INTRODUCTION

The United States is a violent country. It was established in the context of the violence of a revolution and presently it remains engaged in conflict with other nations. Within its boundaries, violence manifests itself in multiple forms such as child abuse, maltreatment, domestic violence as well as oppression and poverty. Community violence also permeates American society. During the 1990’s, exposure to community violence became a national public health concern as increasing numbers of children were exposed repeatedly to violence as observers or as friends or relatives of victims (Gliderich, 1998; Koop & Lundberg, 1992). The National Survey of Adolescents found that 23% of adolescents reported having been both a victim of assault and a witness to violence (Kilpatrick, Saunders, Resnick, & Smith, 1995). Other studies have reported that between 50% and 96% of urban children have witnessed at least one act of community violence in their lifetimes (Aisenberg, 2001; Gorman-Smith & Tolan, 1998; Schwab-Stone et al., 1995; Singer, Anglin, Song & Lunghofer, 1995).

These statistics underscore that exposure to community violence as a victim or as a witness is a serious risk factor in the lives of children and adolescents. Exposure to community violence is a cumulative stressor that has potential effects on children’s physical and emotional health (Jenkins & Bell, 1997; Pynoos, Steinberg & Wraith, 1995). Also, it shapes and influences children’s sense of safety, their worldview, and expectations for future happiness (Garbarino et al., 1991; Pynoos, Steinberg & Goenjian, 1996).

This article responds to two significant gaps in our knowledge: 1) the paucity of information on parental exposure to community violence and their distress symptomatology (depression and posttraumatic stress disorder) which greatly contributes to the lack of research on the interpersonal context of children and parents coping with chronic community violence (Aisenberg & Mennen, 2000) and 2) the scant research on the frequency and effects of exposure to community violence among Latino children and families.

The study of the intersection of traumatic effects and parental psychopathology among parents and children exposed to community violence is crucial (Osofsky & Scheeringa, 1997). Many parents and children are exposed to community violence on an on-going and repetitive basis. Little is known, however, about the indirect effects of maternal distress in predicting child psychological and behavioral problems. An examination of both direct and indirect predictors of child symptomatology is essential to fully understand the impact of community violence.

Latinos constitute the largest minority group in the United States (US Census Bureau, 2000). However, they have been understudied in research on community violence. Investigation of the frequency of exposure to community violence in the United States and its impact has focused primarily on low-income African-American school-age children and adolescents (Bell & Jenkins, 1993; Hill & Madhere,
Only a few studies have examined the prevalence of exposure of Latino children or their parents, especially Latino immigrant families, to community violence and the association between exposure and psychological consequences of exposure in different groups and across gender (Aisenberg, 2001; Kataoka et al., 2003; Stein et al., 2001).

The immigration experience is especially salient for Latino families. Many have experienced war, civil unrest, abject poverty, corrupt government and civil officials in their home country. Also, the experience of migration often involved life-threatening events such as rape, assaults, and robbery. In addition, women in particular have been subject to oppression and violence derived from the preponderance of male dominance and machismo in their country of origin. Having immigrated to the United States, Latina mothers are often still subjected to a male dominated culture and are disproportionately at higher risk for exposure to community violence, as they tend to initially reside in low-income, high crime communities.

As a result of such experiences and trauma, the perceptions, attributions, and reactions to community violence of Latinos may be divergent compared with other racial/ethnic groups such as African-Americans in spite of residing in the same neighborhoods. Thus, the ways in which exposure to community violence influence child depression and behavior problems remain in question with knowledge about Latino mothers and children particularly sparse (Aisenberg, 2001).

In attempt to specify the role of parents as mediators and/or moderators of the effects of neighborhood violence on child and adolescent development the present study tests the following model depicted in figure 1. The model purports that child and parent both suffer direct and negative effects of exposure to community violence. In addition, the child may experience the direct effects of maternal exposure to community violence and/or the indirect effects of maternal depression contributing to her/his behavior problems.

FIGURE 1. MODEL OF DIRECT AND INDIRECT EFFECTS OF COMMUNITY VIOLENCE

[Diagram showing the model with arrows indicating direct and indirect effects of exposure to community violence on depression and child behavior problems.]

Informed by this model, this study aims to: 1) identify and measure the type and frequency of lifetime exposure to community violence experienced by 47 Latino mothers and their children living in an urban city in Los Angeles County; 2) measure the psychological and behavioral effects of community violence exposure upon the dyads; 3) assess and measure the association between community violence exposure and child and maternal depression and child behavior problems; and 4) investigate the pathways of influence of maternal depression upon child behavior problems.

Based on data collected from children, mothers, and teachers, this study tests the following hypotheses:
1) Children’s exposure to community violence contributes to elevated depression and total behavioral problem scores.
2) Mothers exposed to community violence will manifest higher depression scores.
3) Maternal exposure to community violence contributes to child behavior problems.
4) Maternal depression is a mediator of child behavior problems so that higher maternal depression scores contribute to an increase in child behavioral problems.
Overview

Definition

For purposes of this study, community violence refers to the intentional threat or use of force to physically harm, injure or kill another person or persons that occurs in the child's environment, i.e. neighborhood, school, outside the child’s home. Such violence is distinct from domestic violence, which involves family members and usually occurs in the family home (Rosenberg & Fenley, 1992; Wallen & Rubin, 1997). Community violence stems from direct exposure through victimization or through witnessing of violence. It does not include hearing of violent acts such as gunshots or hearing from others about violent events.

Epidemiological Information

Exposure to community violence

Epidemiological data on the national prevalence and incidence of children's exposure to community violence in the United States is lacking (Amaya-Jackson & March, 1995). Due to the divergent methods of data collection and lack of uniformity in defining community violence, statistics estimating the rates and types of violence exposure vary widely. While definitive patterns are not yet evident, more studies report insignificant results for the demographic variables of age, gender, and ethnicity as potential risk factors for exposure to community violence (Foy & Goguen, 1998). One national study revealed that higher numbers of Latino students compared to Caucasians (9.8% to 6.6%) reported that they had been threatened or injured with a weapon at school (Centers for Disease Control and Prevention, 1999). Other studies note substantially higher rates of violence exposure. Aisenberg (2001) reported that Latina mothers and their preschool children at a Head Start program in a medium size municipality in Los Angeles County experienced high levels of exposure to community violence. Seventy-seven percent of the mothers and eighty-one percent of the preschool children had been a victim or a witness of community violence in their lifetime. In screening nearly 900 Latino immigrant children attending elementary and middle schools in the Los Angeles Unified School District, Kataoka and colleagues (2003) found that 31% of children had been exposed to community violence and manifested posttraumatic stress disorder symptomatology or depressive symptoms. Stein and colleagues (2001) sampled 300 children ages 6 to 12 who were living in an out-of-home placement in Los Angeles County. They reported that 85% of the 100 Latino foster care children were witness to acts of community violence and 51% were victims of violence during their lifetime.

Epidemiological information on adult Latinos’ exposure to community violence is scarce due in large part to the fact that the Bureau of Justice statistics does not specifically identify Latinos. Its data is based on the categories of Caucasian, African-American and Other.

Effects on Children

Research documents that community violence is a chronic and cumulative stressor that has potential effects on children’s health as well as school performance and social functioning (Jenkins & Bell, 1997; Pynoos, Steinberg, & Wraith, 1995). Studies of community violence have revealed positive correlations between the exposure and symptoms of anxiety and depression as reported by youngsters (Gorman-Smith & Tolan, 1998; Kliewer, Lepore, Oskin & Johnson, 1998; Lynch & Cicchetti, 1998; Pynoos, Goenijian & Steinberg, 1998; Schwab-Stone et al., 1999; Stein et al., 2001). Exposed children also are at risk for posttraumatic stress disorder (PTSD) (Boney-McCoy & Finkelhor, 1995; Fairbank, Schlenger, Saigh & Davidson, 1995; Kliewer, Lepore, Oskin & Johnson, 1998; Saltzman, Pynoos, Layne,
Steinberg & Aisenberg, 2001). Many violence-exposed children experience difficulties concentrating in the classroom and show impaired academic achievement (Bowen & Bowen, 1999; Saltzman et al., 2001; Warner & Weist, 1996). Some engage in aggressive, delinquent or high risk sexual behaviors and others are at increased risk for substance abuse and dependence (Farrell & Bruce, 1997; Kilpatrick, Acierno, Saunders, Resnick & Best, 2000; Saigh, Mroueh, & Bremner, 1997). Evidence suggests that the effects of traumatic exposure to violence for children extend beyond current distress and impairment to include long-term disruption of normal development (Pynoos, Steinberg, & Piacentini, 1999; Pynoos et al., 1995).

The Surgeon General’s Report on Mental Health (2001) indicates that Latino children are at significant risk of mental health problems, i.e., they are more likely to drop out of school, to report depression, and to consider suicide than white youth. Additionally, Latino immigrant children exposed to violence in their county of origin are at high risk for mental disorders such as depression and PTSD (DHHS, 2001). These risk factors have significant implications for the ongoing health of the nation’s youth given that the adolescent population of Latinos is increasing more rapidly than that of any other racial or ethnic group (DHHS, 2001; Ozzer, Brindis, Millstein, Knopf, & Irwin, 1997).

Effects on Parents

Community violence directly and negatively impacts the parent who may experience distress symptoms similar to those experienced by their children. Exposure contributes to parental depression, PTSD, anxiety, and diminished sense of self-esteem and self-efficacy (Aisenberg, 2001). Likely, it has adverse effects on the exchange of social support among family members and the child's ability to cope (Barrera & Li, 1996).

Experienced on a repetitive basis, community violence taxes a parent’s resources, heightens stress and may impair one’s ability to be emotionally responsive and to fulfill parental tasks and responsibilities effectively (Planos, Zayas & Busch-Rossnagel, 1997). Parents living in communities with high rates of violence frequently express a sense of helplessness and frustration with their inability to fulfill their responsibility to protect their children (Lorion & Saltzman, 1993; Richters & Martinez, 1993). Parents or caregivers may become too depressed or overwhelmed to form and enjoy a secure attachment with their child (Garbarino et al., 1992). As a result, they may become less able to buffer the detrimental effects of community violence in the lives of their sons and daughters.

Recent research shows that adult Latinos are considered to be at a higher risk for disorders such as depression and anxiety (Organista, 2000). In the National Comorbidity Survey (NCS) (Kessler et al., 1994), Latinos had significantly higher prevalence of current affective disorders compared with non-Latino Whites and African-Americans. On the other hand, other studies reveal that 6-10% of Mexican-Americans in California suffer depression, a rate consistent with that of the general population (Vega, Kolody, Aguilar-Gaxiola, Alderete, Catalano, & Caraveo-Anduaga, 1998).

Method

Procedures

The present study built on the work conducted by the UCLA Child Trauma Reduction Program of the UCLA Trauma Psychiatry Service (Saltzman et al., 2001). The UCLA program systematically screened 1100 middle school students for violence exposure, depression, and PTSD from two schools serving students from the same neighborhood in a major city in Los Angeles County. The overwhelming majority of students were African-American and Latino. The screening took place in a large group format of 20 –40 students in the schools’ cafeterias. Overall, 73% of the mothers gave consent for their child to
participate in the UCLA screening. This school-based program then provided treatment for identified students who manifested PTSD symptoms and grief as a result of traumatic exposure to violence and loss. The author served as program coordinator.

The present study, although not originally a part of the UCLA screening, extended the UCLA study. It collected data from mothers of a sub-sample of the previously screened students. A random stratified sampling design was utilized in which 200 Latino students from the total diverse pool of 1100 students were stratified based on gender and level of violence exposure (high/low). A high level of exposure was based on a total exposure score of 3 or more discrete violent events. This criteria was based on the categorization of the Project on Human Development in Chicago Neighborhood Study in which 3 or more experiences of distinct acts of community violence such as beatings, threatened with a weapon, and seeing someone get shot, were determined to constitute a high level of violence exposure (Gorman-Smith & Tolan, 1998).

The mothers of the selected students were recruited via letter sent by mail to the family home. The letter explained the nature and purpose of the study in English and Spanish and detailed the confidentiality of information that would be safeguarded. A response to participate (yes/no) was requested. Overall, 135 responses were received (67.5%) with 47 mothers agreeing to participate (23.5%).

The mothers who affirmed their willingness to participate in the study were contacted via telephone by a trained interviewer who scheduled an appointment to complete the study’s measures. The mothers were given the choice of being interviewed in their home or at their child’s school. All mothers preferred being interviewed at home. The interviewers met with the mothers on an individual basis. All but three mothers completed the measures in Spanish. These interviews took place 3 to 9 months following the initial child screening. This was primarily due to the fact that the present study was not originally a part of the UCLA screening. Thus, additional approval from the school district and the Institutional Review Board (IRB) had to be obtained. Then, additional time was required to identify potential subjects, request their permission, and schedule the assessment of the mother.

The study’s author met with the English teachers at both schools at a departmental meeting to inform them of the nature and purpose of the study and invite their participation by completing a standardized measure of classroom behavior. Teacher participation was 100%.

Participants

Forty-seven Latino mother-child pairs participated in the study. Criteria for inclusion in the study were: participants must be the biological mother of a 6th, 7th or 8th grade student attending either of the 2 selected middle schools or a student at such schools, Latino residents of the identified neighborhood, and able to speak English or Spanish. T-test analysis confirms that based on total exposure and gender no significant differences exist between the study’s subjects and the larger UCLA sample from which the study’s sample was drawn (\( t = .080; \ p = .94 \)).

The families reside in a diverse, urban city with a population of approximately 135,000 (U.S. Census Bureau, 2000). According to the State Crime Index, a monthly average of 137 cases of crimes such as armed robbery and assault were committed within the study’s city limits (California Crime Index, 1999). However, nearly 70% of the city’s violent crime is committed within the six square mile region in which the subjects reside (Pasadena City Report, 2001).

According to 2000 statistics, the median income for a family of four in the study’s city was $58,423 compared to $49,800 for residents of Los Angeles County (California Department of Finance, 2000). Despite this city’s high median income, disproportionate numbers of families experience poverty. Twenty-six percent of the households live below the poverty level. More than one of every five families survives on annual incomes of less than $15,000 (Pasadena City Report, 2001).

The mothers received a small stipend to compensate them for their time. The students were not compensated for their participation. The teachers completed their measure within the same timeframe as the mothers and received nominal compensation for their effort.
Measures

Child Self-Reports

Students completed the UCLA Community Violence Exposure Survey (Saltzman, Layne, & Steinberg, 1998), which is a modified version of the Richters and Saltzman (1990) violence questionnaire, the Reynolds Adolescent Depression Scale (RADS, Reynolds, 1987), and the UCLA PTSD Reaction Index-Revised Adolescent Version (RI-R; Rodriguez, Steinberg, & Pynoos, 1999).

The Violence Survey includes 38 items addressing different types of violence exposure including beating, knife attack, and kidnapping. Possible responses were yes/no. Items were summed for a total score of exposure to community violence. For purposes of analysis, exposure to disaster and accidents were not included. Cronbach’s alpha for the subscale of victimization was .68 and for the witnessing subscale was .67.

The RADS is a self-report measure of depressive symptoms among adolescents between the ages of 12 and 18. It consists of 30 items with a four-point Likert-type response format (1-4), from “almost never” to “most of the time”. A cut-off score of 77 represents clinical levels of depression with higher scores indicating higher levels of depression. The RADS has been previously used to measure depressive symptomatology among Latino adolescents (Davis, 1991). It has demonstrated excellent validity and reliability. A range of studies has reported alpha coefficients ranging from .90 through .96, indicating high internal consistency of the instrument (Reynolds, 1987). With a sample of over thousand young adolescents ages 12 to 14, Reynolds (1987) found a strong correlation of 0.70 between the RADS and the Children’s Depression Inventory (Kovacs, 1992).

The UCLA PTSD Reaction Index-Revised Adolescent Version is a self-report instrument measures the presence and frequency over the past month of all 17 DSM-IV PTSD symptoms. It is rated on a 5 point Likert-type scale ranging from 0 (none of the time) to 4 (most all the time). The RI-R is a revised version of the DSM III-R UCLA Reaction Index (Frederick, Pynoos, & Nader, 1992) and worded for the adolescent age group. It is appropriate for youth aged twelve and older, and may be administered either to individuals or in a group setting. Twenty of the 22 items assess core PTSD symptoms; two additional questions assess associated features including fear of recurrence and trauma-related guilt. An evaluation of the psychometrics of the DSM III-R version reported excellent test-retest reliability. Kutlc and colleagues (2000) reported a Chronbach’s alpha of .92 and evidence of good convergent validity. Additionally, a cutoff score of 30 has been identified as having good sensitivity and specificity in detecting cases of moderate PTSD and a score of 40 to detect cases of severe to very severe PTSD (Pynoos et al., 1993). For purposes of analysis, a cutoff score of 30 was used.

Mother Self-Reports

The mothers completed several measures in their preferred language. The Self-Assessment of Exposure to Community Violence, Parent Version, (SAVE-P) (Aisenberg, 1998), is a 54-item questionnaire that measures the mother’s lifetime exposure to violent events (yes/no) and at various intervals of time, (e.g. within 6 months, within the past year, over one year ago). Also, it asks the respondent to specify the different settings of the occurrence, and her relationship to the perpetrator or victim. In addition, it ascertains if the child was a witness to the violent event. Rather than tally the number of times mothers were exposed to each violent event and use this total frequency, items were summed for a total score of violence exposure with exposure to 3 or more discrete violent events constituting a high level of exposure.

The SAVE-P was used in an earlier study in which it was cross-translated into Spanish to ensure clarity and enhance comprehension and reliability. Face validity was established (Aisenberg, 2001). In the present study, Cronbach’s alpha for the victimization scale is .67 and for the witnessing scale is .57.

The mothers also completed the self-report depression subscale of the Brief Symptom Inventory (BSI) (Derogatis & Melisaratos, 1983). It contains 6 items with a severity scale of 0 to 4 indicating the
degree to which the participant was disturbed by each item during the preceding month. A higher score indicates greater psychiatric symptomatology (Canetti, Bachar, Galili-Weisstub, Kaplan De Nour & Shalev, 1997). A T-score of 63 is considered the clinical cut-off point (Derogatis, 2000). The internal consistency reliability coefficient for the Depression subscale is .85 and test-rest reliabilities are .84.

The mothers also completed the Posttraumatic Diagnostic Scale (PDS) (Foa, 1997). This instrument measures adult PTSD and is the only self-report measure to assess all six criteria for PTSD according to the DSM-IV. It yields both a dichotomous PTSD diagnostic score and a continuous symptom severity score (Weathers & Keane, 1999). Test-retest reliability for symptom severity is .83 over a two-week interval. A Cronbach alpha of .92 has been calculated on the items comprising the Symptom Severity Score, indicating that the Symptom Severity Score is internally consistent. The PDS’ sensitivity has been reported to be 82% and its specificity to be 76.7% (Foa, 1995).

Maternal Reports on Child

The mothers assessed their child’s exposure to community violence by completing the Parent Assessment of Child Exposure (PACE) (Aisenberg, 1998). PACE is a 60-item survey that asks the parent to indicate to the best of their knowledge their child’s lifetime experience of community violence events (yes/no) within various time intervals. This questionnaire was developed for the purposes of this study, cross-translated into Spanish, and pilot-tested prior to its use in this study. Cronbach’s alpha for the victimization scale is .67 and for the witnessing scale is .42.

Teacher Reports on Child

The child’s English teacher completed the Conners’ Teacher Rating Scale-Revised (CPRS-R) (Conners, 1997) based on their observations of the designated students classroom performance and behavior. The CPRS-R is a 59-item measure that focuses on disruptive child behaviors. It has internal reliability ranging from .75 to .92 with an overall correct classification rate of 93.4% (Conners et al., 1998). Important subscales include Oppositional, ADHD, PTSD, Hyperactive, and Global Index Total. T-scores of at least 65 signify clinical caseness. For purposes of this study, the Global Index T-score was used to indicate child behavior problems.

Analysis

Univariante t tests without correction for multiple comparisons and bivariate correlations were used to examine the sociodemographic characteristics of the subjects. Regression analyses were conducted to test the study’s hypothesis. Baron and Kenny’s (1986) recommendations were followed to determine and verify the presence of a mediational relationship between mother’s depression (the mediator) and child’s behavior problem (the outcome variable).

Results

Table 1 summarizes the descriptive data of the forty-seven pairs of middle school students and their mothers who completed the assessment battery. The youngsters range from 11 to 14 years of age (M = 12.32; SD = .84). Girls constituted the majority of child subjects (53.2%). Over seventy percent of the child subjects were born in the United States while all the mothers were foreign-born. The mothers ranged in age from 29 to 54 years (M=37.28; SD = 4.87). All spoke Spanish, with 85.1% speaking only Spanish. Eighty-three percent of the mothers were born in Mexico. It is noteworthy that while 8 mothers (17%) were born in Central America, only 1 child was born in a Central American country. The differences in nativity of child and mother highlight the extensive movement and immigration that occurred within this sample.
The vast majority of mothers had attained less than a high school education. Eighty-three percent had fewer than 11 years of formal education (M = 7.47 years; SD = 3.13). Although over 52% of the mothers were employed and 86.1% of the fathers were employed at least on a part-time basis, 31.9% of the families had monthly incomes of one thousand dollars or less. Overall, 78.7% of the families earned less than $18,000 per year. These figures are more alarming since 27.7% of the households had extended family members living with them who likely contributed to the total family income.

Child Violence Exposure—Self-Report

Child lifetime exposure to discrete violent events as reported by the sample dyads is substantial as revealed by Table 2.

Thirty-eight children reported lifetime exposure to community violence (80.9%). The students’ mean total exposure was 4.30 (SD = 3.80). Sixty-eight percent of the boys and 52% of the girls reported high levels of exposure. Nine students had no lifetime exposure to violence (19.1%). Overall, 38% of the youngsters had low exposure.

Child Violence Exposure—Maternal Report

Table 2 also depicts the prevalence rates of child lifetime exposure to violence as reported by their mother. The most commonly reported event by the mothers was their child seeing someone get beaten (29.8%). This contrasts with over half of the students indicating they were witnesses to a beating (55.3%). Maternal reports on child lifetime exposure differ substantially from the child self-report. Whereas 70% of the mothers reported their child’s exposure to be low, 62% of the students reported high levels of exposure. Nearly 43% of the mothers indicated that their child lacked exposure to community violence compared to only 19.1% of students who expressed that they had never been exposed to community violence.

Mother Exposure to Violence—Self-Report

Maternal exposure to community violence is highlighted in Table 3. Nearly sixty-two percent of the mothers had low levels of exposure to community violence (61.7%) with 15 mothers (31.9%) having no lifetime exposure to violence. The vast majority of the mothers’ exposure to community violence occurred over one year from the time of participating in the study. Only 17% of the women reported victimization within the past year (N = 8). Nearly all of the mother’s exposure to violence was outside the presence of their child, except for the act of beating. Three mothers (6.4%) reported that their child had co-witnessed this violent event.
Child Self-Reported Symptomatology

Reynolds Adolescent Depression Scale

Using this instrument, young adolescents reported a mean total score of 62.98 (SD = 13.86). Ten students (21.3%) scored at or above the cut-off score of 77, thus meeting the criteria for depression. While girls scored higher than boys on the depression measure, this was not statistically significant (t = -1.447; p = .156). Girls’ mean score was 64.75 (SD = 14.82) compared to the boys’ mean score of 58.47 (SD = 13.20). Twenty eight percent of the girls scored in the depression range compared to only 6.4% of the boys.

UCLA PTSD Reaction Index-Revised

The average score of Latino children was 16.37 (SD = 15.99). Seventeen percent of the young adolescents met the criteria for PTSD. This percentage reflects an elevated level of PTSD compared to epidemiological findings of less than 10% in the general adolescent population.

Child Symptomatology—Teacher Report

Conners Teacher Rating Scale-Revised (Conners, 1997)

In completing this measure teachers reported student mean T-scores for the following subscales: Oppositional—51.30 (SD = 10.94); Hyperactivity—52.02 (SD = 11.10); ADHD—50.80 (SD = 9.76); PTSD—51.57 (SD = 11.96); and Global Index Total—53.38 (SD = 11.36). Nearly 15 percent of the students scored at or above the cutoff score of 65 for Oppositional (14.9%), 10.6% scored in the clinical range for ADHD, 19.1% met the cutoff score for Hyperactivity, 12.8% met the criteria for PTSD, and 19.1% scored above the cutoff for Global Index Total, reflective of general problematic behavior.

The mean total score for the girls (53.86; SD = 10.42; range 44-82) was slightly higher than for the boys (51.88; SD = 10.42; range 43-82). However, no statistically significant differences due to gender were found in any of the scores.

Mother Self-Report Symptomatology

Brief Symptom Inventory—Depression subscale

The BSI has established community norms for females with T-scores at or above 63 determining clinical caseness. The mothers’ mean T-score for depression was 48.85 (SD = 8.42). Seventeen percent of the mothers reported elevated depressive symptoms above the cut-off score, a rate higher than the general population rate.

Posttraumatic Diagnostic Scale (PDS)

Research has determined a cut-off score of 21 with the PDS to indicate moderate to severe PTSD (Foa, 1995). In the present study, the mean total symptom severity score of Latina mothers is 14.13 (SD = 10.43) with 8 mothers (17%) meeting criteria for PTSD.

Testing of Hypothesis

Regression analyses were conducted to test each of the four study hypotheses. The analysis affirms that the first hypothesis—children exposed to community violence based on self-report will manifest elevated depression scores and total behavioral problem scores—was true. Child self-reported total exposure scores predict child depression, $B = .431$; R square = .186; $p < .001$. Thus, violence exposure
accounts for nearly 19% of the variance in child depression scores. However, child self-reported exposure scores failed to predict total behavior problems, $B = .009; p = .957$.

The second hypothesis was also supported. Mother’s self-reported total exposure scores predict their depression scores, $B = .529; R^2 = .280; p < .001$. Thus, maternal exposure to violence explains 28% of the variance in their depression scores.

The third hypothesis—maternal self-reported exposure to community violence has a direct effect on child behavior problems as reported by the child’s teacher—was not supported. Regression analysis revealed findings approaching significance, $B = .28; R^2 = .08; p = .08$. Also, maternal exposure to violence did not have a significant direct effect on child-reported depression scores, $B = -.052$, $R^2 = .003$, $p = .74$.

Mediating Effects

Following the recommendations of Baron and Kenny (1986), equations were computed to determine if the fourth hypothesis—maternal depression is a mediator of child total behavior problems—was true. Table 4 shows the results. Controlling for child’s total violence exposure, maternal depression was regressed on maternal total violence exposure scores ($R^2$ change = .353; $p = < .01$) in equation one. In equation two, child’s Global Index Total T-scores were regressed on maternal total exposure scores ($R^2$ change = .162; $p < .02$). In equation three, the Global Index T-scores were regressed on both maternal total violence exposure and maternal depression scores. The outcomes reveal that maternal depression was a significant predictor of child total behavior problem scores ($R^2$ change = .296; $B = .47; p < .02$). The previously significant relation between mothers’ exposure and problem scores was no longer significant ($p = .47$). In addition, the standardized coefficient for maternal exposure in equation three (.134) was substantially less than in equation two (.402).

Thus, each of the criteria outlined by Baron and Kenney (1986) for a mediating relationship was met. Whereas exposure to community violence continues to have an effect on child behavior problems, it has less a direct effect than previously established ($B = .134; p = .47$).

Discussion

A strength of this study is that mothers, children, and the English teachers of the children completed paper and pen measures on a variety of domains. Research affirms the use of multiple informants to provide more reliable data (Holmbeck, Li, Schurman, Friedman, & Coakley, 2002). The study’s findings reveal that Latino mothers and children experience substantial exposure to the stressful life event of community violence. Whereas research to date has focused almost exclusively on the direct effects of community violence on children and adolescents, the study documents that community violence has negative direct effects on the adult as well.

Consistent with the literature on non-Latino populations, the study confirmed that childhood exposure to community violence contributes to depression. Also, it found that maternal exposure is a significant predictor of her own depression. This finding of a positive relationship between maternal violence exposure and her depression underscores the importance to assess the caregiver’s exposure to community violence (Aisenberg & Mennen, 2000).

The study’s findings emphasize that exposure to community violence also has indirect effects that contribute to negative children outcomes. Community violence exposure exerts at least some of its influence on children’s behavior problems through its effect on the mother. This finding of the pathway of influence of maternal depression upon child’s behavior problems is significant. It highlights that the
greater or more severe a mother’s depression the more likely a child exhibits increased behavioral and emotional problems. Based on the reports of multiple informants, the finding of the hypothesized mediating relationship of maternal depression provides empirical support that maternal depression may be more important than exposure to community violence in contributing to children’s heightened distress and behavior problems.

This study does not assume or posit that community violence is a causal factor of maternal depression, exclusive of other factors. Co-existing risk factors and unexamined antecedent factors may also contribute to the symptomatology. This is especially salient in view of the fact that all mothers were immigrants to the United States. Future studies are warranted to investigate these factors and their impact as well as to attempt to disentangle the co-morbidity.

Limitations

Four principal limitations should be considered when interpreting the data. First, the findings are not generalizable to other populations. The sample consisted of low-income Latino families living in a violent neighborhood. The lack of acculturation among the mothers was mostly uniform as indicated by the overwhelming preference to complete the study’s measures in Spanish. Families from divergent SES backgrounds and acculturation levels as well as from less violent neighborhoods should be included in future research to explore similarities and differentials in exposure and symptomatology.

Second, the limits of the sample’s size may qualify findings from the mediational analysis. Future studies using broader demographic samples and a larger number of families are necessary to rule out possible spurious relationships and to specify the potential impact of exposure to community violence on child developmental outcomes.

Third, the intervening time between student self-report and maternal and teacher reports may have introduced history effects and led to biases in reporting. However, while the time gap may have contributed to the mothers’ experiencing more violence, most of the exposure reported by the mothers occurred more than a year ago.

Fourth, the instruments developed for this study to assess violence exposure share the limitations of most self-report questionnaires designed to assess exposure to community violence, namely, they are additive in nature. Merely tallying or adding up the violent events fails to provide a good measure. Also, it is doubtful that the violent events are comparable due to their heterogeneous nature and differences in the subjects’ perception of the severity of the violent events as well as their impact (Horn & Trickett, 1998). Obtaining qualitative information regarding the subjects’ perceptions of what they consider to be the most distressing or upsetting event to them would provide important contextual understanding and improve the measurement of violence exposure.

Implications for Application and Public Policy

This study provides information crucial for the appropriate assessment and treatment of the underserved Latino population. The study signals that further research on the dynamics of the processes engaged in by parents and their children coping with chronic community violence is warranted, especially with Latinos and other ethnic groups that espouse a spirit of collectivism and familialism. Further specification of the interdependent processes through which family factors relate and interact with exposure to community violence to affect potential outcomes for children is clearly needed (Gorman-Smith & Tolan, 1998).

An important issue that warrants further investigation is the interaction of risk factors with parenting. Risk factors may accentuate or amplify the impact of depressive symptoms resulting in more dysfunctional patterns of caregiving, ineffective communication, and poorer child outcomes than might be
observed in the presence of depressive symptoms alone (Rutter, 1990). Likewise, future investigation of the specific processes and circumstances which serve as protective factors for families that enable and strengthen effective parenting under conditions of high threat, stress, and neighborhood violence is necessary, especially for families of color that are disproportionately reside in low-income, high crime communities (Jenkins and Bell, 1997).

The study’s finding supporting the hypothesized mediating relationship of maternal depression calls for a fundamental shift from focusing primarily on the resiliency of the individual child to the resiliency of the family (Walsh, 1996). Violence prevention programs and mental health interventions predominantly focus on the individual child. Practitioners and mental health professionals rarely obtain information on the parent’s exposure to neighborhood violence and their distress symptomatology. As a result, parents are not routinely included in the delivery of mental health services for this at-risk population.

The study’s results alert us to the crucial need to include parents in the treatment process as many parents, especially those who are depressed or distressed, fail to seek or receive appropriate treatment. For example, among Mexican Americans with mood or anxiety disorders, less than a third receive any treatment in the general medical or mental health sector (Vega et al., 1998). To listen to and address the needs of Latina mothers who have been victims of violence exposure and often times oppressed is essential. Ignoring the mother can send the wrong message—that the mother is part of the problem instead of a powerful resource that may be able to promote the resiliency of her child. Also, it ignores that the coping and functioning of parent and child are interwoven and interdependent and thus exert a profound influence upon each other. The parents' distress and coping response directly influence the coping response of the child and is a significant and crucial mediator of the child's distress (Pynoos et al., 1995). The study’s finding of an indirect effect of maternal depression upon child behavioral problems suggests that intervening directly with the parent will result in improved psychological, emotional, and behavioral outcomes for the child.

To adequately address the needs of the child exposed to the cumulative effect of community violence policy advocates, researchers and practitioners must address the parent who likewise suffers the traumatic effects of exposure to community violence. Studies of traumatized or high-risk youth reveal that intervening with the parent or conjointly with parent and child may be more effective and produce better child outcomes (Celano, Hazzard, Webb & McCall, 1996; Henggeler, 1997). These studies indicate that when parents and families are viewed and empowered as the primary change agents in the life of their child favorable therapeutic outcomes can be attained (Henggeler, 1997).

This study provides empirical support for focusing on the mother’s strengths and empowering her so that she can parent well will likely produce better child outcomes. Indeed, the more effectively the parent copes with community violence, the less overwhelmed and more resilient the child will be. Thus, intervention must target and include the parent and address the system of relationships within the family as well as community organizations and institutions.

<table>
<thead>
<tr>
<th>Table 1. Demographic Descriptives of Children and their Mothers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CHILDREN</strong></td>
</tr>
<tr>
<td>Name of Variable</td>
</tr>
<tr>
<td>Gender of Child</td>
</tr>
<tr>
<td>Male</td>
</tr>
<tr>
<td>Female</td>
</tr>
<tr>
<td></td>
</tr>
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<td></td>
</tr>
</tbody>
</table>
### Age of Child in Years

<table>
<thead>
<tr>
<th>Age of Child in Years</th>
<th>Nativity of Mother</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>Mexico</td>
</tr>
<tr>
<td>12</td>
<td>El Salvador</td>
</tr>
<tr>
<td>13</td>
<td>Guatemala</td>
</tr>
<tr>
<td>14</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>United States</th>
<th>Mexico</th>
<th>El Salvador</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>8</td>
<td>19</td>
<td>17</td>
</tr>
<tr>
<td>Nativity of Child</td>
<td>17.0%</td>
<td>40.4%</td>
<td>36.2%</td>
</tr>
</tbody>
</table>

### Nativity of Child

<table>
<thead>
<tr>
<th>Nativity of Child</th>
<th>United States</th>
<th>Mexico</th>
<th>El Salvador</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>33</td>
<td>13</td>
<td>1</td>
</tr>
<tr>
<td>Nativity of Child</td>
<td>70.2%</td>
<td>27.7%</td>
<td>2.1%</td>
</tr>
</tbody>
</table>

### Mother’s Education

<table>
<thead>
<tr>
<th>Mother’s Education</th>
<th>United States</th>
<th>Mexico</th>
<th>El Salvador</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than High School</td>
<td>33</td>
<td>13</td>
<td>1</td>
</tr>
<tr>
<td>Some High School</td>
<td>7</td>
<td>13</td>
<td>1</td>
</tr>
<tr>
<td>Graduated High School</td>
<td>7</td>
<td>13</td>
<td>1</td>
</tr>
<tr>
<td>Some College</td>
<td>7</td>
<td>13</td>
<td>1</td>
</tr>
</tbody>
</table>

### Marital Status

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>United States</th>
<th>Mexico</th>
<th>El Salvador</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td>37</td>
<td>13</td>
<td>1</td>
</tr>
<tr>
<td>Single</td>
<td>5</td>
<td>13</td>
<td>1</td>
</tr>
<tr>
<td>Living Together</td>
<td>2</td>
<td>13</td>
<td>1</td>
</tr>
<tr>
<td>Separated</td>
<td>2</td>
<td>13</td>
<td>1</td>
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</table>

### TABLE 2. Child Lifetime Exposure to Discrete Violent Events as Victim and as Witness

<table>
<thead>
<tr>
<th>Type of Violence</th>
<th>Child Self-Report % Rates</th>
<th>Mother’s Report on Child Exposure % Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Victim</td>
<td>Witness</td>
</tr>
</tbody>
</table>

13
TABLE 3. Maternal Lifetime Exposure to Discrete Violent Events

<table>
<thead>
<tr>
<th>Violent Event</th>
<th>Victim</th>
<th>Witness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beaten</td>
<td>19.1%</td>
<td>29.8%</td>
</tr>
<tr>
<td>Sexually abused as child</td>
<td>23.4%</td>
<td>19.1%</td>
</tr>
<tr>
<td>Sexually abused as adult</td>
<td>17.0%</td>
<td>14.9%</td>
</tr>
<tr>
<td>Robbed</td>
<td>21.3%</td>
<td>6.4%</td>
</tr>
</tbody>
</table>

Prevalence Rates
Threatened with weapon                          14.9%
At home during burglary        8.5%
Choked           4.3%
Domestic violence       4.3%
Attacked with knife               4.3%

Seen someone get beaten        29.8%
Seen someone shot at          14.9%
Seen dead body                17.0%
Seen someone choked            2.1%
Seen forced entry in house    8.5%
Seen family member hurt      4.3%
Seen someone hurt at home     4.3%
Heard gunshots near home      70.2%

Lifetime Victimization        47.6%
Lifetime Witnessing           45.2%

**TABLE 4. Standardized Regression Coefficients for Measures of Mediator Effects on Child Behavior Problems**

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Standardized Betas</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Equation One:</strong></td>
<td></td>
</tr>
<tr>
<td>Maternal Depression</td>
<td>.53**</td>
</tr>
<tr>
<td>R squared change = .35</td>
<td></td>
</tr>
<tr>
<td>F change = 17.265**</td>
<td></td>
</tr>
<tr>
<td><strong>Equation Two:</strong></td>
<td></td>
</tr>
<tr>
<td>Maternal Total Exposure to Community Violence</td>
<td>.40*</td>
</tr>
<tr>
<td>R squared change = .16</td>
<td></td>
</tr>
<tr>
<td>F change 6.366*</td>
<td></td>
</tr>
<tr>
<td><strong>Equation Three:</strong></td>
<td></td>
</tr>
<tr>
<td>Maternal Depression</td>
<td>.47**</td>
</tr>
<tr>
<td>Maternal Total Exposure to Community Violence</td>
<td>.13</td>
</tr>
</tbody>
</table>

*p < .05   **p < .001

**REFERENCES**


City of Pasadena (2001). www.ci.pasadena.ca.us


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