POSTTRAUMATIC STRESS DISORDER AND DEPRESSION AMONG U.S.-BORN LATINO STUDENTS EXPOSED TO COMMUNITY VIOLENCE

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DISSERTATION APPROVAL PAGE

We hereby approve the dissertation

Posttraumatic Stress Disorder and Depression Among U.S. Born Latino Students Exposed to Community Violence

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DEDICATION

Dedicated to my parents Bill and Esther Dong, for their love and determination to educate their children; to my own children Ada Alexander and Matthew Marlens, who inspire my work and teach me new lessons of devotion every day; With special thanks to Bradley Stein, Sheryl Kataoka, Lisa Jaycox, Arlene Fink, Nihua Duan, Wenli Tu, Ken Wells, Bob Brook, Roberta Bernstein, Barbara Colwell, Steven Fong, and Windy Wilkins who made research in the real world possible; and to Dr. Elinor Grayer and Dr. William Dombrowski for their patience, wisdom and knowledge.

Marleen Wong
The Sanville Institute, 2005
Elinor Grayer, Chair

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ABSTRACT

Objective: This study examines the prevalence of posttraumatic stress disorder and depression, a common co-morbid disorder, among a sample of U.S.-born Latino middle school students exposed to community violence. **Method:** 672 U.S.-born sixth-grade students (11-12 years of age) were surveyed about their exposure to community violence utilizing a modified version of the Life Events Scale (Singer et al., 1999) and were screened for symptoms of posttraumatic stress disorder (PTSD) and depression utilizing items taken from the FOA PTSD Scale and the Children's Depression Inventory (Kovacs, 1992). **Results:** 91.2% of the participants reported violence exposure as victims and/or witnesses to violence. 35.3% of the participants reported PTSD symptoms in the clinical range. However, 48% of violence victims registered PTSD symptoms in the clinical range. 32% of female violence victims and 17% of male victims registered symptoms of Depression. **Conclusions:** Screening measures may be necessary to identify the negative mental health effects of community violence exposure and the "hidden" disorders of PTSD and depression. These findings document

the need for a public health approach to provide assessment and intervention to students in violence prone communities.

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CHAPTER I: INTRODUCTION

Statement of the Problem

In urban neighborhoods of socioeconomic impoverishment, overcrowded housing, and high rates of crime, exposure to community violence is so pervasive that it has been characterized as a "public health epidemic" (Koop & Lundberg, 1992). Rates of urban violence in the United States began to rise in the 1980s and continued to rise through the 1990s, leading then Surgeon General Koop to identify violence as one of the primary public health issues facing America (Koop and Lundberg, 1992). Following Surgeon General Koop's announcement, a landmark National Institute of Mental Health (NIMH) study noted the lack of attention given to the "possible adverse psychological consequences" to children of exposure to acute or chronic violence in their communities. Martinez and Richters, the authors of the study, further stated, "there has been no systematic research to date concerning the psychological consequences to children of being raised in chronically violent neighborhoods" (Martinez and Richters, 1993).

Today, in some neighborhoods within the urban core, such as South and East Los Angeles, violence continues unabated due to gang and/or drug related crimes and high rates of unsolved homicides (Leovy & Smith, 2004). This study examined some of the negative psychological consequences of that impact on Latino students who attend schools in neighborhoods of violence and crime.

History and Context for the Study: Los Angeles Unified School District (LAUSD), the Mental Health Intervention Program (MHIP), and the Emergency Immigrant Education Program (EIEP)

Within the boundaries of the 703 square miles that comprise the Los Angeles Unified School District (LAUSD), 748,000 students are enrolled in regular schools, special education, and other programs that meet specialized student needs. Since 1933, the Mental Health Services and Crisis Counseling Services Units have provided treatment and crisis recovery services to the students of LAUSD. One such student program was the Emergency Immigrant Education Program (EIEP), federally funded to support the educational and social adjustment of students who had been in the U.S. for three years or less.

Prompted by teachers' concerns about the impact of violence on their immigrant students, and confronted with an unexpected funding opportunity, the author, then the director of School Mental Health Services, convened a team of researchers and mental health clinicians from RAND, UCLA Health Services Research Center, and the UCLA Clinical Scholars Program (UCLA Medical School) to develop a school-based mental health program for the students enrolled in the EIEP. Their collaboration resulted in the creation of the Mental Health Intervention Program (MHIP).

The MHIP was a multifaceted "counseling" program whose mission, based on the requirements of the federal funding, was to facilitate the social,

emotional and educational adjustment of immigrant students who had been in the U.S. for three years or less. Located in several schools serving children in neighborhoods of poverty, crime and gang activity, the MHIP attempted to take a comprehensive approach to program development. Although the ultimate goal was to provide an evidence based intervention that ameliorated the negative effects of violence exposure on students, the MHIP was initiated with an epidemiological and public health approach to the problems articulated by the EIEP teachers. A violence exposure survey and screening for mental disorders was compiled to assess the extent of violence exposure among the students and to measure the symptoms of traumatic stress and depression that the EIEP teachers often described.

The data gathered from the initial survey and screening were used to identify students who met program eligibility criteria, i.e., students who reported at least three experiences with violence involving threat or physical assault or at least one experience with weapons violence. The students also had to screen positively at clinical levels of PTSD and depressive symptoms. Eligible students were then provided with the Cognitive Behavioral Intervention for Trauma in Schools (CBITS), a 10-session group intervention developed by Dr. Lisa Jaycox, a RAND scientist.

Over a period of three years, the EIEP funding was reduced. A smaller amount of state general funds replaced federal funding and the MHIP staff were

reduced by two thirds, including bilingual staff. The MHIP redirected services to U.S.-born Latino students.

This study was based on survey and screening data gathered from a sample of 672 U.S.-born Latino students screened during the third year (2000) of the MHIP.

Research Questions

As the funding and client base for the MHIP changed (from immigrant students from 20 schools, of various ages, and from several countries) to non-immigrant students in middle schools, an important question was what the rates of overall violence, PTSD and depression would be for non-immigrant students.

The MHIP staff collected data in the fall of 2000 from a Student Screening Questionnaire, which assessed three categories of violence exposure, as well as symptoms of posttraumatic stress disorder (PTSD) and depression. U.S.-born Latino students in sixth grade from two middle schools in East Los Angeles were the target group for the data collection. The original use of the data was to determine eligibility for treatment, by identifying students who reported 3 or more exposures of violence during the 12 months previous to the screening process and had symptoms of PTSD or depression.

This dissertation study re-examined the screening data to provide descriptive, epidemiological information about the overall level of violence

exposure among the sample of 672 students, and to examine the association, if any, between violence exposure and student symptoms consistent with the mental disorders of PTSD and depression.

Although much data was gathered through the survey and screening process, it should be noted that only the data, which answered the dissertation research questions were examined. Specifically, this dissertation study addressed the following questions:

1. What percentage of U.S-born Latino middle school students, ages 11 and 12, report exposure to community violence, i.e., violence outside the home, in the 12 months preceding the completion of the Student Screening Questionnaire?
2. What are the prevalence rates of clinical level symptoms of PTSD and Depression among students exposed to community violence as compared to students not exposed to community violence?
3. Are there differences in exposure to violence and in the prevalence rates of PTSD and depression between male and female students?

Relevance of the Study

Although the negative psychological effects of community violence in the United States on children have been examined, most studies have focused on ethnic and racial groups other than Latino children. From a historical perspective, community violence in the United States has been examined primarily on a Black versus White continuum. As a result, data on U.S.-born racial and ethnic groups other than African Americans and Whites are often lacking.

However, Latinos in the United States are a fast growing population, especially in cities in the west and southwestern regions of the country. The 1960 census counted 6.9 million Latinos residing in the United States. In the 2000 census, Latinos grew to over 38 million, exceeding the number of African Americans for the first time in U.S. history. It is an ethnic group projected to grow to 55 million by 2020, with the largest numbers in California, New Mexico, Arizona and Texas (Chavez, 2003).

Using demographic data, Straussner & Straussner (1997) demonstrated that African American children from low-income families are at increased risk for violence exposure and mental health problems due to multiple risk factors. As noted in the literature review section of this document, the majority of violence exposure and impact studies in the past 10 years concentrate on African

American youth in the inner cities of Boston, Chicago, Washington, D.C., and New Orleans.

Garrison, Roy, and Azar (1999) suggest that demographic and socioeconomic risk factors similar to those found within poor, urban African American communities, appear to place Latino children in jeopardy for "youth victimization" and "child mental disorders." In addition, Kataoka and her colleagues documented that Latinos are a group that have been underserved by the mental health community and that disparities are associated with lower economic status, employment, education, health, housing, and crime (Kataoka et al., 2002).

The significance of this study is that it focuses on the assessment of community violence, symptoms of PTSD and depression among a group of U.S.-born Latino students who are affected by socioeconomic factors similar to those of impoverished African American children, which may go unrecognized.

It is the hope of the author that the findings from the study may shed further light on the extent of this group's unidentified and unmet mental health needs due to risks of exposure to violence in communities of high crime and poverty. In addition, the data may inform community and school-based mental health practice and policy as well as suggest new areas of study that will reduce health disparities and increase positive health and mental health outcomes in underserved communities.

CHAPTER II: REVIEW OF RELEVANT LITERATURE

Studies of Children's Exposure to Community Violence

Although Martinez and Richters (1993) bemoaned the lack of scientific inquiry into the negative psychological effects of violence exposure on children, there have been early efforts to survey children's experiences with violence in the community.

For example, Bell and Bell conducted several surveys of elementary and high school students who lived in the Southside of Chicago. In one of their studies of 500 African American elementary school students, the authors reported that one in four had witnessed a shooting and one in three had witnessed a stabbing (Bell & Jenkins, 1993).

In Washington, D.C., a 1993 study was conducted in a low-income neighborhood with a "moderate level violence," as defined by the District of Columbia Police Department. After interviewing 165 African American mothers, the researchers reported that 32% of their children, ages 6 to 10, had been victims of neighborhood violence by being chased, beaten or having a gun held to their heads. They also reported that 61% of their children in first and second grades and 72% of the children in fifth and sixth grades had been witnesses of community violence (Martinez & Richters, 1993).

In 1993 researchers studied 53 African American mothers living in a high crime neighborhood of New Orleans, where at least one murder or other violent crime occurred per week. They reported that 51% of the children had been victims of physical violence in their neighborhood (Osofsky, Wewers, Hann, and Fick, 1993).

In a 1997 survey of 200 African American high school students in Chicago, Bell and Bell found higher rates of violence as compared to their earlier studies. They reported that two out of three students were witnesses to a shooting and almost one half of them had witnessed a stabbing. Sixty percent of the students who witnessed a shooting or stabbing indicated that the attack resulted in a death. Further, 25% of the high school students reported that they had been victims of severe violence, that is, beaten, mugged, shot or attacked with a gun or knife (Jenkins & Bell, 1997).

Studies on Latino children's exposure to violence have focused primarily on refugee children's experiences in their countries of origin, leading to similar conclusions. Using structured interviews, the authors found that there were "high" levels of violence exposure, particularly among immigrant Latino children from war-torn countries. These studies noted the high crime rates and possible exposure to violence in the U.S. resettlement communities but do not measure exposure to violence in the U.S. with scientifically validated instruments (Arroyo & Eth, 1985; Arroyo, 1998).

Only one study, published by Jaycox et al. (2002) utilized scientifically validated survey and screening instruments to assess children's exposure to violence. Jaycox found that 88% of a sample of 1004 immigrant children from Armenia, Central America, Korea, Mexico and Russia, ranging in age from 8 to 15, had been victimized or had witnessed some form of violence in their countries of origin, in the process of immigration or in their neighborhoods of residence.

Mental Health Effects of Violence in the Community

The relatively small number of scientific studies on the mental health effects of *community* violence is a reflection, in part, of the relatively recent recognition of the psychiatric diagnosis of PTSD for children and a focus on clinical rather than public health approaches to identifying and treating PTSD.

In 1980, the American Psychiatric Association formally included the diagnosis of PTSD for adults in the DSM-III based on modifications from the long history of reported symptoms from American veterans of combat from the Civil War, World War I, II and the Vietnam War.

As late as 1985, mental health professionals were skeptical about the PTSD diagnosis for children. In 1985, Benedek published a widely circulated article suggesting that children were too developmentally and "emotionally immature"

to remember traumatic experiences and insufficiently capable of suffering the full effects of trauma (Benedek, 1985).

In that environment of scientific skepticism, the first studies of child trauma were related to dramatic and catastrophic events. Lenore Terr, a child psychiatrist from University of California/San Francisco Medical Center, risked professional criticism by initiating a landmark study of children who survived the Chowchilla, California school bus kidnapping. Years after this highly publicized incident, Terr found that every child kidnap victim suffered long-standing, negative effects of PTSD over time with some symptoms extending to early adulthood, even though the children appeared to be without symptoms when freed (Terr, 1990).

Another pioneer in the field of childhood PTSD, Dr. Robert Pynoos, helped to elucidate the child diagnosis to include the experience of a child *witness* to violence as a PTSD criterion. Pynoos was instrumental in studying elementary students' experience with exposure to life threatening violence after a 1984 sniper shooting at the 49th Street Elementary School, in South Central Los Angeles. Pynoos and his colleagues interviewed several of the child survivors and followed their progress for over a year. He found that the students suffered from high levels of posttraumatic stress after a single exposure to life threatening violence. He observed that 67% of the children victimized as victims and

witnesses to the sniper attack continued to experience symptoms of PTSD and required treatment a year after the shooting (Pynoos et al., 1987).

Clinical experts such as Pynoos and Terr contributed to the expansion of PTSD symptomatology in children in the DSM-III-R in 1987, which was once again revised and expanded in the DSM-IV. The following studies reflect studies of children who meet the most recent DSM-IV diagnostic criteria.

Fitzpatrick and Boldizar (1993) observed that 27.1% of low-income African American youths in their survey met the DSM-IV criteria for PTSD. Horowitz, Weine, and Jekel (1995) found that 67% of their sample of urban adolescent girls (ages 12-21) who had multiple experiences of trauma in the community met the diagnostic criteria for PTSD. Kliewer, Lepore, Oskin, and Johnson (1998) found that 8 to 12 year-old African American students who were exposed to community violence showed elevated rates of depression and anxiety.

Jaycox et al. (2002), a RAND research partner with the original MHIP, has assessed the rate of PTSD and depression association with violence exposure among her sample of 1004 immigrant, limited English-speaking students, ranging in age from 8 to 15, who attended one of 20 schools in Los Angeles, East Los Angeles and the San Fernando Valley. In her study, 32% of the immigrant students exposed to community violence had PTSD symptoms in the clinical range and 16% of the students had symptoms of depression in the clinical range,

demonstrating a strong correlation between violence exposure and serious mental health disorders.

Despite the early work of Pynoos, little, if any research has subsequently been conducted to assess the negative psychological effects of school-associated violence on students, even after high profile school shootings. Between 1994 and 1999, U.S. Department of Education officials estimated approximately 220 violent events at schools that resulted in 253 deaths. Although anecdotal accounts have noted anxiety, depression and posttraumatic stress symptoms among students, no published reports of diagnostic screening for mental health disorders can be found from any of the hundreds of incidents of targeted student violence in schools across the United States (Anderson et al., 2001).

Mental Health Effects of Terrorism on School Age Students

In a landmark study commissioned by the New York Board of Education (NYBOE) after the terrorist attacks of 9/11, researchers from the Mailman School of Public Health at Columbia University estimated that as many as 26.5% or 190,000 of the 1.2 million public school students in grades 4 - 12 had at least one major mental health disorder at the six-month mark after the terrorist attacks. Of those students 75,000 were estimated to have symptoms consistent with PTSD, 60,000 with symptoms of major depression, 88,000 children with symptoms of

separation anxiety and 107,000 with symptoms of agoraphobia (Initial Report to the New York City Board of Education, 2002).

Although the timing of the study might suggest serious and widespread negative mental health consequences associated with the terrorist attack, no previous baseline study exists to compare with the findings. The lack of baseline data (prevalence rates of children's mental disorders prior to September 11, 2001) limits some of the conclusions that can be drawn about the full psychological impact of terrorism, one of the most extreme examples of exposure to violence outside the home.

CHAPTER III: METHODOLOGY

As part of the Mental Health Intervention Program (MHIP), the data examined in this study were collected during the fall of 2000 academic year with the objective of establishing individual student eligibility for treatment with a cognitive behavioral intervention. This dissertation research examined the existing data from the MHIP to determine the overall rates of violence exposure experienced by the students and symptoms consistent with clinical levels of PTSD and depression. As a result, the methodology section includes a description of the original methodology used to gather the data for the MHIP and the specific way in which the MHIP data were organized and analyzed for the purposes of this dissertation.

Selection of Schools and Participants in the MHIP

The subjects of the MHIP study were U.S.-born Latino students, ages 11 and 12, who attended sixth-grade classes in two middle schools in East Los Angeles in 2000. The two middle schools were selected using criteria such as administrator "buy-in" and teacher cooperation as well as the need to limit the number of schools and students accepted into the MHIP due to significantly decreased staff and funding.

The rationale for selecting sixth-grade students for MHIP services was based on the consensus of educators and the social work staff that the first year

of middle school is often a difficult adjustment for students who have left the "protected" environment of an elementary school. Not only must they adjust to moving from class to class during a school day, they may also travel longer distances from home to school in the community, potentially exposing them to more community violence. In short, sixth-grade students might benefit from the MHIP as an elementary to middle school "transition" program that provided early assessment and intervention for students at risk for community violence exposure and, therefore, more at risk for PTSD and depression.

After principal approval was secured at the two middle schools, each sixth-grade homeroom teacher was given the opportunity to make an independent decision to allow his or her class to participate in the program. About half of the sixth-grade teachers at each school consented. An "informed" consent form was sent home to parents of students in the "consenting teachers" classrooms.

In contrast to the teacher assent rate of 50%, over 94% of the students and parents from the participating classrooms, consented to participate in the survey and screening process. This brought the final sample count to 672 subjects.

Measures

A violence exposure survey and PTSD/depression screening instrument was developed by the RAND/UCLA researchers and pre-tested with small

groups of ethnically and linguistically diverse students (Armenian, Korean, Russian and Spanish languages) over a period of several months. The resulting Student Screening Questionnaire or "Screener" (See Appendix B) was a compilation of 110 questions gathered from three widely used and scientifically validated survey instruments:

1) The Life Events Scale (Singer et al., 1992)
2) The Child PTSD Symptom Scale (Foa, Johnson, Feeny, & Treadwell, 2001)
3) Child Depression Inventory (Kovacs, 1992)

Modifications were made from the original scales to maintain the focus of the questions on school and community violence and to eliminate questions about violence in the home. The modifications are noted in the description of original instruments that follows.

Components of the Student Screening Questionnaire

The Life Events Scale

Community violence exposure was surveyed in the Student Screening Questionnaire using questions from the Life Events Scale, developed by Singer et al. (1999). The Life Events Scale is a 34-item measure that asks about the frequency of recent and past exposure to several types of violence, including assaults and/or threats of physical violence and violence exposure involving

weapons. For each type of violence, such as being hit, kicked, beaten or threatened with a gun or knife, students were asked to choose one of four frequency levels of exposure in the past year: Never, sometimes, lots of times, almost every day. A student response indicating any of the latter three options- "sometimes, lots of times or almost every day" was considered an exposure to violence.

Because the MHIP study was focused on community violence, two questions in the Life Events Scale regarding child abuse and domestic violence in the home were eliminated from inclusion to the screening questionnaire. Students were instructed to report violence that was personally witnessed or experienced outside the home, such as in the school or community. In addition to excluding questions about violence in the home, they were instructed not to include any violence that they only heard about from others or violence from television, radio, newsprint, magazines or the movies.

Although two time frames were queried in the MHIP Student Screening Questionnaire-violence in the past year and "lifetime" violence experienced at any time prior to the past year-only violence experienced in the past year was examined in this dissertation research. Many students did not respond to the questions about violence prior to the past year and a preliminary review of the "lifetime" data did not appear to provide any additional meaningful information about violence exposure.

The Child PTSD Symptom Scale (CPSS)

Posttraumatic stress disorder symptoms were assessed in the Student Screening Questionnaire incorporating questions from the Child PTSD Symptom Scale (CPSS) Measure, the child version of the Posttraumatic Diagnostic Scale for Adults (Foa, Johnson, Feeny, & Treadwell, 1997).

The students were asked to respond to 17 questions and to choose from among four symptom severity levels that best described how they had felt during the past month. Symptoms from all three DSM IV PTSD symptom clusters were queried. These included 1) re-experiencing the violent incident 2) arousal from reminders and 3) avoidance of people, places or situations associated with the violent event. In addition, the children were allowed to self-report their level of impairment in daily life by responding to seven yes/no impairment items.

Based upon standard scoring of the instrument, a score of less than 12 indicated a "subclinical" level of symptoms or symptoms that do not reach the level of a diagnosis of PTSD. Scores above 12 on the scale indicated a clinical and moderate level of posttraumatic stress disorder symptoms. Scores greater than 18 indicated a high or serious to severe level of symptoms of PTSD.

The CPSS has been used in school-age children as young as 8 and has shown good convergent and discriminant validity and high reliability, i.e., the Child PTSD Symptom Scale (CPSS) assessed all PTSD symptoms as noted in the

DSM-IV, including symptom severity and the realms of functional impairment, including difficulty with school, family and/or friends. These are psychometric properties not found in other self-report instruments for youth (Foa, Johnson, Feeny, & Treadwell, 2001).

All questions from the Child PTSD Symptom Scale (CPSS) were included in the Student Screening Questionnaire. No modifications to the questions were made. However, added to each question was a graphic of a thermometer to assist the students in assessing the level of symptom severity. (See Appendix B.)

Because the student sample did not reflect the racial and socioeconomic demographics of the standardized studies of the CPSS, pretests were conducted in the first year of the MHIP with students who spoke four different languages—Armenian, Korean, Russian and Spanish—to determine ease of use, students' understanding of the directions and questions.

Pretests indicated that this scale translated easily into Spanish. In Spanish or English, students found the scale easy to read, understandable and easy to complete. Pre-testing of this instrument was also conducted with a sample of English-speaking Latino students who did not participate in the study. Post-screening interviews revealed that the students appeared to understand the content of the questions and the response items.

The Child Depression Inventory (CDI)

Depressive symptoms were assessed using all but one of the items in the Child Depression Inventory developed by Kovacs (1992). The CDI is a 27 item self-report measure, which allows children to choose from three symptom severity levels, describing how they felt during the past two weeks. The CDI assesses children's cognitive, affective and behavioral depressive symptoms consistent with the DSM-IV diagnostic criteria.

The scale has high internal consistency, moderate test-retest reliability, and correlates with measures of related constructs of depression, e.g. self-esteem, negative attributions, and hopelessness (Kendall, Cantwell & Kazdin, 1989).

One question was eliminated from the original version of the Child Depression Inventory (CDI), that measuring suicidal intent. In the original CDI, the respondent is asked to select one of three sentences that best described them in the past two weeks:

- I do not think about killing myself
- I think about killing myself but I would not do it
- I want to kill myself

After pretest parent interviews, MHIP social workers reported that Latino parents were "very upset" about this part of the survey and did not want their children to be asked any questions about "killing themselves." Due to the groundswell of parental opposition in the focus groups, it was decided by the

MHIP team to eliminate the question. The other 26 questions measuring depression remained in the Questionnaire.

Concerned about the accuracy of the altered CDI, RAND statisticians utilized a calculation known as the Cronbach's Alpha to test the reliability of the modified instrument comparing the results with and without the "suicide" question. The scale without the suicide question still achieved a "scale reliability coefficient" of 0.9028 signifying a very high or excellent instrument reliability in measuring symptoms of clinical depression.

Protection of Human Subjects

This study was conducted in compliance with the requirements of the Research Review Committee/Interview Review Boards (IRBs) of the Los Angeles Unified School District, RAND and UCLA. As previously noted, approval for the screening and student participation was sought and given by the Los Angeles Unified School District, and MHIP participants, including school principals, teachers, parents as well as the students themselves.

Informed Parental Consent

Written in Spanish and English, the parent consent form included a description of the purpose of the survey, the objectives of the intervention

program and community referrals available to study participants. Parents were given the names and contact information of Spanish-speaking school social workers whom they could contact if they had questions. This procedure ensured that the participants would have resources and information about related community services throughout the screening procedure.

Parents were instructed to return the consent form if they did not want their child to participate in the screening. Students were also given the option not to participate. Many parents took advantage of the opportunity to ask questions and to discuss the survey process and objectives. After these steps were taken, less than 10% of parents declined to allow their children to be screened. The consent form in Spanish and English can be found in Appendix C.

Screening of Participants

Groups of 20 to 30 students in a classroom completed the "Screener" or Student Screening Questionnaire at each school during various class periods. A social worker read each question aloud in English while a second bilingual social worker circulated in the classroom to respond to student questions or concerns. Bilingual staff was made available as an added measure even though all the students were born in the U.S. and identified English as their primary language. Students were seated at a sufficient distance from each other to allow for as

much privacy as possible in a classroom setting. The time allotted to complete the Screening Questionnaire was one class period of approximately 50 minutes.

The social workers involved in administering the Student Screening Questionnaire were bilingual in Spanish and English. Prior to the screening and interactions with students, parents, and educators, the social workers were provided with two full days of training on the Life Events Scale, the Child PTSD Symptom Scale, and the Children's Depression Inventory (Kovacs, 1992). Detailed instructions were given by the RAND and UCLA research team on how to administer the Student Screening Questionnaire.

Data Collection and Analysis

Immediately after completion, the Student Screening Questionnaires were collected from the students by the school social workers and sent directly to the RAND Corporation for statistical analysis. As noted earlier, the original purpose of the data collection and analysis was to identify individual students who met eligibility criteria for treatment in the Mental Health Intervention Program.

For the purposes of this dissertation research, the data gathered in 2000, were re-analyzed specifically to address the following questions:

Research Question 1: What percentage of students in the total sample reported exposure to community violence in the past year?

Student experiences were sorted into one of three categories:

1. "No Violence Exposure," indicating that the student reported being neither victim nor witness to community violence in the past 12 months.
2. "Victim," indicating that the student reported being physically hit, kicked, slapped, beaten or assaulted with a weapon, or that the student reported being the target of a direct threat of physical assault or weapon violence.
3. "Witness Only," indicating that the student reported only being witness to another person physically assaulted or threatened bodily harm and did not report being a victim of violence or threat of violence.

Some students in the sample reported more than one experience with violence. However, this dissertation research did not attempt to assess the effects of multiple incidents of violence; the focus was on any violence exposure versus no exposure to violence. Therefore, the "Victim" category may include victimized students who have also had experiences as witnesses to violence. But in the "Witness Only" category, the students is reporting that s/he has "only" *witnessed* violence perpetrated on another person and has not been a victim or an assault or threat of an assault.

Since the MHIP study was conducted on behalf of the Los Angeles Unified School District, the data collected made an original distinction between violence experienced in the community and that experienced at school. This was an important distinction for the school district, but it was not a distinction made for this dissertation research in order to focus primarily on the mental health effects of violence. Therefore, in the dissertation data analysis the responses to these sets of questions were combined to include any experience of violence, without regard to where it was experienced.

Research Question 2: What were the prevalence rates of symptoms consistent with PTSD and Depression among students exposed to community violence as "Victims" or "Witnesses Only" as compared to students with "No Violence Exposure"?

The cutoff scores of posttraumatic stress disorder (PTSD) were guidelines established by the developer of the instrument (Foa et al., 2001) as follows:

- "Subclinical Level" or a symptom level indicating "No PTSD" is represented by a CPSS score of less than 12
- "Moderate PTSD" or scores that range from 12 to 18 on the CPSS indicate symptoms consistent with a diagnosis of PTSD
- "High PTSD" or CPSS scores higher than 18 indicate that the student has symptom levels representing a serious or severe level of PTSD

The cutoff scores for depression were standard guidelines established by the

developer of the instrument (Kovacs 1992):

- "Subclinical Level"-A score on the Children's Depression Inventory (CDI) of less than 18 indicating "No depression"
- "Clinical Level"-A score in the range of 18 to 22 on the CDI indicating symptoms consistent with the diagnosis of clinical depression
- "High Level" -Score of greater than 23 consistent with symptoms of serious to severe depression

Research Question 3: Are there gender differences in exposure to violence and prevalence rates of PTSD and depression? The data were further examined for gender differences in rates of violence exposure, PTSD and depression at subclinical, clinical, and high symptom levels in each of the three violence exposure categories.

CHAPTER IV: RESULTS

Of the total sample of 672 students, ages 11 and 12, 610 students or 91.8% were exposed to community violence either as a victim or witness to violence. Only 9.2% of the students reported that they had no violence exposure in the past year either as a victim or a witness. Of the 91.8% of students exposed to violence, 27.3 % reported being "Witness Only" to violence or threat of violence (see Table 1) and 63.5% identified themselves as a "Victim" of violence or threat of violence.

Table 1 Level of Exposure to Violence Within the Total Sample and by Gender (n=672) +

	Total Sample (n=672)	Males (n=342)	Females (n=330)
"No Violence Exposure- Neither "Victim" nor Witness" (n=124)	9.2% (n=62)	4.4% (n=15)	14.2% (n=47)
"Witness Only" to violence or threat (n=366)	27.3% (n=183)	19.3% (n=66)	35.5% (n=117)
"Victim" of violence or threat (n=854)	63.5% (n=427)	76.3% (n=261)	50.3% (n=166)
"Students Exposed to Violence" - Combined Categories of "Witness Only" and "Victim"	91.8% (n=610)	95.6% (n=327)	85.8% (n=283)

+$Chi^2 = 52$, df=2, $p<0.001$

By gender, the rate of violence exposure among male students at 95.6% of the sample was significantly higher than the rate among female students, which was 85.8%.

The percentage of the males who reported being a "Victim" was 76.3%; 19.3% reported being a "witness only" to violence. Only 4.4% of males reported no violence exposure of any kind. Fewer female students reported being a "Victim" of violence (50.3%) but a larger percentage of female students (35.5%) reported being a "Witness Only" to violence.

The experience of "no violence" was more common among female students than male students. A higher percentage of female students (14.2%) reported "no violence" exposure of any kind as compared to male students (4.4%).

When "Victim" and "Witness Only" categories are examined for gender differences, the results show that the level of violence exposure is strongly associated with gender ($chi2 = 52$, $p<.001$), with males in the sample having significantly greater exposure rates as "Victims" than females.

Violence Exposure and Posttraumatic Stress Disorder (PTSD)

Of the total sample, 35.3% of the students (n=237), ages 11 and 12, reported PTSD symptoms in the clinical range (combined moderate and high

levels of PTSD). In the overall sample, 64.7% of the students scored at subclinical levels, indicating "no PTSD."

When type of violence is examined in relationship to PTSD symptoms, "Victims" had higher rates of PTSD as compared to those with no violence or those who were "Witness Only." 47.5% of students in the "Victim" category had the highest rates of PTSD as compared to a PTSD rate of 17.5% of those who were "Witness Only."

Table 2. Level of PTSD* by Level of Exposure to Violence (n=672)+

PTSD Scores*	Subclinical Level	Moderate PTSD	High PTSD	High and Moderate PTSD
Overall Sample (n=672)	64.7% (n=435)	18.3% (n=123)	17.0% (n=114)	35.3% (n=237)
No Violence (n=62)	96.8 % (n=60)	1.6% (n=1)	1.6% (n=1)	3.2% (n=2)
Witness Only (n=183)	82.5% (n=151)	12.0% (n=22)	5.5% (n=10)	17.5% (n=32)
Victim (n=427)	52.5% (n=224)	23.4% (n=100)	24.1% (n=103)	47.5% (n=203)

+$Chi^2 = 84$, df=4, $p<0.001$

*PTSD Scores: Subclinical = CPSS score < 12

Moderate PTSD = CPSS score = 12-18

High PTSD = CPSS score >18

On closer examination of moderate and high PTSD rates and type of violence exposure, student "Victims" were almost two times more likely to have moderate levels of PTSD and over four times more likely to have high levels of PTSD compared to students who only witnessed violence. "Victims" who had moderate levels of PTSD measured 23.4%, and 24.1% scored at high levels of PTSD as compared to "Witness Only" students, who scored substantially lower at 12.0%, and 5.5% respectively for moderate PTSD and high PTSD. Overall, these results demonstrate a clear association between PTSD and type of violence exposure. "Victims" in this sample were more likely to have PTSD at both moderate and high levels. Students in the sample who were "Witness Only" had substantially lower PTSD rates at both moderate and high levels, and students in the sample with "No Violence" had almost no evidence of PTSD which would be expected since the sine qua non for a PTSD diagnosis is exposure to a violent or traumatic event.

Interestingly, two students had PTSD at clinical levels, one with moderate and one with high PTSD, without a corresponding report of violence exposure in the Screening Questionnaire as either a victim or witness. One would expect that a student with "No Violence" exposure would score at the subclinical PTSD level. Although this may seem contrary to the required presence of an exposure to a traumatic event as the first DSMH-IV diagnostic criterion for PTSD, one possible explanation for these scores may be that the two students (who are both

identified as female in Table 3) may have experienced a type of trauma such as sexual abuse that was not specifically queried on this screener. Also, since this study examines violence that occurred in the past year, another possible explanation is that these students experienced traumas prior to the past year. Many students did not respond to the questions about violence prior to the past year.

The results in Table 2 also show that not all students exposed to violence develop clinically significant PTSD symptoms. Despite being directly victimized by physical violence, 52.5% of those students had a "subclinical" score or a finding of "No PTSD, and 82.5% of students who had been witness to some type of violence did not go on to develop clinical levels of PTSD symptoms. Therefore, while an experience with violence may be a criterion for a diagnosis of PTSD, not all students exposed to violence have PTSD in this sample.

Overall these results demonstrate a statistically significant and clear association between the level of violence exposure and the level of PTSD symptoms.

Violence Exposure, Posttraumatic Stress Disorder, and Gender

When examining students by gender, the overall PTSD rate in the sample of male students exposed to violence was 34.5%. The rate for female students

exposed to violence was 36.1%. These rates reflect the combined levels of High and Moderate PTSD.

Table 3 Level of PTSD by Gender and Exposure to Violence

	Male PTSD (n=342) Moderate and High PTSD = 34.5%			**Female PTSD** (n=330) Moderate and High PTSD = 36.1%		
	Sub-clinical 65.5%	Moderate PTSD 18.7%	High PTSD 15.8%	Sub-clinical 63.9%	Moderate PTSD 17.9%	High PTSD 18.2%
No Violence	100% (n=15)	0% (n=0)	0% (n=0)	95.8% (n=45)	2.1% (n=1)	2.1% (n=1)
Witness Only	81.8 % (n=54)	15.2% (n=10)	3.0% (n=2)	82.9% (n=97)	10.3% (n=12)	6.8% (n=8)
Victim	59.4% (n=155)	20.7% (n=54)	19.9% (n=52)	41.6% (n=69)	27.7% (n=46)	30.7% (n=51)
Total	65.5% (n=224)	18.7% (n=64)	15.8% (n=54)	63.9% (n=211)	17.9% (n=59)	18.2% (n=60)

$^{+}$ For males, $Chi^2 = 23$, $p<0.001$ $^{++}$ For females, $Chi^2 = 76$, $p<0.001$

The rates of PTSD within the overall sample appeared high, but, for the subset of students exposed to violence for PTSD (excluding the students who reported "No Violence,") the overall rates of PTSD as well as the levels of PTSD (moderate and high) increased significantly. As Table 4 indicates, PTSD rates among only the male students exposed to violence rose to 49.6%. The PTSD rate among only the female students who were exposed to violence was 58.4%.

Table 4 Levels of PTSD among Victims of Violence by Gender

PTSD Level	Male "Victim" Violence	Females "Victim" Violence
High	(n=52) 19.9%	(n= 51) 30.7%
Moderate	(n=54) 20.7%	(n=46) 27.7%
Subclinical	(n=155) 59.4%	(n=69) 41.6%
Total Male/Female Students Exposed to Violence	(n=261) 100.0%	(n=166) 100.0%

Chi-square = 13.18, $p<.01$

Table 4 data also show that the differences between male and female students exposed as "Victims" are statistically significant and that the statistically significant association between violence and PTSD holds regardless of gender.

Violence Exposure and Depressive Symptoms

Of the 427 students who report being a "Victim" of community violence, 23% scored within the clinical range of depression (12.2% at the moderate level and 11.2% at the high level). Only 6% of "Witness Only" students scored in the clinical range of depression. 100% of the students (62 out of 62) who reported no exposure to violence of any kind scored at subclinical levels on the CDI, indicating negative findings for depression.

Table 5. Level of Depression* by Level of Exposure to Violence+

	Subclinical Level	Moderate Level	High Level	Combined Moderate and High Levels of Depression
No Violence (n=62)	100 % (n=62)	0% (n=0)	0% (n=0)	0% (n=0)
Witness Only (n=183)	94.5% (n=173)	2% (n=3)	4% (n=7)	6% (n=10)
Victim (n=427)	77% (n=327)	12% (n=52)	11% (n=48)	23% (n=100)

+Chi square= 44, $p<0.001$

* Depression Scale: Subclinical Score = CDI score <18

Clinical Level Score= CDI score 18-22

High Score = CDI score >23

In summary, data in Table 5 demonstrate that "Victim" violence is associated with depressive symptoms.

Violence Exposure, Depressive Symptoms and Gender

Overall, depression was statistically associated with violence exposure for females "Victims," but the statistical association did not hold for males in any type of exposure. In the total sample of males who report any kind of violence exposure, 18% in the "Victim" category (9% at the clinical level and 9% scoring at high levels) and 6% of the Witness only" (3% at the clinical level and 3% scoring

at high levels) report symptoms consistent with a diagnosis of depression. Among males, 100% of those who never witnessed or were victims of violence or threat of violence scored at the subclinical level for depression on the CDI scale.

Table 6. Level of Depression by Gender and Exposure to Violence

	Male (n=342) Depression			**Female** (n=330) Depression		
	Sub-clinical	Moderate	High	Sub-clinical	Moderate	High
No Violence	100% (n=15)	0% (n=0)	0% (n=0)	100% (n=47)	0 % (n=0)	0% (n=0)
Witness Only	94% (n=62)	3% (n=2)	3% (n=2)	95% (n=111)	1% (n=1)	4% (n=5)
Victim	82% (n=214)	9% (n=23)	9% (n=24)	68% (n=113)	17.5% (n=29)	14.5% (n=24)
Total	85.1% (n=291)	7.3% (n=25)	7.6% (n=26)	82.1% (n=271)	9.1% (n=30)	8.8% (n=29)

+ The chi2 for males is 9, $p<.07$ (NS) ++ The chi2 for females is 47, $p<0.001$

For both males and females, experience of violence as "Witness Only" results in fairly low levels of depression in both boys and girls. Only 6% of boys suffered identifiable depression as witnesses whereas 5% of girls suffered from depression from the same type of exposure.

However, when we examine the experience of boys and girls who are victims of violence, we find more significant differences. Eighteen percent of boys who are victims of violence suffer depression, while 32% of female victims of violence suffered from depression. The figures for female "Victims" include both high and moderate scores of depression. In the "Victim" category, 17.5% of the female students scored at the clinical level, and 14.5% scored at high levels. Among females, who were neither victims nor witnesses to violence or threat of violence, 100% scored at the "subclinical" level for depression on the CDI scale.

For female students only exposure to violence as a "Victim" is statistically associated with depressive symptoms ($Chi2=47$, $p<0.001$). Statistically among the male students, there is an insignificant trend of an association of violence exposure and depressive symptoms ($Chi2=9$, $p=.07$). For that reason, a table showing rates of depression only for the subset of students exposed to violence was not created.

CHAPTER V: DISCUSSION AND RECOMMENDATIONS

This study reveals a 91.2% rate of overall violence exposure among a sample of 672 sixth-grade Latino students, ages 11 and 12, from two middle schools in East Los Angeles. All students in the sample were born in the U.S. and living in Los Angeles, California at the time of the screening. When examined for gender differences, both males and females reported high rates of violence exposure as victims and witnesses of violence. Ninety-five and six-tenths percent of all male students reported exposure to violence, while 85.8 % of all female students reported such exposure. These results showed that not only was the level of violence exposure very high, it was also strongly associated with gender ($chi2 = 52$, $p<.001$), with males in the sample having significantly greater violence exposure rates than females.

Levels of PTSD were also related to gender and type of violence exposure. Exposure to violence, especially "Victim" violence was strongly correlated with symptoms of emotional distress, chief among them high rates of symptoms consistent with posttraumatic stress disorder. The corresponding rates of PTSD in the sample among male and female "Victims" are 41% and 58% respectively. It should be pointed out that while the exposure rate for males is higher (96%) than females (85.8%), females exhibit higher levels of PTSD and depression. Remembering that these are middle school children, ages 11 and 12, one observes

the high levels of violence exposure and prevalence of PTSD symptoms. One might also wonder at the statistically significant gender differences already demonstrated here. Could it be that by age 11 or 12, boys, and particularly Latino boys, have learned to repress their fear and discomfort, while girls are allowed to express higher levels of emotional distress?

Cultural issues may be at work in these findings. Latino cultural values of "machismo" among males may account for males spending more time out of the home and on the streets of their neighborhoods. If females are protected and kept closer to home because of traditional values, which define the female role in the family, this phenomenon may account for their lower rates of exposure to community violence. Regardless of the differences in rates of violence exposure and rates of PTSD, both rates appear extremely high and further studies of both environmental and cultural factors may be helpful to elucidate the dynamics that contribute to the high rates of violence exposure among males and female students.

As noted in the findings, 76.3% of the males reported being a "Victim" and 19.3% reported being a "witness only" to violence. Only 4.4% of males reported no violence exposure of any kind. By contrast, 50.3% of female students reported being a "Victim" of violence while more female students (35.5%) reported being a "Witness Only." Further, only 4.4 % of boys reported no

violence exposure while more female students (14.2%) reported "no violence" with violence.

The discrepancy between boys' and girls' exposure to the direct experience of violence is significant. In this study, girls are victims of violence at a lower rate than boys and are witnesses to violence at a higher rate than boys. The discrepancy between direct experience of violence and witnessing violence between boys and girls may be attributed to culturally based gender differences. Whereas boys may become more actively involved in physical conflict, girls may stand aside and watch.

For both males and females, the rates of PTSD follow the direction of exposure to violence, i.e., victim violence is associated with higher rates of PTSD than being a "witness only" to violence. However, it is a curious finding that girls suffer higher rates of PTSD and Depression in both categories of "Victim" and "Witness Only" violence than boys. In addition, depression among the male students demonstrated a statistical "trend" rather than a strong association. Again, as indicated above, Latino boys may not openly acknowledge upsetting emotions or have learned to repress their fear and discomfort while Latino girls are freer to express higher levels of emotional distress.

The findings regarding the presence of depression indicated fairly low levels of depression in both boys and girls who were "Witness Only" to violence.

Only 6% of boys suffered identifiable depression as witnesses whereas 5% of girls suffered from depression from the same type of exposure.

However, there were significant rates of depression for those who were "Victims" of violence. Eighteen percent of male victims suffered depression while twice the rate of female students (32%) suffered from depression.

The sine qua non for PTSD is exposure to violence. Because there is no similar sine qua non for depression, it is difficult to explain the association between exposure to violence and depression. However, one might speculate that boys' tendency to have higher rates of violence exposure but lower rates of PTSD and depression compared to girls is linked to the male proclivity to action. Similarly, the girl's higher rates of PTSD and depression but lower rates and levels of violence exposure may be linked to their tendency to withdraw and observe rather than act in response to violence. One might also speculate the higher rates of PTSD and depression may reflect the girls' willingness to acknowledge distressing emotions.

The general trend of this study shows that more 11 and 12 year-old boys experienced violence directly as "Victims" than do girls. In this sample, 11 and 12 year old girls witnessed violence at a higher frequency than did boys, but girls reported PTSD and depression at a higher rate than did boys. The combination of findings opens the door for much speculation about gender differences and suggests the value of further study.

This study also suggests that contrary to commonly held assumptions about student mental health, the rate of both disorders is significantly higher than one might imagine from public health reports. Most statistics are generated from reports from mental health professionals who diagnose and treat clients referred for professional help. The findings also suggest that students suffering from PTSD and depression do not seek help and that screening may assist with identifying those who are not aware of the seriousness of their symptoms.

Often behaviors that are indicative of PTSD or depression may be viewed as a "behavior problem" in school and dealt with accordingly. Therefore, screening may be a means of assisting educators with identifying children who are suffering from mental disorders and facilitate the identification, referral, and early intervention with children experiencing these kinds of difficulties. The study findings suggest that screening may be a more accurate reflection of mental health needs than dependence on rates documented by calculating the number of individuals referred and/or treated.

Previous research documented that a diverse group of immigrant students across a wider age range reported substantial exposure to violent events and this exposure was highly correlated with PTSD and depression (Jaycox, et al., 2002). The current study of U.S.-born students documented slightly higher rates of violence exposure and even higher rates of PTSD and depression as compared to

immigrant students living in the U.S. for three years or less, as studied by Jaycox et al. (2002).

Noting these differences, several questions are suggested. Did speaking another primary language affect the overall results of the previous study? Could there have been fears of discovery and deportation that affected immigrant student responses that were not in operation for U.S.-born, English-speaking students? Do recently immigrated parents keep their children closer to home and out of the neighborhood streets? Conversely, one might also speculate that the American Latino family imposes fewer controls and experiences more breakdown than the traditional immigrant family.

It is important to remember that this study only examines violence in the community. It does not examine the psychological effects of violence exposure in the home or the media. Whether there is an effect from home or media based violence on the rates of PTSD and depression cannot be determined in this sample of students.

Notwithstanding, the clinical implications for this study are several. Although violence exposure was almost universal in this student sample, questions about violence exposure are rarely asked in clinical interviews to formulate a diagnosis unless there is foreknowledge of a specific traumatizing event. One might also surmise that PTSD is not often suspected by teachers or clinicians, as many reactions of these professionals to the high rates of violence

exposure, PTSD and depression are uniformly one of shock and dismay. This response suggests that trauma and depression-related behaviors in schools may be perceived as troublesome but not seen as pathological, leading to adult behaviors that consider disciplinary actions rather than attempting to identify the psychogenesis of the child's behavior.

Sadly, a follow-up interview of students who completed the Student Screening Questionnaire revealed that almost none of the students had been referred to a school counselor, social worker, or school psychologist for mental health services prior to the screening, nor had any of the school mental health professionals suspected that the children were suffering from a major mental health disorder. The lack of recognition of the widespread prevalence of PTSD and depression among the students in the sample point out the "hidden" nature of the disorders.

The most effective way of detecting PTSD and depression at present may be using questions from a scientifically validated screening instrument with student self-reports of symptoms. The President's New Freedom Commission supports screening as the best means of early identification and intervention among children. Further, the Commission recommends expanding and enhancing mental health services in schools, where the negative effects of mental disorders are more likely to be identified and treated (New Freedom Commission on Mental Health, 2003).

A public health screening approach is not new to schools. Children have long been screened by school nurses for vision, hearing, and some communicable diseases. It is not a great conceptual leap to adopt a similar rationale for mental health disorders. This study points to the value for a public health screening approach to mental health care. It is difficult to provide mental health care when the need for treatment is not recognized. Under the current system of school mental health, services are available to a child referred for treatment. The usual referral is of a child who is seen as causing disturbances in the classroom or playground. Many children with PTSD and Depression do not act out. Hence, their disturbance is "invisible," may not disrupt the classroom and are, therefore, easily missed.

School mental health professionals might consider screening to identify the most common mental disorders of childhood such as depression and posttraumatic stress disorder that may prevent children from learning. In schools, depressed children who feel helpless or hopeless lack the motivation to learn and traumatized children who are vigilant, fearful, experience sleep disorder and violent sensory cues suffer from impaired attentional, emotional, and cognitive skills needed to learn. One of the outgrowths of a public health screening approach might be a reduction in the shame and stigma now associated with mental disorders, if early identification and early intervention

were routine approaches to supporting academic progress and the healthy development of children.

Limitations of the Study

This study was conducted in one ethnic community within the City of Los Angeles with a small sample of U.S.-born Latino students. The results may not be generalizable to other sixth-grade students of different racial, ethnic or socioeconomic groups in other parts of the city, region, state or country. African Americans, Asian Americans, Native Americans, or others within the city or in other areas may not report the same levels of violence exposure, PTSD or depression. The assessment of students who attend private or religious schools in the same neighborhood may also produce different results.

This study was limited in scope, identifying only those students who reported their experiences as "Victim," "Witness Only," or "No Violence" exposure within the previous twelve months in the community. It specifically excluded violence experienced in the home or shown in the media, although the effects of these factors may, in fact, be operating in the lives of the students.

A more detailed factor analysis of the data available in the larger MHIP study might elucidate the mental health effects of different kinds and intensities of violence exposure. However, that data has yet to be analyzed.

Among the questions to be considered in future research, one might wonder whether students who were victims of gun violence would show higher rates of PTSD when compared to those who were physically assaulted. One might wonder if students with multiple experiences of violence in one year, would demonstrate a higher degree of PTSD or depression than students who experience only one incident of violence. In other words, does the incidence of PTSD and depression rise with increased exposure to violence as is commonly believed?

Additional questions might query whether PTSD and depression vary with age. A variant might inquire whether age and developmental level play a role in determining vulnerability to PTSD and depression after violence exposure. As of yet, there are no answers but the questions open the field for further exploration and understanding of the psychological, social, cognitive and behavioral sequelae of children who are exposed to traumatic events. Studies of violence exposure might help to identify points of vulnerability along the developmental continuum and suggest interventions that build a child's resistance to the negative effects of community violence.

Also, further study is warranted on the students who were exposed to violence but who seemingly suffered no ill effects. Could there have been resiliency factors at play that protected them from impairment and dysfunction? What role might teachers or parents have played in support of those factors? Are

there educational interventions that might mitigate the negative effects of violence exposure and trauma, for example, educational initiatives such as anti-bullying programs, peer conflict mediation, or social skills development?

Discussions with children who are victims of violence suggest that some react to victimization by becoming a perpetrator of violence. New research in this area might focus on identifying the number of child victims who subsequently perpetrate violence on others. What are the factors that "turn" a child victim into a perpetrator of violence? Is there an identifiable "cycle" of violence?

Finally, new research might follow the developmental trajectory of this sample of children. If 91% of the children in this sample experience violence exposure in the sixth grade, does this foreshadow a violence exposure rate of 100% by middle school graduation at the end of 8th grade? Does violence exposure affect their attendance at school? Do they become dropouts or school failures? Do the effects of violence exposure go beyond the clinical assessment and treatment issues and affect daily behaviors that impede academic success?

This study suggests the value of screening assessments and interventions that are broader in scope than our current system allows but calls for more and varied research to illuminate the unanswered questions.

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APPENDIX A: WORKING DEFINITIONS

The following definitions are used to describe the child's "exposure to community violence" in this study.

- "Victim" Violence - The direct and personal experience of being hit, kicked, beaten or assaulted with a gun or knife or the experience of 'being threatened' to be hit, kicked, beaten or threatened with a gun or knife.
- "Witness Only" Violence is the experience of observing another person or persons who are being hit, kicked, beaten or assaulted with a gun or knife or who are 'being threatened' with being hit, kicked, beaten or threatened with a gun or knife.
- "No Violence" indicates that the student has not had any personal experience with violence in the community as a victim or a witness to violence.

Violence experiences excluded: Students were directed not to include stories of violent events that they have been told. Also excluded were any violence viewed in the media (television, radio, movies or video games), newsprint or magazines.

APPENDIX B: LOS ANGELES UNIFIED SCHOOL DISTRICT STUDENT SCREENING QUESTIONNAIRE

Violence in School and the Community

ID: 1A

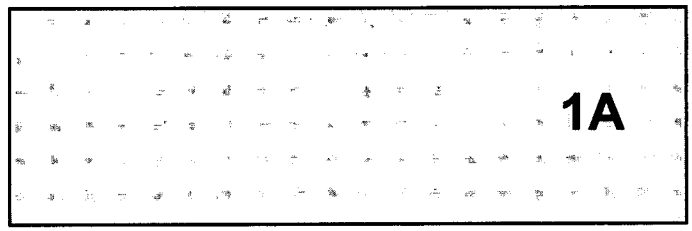
Student Name: _____

School: _____ Grade: _____

Teacher: _____

Phone Number: _____

STUDENT ID:



GENERAL INFORMATION:

1. **How old are you?**

_____ years old

2. **When is your birthday?**

_____(month), _____(day)

3. **What grade are you in right now?**

_____ grade

4. **Are you a ...**

☐ Girl [1]

☐ Boy [2]

5. **What country were you born in?**

☐ USA..... [1]

☐ El Salvador..... [2]

☐ Guatemala..... [3]

☐ México..... [4]

☐ Other Country..... [5]

(Specify):_____

6. Are you Latino or Hispanic?

☐ Yes..... [1]

☐ No..... [2]

7. What is your race?

- ☐ African American / Black [1]
- ☐ American Indian or Alaska Native [2]
- ☐ Asian / Pacific Islander [3]
- ☐ White / Caucasian [4]
- ☐ Other [5]

(Specify)_____

8. How well do you speak English?

- ☐ Not at all [1]
- ☐ A little [2]
- ☐ Pretty well [3]
- ☐ Extremely well [4]

9. Do you speak another language?

- ☐ Yes [1]
- ☐ No [0] **(Go to PART 1)**

9a. **If Yes,** then what **other language** do you speak?

- ☐ Spanish [1]
- ☐ Other [2] _____

9b. How well do you speak another language?

- ☐ Not at all [1]
- ☐ A little [2]
- ☐ Pretty well [3]
- ☐ Extremely well [4]

PART 1:

Sometimes young people see, hear about, or experience scary, frightening, or violent events. VIOLENCE is when somebody attacks or hurts another person. We would like to know about the experiences you have had like this over the past year.

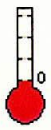
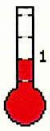
Do not include things you may have only heard about from other people or from the TV, radio, news, or the movies. Only answer what has happened to you in real life. Some questions ask about what you SAW happen to someone else. And other questions ask about what actually happened to YOU.

I will read each question aloud to you. Circle the answer that best describes your experiences.

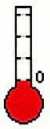
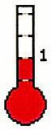
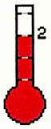
This is an example of how this form works. Here are some thermometers to help you answer these questions. Just like a regular thermometer that tells you how hot you are, you can use this thermometer to tell how often something happens to you. The low temperature, "0," means that it NEVER happens to you and the high temperature, "3," means that it happens to you ALMOST EVERY DAY.

Circle the answer that best describes what has happened to you. Let's practice.

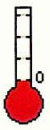
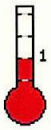
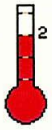
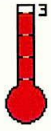
EXAMPLE:

	0	1	2	3
				
How often over the past year did anyone at home read a book with you?	Never	Sometimes	Lots of times	Almost every day

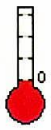
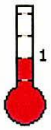
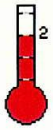
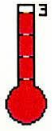
These first three questions are about someone threatening **YOU** over the past one year. Questions 10, 11 and 12 are all the same except that they ask about this happening in different places: at school, in your neighborhood, and anywhere else.

	0 	1 	2 	3 
10. How often over the past year did anyone **at school** tell you they were going to hurt you?	Never	Sometimes	Lots of times	Almost every day
11. How often over the past year did anyone **in your neighborhood** tell you they were going to hurt you?	Never	Sometimes	Lots of times	Almost every day
12. How often over the past year did anyone **anywhere else** tell you they were going to hurt you?	Never	Sometimes	Lots of times	Almost every day

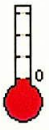
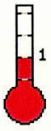
Now, these next three questions are the same except they ask about you seeing **SOMEONE ELSE** being threatened.

	0 	1 	2 	3 
13. How often over the past year did you see someone else **at school** being told they were going to be hurt?	Never	Sometimes	Lots of times	Almost every day
14. How often over the past year did you see someone else **in your neighborhood** being told they were going to be hurt?	Never	Sometimes	Lots of times	Almost every day
15. How often over the past year did you see someone **anywhere else** being told they were going to be hurt?	Never	Sometimes	Lots of times	Almost every day

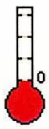
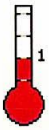
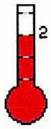
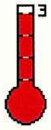
These next three questions are about YOU getting slapped, hit, or punched over the last one year.

	0 	1 	2 	3 
16. How often over the past year have you yourself been slapped, punched, or hit by someone **at school**?	Never	Sometimes	Lots of times	Almost every day
17. How often over the past year have you yourself been slapped, punched, or hit by someone **in your neighborhood**?	Never	Sometimes	Lots of times	Almost every day
18. How often over the past year have you yourself been slapped, punched, or hit by someone **anywhere else**?	Never	Sometimes	Lots of times	Almost every day

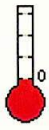
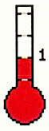
The next three questions are about you seeing SOMEONE ELSE being slapped, punched, or hit over the last year.

	0 	1 	2 	3 
19. How often over the past year have you seen someone else being slapped, punched, or hit by someone **at school**?	Never	Sometimes	Lots of times	Almost every day
20. How often over the past year have you seen someone else being slapped, punched, or hit by someone **in your neighborhood**?	Never	Sometimes	Lots of times	Almost every day
21. How often over the past year have you seen someone else being slapped, punched, or hit by someone **anywhere else**?	Never	Sometimes	Lots of times	Almost every day

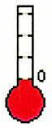
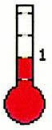
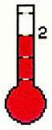
The next three questions are about YOU getting beaten up over the last one year. Beaten up means being slapped, punched, or hit so that you were badly hurt. Questions 20, 21, and 22 are all the same except that they ask about this happening in different places: at school, in your neighborhood, and anywhere else.

	0 	1 	2 	3 
22. How often over the past year have you been beaten up **at school**?	Never	Sometimes	Lots of times	Almost every day
23. How often over the past year have you been beaten up **in your neighborhood**?	Never	Sometimes	Lots of times	Almost every day
24. How often over the past year have you been beaten up **anywhere else**?	Never	Sometimes	Lots of times	Almost every day

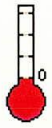
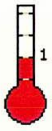
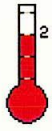
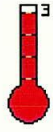
The next three questions are the same except they ask about you seeing someone else getting slapped, punched, or hit so that they were badly hurt.

	0 	1 	2 	3 
25. How often over the past year have you seen someone else getting beaten up **at school**?	Never	Sometimes	Lots of times	Almost every day
26. How often over the past year have you seen someone else getting beaten up **in your neighborhood?**	Never	Sometimes	Lots of times	Almost every day
27. How often over the past year have you seen someone getting beaten up **anywhere else?**	Never	Sometimes	Lots of times	Almost every day

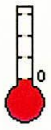
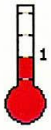
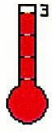
The next two questions are about knife attacks that have happened over the last one year. A knife attack is when someone tries to hurt you or does hurt you with a knife.

	0 	1 	2 	3 
28. How often over the past year have you yourself been attacked or stabbed with a knife?	Never	Sometimes	Lots of times	Almost every day
29. How often over the past year have you seen someone else being attacked or stabbed with a knife?	Never	Sometimes	Lots of times	Almost every day

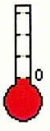
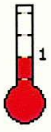
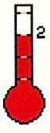
The next two questions are about someone using a gun at **YOU.** Remember, this is over the last one year.

	0 	1 	2 	3 
30. How often over the past year has someone pointed a **real** gun at you?	Never	Sometimes	Lots of times	Almost every day
31. How often over the past year have you yourself actually been shot at or shot with a **real** gun?	Never	Sometimes	Lots of times	Almost every day

The next two questions are about you seeing someone use a gun at **SOMEBODY ELSE.**

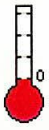
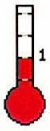
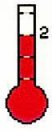
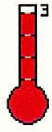
	0 	1 	2 	3 
32. How often over the past year have you seen someone pointing a **real** gun at someone else?	Never	Sometimes	Lots of times	Almost every day
33. How often over the past year have you seen someone else being shot at or shot with a **real** gun?	Never	Sometimes	Lots of times	Almost every day

Sometimes children do violent things. We would like to know about violent things YOU may have done over the past year.

	0 	1 	2 	3 
34. How often over the past year have you told others that you would hurt them?	Never	Sometimes	Lots of times	Almost every day
35. How often over the past year have you slapped, punched, or hit someone before they hit you?	Never	Sometimes	Lots of times	Almost every day
36. How often over the past year have you slapped, hit, or punched someone after they hit you?	Never	Sometimes	Lots of times	Almost every day
37. How often over the past year have you beaten up someone?	Never	Sometimes	Lots of times	Almost every day
38. How often over the past year have you attacked or stabbed someone with a knife?	Never	Sometimes	Lots of times	Almost every day

EARLIER LIFE EXPERIENCES

When you were younger (NOT including the past year), how often did any of the following happen to you either in your neighborhood, in school, or anywhere else?

	0 	1 	2 	3 
39. <u>You</u> being told by someone that they were going to hurt you?	Never	Sometimes	Lots of times	Almost every day
40. Seeing <u>someone else</u> being told that they were going to get hurt?	Never	Sometimes	Lots of times	Almost every day
41. <u>You</u> being slapped, punched or hit?	Never	Sometimes	Lots of times	Almost every day
42. Seeing <u>someone else</u> being slapped, punched or hit?	Never	Sometimes	Lots of times	Almost every day
43. <u>You</u> being beaten up?	Never	Sometimes	Lots of times	Almost every day
44. Seeing <u>someone else</u> being beaten up?	Never	Sometimes	Lots of times	Almost every day
45. <u>You</u> being attacked or stabbed with a knife?	Never	Sometimes	Lots of times	Almost every day
46. Seeing <u>someone else</u> being attacked or stabbed with a knife?	Never	Sometimes	Lots of times	Almost every day
47. <u>You</u> being shot at or shot with a <u>real</u> gun?	Never	Sometimes	Lots of times	Almost every day
48. Seeing <u>someone else</u> being shot at or shot with a <u>real</u> gun?	Never	Sometimes	Lots of times	Almost every day

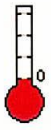
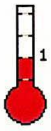
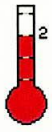
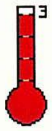
Now the next question asks about **where** any of these violent and scary things have happened to you.

49. Where did these violent things happen to you? <u>If violent things didn't happen to you skip to **PART 2.**</u>

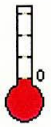
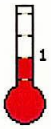
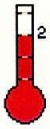
- ☐ In the United States [1]
- ☐ In another country [2]
- ☐ Both United States AND another country [3]

PART 2:

Below is a list of problems that kids sometimes have after experiencing something scary like we were just talking about. Of all the things that we just talked about, try to remember the thing that bothered you the most.

Now these next questions ask about the thing that bothered you most (whether it was getting hit, beaten up, threatened, or anything else). Listen carefully and circle the word that best describes how often these problems have bothered you IN THE PAST MONTH.	0 	1 	2 	3 
50. Have you had upsetting thoughts or images about the event that came into your head when you didn't want them to?	Not at all	Once in a while	Half the time	Almost always
51. Have you had bad dreams or nightmares?	Not at all	Once in a while	Half the time	Almost always
52. Have you been acting or feeling as if the event was happening again (for example, hearing something or seeing a picture about it and feeling as if you were there again)?	Not at all	Once in a while	Half the time	Almost always
Have you been feeling upset when you think about or hear about the event (e.g., feeling scared, angry, sad, guilty, etc.)?	Not at all	Once in a while	Half the time	Almost always
53. Have you had feelings in your body when you think about or hear about the event (for example, breaking out in a sweat, heart beating fast)?	Not at all	Once in a while	Half the time	Almost always

54. Have you been trying not to think about, talk about, or have feelings about the event?	Not at all	Once in a while	Half the time	Almost always
55. Have you been trying to avoid activities, people, or places that remind you of the event (for example, not wanting to play outside or go to school)?	Not at all	Once in a while	Half the time	Almost always

	0 	1 	2 	3 
56. Have you not been able to remember an important part of the event?	Not at all	Once in a while	Half the time	Almost always
57. Have you had much less interest or not wanting to do things you used to do?	Not at all	Once in a while	Half the time	Almost always
58. Have you not felt close to people around you?	Not at all	Once in a while	Half the time	Almost always
59. Have you not been able to have strong feelings (for example, being unable to feel very happy)?	Not at all	Once in a while	Half the time	Almost always
60. Have you been feeling as if your future plans or hopes will not come true (for example, you will not have a job or getting married or have kids or go to high school)?	Not at all	Once in a while	Half the time	Almost always
61. Have you had trouble falling or staying asleep?	Not at all	Once in a while	Half the time	Almost always
62. Have you been feeling irritable or having fits of anger?	Not at all	Once in a while	Half the time	Almost always
63. Have you had trouble concentrating (e.g., losing track of a story on television, forgetting what you read, not paying attention in class)?	Not at all	Once in a while	Half the time	Almost always
64. Have you been overly careful (for example, checking to see who is around you and what is around you)?	Not at all	Once in a while	Half the time	Almost always
65. Have you been jumpy or easily startled (for example, when someone walks up behind you)?	Not at all	Once in a while	Half the time	Almost always

Thinking about the experiences that happened to you, please answer the following questions:

66. Have you been more upset than you used to be before this happened?

☐ Yes [1]

☐ No [0]

67. Have you been having problems with your classmates or other people since this happened?

☐ Yes [1]

☐ No [0]

68. Have you been unable to go to school since this happened?

☐ Yes [1]

☐ No [0]

69. Have your grades in school gotten worse since this happened?

☐ Yes [1]

☐ No [0]

70. Have you been having more problems with your parents or the people you live with since this happened?

☐ Yes [1]

☐ No [0]

71. Have you been having more problems with your teachers since this happened?

☐ Yes [1]

☐ No [0]

PART 3:

Kids sometimes have different feelings and ideas. This form lists the feelings and ideas in groups. From each group, pick <u>one</u> sentence that describes you best for the past two

weeks. After you pick a sentence from the first group, then we will go on to the next group.

There is no right answer or wrong answer. Just pick the sentence that best describes the way you have been recently. Put a mark like this [X] next to your answer. Put the mark in the box next to the sentence that you pick.

Here is an example of how this form works. Try it. Put a mark next to the sentence that describes you best.

EXAMPLE:

[ ] I read books all the time

[ ] I read books once in a while

[ ] I never read books

Remember, pick out the sentence that describes your feelings and ideas IN THE PAST TWO WEEKS.

72. [ ] I am sad once in a while. [1]
[ ] I am sad many times. [2]
[ ] I am sad all the time. [3]

---

73. [ ] Nothing will ever work out for me. [1]
[ ] I am not sure if things will work out for me. [2]
[ ] Things will work out for me O.K. [3]

74.
- [ ] I do most things O.K. [1]
- [ ] I do many things wrong. [2]
- [ ] I do everything wrong. [3]

75.
- [ ] I have fun in many things. [1]
- [ ] I have fun in some things. [2]
- [ ] Nothing is fun at all. [3]

76.
- [ ] I am bad all the time. [1]
- [ ] I am bad many times. [2]
- [ ] I am bad once in a while. [3]

77.
- [ ] I think about bad things happening to me once in a while. [1]
- [ ] I worry that bad things will happen to me. [2]
- [ ] I am sure that terrible things will happen to me. [3]

Remember, pick out the sentences that describe your feelings and ideas IN THE PAST TWO WEEKS.

78.
- [ ] I hate myself. [1]
- [ ] I do not like myself. [2]
- [ ] I like myself. [3]

79.
- [ ] All bad things are my fault. [1]
- [ ] Many bad things are my fault. [2]
- [ ] Bad things are usually not my fault. [3]

81.
- [ ] I feel like crying everyday. [1]
- [ ] I feel like crying many days. [2]
- [ ] I feel like crying once in a while. [3]

82. ☐ Things bother me all the time. [1]
☐ Things bother me many times. [2]
☐ Things bother me once in a while. [3]

---

83. ☐ I like being with people. [1]
☐ I do not like being with people many times. [2]
☐ I do not want to be with people at all. [3]

Remember, pick out the sentences that describe your feelings and ideas IN THE PAST TWO WEEKS.

84. ☐ I cannot make up my mind about things. [1]
☐ It is hard to make up my mind about things. [2]
☐ I make up my mind about things easily. [3]

---

85. ☐ I look O.K. [1]
☐ There are some bad things about my looks. [2]
☐ I look ugly. [3]

---

86. ☐ I have to push myself all the time to do my schoolwork. [1]
☐ I have to push myself many times to do my schoolwork. [2]
☐ Doing schoolwork is not a big problem. [3]

---

87. ☐ I have trouble sleeping every night. [1]
☐ I have trouble sleeping many nights. [2]
☐ I sleep pretty well. [3]

---

88. ☐ I am tired once in a while. [1]
☐ I am tired many days. [2]
☐ I am tired all the time. [3]

---

89. ☐ Most days I do not feel like eating. [1]
☐ Many days I do not feel like eating. [2]
☐ I eat pretty well. [3]

Remember, pick out the sentences that describe your feelings and ideas IN THE PAST TWO WEEKS.

90. ☐ I do not worry about aches and pains. [1]
☐ I worry about aches and pains many times. [2]
☐ I worry about aches and pains all the time. [3]

---

91. ☐ I do not feel alone. [1]
☐ I feel alone many times. [2]
☐ I feel alone all the time. [3]

---

92. ☐ I never have fun at school. [1]
☐ I have fun at school only once in a while. [2]
☐ I have fun at school many times. [3]

---

93. ☐ I have plenty of friends. [1]
☐ I have some friends but I wish I had more. [2]
☐ I do not have any friends. [3]

---

94. ☐ My schoolwork is all right. [1]
☐ My schoolwork is not as good as before. [2]
☐ I do very badly in subjects I used to be good in. [3]

95. ☐ I can never be as good as other kids. [1]
☐ I can be as good as other kids if I want to. [2]
☐ I am just as good as other kids. [3]

Remember, pick out the sentences that describe your feelings and ideas IN THE PAST TWO WEEKS.

96. ☐ Nobody really loves me. [1]
☐ I am not sure if anybody loves me. [2]
☐ I am sure that somebody loves me. [3]

97. ☐ I usually do what I am told. [1]
☐ I do not do what I am told most times. [2]
☐ I never do what I am told. [3]

98. ☐ I get along with people. [1]
☐ I get into fights many times. [2]
☐ I get into fights all the time. [3]

Part 4:

For the next set of questions, I would like you to circle the answer that best describes your behavior in school, with friends, and at home for the LAST TWO (2) WEEKS.

99. How many days of classes did you miss in the last 2 weeks?

- [ ] No days missed.
- [ ] A few days missed.
- [ ] I missed about half the time.
- [ ] I missed more than half time but did make at least one day.
- [ ] I did not go to classes at all.

100. Have you been able to keep up with you class work in the last 2 weeks?

- [ ] I did my work very well.
- [ ] I did my work well but had some problems.
- [ ] I needed help with my work and did not do well about half the time.
- [ ] I did my work poorly most of the time.
- [ ] I did my work poorly all of the time.

---

101. During the last 2 weeks, have you been ashamed of how you do your schoolwork?

- [ ] I never felt ashamed.
- [ ] Once or twice I felt ashamed.
- [ ] About half the time I felt ashamed.
- [ ] I felt ashamed most of the time.
- [ ] I felt ashamed all of the time.

---

102. Have you had any arguments with kids at school in the last 2 weeks?

- [ ] I had no arguments and got along very well.
- [ ] I usually got along well but had some problems.
- [ ] I had more than one argument.
- [ ] I had many arguments.
- [ ] I was constantly in arguments.
- [ ] I did not attend school; can't answer.

---

103. Have you felt unhappy at school during the last 2 weeks?

- [ ] I never felt unhappy.
- [ ] Once or twice I felt unhappy.
- [ ] Half the time I felt unhappy.
- [ ] I felt unhappy most of the time.
- [ ] I felt unhappy all of the time.
- [ ] I did not attend school; can't answer.

104. Have you found your schoolwork interesting in the last 2 weeks?

- [ ] My work was almost always interesting.
- [ ] Once or twice my work was not interesting.
- [ ] Half the time my work was not interesting.
- [ ] Most of the time my work was not interesting.
- [ ] My work was never interesting.

105. How many friends have you seen or spoken to on the phone in the last 2 weeks?

- [ ] Nine or more friends.
- [ ] Five to eight friends.
- [ ] Two to four friends.
- [ ] One friend.
- [ ] No friends.

106. Have you been able to talk about your feelings and problems with at least one friend during the last 2 weeks?

- [ ] I can always talk about my feelings.
- [ ] I usually talk about my feelings.
- [ ] About half the time I felt able to talk about my feelings.
- [ ] I was never able to talk about my feelings.
- [ ] I have no friends; can't answer.

107. How many times in the last 2 weeks have you been with other kids? For example: visited friends, gone to the movies, bowling, invited friends to your home?

- [ ] More than three times.
- [ ] Three times.
- [ ] Twice.
- [ ] Once.
- [ ] None.

---

108. How much time have you spent on hobbies or other activities during the last 2 weeks? For example: arts and crafts, sports, reading?

- [ ] I spent most of my spare time on hobbies almost everyday.
- [ ] I spent some spare time on hobbies some of the days.
- [ ] I spent a little spare time on hobbies.
- [ ] I usually did not spend any time on hobbies but did watch T.V.
- [ ] I did not spend any spare time on hobbies or watching T.V.

---

109. Have you had arguments with your friends in the last 2 weeks?

- [ ] I had no arguments and got along very well.
- [ ] I usually got along well but had some arguments.
- [ ] I had more than one argument.
- [ ] I had many arguments.
- [ ] I was always in arguments.
- [ ] I have no friends; can't answer.

110. If your feelings were hurt by a friend during the last 2 weeks, how badly did you take it?

- [ ] It did not bother me or it did not happen.
- [ ] I got over it in a few hours.
- [ ] I got over it in a few days.
- [ ] I got over it in a week.

☐ It will take me a long time to feel better.

☐ I have no friends; can't answer.

---

111. Have you felt shy or nervous with people in the last 2 weeks?

- [ ] I always felt O.K.
- [ ] Sometimes I felt nervous but could relax after a while.
- [ ] About half the time I felt nervous.
- [ ] I usually felt nervous.
- [ ] I always felt nervous.
- [ ] I was never with people; can't answer.

---

112. Have you felt lonely and wished for more friends during the last 2 weeks?

- [ ] I have not felt lonely.
- [ ] I have felt lonely a few times.
- [ ] About half the time I felt lonely.
- [ ] I usually felt lonely.
- [ ] I always felt lonely and wished for more friends.

---

113. Have you felt bored in your spare time during the last 2 weeks?

- [ ] I never felt bored.
- [ ] I usually did not feel bored.
- [ ] About half the time I felt bored.
- [ ] Most of the time I felt bored.
- [ ] I was constantly bored.

FAMILY:

114. Have you had arguments with your parents in the last 2 weeks?

- [ ] We always got along very well.
- [ ] We usually got along very well but had some arguments.
- [ ] I had more than one argument with at least one parent.
- [ ] I had many arguments.
- [ ] I was always in arguments.

115. Have you been able to talk about your feelings and problems with your parents in the last 2 weeks?

- [ ] I can always talk about my feelings with my parents.
- [ ] I usually can talk about my feelings.
- [ ] About half the time I felt able to talk about my feelings.
- [ ] I usually was not able to talk about my feelings.
- [ ] I was never able to talk about my feelings.
- [ ] No contact with my parents in the last 2 weeks; can't answer.

---

116. Have you wanted to do THE OPPOSITE of what your parents wanted in order to make them angry during the past 2 weeks?

- [ ] I never wanted to do the opposite of what my parents wanted.
- [ ] Once or twice I wanted to do the opposite of what my parents wanted.
- [ ] About half the time I wanted to do the opposite.
- [ ] Most of the time I wanted to do the opposite.
- [ ] I always wanted to do the opposite.

---

117. Have you been worried about things happening to your family without good reason in the last 2 weeks?

- [ ] I have not worried without reason.
- [ ] Once or twice I worried.
- [ ] About half the time I worried.
- [ ] Most of the time I worried.
- [ ] I have worried the entire time.

118. During the past 2 weeks, have you been thinking that you let your family down or have been unfair to them at any time?

- [ ] I did not feel that I let them down at all.
- [ ] I usually did not feel that I let them down.
- [ ] About half the time I felt that I let them down.

☐ Most of the time I have felt that I let them down.

☐ I always felt that I let them down.

---

119. During the last 2 weeks, have you been thinking that your family let you down or has been unfair to you?

☐ I never felt that they let me down.

☐ I felt that they usually did not let me down.

☐ About half the time I felt they let me down.

☐ I usually have felt that they let me down.

☐ I am very mad that they let me down.

THANK YOU FOR FINISHING THESE QUESTIONS.

OFFICE USE ONLY

STUDENT ID:

INTERVIEWER CODE: _____ _____ _____

SCHOOL CODE: _____ _____

DATE: _____ _____ / _____ _____ / _____ _____

APPENDIX C: PARENTAL CONSENTS

Parental Notice of Survey about Community Violence

Dear Parent/Guardian:

A recent study of children has found that many of our students have been victims or witnesses to violence on the streets of Los Angeles. The study also found that violence in the community has a negative effect on grades and school attendance. LAUSD would like to determine how much community violence has affected its sixth-grade students. We want to use the information to keep children safe in school and to improve their ability to learn. With this information, we may be able to organize new counseling and safety programs.

Survey Questions: For this project, we will ask your child to fill out a survey at school during one class period. The survey will take about 45 minutes to complete. The survey will ask your child general questions about <u>how often</u> they have seen or experienced violent events at school or in the neighborhood and how it has affected them. Sample questions include:

- "<u>How often</u> in the past year did you see someone hurt in your neighborhood?"
- "<u>How often</u> over the past year did anyone at school tell you they were going to hurt you?"

The students can choose one of four answers: Never, sometimes, lots of times or almost every day. No other information will be requested.

This survey DOES NOT ask personal questions about family life, religious beliefs or politics. If you wish to review it, the survey is available at the office of Crisis Counseling and Intervention.

Potential Benefits: Based on the overall results of the survey, we may be able to offer a school program that teaches children how to stay safe and to better cope with upsetting experiences.

Participation is voluntary and confidential: Your child's answers will be kept confidential and are disclosed only as required by law. If additional safety or counseling programs are organized because of the new information, you will be informed. No new services will be provided to your child without your consent. You and your child can choose not to participate in this survey.

PARENT CONSENT

I understand that the purpose of the survey is to learn about students' experiences with community violence. I understand that the information will be used to organize safety programs and counseling services that may help my child and other sixth-grade students do better in school.

If I agree to let my child participate in the survey, I understand that I do not have to sign or send in this form. If I do not want my child to participate in the survey, I will complete and return this form, with my signature and my child's name to the school by October 30....

_____ Yes, I give my permission for my child to participate in the survey.

_____ No, I do not want my child to participate in the survey.

_____ _____

Signature of Parent Date

_____ _____

Name of Child Date

If you have questions, please call Marleen Wong at (213) 241-2174. Ask for "Ada: for information in Spanish. Thank you for your help with this important survey.

Autorización del Padre de Familia para la Participación en una Encuesta Sobre la Violencia en la Comunidad

Estimado padre, madre o tutor(a):

En un estudio reciente se ha concluido que muchos de nuestros alumnos han sido víctimas o testigos de la violencia que se da en las calles de Los Ángeles. En dicho estudio también se determinó que la violencia en la comunidad afecta de manera adversa las calificaciones y la asistencia a la escuela. El LAUSD desea saber hasta qué punto la violencia en la comunidad ha influido en los estudiantes de sexto grado. Queremos utilizar esta información para mantener fuera de peligro a los niños en la escuela y para mejorar su capacidad de aprender. Con estos datos tal vez podamos organizar nuevos programas de orientación y seguridad.

Las preguntas en la encuesta: Con su permiso, le pediremos a su hijo(a) que llene una encuesta en la escuela durante un período de clase. Demorará aproximadamente 45 minutos contestar la encuesta. En ésta se le harán preguntas generales a su hijo(a) acerca de <u>la frecuencia</u> con la que ha visto o experimentado sucesos violentos en la escuela o en el vecindario. Entre las preguntas de muestra se incluyen:

- "¿<u>Con qué frecuencia</u> has visto lastimar a alguien en tu vecindario durante el último año?"

- "¿Con qué frecuencia te ha dicho alguien en la escuela durante el último año que te iba a hacer daño?"

Los estudiantes pueden escoger una de cuatro respuestas: nunca, algunas veces, muchas veces o casi todos los días. No se solicitará otra información.

En esta encuesta NO se hacen preguntas personales sobre la vida familiar, las creencias religiosas ni la política. Si usted desea verla, la encuesta está disponible en la oficina de Orientación e Intervención en Casos de Crisis (Crisis Counseling and Intervention).

Posibles beneficios: En base a los resultados generales de la encuesta, posiblemente podamos ofrecer un programa escolar que enseñe a los alumnos a mantenerse fuera de peligro y enfrentar mejor ciertas experiencias perturbadoras.

La participación es voluntaria y confidencial: Usted y su hijo(a) pueden decidir si participar o no en la encuesta. Las respuestas de su hijo(a) se mantienen confidenciales y se revelan sólo según lo exige la ley. Si se organizan programas adicionales de seguridad u orientación debido a la nueva información, se les informará. No se proporcionará ningún servicio nuevo sin el consentimiento de usted.

AUTORIZACIÓN DEL PADRE O DE LA MADRE

Entiendo que el objectivo de esta encuesta consiste en obtener información sobre las experiencias de los alumnos con la violencia en la comunidad. Comprendo que los datos que se recopilen se utilizarán para organizar

programas de seguridad y servicios de orientación que podrían ayudar a mi hijo(a) y a otros estudiantes de sexto grado a progresar más en la escuela.

Si acepto permitir que mi hijo(a) participe en la encuesta, entiendo que no tengo que firmar ni enviar este formulario. Si no quiero que mi hijo(a) participe, llenaré y devolveré este formulario a la escuela para el ___de octobre de .... con mi firma y con el nombre y el apellido de mi hijo(a).

_____ SÍ. Doy mi autorización para que mi hijo(a) participe en la encuesta.

_____ NO. No deseo que mi hijo(a) participe en la encuesta.

_____ _____

Firma del padre o de la madre Fecha

_____ _____

Nombre y apellido del (de la) alumno(a) Fecha

Si usted tiene preguntas, sírvase llamar a Marleen Wong a al (213) 241-2174. Si desea información en español, pregunte por "Ada" . Gracias por su ayuda con esta importante encuesta.

MARLEEN WONG Ph.D. 2005