NFS

Navy Family Study

Families Helping Families

The Navy's Future: Issues Related to Children Living in Families Reported to the Family Advocacy Program

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Navy Family Study

The Navy Family Study (NFS) was comprised of two parts. The major effort was a longitudinal, prospective study of a sample of 530 Navy families referred to the Navy's Family Advocacy Program (FAP) for at least one of three types of family violence, parent-child sexual abuse (CSA), parent-child physical abuse (CPA), or spousal/partner violence (PV). This sample will be referred to as the "FAP sample" throughout this report. The FAP sample families were assessed soon after the report of family violence to FAP and were evaluated at an additional three follow-up assessment points. In the second part of the study, a comparison sample of 127 Navy families who had no history of being reported to FAP and who were matched on several important demographic variables to the FAP sample were recruited into the study and assessed on one occasion. This sample is referred to as the "Comparison sample." This report describes information obtained from the 195 children ages 7 to 17 living in the FAP sample families and interviewed at the time of the report to FAP, and the 60 children age 7-17 living in the comparison sample families.

A previous report titled ***Victimization, Mental Health, Delinquency, and Substance Use Among Children Living in Families Referred to the Family Advocacy Program*** **(15 Nov 2002)** described the goals, research methods, and much of the descriptive information from the initial assessment of the children in the FAP sample. It presented a profile of FAP child clients concerning their histories of victimization, mental health problems, involvement in delinquency, and substance use. That report made several clinical and program recommendations based upon this descriptive data. This report will describe further information obtained from these children at the initial evaluation point and at the three follow-up assessment points. Also, descriptive information from the single assessment of the comparison sample children will be presented.

The report is organized around sections that describe specific topic areas of interest. Each of these sections presents a specific question that is of clinical or programmatic interest, the issues surrounding that question, relevant results from the NFS about the topic, conclusions regarding the question, and clinical and program implications of the findings for the FAP program.

NFS Methods

Participant families for the NFS were recruited from 12 major naval installations in four geographic areas: 1) the Hampton Roads, Virginia area, 2) Jacksonville, Florida and Kings Bay in Georgia, 3) San Diego, California, and 4) the Puget Sound, Washington area. For the FAP sample, newly reported cases of parent-child sexual abuse (CSA), parent-child physical abuse (CPA), and spousal/partner violence (PV) were screened for meeting the inclusion criteria of the study using FAP intake information. Because of the volume of cases at some bases, cases of partner violence

and child physical abuse were randomly sampled, while all cases of parent-child sexual abuse were accepted for further screening. Family members in cases that appeared to meet the study's criteria were contacted by a NFS research assistant and screened to insure they met study inclusion criteria. Family members of eligible families were then offered participation in the study through the informed consent process. Those family members that agreed to participate in the study and signed the appropriate informed consent forms were interviewed by a trained NFS research assistant.

Comparison families were randomly selected from lists of Navy families who were matched to the FAP sample on important variables such as age, gender, years of Naval service, rank, current base, and age and gender of the child.

FAP Sample Participants

Participants eligible for the FAP sample of the NFS were Navy service members, their spouses or cohabitating partners, and their children who: 1) were working in commands associated with one of the participating installations, 2) were referred to FAP for spousal/partner violence (PV), parent-child physical abuse (CPA), or parent-child sexual abuse (CSA), and 3) who met the study's inclusion criteria. NFS inclusion criteria were:

1. A report was made to the FAP located at one of the participating Naval bases about a Navy family for a concern about partner violence, parent-child sexual abuse, or parent-child physical abuse.

2. The adults in the family had been in a cohabitating, romantic relationship for at least six months prior to report.

3. A child (person less than 18 years old) was residing in the home with the adults at the time of the report.

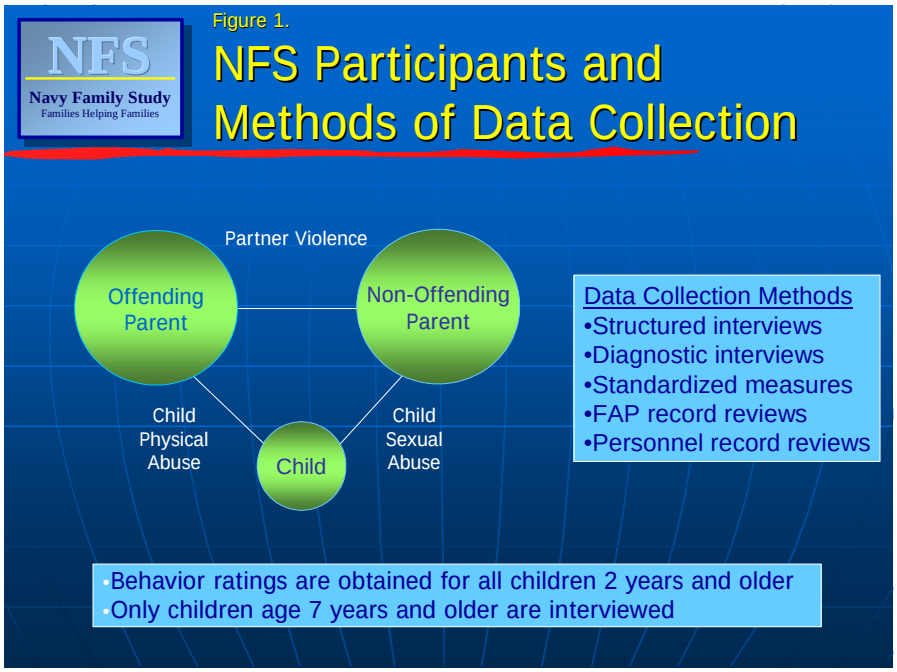
4. Both adults have functioned in a parental relationship to child for the six months prior to the FAP report.

Reports to FAP of alleged family violence did not have to be substantiated for the family to be eligible. Only a referral to FAP for allegations of one of the three types of family violence was necessary for eligibility. Even if the emergent allegation of family violence that precipitated the report to FAP subsequently was found to be unfounded by either civilian or military authorities or a FAP Case Review Committee, the case was maintained in the study.

Data were collected from the alleged Offending Parent (OP), the Nonoffending Parent (NOP) and the Index Child (IC). For CSA and CPA cases, the index child participants in the NFS were the victims of the alleged incidents that caused the report to FAP. In cases of multiple child victims of physical or sexual abuse, the oldest child victim was selected as the index child. In cases of partner violence, the oldest child living in the home was selected as the index child.

Behavioral ratings by parents were obtained for all index child participants age 2 to 17. However, only index children age 7 to 17 were directly interviewed and assessed by NFS staff.

Whenever possible, the NOP, OP, and IC from the family were all interviewed. In some cases, however, some family members could not be located or contacted. In other cases family members may have been unavailable for interview, unwilling to participate in the study, or unwilling for their child to participate. Also, only children age 7 and older were eligible for interview. Therefore, data from all three family members are not available in all cases. Interviewed participants enrolled in the NFS and completing an interview include 1,065 respondents representing 530 families. Of these 195 children ages 7-17 were interviewed at the initial assessment. Figure 1 depicts the participants and data collection methods used.

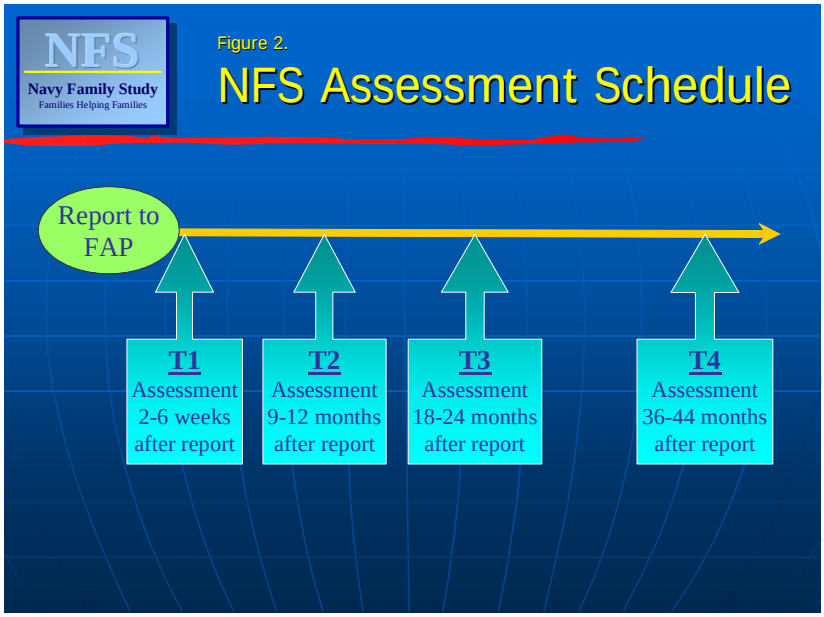


Comparison Sample Participants

Similar methods were used with the comparison sample. Participants were randomly selected from lists of active Naval personnel who matched the FAP sample on several demographic characteristics, and who had no history of involvement with the FAP program. Potential participants were contacted by telephone and screened for eligibility. If eligible, the informed consent process was completed and interviews conducted. Attempts were made to interview both parents and eligible children (i.e., children age 7-17). In all, some family members were interview from 127 comparison families, including 60 children age 7-17. Comparison families were interviewed on only one occasion. The same assessment methods were used with the comparison families as the FAP sample families.

Data Collection Schedule

The FAP sample portion of the NFS was a longitudinal, prospective study of families reported to FAP. Data were collected from the alleged Offending Parent (OP)



(i.e., the parent purported to be the offender in the emergent allegation of family violence), the Non-Offending Parent (NOP), and the Index Child (IC) depending upon who agreed to participate in the study. All participants were assessed 4 times over a 3 to 4 year period. The initial assessment (T1) occurred as soon as is feasible after the initial report to FAP, usually within 4 to 6 weeks. The Time 2 (T2) assessment was conducted 9-12 months after the report to FAP. The Time 3 (T3) assessment occurred 18-24 months after the report, and the Time 4 (T4) took place 36-44 months after the report to FAP. Figure 2 depicts the data collection schedule for the FAP sample. The comparison sample was interviewed on only one occasion.

Human Subject Protection

The research protocol used for the Navy Family Study was approved by the Institutional Review Boards of the University of New Hampshire, the Medical University of South Carolina, and Wellesley College. Each of these boards monitored the study for human subject protection.

Informed Consent

Participation in the project was completely voluntary for all potential respondents, including for service members. All participants completed an informed consent procedure and signed an informed consent form approved by the appropriate Institutional Review Board acknowledging their understanding of the study and their voluntary participation in it. Custodial parents or guardians granted permission for children to participate. If a child had been taken into foster care, the relevant custodial guardian agency granted permission for the child to participate. Children whose parent or guardian gave consent for them to participate also went through the informed consent procedure and granted assent to participate in the study.

Confidentiality

An extraordinary level of confidentiality was exercised in this study. The NFS data collection procedure was completely separate from regular FAP activities. Names or identifying information for participants were not revealed to anyone, including FAP staff.

No identifying marks were allowed on paper records of study data. All records were maintained by code number only. All records and data are stored and maintained outside of the states of the participating bases. All data are reported only in aggregate form and are not separated by base or location. All project staff signed a confidentiality oath and were thoroughly trained in the confidentiality procedures used in the project. A Certificate of Confidentiality was obtained from the U.S. Department of Health and Human Services to protect the project data from involuntary disclosure.

The project used a progressive person in danger protocol for assessing, judging, and responding to situations discovered where a participant may have been in imminent danger or a serious threat of harm existed, and confidentiality had to be broken for human protection. This protocol is similar to those used in previous studies and was designed to offer the highest levels of confidentiality while providing appropriate responses to situations of risk or danger. This protocol was disclosed and discussed in the informed consent process.

Information Collected from Child Participants

As noted above, child participants in both the FAP sample and the comparison sample completed structured in-person interviews. For the FAP sample, these interviews were completed at all 4 assessment points. Information collected in these interviews included:

- Demographic characteristics
- History of witnessing community violence
- History of sexual abuse and sexual assault
- History of physical assault
- History of physical abuse by parents
- History of observing parental violence
- History of substance use, including tobacco, alcohol, unprescribed medical drugs, and illicit drugs
- Association with delinquent peers
- History of delinquent acts

Children were also administered diagnostic interviews to assess whether they met DSM-IV criteria for major depressive disorder or posttraumatic stress disorder. Initial interviews determined the child's lifetime history of these problems and disorders. Follow-up interviews assessed their occurrence since the previous interview.

Assessment of victimization history followed currently accepted procedures for this sort of assessment. Children were asked multiple questions within each class of violence. For example, children were asked 7 questions regarding their history of sexual assault, and 5 questions about physical assault. Also, all questions were behaviorally specific and avoid euphemistic or summary terms to describe violence. Past research has shown that assessments using multiple screening questions that are behaviorally specific typically yield more accurate results than single "gate" questions, or questions that are more vague in their descriptions. Many of these victimization questions and the

diagnostic interviews are revisions of the interview used in the National Survey of Adolescents, a victimization survey of a nationally representative sample of 4023 adolescents living in households in the U.S. (Kilpatrick, Saunders, & Smith, 2003). Therefore, at least some of the results of the NFS can be compared to results obtained from this national sample.

Children also completed a battery of standardized assessment measures. Children in the FAP sample completed these instruments at every assessment point. The standardized measures included:

- Children's Depression Inventory
- Revised Children's Manifest Anxiety Scale
- Trauma Symptom Checklist for Children
- Children's Attribution and Perception Scale--Self Report
- Children's Attributional Style Questionnaire
- Parent Perception Inventory (completed for each parent)
- Harter Perceived Social Support Scale

Each of these measures is a well-accepted scientific measure with levels of reliability and validity. Each is commonly used in behavioral science research.

Results for FAP Sample Child Participants

The FAP sample participant families contained 530 children. Of these, 245 (46%) were younger than age 7 and were not eligible for interview. However, behavioral rating information was obtained from the parents for children age 2 and older in this group. The remaining 285 children were age 7 years and older and were eligible to be interviewed. Of these, 195 (68%) were recruited into the study and interviewed at T1. An additional 6 (2%)were recruited and interviewed at Time 2 for a total eligible recruitment rate of 71%. As reported in Figure 3, 157 children were interviewed at T2, a retention rate of 80.5%; 133 were interviewed at T3, which was 68.2% of the original sample; and 141 were interviewed at T4, for a final retention rate of 72.3%.

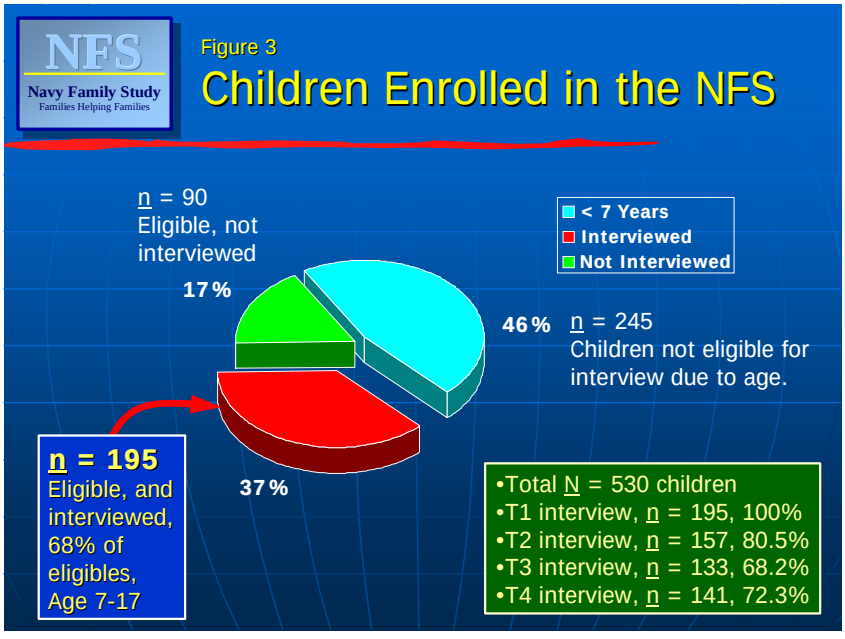


Table 1 presents the demographic characteristics for all 530 children in the NFS families, as well as the subsample of 195 children who completed a T1 interview. As indicated in Table 1, less than half of the children in the total NFS child sample were boys (42.6%), whereas approximately one-third of the 195 interviewed children were boys (37.4%). This discrepancy was due primarily to the large over-representation of girls over age 7 in families reported for sexual abuse.

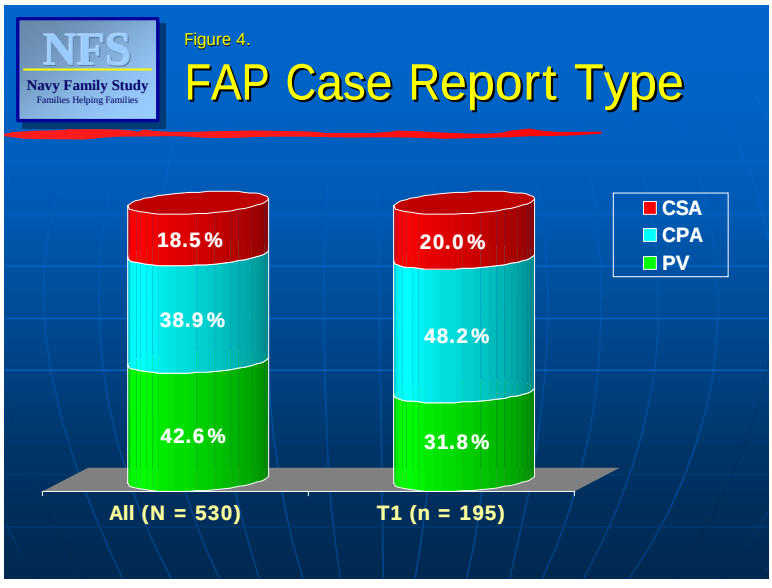
Table 1

Demographic Characteristics of FAP Sample Children

	All (N=530)	T1 (n=195)
Gender		
Male	42.6	37.4
Female	57.4	62.6
Race/Ethnic		
African American	27.2	29.7
White	50.2	51.8
Hispanic/Latino	4.7	2.6
Asian	7.0	5.6
Other/Unknown	10.8	10.2
Age (M (sd))	7.8 (5.4)	12.2 (3.1)

The distribution of racial and ethnic groups between the total sample and the interviewed subsample were roughly comparable. Approximately half of the sample was identified as Caucasian, and nearly 30% were African American. However, there were considerably fewer Hispanic/Latino children in the interviewed group because Hispanic/Latino children tended to be younger. The median age of the full sample was 7, meaning that one-half of the full sample was age 7 or younger. Because of the age requirement for interview, the average age of the interviewed subsample was substantially greater than the full sample. Of the interviewed sample, the median age was 12, meaning that approximately half of the interviewed children were age 7 to 12 and half were teenagers.

Figure 4 presents the breakdown of the type of case report that brought the families into contact with FAP. For the full 530 children, about 2 in 5 were living in families reported to FAP for child physical abuse. An additional 2 in 5 were in homes referred for partner violence, and 1 in 5 lived in families where sexual abuse was reported. Of the 195 children interviewed, a little less than half lived in families reported to FAP for child physical abuse. About one-third were in families referred for partner violence, and less than one-quarter were in families where child sexual abuse was alleged. It should be noted that these percentages do not reflect the actual breakdown of all FAP cases because of the sampling scheme used in selecting physical abuse and partner violence cases. Because of the very large volume of partner violence cases and the substantial number of child



physical abuse cases, families referred to FAP for these types of violence were sampled. However, all cases of child sexual abuse were eligible for the study. Therefore, because of sampling, the breakdown of case types in the NFS is not representative of all the referrals to the FAP program. However, it is reasonably representative within the referral type.

Navy Children: The Navy's Future

A reasonable question to ask is, why should the Navy be concerned with the children of Navy service members? After all, while the Navy is a unique employer, it is still an employer. And few employers offer significant social and health programs for children of their employees. Therefore, why should the Navy have programs designed for the children of its employees? This question has many answers, including the roles family stress and problems with children in the critical issue of job performance and force readiness for Navy service members. However, recent research, as well as some new data from the Navy Family Study, emphasize a new reason for being concerned about Navy children. Many of these children are our future Navy.

In a well-known study, Stander and Merrill (2000) conducted a survey of over 11,000 new Navy recruits beginning training at the Recruit Training Command in Great Lakes, IL. In this study they found that over one-half of these new Navy recruits came from military families, and that 25% of those came from Navy families. Therefore, results of this study suggest that a very large proportion of new recruits come from military families.

In the Navy Family Study, the FAP sample children were asked at the final assessment point if they were considering joining the military. The average age of the sample at this point was 15.5 years, a prime time for this decision-making process. Furthermore, this assessment period took place after the 9/11 attacks and after the Afghanistan war had started. And, approximately one-half of the T4 interviews took place prior to the Iraq invasion, and one-half after. Therefore, this assessment took place during a time of national emergency, great military activation, and war – in other words, a time when the dangerous reality of military service were clearly understood. In the FAP sample, 18.5% of these children said that they definitely planned to join the military, and about a third of these said they definitely planned on making the military their career. Another 35% said they were seriously considering joining the military, but were not sure at this point. Therefore, over half of the children and adolescents in this sample of FAP-referred families were at least considering a military career, and about 1 in 5 indicated they definitely planned to join the military.

Similar results were found with the 60 children in the comparison sample. In this sample, 15% of the children and adolescents indicated that they definitely planned on joining the military, and about a third of those stated that they definitely planned on making the military their career. Another 36.7% stated that they were considering joining the military, but were not sure at this point. Therefore, like the FAP sample, nearly one-half (46.7%) of the comparison sample children were at least considering a military career. These children also were asked, if they were to join the military, which branch would they join? Almost one-half (45%) indicated they would join the Navy.

The results reported by Stander and Merrill and these new data from the NFS indicate that a substantial proportion of children in current Navy families are considering joining the military, and that over one-half of current recruits come from military families. Therefore, children from military families, particularly Navy families, will form a very large

proportion of tomorrow's Navy, perhaps up to one-half of future recruits. Therefore, the Navy is, in effect, growing its own new recruits of the future in its current Navy families. Therefore, providing support programs for children in today's Navy families will not only help today's sailors by reducing familial stress, it will help tomorrow's sailors as well. The more the Navy can help provide a safe, functional, supportive, and healthy home life for children in today's Navy families, the more functional and prepared a large proportion of tomorrow's recruits will be. Consequently, programs that help today's Navy's children will have both immediate and long term benefits to the Navy.

Conclusions

- **Over one-half of Navy recruits come from military families.**
- **Approximately 1 in 5 Navy children and adolescents report that they definitely plan to join the military, and one-third of these indicate they plan to make the military their career.**
- **Approximately one-half of Navy children and adolescents indicate that they are at least considering joining the military.**
- **Approximately one-half of Navy children and adolescents state that if they join the military, they will join the Navy.**

Implications

- **The Navy is literally "growing its own" future recruits in its current Navy families**
- **Programs designed to provide effective help and support to Navy children today will result in more functional a better prepared recruits in the future.**

Functioning of Children With Complex Victimization Histories

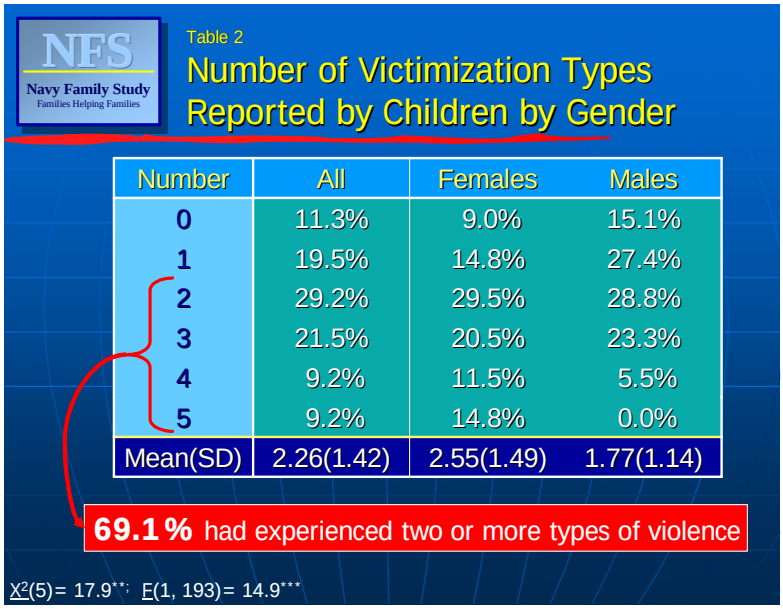
There now is a considerable research literature concerning many different aspects of children exposed to violence. The prevalence and incidence of many types of violence in childhood is now well known, and few question that violence is a problem for a many if not most children (Boney-McCoy & Finkelhor, 1995; Kilpatrick et al., 2003). It is also clear that victimization experiences have serious consequences for those exposed to them (Beitchman et al., 1992; Kolko, 2002; Polusny & Follette, 1995). Within this body of large research, various forms of childhood victimization have been linked, at least statistically, to a multitude of negative outcomes. It seems that experiencing violence in childhood is a significant risk factor for a great variety of human problems that occur in childhood, adolescence and in adulthood. In fact, a comprehensive list of all the psychological, psychiatric, social, behavioral, and medical problems found to be associated with a history of childhood exposure to violence would be difficult to construct at this point.

However, most research has focused on sexual abuse, and most studies have focused on only one form of victimization. Relatively few have examined the prevalence and impact of multiple forms of victimization (Saunders, 2003). Similarly, most studies assess only one outcome for victimized children, and few have examined comorbidity of disorders and problems.

One strength of the NFS is that it assessed several different types of violence exposure, including personal physical and sexual assaults and witnessing violence in the home and the community. Also, it evaluated several outcomes including two diagnostic disorders, depression and posttraumatic stress disorder. Preliminary information regarding multiple or complex victimization histories and comorbid outcomes was described in the first report (Saunders et al., 2002). However, several further questions will be explored here. Specific questions to be answered are:

1. What is the prevalence of complex victimization history among FAP referred children?
2. Are certain groups more likely to have complex histories than others?
3. What is the prevalence of complex outcome presentations?
4. Are complex victimization histories related to more adverse outcomes?

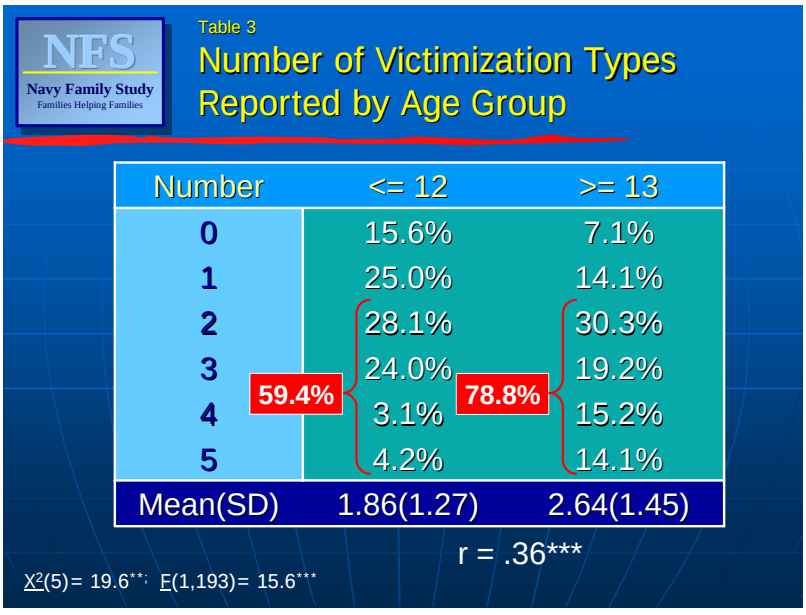
Table 2 reports the prevalence of a history of multiple victimization types among the 195 children in the FAP sample, and compares that prevalence between boys and girls. Children may have reported up to five different types of violence, sexual assault, physical assault in the community, physical abuse by a parent, witnessing community violence, and witnessing partner violence in the home. As noted in the previous report, only 11.3% of children in the FAP sample reported no exposure to any of these five types of violence. However, 7 out of 10 of the children had been exposed to at least two forms of violence, and nearly 1 out of 5 had experienced 4 or 5 different forms of violence. On average, the children had experienced 2.26 different forms of violence. This high prevalence of complex victimization history is particularly important given that



the average age of the children was 12 years. For children in FAP referred families, having a history of multiple types of violence appears to be the most common presentation. Single types of victimization or no self-reported history of victimization was true for less than a third of the sample. Therefore, it is clear that clinical approaches and programs must account for the fact that for most children referred to FAP, the nature of the emergent report does not characterize their full history.

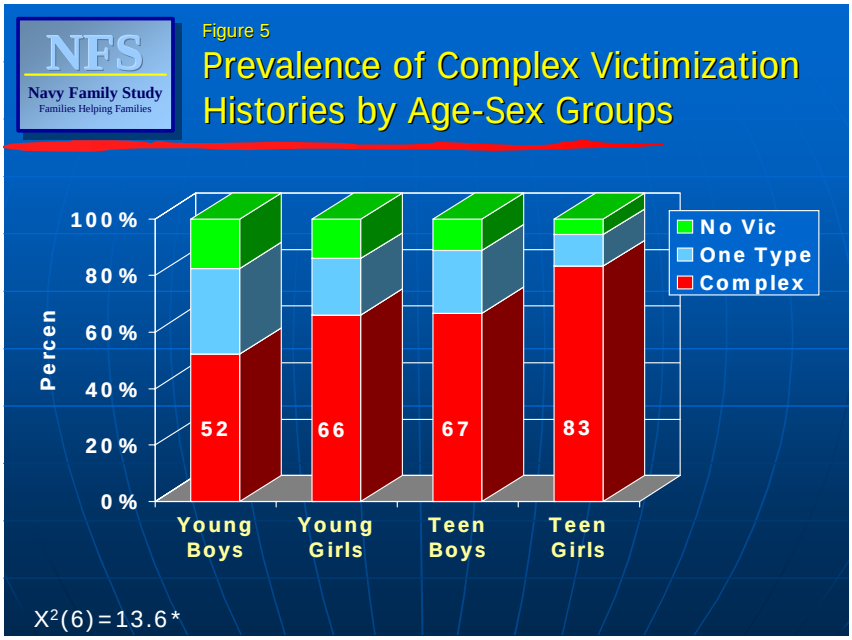
As presented in Table 2, girls were more likely than boys to have a complex victimization history (76.2% vs. 57.5%). On average girls experienced 2.55 types of violence vs. 1.77 for boys. One in 4 girls vs. only 1 in 20 boys had experienced 4 or 5 different violence types. Therefore, girls in families reported to FAP are clearly more at risk for experiencing multiple types of violence compared to boys. However, the most common presentation for both boys and girls was a complex victimization history.

Table 3 reports the prevalence of complex victimization history for older (age 13-17) and younger (age 7-12) FAP children. Not unexpectedly, older children were more likely to have a complex victimization history (78.8% vs. 59.4%) than younger children. This was expected since they have lived longer and have more years to be exposed to violence. On average older children had experienced 2.64 different forms of violence compared to 1.86 for younger children. It must be noted, however, that complex victimization histories were the most common presentations, even among younger children reported to FAP.



No differences were found between racial/ethnic groups on the number of victimizations experienced. Racial or ethnic minority child participants were no more likely to have a complex victimization history than white participants.

Figure 5 breaks down the victimization histories of the full FAP sample by age and gender groups. Young boys and girls are those age 7-12 and teen boys and girls are those 13-17. The red (bottom) part of the bar represents the proportion of that age-gender group that reported a complex victimization history. The blue (middle) part of the bar is the proportion of children in that age-gender group describing a history of a single type of victimization, and the green (top) portion is the proportion of children who did not report any history of the five types of victimization measured. For all age and gender groups, multiple victimization is the most prevalent presentation. Children who come into FAP with either no self-reported history of victimization, or who have been victims of only a single type of victimization are the exception not the rule. Most have complex victimization histories. Girls are at special risk, with two-thirds of younger girls and 8 out of 10 teenage girls reporting a complex victimization history. This is primarily due to the relative high prevalence of sexual assault among girls compared to boys. The first NFS child report took note of the fact that teenage girls living in families referred to FAP are a special population that may require special programs and tailored clinical approaches. These results clearly support that suggestion.



The results presented above indicate that a complex or multiple victimization history is not only common, but the modal presentation for children living in families reported to FAP. Nearly 7 out of 10 of these children have been victimized in more than one way with girls, particularly teenager girls being a significantly higher risk for complex victimization histories. These findings raise a similar question about outcomes. What proportion children in FAP-reported families exhibit any significant mental health or behavioral outcomes, and how many have comorbid outcomes?

The NFS measure five major mental health and behavioral outcomes. These include meeting full diagnostic criteria for either major depression or PTSD, past year problem alcohol use, non-experimental drug use, and past year delinquent behavior. Past year problem alcohol use was defined as drinking alcohol at least once per month. Non-experimental drug use was defined as using an illegal drug (e.g., marijuana, cocaine, ecstacy) or a medical drug without a doctor's prescription (e.g., barbiturates, amphetamines, ritalin) more than 4 times. Past year delinquency was defined as committing at least one index legal offense within the past year.

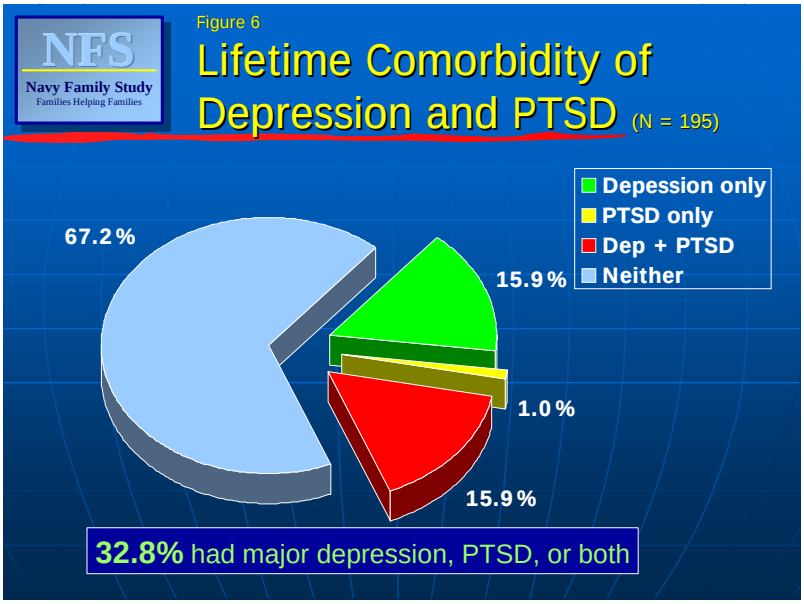


Figure 6 depicts the comorbidity of major depression and PTSD. Nearly one-third of the children in the FAP sample met full diagnostic criteria for one or both of these disorders at the T1 interview. Of these, nearly half met diagnostic criteria for both disorders, representing 15.9% of the full sample. It should be noted that these were not children who were sad or feeling a little down. Rather, nearly one-third of this sample met full diagnostic criteria for one of these two major psychiatric disorders and 1 in 6 met criteria for both. Comorbidity between depression and PTSD is common in clinical research. So, the findings of high levels of comorbidity between these two disorders is not surprising.

Table 4 presents findings for problem alcohol and drug use and delinquency. For these outcomes, data are presented only for the 99 teenage participants because of the nature of the problems. These problems typically do not emerge until adolescence and the prevalence of these difficulties among younger children is negligible. Analysis of the data of our NFS child participants indicated extremely low levels of these problems. Therefore, presenting the prevalence rates for the teenage participants is the most relevant analysis.

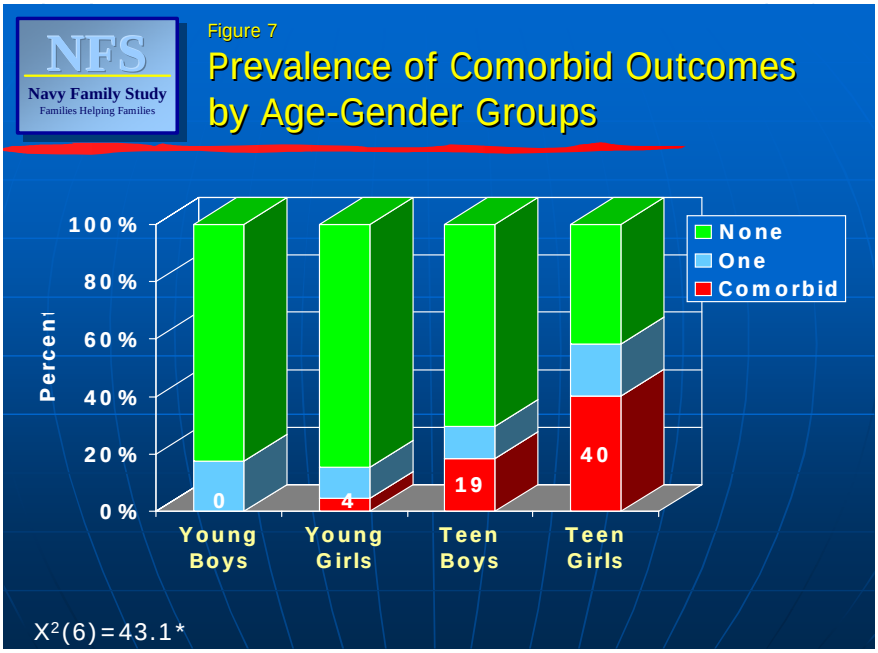
Table 4
NFS Navy Family Study Families Helping Families
Prevalence of Other Outcomes and Comorbidity with PTSD and Depression for FAP Teenagers (n=99)

Problem	Prev.	PTSD	Dep.
Past Year Problem Alcohol Use (1x/m)	13.1%	38.5%	69.2%
Non-experimental Drug Use (>3x)	26.3%	50.0%	73.1%
Past Year Delinquency	15.2%	46.7%	80.0%

Results of this analysis indicated that about 1 in 7 adolescents had difficulty with problematic alcohol use in the year prior to the T1 interview. Also, over a quarter had used medical or street drugs in a non-experimental fashion, and 1 in 6 had committed a serious delinquent act in the past year. The third and fourth columns of this table indicate a significant level of comorbidity between these problems and a diagnosis of either major depression. Of the 13.1% of NFS teenage participants who had experienced problematic alcohol use in the past year, 38.5% percent of them also met diagnostic criteria for PTSD and 69.2% met diagnostic criteria for major depression. Similarly, of those teenagers with

problematic drug use, half met diagnostic criteria for PTSD and nearly three-fourths for major depression. Finally, of those children with problems with past year delinquency, nearly half met criteria for PTSD and 8 in 10 for PTSD. These results demonstrate that while there is certainly not a one to one correspondence, many teenagers who have one serious problem that we measured also have another. Therefore, comorbidity of outcomes appears to be common among teenagers living in FAP-reported families.

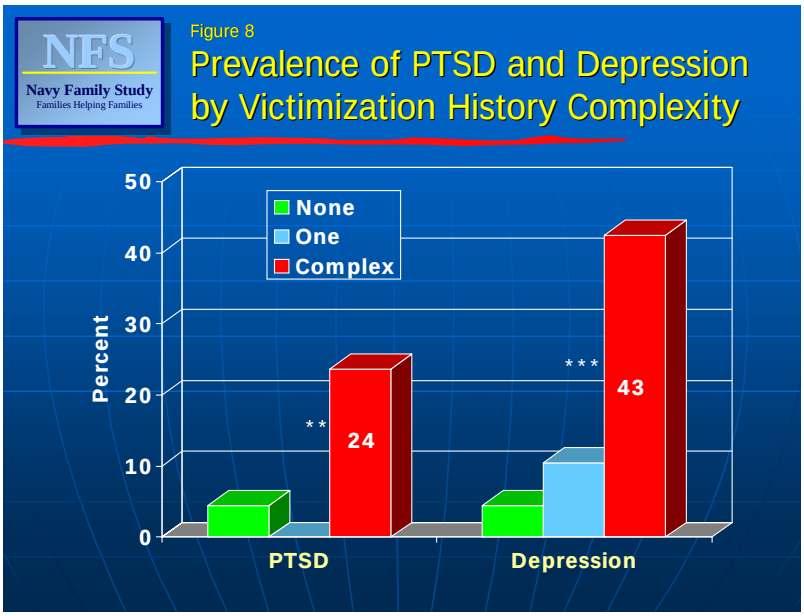
Figure 7 presents the prevalence of comorbid outcomes by age and gender groups. As can be seen there are substantial differences in the prevalence of comorbid outcomes between these groups. In this sample, no young boys (age 7-12) exhibited more than one negative outcome. In fact, the large majority of young boys had none of the five psychiatric and behavioral outcomes measured in the NFS interview. Over 80% of the boys presented with no outcome, and 17.4% had only one outcome. It should be remembered that a prevalence rate for major psychiatric and behavioral problems of 1 in 6 is very high in any population. Therefore, this prevalence rate among young boys is not trivial by any means.



The prevalence rate of both having any disorder and having comorbid disorders for teenage girls was shockingly large. Nearly 60% of the teenage girls exhibited at least one of the measured problems. Most interesting, 40% had comorbid problems. This means that 2 of every 5 teenage girls had at least 2 major psychiatric or behavioral problems. This rate of comorbidity was twice as high as that found in teenage boys, which at nearly 1 in 5, is quite high as well.

Therefore, it appears that comorbidity of negative outcomes is clearly related to age, with teenagers much more likely than younger children to have two or more negative outcomes. It also appears to be related to gender, with girls more likely to present with comorbidity. These two risk factors converge to produce a seriously high rate of comorbid negative outcomes among teenage girls. It is clear that teenage girls are far and away most at risk for multiple disorders and behavioral problems.

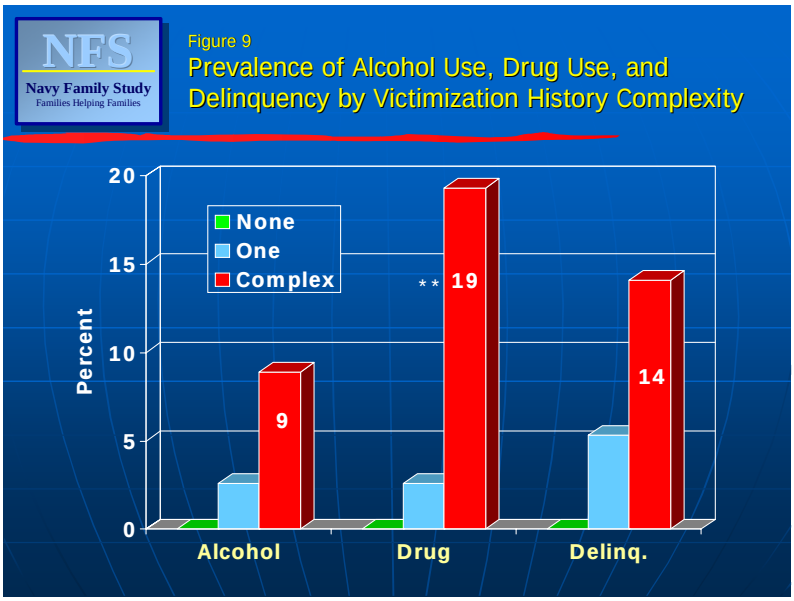
The final question to be answered in this analysis is whether or not complex victimization is related to more adverse outcomes, or does experiencing additional types of violence have little effect on subsequent difficulties. To assess this question, the prevalence rates for the five outcomes assessed were compared across the groups of children who reported experiencing no violence, a single type of violence, or multiple types of violence. These results are presented in Figures 8 and 9. In Figure 8, less than 5 % of child participants who reported no history of any type of violence had a history of either PTSD or major depression. These figures are generally consistent with epidemiological data about the prevalence of PTSD and major depression in the general population. Therefore, children who did not report a history of violence exposure were no more likely to have major depression or PTSD than children in the general population.



Surprisingly, no child who reported exposure to only one form of violence met diagnostic criteria for PTSD. This is somewhat surprising since other research has demonstrated that even one experience of serious violence can increase the likelihood of PTSD dramatically. Therefore, this finding is somewhat at odds with the scientific literature. However, children who reported experience with only one type of violence were over twice as likely to have major depression than those who reported no exposure. This finding is consistent with other research. The most dramatic finding, however, is the large increase in prevalence of both PTSD and major depression among those children with complex victimization histories. One in 4 of children with complex victimization histories met diagnostic criteria for PTSD. This represents over a five-fold increase over those who reported no history of violence (Relative Risk=5.3). These results were statistically significant. A similar significant result was found for major depression. Children with complex victimization histories were over 9 times more likely to have had major depression than those with no victimization history (RR=9.4), and 4 times more likely than those that had experienced only one type of violence (RR=4.0). Therefore, complex victimization history is a powerful predictor of both PTSD and major depression among FAP children.

Figure 9 depicts the same analysis with problem alcohol use, problem drug use, and past year delinquency. In these analyses, only the relationship between complex victimization history and problem drug use was statistically significant, though the trend was clearly in the expected direction for both alcohol use and delinquency. These

analyses were not significant primarily due to the relatively low samples sizes in these subgroups. For drug use, no child who had not experienced any form of violence reported a history of non-experimental drug use. Therefore, every child who had a problem with drug use had a history of some type of victimization.



It is worth noting, even though the relationships were not statistically significant, that similar results were found in this sample for both problem alcohol use and past year delinquency. Every child in this sample who reported difficulties with problem alcohol use or delinquency had a history of some form of victimization. Therefore, in this sample no child who had no history of exposure to violence reported problems with alcohol, drugs, or delinquency.

Even children who had experienced only one form of violence had rather low levels of all three of these problems, ranging from 2 to 5 percent. However, as with depression and PTSD, children with complex victimizations histories were much more likely to experience difficulties. One out of 5 children with complex victimization histories reported non-experimental drug use. This rate was over 7 times greater than those children who reported exposure to only one violence type (RR=7.4).

These univariate results demonstrate that for major depression, PTSD, and non-experimental drug use, complex victimization history is a powerful predictor. The increased risk over those children who experienced no victimization was somewhat expected, given the large literature demonstrating how various forms of victimization are significant risk factors for these outcomes. However, the striking increase in risk over those children with a history of only single violence type was unexpected.

Given the results reported above demonstrating the differences between boys and girls and young children and teenagers in the prevalence of both complex victimization and comorbid outcomes, an analysis controlling for the effects of these two variables was indicated. In this way, the predictive power of the gender and age can be removed and the unique predictive power of complex victimization history better understood. Logistic regressions were conducted for each of the five outcome variables, using number of victimization types (0-5) as a predictor, and controlling for the effects of gender and age. Table 5 presents these analyses.

When age and gender were controlled, the number of violence types experienced by the children was significantly related to all five outcomes. The column in the red box is the odds ratio for each of the outcome variables. This statistic represents the relative increase in the odds, controlling for gender and age, that a child will develop the particular outcome for every new type of violence experienced. In other words, the odds of developing PTSD for children who experience one type of violence are 2.76 times greater than the odds for children who experience no violence. Children who experience three types of violence are 2.76 times more likely to develop PTSD than children who experience only 2 forms of violence. The increase in risk is cumulative with every new type of violence experienced. So, a child that has experienced 3 types of violence is 21.0 times more likely to develop PTSD than a child who was never exposed to violence (2.76 x 2.76 x 2.76=21.02). These results confirm that complex victimization history is strongly related to the development of each of these outcomes, even when the known effects of gender and age are removed.

Table 5

Number of Victimization Types Predicting Outcomes, Controlling for Sex and Age

Outcome	B	Wald	OR	95% CI
PTSD Dx	1.02	24.2***	2.76	1.84 - 4.14
Dep. Dx	0.86	28.9***	2.36	1.73 - 3.23
Alcohol Use	0.57	5.2*	1.77	1.09 - 2.89
Drug Use	0.75	14.3***	2.13	1.44 - 3.14
Delinquency	0.71	11.9**	2.04	1.36 - 3.05

The number of victimization types experienced also was found to be significantly and substantially related to the number of outcomes experienced (r=.57). That is, children who have been exposed to more types of violence were more likely to exhibit multiple negative outcomes. This effect also held up when gender and age were controlled (ΔR^2=.17).

Conclusions

- **Over two-thirds of children in this sample reported histories of exposure to multiple types of violence.**

These results clearly indicate that a very large proportion of children living in families reported to FAP have complex victimization histories that are far more significant than simply the allegations that brought them into contact with FAP. Often, the incident that brings a family into contact with the response system is the focus of most assessment and intervention activities. Children are identified as “sexual abuse victims” or “physical abuse victims” based solely upon the nature of the emergent report. Services may be constructed based upon only on this identification. These results suggest that such characterizations may be misleading in a large percentage of FAP

cases. In fact, the emergent report, if it is substantiated, is likely to be only part of a child's victimization history, and maybe not be the most significant part. Children may be identified as a certain type of single victim based only on the nature of the reported incident, when other victimizations are far more significant to them and are the basis for current problems. If these other victimizations are not assessed, they will remain unknown and children may not get the services they need. For children where the emergent case is not substantiated, services may not be provided at all since the conclusion is the incident did not occur. Exposure to violence other than what is alleged in the emergent report may not be assessed and child with significant victimization-related problems may not receive services. Children in families reported for domestic violence may not be assessed at all. However, as is know from the previous report, many of these children have significant victimization histories. These results suggest that many children in these domestic violence homes not only witness domestic violence, a large percentage may be victims of other forms of victimization as well.

- **No significant differences were found between racial/ethnic groups on the prevalence of complex victimization history.**

Minority children in families reported to FAP were not more or less likely to have complex victimization histories than white children. Many forms of victimization are related to socio-economic status, which is often also related to race or ethnic identification. Since this group of Navy families have very similar economic levels, it is not surprising that no racial/ethnic differences were found.

- **The number of victimization types experienced was positively related to age**.

Older children were more likely than younger children to have complex victimization histories. This is not surprising and is consistent with other research. Older children have lived longer and have had more time to be exposed to various forms of violence.

- **Girls were more likely than boys to report complex victimization histories.**

Previous results indicated that sexual assault was much more prevalent among girls than boys. Therefore, it is not surprising that girls were more likely to experience more forms of victimization than boys. However, the level of this difference is quite surprising. Over 25% or girls vs. only 5% of boys had experienced 4 or 5 different forms of violence. This difference is not accounted for solely by a greater likelihood of sexual assault for girls. Girls appear to be more likely to be victimized more and in more different ways than boys at every age level. Therefore, gender is a significant and powerful predictor of complex victimization history.

- **Teenage girls were at particular risk (83%) for having complex victimization histories.**

A very large percentage, 8 out of 10, teenage girls reported a complex victimization history. As was described in the previous report, this is a uniquely vulnerable population that likely requires special attention.

- **Comorbidity of outcomes was more prevalent than single outcomes.**

Not only are most of these children victims of more than one form of violence, they are also very likely to exhibit multiple mental health a behavioral problems. This finding is primarily true of teenagers. Of the 5 outcomes measured, three tend to emerge in adolescence (alcohol problems, drug problems, and delinquency). Therefore, given what was measured, it is not surprising that adolescents rather than younger children tended to have comorbid clinical presentations. The prevalence of these serious outcomes was somewhat surprising, however.

- **Girls, particularly teenage girls were more likely than boys to have comorbid outcomes**

Teen girls seem to be particularly vulnerable to comorbid outcomes, with 40% of them having this clinical presentation. The fact that they are also the population with the highest level of complex victimization history is probably not simply a coincidence.

- **Negative clinical outcomes (PTSD, Depression, Problem Alcohol Use, Problem Drug Use, and Delinquency) were significantly related to a history of complex victimization histories, even controlling for gender and age.**

Having a complex victimization history greatly increases the chance of having significant mental health and behavioral problems. The likelihood of having a negative outcome increases between 1.8 and 2.8 times for each type of violence experienced, depending on the problem. These effects are cumulative with every additional violence type experienced. Therefore, the risk for children with complex victimization histories of developing mental health and behavioral problems is very high.

Implications

These results appear to have several implications for FAP practice and special program development. These are described below.

- **Extend the focus of FAP activities beyond the emergent report and current allegations.**

Currently, a great deal of FAP activity is devoted to investigating and making a determination about the validity of the report that brought the family into FAP. While this obviously is an important function, it tends to make the primary focus of intervention and service about the emergent report. As noted above, children become “physical abuse victims” because that is the nature of the report, rather than that is their full history. Consequently, services tend to revolve around the current report. The danger, of course, is that much will be missed and children will not receive the services they need

because of this focus on the current report. Also, children living in families where the report is about domestic violence may not even be assessed, even though data indicate they often have significant victimization histories. Children living in families where the current report is unsubstantiated may not receive services because case workers may think that because the reported case was determined to be unfounded, they are not "victims" and do not need services. These data clearly show that most children reported to FAP have victimization histories that go far beyond the current report and that many need assessment and intervention as a result. In fact, at least for some children, the violence associated with the current report may be relatively minor compared to their previous history. Therefore, whether the current emergent case is founded or unfounded may actually mean relatively little to some children, given their history. Focusing only on the current report my cloud the FAP system's ability to understand and respond to the full history of the child. These data indicate that many, if not most, of these children likely need intervention services and treatment whether the current emergent report is determined to be founded or unfounded. Therefore, FAP should consider policies and procedures that promote examining the whole history of a child, and responding to the child's full history and clinical presentation, in addition to issues surrounding the current report.

- **All children from all families referred to FAP should receive a <u>clinical</u> evaluation that assesses their victimization history and relevant mental disorders and behavioral problems.**

Results from the first report and these additional analysis confirm that most children (9 out of 10) whose families come into contact with FAP have a positive history of exposure to violence and that many (7 out of 10) have been exposed to more than one type of violence and have complex victimization histories. Also, nearly one-third meet diagnostic criteria for either PTSD, major depression, or both, and up to one-third of all teenagers living in families reported to FAP have problems with alcohol or drug use or are involved in delinquent behavior. In short, these children have significant problems, whether or not the current report is founded or unfounded, and are in need of effective treatment. In order for FAP to be aware of a child's victimization history and current clinical presentation, these children need to be adequately assessed. They are in need of a <u>clinical</u>, not a forensic, assessment. That is, the purpose of the assessment should be to determine the history, functioning, treatment needs of the child, not gather evidence for criminal justice purposes. Therefore, policies and procedures should be developed to see that these children are adequately assessed regardless of the nature of the current report of family violence or the determination of its validity. This assessment should be separate from the forensic activities of the FAP program and should focus on the clinical needs and welfare of the child and family.

The NFS interviews have been adapted for clinical use and can be used for this sort of assessment with FAP children. These clinically adapted interviews are contained in Appendix A of this report.

- **Treatment plans and interventions should be developed that account for the whole history of the child, and should not be based solely on the nature of the current report of violence.**

As noted above, too often treatment plans are based on the nature of the current report of violence and children are identified as that type of victim. These data indicate that for most children in FAP-reported families, such treatment planning is inadequate. Most children have multiple victimization histories and more important, comorbid problems. FAP should develop policies and procedures that encourage the assessment and recognition of complex victimization histories and comorbid presentations in treatment planning.

- **Specific, specialized programs should be developed for teenage girls living in families who come into contact with FAP.**

As described in the previous report, these data clearly indicate that teenage girls are an especially vulnerable subpopulation in an already vulnerable population of children. These data confirm that they are more likely as any other subgroup to have complex victimization histories, and twice as likely to have comorbid outcomes. The data described above strongly reinforce the previous recommendation for the development of special programs and interventions for teenage girls.

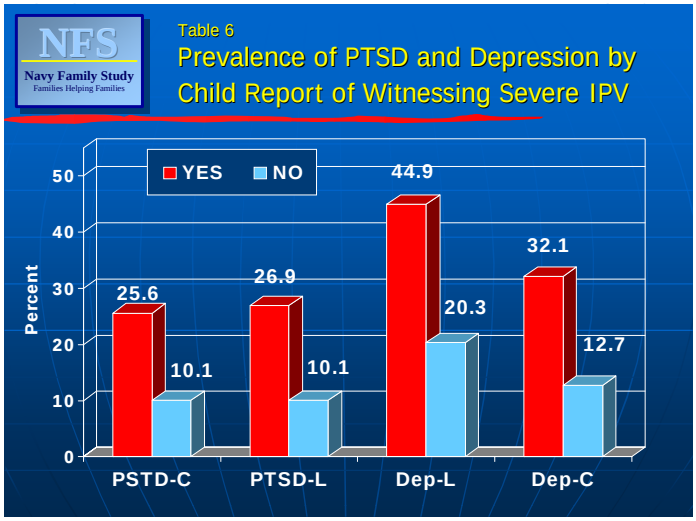
Maternal and Child Reports of Intimate Partner Violence

Data from numerous sources indicate high prevalence rates of intimate partner violence (IPV) in the United States. According to the National Violence Against Women (NVAW) Survey, a survey of a nationally representative sample of 8,000 U.S. men and women, nearly 25 % of women and 7.6% of men reported they had been raped and/or physically assaulted at some point in their life by a current or former spouse, cohabiting partner (Tjaden & Thoennes, 2000). Based on these estimates, approximately 1.5 million women and 834,000 men in the United States are physically assaulted or raped by an intimate partner each year (Tjaden & Thoennes, 2000).

An important concern is the children that live in these households and who may be exposed to IPV. More than half of female victims of IPV live in households with one or more children under age 12 (U.S. Department of Justice, 1998). It has been estimated that approximately 10-18 million children witness IPV annually (Holden, 1998). However, it is quite difficult to obtain accurate estimates because:

- Parents may be unaware that their children are witnessing IPV;
- Parents may purposely under-report because of fears of repercussions;
- Children may be fearful of reporting (i.e., fear of being removed from the home; concern about the parent going to jail; threats from offender).

What is clear from previous studies is that children exposed to IPV exhibit a host of behavioral, emotional, and cognitive difficulties.



As seen in Table 6, children in the NFS FAP sample who reported being exposed to IPV in their homes were significantly more likely to meet criteria for major depression as well as PTSD, both lifetime and current, compared to children who did not report IPV. Relative risk ratios for IPV exposed vs. nonexposed children ranged from 2.2 to 2.7. Therefore, consistent with previous research, exposure to IPV is a significant risk factor for depression and PTSD among FAP-referred children.

Given the significant association between IPV and negative outcomes, it is critically important to be able to identify those children who appear to be at high risk for significant behavioral and emotional difficulties. Studies suggest that parents may severely underestimate the degree to which their children are exposed to IPV (Edelson, 1999). If parents are unaware of their child's exposure to IPV, they may be less likely to provide a stable, supportive environment for their child, which is necessary to ameliorate the negative effects of violence exposure (Cichetti & Lynch, 1993; Kliewer et al., 1998).

Also, parents who recognize that their children are witnessing the partner violence and suffering negative effects as a result, may be more likely to stop the violence. Therefore, a first step in understanding the parent's role as a protective factor is to examine the degree of agreement between the reports by parents and by children about the children's exposure to IPV. Given these important issues, data from the NFS were used to:

1. investigate the concordance rates between nonoffending parent's and children's reports of IPV exposure; and

2. examine relationships between maternal and child reported levels of distress among families in which IPV has occurred.

Table 7

Mother Report of What Child Saw and Child Report of IPV

Violent Behavior	NOP	Child
Threw something	17.8	34.4
Pushed, shoved or grabbed	40.1	33.8
Slapped or hit with open hand	14.7	15.9
Kicked or punched	Not asked	19.1
Beat up	15.9	11.5
Hit with object	4.5	10.8
Choked	5.7	3.8
Threatened with a weapon	4.4	6.4
Burned or scalded	0.0	Not asked
Threatened to kill	5.7	Not asked
Threatened to force sex	0.0	Not asked

Data from the NFS T1 assessment indicated that a significant number of parents reported that they had experienced IPV and many children reported they had witnessed it. Table 7 reports the percentage of mothers who said their child had witnessed the specific IPV behavior, and the percentage of children who said they had witnessed each behavior. Percentages of children and parents varied considerably with a greater number of children responding positively than mothers. For example, twice as many children reported that they had witnessed their parents throw something as compared to mothers' report of what their children had witnessed. Twice as many children reported that they had seen one parent hit another with an object. These results suggest that many mothers either are unaware that their child is witnessing violence, or are unwilling to report it.

As seen in Table 8, nearly two-thirds of the women (63.1%) and half of the children (49.7%) reported experiencing (women) or witnessing (children) severe IPV. Not surprisingly, there was not 100% concordance between maternal and child's reports of IPV. This finding is important in terms of case identification. Of the 157 parent-child pairs, either a parent or child indicated IPV in 119 (76%). This is a significant increase in case identification over single report of either the parent or the child. Therefore, these results suggest that multiple family member reports of IPV likely will result in greater case identification and a more complete picture of what is happening in the family. They also indicate that relying exclusively on the report of parents or children will result in an under-identification of children who may have witnessed IPV.

Table 8

Concordance of Mother and Child Reports in IPV Case Identification

$X^2(1) = 7.56, p<.01$

			Child: Yes	Child: No	Child: Total
Mo	Yes	Total	58 36.9%	41 26.1%	99 63.1%
		Row	58.5%	41.4%	100%
		Col	74.4%	51.9%	63.1%
	No	Total	20 12.7%	38 24.2%	58 36.9%
		Row	34.5%	65.5%	100%
		Col	25.6%	48.1%	36.9%
	Total		78 49.7%	79 50.3%	157 100%
		Row	49.7%	50.3%	100%
		Col	100%	100%	100%

Table 9 summarizes the concordance between child and mother reports of whether or not the child had ever witnessed IPV. Generally, there were significant discrepancies between what mothers reported their child had witnessed and what the child said they had witnessed. Differences were in both directions, over- and under-identification. For example, of the 77 women who reported that their child had witnessed IPV, 51 (66%) of their children agreed and reported witnessing IPV. However, this finding means that one-third of these women's children denied witnessing IPV when their mothers reported they had. Similarly, of the 80 women who said their children had never witnessed IPV, 27 (34%) of the children said they had witnessed IPV. Therefore, regardless of whether the mother reports they believe the child has or has not witnessed IPV, there appears to be a significant lack of concordance with what approximately one-third of the children reported. This significant lack of concordance seems true whether or not the mother acknowledged being the victim of IPV.

Table 9

Summary of Concordance of Reports by Mothers and Children

Mo Reports IPV		Yes n=99 (63.1%)		No n=58 (36.9%)	
Mo Reports Child Witnessed IPV		Yes n=62 (39.4%)	No n=37 (23.6%)	Yes n=15 (9.6%)	No n=43 (27.4%)
Child Reports IPV	Yes n=78 (49.7%)	26.8% n=42	10.2% n=16	5.7% n=9	7.0%[a] n=11
	No n=79 (50.3%)	12.7% n=20	13.4% n=21	3.8% n=6	20.4%[b] n=32

[a] $X^2(1) = 9.7^{**}$

[b] $X^2(1) = 4.9^{*}$

Conclusions

- **Reports of exposure to IPV are significantly discrepant between mothers and children.**

Implications

- **Assessment of both parents and children is critical in IPV case identification.**

The discrepancy between maternal and child reports suggests that assessment of both the children and parents is critical in cases at risk for IPV. This discrepancy also has significant clinical implications for the family. If parents are not aware that their children have seen IPV, they cannot assess the impact on the child, nor can they seek appropriate services for the child if they are needed. If the parent indicates the child has witnessed IPV, but the child does not, it is possible that the child may be denying the event to protect the parents, or that the child may be too afraid to make a disclosure. These findings suggest that assessment of all members of the family, including the child, is important in cases of IPV.

Parent-Child Relationships after FAP Referral

Children in violent families are at risk for numerous significant difficulties. Most of the time, clinicians concern themselves with assessing and treating symptoms of post-traumatic stress and other forms of psychopathology (e.g., depression, anxiety, disruptive behavior). However, in addition to these consequences of violence exposure, families may undergo significant structural and interpersonal changes after reports of violence reach authorities. Family constellations may change due to separation or divorce, incarceration of the offender, or substitute care placements. Relationships between parents and children may also be altered. For example, children may become increasingly close with non-offending parents if the offending parent is no longer living at home. Alternatively, child relationships with non-offending parents may worsen if the child perceives the non-offending parent to be responsible for negative family consequences (such as the child's separation from the offending parent). These structural and relational changes in families may have a significant impact on treatment planning and delivery, as well as case management activities. However, few data exist regarding the relational trajectory of families who have experienced intrafamilial violence, or about the changes in parent-child relationships that occur over time following such violence. The major questions of these analyses were:

1. How many families divorce or separate after reports of intrafamilial violence? How many stay together?

2. Are different forms of family violence more likely to result in family fragmentation?

3. Do parent and child perceptions of parent-child relationship quality change over time once a case has been reported?

To examine these issues, interview and questionnaire data from non-offending parents and children were examined. Data regarding the family trajectory was obtained from the non-offending parent. Child violence exposure information was gathered from the child T1 interview. Information about parent-child relationships was based on the Parenting Practices Inventory (PPI). The PPI was completed by the non-offending parent in reference to the index child. Two parallel forms of the PPI were completed by the index child, one in reference to the child's relationship with the female parent, and the other in reference to the child's relationship with male parent. The PPI yields separate scores reflecting the frequency of both positive parenting behaviors (e.g., listening, praising, nonverbal affection) and negative parenting behaviors (yelling, criticizing, nagging).

Recognizing that family structures vary in the aftermath of familial stress (e.g., some families may separate temporarily, or children may be briefly placed in emergency protective custody), it is important to try to measure family status after a long enough period has elapsed so that reasonably permanent family changes will have occurred. For these analyses, data from T1 were compared to those from T3 (approximately 18 months after T1). However, in cases where T3 data were missing and T2 data were available, T2 data were used.

The average time between assessments was 15.6 months. Of the 478 non-offending parents in the entire sample, usable data was available from 398. For the remaining 80, either they only completed a T1 assessment, or insufficient information was available to classify their family status. These 398 non-offending parents had 158 children who completed assessments at T1 and at the follow-up interview.

Question 1. How many families divorce or separate after reports of intrafamilial violence? How many stay together?

For this analysis, we determined that families were Intact if the non-offending parent reported that the family was legally married or cohabiting at T1 and legally married or cohabiting at follow-up. Of the 398 non-offending parents, 237 (or 60%) described their relationship with their partner as intact. These intact families included:

- 197 who were legally married at both time points
- 27 who were married at T1, had separated for some time between T1 and follow-up, but who had reunited at follow-up
- 7 who were cohabiting at T1 and either still cohabiting or had gotten legally married by follow-up
- 6 who had been legally separated at T1, but who had reunited by follow-up

By comparison, families were Fragmented if the non-offending parent reported either a) that the parents were legally married or cohabiting at T1 and legally separated or divorced at follow-up; or b) legally separated at T1 and divorced at follow-up. There were 160 (or 40%) of non-offending parents who described their relationship with their partner as fragmented. These families included:

- 102 who were married at T1 and legally separated at follow-up
- 43 who were married at T1 and divorced at follow-up
- 15 who were separated at T1 and divorced at follow-up
- 1 who described cohabiting at T1 and being “separated” at follow-up

Question 2. Are different forms of family violence more likely to result in family fragmentation?

For this analysis, family violence exposure was defined as the child’s report of intrafamilial child sexual abuse (CSA), intrafamilial child physical abuse (CPA), or witnessing inter-parental violence at T1. The odds of family fragmentation were significantly higher if the child reported experiencing CSA. In fact, families of the children who reported CSA were over 7 times more likely to separate or divorce than families of

children who did not report CSA. The odds of fragmentation in families of children who reported CPA was almost twice that of non-CPA families, but this was not a statistically significant difference. There were no differences in family status among families according to whether the child reported inter-parental violence. Thus, it seems clear that Question 2 has a definitive answer, and that is that intrafamilial CSA is very strongly associated with family fragmentation, whereas physical violence (whether between a parent and a child, or between both parents) is less likely to lead to separation or divorce.

Question 3. Do parent and child perceptions of parent-child relationship quality change over time once a case has been reported?

This question was examined using PPI scores from non-offending parents and children. Two main comparisons were made in each analysis. First, we were concerned with any possible differences in parenting behaviors among Intact versus Fragmented families. Second, we examined whether perceptions of parenting behaviors changed over time (i.e., did parenting behaviors change for the better or for the worse after violence was reported).

Analyses indicated that non-offending parents' reports of their own parenting behaviors, based on scores on the PPI, showed no differences between Intact and Fragmented families, and that there were no changes over time, in either positive or negative parenting behavior. That is, non-offending parents saw their parent-child relationships as very consistent over time, regardless of whether their families stayed together or separated.

Similarly, children reported no changes over time in the frequency of positive parenting behavior from either their male or female parent. However, children in the Fragmented group reported a significantly lower level of positive behavior from their male parent than children in the Intact group. Therefore, children in Fragmented families indicated that their fathers used less positive parenting approaches than children in Intact families.

With respect to child reports of negative parent behavior, no differences between Fragmented and Intact families were found. Children in both Intact and Fragmented families did report a significant decrease in negative behavior over time for both their male and female parents. This finding suggests that, from the child's perspective, the balance between positive and negative parenting strategies significantly shifts to the positive direction after a report to FAP.

Conclusions

- **Families that experienced intrafamilial sexual were more likely to be fragmented than those that experienced physical violence.**

- **Parents tend to report no changes in the positive or negative parenting practices over time, regardless of family fragmentation.**

- **Children in fragmented families report less use of positive parenting practices on the part of their fathers than children in intact families.**

- **Children in both intact and fragmented families report a significant decrease in negative parenting practices after a report to FAP.**

Implications

- **Interventions should recognize that most FAP families will remain intact.**

These findings suggest that clinicians and case managers must be aware that many, and in fact the majority of, families reported to FAP for intrafamilial violence remain intact, even though there may be transient separations in the aftermath of a report. The impact of interventions that focus exclusively on the child victim, or the dyad of the child and the non-offending parent, may therefore be of limited value. The presence of the offending parent in the home is likely to have a powerful influence on family functioning and the dynamics of relationships among family members. In order to insure the healthy resolution of children and families as they cope with family violence, interventions should be targeted at multiple levels of the family environment. Changing family interaction patterns, modifying parenting behavior, improving family problem solving and communication patterns, modifying couple functioning, and addressing individual-level problems in parents, as well as child victims, may all be clinically vital.

- **Information about family functioning should be gathered from both parents and children.**

The discrepancy between non-offending parent and child perceptions of parent-child relationships underscores the importance of gathering information directly from children regarding family relationships. Clinicians relying solely on parental report, even from non-offending parents, are likely to be missing important perspectives on the family's interactions.

- **The quality of parent-child relationships cannot be inferred from whether families stay together or not.**

It is noteworthy that few differences in perceived parent-child relationships were noted between Fragmented and Intact families. The primary exception to this was that children in Fragmented families reported less positive parenting from their male parents. Clinicians therefore may want to be cautious about making assumptions regarding the quality of parent-child relationships based on whether families stay together or separate. These issues are likely to be complex.

- **A report to FAP should be considered an opportunity for improving parent-child relationships.**

On a positive note, children perceive negative parenting to decrease over time, and professionals working with families may want to capitalize on this developing

strength in families in working toward achieving healthy outcomes. When planning intervention programs for families who engage in violence, these data suggest the importance of developing an integrated and coordinated menu of services that targets not only the individual (e.g., perpetrator's group, child individual therapy), but the family unit as well. Service programs that are capable of coordinating treatment planning for different family members and facilitating communication between different agencies and service providers seem necessary. This may require that FAP staff assist families in understanding how the pieces of their overall treatment plan fit together, and that staff serve as a centralized communication resource for multiple systems and service providers involved in a case. Child physical abuse and inter-parental violence were less likely to result in family separation and divorce, whereas sexual abuse was most strongly associated with family break up. Understanding these trajectories and developing flexible intervention plans that can be tailored to families that plan to remain together (e.g, family resolution therapy, safety planning), as well as those that eventually fragment (e.g., abuse clarification), is likely to provide the greatest benefit to the wide variety of FAP clients.

Revictimization of Children in Families Reported to FAP

The NFS was a prospective, longitudinal study that assessed families at three follow-up points over a 36 to 44 month period after the report to FAP. At each follow-up assessment, children were carefully screened for victimization experiences that had occurred since the previous interview. Because of this design, it is possible to examine how many children who reported a history of victimization at the initial T1 interview were revictimized during the follow-up period. The rate of new victimizations that occurred to children who did not report victimization at the T1 interview can also be determined. Such information is important, since presumably a critical objective of the Family Advocacy Program is to prevent revictimization and new victimization experiences for its clients.

Table 10 reports the within type revictimization rates for children who had a history of one of the five types of violence at the T1 assessment. That is, of those children who reported exposure to a particular type of violence at T1, this table identifies the percentage of children that reexperienced that same type of violence at T2, T3, and T4. The T1 column in this table gives the number of children in the full sample that reported this type of violence at the initial assessment. Columns T2, T3, and T4 describe the percentage of these children that experienced this same type of violence in the time period leading up to each follow-up assessment. More specifically, 70% of children reported witnessing serious community violence at T1. Of these children, 34% reported witnessing community violence between T1 and T2, 25% between T2 and T3, and 35% at T4. The Total column is the percentage of these children that experienced revictimization of this same type at any point during the follow-up period. Therefore, 56% of the children witnessed serious community violence at some point between the first assessment and the final assessment point. For the 44% of children who had reported witnessing partner violence at T1, 21% reported further exposure to partner violence at T2, 5% at T3, and 4% at T4. Nearly 1 in 4 (24%) of these children witnessed partner violence during the follow-up period. For children reporting a history of sexual assault at T1, 7% of this group reported at least one incident of sexual assault at T2, 2% at T3, 9% at T4, and they had an overall revictimization rate of 23%. In terms of child physical abuse, 10% reported new incidents of physical abuse at T2, 3% at T3, 5% at T4, and an overall follow-up rate of 14%. Of the children who reported physical assault in the community at T1, 16%

Table 10

NFS Navy Family Study Families Helping Families

Within Violence Type Revictimization Since T1

	T1	T2	T3	T4	Total
Wit. Comm. Viol.	70.3% (137)	34.4%	24.8%	35.0%	56.2%
Wit. PV	44.1% (88)	20.9%	4.7%	3.5%	24.4%
Sexual Abuse	29.2% (57)	7.0%	1.8%	8.8%	22.8%
Physical Abuse	48.2% (94)	9.6%	3.2%	5.3%	13.8%
Physical Assault	34.4% (67)	16.4%	20.9%	17.9%	68.2%
Any Victimization	86.1%	59.5%	52.6%	34.7%	75.1%

reported revictimization at T2, 21% at T3, 18% at T4, and an overall revictimization rate of 68%. Finally, of the 86% of children who reported a history of at least one of the five types of victimization at T1, 60% described some type of revictimization of at least one of these five types of violence between T1 and T2. At T3 53% reported some sort of revictimization, and 35% at T4. The overall revictimization rate over the 3-4 year follow-up period for those children who reported some history of some type of victimization at T1 was 75%. Therefore, 3 out of 4 children who reported a history of victimization at T1 experienced at least one type of revictimization over the 3 to 4 year follow-up period.

These data demonstrate that revictimization of some sort is not uncommon among FAP children. Not surprisingly, witnessing serious community is the most common form of violence exposure among these children, since it was also the most common form at T1. This sort of violence is most directly related to the character of the neighborhood in which the child lives and the school they attend. Unless the family moves, the child is removed from the home, or there is another reason for residence or school changes, this environment likely would not be a target of FAP intervention. Consequently, the fact that it stays relatively high over the follow-up period is not surprising. Unfortunately, witnessing serious violence in the community or school is a fact of life for a large proportion of these children. These data reinforce the need for a broad approach to assessing violence exposure. Too often, while family violence is carefully assessed, community violence is not.

About 1 in 5 of the children who reported witnessing partner violence at the T1 assessment reported witnessing it between the T1 and T2 assessment. The circumstances around these subsequent incidents will require further analysis. For example, were these cases experiencing revictimization originally reported to FAP as partner violence cases, or other forms of family violence? It may be that many of these new cases occurred in families who did not receive services for partner violence. If so, that would suggest the need for more broad based assessment and subsequent intervention so risk situations can be identified early in the process, regardless of the nature of the emergent report to FAP. Most interesting is the fact that these children report a distinct drop-off in witnessing partner violence in the home at the T3 and T4 assessment point which are 18 and 36 months after the report to FAP. Again, the circumstances associated with this steep decline will require further analysis. However, intervention takes place primarily during the first follow-up period. It seems that after this period of intervention, exposure to partner violence among children dramatically decreases. This could be because families are separating or that intervention is successful. Further analysis is required, but these data are encouraging.

This trend holds for the other two forms of violence that are typically the targets of FAP intervention, sexual abuse and physical abuse. Revictimization between T1 and T2, is elevated compared to the rest of the follow-up period. T3 and T4 rates of revictimization drop dramatically. However, for Physical Assault, which typically occurs at school or in the community and is not usually a target for FAP intervention, the rates remain substantial across all three follow-up periods.

Physical assault reoccurrences were more elevated. Again, this is a type of violence against children that is often overlooked when family violence is the focus of a program. However, children experiencing serious physical assaults at school or in the community is far from rare, and over a third of children reported these types of experiences at T1. Of all the types of personal victimization, physical assault had the largest revictimization rates at all three follow-up periods. This finding suggests that treatments and interventions likely are directed at family violence, resulting in lower recidivism rates for these types of violence compared to physical assault in the community, even though the initial baseline levels of family violence are higher than physical assault. While this is good news for interventions directed toward family violence, and suggests that they are having a good effect, it points to a hole in the service system for these children regarding physical assault. This result again supports the idea that these children require a broader approach to assessment and possibly intervention.

Table11 reports on brand new cases of the five different violence types occurring in the follow-up period. The T1 column presents the percentage of children who denied experiencing each type of violence at the initial interview. For example, 29.7% of the children at T1 said they had never witnessed serious community violence. Of these children who denied exposure to a particular type of violence at T1, the table presents the percentage of children who reported new incidents of victimization of this type at T2, T3, T4, and at any point during the follow-up period. More specifically, of the 29.7% of children who denied ever witnessing community violence at T1, 16% reported at least one incident of witnessing community violence at T2, 7% at T3, and 14% at T4. One out of three of these children (33%) had some sort of new incident of witnessing community violence over the follow-up period. With regard to witnessing partner violence, 55.9% of children reported no exposure at T1. Of those children, on 4% reported new exposure to partner violence at T2, 2% at T3, 1% at T4, and 6% overall. For child sexual assault, 13% of the children who had no history of sexual assault were sexually assaulted during the follow-up period. For child physical abuse, 51.8% reported no history at T1. Of this group, only 7% reported new incidents at in the total follow-up period. Lastly, of the 65.6% of children who denied a history of physical assault at T1, about 1 in 3 (36%) reported new incidents over the follow-up period. Finally, of the 14% of children who reported no history of any of the five types of

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Table 11
New Victimizations Among Children Not Reporting Violence Type at T1

	T1	T2	T3	T4	Total
Wit. Comm. Viol.	29.7% (58)	15.5%	6.9%	13.8%	32.8%
Wit. PV	55.9% (109)	3.7%	1.8%	.9%	6.4%
Sexual Abuse	70.8% (138)	.7%	2.9%	2.2%	13%
Physical Abuse	51.8% (101)	1%	1%	5%	6.9%
Physical Assault	65.6% (128)	6.5%	33.3%	2.9%	35.9%
Any Victimization	13.9%	32.1%	32.1%	25%	53.6%

victimization at T1, over half reported some type of new victimization during the 3 to 4 year follow-up period.

These rates of new victimizations for these children who had no history of each type of violence are generally lower than the revictimization rates reported by those children who did have a prior history. This finding is not surprising since most research has found that prior victims are at greater risk for revictimization than those without such a history. It was expected that revictimization rates would be larger than the new victimization rates. However, this finding requires further analysis. It may be that these results are confounded by age or gender, both of which are risk factors for different forms of violence.

Conclusions

- **Most children in FAP-referred families will experience revictimization and new incidents of violence in the three years after a report to FAP.**

Over the three year follow-up period well over one-half of the children experienced new incidents of violence of some type. Therefore, children living in FAP-referred families remain at significant risk for victimization even after contact with FAP. The finding that many children continue to experience some forms of violence after a report to FAP suggests that ongoing assessment of possible victimizations is needed. It may be that emergent or continued mental health problems may be the result of new experiences of violence.

- **Most new incidents of violence exposure concerned witnessing community violence and physical assault.**

The most prevalent forms of violence exposure subsequent to a report to FAP were witnessing community violence and physical assault in the community. As noted above, these types of incidents usually are not the focus of FAP involvement, yet they occur at a rate higher than any form of family violence.

- **Forms of violence that usually are the target of FAP intervention (i.e., family violence) had lower rates of revictimization at T3 and T4 compared to T2.**

New victimization experiences for family violence types dropped substantially at T3 and T4, while community violence seems to have remained fairly constant. This finding may be due to the fact that families separate, decreasing the opportunities for family violence, or that FAP intervention works to reduce recidivism, or a combination of the two. Further analysis is required to better understand this finding.

- **Children having a prior history of exposure to violence were at greater risk of experiencing new incidents of violence.**

This finding is consistent with previous research. Children with a history of experiencing violence were more likely to experience that same type of violence as well

as other forms. The overall revictimization rates for children with a prior history was over 75% vs. approximately 50% for nonvictimized children. These results may be confounded by differences in gender and age composition.

Implications

- **Children should receive periodic, broad-based assessment of new victimization experiences that may occur during their involvement with FAP services.**

These data indicate that a significant proportion of FAP children will be victimized during the time period of their involvement with FAP services. The nine months immediately following the report to FAP appears to be the greatest period of risk for most children. It is important that case managers know about new, emergent incidents of violence so that they can react accordingly and adjust treatment plans and interventions if needed. Therefore, children should be specifically screened, either formally or informally, at regular intervals (e.g., every 3 months) for new incidents of violence. This screening should include a broad range of possible violence types, including exposure to violence in and outside the home. Specifically, incidents of witnessing community violence and physical assault in the community should be screened for, since they are the most common types of subsequent violence exposure. This screening can be done formally, such as using the *Event History Interview* contained in Appendix A, or more informally through clinical interview.

- **Programs and interventions should be developed to increase child safety during the first nine months after a report to FAP.**

The first nine months after a report to FAP are a substantial period of risk for children living in families reported to FAP. These data indicate that most children that are going to be revictimized by family violence are likely to have these experiences during the first nine months after a report. Nearly 60% of children will experience some type of revictimization in those nine months. Therefore, increased attention should be paid to child safety during this period. Specific child safety plans should be developed, implemented, and vigorously enforced during this period. All interventions should take into account this period of increased risk and work to reduce it. And, child safety and possible revictimization should be rigorously assessed and monitored.

- **Therapists should guard against attributing all mental health problems to the emergent case report.**

There is a natural tendency in the family violence field to attribute all mental health and behavioral problems exhibited by a child to the incidents that brought the family into contact with the intervention system. These data suggest doing so likely would be a substantial mistake. As described above, many of these children have complex victimization histories as they come to FAP, and attributing all their problems to the episodes that spawned the FAP report is a mistake. These revictimization and new incident data now demonstrate that many children will be victimized in some fashion after

their involvement with FAP. These new incidents may be quit serious, even more serious than the original report, and may cause new problems or exacerbate old ones. Through careful, ongoing assessment, therapists should be aware of the child's complete history, including new incidents of victimization. Through a careful and ongoing case reformulation process that includes examining all the factors in a child's life, including the nature of the current report of violence, their past history, and an new incidents of violence, a treatment plan should be constructed. The treatment approach should be reexamined periodically to take into account new assessment information. Clinically effective interventions and programs must account for the full history and broad experience of FAP children, and not focus exclusively on the current emergent report.

Course of Depression and PTSD Diagnoses

Since children were assessed over time, the course of their functioning in various areas could be tracked. Children who met full diagnostic criteria for either major depression or PTSD were of special concern because of the severity of these two disorders. Two questions were of interest. First, do children who meet criteria for either PTSD or depression at the time of the FAP report maintain those symptoms over time, or do they get better? Prior research has demonstrated that children tend to improve over time, but that symptoms can wax and wane. Of course, if children do improve over time, this improvement cannot be attributed to FAP services, since no control group exists for this comparison. Similarly, if children do not improve or get worse, this result cannot be attributed to FAP intervention either. However, understanding the course of these children who exhibit these serious psychiatric disorders can be helpful in treatment and program planning.

A second question is, how many children that do not meet criteria for either depression or PTSD at the T1 interview will develop these disorders during the followup period. This is an important issue because it will reveal the risk that children have for future short term problems, even though they may not have difficulties now. Also, as we have seen above, children often experience new incidents of victimization after a FAP referral, which may cause new difficulties not originally seen in the initial evaluation. This information also can be useful in treatment and program planning.

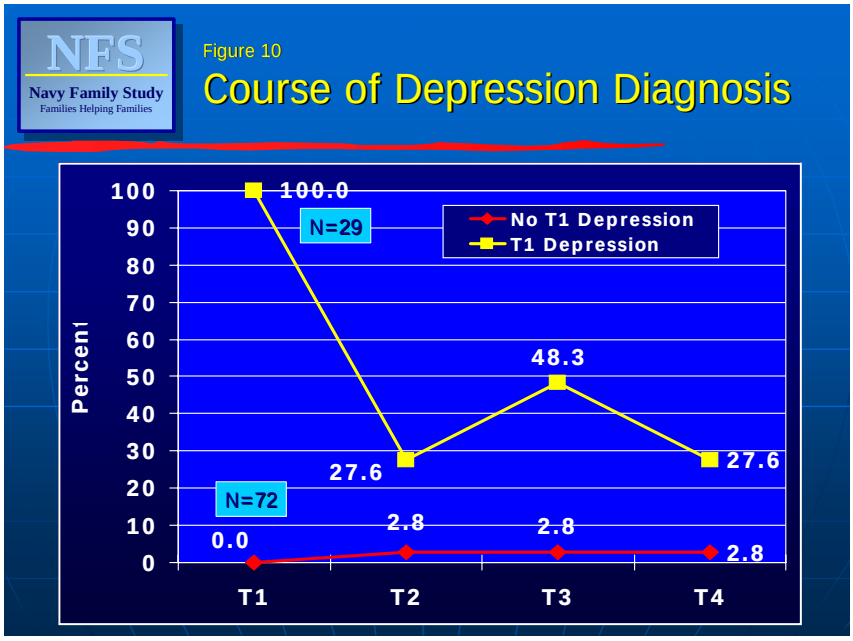
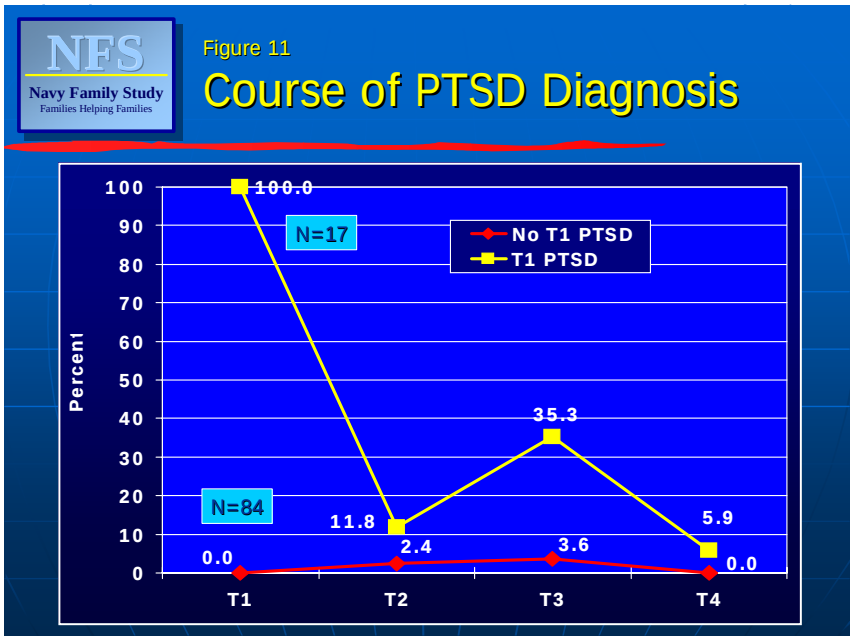


Figure 10 presents results for the course of major depression among the 101 FAP-referred children who completed diagnostic interviews at all four assessment points over the three to four year follow-up period. At the T1 assessment, 72 of these children had never met diagnostic criteria for major depression, and 29 children had a positive history of depression. Of the children who reported no history of depression at T1, very few developed the disorder over the follow-up period. Only 2.8% of these children developed new cases of major depression during this period. Therefore, new, emergent cases of depression were rare. However, of the children who did report a history of major depression at the T1 assessment, 28% met diagnostic criteria at T2, nearly half (48%) met criteria at T3, and 28% had the disorder at T4. Therefore, a substantial proportion of these children appear to have persistent and chronic problems with depression. These results suggest that

children identified as depressed at the time of a FAP report are at great risk for being depressed in the future, compared to those that are not depressed at T1. Relative risk ratios were 9.6 at T2, 17.3 at T3, and 9.6 at T4.

Similar results were found for PTSD, and these results are reported in Figure 11. Of the 101 children completing diagnostic interviews at all four assessments, 17 met diagnostic criteria for PTSD at the T1 assessment, and 84 did not. It should be noted that many of the children in the "No PTSD" group may have had significant PTSD symptoms. However, they did not meet full diagnostic criteria. As was the case with depression, new, emergent cases of PTSD were rare. Only 2% of the children who did not have PTSD at the T1 interview met full diagnostic criteria at T2, 4% at T3, and none at T4. Among children that did meet criteria for PTSD at T1, only 12% had PTSD at T2. However, over one-third (35%) met criteria at T3. At T4, 6% met criteria. Therefore, over one-third of children who had PTSD at T1 continued to meet full criteria at some point over the follow-up period, particularly at the 18 month follow-up assessment. Children that had PTSD at the T1 assessment were more likely to have PTSD at follow-up than children who did not. Relative risk ratios were 4.9 at T2, 11.8 at T3, and not calculable at T4 since the rate for the No T1 PTSD group was 0. These results indicate that while depression may be persistent among a greater percentage of children, PTSD is also chronic for up to a third of all children who have it at the time of a FAP report.



Conclusions

- **New, emergent case of depression and PTSD are rare among FAP children.**

Children that have no history of PTSD or depression at the time of a FAP report are at very low risk of developing this disorder over the three to four years following the FAP report. These children are less likely to have complex victimization histories and less likely to suffer revictimization over the follow-up period. Also, a proportion of these people also exhibit significant resiliency in the face of victimization and revictimization. Further research is required to better understand why some children are resilient over time, even with serious victimization and revictimization histories.

- **Up to one-half of FAP children with a disorder at the time of the FAP report will have chronic depression and/or PTSD.**

Children with a history of either major depression or PTSD at the time of a FAP report run a very high risk of continuing to experience those symptoms over time. While symptoms may wax and wane at any one point in time, over a three to four year follow-up period, children with a history of a diagnosis at FAP intake have about at 50% chance of meeting criteria for one of these serious disorders in the future.

Implications

- **Children with depression or PTSD need effective mental health care over time.**

Results reported in the first NFS report on FAP-referred children indicated that a large proportion of FAP-referred children, up to one-third, meet full diagnostic for one or both of these two very serious psychiatric disorders. Therefore, these children require adequate assessment and treatment for these problems at the time of FAP intake. These new results suggest that a large percentage of these children with a disorder at the time of intake, up to one-half, need not just immediate care, but likely will need longer term follow-up.

Course of Depression and PTSD Symptoms

A strength of the NFS is that multiple methods of assessment were used. Data presented above regarding the prevalence of a diagnosis of PTSD and depression at the four assessment points were from derived from the structured diagnostic interviews that were administered directly to children by trained research assistants. However, as noted above, children can suffer from many symptoms of depression and PTSD that greatly affect their functioning without meeting full diagnostic criteria. To better understand the level of symptoms experienced, children also were administered a battery of standardized, self-report measures that offer a more continuous picture of these symptoms. This battery included the Trauma Symptom Checklist for Children (TSCC), a 54 item multidimensional instrument that measures several important trauma-related symptoms. Results from three of the TSCC subscales, Anxiety, Depression, and Posttraumatic Stress (PTS), will be presented in this section. The battery also included the Children's Depression Inventory (CDI), a 27 item measure that assesses current depression symptoms in children. These self-report measures were administered to children at the initial assessment and at all three of the follow-up waves. The initial assessment (T1) provided important information on children's immediate reactions to the FAP report, and provided a baseline to track children's symptoms over time.

Children in the NFS were administered a battery of self-report questionnaires to address the following questions:

1. What types of symptoms do children experience immediately after a report has been made to FAP?

2. Do children's depression, anxiety and PTS symptoms change over time?

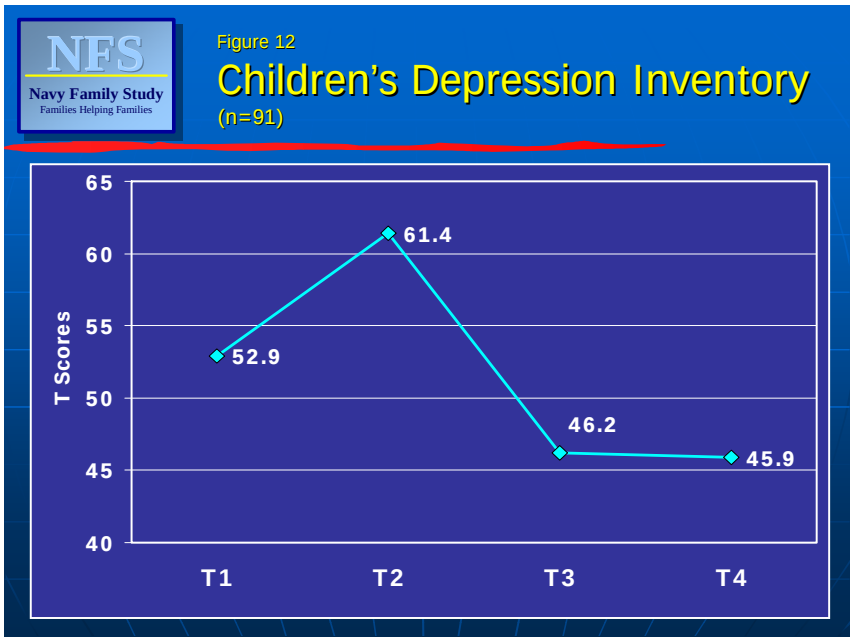
3. Are there gender differences in the types of symptoms reported by children?

4 Are there differences in children's symptoms as a result of exposure to partner violence?

In these analyses, only the 91 children who completed the full battery at all four assessment points were used. This subsample allows a more accurate depiction of the course of these symptoms over time.

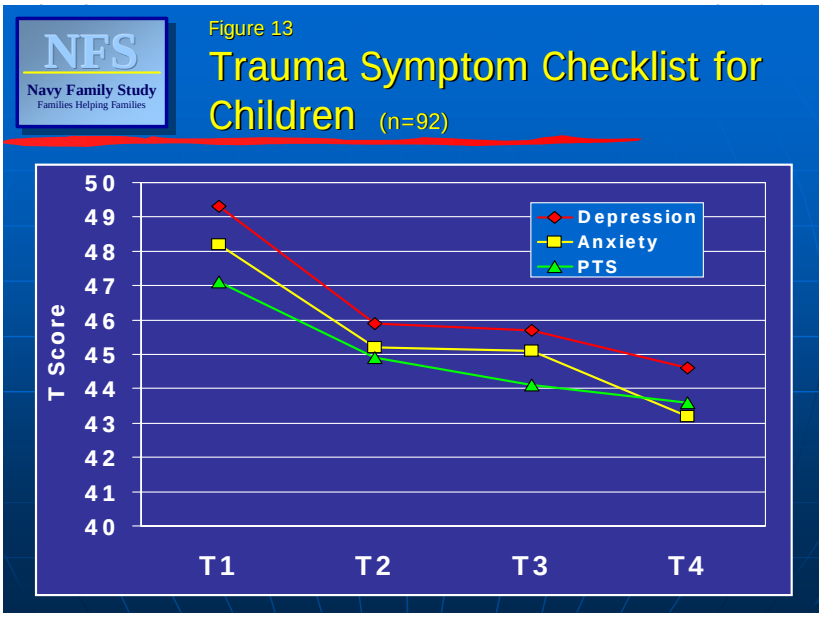
Child Symptoms Over Time

As seen in Figure 12, children reported higher levels of depression symptoms on the CDI at T2 compared to T1. This finding is in contrast to the drop in prevalence of the full depressive diagnosis at T2 seen in the analysis above. After T2, children's scores on the CDI declined over time. Again, this finding is in contrast to the increase in children meeting diagnostic criteria for depression found above. It seems that for many children,



as the time since the FAP report increased, they were less likely to report symptoms on the CDI. These differences in standardized scores vs. prevalence of diagnosis may be due to several factors. One obvious difference is measurement method. Children may respond differently due to method. However, the mix of levels of CDI scores among children with and without the diagnosis may be a factor as well.

A slightly different pattern of results were found on the TSCC (see Figure 13). No spike in reported symptoms occurred in T2. Instead, the children's TSCC scores gradually declined over time, suggesting an improvement in symptoms over time. It is important to note that these scores were not in the clinical range. Thus, as a group, children in the NFS were not reporting clinically elevated symptoms on this self-report measure. It is possible that this particular measure was not sensitive enough to children's symptoms or that it did not measure the types of difficulties that these children were experiencing. This explanation is likely given the fact that a significant number of children met diagnostic criteria for major depression and posttraumatic stress disorder based on information gathered from the interview. These findings highlight the importance of obtaining a variety of information from children, including both self-report questionnaires as well as direct interviews. Over-reliance on a single method of assessments may lead to under-identification of clinical problems.



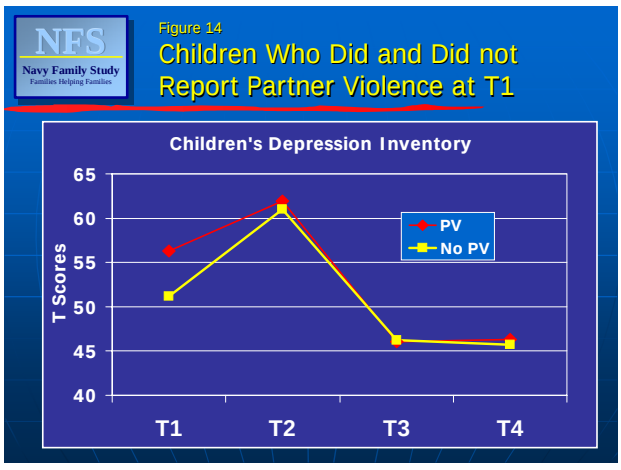
Gender Differences

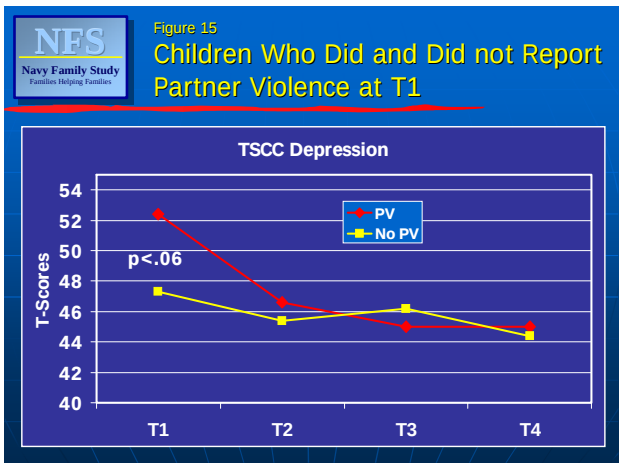
At the initial assessment, girls scored significantly higher on the CDI than boys, indicating greater levels of depression. However, there were no gender differences on the CDI for any other assessment time periods. Interestingly, on the TSCC Depression, Anxiety and PTS subscales, no gender differences were found at any of the assessment periods. With regard to the different findings between the CDI and TSCC, this suggests that the two measures may be assessing different components of depression. This lack of differences on some of the standardized measures may be due to the use of standard T-scores. T-scores control for gender and age effects. This fact bolsters the findings of gender differences on the CDI and supports the finding of a significantly greater level of depressive symptoms among girls.

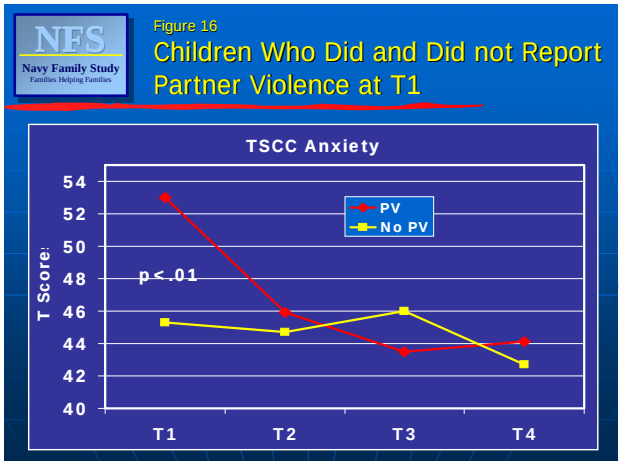
Symptoms and Exposure to Partner Violence

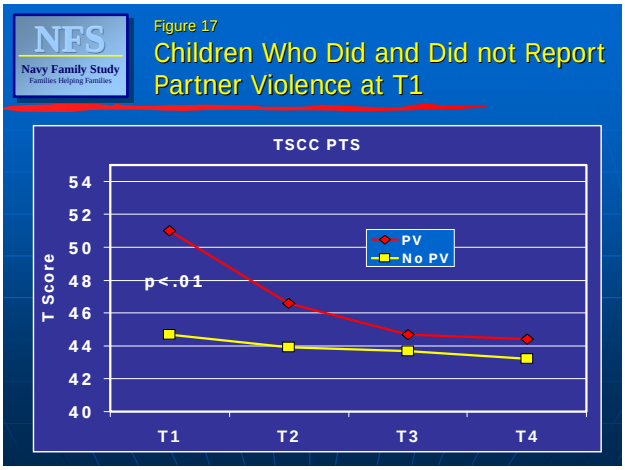
We also examined children's responses on the CDI and TSCC over time to determine if there were differences between those who reported witnessing partner violence during the initial T1 interview and those who did not. These data are presented in Figures 14-17 What is notable across all of these figures is that, on average, children gradually improved as the time since the FAP report increased. As stated above, these findings suggest that, for most children, symptoms will gradually improve over time. A second important point is that few children scored in the clinical range. Thus, although children were endorsing some symptoms of depression, anxiety, and PTS, few reported clinically significant problems on these measures. These findings differ somewhat from those found in the interview, where a significant number of children endorsed symptoms of major depression and/or PTSD. These somewhat discrepant findings highlight the importance of obtaining information using a variety methods.

With regard to specific findings on the CDI and TSCC, there are some points to highlight. On the CDI (see Figure 14), there was a spike in symptoms reported during T2. As seen in Figure 14, children's symptoms do dissipate over time which may correspond to a return to more stable family routines. On the CDI, there were no significant differences between children who did and did not report partner violence.









In contrast to findings on the CDI, there were differences between children who did and did not report partner violence on the TSCC. However, these were only significant for the T1 assessment. As seen in Figures 15-17, children who reported partner violence had significantly higher levels of depression, anxiety, and posttraumatic stress at T1. Over time, these symptoms declined for all children, with no differences noted between children reporting versus not reporting exposure to partner violence at T1

Conclusions

- **Depressive symptoms tend to increase between T1 and T2, then fall.**

After a report to FAP, many children undergo a significant number of changes and disruptions in their lives. These can exacerbate trauma symptoms. For example, they may be interviewed by numerous professionals for both forensic and clinical purposes. In some cases, families may be disrupted, with parents divorcing and children experiencing changes in custody and living arrangements. These types of changes undoubtedly impact children, and may spawn depressive symptoms, but not necessarily the full disorder.

- **Anxiety and traumatic stress symptoms tend to decrease over time.**

- **In general, there was no difference between boys and girls in the patterns of symptoms over time.**

- **Children who witnessed partner violence tend to have higher levels of symptoms at the initial assessment, but these differences dissipate over time.**

Findings from the NFS also indicated that children who reported exposure to partner violence do evidence more symptoms of depression and anxiety than children who do not report these experiences. These differences were particularly apparent during the initial assessment which occurred immediately after the report to FAP. These

findings suggest that it is important to intervene as soon as possible with these families to lessen the likelihood of future problems.

Implications

- **Ongoing assessment over time is indicated.**

Mental health problems and symptoms may be evident immediately after an incident occurs, as evidenced by the symptoms reported by NFS children at the initial assessment. As seen by these data, symptoms can worsen during the first several months following a report. Thus, it is important to assess children at multiple time points to determine if interventions are necessary. Findings from the NFS also indicated that, for most children, symptoms will dissipate over time. From a clinical perspective, these findings indicate that it is important to assess children periodically after a traumatic event has occurred to determine if they need intervention at any point in time.

- **Multiple methods of assessment are necessary.**

These findings from the NFS highlight the importance of including both self-report questionnaires as well as direct interviews with children in the assessment process. As seen in this report, different information can be obtained from an interview compared to self-report questionnaires. Both types of information yield important and clinically useful information, and, whenever possible, both methods should be included when assessing families reported to FAP.

Services Received by Child Clients of FAP

As has been confirmed by data from the NFS, exposure to many forms of violence is strongly linked to the development of a variety of mental health problems. This relationship has been known for some time. Therefore, it is surprising that nearly all studies have found that most children who are exposed to violence receive no treatment, those that do receive services often receive only minimal services, and the services received are often of questionable effectiveness. In short, most victimized children do not receive the services they need.

The reasons for this service deficit are many and complex. However, one factor is not that nothing is known about what services are effective. As part of a project completed for the U.S. Department of Justice, Saunders et al. (2004) surveyed 24 treatments commonly used with abused and traumatized children. Of these, 16 were found to have at least some empirical support for their effectiveness. Since data collection was completed for that project, more research has been completed further establishing certain treatments as clearly effective with this population. Therefore, while much research needs to be done and there is not an empirically supported treatment for every problem, there is a strong set of effective, evidence based treatments available for abused and traumatized children with the difficulties assessed in the NFS. The problem does not appear to be a lack of effective interventions, but rather a poor delivery system.

Another recently completed project, the Kauffman Best Practices Project (Chadwick Center for Families and Children, 2004) supported this conclusion. An effort of the National Child Traumatic Stress Network (www.nctsn.org), the Kauffman report concluded that clearly effective treatments are available for abused and traumatized children. It identified three "best practices" that should be used by nearly all mental health service delivery systems working with victimized youth. It also described the many difficulties associated with effective and rapid dissemination of evidence based treatments throughout the child service delivery system, and the many barriers that inhibit organizations from adopting evidence based practices.

In light of this national problem, a primary question for the NFS was, do children in families reported to FAP receive appropriate services. While this question cannot be answered fully based upon data collected from the children, such data are important since they reflect the perceptions of the children themselves. At the second assessment point (T2) approximately 9 months after the report to FAP, children were asked about the services they had received. These data are reported below.

One role of FAP is to gather information regarding the validity of the current report. Presumably, interviewing the child would be a primary source for gathering this information. These interviews may be done by military or civilian professionals. Table 12 presents the interviews that children reported they had undergone. The table describes the percentage of children that said they had undergone the different types of interviews and the mean number of each type of interview that were conducted with the children. Over one-quarter of the children (27%) stated that they had been interviewed by civilian police, 7% were interviewed by Navy law enforcement, and 7% had been

Table 12

T2, Number of Investigative Interviews of Children (N = 157)

Type of Interview	Percent	Mean (SD)
Civilian Police	26.8%	0.53 (1.21)
Navy Police	7.0%	0.11 (0.53)
CPS Caseworker	28.7%	0.69 (2.07)
FAP Caseworker	11.5%	0.24 (0.99)
Prosecutor	7.0%	0.09 (0.35)
Medical Exam	7.0%	0.11 (0.51)
Other	7.0%	0.17 (0.97)
Total Interviews	**54.1%**	**1.94 (3.27)**

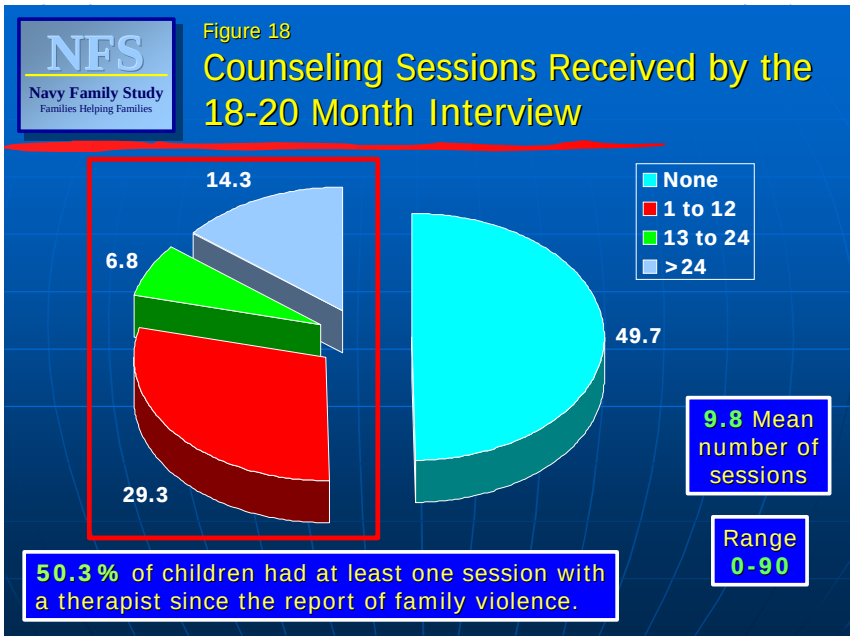
interviewed by either a civilian or military prosecutor. Therefore, at least 1 in 4 of these children had contact with either the Navy or civilian criminal justice system. Civilian caseworkers from child protective service workers interviewed 29% of the children. A forensic medical examination was described by 7% of the children. This type of examination is typically only conducted when there are charges of sexual abuse, which characterized only about 20% of the cases. Therefore, about one-third of the children in the sexual abuse cases received forensic medical examinations. Another 7% of children were interviewed by other types of professionals.

It is interesting to note that only 11.5% of these children could recall an assessment interview with a FAP caseworker. Further analysis of FAP records is required to better understand the how many children were actually interviewed by FAP. However, at this point, it seems that FAP interviewed 1 out of 10 of these children.

The average number of forensic interviews was examined by the type of FAP case report. Of children who were interviewed, children in cases reported for sexual abuse and children in physical abuse cases were both forensically interviewed an average of 2.4 times. Children in cases of partner violence were interviewed an average of 1 time.

Children were asked about their involvement in counseling sessions relating to the case reported to FAP at both the T2 and T3 assessment sessions. Figure 18 presents the number of counseling sessions received by the children that specifically concerned the allegations of the FAP report. By 18 to 20 months after the report of family violence to FAP, 50% of the children had received at least one counseling session. Most of these children (29% of all the children) received 1 to 12 therapy sessions, 7% of the children received 13 to 24 sessions, and 14% received more than 24 sessions of therapy. The average number of therapy sessions received by the children was 10 with a range of 0 to 90. Of the children who received some counseling, 74% received at least one session of individual therapy, 10% received some group therapy, and 42% received some family therapy.

These results raise the question as to whether or not this level of service delivery is good or bad compared to civilian populations. This is a difficult question to answer. Comparable data about forensic and investigative services is difficult to find. Therefore,



it is difficult to make a judgment regarding this performance. A more important question concerns whether these results conform to FAP policy and service delivery goals.

Burns and colleagues (Burns et al., 2004) have developed data regarding counseling services that may be helpful. They examined data from the National Survey of Child and Adolescent Well-Being, which is a survey of a nationally representative sample of 3,803 youth ages 2-14 with completed child welfare investigations. This sample is somewhat comparable to a FAP-referred sample of children, though they would be unlikely to include children reported to the system only for allegations of partner violence. Of these children in the child welfare system, only 15.8% had received any mental health services in the previous 12 months. Therefore, only 1 in 6 of these children received any mental health services. Data from the NFS indicated that 45.9% of the FAP-referred children had received mental health services by T2, which was 9 to12 months after the report to FAP. Therefore, children in these FAP-referred families were three times more likely to receive mental health services than the civilian children in this representative sample of children involved in the child welfare system. It should be noted that this is a conservative comparison for several reasons. First, the FAP sample includes children in families referred exclusively for partner violence. These types of cases are not often referred for child welfare investigations and children in partner violence cases are not referred for mental health services as often as abused children. Second, the service period length was longer in the Burns study than in the NFS, meaning those children had more time to receive services. So, this is conservative comparison.

Children who had received some counseling were asked if they thought it was helpful. Of these children, 48.6% believed the counseling was either Very or Extremely helpful. Therefore, nearly one-half of the FAP children judged the treatment they received as very helpful.

Children in families reported to FAP for sexual abuse received far more sessions of therapy, on average, than children in families reported to FAP for either physical abuse or partner violence. Children in sexual abuse cases received a mean of 22.8 sessions vs. 9.2 for physical abuse cases and 2.8 for partner violence cases. Therefore, sexual abuse cases get over twice as much counseling as other forms of violence. This

raises a question as to whether children are receiving services based only on the nature of the case reported, rather than their true mental health difficulties.

Presumably, children with a diagnosis or other serious mental health problem would receive more counseling sessions than those without such problems, regardless of the nature of the case reported to FAP. Table 13 examines the number of counseling sessions received by children according to the diagnoses and problems assessed at T1. In all cases except for delinquency, children with a diagnosis or assessed problem at T1 received more sessions of therapy between T1 and T3. In general, children with a diagnosis or significant problem received two to three times the number of counseling sessions than those that did not. Of course, as noted above, many of these problems are comorbid. But, these results do support the conclusion that children are more likely to receive significant mental health services if they, in fact, have a diagnosis or problem. Therefore, the children that seem to need help the most, appear to be getting the most help.

Table 13
Mean Number of Mental Health Sessions by T1 Diagnosis or Problem

Problem	Yes	No
Depression	10.97 (14.25)**	4.98 (9.54)
PTSD	15.05 (14.64)***	4.72 (9.39)
Alcohol Use	13.33 (15.05)*	5.57 (10.27)
Drug Use	16.70 (16.21)***	4.63 (8.92)
Delinquency	7.88 (10.73)	5.97 (10.88)

To better understand this issue of predictors of mental health services, a hierarchical multiple regression was conducted. These results are presented in Table 14. First, the type of FAP case report was entered in the predictive model. This relationship was significant and explained 17% of the variance in mental health sessions. Next, whether the child reported a history of sexual assault in the T1 interview was entered in the model. This variable was not significant. Finally, whether or not the child met diagnostic criteria for depression or PTSD at T1, or had problematic alcohol or drug use at T1, were all entered as a block. This block of problems was also statistically significant and explained an additional 9% of the variance in mental health sessions. Therefore, this analysis suggests that both the nature of the FAP case report, specifically a report of sexual abuse, and whether or not the child exhibits problems at T1 were independent predictors of the number of mental health sessions received.

Table 14
Predictors of Number of Mental Health Sessions

Variable	Beta	R^2	ΔR^2	Adj. R^2
Case	.28**	.17***	.17***	.16
SA	.06	.18***	.01^T	.17
Dep	-.03	.27***	.09**	.24
PTSD	.12			
Alcohol	.02			
Drug Use	.26**			

Conclusions

- **Approximately half of children in FAP families received some type of investigative interview.**

- **Only 1 in 9 children reported being interviewed by a FAP case manager.**

- **Approximately half of the children received at least some counseling during the 18-20 months following a report to FAP.**

- **Compared to data from a nationally representative sample of civilian children involved in child welfare investigations, three times as many children in FAP-referred families received mental health services.**

While only about half of FAP-referred children received mental health services, this is substantially more than civilian samples. A primary difference in FAP vs. civilian samples is that Navy children have a FAP manager. One logical explanation of the greater number of Navy vs. civilian children receiving services is the fact that a FAP manager is involved. The involvement of a FAP manager appears to triple the chances that a FAP referred child will receive mental health services. This could be considered the "value added" of FAP services.

- **Children in reported cases of sexual abuse received more mental health sessions.**

- **Children with a diagnosis or clinically significant problem received more counseling sessions.**

Implications

- **FAP program mangers need to consider if policy and procedures suggest that more children should be interviewed by FAP case mangers.**

Nearly all the data from the NFS have indicated that all children in FAP referred families should receive a clinical assessment, regardless of the nature of the allegation. Many children in "minor" cases of abuse, or cases of partner violence, have histories of serious personal victimization and significant mental health problems. They are in need of assessment and subsequent appropriate services. Such assessments may not necessarily be conducted by FAP case managers. But, case managers should insure that these children are evaluated by competent therapists if it is not done by FAP personnel.

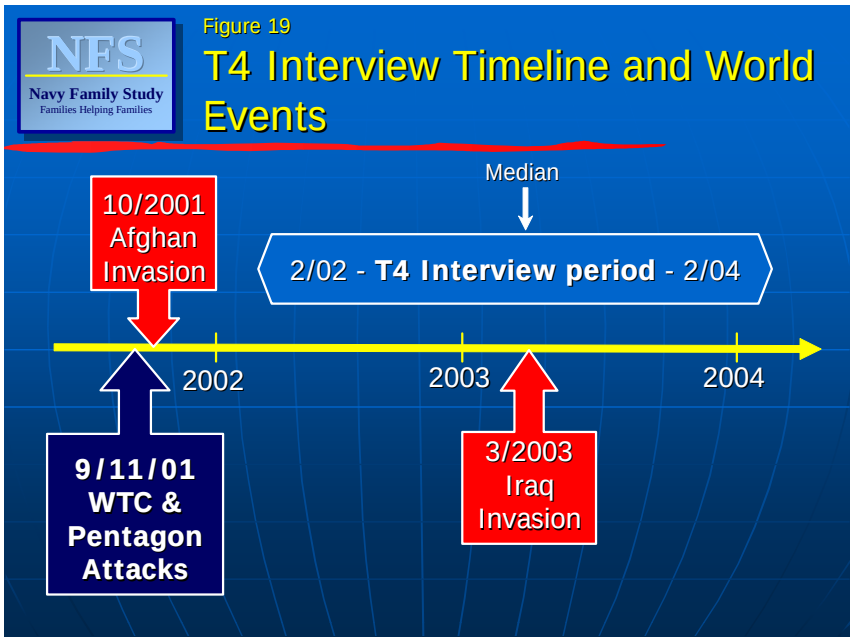
- **Children with mental health problems should receive mental health treatment, regardless of the nature of the FAP report.**

Data are encouraging that children with mental health problems receive more mental health sessions than those without problems. However, the biggest predictor of

mental health sessions is whether the FAP case report was about sexual abuse. While many of the children in these cases likely required services, it does raise the possibility that children in families reported for other forms of violence may be underserved. Sexual abuse cases typically garner more professional attention and concern than other types of family violence. This can result in other children receiving less attention and not getting the services they need.

Reactions to 9/11 and the Iraq-Afghanistan War

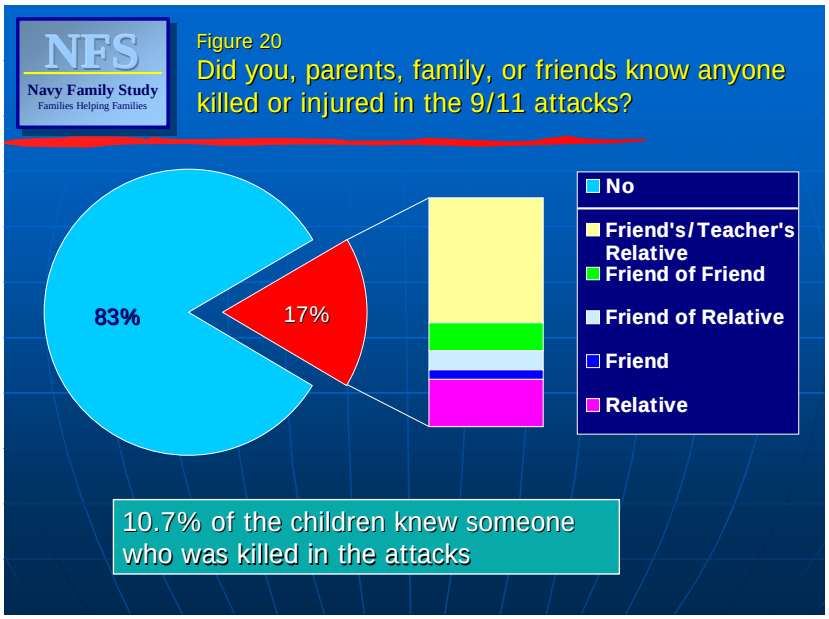
Children in military families may be uniquely vulnerable, compared to civilian children, in times of national crisis and war. In these times, military families bear significant responsibilities in any national response. They constantly face family separation, danger, and the possibility of injury or even death because of the job military parents have chosen. The 9/11 attacks and the war in Afghanistan occurred immediately before the final (T4) wave of the NFS went into the field. The war in Iraq began approximately half way through the T4 data collection period. Figure 19 depicts the timing of these events relative to the T4 data collection period. In an effort to obtain some description of how children were reacting to these attacks, given that many of them still had a parent in the military, questions were added about their level of exposure to the attacks, including watching replays of the attacks on the World Trade Towers, the aftermath of the WTC and Pentagon attacks, and whether or not they knew or knew of anyone injured or killed in the attacks. Specific questions were also added about their levels of fear and anxiety related to the attacks. Finally, questions were added about their concerns or fears about their military parent, whether their parent had been deployed to a combat zone, whether they had sustained any injuries, and their concerns for their parent.



At the T4 assessment point, 141 children completed the interview, which is 72.3% of the completed sample. Gender and racial/ethnic demographics of the T4 sample were similar to the original sample, with 65% of the sample being girls, about half white, 30% African American, and the rest other racial and ethnic identification. The obvious demographic difference from T1 was age. On average, children were now three years older and the average age at T4 was 15.5 years and ranged from 10 to 22 years. Of the children interviewed at T4, 85% still lived with their parents and 59.6% still had at least one parent in the Navy. The average length of time from the 9/11 attacks to the T4 interview was 18 months and 85% of the interviews were conducted within 2 years of the attacks. As noted in the figure above, about half of the interviews were conducted before the invasion of Iraq and about half after.

Regarding their exposure to the 9/11 attacks, about half (54%) of the children said they first learned about the attacks by seeing it on the television or hearing it on the

radio, and about a quarter (26%) learned about it from a teacher, principal, or counselor at school. Only 12% first learned of the attacks from a parent. Nearly 80% of the children (79.3%) estimated that they had seen replays of the planes hitting the buildings more than 10 times, 11% said they had seen them 5 to 10 times, 6% 3-5 times, and 3% 1 or 2 times. Therefore, this sample had relatively high exposure to media replays of the 9/11 events.



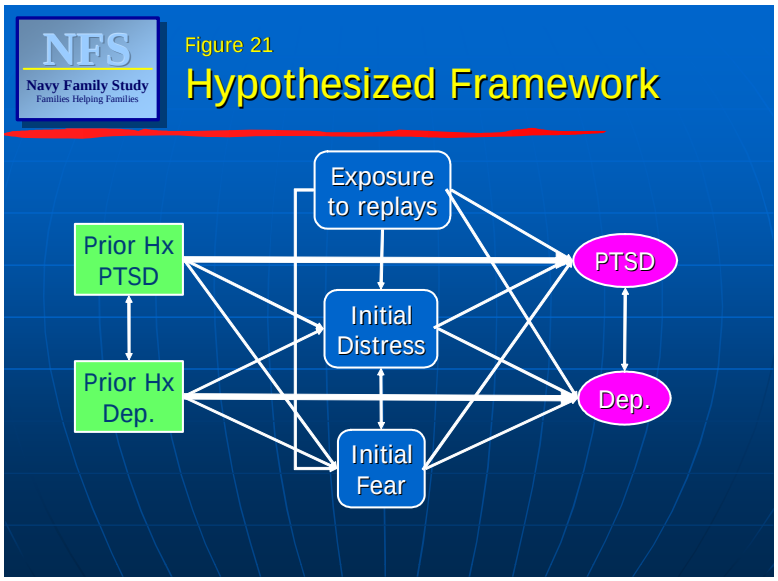
The children were asked if they, their parents, or friends know anyone who was killed or injured in the 9/11 attacks. As reported in Figure 20, 17% of the children responded "Yes," and 10.7% of the children indicated that they directly knew someone who was killed in the attacks at either the WTC or the Pentagon. The most common relationship was a friend's or teacher's relative, their own relative, or a friend of a friend. Therefore, a significant proportion of these children had some type of meaningful link with a person who was killed or injured in the attacks.

The children were asked how distressed or scared they were when they first heard about the attacks. One-third of the children (33.6%) indicated that they were Very or Extremely distressed by the attacks, and nearly one-quarter (23.0%) indicated they were Very or Extremely scared after the attacks. Two out of every 5 of the children (40.7%) indicated that they were Not at All or A Little distressed, and about a quarter (26.1%) said they were Not at All or A Little scared after the attacks. Therefore, a substantial proportion of the children were distressed and scared immediately after due to the attacks, but this feeling was not universal.

A significant question was whether the attacks were related to either major depression or PTSD diagnosis at the T4 assessment point. There has been much speculation about the mental health effects of such world events, and how they might differentially affect children. This is of particular interest to military families since they are called upon to respond to these national emergencies. If children are greatly affected by distress and fear due to the world events, that response may cause significant concern on the part of military parents. If this concern is great, it might affect their work performance, and ultimately, decrease military readiness. Therefore, if it possible to discern which children might be more or less affected by tragic world events that require a military response, services could be provided to those children to ease their distress.

This would decrease the concerns of military parents and have a direct impact on military readiness.

Based upon prior literature, it was hypothesized that several factors might explain the relationship between the 9/11 attacks and PTSD and depression symptoms at T4. First, children with a prior history of PTSD or depression were expected to be at greater risk. Second, children with greater exposure to the 9/11 events were expected to have higher levels of distress. So, children who had seen pictures of the events more, or knew of someone killed or injured in the attacks were expected to have more distress. Finally, it was expected that higher levels of initial distress to learning about the attacks would be related to greater subsequent distress. These relationships are depicted in the hypothesized model presented in Figure 21. This model reflects the temporal relationships between these factor and the hypothesized direction of impact. A prior history of PTSD or depression was expected to be the largest predictor, with the 9/11 exposure variables making a secondary contribution.



Depression at T4 was measured by the number of depression symptoms reported on the in-person interview, and the child's score on the Children's Depression Inventory. PTSD was measured by the number of PTSD symptoms reported in the interview and the PTS subscale of the Trauma Symptom Checklist for Children. Separate hierarchical multiple regression analyses were run for each of these dependent variables. In each of the models, whether or not the child met diagnostic criteria for either depression or PTSD, depending on the dependent variable, at T1 was entered first. Next the 9/11 exposure variables of number of TV replays viewed and if they knew of someone killed or injured in the attacks, were entered. Finally, the immediate reaction variables of distress and fear were entered.

In all four analyses, prior history of either depression or PTSD was statistically significant, with change in R^2 statistics ranging from .15 to .32. Therefore, as hypothesized, a prior history of depression at T1 was related to depression symptoms at T4, and the same for PTSD. However, neither the 9/11 exposure variables or the initial distress variables were significantly related to depression or PTSD symptoms at T4. Therefore, the hypotheses regarding these predictor variables were not supported. Greater exposure to media depictions of the 9/11 events, knowing of someone killed or injured in the attacks, and initial distress or fear were <u>not</u> related to T4 depression and PTSD symptoms controlling for a past history of depression or PTSD. The analysis did

confirm that a past history of PTSD or depression at T1 was a significant predictor of a greater number of these symptoms at T4.

These findings raised a second question. Perhaps a prior history of depression or PTSD is related to initial reactions of distress and fear related to the 9/11 attacks? That is, perhaps these children with prior mental health histories are more vulnerable to subsequent triggers for fear and anxiety. Correlational analysis indicated that both a prior history of depression and PTSD were significantly related to self-reported post-9/11 fears, but not initial distress (depression x fear, r=.14; PTSD x fear, r=.23). Though the associations were not large, they do provide some indication that children with a history of depression or PTSD maybe at increased risk for significant fear during times of national emergency.

Children also were asked how worried they were about a terrorist attack on their town or city. Given that most of these children had a parent in the Navy and were likely to be living in a city or town with a significant military presence, many might be concerned about a terrorist attack. Results indicated that about 1 out of 5 (21.4%) of these children were Very or Extremely worried that their city or town would be hit with a terrorist attack. Nearly 1 in 10 (9.4%) were Very or Extremely worried that they themselves might be injured or killed in a terrorist attack, and 1 in 4 (25.0%) were Very or Extremely worried about a parent being killed or injured in a terrorist attack. Interestingly, children with parents who had been in the Navy since 9/11 were <u>not</u> more likely to be worried about their parents being hurt in a terrorist attack than those whose parents were civilians. There also was no relationship between these fears and a prior history of depression or PTSD. These results indicate that a substantial proportion of these children had ongoing and significant fears of terrorist attacks, and fears that they or their parents might be killed or injured in a terrorist attack. Significant fears about terrorism appears to be present in about 1 in 4 of these children.

Of all the children interviewed at T4 (N=141), 91 (64.5%) had at least one parent who continued to be in the Navy after the 9/11 attacks, and 84 (59.6%) had at least one parent in the Navy at the time of the T4 interview. The 91 children with parents in the Navy after 9/11 were asked about several issues related to their parent's work that might cause significant stress in the family and for the child. These results are contained in Table 15. Nearly 40% of the children believed the parent was working more and at home less since the 9/11 attacks. Given that the Afghanistan war began soon after the attacks and the invasion of Iraq occurred during this data collection wave,

NFS Navy Family Study
Families Helping Families

Table 15

Since the 9/11 attacks...

T4 Question	Percent
Is parent working more, at home less	38.5
Has parent been deployed away from home	33.0
Has parent been deployed to a war zone	16.5
Has parent been in combat	8.8
Has parent been injured due to military duties	3.3

Note: Asked only of children with parent in military since 9/11, n=91.
No relationships to past or current depression or PTSD symptoms.

it is not surprising that many children noticed their Navy parents were working longer hours. One-third of the children indicated a parent had been deployed away from home and 1 in 6 reported their parent had been deployed to a war zone. Approximately 9% of the children indicated their parent had been in combat, and 3% had been injured due to military duties.

The children were also asked about their worries related to their military parent's job. Over one-third (35.2%) reported that they were Very or Extremely worried about their military parent's safety, and nearly 2 in 5 (38.5%) stated they were Very or Extremely worried about their parent being deployed to a war zone. Nearly one-half (48.4%) of the children stated that they were Very or Extremely worried that their military parent would be killed in war.

Of course, these results reflect only the report of the children in these families and may not be accurate representations of the Navy parent's true service and deployment schedule. However, these data are important because they reflect the perceptions of these Navy children about stressful life events related to their parent's job in the Navy. From a family stress standpoint, these perceptions likely are more important than the service reality. For example, even though a parent may have actually been deployed in a noncombat area, if a child perceives their parent as "at war," the stress will be just as great. Clearly, many Navy children do notice when there is a change in the workload of their parents due to a national emergency or war, and many have strong concerns when their parent is deployed, particularly to a war zone. Nearly half of these children fear that their parent will be killed in war. Therefore, the stress on these children during this time after the 9/11 attacks, after the Afghanistan war began, and for some, after the Iraq invasion, was very high. High levels of family stress and worries about children may be related to increased stress on the service member which produces more difficulties doing their job, particularly in times of national emergency. All of these factors may work to decrease force readiness. Therefore, understanding the impact of the job related factors on Navy service members' children is important to maintaining force readiness.

It is difficult to make a direct conclusion from these data about the overall readiness of sailors who had a history of being involved with FAP. It is often speculated that sailors who come into contact with FAP have greater problems with readiness. Unfortunately, the lack of a control group of sailors makes it impossible to answer this question. But, these results do suggest that a substantial proportion (one-third) of these Navy parents, all with a history of FAP involvement, were able to be deployed and many deployed to a war zone during the period immediately after 9/11. While further research is needed to determine specifically if a history of FAP involvement significantly reduces readiness, these results are encouraging about the potential impact on readiness for sailors with a history of involvement in FAP.

Conclusions

- **1 in 6 children knew or knew of someone killed or injured in the 9/11 attacks.**

- **One-third of the children were Very or Extremely distressed or fearful after the 9/11 attacks.**

- **Repeated exposure to media pictures of the 9/11 attacks or knowing of someone killed or injured in the attacks was not related to PTSD or depression symptoms at T4.**

This finding was counter to expected results. Prior research has suggested that greater exposure to a traumatic event was related to more serious mental health problems. Using these measures of exposure to 9/11 and controlling for a pre-9/11 history of depression or PTSD, this hypothesis was not supported.

- **The primary predictor of PTSD or depression symptoms at T4 was a prior history of these diagnoses at T1.**

Children with a prior history of PTSD or depression were at significantly greater risk than children with no history for having more of these symptoms at T4. This finding supports the conclusion that a prior history of these two disorders places children in a vulnerable situation for future mental health difficulties.

- **A prior history of depression or PTSD at T1 was associated with initial reactions of great fear following the 9/11 attacks.**

Children with a prior history of depression or PTSD were more likely than children with no history to be more fearful after the 9/11 attacks. This again, supports the conclusion that these children are more vulnerable to future stressful life events and may require special care.

- **1 in 5 children reported that they were Very or Extremely worried about a terrorist attack on their town or city.**

- **1 in 10 children reported that they were Very or Extremely worried about being killed in a terrorist attack.**

- **1 in 4 children reported that they were Very or Extremely worried about a parent being killed in a terrorist attack.**

A significant proportion of these children exhibited significant anxiety over issues related to terrorist attacks. These anxieties may result in increased family stress for the Navy service member, which may affect job performance and readiness.

- **Up to 40% of the children had noticed significant job related events for their Navy parent, including increased working hours, deployment, and deployment to a combat zone.**

- **1 in 3 children reported that they were Very or Extremely worried about their Navy parent's safety**

- **40% of the children reported that they were Very or Extremely worried about their parent being deployed to a war zone.**

- **Nearly half of the children reported that they were Very or Extremely worried about their parent being killed in a war.**

It is clear from these results, that the combat activities have affected many Navy children by increasing their level of fear an anxiety. Only about 1 in 6 of the children reported their parent had actually been in a combat zone. However, fully one-half of the children were very worried about their parent being killed I war. This level of fear and anxiety among this subset of children may be expressed in many different ways, including externalizing behavior problems. The increased family stress may affect the Navy service member's job performance and readiness.

It should be noted that a substantial proportion of these Navy children did not express serious fears over these war-related events. Given their age at this data collection wave (average age 15 years), it is unlikely that they are just too young to be aware of or understand world events. Therefore, they appear to be resilient in the face of this increased stress due to their parent's job in the Navy. Further research needs to be conducted to better understand why some Navy children are highly fearful and anxious concerning war-related events, and others are not. Better understanding this phenomenon of resilience in children could lead to interventions or programs that could help less resilient children, which would decrease family stress for the Navy service member and increase readiness.

Implications

- **Programs should be developed to respond to the increase fears and concerns of Navy children in the wake of national emergencies that require a military response.**

As noted above, a significant subset of Navy children had significant fears and concerns after 9/11, as well as worries concerning war-related events. A significant predictor of negative reactions appears to be a prior history of depression and PTSD. Therefore, children with a prior history could be targeted for special intervention and prevention programs to help them cope better with stress related to national emergencies and war.

- **Further research on Navy children is needed to better understand the dynamics of resilient children.**

Resiliency in children is an important topic in the child traumatic stress field. It may be particularly relevant to military children because of the unique stressors they face. Understanding better why some children are able to effectively manage this stress while others have more difficulty could lead to better prevention and intervention programs. If specific skills used by resilient children could be identified, programs could be developed to aid less resilient children by teaching those skills. As noted above, this

likely would have the effect of decreasing stress among particularly vulnerable Navy families, which likely would translate into better job performance and increased readiness. Therefore, specific research into this question is needed.

Results for Comparison Sample Children

In the comparison portion of the NFS, 127 families were recruited into the study. Each of these families had at least one child. However, approximately one-half of these children were not eligible for interview because they were under age 7, and only children age 7 to 17 were interviewed. Overall, 60 eligible children were interviewed in the comparison portion of the NFS. They were interviewed regarding their exposure to five types of violence and with respect to their lifetime and current experiences with Post-traumatic Stress Disorder (PTSD) and Major Depressive Episode (MDE). The sections below describe their demographic characteristics, reports of exposure to various forms of violence, and prevalence rates of PTSD and MDE.

Demographic Information

Table 16
Demographic Characteristics of Comparison Sample Children

	All	Interviewed
Gender	N=127	N=60
Male	44.5%	40.0%
Female	55.5%	60.0%
Race/Ethnic		
African-American	17.2	20.3%
White	55.5	45.8%
Hispanic/Latino	9.4	13.6%
Native American	0.8	1.7%
Mixed/Other	17.2	18.6%
Age (years, M (sd))	7.8 (5.2)	12.2 (2.9)

Demographic characteristics of all the children in the full sample and the interviewed children are presented in Table 16. The average age in the full sample of children was 7.8 years. Most were female, and most were white. Interviewed children averaged of 12.1 years of age. Exactly half (n=30) children were between 7-12 years, and half were 13 or older. With respect to gender, 60% (n=36) were girls. Exactly half the interviewed sample was Caucasian, with smaller percentages of African American, Mixed race, and Hispanic children.

Exposure to Violence and Victimization

As with the FAP sample, the 60 interviewed children in the Comparison sample were asked about their history of exposure to five types of personal victimization: sexual assault, physical assault in the community, physical abuse by a parent, witnessing serious community violence, and witnessing domestic (inter-parental) violence. Table 17 describes the prevalence of these violence types reported among all 60 of the interviewed Comparison sample children. These prevalence rates are also broken down by gender. Not surprisingly, the overall level of violence exposure was substantially lower in the Comparison sample, compared to the FAP sample. Although fully half of Comparison children reported exposure to at least one form of violence, among the FAP sample the prevalence rate of any type of violence exposure was nearly 90%. Rates of personal victimization and witnessed victimization are both lower among Comparison children. Similar to the FAP sample, witnessing severe community violence was by far the most commonly endorsed form of violence. In contrast to the FAP sample, however,

Table 17

Child-reported Exposure to Violence by Gender (N=60)

Violence Type	All	Girls*	Boys
Sexual Assault Victim	11.7	16.7	4.2
Physical Assault Victim	13.3	11.1	16.7
Physical Abuse Victim	11.7	5.6	20.8
Personal Assault	23.3	19.4	29.2
Witnessed Community Violence	46.7	50.0	41.7
Witnessed Domestic Violence	6.7	5.6	8.3
Witnessed Any Violence	46.7	50.0	41.7
Victim or Witness of Violence	50.0	52.8	45.8

*All gender differences are non-significant.

no gender differences in types of violence exposure were observed. This is likely due to the relatively small number of children in the Comparison sample. Even in this relatively young, nonreferred sample of Navy children, 1 in 6 of the girls had been the victim of a sexual assault, 1 in 6 boys had been physically assaulted in the community, 1 in 5 boys had been victims of physical abuse, half had witnessed serious community violence. Therefore, even in this community, non-referred sample of children, exposure to serious violence both in and outside of the home was far from rare.

Some age differences were found for prevalence of victimization with the Comparison children, although the number of age differences was lower than that found in the FAP sample. Again, this is likely due to the relatively low sample size for this group of children. Table 18 presents the prevalence of the five types of victimization assessed by age group. Children 12 and younger were much less likely to report witnessing severe community violence and experiencing sexual assault, compared to adolescents 13 and older. These differences were largely responsible for the overall greater exposure levels to all types of violence reported by the adolescents. This finding, which is consistent with data from the FAP sample, is consistent with the idea that older children and adolescents spend more time outside the home and away from their parents' supervision, and may therefore have greater exposure to potential perpetrators of violence and sexual assault. Older children also have lived longer and have had more years in which to get victimized compared to younger children. Therefore, this pattern of results was similar to that seen in the FAP sample.

Table 18

Child-reported Exposure to Violence by Age Group (N=60)

Violence Type	<= 12	>= 13
Sexual Assault Victim*	3.3	20.0
Physical Assault Victim	13.3	13.3
Physical Abuse Victim	10.0	13.3
Personal Assault	20.0	26.7
Witnessed Community Violence**	26.7	66.7
Witnessed Domestic Violence	3.3	10.0
Witnessed Any Violence**	26.7	66.7
Victim or Witness of Violence**	33.3	66.7

*X^2 $p<.05$; **$p<.01$

As described above, one of the most striking findings from the FAP sample was the very high proportion (69%) of children who reported being exposed to two or more types of violence. As the analysis above demonstrated, these children with complex

Table 19

Number of Victimization Types by Gender (N=60)

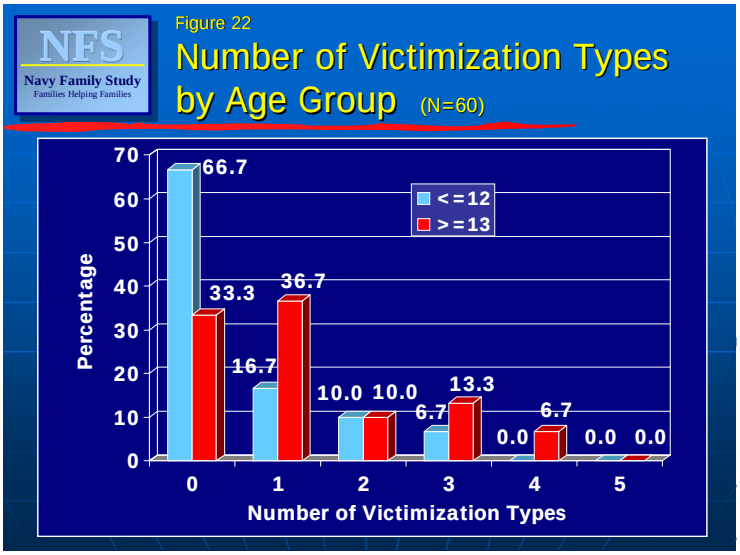
Number	All	Girls	Boys
0	50.0	47.2	54.2
1	26.7	30.6	20.8
2	10.0	11.1	8.3
3	10.0	8.3	12.5
4	3.3	2.8	4.2
5	0.0	0.0	0.0
Mean (SD)	.90 (1.2)	.89 (1.1)	.92 (1.2)

23.3% had experienced more than two types of violence.

victimization histories are at significantly greater risk for mental health problems. Table 19 presents the percentage of children in the comparison sample with complex victimization histories, broken down by gender. Although the proportion of Comparison children who reported exposure to two or more violence types was much smaller than the FAP sample, almost one-quarter of these non-referred children had complex victimization histories. None of the children in the Comparison sample reported experiencing all five violence types. In contrast to the FAP sample, there were no gender differences in the number of violence types reported. In this sample, boys were just as likely as girls to have complex victimization histories. Figure 22 indicates that adolescents were more likely to have experienced more types of violence than younger children. On average, teens reported more victimization types (M = 1.23) than younger children (M = 0.57), $t(58) = 2.34$, $p < .05$, and teens were more likely to have experienced 3 and 4 types of violence compared to younger participants. Again, this finding is not surprising for the reasons described above.

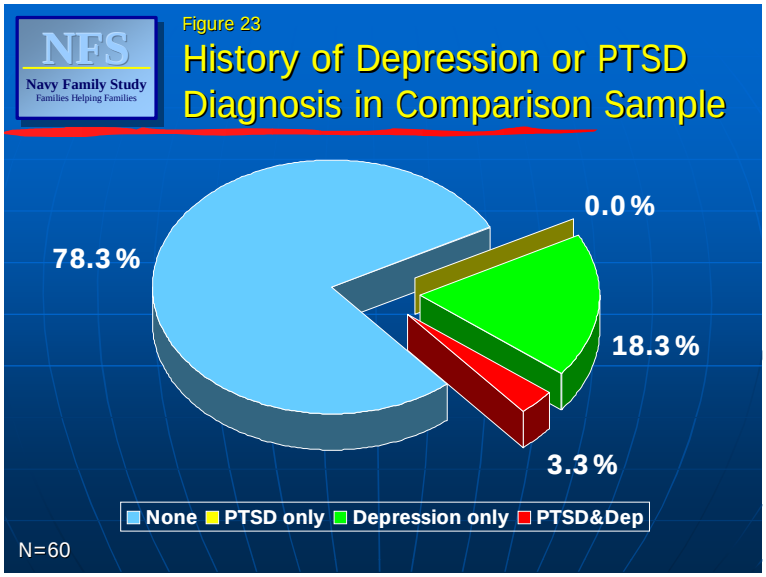
Figure 22

Number of Victimization Types by Age Group (N=60)



Mental Health

Children in the Comparison sample were administered two structured diagnostic interviews, one for major depressive disorder and one for PTSD. Compared to the FAP sample, rates of PTSD and major depression were notably lower in the Comparison sample. As presented in Figure 23, almost four out of five children (78.3%) in the Comparison sample had never met diagnostic criteria for either disorder at any time in their lives. Almost one in five (18.3%), however, had at some point in their lives met full diagnostic criteria for major depressive disorder. As might be expected given the lower rates of exposure to personal victimization in the Comparison sample, few children reported symptoms sufficient to warrant the diagnosis of PTSD. Indeed, the only children that did meet PTSD criteria also surpassed the diagnostic threshold from major depression. Of all comparison sample children, 3.3% had met full diagnostic criteria for



both PTSD and major depression. No child reported having PTSD without comorbid major depression.

Though the mix of single and comorbid disorders is somewhat different from the FAP sample, the prevalence of these two disorders is surprisingly high for a never referred community sample of relatively young children. In the FAP sample, the prevalence rate was 1 in 3 and in this sample it was approximately 1 in 5. This finding suggests that a significant percentage of Navy children have a positive history of either depression or PTSD.

Conclusions

- **1 in 2 of the children in this sample of never referred, relatively young Navy children reported exposure to at least one type of serious violence.**
- **2 out of 3 adolescents in this sample had been exposed to at least one form of serious violence.**
- **Rates of victimization within this sample were significantly less than in the FAP sample.**
- **Approximately 1 in 4 of these children had complex victimization histories.**
- **Older children were more likely to have complex victimization histories than younger children.**
- **1 in 5 of the comparison children had a history of either major depression, or both major depression and PTSD.**
- **Major depression and PTSD were less prevalent among the comparison sample than the FAP sample.**

Implications

- **Programs should be developed to identify at-risk children not referred to FAP.**

While, as expected, the prevalence rates of both victimization and mental disorders was significant less among the comparison sample participants compared to the FAP sample, the rates were not inconsequential. Fully one-half of these never referred children had been exposed to some form of serious violence and 1 in 5 had a history of one of these two serious mental disorders. As the previous analysis has demonstrated, these children are at great risk for revictimization and reoccurrence of these mental disorders. Outreach programs could be developed that are designed to identify these children and intervene in a preventative fashion, rather than waiting to respond to an emergent incident.

Conclusion

Results of this report build upon results described in the previous 15 November 2002 report regarding child participants in the NFS. Analyses in this report indicate that the Navy's Family Advocacy Program sees many children with complex victimization histories that go far beyond the nature of the emergent case. In fact, most children seen by FAP have a history of more than one type of victimization. The nature of their history is much more complex than the nature of the emergent incident that may have spawned a report to FAP. Similarly, many FAP children exhibit comorbid emotional and behavioral problems. FAP children who present with more than one psychiatric diagnosis or significant behavioral problem are not uncommon and comprise a large proportion of FAP children. Also, revictimization or new incidents of victimization in the years following a FAP report is common as well. The most significant risk period appears to be within the 9 months immediately after a FAP report. A positive finding was that a much larger proportion of FAP children receive appropriate services compared to civilian children who have been victimized. Data concerning the national emergency of 9/11 and the wars in Iraq and Afghanistan indicate that a substantial percentage of Navy children have a high level of anxiety about these world events and half are very concerned about their Navy parent being killed in war. However, despite these worries, half of these children either are definitely planning to join the military or are seriously considering it.

A variety of program and clinical recommendations were made in this report. Most involve insuring that all children living in families reported to FAP receive appropriate assessment and treatment services, along with other family members. While these services may be difficult to provide, in the long run they appear to work to reduce difficulties and problems in the family and help children improve in their functioning. Such services are likely to reduce stress in Navy families and result in improved job performance. In the long run, force readiness is improved.

As noted previously, children in current Navy families are the Navy's future. They will comprise a substantial proportion of future Navy recruits. Programs implemented now to provide help and support where needed not only will have immediate benefits, but will result in more functional and better prepared recruits in the future. Helping to provide Navy children with a safe, functional, supportive family life free from violence is a goal of the Navy's Family Advocacy Program. Accomplishing this goal helps contribute to force readiness today, and in the future.

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APPENDIX A

Event History Interview for Children

Clinical Assessment Interview for Children

Event History Interview for Children

Version 1.01

Client

Name:_____

Date of Birth:_____ Age:_____ Grade:_____

Race/Ethnic Identification:_____ Gender: M F

Interviewer:_____

Date of Interview_____

Place of Interview:_____

Note:
This interview schedule is a clinical adaptation of portions of the child interview schedule used in the ***Navy Family Study,*** conducted by the Wellesley Centers for Women at Wellesley College and the National Crime Victims Research and Treatment Center at the Medical University of South Carolina. Portions of this interview schedule were derived from the ***National Survey of Adolescents*** interview schedule developed by the National Crime Victims Research and Treatment Center at the Medical University of South Carolina. Questions about this interview schedule should be directed to Benjamin E. Saunders, Ph.D., National Crime Victims Research and Treatment Center, Medical University of South Carolina, 165 Cannon Street, Box 250852, Charleston, SC 29425.

STRESSFUL LIFE EVENTS

Now I am going to read you a list of experiences that can happen to people at one time or another. I'd like you to tell me which of these have happened to you <u>in the past year</u>.

In the past year.....(READ ITEM).

No.	Item	Yes	No	Not sure	Refused
L1.	**Have you moved to a new home**	1	2	8	9
L2.	**Have you changed to a new school.**	1	2	8	9
L3.	**Has a family member had a serious injury or illness**	1	2	8	9
L4.	**Have your parents separated or divorced**	1	2	8	9
L5.	**Has your mother or father lost their job**	1	2	8	9
L6.	**Has a close family member died**	1	2	8	9
L7.	**Has a close friend died**	1	2	8	9
L8.	**Has a close friend had a serious illness or injury**	1	2	8	9
L9.	**Have you gotten a new stepmother or stepfather**	1	2	8	9
L10.	**Have you gotten married**	1	2	8	9
L11.	**Have you gotten separated or divorced**	1	2	8	9
L12.	**Have you lost a close friend**	1	2	8	9
L13.	**Have you had to repeat a school grade**	1	2	8	9
L14.	**Have you had a serious personal illness or injury**	1	2	8	9
L15.	**Have you been suspended from school**	1	2	8	9
L16.	**Have you gotten a failing grade on a report card**	1	2	8	9
L17.	**Have you been in a natural disaster like a tornado, hurricane, or earthquake**	1	2	8	9
L18.	**Have you had a pet die**	1	2	8	9
L19.	**Have you had a house, trailer or apartment fire**	1	2	8	9

L20. **Anything else happen that was upsetting or distressing for you?**

_____

_____

WITNESSING VIOLENCE

I would like to ask about times when you may have seen one person violently attack another person? By seeing a violent attack, I mean when you have actually seen someone hit, beat up, rob, sexually assault, stab, shoot, or even kill another person. The people involved in the attack may have been strangers, people you did not know, or people you do know, like friends, neighbors, or even family members. These attacks could have happened at school, in your neighborhood, somewhere else, or even in your home.

We are not talking about things that have happened to you personally or things you have done. We are not talking about things you may have only heard about from friends, or family members. We want to know only about events that happened to other people but that you actually saw. We mean seeing violent attacks in real life, not on TV or in movies.

Have you ever... (READ ITEM BELOW)

No.	Item	Yes	No	Not sure	Refused
W1a.	**Seen someone actually shoot someone else with a gun?**	1	2	8	9
W2a.	**(Not counting any incidents you already told me about), seen someone actually cut or stab someone else with a knife or other sharp weapon?**	1	2	8	9
W3a.	**(Not counting any incidents you already told me about,) seen someone being molested, sexually assaulted or raped?**	1	2	8	9
W4a.	**(Not counting any incidents you already told me about,) seen someone being mugged or robbed?**	1	2	8	9
W5a.	**(Not counting any incidents you already told me about,) seen someone threaten someone else with a knife, a gun, or some other weapon?**	1	2	8	9
W6a.	**(Not counting any incidents you already told me about,) seen someone beaten up, hit, punched, or kicked such that they were hurt pretty badly?**	1	2	8	9

You mentioned you had seen.... (READ THE ITEMS ANSWERED WITH A "Yes"). **Now I would like to ask you some questions about those things you saw. Now, you said you had seen....** (READ THE FIRST ITEM ANSWERED WITH A "Yes").

W_b. SERIES: **How many times have you seen something like this happen?**

ENTER NUMBER IN BOX BELOW.

W_c. TIME: **When was the last time you saw this happen? Was it.....**

1 = **Within the past week**
2 = **Within the past month**
3 = **Within the past 6 months**
4 = **Within the past year**
5 = **More than a year ago**

8 = Not sure
9 = Refused

W_d. WHERE: **The last time you saw this happen, where did it happen? Was it.....**

	Clarifications if needed:
1 = **At home**	(By "home", I mean inside your house/apartment/trailer or in your front or backyard)
2 = **At school**	(By "at school," I mean in the school building, on school grounds, or on a school bus)
3 = **In your neighborhood**	(By "neighborhood", I mean the area near your home)
4 = **In the community**	(Outside of the neighborhood)
5 = **Somewhere else**	(SPECIFY THE LOCATION)
8 = Not sure	
9 = Refused	

W_e. VICTIM: **The last time you saw this happen, who was the person who was attacked?**

WRITE IN THE RELATIONSHIP TO THE CHILD

W_f. PERP: **The last time you saw this happen, who was the person who did it?**

WRITE IN THE RELATIONSHIP TO THE CHILD

W_g. FEAR: **Whenever you have seen this happen, what is the most afraid you have been?**

1 = **Not at all afraid**	8 = Not sure
2 = **A little afraid**	9 = Refused
3 = **Very afraid**	

W_h. INJURY: **Whenever you have seen this happen, were you ever afraid that you yourself might be physically hurt or injured?**

1 = Yes	8 = Not sure
2 = No	9 = Refused

W_i. KILLED: **Whenever you have seen this happen, were you afraid that you yourself might actually be killed?**

1 = Yes	8 = Not sure
2 = No	9 = Refused

WITNESSING VIOLENCE FOLLOW-UP QUESTIONS ANSWER CODE BOX.

a	b.	c.	d.	If d. = 5	e.	f.	g.	h.	i.
W	Series	Time	Where	Location -- Write in	Victim	Perp	Fear	Injury	Killed
1									
2									
3									
4									
5									
6									

W7. **How dangerous or violent is the neighborhood in which you live? Would you say it is....**

1._____ **Not at all dangerous or violent**
2._____ **A little dangerous or violent**
3._____ **Very dangerous or violent**

W8. **What is the scariest or most frightening thing you ever saw happen in your neighborhood?**

_____

_____

W8. **How dangerous or violent is the school your go to? Would you say it is....**

1._____ **Not at all dangerous or violent**
2._____ **A little dangerous or violent**
3._____ **Very dangerous or violent**

W8. **What is the scariest or most frightening thing you ever saw happen at your school?**

_____

_____

SEXUAL ASSAULT

Now I would like to ask you about a person doing sexual things to a young person that the young person doesn't want. These unwanted sexual things can happen to boys as well as girls, and to young men as well as young women. People who try to do unwanted sexual things to young people are not always strangers. They can be someone you know well like a friend, neighbor, teacher, coach, counselor, baby-sitter, minister or priest. They can even be a boyfriend or a family member. They can even be a parent. People who try to make young people do unwanted sexual things aren't always men or boys -- they can also be women or girls. I would like you to think about <u>any</u> experiences you have ever had where someone tried to make you do something sexual you didn't want to do, no matter who did it, or whether or not it was reported to police or other authorities.

S1. **Has a man or boy ever put a sexual part of his body inside your private sexual parts, inside your rear end, or inside your mouth when you didn't want him to? By "sexual part of his body" we mean his penis.**

SAY TO GIRLS ONLY: **By "your private sexual parts", we mean your vagina.**

(1) _____ Yes GO TO SUMMARY BOX AND ASK CF1 - CF3
(2) _____ No
(8) _____ Not sure
(9) _____ Refused

S2. **(Not counting any incidents you already told me about), has anyone, male or female, ever put fingers or objects inside your private sexual parts or inside your rear end when you didn't want them to?**

(1) _____ Yes GO TO SUMMARY BOX AND ASK CF1 - CF3
(2) _____ No
(8) _____ Not sure
(9) _____ Refused

S3. **(Not counting any incidents you already told me about), has anyone, male or female, ever put their mouth on your private sexual parts when you didn't want them to?**

SAY TO BOYS: **By "private sexual parts" we mean your penis.**
REMIND GIRLS YOU MEAN THEIR VAGINA

(1) _____ Yes GO TO SUMMARY BOX AND ASK CF1 - CF3
(2) _____ No
(8) _____ Not sure
(9) _____ Refused

S4. **(Not counting any incidents you already told me about), has anyone, male or female, ever touched any of your private sexual parts when you didn't want them to.**

SAY TO GIRLS: **By "any of you private sexual parts" we mean your breasts or your vagina.**

(1) _____ Yes GO TO SUMMARY BOX AND ASK CF1 - CF3
(2) _____ No
(8) _____ Not sure
(9) _____ Refused

S5. **(Not counting any incidents you already told me about), has anyone, male or female, ever made you touch their private parts when you didn't want to?**

(1) _____ Yes GO TO SUMMARY BOX AND ASK CF1 - CF3
(2) _____ No
(8) _____ Not sure
(9) _____ Refused

S6. **(Not counting the incidents you already told me about), has anyone, male or female, ever touched other parts of your body in a sexual way when you did not want them to?**

(1) _____ Yes GO TO SUMMARY BOX AND ASK CF1 - CF3
(2) _____ No
(8) _____ Not sure
(9) _____ Refused

S7. ASK BOYS ONLY. IF NOT A BOY, SKIP TO S8a.

(Not counting any incidents you already told me about), has a woman or girl ever put <u>your</u> private sexual part inside her body when you didn't want her to?

IF NECESSARY, EXPLAIN THAT "inside her body" MEANS VAGINA OR ANUS

(1) _____ Yes GO TO SUMMARY BOX AND ASK CF1 - CF3
(2) _____ No
(8) _____ Not sure
(9) _____ Refused

SEXUAL ASSAULT INCIDENTS SUMMARY BOX

Incident Number	Screening Question Number S1-S7	CF1 -- Perpetrator's relationship to the child	CF2-- Age of the child
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

SCREENING ITEMS FOLLOW-UP QUESTIONS

CF1. **What was your relationship to the person who did this to you -- friend, neighbor, boyfriend, parent, uncle, cousin, teacher, stranger or what?**

IF THE INCIDENT HAD MORE THAN ONE PERPETRATOR, ASK CHILD ABOUT THE ONE WHO DID THE MOST, OR THE WORST ACTS....THE ONE THEY CONSIDER THE MAIN PERPETRATOR

WRITE THE RELATIONSHIP OF THE PERPETRATOR TO THE CHILD IN THE BOX ABOVE.

CF2. **How old were you when this happened?**

WRITE IN THE CHILD'S AGE AT THIS INCIDENT IN THE BOX ABOVE.

CF3. **Has anyone else ever done this to you?**
(READ/REMIND CHILD OF CURRENT SCREENING QUESTION)

MAKE SURE THE CHILD UNDERSTANDS THAT "this" MEANS THE BEHAVIOR DESCRIBED IN THE SCREENING QUESTION YOU ARE WORKING ON, NOT OTHER TYPES OF SEXUAL ASSAULTS. OTHER TYPES OF SEXUAL ASSAULT WILL BE COVERED LATER.

IF THE CHILD ANSWERS "Yes", WRITE IN THE SCREENING ITEM NUMBER IN THE NEXT AVAILABLE ROW IN THE BOX ABOVE AND GO TO CF1 AND ASK THE SCREENING ITEMS FOLLOW-UP QUESTIONS ABOUT THIS NEW INCIDENT. CONTINUE TO ASK ABOUT NEW INCIDENTS UNDER THIS SCREENING QUESTION UNTIL THE CHILD ANSWERS "No" TO CF3. THEN GO TO THE NEXT SCREENING QUESTION ABOVE.

CHECKPOINT: FOR FOLLOW-UP TO SEXUAL ASSAULT SCREENING QUESTIONS

EXAMINE THE "SEXUAL ASSAULT INCIDENTS SUMMARY BOX" ABOVE AND NOTE THE NUMBER OF SEXUAL ASSAULT INCIDENTS REPORTED BY THE CHILD. GO TO THE NUMBER OF SEXUAL ASSAULT INCIDENTS BELOW AND FOLLOW THE DIRECTIONS.

Number

0 --> IF THE CHILD REPORTED NO SEXUAL ASSAULT INCIDENTS, SKIP TO THE NEXT SECTION.

1 --> IF THE CHILD REPORTED ONLY ONE SEXUAL ASSAULT INCIDENT, ASK S9a.

S9a. **You said that ....**(RECALL THE INCIDENT FROM THE SUMMARY BOX).
I like to ask you some questions about that incident.

GO TO SF1. GO THROUGH THE SEXUAL ASSAULT FOLLOW-UP LOOP AND MARK ANSWERS IN THE "First" COLUMN, THEN GO TO NEXT SECTION.

2 --> IF THE CHILD REPORTED TWO SEXUAL ASSAULT INCIDENTS, ASK S9b.

S9b. **You said that..**(RECALL THE TWO INCIDENTS FROM THE SUMMARY BOX).

Which of these incidents happened to you first?
CROSS CHECK AGES AND CLARIFY IF NECESSARY.

RECORD THE INCIDENT NUMBER OF THE FIRST INCIDENT FROM THE SUMMARY BOX.

_____ Incident number of FIRST sexual assault

Now I would like to ask you some questions about that FIRST incident.
GO TO SF1. GO THROUGH THE SEXUAL ASSAULT FOLLOW-UP LOOP FOR THE FIRST INCIDENT AND MARK ANSWERS IN THE "First" COLUMN. THEN RETURN AND ASK S9c.

S9c RECORD THE INCIDENT NUMBER OF THE SECOND INCIDENT FROM THE SUMMARY BOX.

_____ Incident number of MOST RECENT sexual assault

You said that.. (RECALL THE SECOND INCIDENT FROM THE SUMMARY BOX).

Now I'd like to ask you some questions about the other incident.
GO TO SF1. GO THROUGH THE SEXUAL ASSAULT FOLLOW-UP LOOP FOR THE MOST RECENT INCIDENT AND MARK ANSWERS IN THE "MRecent" COLUMN. THEN GO TO NEXT SECTION.

3 --> IF THE CHILD REPORTED THREE OR MORE SEXUAL ASSAULT INCIDENTS, ASK S9d.

S9d. **You said that ....**(RECALL THE INCIDENTS FROM THE SUMMARY BOX).

Which of these incidents happened to you first?
CROSS CHECK AGES AND CLARIFY IF NECESSARY.

RECORD THE INCIDENT NUMBER OF THE FIRST INCIDENT FROM THE SUMMARY BOX

_____ Incident number of FIRST sexual assault

Now I would like to ask you some questions about that first incident.
GO TO SF1. GO THROUGH THE SEXUAL ASSAULT FOLLOW-UP LOOP FOR THE FIRST INCIDENT AND MARK ANSWERS IN THE "First" COLUMN. THEN RETURN AND ASK S9e.

S9e. **You said that..**(RECALL THE OTHER INCIDENTS FROM THE SUMMARY BOX).

Which of these incidents happened to you most recently?
CROSS CHECK AGES AND CLARIFY IF NECESSARY.

RECORD THE INCIDENT NUMBER OF THE MOST RECENT INCIDENT FROM THE SUMMARY BOX.

_____ Incident number of the MOST RECENT sexual assault

Now I would like to ask you some questions about that MOST RECENT incident.

GO TO SF1. GO THROUGH THE SEXUAL ASSAULT FOLLOW-UP LOOP FOR THE MOST RECENT INCIDENT AND MARK ANSWERS IN THE "MRecent" COLUMN, THEN GO TO S9f.

S9f. IF THE CHILD REPORTED ONLY ONE OTHER SEXUAL ASSAULT, RECORD THE INCIDENT NUMBER BELOW.

IF THE CHILD REPORTED MORE THAN ONE OTHER SEXUAL ASSAULT, ASK.....

You said that..(RECALL THE REMAINING INCIDENTS FROM THE SUMMARY BOX).

Which of these other incidents, not counting the FIRST or the MOST RECENT ones we already talked about, was the most serious, most distressing, or worst for you?

RECORD THE INCIDENT NUMBER OF THE WORST INCIDENT FROM THE SUMMARY BOX

_____ Incident number of the WORST sexual assault

Now I would like to ask you some questions about that incident. (GO TO SF1 FOR "Worst")

SEXUAL ASSAULT FOLLOW-UP QUESTIONS

SF1. **How old were you when this (first) happened?**

IF INCIDENT IS A SERIES, RECORD CHILD'S AGE WHEN IT STARTED.
WRITE IN AGE OR CODE

First		MRecent		Worst			
						Code:	88 = Not sure
____	____	____	____	____	____	Age in years	99 = Refused

SF2. **Was this a single incident or a series of incidents where the same person did similar things over a period of days, weeks, or months?** CHECK ONE.

	First	MRecent	Worst	
(1)	_____	_____	_____	Single incident
(2)	_____	_____	_____	Series of incidents
(8)	_____	_____	_____	Not sure
(9)	_____	_____	_____	Refused

F/U SF3. **How old were you the last time this happened?** WRITE IN AGE OR CODE

First		MRecent		Worst			
						Code:	98 = Not sure
____	____	____	____	____	____	Age in years	99 = Refused

F/U SF4. **How often did this happen to you?**

	First	Mrecent	Worst	
(1)	_____	_____	_____	Once a week or more
(2)	_____	_____	_____	2-3 times per month
(3)	_____	_____	_____	Once a month
(4)	_____	_____	_____	Once every two to three months
(5)	_____	_____	_____	Once every six months
(6)	_____	_____	_____	Once a year
(7)	_____	_____	_____	Less than once a year

SF5. IF INCIDENT IS FOR SCREENING QUESTIONS S1 OR S2 ASK THE FOLLOWING QUESTIONS. ELSE SKIP.

Did the person (persons) who did this:

WRITE IN CODE IN SPACES BELOW
Code: 1 = Yes 8 = Not sure
2 = No 9 = Refused

ASK GIRLS ONLY:

	First	MRecent	Worst	
SF5a.	_____	_____	_____	**Put their sexual parts inside your sexual parts**
SF5b.	_____	_____	_____	**Put their fingers inside your sexual parts**
SF5c.	_____	_____	_____	**Put objects inside your sexual parts**

ASK BOYS AND GIRLS:

	First	MRecent	Worst	
SF5d.	_____	_____	_____	**Put their sexual parts inside your rear end**
SF5e.	_____	_____	_____	**Put their sexual parts inside your mouth**
SF5f.	_____	_____	_____	**Put their fingers inside your rear end**
SF5g.	_____	_____	_____	**Put objects inside your rear end**

SF6. **Where did this incident take place? Was it ... ?**

	First	MRecent	Worst	
(1)	_____	_____	_____	**In your home**
(2)	_____	_____	_____	**At school**
(3)	_____	_____	_____	**In your neighborhood**
(4)	_____	_____	_____	**Somewhere else**
(8)	_____	_____	_____	Not sure
(9)	_____	_____	_____	Refused

F/U SF7. IF SF6 IS (4) "Somewhere else", SPECIFY THE LOCATION BELOW

First:_____

MRecent:_____

Worst:_____

SF8. **Was the person who did this to you male or female?**

	First	Mrecent	Worst	
(1)	_____	_____	_____	Male
(2)	_____	_____	_____	Female
(8)	_____	_____	_____	Not sure
(9)	_____	_____	_____	Refused

SF9. **About how old was this person?**

First	MRecent	Worst		
				Code: 88 = Not sure
_____	_____	_____	Age in years	99 = Refused

SF10. **When this happened, did the person use physical force, or threaten to physically hurt you or someone else you care about if you didn't do what they wanted? Did the person ...**
Code: 1= Yes 2=No 8=Not sure 9=Refused

	First	MRecent	Worst	
(a)	_____	_____	_____	**Use physical force**
(b)	_____	_____	_____	**Threaten to physically hurt you**
(c)	_____	_____	_____	**Threatened to hurt someone else**

SF11. **Did the person make other threats, pressure you, use tricks, or give you bribes and rewards to get you to do what they wanted? Did the person ...**
Code: 1= Yes 2=No 8=Not sure 9=Refused

	First	MRecent	Worst	
(a)	_____	_____	_____	**Threaten to tell someone something**
(b)	_____	_____	_____	**Threaten to take something away or not let you do something**
(c)	_____	_____	_____	**Use pressure**
(d)	_____	_____	_____	**Use tricks**
(e)	_____	_____	_____	**Use bribes or rewards**
(f)	_____	_____	_____	**Do something else**

SF12. **Did the person say anything to you about telling others about what they did? Did the person ...**
Code: 1= Yes 2=No 8=Not sure 9=Refused

	First	MRecent	Worst	
(a)	_____	_____	_____	**Tell you not to tell anyone**
(b)	_____	_____	_____	**Tell you they would get into trouble or go to jail if you told**
(c)	_____	_____	_____	**Threaten to hurt you if you told**
(d)	_____	_____	_____	**Threaten to hurt someone else if you told**
(e)	_____	_____	_____	**Tell you something bad would happen if you told**
(f)	_____	_____	_____	**Say you would get into trouble if you told**
(g)	_____	_____	_____	**Do something else**

SF13. **During this incident, how afraid were you, if at all? Were you...**

	First	MRecent	Worst	
(1)	_____	_____	_____	**Not at all afraid**
(2)	_____	_____	_____	**A little afraid**
(3)	_____	_____	_____	**Very afraid**
(8)	_____	_____	_____	Not sure
(9)	_____	_____	_____	Refused

SF14. **During this (these) incident(s), were you ever afraid that you might be seriously injured?**

	First	MRecent	Worst	
(1)	_____	_____	_____	Yes
(2)	_____	_____	_____	No
(8)	_____	_____	_____	Not sure
(9)	_____	_____	_____	Refused

SF15. **During this (these) incident(s), were you ever afraid that you might even be killed?**

	First	MRecent	Worst	
(1)	_____	_____	_____	Yes
(2)	_____	_____	_____	No
(8)	_____	_____	_____	Not sure
(9)	_____	_____	_____	Refused

SF16. **Did you suffer serious physical injuries, minor injuries or no injuries, as a result of the incident(s)?**

	First	MRecent	Worst	
(1)	_____	_____	_____	No injuries
(2)	_____	_____	_____	Minor injuries
(3)	_____	_____	_____	Major injuries
(8)	_____	_____	_____	Not sure
(9)	_____	_____	_____	Refused

SF17. **Have you ever told anyone about this incident?**

	First	MRecent	Worst	
(1)	_____	_____	_____	Yes
(2)	_____	_____	_____	No
(8)	_____	_____	_____	Not sure
(9)	_____	_____	_____	Refused

F/U SF18. **Who did you tell first?** WRITE IN RELATIONSHIP TO CHILD

First:_____

MRecent:_____

Worst:_____

F/U SF19. **How long after the incident did you first tell someone about it?**

	First	MRecent	Worst	
(1)	_____	_____	_____	Within one day
(2)	_____	_____	_____	Within one week
(3)	_____	_____	_____	Within one month
(4)	_____	_____	_____	Within six months
(5)	_____	_____	_____	Within one year
(6)	_____	_____	_____	1 to 3 years
(7)	_____	_____	_____	More than 3 years later
(8)	_____	_____	_____	Not sure
(9)	_____	_____	_____	Refused

SF20. **How afraid were you to tell someone, if at all?**

	First	MRecent	Worst	
(1)	_____	_____	_____	**Not at all afraid**
(2)	_____	_____	_____	**A little afraid**
(3)	_____	_____	_____	**Very afraid**
(8)	_____	_____	_____	Not sure
(9)	_____	_____	_____	Refused

SF21. **Was this incident ever reported to the...**

Code: 1= Yes 2=No 8=Not sure 9=Refused

	First	MRecent	Worst	
(a)	_____	_____	_____	**Police**
(b)	_____	_____	_____	**Child Protection Agency**
(c)	_____	_____	_____	**Other authorities**

SF22. **Did anyone like a caseworker, a police officer, a detective, or someone like that ever talk to you about exactly what happened in this incident, and ask for lots of details about it? Did you ever talk to a....**

Code: 1= Yes 2=No 8=Not sure 9=Refused

	First	MRecent	Worst	
(a)	_____	_____	_____	**Police officer or detective**
(b)	_____	_____	_____	**Caseworker from child protective services**
(c)	_____	_____	_____	**Caseworker from a child advocacy center**
(d)	_____	_____	_____	**Prosecutor**
(e)	_____	_____	_____	**Other investigating authorities**

F/U SF23. **How many times were you interviewed about what happened?**

First		MRecent		Worst		WRITE IN NUMBER., "88" = Not sure "99" = Refused
____	____	____	____	____	____	

F/U SF24. **How hard and distressing were these interviews for you? Were they.....?**

	First	MRecent	Worst	
(1)	_____	_____	_____	**Not at all hard and distressing**
(2)	_____	_____	_____	**A little hard and distressing**
(3)	_____	_____	_____	**Very hard and distressing**
(8)	_____	_____	_____	Not sure
(9)	_____	_____	_____	Refused

SF25. **Did you ever see a doctor and have a medical examination because of this incident?** CHECK ONE.

	First	MRecent	Worst	
(1)	_____	_____	_____	Yes
(2)	_____	_____	_____	No
(8)	_____	_____	_____	Not sure
(9)	_____	_____	_____	Refused

F/U SF26. **How hard and distressing was this medical examination for you? Was it.....?**

	First	MRecent	Worst	
(1)	_____	_____	_____	**Not at all hard and distressing**
(2)	_____	_____	_____	**A little hard and distressing**
(3)	_____	_____	_____	**Very hard and distressing**
(8)	_____	_____	_____	Not sure
(9)	_____	_____	_____	Refused

SF27. **Was this person (any of the persons) who did this arrested for this incident?**

	First	MRecent	Worst	
(1)	_____	_____	_____	Yes
(2)	_____	_____	_____	No
(8)	_____	_____	_____	Not sure
(9)	_____	_____	_____	Refused

SF28. **Did you ever have to testify in any court about this incident?**

	First	MRecent	Worst	
(1)	_____	_____	_____	Yes
(2)	_____	_____	_____	No
(8)	_____	_____	_____	Not sure
(9)	_____	_____	_____	Refused

F/U SF29. **How many times have you testified in court about this incident?**

First	Mrecent	Worst	
			88= Not sure 99= Refused
____ ____	____ ____	____ ____	

F/U SF30. **How hard and distressing was it for you to testify in court? Was it.....**

	First	Mrecent	Worst	
(1)	_____	_____	_____	**Not at all hard and distressing**
(2)	_____	_____	_____	**A little hard and distressing**
(3)	_____	_____	_____	**Very hard and distressing**
(4)	_____	_____	_____	**Extremely hard and distressing**
(8)	_____	_____	_____	Not sure
(9)	_____	_____	_____	Refused

SF31. **Did the person who did this ever go to jail for doing this to you?**

	First	Mrecent	Worst	
(1)	_____	_____	_____	Yes
(2)	_____	_____	_____	No
(8)	_____	_____	_____	Not sure
(9)	_____	_____	_____	Refused

PHYSICAL ASSAULT

Sometimes young people get hit, beaten up or physically assaulted by another person. The person who hits, attacks or beats-up a young person isn't always a stranger, but can be someone who the young person knows well. It can be a family member, a friend, a dating or romantic partner, or even a parent. The person doing the hitting can be older than the young person, about the same age, or even younger than the young person. Young people tell us they sometimes get hit, attacked or beaten up at school, in their neighborhood, or even at home. These types of attacks even can happen to small children sometimes. Many times, young people never tell anyone about these events. I would like you to think about any experiences you have ever had like this.

P1. **Has anyone -- including family members, dating partners, or friends – ever <u>attacked</u> you with a gun, knife or some other weapon, regardless of whether you ever reported it to the police or other authorities.**

(1) _____ Yes GO TO SUMMARY BOX AND ASK AF1 - AF3
(2) _____ No
(8) _____ Not sure
(9) _____ Refused

P2. **(Not counting any incidents you already told me about), has anyone -- including family members, dating partners, or friends -- ever physically <u>attacked</u> you <u>without</u> a weapon, and you thought they were trying to kill or seriously injure you.**

(1) _____ Yes GO TO SUMMARY BOX AND ASK AF1 - AF3
(2) _____ No
(8) _____ Not sure
(9) _____ Refused

P3. **(Not counting any incidents you already told me about), has anyone -- including family members, dating partners, or friends – ever <u>threatened</u> you <u>with</u> a gun or knife, but didn't actually shoot or cut you?**

(1) _____ Yes GO TO SUMMARY BOX AND ASK AF1 - AF3
(2) _____ No
(8) _____ Not sure
(9) _____ Refused

P4. **(Not counting any incidents you already told me about), has ever anyone -- including family members, dating partners, or friends -- <u>beat you up</u>, <u>attacked you</u>, or <u>hit you</u> with something like a stick, club, or bottle so hard that you were hurt pretty bad?**

(1) _____ Yes GO TO SUMMARY BOX AND ASK AF1 - AF3
(2) _____ No
(8) _____ Not sure
(9) _____ Refused

P5. **(Not counting any incidents you already told me about), has anyone -- including family members, dating partners, or friends -- ever beat you up with their <u>fists</u> so hard that you were hurt pretty bad?**

(1) _____ Yes GO TO SUMMARY BOX AND ASK AF1 - AF3
(2) _____ No
(8) _____ Not sure
(9) _____ Refused

<u>PHYSICAL ASSAULT SCREENING ITEMS FOLLOW-UP QUESTIONS</u>

AF1. **What was your relationship to the person who did this to you -- friend, neighbor, boyfriend, parent, uncle, cousin, teacher, stranger or what?**

WRITE THE RELATIONSHIP OF THE PERPETRATOR TO THE CHILD IN THE BOX BELOW.

AF2. **How old were you when this happened?**

WRITE IN THE CHILD'S AGE AT THIS INCIDENT IN THE BOX BELOW.

AF3. **Has someone else ever done this to you?**

IF THE CHILD ANSWERS "Yes", WRITE IN THE SCREENING ITEM NUMBER IN THE NEXT AVAILABLE ROW IN THE BOX BELOW AND GO TO PF1 AND ASK THE SCREENING ITEMS FOLLOW-UP QUESTIONS ABOUT THIS NEW INCIDENT. CONTINUE TO ASK ABOUT NEW INCIDENTS UNDER THIS SCREENING QUESTION UNTIL THE CHILD ANSWERS "No" TO AF3. THEN GO TO THE NEXT SCREENING QUESTION ABOVE (P1 - P5)

PHYSICAL ASSAULT INCIDENTS SUMMARY BOX

Incident Number	Screening Question Number P1-P5	AF1 -- Perpetrator's relationship to the child	AF2-- Age of the child
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

CHECKPOINT:FOR FOLLOW-UP TO PHYSICAL ASSAULT SCREENING QUESTIONS

EXAMINE THE "PHYSICAL ASSAULT INCIDENTS SUMMARY BOX" ABOVE AND NOTE THE NUMBER OF PHYSICAL ASSAULT INCIDENTS REPORTED BY THE CHILD. GO TO THE NUMBER OF PHYSICAL ASSAULT INCIDENTS BELOW AND FOLLOW THE DIRECTIONS.

Number

0 --> IF THE CHILD REPORTED NO PHYSICAL ASSAULT INCIDENTS, SKIP TO THE NEXT SECTION.

1 --> IF THE CHILD REPORTED ONLY ONE PHYSICAL ASSAULT INCIDENT, ASK P6a.

P6a. **You said that ....**(RECALL THE INCIDENT FROM THE SUMMARY BOX).
I like to ask you some questions about that incident.

GO TO PF1. GO THROUGH THE PHYSICAL ASSAULT FOLLOW-UP LOOP AND MARK ANSWERS IN THE "First" COLUMN, THEN GO TO NEXT SECTION.

2 --> IF THE CHILD REPORTED TWO PHYSICAL ASSAULT INCIDENTS, ASK P6b.

P6b **You said that ....**(RECALL THE TWO INCIDENTS FROM THE SUMMARY BOX).
Which of these incidents happened to you first?

CROSS CHECK AGES AND CLARIFY IF NECESSARY.
RECORD THE INCIDENT NUMBER OF THE FIRST INCIDENT FROM THE SUMMARY BOX.

_____ Incident number of FIRST physical assault

Now I would like to ask you some questions about that FIRST incident.

GO TO PF1. GO THROUGH THE PHYSICAL ASSAULT FOLLOW-UP LOOP FOR THE FIRST INCIDENT AND MARK ANSWERS IN THE "First" COLUMN. THEN RETURN AND ASK P6c.

P6c RECORD THE INCIDENT NUMBER OF THE SECOND INCIDENT FROM THE SUMMARY BOX.

_____ Incident number of MOST RECENT physical assault

You said that ....(RECALL THE SECOND INCIDENT FROM THE SUMMARY BOX). **Now I'd like to ask you some questions about the other incident.**

GO TO PF1. GO THROUGH THE PHYSICAL ASSAULT FOLLOW-UP LOOP FOR THE MOST RECENT INCIDENT AND MARK ANSWERS IN THE "MRecent" COLUMN.

3 --> IF THE CHILD REPORTED THREE OR MORE PHYSICAL ASSAULT INCIDENTS, ASK P6d.

P6d. **You said that ....**(RECALL THE INCIDENTS FROM THE SUMMARY BOX). **Which of these incidents happened to you first?**

CROSS CHECK AGES AND CLARIFY IF NECESSARY.
RECORD THE INCIDENT NUMBER OF THE FIRST INCIDENT FROM THE SUMMARY BOX

_____ Incident number of FIRST physical

Now I would like to ask you some questions about that first incident.

GO TO PF1. GO THROUGH THE PHYSICAL ASSAULT FOLLOW-UP LOOP FOR THE FIRST INCIDENT AND MARK ANSWERS IN THE "First" COLUMN. THEN RETURN AND ASK P6e.

P6e. **You said that ....**(RECALL THE OTHER INCIDENTS FROM THE SUMMARY BOX). **Which of these incidents happened to you most recently?**

CROSS CHECK AGES AND CLARIFY IF NECESSARY.
RECORD THE INCIDENT NUMBER OF THE MOST RECENT INCIDENT FROM THE SUMMARY BOX

_____ Incident number of the MOST RECENT physical assault

Now I would like to ask you some questions about that MOST RECENT incident.

GO TO PF1. GO THROUGH THE PHYSICAL ASSAULT FOLLOW-UP LOOP FOR THE MOST RECENT INCIDENT AND MARK ANSWERS IN THE "MRecent" COLUMN. THEN GO TO P6f.

P6f. IF THE CHILD REPORTED ONLY ONE OTHER PHYSICAL ASSAULT, RECORD THE INCIDENT NUMBER BELOW.

IF THE CHILD REPORTED MORE THAN ONE OTHER PHYSICAL ASSAULT, ASK.....

You said that...(RECALL THE REMAINING INCIDENTS FROM THE SUMMARY BOX). **Which of the other incidents, not counting the FIRST or the MOST RECENT we already talked about, was the most serious, most distressing, or worst for you?**

RECORD THE INCIDENT NUMBER OF THE WORST INCIDENT FROM THE SUMMARY BOX

_____ Incident number of the WORST physical assault

Now I would like to ask you some questions about that incident.

PHYSICAL ASSAULT FOLLOW-UP QUESTIONS LOOP

PF1. **How old were you when this happened?** WRITE IN AGE OR CODE

First Mrecent Worst

____ ____ ____ ____ ____ ____Age in years

Code: 88 = Not sure
99 = Refused

PF2. **Where did this incident take place? Was it ... ?**

	First	Mrecent	Worst	
(1)	_____	_____	_____	**In your home**
(2)	_____	_____	_____	**At school**
(3)	_____	_____	_____	**In your neighborhood**
(4)	_____	_____	_____	**Somewhere else**
(8)	_____	_____	_____	Not sure
(9)	_____	_____	_____	Refused

F/U PF3. IF PF2 IS (4) "Somewhere else", SPECIFY THE LOCATION BELOW

First: _____

MRecent: _____

Worst: _____

PF4. **Was the person who did this to you male or female?**

	First	Mrecent	Worst	
(1)	_____	_____	_____	Male
(2)	_____	_____	_____	Female
(8)	_____	_____	_____	Not sure
(9)	_____	_____	_____	Refused

PF5. **About how old was this person?** WRITE IN AGE OR CODE. Code: 888 = Not sure, 999 = Refused

First Mrecent Worst

____ ____ ___ ____ ____ ____ ____ ____ ____ Age in years

PF6. **During this incident, how afraid were you, if at all? Were you...**

	First	MRecent	Worst	
(1)	_____	_____	_____	**Not at all afraid**
(2)	_____	_____	_____	**A little afraid**
(3)	_____	_____	_____	**Very afraid**
(8)	_____	_____	_____	Not sure
(9)	_____	_____	_____	Refused

PF7. **During this incident, were you ever afraid that you might be seriously injured?**

	First	Mrecent	Worst	
(1)	_____	_____	_____	Yes
(2)	_____	_____	_____	No
(8)	_____	_____	_____	Not sure
(9)	_____	_____	_____	Refused

PF8. **During this (these) incident(s), were you ever afraid that you might even be killed?**

	First	Mrecent	Worst	
(1)	_____	_____	_____	Yes
(2)	_____	_____	_____	No
(8)	_____	_____	_____	Not sure
(9)	_____	_____	_____	Refused

PF9. **Did you suffer serious physical injuries, minor injuries or no injuries, as a result of the incident(s)?**

	First	Mrecent	Worst	
(1)	_____	_____	_____	No injuries
(2)	_____	_____	_____	Minor injuries
(3)	_____	_____	_____	Major injuries
(8)	_____	_____	_____	Not sure
(9)	_____	_____	_____	Refused

PF10. **Did you see a doctor and have a medical examination or treatment because of this incident?**

	First	MRecent	Worst	
(1)	_____	_____	_____	Yes
(2)	_____	_____	_____	No
(8)	_____	_____	_____	Not sure
(9)	_____	_____	_____	Refused

PF11. **Have you ever told anyone about this incident?**

	First	Mrecent	Worst	
(1)	_____	_____	_____	Yes
(2)	_____	_____	_____	No
(8)	_____	_____	_____	Not sure
(9)	_____	_____	_____	Refused

F/U PF12. **Who did you tell first?** WRITE IN RELATIONSHIP TO CHILD

First:_____

MRecent:_____

Worst:_____

F/U PF13. **How long after the incident did you first tell someone about it?** CHECK THE BEST ANSWER

	First	Mrecent	Worst	
(1)	_____	_____	_____	Within one day
(2)	_____	_____	_____	Within one week
(3)	_____	_____	_____	Within one month
(4)	_____	_____	_____	Within six months
(5)	_____	_____	_____	Within one year
(6)	_____	_____	_____	1 to 3 years
(7)	_____	_____	_____	More than 3 years
(8)	_____	_____	_____	Not sure
(9)	_____	_____	_____	Refused

PF14. **Was this incident ever reported to the...**
Code: 1= Yes 2=No 8=Not sure 9=Refused

	First	MRecent	Worst	
(a)	_____	_____	_____	**Police**
(b)	_____	_____	_____	**Child Protection Agency**
(c)	_____	_____	_____	**Other authorities**

PF15. **Did anyone like a caseworker, a police officer, a detective, or someone like that ever talk to you about exactly what happened in this incident, and ask for lots of details about it? Did you ever talk to a....**
Code: 1= Yes 2=No 8=Not sure 9=Refused

	First	MRecent	Worst	
(a)	_____	_____	_____	**Police officer or detective**
(b)	_____	_____	_____	**Caseworker from child protective services**
(c)	_____	_____	_____	**Caseworker from a child advocacy center**
(d)	_____	_____	_____	**Prosecutor**
(e)	_____	_____	_____	**Other investigating authorities**

F/U PF16. **How many times were you interviewed about what happened?**

First		MRecent		Worst		WRITE IN NUMBER., "88" = Not sure "99" = Refused
____	____	____	____	____	____	

F/U PF17. **How hard and distressing were these interviews for you? Were they.....?**

	First	MRecent	Worst	
(1)	_____	_____	_____	**Not at all hard and distressing**
(2)	_____	_____	_____	**A little hard and distressing**
(3)	_____	_____	_____	**Very hard and distressing**
(8)	_____	_____	_____	Not sure
(9)	_____	_____	_____	Refused

PF18. **Was the person (any of the persons) who did this arrested for this incident?**

	First	MRecent	Worst	
(1)	_____	_____	_____	Yes
(2)	_____	_____	_____	No
(8)	_____	_____	_____	Not sure
(9)	_____	_____	_____	Refused

PF19. **Did you ever have to testify in any court about this incident?** CHECK ONE.

	First	MRecent	Worst	
(1)	_____	_____	_____	Yes
(2)	_____	_____	_____	No
(8)	_____	_____	_____	Not sure
(9)	_____	_____	_____	Refused

F/U PF20. **How many times have you testified in court about this incident?**

First		Mrecent		Worst		
						88= Not sure
						99= Refused
____	____	____	____	____	____	

F/U PF21. **How hard and distressing was it for you to testify in court? Was it.....**

	First	Mrecent	Worst	
(1)	_____	_____	_____	**Not at all hard and distressing**
(2)	_____	_____	_____	**A little hard and distressing**
(3)	_____	_____	_____	**Very hard and distressing**
(8)	_____	_____	_____	Not sure
(9)	_____	_____	_____	Refused

PF22. **Did the person who did this ever go to jail for doing this to you?** CHECK ONE.

	First	Mrecent	Worst	
(1)	_____	_____	_____	Yes
(2)	_____	_____	_____	No
(8)	_____	_____	_____	Not sure
(9)	_____	_____	_____	Refused

PHYSICAL ABUSE

ASK ABOUT WHETHER ANY PARENT OR OTHER PRIMARY CAREGIVER LIVING IN THE HOME, HAS EVER DONE ANY OF THESE THINGS TO THE CHILD.

Different families have different ways of punishing or disciplining young people if they think they have done something wrong. Now I would like to ask you about some things that any of your parents might have done when they thought you had done something wrong or at any other time.

READ BEFORE EACH ITEM: **Has any parent ever .....** (READ THE ITEM).

No.	Item	Yes	No	Don't know	Refused
A1.	**Yelled or screamed at you**	1	2	8	9
A2.	**Sent you to your room, taken away something you liked, or not let you do something you wanted to do**	1	2	8	9
A3.	**Called you bad names or cursed at you**	1	2	8	9
A4.	**Spanked you with their hand**	1	2	8	9
A5.	**Slapped you on the head or face with their hand**	1	2	8	9
A6.	**Pushed or shoved you around**	1	2	8	9
A7.	**Spanked or hit you with something like a belt, hairbrush, switch, paddle or other hard object.**	1	2	8	9
A8a.	**Spanked or hit you so hard it caused bad marks, bruises, cuts or welts on you**	1	2	8	9
A9a.	**Beat you up, hit you with a fist, or kicked you hard**	1	2	8	9
A10a.	**Grabbed you around the neck or choked you**	1	2	8	9
A11a.	**Burned or scalded you on purpose**	1	2	8	9
A12a.	**Locked you in a closet, tied you up, or tied you to something**	1	2	8	9
A13a.	**Threatened you with a gun, knife, or other weapon**	1	2	8	9
A14a.	**Used a knife or fired a gun at you on purpose**	1	2	8	9

CHECKPOINT: FOR EACH "Yes" IN QUESTIONS A8a THRU A14a, ASK THE FOLLOW-UP SERIES QUESTIONS A_b THRU A_i BELOW. MARK THE ANSWERS IN THE PHYSICAL ABUSE FOLLOW-UP QUESTIONS CODE BOX. IF ALL A7a THRU A14a ARE "No", SKIP TO THE NEXT SECTION

You said one of your parents or caregivers had.....(READ ITEMS ANSWERED WITH A "Yes"). ***Now I would like to ask you some questions about each of these incidents. I'd like you to think about...***(READ THE INCIDENT). REPEAT FOR EACH "Yes" ITEM.

A_b. SERIES: **Has this happened more than once?**

1 = Yes
2 = No
8 = Not sure
9 = Refused

A_c. AGEF: **How old were you when this happened the first time?**

A_d. AGEL: **How old were you the last time this happened?**

A_e. FRE: **How often has this happened to you?**

1 = Once a week or more
2 = 2-3 times per month
3 = Once a month
4 = Once every two to three months
5 = Once every six months
6 = Once a year
7 = Less than once a year

A_f,g. PARENT 1, 2: **Which of your parents or caregivers has done this?**

WRITE-IN THE CAREGIVERS RELATIONSHIP TO THE CHILD.
IF MORE THAN ONE CAREGIVER, LIST THE TWO WHO HAVE DONE IT THE MOST.

A_h. FEAR: **When this has happened, how frightened or scared were you, if at all? Were you...**

1 = **Not at all afraid**
2 = **A little afraid**
3 = **Very afraid**
8 = Not sure
9 = Refused

A_i. INJURY THREAT: **When this happened, did you ever think you might be physically injured?**

A_j. LIFE THREAT: **When this happened, did you ever think you might actually be killed?**

A_k. INJURY: **Did you ever have any physical injuries as a result of this?**

A_l. DOCTOR: **Did you see a doctor because of this?**

CODE FOR ALL QUESTIONS:

1 = Yes
2 = No
8 = Not sure
9 = Refused

PHYSICAL ABUSE FOLLOW-UP QUESTIONS CODE BOX

Item	b. Series	c. AGEF	d. AGEL	e. FRE	f. CAREGIVER 1	g. CAREGIVER 2	h. Fear	i. Inj. threat	j. Life threat	k. Injury	l. Doctor
8a.											
9a.											
10a.											
11a.											
12a.											
13a.											
14a.											

OBSERVING PARENTAL VIOLENCE

Sometimes parents get angry and argue or even fight with each other. I would like to ask you some questions about times you might have seen or heard your parents argue, fight, or even get violent with each other.

READ BEFORE EACH ITEM. **Have you ever seen or heard.....** (READ THE ITEM)

F/U IF THE RESPONSE IS "Yes", ASK, **Did you actually <u>see</u> it happen or only <u>hear</u> it happen?**

No.	Item	See	Hear Only	No	Don't Know	Refused
V1.	**Your parents argue with each other**	1	2	3	8	9
V2.	**One of your parents yell or scream at the other**	1	2	3	8	9
V3.	**One of your parents call the other one bad names or curse at them**	1	2	3	8	9
V4a.	**One of your parents throw something at the other one that could hurt**	1	2	3	8	9
V5a.	**One of your parents push or shove the other one in anger**	1	2	3	8	9
V6a.	**One of your parents slap the other one on the head or face with their hand**	1	2	3	8	9
V7a.	**One of your parents punch or hit the other one with their fist or kick them real hard**	1	2	3	8	9
V8a.	**One of your parents beat up the other**	1	2	3	8	9
V9a.	**One of your parents choke the other**	1	2	3	8	9
V10a.	**One of your parents hit the other with an object like a pan, bat, lamp, or vase.**	1	2	3	8	9
V11a.	**One of your parents threaten the other with a gun, knife, or other weapon**	1	2	3	8	9
V12a.	**One of your parents actually used or tried to use a gun, knife, or other weapon against the other**	1	2	3	8	9

You said you had seen your parents...(READ ITEMS ANSWERED WITH A "Yes"). ***Now I would like to ask you some questions about each of these incidents. I'd like you to think about...***(READ THE FIRST INCIDENT). REPEAT.

CODE FOR ALL QUESTIONS: 1 = Yes 8 = Not sure
2 = No 9 = Refused

V_b. SERIES: **Have you seen or heard this happen more than once?**

V_c. AGEF: **How old were you when this happened the first time?**

V_d. AGEL: **How old were you the last time this happened?**

V_e. FRE: **How often have you seen or heard this happen?**

1 = Once a week or more
2 = 2-3 times per month
3 = Once a month
4 = Once every two to three months
5 = Once every six months
6 = Once a year
7 = Less than once a year

V_f,g. PARENT 1, 2: **Which of your parents have you seen or heard do this?**

V_h. FEAR: **When you saw or heard this happen, how frightened or scared were you, if at all? Were you...**

1 = **Not at all afraid**
2 = **A little afraid**
3 = **Very afraid**
8 = Not sure
9 = Refused

V_i. INJURY THREAT: **When you saw or heard this happen, were you worried that you might be physically hurt or injured?**

V_j. LIFE THREAT: **When you saw or heard this happen, did you ever think you might actually be killed?**

V_k. PARENT INJURY: **When you saw or heard this happen, were you afraid one of your parents might be physically hurt?**

V_l. PAR. LIFE THREAT: **When you saw or heard this happen, were you afraid one of your parents would be killed?**

V_m. INJURED: **When you saw or heard this happen, was either parent physically injured?**

V_n. DOCTOR: **Did either of your parents have to see a doctor after this happened?**

PARENTAL VIOLENCE FOLLOW-UP QUESTIONS CODE BOX

a.	b.	c.	d.	e	f.	g.	h.	i.	j.	k.	l.	m.	n.
Item	Series	Agef	Agel	Fre	Parent 1	Parent 2	Fear	Injury	Life	Parent	Parent life	Parent	Doctor
4.													
5.													
6.													
7.													
8.													
9.													
10.													
11.													
12.													

Clinical Assessment Interview for Children

Version 1.01

Client

Name:_____

Date of Birth:_____ Age:_____ Grade:_____

Race/Ethnic Identification:_____ Gender: M F

Interviewer:_____

Date of Interview_____

Place of Interview:_____

Note:

This interview schedule is a clinical adaptation of portions of the child interview schedule used in the ***Navy Family Study,*** conducted by the Wellesley Centers for Women at Wellesley College and the National Crime Victims Research and Treatment Center at the Medical University of South Carolina. Portions of this interview schedule were derived from the ***National Survey of Adolescents*** interview schedule developed by the National Crime Victims Research and Treatment Center at the Medical University of South Carolina. Questions about this interview schedule should be directed to Benjamin E. Saunders, Ph.D., National Crime Victims Research and Treatment Center, Medical University of South Carolina, 165 Cannon Street, Box 250852, Charleston, SC 29425.

SUBSTANCE USE

Now I have some questions about your experiences with tobacco, alcohol, and drugs.

SMOKING

U1. **Have you ever tried cigarette smoking, even one or two puffs?**

(1) _____ Yes
(2) _____ No
(8) _____ Not sure
(9) _____ Refused

F/U U2. **How old were you when you smoked a whole cigarette for the first time?**

_____ Age in years

F/U U3. **Have you ever smoked cigarettes regularly, that is, at least one cigarette every day for 30 days?**

(1) _____ Yes
(2) _____ No
(8) _____ Not sure
(9) _____ Refused

F/U U4. **During the past 30 days, on how many days did you smoke at least one cigarette?**

_____ Days

SMOKELESS TOBACCO

U5. **Have you ever used chewing tobacco, such as Redman, Levi Garrett, or Beechnut, or snuff, such as Skoal or Copenhagen?**

(1) _____ Yes
(2) _____ No
(8) _____ Not sure
(9) _____ Refused

F/U U6. **How old were you when you first used chewing tobacco or snuff?**

_____ Age in years

F/U U7. **Have you ever used chewing tobacco or snuff regularly, that is, at least one chew every day for 30 days?**

(1) _____ Yes
(2) _____ No
(8) _____ Not sure
(9) _____ Refused

F/U U8. **During the past 30 days, on how many days did you use chewing tobacco or snuff?**

_____ Days

ALCOHOL

U9. **Have you ever had a drink of beer, wine, liquor or any alcoholic beverage?**

(1) _____ Yes
(2) _____ No
(8) _____ Not sure
(9) _____ Refused

F/U U10. **How old were you when you first drank a whole beer, a whole glass of wine, or a whole drink of liquor or other alcoholic beverage?**

_____ Age in years

F/U U11. **In the past 12 months, have you ever had a drink of beer, wine, liquor or any alcoholic beverage?**

(1) _____ Yes
(2) _____ No
(8) _____ Not sure
(9) _____ Refused

F/U U12. **During the past 12 months, how often have you had any kind of alcoholic beverage?**

(1) _____ Daily
(2) _____ Two or three times a week
(3) _____ Once a week
(4) _____ Two or three times a month
(5) _____ Once a month
(6) _____ Every two or three months
(7) _____ Three or four times in the past year
(8) _____ Once or twice in the past year
(9) _____ Not sure
(10)_____Refused

F/U U13. **During the past year, how many days did you have five or more drinks of an alcoholic beverag**e?

_____ Days

F/U U14. **During the past year, how many days have you "gotten drunk" or very high from drinking alcohol?**

_____ Days

MEDICAL DRUGS

U15. ***Doctors prescribe medicine like tranquilizers to help people calm down and quiet their nerves. They also prescribe medicine to help people sleep, deal with pain, lose weight or other things. Besides the medical uses, people sometimes take these pills or medicines on their own to get high or to change the way they feel. They may get the pills or medicines from other people, not with a doctor's prescription from a drug store.***

Have you ever taken [READ THE ITEM] **on your own, without a doctor's prescription or a medical reason, just to get high or change the way you feel?**

F/U U16. **Would you say you have taken** [READ THE ITEM] **on your own on 1-3 occasions, 4-10 occasions, or more than 10 occasions?**

F/U U17. **How old were you when you first took** [READ THE ITEM] **on your own?**

F/U U18. **In the past 12 months, how many times have you taken** [READ THE ITEM] **on your own?** .

		U15		U16			U17	U18
No.	Item	Yes	No	1-3	4-10	>10	1st Age	Past 12m
a.	**Tranquilizers like Valium, Librium, or Xanax**	1	2	1	2	3	_____	_____
b.	**Sleeping pills, sedatives, "downers" like barbiturates, Seconal, Halcyon, Quaaludes**	1	2	1	2	3	_____	_____
c.	**Stimulants or diet pills like amphetamines or speed, "uppers"**	1	2	1	2	3	_____	_____
d.	**Pain medicines like Codeine, Darvon, Percodan, Demerol, morphine, methadone, or dilaudid**	1	2	1	2	3	_____	_____
e.	**Ritalin**	1	2	1	2	3	_____	_____
f.	**Nyquil, cough syrup**	1	2	1	2	3	_____	_____
g.	**Steroid pills or shots**	1	2	1	2	3	_____	_____
e.	**Other:**_____ **(Specify)**	1	2	1	2	3	_____	_____

STREET DRUGS

U19. ***Some people these days use other drugs to get high or change the way they feel that are not prescribed by a doctor and are not used for medical purposes.***

Have you ever used [READ THE ITEM]

F/U U20. **Would you say you have ever used** [READ THE ITEM] **on 1-3 occasions, 4-10 occasions, or more than 10 occasions?**

F/U U21. **How old were you when you first used** [READ THE ITEM]?

F/U U22. **In the past 12 months, how many times have you used** [READ THE ITEM]?

		U19		U20			U21	U22
No.	Item	Yes	No	1-3	4-10	>10	1st Age	Past 12m
a.	**Marijuana, pot, grass, weed**	1	2	1	2	3	_____	_____
b.	**Cocaine or Crack**	1	2	1	2	3	_____	_____
c.	**Angel dust or PCP**	1	2	1	2	3	_____	_____
d.	**LSD or other hallucinogenics like peyote, psilocybin, or mushrooms**	1	2	1	2	3	_____	_____
e	**Inhalants like glue, nitrous oxide, amyl nitrate, poppers, paint or gasoline**	1	2	1	2	3	_____	_____
f.	**Methamphetamine, Crystal meth, crank**	1	2	1	2	3	_____	_____
g.	**Ecstacy**	1	2	1	2	3	_____	_____
f	**Heroin or methadone**	1	2	1	2	3	_____	_____
e.	**Other:**_____ **(Specify)**	1	2	1	2	3	_____	_____

DELINQUENCY

Now let's talk about your friends' behavior in the past 12 months. I'd like to ask you how many of your close friends have done each thing I will read to you.

D1. **In the past 12 months, have any of your close friends ever** [READ THE ITEM]?

F/U D2. **Would you say <u>all</u> of your friends, <u>most</u> of them, <u>some</u> of them, or <u>very few</u> of them did this in the past 12 months?**

		D1		D2			
No.	Item	Yes	No	All	Most	Some	Few
a.	**purposely damaged or destroyed property that did not belong to them**	1	2	4	3	2	1
b.	**used marijuana or hashish**	1	2	4	3	2	1
c.	**stolen something worth less than $100**	1	2	4	3	2	1
d.	**beat up or physically attacked someone**	1	2	4	3	2	1
e.	**gotten drunk drinking beer, wine, liquor or other alcoholic beverage**	1	2	4	3	2	1
f.	**broken into a vehicle, office building or store in order to steal something**	1	2	4	3	2	1
g.	**used cocaine, crack, methamphetamine, heroin, LSD, or other street drugs**	1	2	4	3	2	1
h.	**stolen something worth more than $100**	1	2	4	3	2	1
i.	**used prescription or other medical drugs when there was no medical reason to do so**	1	2	4	3	2	1
j.	**sold drugs such as pills, marijuana, cocaine, crack, methamphetamine, LSD or heroin**	1	2	4	3	2	1
k.	**broken into a house, apartment or trailer to steal something**	1	2	4	3	2	1
l.	**stolen or tried to steal a motor vehicle such as a car, truck or motorcycle**	1	2	4	3	2	1
m.	**been involved in gang fights**	1	2	4	3	2	1
n.	**used force or strong-arm methods to get money or things from people**	1	2	4	3	2	1
o.	**attacked someone with a weapon like a gun or a knife**	1	2	4	3	2	1
p.	**attacked someone with the idea of seriously hurting or killing the person**	1	2	4	3	2	1
No.	Item	Yes	No	All	Most	Some	Few

q.	**pressured or forced someone to do something sexual that they did not want to do**	1	2	4	3	2	1
r.	**been arrested**	1	2	4	3	2	1
s.	**gone to jail or juvenile detention**	1	2	4	3	2	1

CHILD'S BEHAVIOR

Now I would like to ask you about some things you might have done.

D3. **Have you ever** [READ THE ITEM]? MARK ANSWER IN THE ANSWER BOX BELOW. IF THE ANSWER IS "Yes" THEN ASK

F/U D4. **How many times in the past 12 months have you [**READ THE ITEM]?

		D3		D4
No.	Item	Yes	No	Past 12m
a.	**purposely damaged or destroyed property that did not belong to you**	1	2	____ ____
b.	**stolen something worth less than $100**	1	2	____ ____
c.	**beat up or physically attacked someone else**	1	2	____ ____
d.	**broken into a vehicle, office building or store in order to steal something**	1	2	____ ____
e.	**stolen something worth more than $100**	1	2	____ ____
f.	**sold drugs such as pills, marijuana, cocaine, crack, methamphetamine, ecstacy, LSD or heroin**	1	2	____ ____
g.	**broken into a house, apartment or trailer to steal something**	1	2	____ ____
h.	**stolen or tried to steal a motor vehicle such as a car, truck or motorcycle**	1	2	____ ____
i.	**been involved in gang fights**	1	2	____ ____
j.	**used force or strong-arm methods to get money or things from people**	1	2	____ ____
k.	**attacked someone with a weapon like a gun or a knife**	1	2	____ ____
l.	**attacked someone with the idea of seriously hurting or killing the person**	1	2	____ ____
m.	**pressured or forced someone to do something sexual that they did not want to do**	1	2	____ ____
n.	**been arrested** _____ **(SPECIFY FOR WHAT)**	1	2	____ ____
o.	**been sent to jail or juvenile detention**_____ **(HOW LONG?)**	1	2	____ ____

DEPRESSION

Now I would like to ask you about your moods and feelings. Everyone has good days and bad days, and feels down and depressed from time to time. In these questions, I would like to ask you about some moods and feelings you may have felt most of the day, nearly every day for a period of two weeks or more, not just now and then.

E1. **Have you ever had a period of two weeks or longer when you were feeling depressed, sad, down, or irritable most of the day, nearly every day?**

(1) _____ Yes (8) _____ Not sure
(2) _____ No (9) _____ Refused

E2. **Has there ever been a time of two weeks or longer when you were uninterested in most things or unable to enjoy things you used to do nearly every day?**

(1) _____ Yes (8) _____ Not sure
(2) _____ No (9) _____ Refused

Have you ever had a period of two weeks or longer when you [READ THE ITEM]?

No.	Item	Yes	No	Not sure	Refused
E3.	**Lost weight without dieting**	1	2	8	9
E4.	**Gained more weight than you should have naturally**	1	2	8	9
E5.	**Had a significant increase or decrease in appetite**	1	2	8	9
E6.	**Slept much more or a lot less than is normal for you**	1	2	8	9
E7.	**Were so fidgety or restless you were unable to sit still**	1	2	8	9
E8.	**Were talking or moving much more slowly than is normal for you**	1	2	8	9
E9.	**Felt tired and low in energy all the time**	1	2	8	9
E10.	**Felt very bad about yourself, like you were worthless**	1	2	8	9
E11.	**Felt guilty about things in the past**	1	2	8	9
E12.	**Had a hard time thinking, concentrating or making decisions about everyday things**	1	2	8	9
E13.	**Felt things were so bad that you thought about hurting yourself or you would be better off dead**	1	2	8	9
E14.	**Thought about death a lot.**	1	2	8	9

E15. **How old were you the first time, if ever, you had a lot of these problems at the same time for a period of two weeks or more?**

_____

E16. **When was the last time, if ever, you had a lot of these problem a the same time for a period of two weeks or more?**

(1) _____ **within the past month**
(2) _____ **within the past six months**
(3) _____ **within the past year**
(4) _____ **more than a year ago**
(8) _____ Not sure
(9) _____ Refused

E17. **Has there ever been a period of two weeks or more when you felt like you wanted to die?**

(1) _____ Yes
(2) _____ No
(8) _____ Not sure
(9) _____ Refused

E18. **Have you ever felt so down and depressed, you seriously thought about killing yourself?**

(1) _____ Yes
(2) _____ No
(8) _____ Not sure
(9) _____ Refused

F/U E19. **How old were you when first thought seriously about killing yourself?**

_____

F/U E20. **When was the last time you thought seriously about killing yourself?**

(1) _____ Past week
(2) _____ Past month
(3) _____ Past 6 months
(4) _____ Past year
(5) _____ More than a year ago
(8) _____ Not sure
(9) _____ Refused

E21. **Have you ever had a plan for killing yourself?**

(1) _____ Yes
(2) _____ No
(8) _____ Not sure
(9) _____ Refused

F/U E22. **What was your plan?**

_____

_____

E23. **Have you ever actually tried to kill yourself**?

(1) _____ Yes
(2) _____ No
(8) _____ Not sure
(9) _____ Refused

F/U E22. **How old were you the first time you tried to kill yourself?**

_____

F/U E23. **What did you do to try and kill yourself?**

_____

_____

F/U E24. **When was the last time you tried to kill yourself?**

(1) _____ Past week
(2) _____ Past month
(3) _____ Past 6 months
(4) _____ Past year
(5) _____ More than a year ago
(8) _____ Not sure
(9) _____ Refused

F/U E23. **What did you do to try and kill yourself?**

_____

_____

PTSD

People experience a variety of moods and feelings from time to time. Now I would like to ask you about some moods and feelings you may have felt nearly every day for a period of two weeks or more .

T1. **Has there ever been a period of two weeks or more during which.....** [READ THE ITEM]?

1 = Yes
2 = No
8 = Not sure
9 = Refused

F/U T2. **How old were you the first time this occurred for two weeks or longer?**

F/U T3. **How long ago was the last time you felt this way for two weeks or more? Was it within the past month, the past six months, the past year, or more than a year ago?**

1 = past month
2 = past 6 months
3 = past year
4 = more than a year ago
8 = Not sure
9 = Refused

		Y/N	FAge	MR
No.	Item	T1	T2	T3
a.	**You had trouble concentrating or keeping your mind on what you were doing, even when you tried to concentrate.**	_____	_____	_____
b.	**You lost interest in activities in your life that used to be important to you**	_____	_____	_____
c.	**You felt you had to stay on guard much of the time**	_____	_____	_____
d.	**You deliberately tried very hard not to think about, have feelings about, or talk about something that had happened to you**	_____	_____	_____
F/U	**What was it you tried not to think, feel, or talk about**			
e.	**You had difficulty falling asleep or staying asleep**	_____	_____	_____
f.	**Unexpected noises startled you more than usual**	_____	_____	_____
g.	**You had repeated bad dreams or nightmares**	_____	_____	_____
F/U	**What were the dreams about**			
h.	**You went out of your way to avoid certain places or activities that might remind you of something that happened to you in the past.**	_____	_____	_____
F/U	**What did those places or activities remind you of?**			
i.	**You felt cut off from other people or found it difficult to feel close to other people.**	_____	_____	_____
j.	**It seemed you could not feel things anymore or that you had much less emotion than you used to**	_____	_____	_____
k.	**Little things bothered you a lot or could make you very angry**	_____	_____	_____
l.	**Disturbing or unpleasant memories, thoughts, or images kept coming into your mind whether you wanted to think of them or not**	_____	_____	_____
F/U	**What were those memories about?**			

No.	Item	T1	T2	T3
m.	**You felt a lot worse when you were in a situation that reminded you of something that had happened in the past**	_____	_____	_____
F/U	**What did these things remind you of?**			
n.	**You found yourself reacting physically to things that reminded you of something that had happened in the past**	_____	_____	_____
F/U	**What did these things remind you of?**			
o.	**You felt as if your future somehow will be cut short**	_____	_____	_____
p.	**You felt that there were parts of a distressing experience that you could not remember?**	_____	_____	_____
F/U	**What was that experience?**			
q.	**You had a "flashback" -- that is, have you ever had an experience in which you imagined that something that happened to you in the past was happening all over again?**	_____	_____	_____
F/U	**What was the flashback about?**			

T4. **How old were you the first time, if ever, you had several of these problems with feelings and moods occur at the same time?**

_____

T5. **At that time, did you have these feelings because something in particular had happened to you that was related to these feelings?**

(1) _____ Yes (8) _____ Not sure
(2) _____ No (9) _____ Refused

F/U T6. **What was it that happened?**

_____

_____

T7. **When was the last time, if ever, you had several of these problems with feelings and moods occur at the same time?**

(1) _____ within the past month
(2) _____ within the past 6 months
(3) _____ within the past year
(4) _____ more than a year ago
(8)_____ Not sure
(9)_____ Refused

T8. **What is the longest period of time, if ever, you have had several of these problems with feelings and moods at the same time?**

(1) _____ one month or less
(2) _____ 2 to 6 months
(3) _____ 6 months to a year
(4) _____ more than a year
(8)_____ Not sure
(9)_____ Refused

T9. **Bad moods, bad feelings and bad memories like we have been talking about can sometimes affect your life in other ways. Did the bad moods, bad feelings, and bad memories you have told me about ever cause.....**

No.	Item	Yes	No	Not sure	Refused
a.	**Problems with your schoolwork, including not doing as well as you did before, bad grades, having to drop out of school, getting in trouble with your teachers, or having to work harder to make the same grades**	1	2	8	9
b.	**Problems with a job, including not being able to do as well as you could before, having to quit, trouble with your boss or co-workers, or being fired.**	1	2	8	9
c.	**Problems with family members or friends, including getting into more arguments or fights than you did before, not feeling you could trust them as much, or not feeling as close to them as you did before.**	1	2	8	9

T10. **When you had several of these bad moods, bad feelings, and bad memories, how distressing was it for you? Was it very distressing, moderately distressing, a little distressing, or not at all distressing?**

(1) _____ Not at all distressing
(2) _____ A little distressing
(3) _____ Very distressing
(8) _____ Not sure
(9) _____ Refused