 to 18 years	This report form measures according to 8 Syndrome scales including Withdrawn, Somatic Complaints, Anxious/Depressed, Social Problems, Thought Problems, Attention Problems, Delinquent Behavior, and Aggressive Behavior. It also includes Adaptive Functioning scales such as Academic Performance, Working Hard, Behaving Appropriately, Leaning, and Happy. Results from each adaptive functioning scale and total adaptive scale and for each syndrome scale and for Internalizing (I), Externalizing (E), & Total Problems (TP) scales.
Behavior	**Early Childhood Inventory (ECI-4)**; Gadow & Sprafkin, 1997, Checkmate Plus, Ltd.	Parent; Teacher	3 to 5 years	This inventory looks at 19 Disorder scales including AD/HD; Oppositional Defiant Disorder, conduct Disorder, Generalized Anxiety Disorder, Social Phobia, Separation Anxiety Disorder, Obsessive-Compulsive Disorder, specific Phobia, Major Depressive Disorder, Dysthymic Disorder, Schizophrenia, Pervasive Developmental Disorder, Asperger's Disorder, Motor Tics, vocal Tics, Selective Mutism, Reactive Attachment Disorder, Posttraumatic Stress Disorder, Problems with Eating, Sleeping, and Elimination. Results generate scores for each scale and the severity classifications for each symptom.

Traumatic Events this appears to be an interview rather than way to analyze	… Pynoos, R. S., & Eth, S. (1986). Witness to violence: The child interview. *Journal of the American Academy of Child Psychiatry, 25*, 306-319.	Child		This interview format was developed for interviewing traumatized children who have recently witnessed an extreme act of violence. The 90-minute interview format includes three stages: opening (projective drawing and story telling), trauma (discussion of actual trauma experience and the perceptual impact), and closing (discussion of the aftermath and its consequences for the child).
Traumatic Events this appears to be an interview rather than way to analyze	… Arroyo, W., & Eth, S. (1995). Assessment following violence-witnessing trauma. In E. Peled, P. G. Jaffe, & J. L. Edelson (Eds.), *Ending the cycle of violence: community responses to children of battered women* (pp. 27-42) Thousand Oaks, CA: Sage.	Child		The authors present a three-stage interview technique to be conducted with children who have witnessed a violent and traumatic incident. The technique is based on an interview protocol developed for youth who witnessed a parental homicide. The three stages of the technique include the following: the opening phase (drawing or making something and relating a story about it), trauma phase (recounting of the incident), and closure phase (terminating the interview and separating from the child). Ideally, the interview should take place shortly after the incident. The authors also encourage conducting a family interview to obtain background information about the child and to consider the child's cultural context. The impact of trauma on children at different developmental stages is also discussed.

Traumatic Events this appears to be an interview rather than way to analyze	***NICHD Investigative Interview Protocol*** Orbach, Y., Hershkowitz, I., Lamb, M.E., Sternberg, K.J., Esplin, P.W., & Horowitz, D. (2000). Assessing the value of structured protocols for forensic interviews of alleged child abuse victims.	Child		This protocol is designed to maximize the amount of information obtained in forensic interviews with child abuse victims using recall memory probes, which are more likely to elicit more accurate information than recognition memory probes. The utility of the protocol was evaluated by comparing 55 protocol interviews with 50 prior interviews by the same investigators. It was found that more details were obtained using open-ended invitations and older children provided more details than did younger children.
Traumatic Events	Acute Response Protocol (Murphy et al., 2000) (Murphy et al., 2000)			This protocol gathers information regarding children's response to the present and past episodes of violence. It is an observation measure developed by the Child Development Community Policing Program to assess acute responses of children to potentially traumatic events.
Traumatic Events	***The Children's Impact of Traumatic Events Scale (CITES-R)*** Wolfe, V. V., Gentile, C., Michienzzi, T., Sas, L., & Wolfe, D. A. (1991). The Children's Impact of Traumatic Events Scale: A measure of post-sexual abuse PTSD symptoms. *Behavioral Assessment*, *13*, 359-383.	Child	8 – 16	This 78-item instrument, used for assessing the impact of sexual abuse from the child's perspective, is based on a research study designed to assess the effects of sexual abuse and to monitor those effects following disclosure. The instrument can be administered through a standardized interview with objective response options or it can be self-administered. The original instrument included 54 items reflecting post traumatic stress disorder (PTSD), traumatic events, attributional style, and eroticism. The revised instrument includes measures of PTSD, social reactions, abuse attributions, and eroticism.

Traumatic Events	**National Youth Survey** (NYS, Elliott, 1990; Menard et al., In press)	youth and young adults		An adaptation of this survey assesses violence exposure for children and their families through interview questions. The NYS has been administered to youth and young adults in a longitudinal national survey that assesses multiple dimensions of family and child psychosocial functioning. The expected cohort of relatively youthful parents of young children involved in the present project makes the NYS a particularly relevant measure of violence exposure and related domains of family stressors, criminal activity, substance use, victimization, and domestic violence. The NYS consists of specific modules within a structured interview format resulting in ease of administration and widespread use of specific modules by a range of investigators. The administration of these specific NYS modules can be supplemented by collateral reports from child protective records and computerized police databases. module 8 of the survey provides an overview of self-reported substance use.
Traumatic Events	**SAHA** no source			This protocol contains questions related to violence exposure, victimization, feelings of safety, and attitudes toward police.
Traumatic Events	Critical Incidents Form (Schaefer, 1998)	Child		This form evaluates children's recent experiences of stressful and potentially traumatic events by querying the frequency of 16 stressful life events, ranging from changes in home placement to instances of assault, arrest, or psychiatric hospitalization.
Traumatic	**Barnett, Manly and Cicchetti Maltreatment Severity Scales**	child		These scales can be used to rate children's maltreatment experiences, as they represent an

Events	(Barnett et al., 1993)			improvement over the severity rating scales used in prior research (Kaufman et al., 1994). The Sexual Abuse, Physical Abuse, Emotional Maltreatment, and Lack of Supervision scales will be used without modification. However, instead of deriving one global score of Physical Neglect, the four subtypes of neglect (food and nutritional neglect; medical, dental, and mental health neglect; clothing and hygiene neglect; and inadequate shelter) included in this scale will be rated separately using the anchor points developed by Barnett and colleagues. Previous research has indicated that children who are exposed to domestic violence are often the victims of abuse and neglect themselves and that the co-occurrence of domestic violence exposure and direct victimization are predictive of poorer child outcome (Egeland and Sroufe, 1981; Rogosch et al., 1995). Based on this prior research, it is assumed that most of the children in the study will have had multiple forms of child maltreatment.
Parent-child interaction	adaption of Rating Scale of Interactional Style (Mayes et al., 1997)	Parent/Child Interaction		This protocol requires a videotaped semi-structured play interaction between mothers and their infants and toddlers. Mothers are asked to interact with their child for five to 10 minutes and the interactions are scored for separate infant and maternal behaviors indicating attention, responsiveness and affective tone. Behaviors are scored from the videotape on five point scales with 1 indicating "low occurrence" and 5 indicating "high occurrence". The coding

				approach was developed by the investigators in studies of normative populations (Feldman et al., 1997) and is an adaptation of (Clark and Seifer, 1983) "Rating Scale of Interactional Style". We have documented adequate interrater reliability for this behavioral coding approach and have shown changes over time in the interactional styles of high-risk substance using families (Mayes et al., 1997)
Parent-Child Interaction	Modified separation no source			In our ongoing studies of high-risk cohorts, we have used a modified separation procedure in which mothers are asked to leave their toddler alone for a period of three minutes and then return to play for another three minutes (Molitor, 2000). The separation episode provides a means to observe these infants' abilities to self-regulate emotional arousal potentially caused by a separation from their mothers and by the simultaneous introduction to a novel person (Grolnick et al., 1996). The post-separation episode allows observations of children's ability to use their mothers as a means to regulate their emotional arousal and resume play. The post-separation episode also allows observations of children's use of their mothers as a secure base from which to explore and play. Additionally, the procedure allows observations about mothers' responsiveness to their children's needs during this potentially arousing situation. All separations are videotaped and scored from videotape based on a system proposed by Aber and Baker (Aber and Baker, 1990) for specific child behaviors at

				the time of separation and for both maternal and child behaviors on reunion. We have achieved adequate observer reliability on these behaviors (Molitor, 2000).
Parent-child Interaction	Parent-Child Conflict Tactics Scales (CTSPC,Straus, 1999)			These scales provide supplemental information related to the management of conflict within a family. This self-report questionnaire results in subscales related to nonviolent discipline, psychological aggression, physical assault, neglect, and sexual abuse. The CTSPC is a self-report questionnaire that can be completed by parents with reference to spousal and parent-child relationships and represents a revision of the original Conflict Tactics Scale with an explicit focus on the quality of parent-child relationships and conflictual interactions among adults.
Parenting	**Adult-Adolescent Parenting Inventory (AAPI-2);** Bavolek & Keene, 1999, Family Development Resources, Inc	Parent/Guardian	Adult	This Inventory measures Inappropriate Expectations of Children, Lack of Empathy Towards Children's Needs, Belief in the use of Corporal Punishment as a Means of Discipline, Reversing Parent-Child Role Responsibilities, and Oppressing Children's Power and Independence. Results show standard scores in each domain and present an index of risk.

Parenting	**Parent-Child Conflict Tactics Scale (CTSPC)**; Straus, Hamby, Finkelhor, Moore, & Runyan, 1995, Family Research Laboratory, University of New Hampshire	Parent/Guardian	Adult	This Scale includes Nonviolent discipline, Psychological Aggression, Physical Assault (minor, severe), and Neglect as well as two supplemental scales, Sexual Maltreatment, and Weekly Discipline. For each scale, prevalence and chronicity are scored and can be compared with rates obtained in Gallup survey. The CTSPC is one of the most widely used measures assessing child maltreatment
Parenting	**The Parenting Scale** Arnold, O'Leary, Wolff, & Acker, 1993, *Psychological Assessment 5*, 137-144	Parent	Adult	This Scale measures Laxness, Overreactivity and Verbosity and scores for each factor and a total (that includes 4 additional items).
Parenting	**Family Environment Scale (FES)**; Moos & Moos, 1994, Consulting Psychologists Press	Child and Parent (Families)		The FES contains 10 subscales including Cohesion, Expressiveness, Conflict, Independence, Achievement Orientation, Intellectual/Cultural Orientation, Active Recreational Orientation, Moral/Religious Emphasis, Organization & Control and has a score for each subscale. It is also used in a variety of research applications with young children. Reviews of the 2nd edition in the Mental Measurements Yearbook (Loyd, 1995; Randhawa, 1995) are generally favorable, particularly for research with groups.
Parenting	**Parenting Sense of Competence Scale** (Gibaud-Wallston, 1978).	Parent	Adult	This scale assesses the parents' sense of competence through the parents' self-evaluation of their performance in the parenting situation. The PSOC consists of 17 items that the respondent rates on a 6 point scale from 'strongly agree' to 'strongly disagree'. Some of the items are worded positively and others negatively. An

				alpha coefficient of 0.80 was reported for first-time parents and test-retest reliability of the scale for a six-week period was 0.80 for mothers and 0.78 for fathers. We have used this measure extensively in our studies of high-risk cohort.
Parenting	**Parent-Child Conflict Tactics Scale** (CTSPC,Straus, 1999)	parents	Adult	The **Parent-Child Conflict Tactics Scales** can provide supplemental information related to the management of conflict within a family. This self-report questionnaire results in subscales related to nonviolent discipline, psychological aggression, physical assault, neglect, and sexual abuse. The CTSPC is a self-report questionnaire that can be completed by parents with reference to spousal and parent-child relationships and represents a revision of the original Conflict Tactics Scale with an explicit focus on the quality of parent-child relationships and conflictual interactions among adults.
Parenting	Arousal Predisposition Scale (APS,Coren, 1988; Coren, 1990) (Coren and Aks, 1991).		Adult	This Scale is a self-report measure intended to capture an individual's own assessment of his capacity for excitability. Individuals rate 12 questions such as "My mood is quickly influenced by entering new places." Scales such as these are intended to capture both an individual's tendency or trait for high arousal, reactivity, or excitability and at the same time, to predict their response in a given situation, that is, to predict state or moment to moment change in stressful situations. For example, individuals rating themselves as high on the APS compared to individuals rating themselves as low performed differently on search tasks with

				auditory and visual distractors This self-report will be administered at baseline, the end of treatment (or 9 months post DV) and 12 months later.
Parenting	Parent Development Interview (PDI) (Slade et al., 1999)	parent	Age group	This interview assesses parents' capacity to reflect on their child and understand experiences from the perspective of their child. This instrument is a 45 question semi-structured clinical interview that assesses a parent's mental representations of her relationship with her child. The parent is given the opportunity to describe her affective experience in relationship to a particular child, in a flexible and coherent manner. Mothers in this project will be asked to focus on their youngest child. Importantly, the mother is not asked simply to describe her child, herself, or her attitude toward her child; rather she is asked to describe her own and her child's experience in moments of interaction and relatedness. The PDI is therefore, presumed to be a relationship-specific measure of an ongoing relationship. The parent is asked to talk about her view of her child by describing her child's favorite and least favorite moments of the day, similarities and differences between herself and her child, and what she likes most and least about her child. The parent then chooses five adjectives to describe her relationship with her child, providing reasons why she chose those adjectives. The next part of the interview is concerned with the parent's affective experience of parenting, where she is asked to describe her strengths and

				weaknesses, and her similarities to and differences from her own parents. She is asked about her child's responses to routine separations and about how her child has changed her. Many questions include probes eliciting the mother's ability to represent and reflect upon the child's and her own emotional responses to various situations, which help assess her mental representations of the relationship. We have accumulated extensive experience with this interview in our studies of high-risk families.
Family Environment	**The Home Observation for Measurement of the Environment-Short Form (HOME-SF);** National Longitudinal Study of Youth , 1989	Adult for interview as well as observational items	< 3 years; 3-5 years, 6-9 years, > 10 years	This measure is a modification of the HOME (Caldwell & Bradley, 1984), University of Arkansas-Little Rock. It has two scales, Cognitive Stimulation (9-14 items) and Emotional Support (9-13 items) and scores for subscales and a total HOME. The HOME-SF demonstrates correlations between it and social demographic factors such as poverty, education, adult to child ratio in home and significant correlations with language, math, reading scores. The HOME is one of the most widely used measures in child development research and the short form is becoming the standard for use in surveys. Mental Measurements Yearbook reviewer Boehm (1985) recommends the original HOME and considers it to be a useful, well-researched tool which can provide users with an in-depth understanding of the quality of the home.
Family	**Family Assessment Device** (FAD, Miller et al., 1985)			Level of family functioning and impairment will be measured with the **Family Assessment**

environment				**Device**, a standardized measure of family functioning. It queries the domains of problem solving, communication, affective responsiveness, affective involvement, and behavior control. The FAD represents one of the most widely used instruments for the assessment of family functioning, with numerous empirical studies supporting its internal scale reliabilities and factorial validity with nonclinical, psychiatric, and medical populations (e.g., Browne et al., 1990; Kabacoff et al., 1990; Keitner et al., 1997).
Family Environment	*Family Environment Scale*	parents and children	3 and older	This scale consists of 10 subscales that measure the social environment of families. It is a semi-structured interview conducted with parents and children to measure families' perceptions of their family environment.
Family Environment	**Parental Bonding Instrument** (Parker et al., 1979)	Parent	Adult	The parental bonding instrument was developed as a self-report measure for adults to rate their experience as children on two dimensions—parental care and parental protection. Categorical divisions created by dividing individuals into quadrants based on low and high scores on the two PBI dimensions, care and protection, appear to be related to depression indices. For example, parents who reported that their own parents cared little but were overprotective (affectionless and controlling) seemed to have a six times greater risk of depression (Parker, 1989; Plantes et al., 1988).
	The Home Observation for Measurement of	Respondent	Age group	This measurement consists of 52 dichotomous,

Family Environment	Environment **(HOMECaldwell, 1978)**			observer-rated items that provide a framework for evaluating the adequacy of children's environmental stimulation for children in the age range of birth to three years.
Family Environment	The Supplement to the HOME for Impoverished Families (SHIF, Ertem et al., 1996)			This Supplement consists of 20 supplemental dichotomous items that allow more precise ratings of environmental factors frequently associated with impoverished settings, including daily routines, appropriate nutrition, stability of living arrangements, and parent-infant interactions. With the HOME, these measures provide a broad overview of the family context in which the infant and toddler develop.
Social Support	**Duke-UNC Functional Social Support Questionnaire** Broadhead, Gehlbach, DeGruy, & Kaplan, 1988, *Medical Care*, 26, 709-723	Parent/Guardian	Adult	This questionnaire measures Confident Support, Affective support, and single items such as Visits, Help around house, Praise for a good job.
Social Support	**Family Support Scale (FSS)**; Dunst, Jenkins, & Trivette, 1988, Brookline Books	Parent/Guardian	Adult	This scale measures support from family, friends, social organizations, & professionals and yields total & subscale scores. However, it does not correlate well with other family measures.
Social Support	**Questionnaire on Social Support (QSS)**; Crnic & Greenberg, 1985, University of Washington-Seattle	Parent/Guardian	Adult	This questionnaire, based on Henderson's Interview Schedule of Social Interaction is part of the Inventory of Parent Experiences. It looks at community or neighborhood, friendships & intimate relationships and yields indexes of satisfaction for each domain and for total social support in those areas.

Treatment	… Gaensbauer, T. J., & Siegel, C. H. (1995). Therapeutic approaches to posttraumatic stress disorder in infants and toddlers. *Infant Mental Health Journal, 16*, 292-305.		Infancy and Toddlers	The authors present general guidelines and specific techniques for the treatment of posttraumatic reactions in infants and toddlers. These therapeutic principles were derived from work with older children and adults. The authors provide suggestions for working with parents as well as a brief discussion on the role of medication. A case study of a 20-month-old boy who was bitten by a dog was presented.
Treatment	Service Assessment for Children and Adolescents (Horwitz, 1999) (SACA,Horwitz, 1999).	parent		This assessment serves as a well-validated interview measure of children's use of mental health and related services. interview Primary caretakers and guardians are queried about recent and lifetime utilization of mental health and protective services, including psychiatric hospitalization, outpatient ambulatory care in day treatment, home, clinic, and office settings, pediatric consultation, protective service contact, juvenile probation, religious counseling, and self-help organizations. The Services Satisfaction and Barriers to Service Use portion of the SACA interview can also be administered to determine perceived benefits of interventions and obstacles to service utilization (e.g. time, transportation, childcare, fear that child will be removed). The SACA has undergone extensive clinical trials demonstrating strong reliability and convergent validity coefficients.
Treatment	Revised Helping Alliance Questionnaire (Luborsky et al, 1996)		Age group	This Questionnaire, a well-validated self-report measure of therapeutic alliance (Luborsky et al., 1996), assesses the quality of the treatment

				relationship between the family and clinical provider. The therapeutic relationship in general and the Helping Alliance Questionnaire in particular have been shown to predict positive treatment response among adults and youth engaged in psychotherapy and other forms of ambulatory psychiatric services (Dore and Alexander, 1996; Gunderson et al., 1997; Hatcher and Barends, 1996; Petry and Bickel, 1999).
	Diagnostic Interview Schedule for Children-Revised (DISC-R) Schaffer, D. et. al (1989). The Diagnostic Interview Schedule for Children – Revised (DISC-R). I. Preparation, field-testing, interrater reliability, and acceptability. Journal of the American Academy of Child and Adolescent Psychiatry, 32, 643-650.	Child or Parent	6 - 18	The DISC-R was developed for use by lay interviewers. The interviewer systematically questions the child or parent
Caregiver Mental Health	**Parenting Stress Inventory—child and parent domains** (Abidin, 1995)	Parent	Adult	The Parenting Stress Inventory is a 101-item parent report questionnaire designed to yield a measure of the relative magnitude of stress in the parent-child system. Two major domains are assessed by the PSI: (1) child characteristics (47 items) and parent characteristics (54 items). Subscales for the child include measures of the child's adaptability, acceptability, demandingness, mood, distractibility/ hyperactivity, and reinforcement of parent. The subscales with the parent domain include depression, attachment, restriction of role, sense

				of competence, social isolation, relationship with spouse/partner, and parent health. Also available is a life events section.
Caregiver Mental Health	**Brief Symptom Inventory (BSI);** Derogatis, 1993, National Computer Systems, Inc.	Parent	13 yrs. To adult	This inventory is a brief form of the Symptom Checklist-90-Revised (SCL-90-R). It consists of a 53-item, likert-type scale designed to assess the major domains of adult psychopathology and has been widely used in studies of adult psychopathology and treatment outcome. The measure yields global indices related to severity and quantity of symptoms and measures according to Somatization, Obsessive-compulsive, Interpersonal Sensitivity, Depression (includes dysphoric mood & affect, lack of motivation, & loss of interest in life), Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation, & Psychoticism scales. It yields scores for 3 global indices including Global Severity Index (GSI), Positive Symptom Total (PST), and Positive Symptom Distress Index (PSDI). There is some evidence that it can predict outcomes of treatment. Reviews by Cudnick, (1989) and Peterson (1989) indicate that the Depression scale is unlikely to be as reliable or valid a measure of depression as scales that focus on that construct alone. They also question how representative the norms are and suggest that the norms may be heavily weighted toward lower classes & over-representative of African Americans.

Caregiver Mental Health	**Center for Epidemiological Studies Depression Scale (CES-D);** Radloff, 1977, *Applied Psychological Measurement*	Parent	Adult	This scale is a measure of general distress, with an emphasis on depressive symptomatology. It looks at depressed mood, feelings of guilt & worthlessness, feelings of helplessness & hopelessness, psychomotor retardation, loss of appetite, & sleep disturbance. It yields a total score that can be compared to community cut off score. This scale can be useful as a screener in a 2-stage sampling design.
Caregiver Mental Health	**Symptom Assessment—45 Questionnaire** (SA-45)	Parent and Child	adult and adolescent	The **Symptom Assessment—45 Questionnaire** consists of a 45-item, likert-type scale designed to assess the major domains of adult & adolescent psychopathology and treatment outcome. The measure is derived from the SCL-90 and yields indices related to severity and quantity of symptoms, as well as the following specific scales: anxiety, depression, hostility, interpersonal sensitivity, obsessive-compulsive, paranoid ideation, phobic anxiety, psychoticism, and somatization.

Caregiver Mental Health	**Composite International Diagnostic Interview-Short Form** (CIDI-SF) (World Health Organization, 1995).	Parent	Adult	This interview, as indicated in its title, is a short form of the Composite International Diagnostic Interview (WHO, 1990). It looks at Generalized Anxiety Disorder, Agoraphobia, Panic Attack, Drug Dependence, Social Phobia, Simple Phobia, Major Depressive Episode, and Alcohol Dependence. This interview can yield a probability or classification of DSMIV-R diagnosis Although there is no review of the CIDI-SF, the 13th Mental Measurements Yearbook includes a review of the CIDI. Both reviewers (Williams, 1998 & Chittooran, 1998) note limitations but recommend its use in research settings.
Caregiver Mental Health	**Parenting Stress Index/Short Form (PSI/SF)**; Abidin, 1990, Pediatric Psychology Press	Parent	Adult	This Index was reduced form the Parenting Stress Index. It looks at Parental Distress (PD), Parent-Child Dysfunctional Interaction (PCI), & Difficult Child (DC); and yields scores for the three stress scales & total stress. Mental Measurements Yearbook reviewers Barnes and Oehler-Stinnett (1998) consider the PSI-SF to be a promising instrument, despite the restriction in norms and lack of independent validity *r* studies
Caregiver Cognitive Ability	Kaufman Brief Intelligence Test (K-BIT,Kaufman and Kaufman, 1990)	child and/or parent	4-90	The Kaufman Brief Intelligence Test can be used as a screening measure for assessing adult cognitive capacity. The K-BIT is a quick cognitive screening test that can be administered to individuals ages 4 through 90 in as little as 15 minutes. It has been normed on a nationally representative sample, has strong psychometric properties of reliability and validity as a measure

				of general cognitive functioning, and has been used extensively for both research and clinical assessment. The K-BIT provides scores for verbal functioning, non-verbal reasoning, and an overall IQ Composite.
Drug Use	Drug Abuse Screening Test (Skinner, 1982)	Parent	Adult	This screening uses a self-report style to measure the extent of substance abuse, specifically the number and types of substances used and whether they were IV or oral.

A. **Assessment of Moderating and Dependent variables**:

At the time of referral, all outcome and moderating variables will also be assessed to obtain baseline data. These include measures in the domains of parental and child reactivity and the five outcome domains including: (1) Child behavioral and psychological functioning; (2) Parental functioning; (3) Parent-Child Relationship; (4) Adult functioning; and (5) Safe and developmentally appropriate environment These domains are described in subsequent sections.

1. Moderating Variables:

a. Child Reactivity: "Reactivity" indicates behavioral (and physiologic) responses to novel and/or stressful situations and is a construct well studied in normative samples of children (Kagan et al., 1987; Kagan et al., 1988; Kagan et al., 1984). To describe children's reactivity, we will use an observational assessment of children's response to an unfamiliar set of toys and/or visual stimuli. We have used such tasks in our ongoing work with prenatally drug-exposed children (Mayes et al., 1996). Reactivity is operationalized as time to interact with the toy or stimulus, time withdrawn or looking away, changes in behavioral state (e.g., decreased or increased activity), and amount of negative affect (e.g., fussing, crying). A continuous measure of behavioral reactivity is defined based on infants' and children's response to the set of novel situations.

i. History of ongoing DV: Ongoing exposure to violence will be assessed as at baseline with questions adapted from the National Youth Survey. This history will be taken at the end of treatment (or 9 months post referring DV incident) and at the two follow-up assessment periods.

ii. Number of moves (physical stability): Parents will be asked in a semi- structured interview developed in our studies of high-risk substance using mothers to provide information on the number of physical moves in the last year after treatment ended.

iii. Protective service involvement: Data on changes in placement over the project interval will be obtained from semi-structured interviews with parents, service assessment questions related to foster placement, and in cases of child protective service involvement, from the DCF LINK system (DCF computerized database) and review of DCF case records. Data on out-of-home placements will be obtained from interviews with social workers from the Department of Children and Families and related care record reviews, using a protocol specifically developed for monitoring placement history and progress in the child protective system (Ballestracci et al., 1988).

a. Child's past medical history: The health of children will be assessed through medical service utilization data obtained from the Service Assessment for Children and Adolescents (Horwitz, 1999). Data will be supplemented through completion of the Parent Report version Child Health Questionnaire (CHQ-PF50Landgraf et al., 1996), a broad assessment of child health indicators.

Abuse information will also be obtained from the DCF LINK system (DCF computerized data base) and from the review of medical records according to previously validated procedures (Leventhal et al., 1997). All the child maltreatment data will be reviewed by one rater who will then code the severity of children's experiences of: 1) sexual abuse; 2) physical abuse; 3) emotional maltreatment; and 4) neglect. Experiences of the following types of neglect will be rated separately: 1) food and nutritional neglect; 2) medical, dental, and mental health care neglect; 3) clothing and hygiene neglect; 4) inadequate shelter; and 5) lack of supervision. In prior research (Kaufman et al., 1994), multiple sources of data were able to be synthesized to provide reliable ratings of maltreatment severity, with Kappa reliability coefficients for rating severity of physical abuse, neglect, sexual abuse, and emotional abuse of 0.88, 0.73, 0.83, and 0.90, respectively. The separate ratings proposed in the present study for the different subtypes of neglect should increase the reliability of the neglect ratings.