

**Safe Start Initiative Phase I**  
**Special Report II**  
**Crisis Intervention Guidelines,  
Tools, Curriculum, and Training**

**Draft**

**REPORT #2007-4**

*July 3, 2007*

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This project was supported by Grant # 2004-JW-MU-K001 awarded by the Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Justice. Points of view or opinions in this document are those of the author and do not necessarily represent the official position or policies of the U.S. Department of Justice.

## Preface

This report on the criteria and process for selecting and implementing measures related to children's exposure to violence and their families is prepared by the Association for the Study and Development of Community (ASDC) for the Office of Juvenile Justice and Delinquency Prevention (OJJDP) for the Safe Start Initiative.

We would like to recognize Katherine Darke Schmitt, Deputy Associate Administrator, Child Protection Division; and Kristen Kracke, Safe Start Program Manager, and Jeff Gersh, Program Manager, for their leadership and support. ASDC staff contributing to this report include: David Chavis (Project Director), Yvette Lamb (Senior Managing Associate), Mary Hyde (Senior Managing Associate), Kien Lee (Principal Associate), Joie Acosta (Managing Associate), Sonia Arteaga (Managing Associate), Deanna Breslin (Associate), and Sylvia Mahon (Office Coordinator). ASDC would like to thank the 21 practitioners, researchers, and researcher-practitioners who participated in phone discussions and provided data on which this report is based. Additionally, ASDC would like to thank the following six Safe Start Demonstration grantees and three Safe Start Promising Approaches grantees for contributing to this report:

Bridgeport Safe Start Initiative  
Bridgeport, Connecticut

Rochester Safe Start Initiative  
Rochester, New York

Chicago Safe Start Initiative  
Chicago, Illinois

San Francisco SafeStart Initiative  
San Francisco, California

Pinellas Safe Start Initiative  
Pinellas County, Florida

Spokane Safe Start Initiative  
Spokane, Washington

Safe Start Promising Approaches Miami  
Linda Ray Center  
University of Miami  
Miami, Florida

Safe Start Promising Approaches  
New York  
New York Presbyterian Hospital Family  
PEACE Program  
New York, New York

Safe Start Promising Approaches Dallas  
Southern Methodist University  
Family Research Center  
Dallas, Texas

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## Executive Summary

The Safe Start Demonstration Project sought to bring about systems change and in the process address practice and research related to exposure to violence among young children (six years and younger). Children's exposure to violence is a significant national problem, with an estimated 90% of children witnessing violence at least once during their childhood (Richters & Martinez, 1993). Currently there is no clear agreement on the definition of children's exposure to violence, hindering adequate measurement of violence exposure; in addition, differing definitions may lead to inconsistencies across programmatic and research findings.

Despite the differences in definition, the most common type of children's exposure to violence is family violence. Thus, for this report, exposure to violence focuses on family violence. Fontes (2000) estimates that as many as 10 million children have witnessed an act of violence between their parents, and that 27% of adults recall witnessing violence between their parents.

Children exposed to violence suffer detrimental short- and long- term effects in the neurological, social, emotional, cognitive, and physical domains (Margolin & Gordis, 2004; Schwartz & Gorman, 2003; Straus, 1992). Furthermore, children exposed to violence between their parents are more likely to be victimized by violence or perpetrate violence against an adult partner, as compared to individuals not exposed to violence as children (Ehrensaft et al., 2003).

Given the high prevalence of children exposed to violence and the detrimental effects of exposure, it is crucial to develop effective measures that both practitioners<sup>1</sup> and researchers<sup>2</sup> can use to assess and treat this population of children and their families. In assessing the effectiveness of a treatment program (e.g., cognitive behavioral therapy) or research intervention (e.g., randomized controlled trial), practitioners and researchers can be more effective when they work collaboratively to address treatment and research goals. To collaborate effectively, practitioners and researchers need to communicate and share information about clients and programmatic outcomes. One way to facilitate better communication is through the use of measurement tools.

This report is intended for researchers, practitioners, early childhood educators, and other individuals who assess and work with children exposed to violence and their families. While both researchers and practitioners value measurement tools, their use of these tools varies. A better understanding of the differences and commonalities in their selection criteria for measures for children exposed to violence, will aid in the development of tools that are useful for both parties. This report underlines the importance of determining how practitioners and researchers understand the need for measurement tools and the criteria by which they judge measures related to children's exposure to violence. This report provides information to further the development of

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<sup>1</sup> For this report, a practitioner is a self-identified individual who has specialized clinical training to work with children exposed to violence (e.g., social worker, counselor, therapist, psychologist).

<sup>2</sup> For this report, "researcher" includes "evaluators"

effective measurement tools and data collection. This knowledge will aid in improving communication between practitioners and researchers and, in many cases, contribute to improved child, family and program outcomes.

### Methodology

The Safe Start National Evaluation Team reviewed the existing literature and had phone discussions with practitioners and researchers regarding the criteria and process for selecting and implementing measures for children exposed to violence and their families. Twenty-one respondents (seven practitioners, seven researchers, and seven researcher-practitioners<sup>3</sup>) participated in phone discussions focused on the following two questions:

- What criteria are important to consider when selecting measures for children's exposure to violence?
- What is the process of selecting and implementing measures for children's exposure to violence?

This report provides:

- A summary of findings on practitioners', researchers', and researcher-practitioners' perspectives on the use of standardized measures, criteria for measures, selection, and implementation process for measures; and
- Recommendations for future work in the development of practice and research measures and tools for children exposed to violence.

### Summary of Findings

Three major findings emerged from the analysis of relevant literature and from discussions with practitioners, researchers, and researcher-practitioners working with children exposed to violence and their families. These findings, 1) perspectives on the use of standardized measures, 2) criteria for measures, and 3) the process for selecting measures, help clarify the tensions that may arise in the collaboration between practice and research.

**1. Perspectives on the use of standardized measures.** Practitioners and researchers approach the use of measures differently. The literature suggests that practitioners tend to rely upon clinical skills and interviews, as opposed to standardized measures, to assess children. Additionally, researchers may want to administer multiple measures, whereas practitioners may prefer to limit the number of measures administered and spend more time on treatment. These perspectives are important to understand in that they influence whether or not practitioners and researchers choose to administer measures.

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<sup>3</sup> These individuals self-identified as researcher-practitioner because they are trained as researchers and direct research projects, but also have clinical skills and conduct therapy and/or supervise clinical work.

**2. Criteria for measures.** Respondents in this sample indicated that there is a lack of adequate standardized measures for assessing children's exposure to violence. Nevertheless, practitioners, researchers, and researcher-practitioners described ten criteria important to choosing a measure. It is worth noting that practitioners and researchers in this sample had significantly more commonalities than differences in the criteria they identified. Thus, practitioners and researchers may differ on how they use measures, but practitioners who intend to use a standardized measure judge potential measures based on criteria similar to those of a researcher.

All three groups identified the following eight criteria as significant components for an effective measurement tool for use with children exposed to violence. The most commonly mentioned criteria are listed first.

***Commonalities (i.e., criteria common to practitioners, researchers and researchers-practitioners)***

- *Family-friendly and non-intrusive.* It is important to develop measures that are brief and do not overburden the child and family. Additionally, measures should be respectful of the family's situation and should not be invasive. Lengthy and/or invasive measures may discourage the child and family from participating in follow-up treatment because they do not want to take the measure again.
- *Cultural competency factors including language availability, literacy level, and validation criteria.* Exposure to violence affects children regardless of ethnicity. Thus, measures must be available in the language of the family. In addition to *language availability*, the *literacy level* of the measure should be appropriate to the reading ability of the intended population. *Validation criteria* is also important, thus the measure should be normed on a similar population.
- *Clinical utility.* A measure that provides clinical information on the child and family can inform treatment. Practitioners are more likely to administer measures that yield useful information for guiding treatment.
- *Captures depth of violence exposure including severity and symptoms.* Data on type, history, severity, and symptoms of exposure to violence can help clarify the impact of the child's exposure to violence, thereby allowing the practitioner and/or researcher to design and implement a more effective treatment protocol and/or intervention to reduce the impact of exposure.
- *Strong psychometric properties.* Psychometric properties of a measure include reliability, validity, and internal consistency. Measures with strong psychometric properties are more likely to adequately assess change over time, to determine whether the child and family improve as a result of treatment and/or research intervention.
- *Developmentally appropriate.* Given the age range of Safe Start participants (i.e., 6 years and younger), measures must take into account the cognitive and speech abilities of young children.

- *Ease of administration and scoring.* Given the many demands on practitioners' and researchers' time, measures must be easy to score and should be administrable by a lay person without an advanced degree.
- *Construct validity.* A measure should capture what it purports to capture.

***Additional criteria for researchers and researcher-practitioners***

Researchers and researcher-practitioners, but not practitioners<sup>4</sup>, identified two additional criteria for measures related to children's exposure to violence and their families. The most commonly mentioned criteria are listed first.

- *Sensitivity to change over time.* Assessing change over time allows researchers to examine whether interventions have an impact on children and their families.
- *Cost.* When choosing a measure, researchers in this sample indicated that they consider the cost of the measure, the cost to train individuals to administer the measure, and the costs to score and interpret the measure.

**3. Process for selection and implementation of a measure.** Collaboration between practitioners and researchers is essential in selecting and implementing a measure. Respondents in this sample indicated that including practitioners as part of the measurement selection process reduces practitioner resistance and increases practitioner buy-in for administering the measure and maintaining fidelity to the measurement protocol. Researchers in this sample stated that practitioner buy-in requires the following steps:

1. Explain to the practitioner the usefulness of the clinical information obtained from the measure.
2. Train the practitioner on how to administer the measure.
3. Provide regular feedback/communication to the practitioner.

In summary, based upon a literature review and phone discussions, respondents in this sample stated that while there is a lack of adequate measures for children exposed to violence and their families, all parties can agree on criteria for an effective measure. Future systems change programs should focus on developing partnerships between practitioners and researchers, in particular, encouraging practitioners to be part of the measurement selection process, to gain buy-in for measure implementation. Such buy-in will not only help practice efforts, but also will improve fidelity to the implementation protocol, thereby improving research outcomes.

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<sup>4</sup> This is not intended to infer that practitioners do not value these criteria; they simply were not mentioned in the phone discussions.

## Recommendations

Based on respondents' thoughts on what is lacking from current measurement tools, the following are recommendations for choosing and implementing a measure for children's exposure to violence:

- *Consider practical factors, including burden on family and clinical utility.* Practical factors include length of time to administer the measure, intrusiveness of the measure, ease of administration and scoring, and cost of the measure.
- *Select measures with strong psychometric properties that can assess change over time.* Measures with strong psychometric properties (e.g., Parental Stress Inventory, Trauma Symptom Checklist for Young Children) increase the confidence of practitioners and researchers in the validity of their findings. Additionally, measures that assess change over time aid practitioners and researchers in determining improvement in a child and family.
- *Look for measures that assess the type(s), severity, and symptoms of exposure to violence.* Measures should assess type of violence exposure, (e.g., family, community, or media violence), intensity of exposure (i.e., the child's proximity to the violence), and impact of the violence (i.e., internalizing and/or externalizing behavioral symptoms). This information can aid in directing the treatment plan.
- *Develop agreed upon definitions of children's exposure to violence.* As mentioned earlier, there is not an agreed upon definition of children's exposure to violence. A common definition will help eliminate inconsistencies across research findings and may lead to a greater standardization of measures for children exposed to violence and their families.
- *Establish collaborative partnerships between practitioners and researchers.* Practitioners and researchers need to work collaboratively to select and implement measures, to further practice and research related to children's exposure to violence.

Further research on these issues is warranted, to move toward better measurement tools for both practitioners and researchers who assess and treat children exposed to violence and their families.

## 1. Introduction

This report examines how practitioners and researchers agree and differ in their perspectives and practices related to measurement of children's exposure to violence. While both practitioners and researchers value measurement tools, their need for these tools varies. For instance, a practitioner may seek a tool that is easy to administer and provides valuable clinical information on a child. On the other hand, a researcher may select a standardized tool with strong psychometric properties that yields reliable research data. Knowledge of such perspectives will further the development of effective measurement tools to aid in the communication between practitioners and researchers and thereby contribute to improved client and program outcomes.

The Safe Start Demonstration Project,<sup>5</sup> funded by the Office of Juvenile Justice and Delinquency Prevention in the U.S. Department of Justice, sought to create comprehensive service delivery focused on policies and practices for children exposed to violence and their families. Safe Start drew on the services and expertise of both practitioners and researchers to assess and treat children exposed to violence and their families.

To determine the effectiveness of a treatment program (e.g., cognitive behavioral therapy) or research intervention (e.g., randomized controlled trial), practitioners and researchers need to work collaboratively to address treatment and research goals. For instance, findings from developmental and clinical research can help inform clinical work with children exposed to violence and their families (Bosquet, 2004). To collaborate effectively, practitioners and researchers need to be able to communicate and share information about clients and programmatic outcomes. One way to facilitate communication is through the use of measurement tools (e.g., Parenting Stress Index, Traumatic Events Stress Inventory).

Safe Start grantees identified, assessed, and treated children exposed to violence and their families. Thus, it was paramount to have measurement tools that adequately capture children's exposure to violence. Measurement tools can be standardized or non-standardized instruments that aid practitioners and researchers in evaluating key criteria in clients and research respondents. While non-standardized measurement tools are commonly used, standardized measurement tools generate normative data that allow a practitioner to determine severity of symptoms by comparing a client's symptoms with those for the appropriate norm group. For a researcher, a standardized tool allows reliable, valid assessment of the impact of an intervention on the child and family. Measurement tools allow both practitioners and researchers to confirm or revise

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<sup>5</sup> The National Safe Start Demonstration Project was initiated in 1999. The purpose of the Safe Start Demonstration Project was to 1) reduce exposure to violence among young children (six years and younger) and 2) reduce the impact of exposure to violence. Eleven sites across the country (six urban, three rural, and two tribal) were part of the Safe Start Demonstration Project. At all sites, children were identified, assessed, and treated for exposure to violence. Department of Justice (1999). *Federal Register*, 64, 16556 – 16571.

hypotheses and provide valuable information for treatment planning (Burrows Horton & Cruise, 1997).

Based upon a review of the literature and structured discussions with practitioners, researchers, and researcher-practitioners, this report addresses: 1) perspectives on the use of standardized measures, 2) commonalities and differences between practitioners, researchers, and researcher-practitioners in their criteria for measures related to children's exposure to violence, 3) the process by which measures are chosen and implemented, and 4) recommendations for future work with children exposed to violence and their families.

### ***1.1 Children's exposure to violence***

Children's exposure to violence is a significant national problem, with an estimated 90% of children witnessing violence at least once during their childhood (Richters & Martinez, 1993). There are no reliable current estimates of national incidence and prevalence of children's exposure to violence, but Carlson (2000) estimates that 10-20% of American children are exposed to adult domestic violence each year. Fontes (2000) estimates that as many as 10 million children have witnessed an act of violence between their parents, and that 27% of adults recall witnessing violence between their parents. Family violence is more likely to occur in households with young children (under five years) than in households with older children (Fantuzzo & Mohr, 1999). Exposure to violence in young children is especially troubling because research has found that early trauma can have detrimental neurological impact (Shore, 2001).

In addition to suffering neurological problems, children who are exposed to violence also may exhibit behavior disorders such as aggression and delinquency; emotional and mood disorders such as depression and anxiety; posttraumatic stress symptoms such as exaggerated startle, nightmares, and flashbacks; health-related problems and somatic symptoms such as sleep disturbances; and academic and cognitive difficulties (Margolin & Gordin, 2004; Schwartz & Gorman, 2003; Straus, 1992). Furthermore, children exposed to violence between their parents are more likely to be victimized by violence or perpetrate violence against an adult partner, as compared to individuals not exposed to violence as children (Ehrensaft et al., 2003).

Many children are thought to have multiple exposures to violence. Multiple exposures tend to be related to higher frequency of exposure and greater seriousness of violence, and therefore may increase negative outcomes. Additionally, multiple exposures are correlated with disruptions in parent-child relations (Margolin & Gordin, 2004).

Because children's exposure to violence is a developing field, definitions of children's exposure to violence are yet to be standardized. With regard to children's exposure, "violence" has been defined variously as family violence, community violence, and/or media violence (Groves, 1997; Osofsky, 1999). Lack of an agreed upon definition is a major concern in the field (Holden, 2003); without a clear definition, children's

exposure to violence cannot be adequately measured. Despite the various definitions, the most common type of children's exposure to violence is family violence exposure. Thus, for this report, exposure to violence focuses on family violence.

Given the estimated high prevalence of children exposed to violence, the detrimental effects of exposure, and need for an agreed upon definition of exposure, it is crucial to develop a common set of effective criteria for measures that both practitioners and researchers can use to assess and treat this population of children and their families.

## **2. Methodology**

To prepare this report, the Association for the Study and Development of Community (ASDC), as the National Evaluation Team (NET) for the Safe Start Demonstration Project, 1) reviewed the literature on children's exposure to violence, 2) examined the websites of the National Center for Children Exposed to Violence and the National Child Traumatic Stress Network, and 3) facilitated structured phone discussions with prominent practitioners researchers, and researcher-practitioners in the field of children's exposure to violence. Participants were selected based upon their experience with children's exposure to violence and participation with the Safe Start Project. A discussion protocol was developed and administered; phone conversations were transcribed and coded for common themes. A total of six researchers and six practitioners from the Safe Start Demonstration Project participated in the phone discussions. Other prominent individuals in the field also took part in the discussion; they included one researcher, one practitioner, and seven individuals who self-identified as both practitioners and researchers ("researcher-practitioners"). This report presents findings from the conversations with all 21 individuals, a review of the aforementioned websites, and a review of the literature.

## **3. Findings**

Three main findings emerged from the literature review and phone discussions. We will discuss first 1) the perspectives of practitioners and researchers on the use of standardized measures. We then will discuss 2) the criteria that the individuals in this sample use to select measures, followed by 3) the process of selecting and implementing measurement tools. Examples of how Safe Start grantees used measurement tools are interspersed throughout the findings section.

### ***3.1 Perspectives on the use of standardized measures***

#### **3.1.1 Clinical interviews versus standardized measures**

The literature suggests that practitioners tend to rely more upon non-standardized assessment techniques (i.e., clinical skills and interviews) to assess children and families, whereas researchers tend to use standardized measures for empirical inquiry (Garland,

Kruse, & Aarons, 2003; Earls & Shackelford, 2006; Sand, Silverstein, Glascoe, Gupta, Tonniges, & O'Connor, 2005). For example, one study found that a majority of mental health practitioners in their study considered clinical intuition more useful and accurate than standardized tools (Garland, Kruse, & Aarons, 2003). Another study found that a majority of pediatricians use non-standardized methods to monitor children's development (Sand, Silverstein, Glascoe, Gupta, Tonniges, & O'Connor, 2005). In addition, the 53<sup>rd</sup> American Academy of Pediatrics Periodic Survey of fellows revealed that 72% of fellows used clinical observation only, and not a screening instrument, to identify children with developmental delays (Earls & Shackelford, 2006). The above findings suggest that practitioners may rely heavily upon clinical skills and may not see a need for standardized measures.

Moreover, even when practitioners are mandated to administer standardized measures, they may not use the results to inform their clinical work. Garland, Kruse, and Aarons (2003) found that 92% of mental health practitioners (i.e., social workers, counselors, psychologists) in their study may have administered standardized measures because of state law, but did not use the scores in their clinical practice for diagnostic evaluation, treatment planning, or treatment monitoring. Garland, Kruse, and Aarons (2003) stated that "most clinicians appreciate and support the need for empirically based effectiveness evaluation, but they are frustrated by currently available methods, which many perceive to be unfeasible, invalid and lacking in clear clinical application" (p.402).

The perception that standardized tools lack clinical utility may lead to practitioner resistance in administering standardized measures. Four discussion respondents (two researchers and two researchers-practitioners) stated that they have experienced initial practitioner resistance to using standardized measures for children exposed to violence and their families in a clinical setting. To overcome this initial resistance, researchers worked with the practitioners by discussing the clinical utility of the measure. Hence, awareness of practitioners' perspective on standardized measures may be a factor in increasing collaboration between practitioners and researchers, and overcoming potential resistance to the use of standardized measures.

### **3.1.2 Differences in adherence to measurement protocol**

If practitioners are most concerned about treating the child and family as quickly as possible, while researchers are most concerned about testing hypotheses through systematic administration of standardized measures then these differing priorities can create tension around the implementation of measurement protocols.

The number of measures administered by researchers and practitioners varies. The researcher may want to administer several measures to obtain convergent validity and to answer several research questions. Administering various measures in a standardized format increases the time spent on assessment. The practitioner may administer only one measure because the clinician 1) does not want to overburden the child and family, 2) considers one measure adequate to obtain useful clinical information, and 3) would rather spend time helping the child in treatment than in administering measures that may not

seem readily helpful to the child and family. The majority of individuals who participated in our discussions indicated that that they did not want to overburden families. Finding a balance between the number of measures tolerable to families and the number needed to obtain quality data for research purposes could possibly satisfy the needs of both researchers and practitioners.

### **3.2 Practitioner and researcher criteria**

Because practitioners and researchers need to collaborate to help children exposed to violence and their families, it is essential to meet the criteria of both groups for an effective measure. Practitioners, researchers, and researchers-practitioners in this sample shared significantly more similarities than differences in terms of their criteria for measures related to children's exposure to violence. In general, respondents look for similar criteria in a measure. Respondents indicated ten criteria they look for when selecting a measure for children exposed to violence and their families. Please refer to Table 1 for a list of, practitioner, researcher, and researcher-practitioner criteria.

#### **3.2.1 Commonalities**

Of the ten criteria indicated, eight were identified as important by practitioners, researchers, and researcher-practitioners. These eight criteria are discussed below.

##### ***Respondents seek measures that are family-friendly and not burdensome.***

The majority of respondents indicated that they seek measures that are family-friendly and do not overburden the family. To better assess children and families, it is important to establish rapport with the family and create a partnership with the child's caregiver (Leiberman & van Horn, 2005). Respondents emphasized the importance of considering the family in choosing the least intrusive measure possible. Respondents stated that the types of questions asked on a particular measure should not be offensive, nor should they have potential negative consequences. For instance, caregivers may be hesitant to answer certain questions given the risk of losing their child (e.g., if a caregiver has physically hit a child and left a mark, clinicians may be required to report the abuse to local authorities).

In addition to their concern for potentially offensive questions, respondents reported that the length of a measure is an important factor, because of the potential burden on families and resultant risk of losing families to follow-up. For instance, if families are given long assessment measures to complete at baseline, they may be less likely to return for follow-up for fear of another long assessment. Practitioner frustration with lengthy standardized measures is a known barrier to the use of these measures (Garland, Kruse, & Aarons, 2003). On the other hand, researchers consider lengthy measures worth the time because they yield information that informs treatment for the child and family.

**Table 1: Criteria indicated as important in choosing a measure for children’s exposure to violence, based upon phone conversations with seven practitioners, seven researchers, and seven researcher-practitioners**

Criteria	Practitioner (N=7)	Researcher (N=7)	Researcher-Practitioner (N=7)
<i>Similarities</i>			
1. Family-friendly measure; low burden for family, including length of measure as well as intrusiveness	(7)	(7)	(5)
2. Cultural Competency factors including: language availability and language literacy and validation criteria (normed on a similar population)	(4)	(4)	(7)
3. Clinical utility, including providing feedback to the parent and helping to make a diagnosis	(3)	(4)	(4)
4. Captures depth of violence exposure, including type of exposure; chronicity, intensity, and proximity of violence; symptoms of violence exposure in multiple domains; severity of symptoms; and trauma history	(5)	(3)	(3)
5. Psychometric properties	(2)	(4)	(4)
6. Developmentally appropriate	(1)	(4)	(4)
7. Administration and scoring, including ease of administration, level of expertise required to administer and interpret, length of time to score	(2)	(2)	(4)
8. Construct validity	(1)	(3)	(2)
<i>Additional Criteria</i>			
9. Cost	(0)	(1)	(2)
10. Sensitivity to change over time	(0)	(2)	(1)

***Cultural competency factors need to be considered.*** African American and Latino children are significantly more likely to be exposed to violence than non-ethnic minority children (Crouch, Hanson, Saunders, Kilpatrick, Resnick, 2000). Thus, it is critical to address how cultural factors such as language and literacy level may impact how children and family respond to measures. Respondents indicated that it is important to administer a measure in the language of the child and family. For instance, when working with a Latino population, the measure chosen should be available in Spanish, with normative data from other Spanish-speaking communities. In addition to *language appropriateness*, both groups indicated that the *literacy level* of the measure should be appropriate to the reading ability of the intended population.

Respondents in this sample also stated that measures need to be normed on populations similar to those that will receive the measure. Choosing a measure valid for the intended population is an important consideration, because clinicians with concerns about the validity of standardized measures are less likely to use measures that have not been validated on a similar population (Garland, Kruse, & Aarons, 2003).

***Clinically useful measures are needed to help children exposed to violence and their families.*** Respondents in this sample were likely to report that they seek measures that are *clinically useful* and can assess symptoms and history of exposure. This clinical information can help determine whether treatment affects symptoms, thereby guiding treatment.

Discussion respondents indicated that the Parenting Stress Index (PSI; Abidin, 1995) provides good clinical information. The PSI is designed to assess parental stress; one participant stated: “it is a good proxy for maternal depression and has good subscales.” According to respondents, the PSI provides information useful to better understanding the child-parent dynamic and how best to treat the family.

***Respondents want a measure that captures multiple domains and identifies depth of violence exposure.*** Respondents indicated the importance of choosing a measure that assesses biological, emotional, social, and cognitive domains (Leiberman & Van Horn, 2005) to obtain a more comprehensive picture of the child. According to respondents, an effective measure should adequately assess not only symptoms of exposure, but also history and severity of exposure. By knowing the symptoms, type, history, and severity of exposure to violence, clinicians and/or researchers may better understand the impact of the exposure, to better design and implement a treatment protocol or intervention that reduces the impact. It is essential to determine whether multiple types of exposures to violence have occurred and how they impact the child (Finkelhor & Hamby, 2001).

The Traumatic Events Screening Inventory (TESI; Ribbe, 1996), an example of a measure that captures information about type of exposure, is a comprehensive checklist used to identify exposure to violence in children aged three to 18 years (please refer to Appendix A for the psychometric properties of measures most commonly mentioned by practitioners and researchers in this sample). Four Safe Start grantees used the TESI, and

three discussion respondents indicated that the tool is useful (please refer to Appendix B for a list of discussion participant comments on the most commonly used assessment tools for children exposed to violence and their families). The TESI does capture a broad range of possible traumatic experiences and exposures to violence, and also is fairly quick to administer; however, its checklist format does not provide the depth of information needed to make a diagnosis or adequately assess symptoms.

***Psychometric properties are important to both practitioners and researchers.***

The fifth most commonly mentioned criterion for a measure was the measure's psychometric properties, including reliability, validity, and internal consistency; respondents seek reliable, standardized measures. On the other hand, practitioners stated that caution should be exercised when utilizing a standardized measure. From a clinical perspective, it is desirable to assess the whole child, including both adaptive and externalizing behaviors. Most measures assess externalizing behaviors, but may not assess adaptive behaviors; in addition, children may be internalizing symptoms not captured by the measure. Standardized measures tend to be caregiver-reported measures; however caregiver reports may be biased as a result of anxiety about reporting violence exposure and symptoms. Hence, practitioners indicated they value standardized measures that adequately assess the child's symptoms, including internalizing and externalizing behaviors, and are sensitive to the caregiver's needs (i.e., not intrusive).

An example of a measure with strong psychometric properties is the Trauma Symptom Checklist for Young Children (TSCYC; Briere, et. al., 2001), used by four Safe Start grantees. The TSCYC assesses trauma symptoms in children aged three to 12 years. Minimal interviewer training is required, the caregiver is the respondent, the measure is available in Spanish, and has good psychometric properties. The TSCYC has eight clinical scales that help assess the child, with an easy-to-use checklist of the child's symptoms. Three discussion respondents indicated that the TSCYC is useful because it taps into trauma-related behaviors. According to Stover and Berkowitz (2005), however, the TSCYC is not appropriate to make a diagnosis of PTSD in three- to four- year-olds. Additionally, the TSCYC does not ask any questions about repetitive play or regression to earlier learned skills, which have been shown to be indicators of traumatic stress among young children. Hence, the TSCYC has good psychometric properties, is easy to administer, and is available in other languages, but has limited clinical utility.

***Respondents want a measure that is developmentally appropriate for their sample.*** Respondents indicated that a measure should be *developmentally appropriate*. According to discussion respondents, measures may exist for exposure to violence among older children, but measures that adequately identify and assess exposure among children six years and younger are lacking. While two respondents indicated the importance of obtaining the child's perspective, for young children, it may be most appropriate to ask the caregiver to complete measures or to conduct clinical observations of the child.

***Respondents are interested in ease of administration and scoring of a measure.*** Respondents indicated several important factors related to the administration, scoring, and interpretation of a measure. First, respondents reported that it is important to choose a

measure that is easy to administer and does not require a great deal of expertise. Secondly, a measure that is easy to score and/or has a standardized scoring protocol (e.g., computerized) is ideal. Lastly, respondents stated that a measure should not require a great deal of time or expertise to interpret.

***Respondents want measures to have construct validity.*** Respondents in this sample stated that certain scientific criteria inform their choice of measures for children exposed to violence and their families. One such criterion is a *clear definition* of what type of exposure is being measured. Related to clear definitions is strong *construct validity*, a priority for both groups. A measure with strong validity is especially useful for clinical purposes. One discussion participant stated: “If a measure is valid, then it can help inform treatment planning.”

### **3.2.2. Additional Criteria mentioned by Researchers and Researcher-Practitioners**

Based upon phone discussions, researchers, and researchers/researcher-practitioners mentioned two additional criteria related to children’s exposure to violence measures. Below is a description of the two criteria explicitly stated by researchers and researcher-practitioners.

***Researchers and researcher-practitioners are interested in assessing change over time.*** Researchers and researcher-practitioners in this sample expressed interest in reliable measures able to assess changes over time. Assessing change over time allows researchers to examine whether an intervention has an impact from baseline to post-treatment. For instance, a measure focused on personality traits would not be useful because personality tends to be consistent over time. Likewise, measures that assess cognitive ability may not be helpful because a significant amount of time (i.e., years) is needed to see cognitive changes in a child. For instance, the Ages and Stages Questionnaire (ASQ; Bricker & Squires, 1999), used by three Safe Start grantees, while useful in assessing the child’s developmental stage, it is not useful to assess change over time; two discussion respondents agreed that the ASQ is not appropriate as a pre/post measure. Additionally, the Child Behavior Checklist (CBCL; Achenbach & Rescorla, 2000), used by three Safe Start grantees, is an example of a measure that has been widely used, has good internal consistency, and is available in other languages, but is not appropriate to assess change over time, as indicated by discussion respondents. While both the ASQ and CBCL are useful in assessing developmental status, they are not useful for researchers interested in assessing change over time.

***The cost of a measure is a consideration.*** Researchers and research-practitioners in this sample mentioned that cost of a measure is a consideration. When choosing a measure, researchers consider cost of the measure, cost to train individuals to administer it, and costs to score and interpret the measure. For instance, a measure such as the Temperament and Atypical Behavior Scale (TABS; Bagnato, Neisworth, Salvia, & Hunt, 1999), used by one Safe Start grantee, may not be an optimal measure for cost-conscious practitioners and researchers because the instrument and scoring manual must be purchased.

### **3.2.3 Convergence of Criteria**

A measure that meets all of the aforementioned criteria would be useful to all who work with children exposed to violence. The criteria identified in the phone discussions are consistent with Bergman's (2004) criteria for choosing a measure. For instance, Bergman (2004) recommends considering the psychometric properties of a measure, who will administer and score the measure, who responds to the measure (e.g., caregiver or child), and cultural competency (e.g., language appropriateness). All of these criteria are important to choosing a measure that will benefit both practitioners and researchers.

The measure identified by discussion respondents as most closely meeting the majority of the aforementioned criteria is the PSI. Six Safe Start grantees used the Parenting Stress Index. The PSI is intended for parents with children aged three to ten years and assesses three major sources of stress (i.e., child variables, parent characteristics, and situational/demographic life stress) in parent-child interactions. Both a long form (120 items) and short form (36 items) exist, and both have good psychometric properties. The short form measures maternal esteem, parent-child interaction, and child self-regulation. The long form provides additional useful clinical information on the parent-child interaction, but can take up to an hour and a half to administer. Five discussion respondents stated that the PSI has strong psychometric properties and provides good clinical information; these respondents would recommend the PSI to someone else working with children exposed to violence and their families.

Many of the respondents indicated that children's exposure to violence is a developing field. As such, no existing measure meets all of their criteria. For instance, while the TESI is quick and comprehensive, it does not capture severity of abuse or symptoms. Other measures such as the TSCYC have good psychometric properties, but limited clinical utility. Measures such as the ASQ and CBCL are useful to describe a child's current developmental stage, but are not sensitive to change over time. The PSI, as indicated by the respondents, comes closest to meeting all of the aforementioned criteria, but still does not meet all of the important criteria indicated by practitioners, researchers, and researcher-practitioners.

### **3.2.4 Summary of literature review and criteria findings**

In summary, practitioners and researchers have different perspectives on the use of standardized measures. Practitioners prefer to assess clients through clinical skills and interviews as opposed to measures. Nevertheless, there is a great deal of consensus around criteria for choosing a measure for children's exposure to violence. The two most commonly mentioned criteria in this sample were family-friendliness (i.e., brevity, non-intrusiveness) and cultural competency factors (e.g., language appropriateness). Practitioners and researchers in this sample also agreed that existing measures for children exposed to violence are lacking in one or more key criteria.

The Safe Start Demonstration Project focused on bringing about systems change and developing partnerships between practitioners and researchers. In particular, this

process focused on encouraging practitioners to participate in the measurement selection process, to gain buy-in for measure implementation. Such buy-in not only helped practice efforts, but also improved fidelity to the measurement protocol, thereby improving research outcomes. The following two sections describe how to engage practitioners in the process of selecting and implementing measurement protocols.

### **3.3 Process for selecting and implementing a measure<sup>6</sup>**

#### **3.3.1 Selection**

*Selection of a measure begins with a review of the literature.* Based upon our phone discussions, researchers tend to lead the process of selecting a measure. As mentioned, practitioners tend to use clinical skills to assess children and are less likely than researchers to use standardized measures, while researchers depend upon standardized measures to ensure reliability and validity of their studies. Regardless of who leads the process, both practitioners and researchers stated that the first step in choosing a measure for children's exposure to violence is to examine background information on measures that have been used with similar populations. For practitioners, this step involves speaking with experts and discussing the clinical usefulness of measures previously employed. Researchers in this sample might consult with experts, but additionally review the literature for appropriate measures to help address their study's hypotheses. Discussion respondents, in particular researchers, also examine the psychometric properties of potential measures to determine whether these properties meet their criteria (see above for researcher's criteria).

*Practitioners and researchers discuss advantages and disadvantages of the measure.* Researchers stated that after they review the literature and find an appropriate measure, they meet with practitioners, discuss the advantages and disadvantages of the measure, and then decide whether or not to use it. The advantage of this collaborative process is the creation of ownership among practitioners in addition to an increased understanding of the importance of the research process and of systematically administering the measure. This increased understanding may lead to increased fidelity of data collection, resulting in more valid findings. The disadvantage of the collaborative process is that it is time-consuming, possibly delaying the onset of a project. One researcher stated that it took up to six months to work through the collaborative process and choose a measure.

*There is a need to consider the culture of an organization when choosing a measure.* Two individuals noted the importance of taking into account the culture of the organization in which the measure will be administered. For instance, a strengths-based organization may resist the use of a measure that emphasizes deficits of the child and family. Thus, a measure such as the Child Behavior Checklist (Achenbach & Rescorla, 2000), which documents the child's deficits, might not be a good choice.

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<sup>6</sup> This process is based upon the individuals we spoke to for this report and may not generalize to all practitioners and researchers.

Likewise, a setting with mostly court-mandated clients may need a measure without questions perceived as threatening; caregivers who have been court-mandated to receive services may be less likely to respond to questions that have potential negative consequences than to questions that are more broad in scope and less potentially negative. Similarly, practitioners and researchers need to be aware of the reporting requirements for children's exposure to violence within their state, as well as how mandated reporting may affect caregivers' responses. Both researchers and practitioners need to be able to work with caregivers to obtain information on children while being sensitive to mandated reporting laws and caregiver fears of legal ramifications.

***It is important to obtain data from multiple sources.*** Obtaining information from multiple sources (e.g., child, caregiver, teacher) increases the validity of findings on children's exposure to violence (Kuo, Mohler, Raudenbush, & Earls, 2000). Both practitioners and researchers stated that having multiple sources of information is ideal; however, obtaining multiple sources of information entails time and cost. Two discussion respondents indicated that the child, in particular, should provide information (if possible) about the exposure event; the literature supports the recommendation that a child provide his/her own narrative of the exposure to violence (Zero to Three/National Center for Clinical Infant programs, 1994). Depending upon age and abilities, the child may verbalize the event, draw pictures, or use toys or other objects to describe the event. The advantage of this approach is that the child conveys his/her thoughts regarding the event, allowing the practitioner to better assess the impact of the exposure to violence. The disadvantage of this approach is that the child may not be developmentally able to describe the event. Additionally, this approach may be time-consuming for the practitioner, as some children are less readily able to express themselves than others.

### **3.3.2 Implementation**

***Early practitioner buy-in helps reduce resistance.*** Respondents in this sample indicated that practitioners who were highly involved in the measure selection process were more likely to feel ownership of the measures and less likely to resist implementation of measurement protocols, as compared to practitioners who were not as involved in the selection process. A major source of tension between researchers and practitioners in this sample was adherence to the measurement protocol. For instance, four discussion respondents indicated that some practitioners, located in clinical settings, were reluctant to administer any measures because they felt that measures over-burdened the child and family and took time away from treatment.

Safe Start evaluators reported that there was initial practitioner resistance to administering standardized assessment tools. Researchers reported that at times practitioners viewed measurement tools as a barrier to treatment. In response, researchers worked with practitioners and explained the usefulness of clinical information that could be attained from the measures.

***Fidelity to the implementation protocol is critical.*** It is important to administer standardized measurement tools in a systematic manner; ensuring fidelity to

administration protocols helps to increase the validity of research findings. Without monitoring, however, there is little accountability and increased room for error.

Researchers in this sample described fidelity to measurement protocols as essential, whereas practitioners considered it more important to veer away from the protocol if a child or family responded to a questionnaire item in a manner that warranted further clinical investigation. According to researchers, adherence to the assessment protocol should be maintained except in extreme circumstances (e.g., an individual expresses suicidal tendencies).

### **3.3.3 Steps to ensure practitioner buy-in**

Respondents described three main steps to engage practitioners in administering standardized measures.

***Step 1. Explain the usefulness of clinical information obtained from the measure.*** According to many researchers in this sample, after a practitioner administered a measure and the measure was scored and interpreted, the practitioner could see how the information would help inform treatment and thereby help the child and family. For instance, many practitioners and researchers described the PSI as extremely useful in their assessment of children and families, because the tool provides useful clinical information on the parent-child interaction dynamic.

In addition, respondents stated that administering measures provided an opportunity to develop rapport with children and families. Similarly, Garland, Kruse, and Aarons (2003) reported that clinicians in their study found the process of administering measures useful in the intake process and developing rapport.

***Step 2. Train practitioners on how to administer the measure.*** Researchers stated that training practitioners on how to administer a measure helped gain buy-in. Similarly, Garland, Kruse, and Aarons (2003) reported that practitioners would be more receptive to using standardized measures if they were trained not only on how to administer the measure, but also on how to score and interpret the findings.

***Step 3. Provide regular feedback/communication to the practitioner.*** This feedback might include information on the practitioner's data, to inform the practitioner of patterns seen in his/her clients. Regular communication with the practitioner also helps to ensure fidelity to the administration protocol. One researcher stated that he/she conducts weekly supervision meetings with practitioners to offer support and updates, and to ensure fidelity to the protocol.

## 4. Recommendations for Future Research

The following recommendations will aid in the development and selection of measures for this population of children. They focus on developing sound methodological approaches to identification and assessment of children's exposure to violence and high utility for practitioners, researchers, and researcher-practitioners.

***Consider practical factors when choosing measures.*** The majority of respondents discussed the importance of paying attention to practical factors such as burden on the family, administration, scoring, and appropriateness of a measure for the target population. In addition to these factors, the clinical utility of a measure also should be considered, to balance the needs of practice and research. A measure should yield valid scientific data, but also should inform the practitioner's work with the child and family.

***Select measures with strong psychometric properties.*** Most respondents indicated that they seek measures with strong psychometric properties. To assess the effectiveness of a treatment protocol and/or research intervention, it is important to select a measure that has been normed on a similar population, has good construct validity, and is reliable. Additionally, for researchers and other individuals interested in assessing how the client improves with treatment, it is vital to select a measure that can assess change over time.

***Choose measures that assess type(s), severity, and symptoms of exposure to violence.*** Measures should examine the proximity of the violence (e.g., home or community) and the relationship between the perpetrator and the child. Measures also should capture information on the timing of exposure, as the child's age at first exposure, frequency of exposure, and length of exposure all are important factors to examine for their impact on outcome. Furthermore, there is a need to assess children's exposure to violence from multiple sources, including the mother, father, other relatives, and community members and service providers. When assessing exposure to violence within a community, measures need to take into account the contextual factors that surround the violence (Phelps, McCart, & Davies, 2002).

***Develop an agreed upon definition of children's exposure to violence.*** To assess children's exposure to violence, an agreed upon definition of exposure is critical. Children may be exposed to various types of violence (e.g., community violence, domestic violence), and each type may impact the child differently (Saunders, 2003). For example, children may be more affected by witnessing domestic violence within their own home than by witnessing a gang fight in the neighborhood.

Researchers need to distinguish between types of violence, intensity of exposure, and frequency of exposure (Margolin & Gordis, 2004). Chronic exposure to violence, events in close proximity to the child, and events that involve persons the child knows all have been associated with more negative outcomes (Martinez & Richters, 1993).

Most studies have not systematically examined the different types of exposure to violence (Holden, 2003). A review of 22 studies on children's exposure to violence from 1987 to 1997 indicated that only 43% of those studies included a description of the nature of violence exposure (Mohr, Noone, Lutz, Fantuzzo, & Perry, 2000). To improve the research and treatment of children exposed to violence, a better definition of violence exposure is needed (Feerick & Silverman, 2006). The criteria mentioned by the respondents can aid in the development of a definition of exposure to violence that is useful for both practitioners and researchers. Improving the definition of children's exposure to violence would have several benefits, including 1) facilitating the communication of research on the topic and 2) improving the identification of key components of treatment that have the greatest impact on children (Prinz & Feerick, 2003).

***Establish collaborative partnerships between practitioners and researchers.*** Practitioners and researchers have different thoughts and approaches related to standardized measures. Despite these potential differences, professionals in both groups need to collaborate in selecting and implementing measures to yield information that will inform both research and clinical work.

## **5. Conclusion**

This report describes the factors that influence practitioners and researchers to choose measures, similarities and differences in their criteria for measures, and the process by which practitioners and researchers jointly select and implement measures. Children's exposure to violence is prevalent and has detrimental physical, social, emotional, and cognitive effects. The Safe Start Demonstration Project sought to bring about systems level changes to help children exposed to violence and their families. Through Safe Start, practitioners and researchers were required to collaborate to best treat children and their families. This report found that practitioners and researchers have different perspectives on standardized measures, but largely agree on the criteria for an effective measure. This report also found that collaboration between practitioners and researchers in the measure selection process is critical to ensure buy-in from all parties and fidelity of measure implementation. Future research should focus on developing a measurement tool that meets all of the criteria described in this report. Additionally, future work should establish a collaborative process between practitioners and researchers to implement measures for children's exposure to violence and their families.

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**Appendix A**  
**Psychometric Properties of the Most Commonly**  
**Mentioned Measures for Children Exposed to**  
**Violence**

## Psychometric Properties of the Most Commonly Mentioned Measures for Children Exposed to Violence

Name of instrument	Purpose	Age group	Psychometric properties (i.e., reliability, validity)	Respon- dent	Other lang.?	# of items	Time to admi nister
Ages & Stages Questionnaires – 2 <sup>nd</sup> Edition (ASQ; Bricker & Squires, 1999)	Assesses child development in 5 areas: communication, gross motor, fine motor, problem solving, and personal-social.	4 to 60 months	<p>Validity: Overall agreement across questionnaires is 83% with a range of 76% to 91%. Sensitivity (i.e., children for whom the ASQ system indicates a delay and who are categorized by the standardized assessment as having a delay) ranges from 38% to 91%. Specificity (i.e., children for whom the ASQ system does not indicate a delay and who are characterized by a standard assessment as developing typically) ranges from 81% to 91%. Positive predictive value (i.e., a measure of the probability that a child with a questionnaire that indicates delay will have a poor outcome on the standardized assessment) ranges from 32% to 64%.</p> <p>Reliability: Test-retest information was collected by asking a group of 175 parents to compete two questionnaires for their children at 2- to 3- week intervals. Classification of each child based on the two questionnaires was compared and found to exceed 90% agreement. Inter-rater reliability was assessed by having a trained examiner complete a questionnaire for a child shortly after a parent had completed a questionnaire. Agreement on classification between 112 parents and three trained examiners was more than 90%.</p>	Parent SR	Span.	30	10-30 min.
Child Behavior Checklist (CBCL; Achenbach & Rescorla, 2000)	<p>Assesses internalizing and externalizing behavior problems.</p> <p>Provides standardized ratings and descriptive information on children's behavioral/emotional problems. Includes 5 DSM-oriented scales linked to DSM IV diagnoses.</p>	1 ½ to 5 years	<p>Test-retest reliability (8-day interval): Pearson correlation 0.79 to 0.92 (Achenbach &amp; Rescorla, 2000).</p> <p>Inter-rater reliability: Agreement between mothers and fathers ranged from 0.51 to 0.67 (Achenbach &amp; Rescorla, 2000).</p> <p>Validity: Referred children compared to non-referred children score significantly higher on problem scales (Achenbach &amp; Rescorla, 2000).</p>	Parent SR	Span., Chin.	100	10-15 min.

Name of instrument	Purpose	Age group	Psychometric properties (i.e., reliability, validity)	Respondent	Other lang.?	# of items	Time to administer
Parenting Stress Index – 3 <sup>rd</sup> Edition (Abidin, 1995)	Assesses three major sources of stress (i.e., child variables, parent characteristics, and situational/demographic life stress) in parent-child interactions. Both short (PSI-SF) and long (PSI) versions exist. The long version includes seven parent subscales and six child domains. The short form has three subscales: parental distress, parent-child dysfunctional interaction, and difficult child.	3 months to 10 years	Alpha reliabilities for the PSI long version (Solis & Abidin, 1991):  Child subscales with white, Hispanic children, respectively: Adaptability, 0.66, 0.65 Acceptability, 0.63, 0.74 Demandingness, 0.62, 0.58 Mood, 0.66, 0.63 Distractibility/hyperactivity, 0.62, 0.65 Reinforces parent, 0.70, 0.76 Child domain score, 0.89, 0.89  Parent subscales: Depression, 0.80, 0.75 Attachment, 0.55, 0.58 Restriction of role, 0.79, 0.74 Sense of competence, 0.74, 0.73 Social isolation, 0.73, 0.74 Relationship with spouse, 0.70, 0.76 Parent health, 0.66, 0.71 Parent domain score, 0.93, 0.92 Total stress score, 0.95, 0.94  The PSI-SF was found to have good internal consistency among a low-income sample (Reitman, Currier, & Stickle, 2002). Alpha reliabilities:  Parental distress, 0.88 Parent-child dysfunctional interaction, 0.88 Difficult child, 0.89 Total stress, 0.95	Parent SR Likert style	Span.	PSI: 120; 54 with parent focus, 47 with child focus  PSI-SF: 36 items, 12 per sub-scale.	20-30 min.  10-15 min.
Temperament and Atypical Behavior Scale (TABS; Bagnato, Neisworth, Salvia, & Hunt, 1999)	55-item questionnaire completed by the parent that measures dysfunctional behavior in infants and young children. Assesses behavior in areas such as temperament, attention, attachment, social behavior, play, vocal and oral behavior,		Four psychometric factors underlie the 55 items, which are arranged into four subsets on the assessment tool. These four factors define a construct of atypical temperament and self-regulation. The factors are detached, hypersensitive active, underreactive, and dysregulated.	Yes		55	12

Name of instrument	Purpose	Age group	Psychometric properties (i.e., reliability, validity)	Respondent	Other lang.?	# of items	Time to administer
Trauma Symptom Checklist for Young Children (TSCYC; Briere et al., 2001)	senses and movement, self-stimulation and self-injury, and neurobehavioral state. Assesses symptoms of exposure to trauma, including PTSD, depression, anxiety, dissociation, and aggression.	3 to 12 years	In a multi-site sample of 219 traumatized children (Briere, et al., 2001), the TSCYC clinical scales had good reliability (alpha values for the clinical scales ranged from 0.81 for sexual concerns to 0.93 for PTSD-total, with an average value of 0.87) and were predictive of exposure to childhood sexual abuse, physical abuse, or witnessing domestic violence. The posttraumatic stress-intrusion (PTS-I), posttraumatic stress-avoidance (PTS-AV), posttraumatic stress-arousal (PTS-AR), and posttraumatic stress-total (PTS-TOT) were most predictive, followed by sexual concerns (SC) in the case of sexual abuse and dissociation (DIS) in the case of physical abuse. Similar reliability and various forms of validity have been demonstrated in a number of other samples (e.g., Becker-Blease, Freyd, & Pears, 2004; Finkelhor, Turner, & Ormrod, in press; Gilbert, 2003; Pollio, Glover-Orr, & Wherry, 2002; Wolpaw, Newman, Davis, Ford, & Briere, in press).	Parent SR	Span.	90	10-20 min.
Traumatic Events Screening Inventory – Child (TESI; Ribbe, 1996)	Screens for exposure to potentially traumatic experiences (e.g., illness, disaster, family or community violence, sexual abuse); assesses Criterion A for PTSD.	4+ years		Child or Parent SR		15-18	10-30 min.

**Appendix B**  
**Discussion Participant Comments on the Most**  
**Commonly Mentioned Measures**

## Discussion Participant Comments on the Most Commonly Mentioned Measures

Measure	Practitioner (N=7)	Researcher (N=7)	Researcher-Practitioner (N=7)
<i>Ages and Stages (ASQ)</i>	<ul style="list-style-type: none"> <li>• The ASQ is not a good pre/post measure; it measures development, not behavioral symptoms.</li> <li>• The ASQ is a developmental tool, there is not a big difference in behaviors between the pre and post test.</li> </ul>	<p>The ASQ is not useful because it is not sensitive to change over time. The ASQ mainly assesses children’s cognitive and physical aspects, which usually do not change quickly.</p>	<p>Ages and Stages is helpful for developmental assessment.</p>
<i>Ages and Stages Social and Emotional (ASQSE)</i>	<ul style="list-style-type: none"> <li>• ASQSE scores differ with age, so the ASQSE is not a good pre/post measure, although it has useful information for the family.</li> <li>• It is a good overview of the child’s social and emotional development, would recommend it to others</li> </ul>	<p>The ASQSE is more sensitive to change over time than the ASQ because the ASQSE assesses children’s social and emotional aspects, which can changes quickly.</p>	
<i>Child Behavior Checklist (CBCL)</i>		<p>CBCL focuses too much on mental health factors and is not sensitive to change over time.</p>	<ul style="list-style-type: none"> <li>▪ CBCL is not a great outcome measure because it does not target changes in symptoms.</li> <li>▪ CBCL may be inappropriate because it focuses on deficits.</li> </ul>
<i>The Parental Stress Index (PSI)</i>	<ul style="list-style-type: none"> <li>▪ The PSI is good in terms of gathering clinical information on parental stress. The short form is simple and quick, but still gets at clinical info. The long form takes 40 minutes, and it is hard to keep the parent engaged, but it helps identify what types of information would be most helpful for the family.</li> <li>▪ Families appreciate the information obtained and shared from the PSI. Clinicians also like the PSI because they are able to gain a great deal of insight into the parent-child relationship. The disadvantage is that some of the PSI questions are personal and families worry that their responses could be used against them.</li> </ul>	<ul style="list-style-type: none"> <li>▪ The PSI is considered the “gold standard” for assessing parental stress. It is a good proxy for maternal depression and has good subscales.</li> <li>▪ The PSI is useful because it can assess the child-parent dynamic; it also comes in different languages and has a defensive scale to identify who was “faking good.”</li> </ul>	<p>The PSI provides useful clinical information</p>

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<i>Temperament and Atypical Behavior Scale (TABS)</i>	<ul style="list-style-type: none"> <li>▪ It gives you an insight in to the parent-child interaction, straightforward, short, would recommend it.</li> <li>▪ Really helpful, but the PSI is a bit confusing... not as useful as it could be , but yields good clinical information, would recommend it.</li> <li>▪ The TABS is not as helpful or as easy as the PSI. The advantage of the TABS is that it provides information on how to deliver feedback to the parents on findings. TABS is most helpful for toddlers. It gets at very specific behaviors if the child is exhibiting those behaviors.</li> <li>▪ The TABS is problematic because it measures atypical behavior, not strengths.</li> </ul>	The TABS has therapeutic value, because you are asking the parent if the child is exhibiting certain behaviors that need to be addressed.	
<i>Traumatic Events Symptoms Inventory (TESI)</i>	The TESI is useful, but cannot be administered alone.	The TESI is too general. For instance, it asks about being hospitalized, which is different than witnessing intentional aggression.	<ul style="list-style-type: none"> <li>▪ The TESI is comprehensive, but too long.</li> <li>▪ The TESI is very useful because it is a comprehensive trauma history inventory.</li> </ul>
<i>Trauma Symptom Checklist for Young Children (TSCYC)</i>	The TSCYC is very helpful because it asks about behaviors that are trauma-related, but it is harder to score; hence it is better for parents, but harder for clinicians.	The TSCYC can measure the impact of violence on a child.	The TSCYC is useful because it is a symptom checklist, with a broad range of symptomatology. The disadvantage is that the TSCYC may not necessarily identify criteria for PTSD.