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Community Violence and Trauma: The Influence of Child Abuse, Bullying, and Intimate Partner Violence

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This dissertation, COMMUNITY VIOLENCE AND TRAUMA: THE INFLUENCE OF CHILD ABUSE, BULLYING AND INTIMATE PARTNER VIOLENCE, by CLAUDINE ANDERSON-ATKINSON, was prepared under the direction of the candidate's Dissertation Advisory Committee. It is accepted by the committee members in partial fulfillment of the requirements for the degree, Doctor of Philosophy, in the College of Education and Human Development, Georgia State University.

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COMMUNITY VIOLENCE AND TRAUMA: THE INFLUENCE OF CHILD ABUSE, BULLYING AND INTIMATE PARTNER VIOLENCE

by

CLAUDINE O. ANDERSON-ATKINSON, MS.

Under the Direction of Dr. Jane Brack

ABSTRACT

Community violence exposure is associated with a myriad of physical and mental health problems and adjustment difficulties (Fowler, Tompsett, Braciszewski, Jacques-Tiura & Baltes, 2009; Senn, Walsh & Carey, 2016 ; Voisin, Chen, Fullilove & Jacobson, 2015). However, the research that investigates the adult mental health consequences of community violence exposure within the context of other potentially traumatic events is still emerging (Walling, Eriksson, Putman & Foy, 2011; Kennedy, Bybee & Greeson, 2014). This dissertation responds to this gap in the literature. This study investigated the interrelationships among violence exposures in community, school, family and intimate relationships and PTSD symptoms. The study also examined whether child abuse, intimate partner violence and school bullying moderated the relationship between community violence exposure and PTSD. The researcher collected data from 499 undergraduate students using a demographic questionnaire, the Trauma Symptom Checklist -40 (Briere & Runtz, 1989), the Survey of Exposure to Community Violence (SECV; Richters & Saltzman, 1990), the Retrospective Bully Questionnaire (RBQ; Schäfer, et al,2004),

the Composite Abuse Scale (Hegarty, Bush, Sheehan, 2005) and the Early Trauma Inventory-Self Report (ETI-SR; Bremner, Bolus & Mayer, 2007). Bivariate correlations revealed significant, positive correlations between PTSD and community violence exposure ($r = .264$, $p < .01$), school bullying ($r = .242$, $p < .01$), intimate partner violence ($r = .327$, $p < .01$) and child abuse ($r = .292$, $p < .01$). Community violence, child abuse, intimate partner violence and school bully significantly predicted the variance in PTSD symptoms. The study found that child abuse, intimate partner violence and school bullying scores were ($\beta = -.000$, $t(216) = -.027$, $p > .01$) not substantial moderators for the relationship between community violence and PTSD with this sample $F(211) = 8.067$, $p < .01$, $R^2 = .192$) . Demographic differences in PTSD symptoms and community violence exposure were observed.

INDEX WORDS: Community Violence, PTSD, Intimate Partner Violence, Child Abuse

COMMUNITY VIOLENCE AND TRAUMA: THE INFLUENCE OF CHILD ABUSE, BULLYING AND INTIMATE PARTNER VIOLENCE

By

CLAUDINE O. ANDERSON-ATKINSON, MS.

A Dissertation

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the Department of Counseling and Psychological Services

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the College of Education

Georgia State University

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DEDICATION

I dedicate this paper to the youth and families residing in garrison communities across the beautiful island of Jamaica. This belongs to the resilient, brave ones who live in neighborhoods and homes plagued by chronic violence, poverty and numerous other adversities. This paper is for those who are not able to access the classrooms of higher learning or visit foreign lands. I am honored and blessed to have been cradled by the realities of inner-city Kingston and pray that I will remain a faithful steward of the gifts that You have lavishly bestowed on me.

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ABSTRACT FOR CHAPTER 1

Community violence is a pervasive public health problem that has been linked to a range of developmental, mental health and adjustment concerns (Fowler et al, 2009; DeCou & Lynch, 2015). The community violence scholarship has historically focused on children and adolescents but there is a small but developing body of literature that explores adult community violence experiences. There is need for additional practice and empirically oriented scholarship with community violence exposed adults. This dissertation responds to this gap in the literature by examining the community violence experiences of emerging adults. This chapter explores the practice implications of adult community violence exposure. It outlines prevalence indicators, reviews the conceptual and measurement concerns that pervade the field and summarizes the consequences of exposure. The chapter proposes the use of the bio-ecological model to explore responses to community violence exposure with emerging adults and presents a case example to illustrate how the bio-ecological model can be used in treatment planning within a college setting. The chapter also discusses clinical implications of exposure.

CHAPTER 1

CONSEQUENCES OF COMMUNITY VIOLENCE: IMPLICATIONS FOR CLINICAL PRACTICE IN UNIVERSITY SETTINGS

National and empirical data suggests that community violence exposure is a notable public health issue in the United States. The Bureau of Justice Statistics' (BJS) National Crime Victimization Survey (NCVS) reported that in 2014 residents over 12 years experienced approximately five and a half million violent victimizations including rape or sexual assault, robbery, aggravated assault, and simple assault and over one million individuals experiencing at least one serious violent victimization in the same year (Truman, Langton & U.S. Department of Justice, 2015). The Bureau of Justice Statistics' (BJS) National Crime Victimization Survey (NCVS) also reported over five million property victimizations which included household burglary, theft, and motor vehicle theft in 2014 (Truman, Langton & U.S. Department of Justice, 2015). These indicators of violent and property crimes provide a general context of violence exposure across the nation.

The existing empirical data on community violence with university and community samples is somewhat dated. Most of the studies with college students in the United States were conducted over a decade ago (Brady, 2006; Banerjee, Rowley & Johnson, 2015; Scarpa, 2001; Scarpa et al, 2002; Scarpa & Ollendick, 2003; Scarpa, Hurley, Shumate & Haden, 2006; Scarpa, Tanaka & Haden, 2008; Rosenthal & Wilson, 2003). Although there are concerns about the recency of majority of these studies, the available empirical data provide preliminary insights on the prevalence of community violence within the university setting. Scarpa (2001) reported that approximately 96% of students reported witnessing and 82% reported being victims of community violence. Scarpa et al (2002) found that approximately 65% and 28% of college

students reported experiencing at least three different forms of violence as a witness or victim respectively. Haden and Scarpa (2008) indicated that approximately 33% of the college population sampled reported experiencing three or more violent experiences in their lifetime. Community violence exposure varies somewhat by sample design and the conceptualization of violence exposure that guides data collection (DeCou & Lynch, 2015) but the previously mentioned indicators none the less confirm that university students are exposed to violence in their communities at significant levels. These indicators suggest that community violence exposure may be pertinent to counseling practice in university settings.

The high rates of community violence exposure are concerning because empirical data has linked exposure with a myriad of negative psychological outcomes. Community violence victimization and or witnessing have been found to be associated with increased vulnerability to mental health and adjustment problems in college populations (Banerjee et al, 2015; Eitle &Turner, 2002; Haden & Scarpa, 2008, Khan et al, 2015; Rosenthal & Wilson, 2003; Scarpa & Ollendick, 2003; Scarpa, 2001; Scarpa et al, 2002).

The high levels of community violence victimization and witnessing and the negative emotional and behavioral sequelae that attend exposure suggests that it is crucial that clinicians working in college settings are sensitive to how mental health difficulties may be exacerbated by or emerge within the context of exposure (Haden & Scarpa, 2008). It is also important that clinicians working in college counseling centers understand the factors that protect against the deleterious effects of community violence (Banerjee et al., 2015). The literature on community violence in college populations is burgeoning but there is still limited data on practice guidelines pertinent to exposure. The succeeding paragraphs will summarize the current conceptualizations and assessment of community violence, the long-term correlates of exposure, and propose a

model for understanding variable responses to community violence exposure. The paragraphs will then provide a case example and a discussion of practice implications of violence exposure with the university setting.

Defining and Assessing Community Violence

Researchers continue to grapple with conceptual and methodological concerns around community violence exposure (DeCou & Lynch, 2015) and explore theoretical frameworks to better understand the factors that influence development within the context of community violence (DeCou & Lynch, 2015). There is a lack of uniformity in the definition and operationalization of community violence. Morrison (2000, p. 299) defined community violence as "crime related and random acts of violence outside the home [that] does not include domestic violence or child abuse." Shahinfar, Fox and Leavitt (2000, p.115) on the other hand conceptualized community violence as "the presence of violence and violence related events within an individual's proximal environment, including home, school, and neighborhood, which may involve direct or threatened harm, be witnessed or experienced, and involve known or unknown perpetrators." While researchers agree that community violence includes exposure to interpersonal violence in one's neighborhood (Mazza & Overstreet, 2000), there is a lack of consensus on what types of exposure should be included.

Some researchers propose a single index which incorporates primary (victimized), secondary (witnessed), and tertiary (heard about) levels of violence exposure (Buka, Stichick, Birdthistle, & Earls, 2001; Kliewer, Lepore, Oskin & Johnson, 1998) while others propose two discrete classifications that distinguish between direct and indirect exposure around personal victimization and witnessing violent events (Mazza & Overstreet, 2000; Shahinfar et al, 2000;). Still other researchers propose a framework that distinguishes between witness and victim

statuses associated with life threatening situations and non-life threatening situations (Cooley & Turner , 1995; Hastings & Kelley, 1997; Singer, Anglin, Song, & Lunghofer, 1995). These inconsistencies illustrate the need for continued research efforts geared at developing and validating a nosology for classifying community violence (Cicchetti & Lynch, 1993) that meaningfully distinguishes it from other forms of violence and victimization such as child abuse and intimate partner violence (DeCou & Lynch, 2015).

Efforts to develop a unified classification and definitional framework for community violence are critical for assessment and clinical practice in college counseling settings because definitional disagreements have implications for measurement and assessment. Census data, examiner-created questionnaires, and standardized measures have been variously utilized to collect community violence data in the scholarly literature (DeCou & Lynch, 2015). The standardized measures that are frequently referenced in the literature include; My Exposure to Violence (My ETV; Selner-O'Hagan, Kindlon, Buka, Raudenbusch, & Earls, 1998), Exposure to Violence Questionnaire (EVQ; Reynolds & Mazza, 1995) Things I Have Seen and Heard (TISH; Richters & Martinez, 1990), Violence Exposure Scale for Children –Revised (VEX-R; Fox & Leavitt, 1995), Children's Report of Exposure to Violence (CREV; Cooley, Turner, & Beidel, 1995), the Survey of Exposure to Community Violence (SECV; Richters & Saltzman, 1990), and the Screen for Adolescent Violence Exposure (SAVE; Hastings & Kelley, 1997). These references to diverse standardized tools reflect the development of the field. Most of the scholarship on community violence has been with child and adolescent populations and so unsurprisingly all of the standardized instruments that have been utilized with college populations were originally developed for use with children (DeCou & Lynch, 2015).

One instrument that was originally designed for children and adolescents is the Survey of Exposure to Community Violence (SECV; Richters & Saltzman, 1990). The Survey of Exposure to Community Violence (SECV; Richters & Saltzman, 1990) is the measure that is most commonly used with college students. The existing data confirms that the measure demonstrates sound psychometric properties across diverse college student populations (DeCou & Lynch, 2015). Even though this measure has been used extensively there are concerns about making definitive comparison across studies. DeCou and Lynch (2015) suggested that researchers and practitioners exercise caution when making comparisons and generalizations based on data from this measure, because most of studies with adult samples have utilized modified versions of the SECV. Future research should be dedicated to verifying that the factor structure of the SECV is invariant across child and adult populations and ultimately developing instruments specifically for adult populations. These developments are urgent because effective treatment within the university counseling context is predicated on adequate assessment of community violence exposure and overlapping factors.

The empirical literature on community violence is in its infancy. There is a lack of consensus about how community violence should be defined and there are only a few available measures of the construct. The discipline's early emphasis on children and youth is evident in the contemporary literature as researchers continue to administer tools to adults that were initially developed for children. The Survey of Exposure to Community Violence (SECV; Richters & Saltzman, 1990) is the most commonly used measure. The measure has demonstrated adequate psychometric properties and been adapted and used in studies examining the correlates of community violence exposure with university populations. Future research is needed to create a unifying construct of community violence that is distinct from other violent experiences. This

conceptual clarity will facilitate reliable and standardized assessment and the development of adult specific measures of community violence. This expanded work will also add credibility to the emerging clinical and research literature that examines the correlates of community violence exposure with adults.

Consequences of Community Exposure

Although the literature on adult outcomes associated with community violence is still emerging, the data linking exposure to psychological disturbance and problems of living in childhood is robust (Cammack, Lambert & Ialongo, 2011; Fowler et al, 2009; Frey, Ruchkin, Martin, & Schwab-Stone, 2009). Given that the risk for community violence exposure remains notable in early adulthood, (Banerjee et al, 2015; Eitle &Turner, 2002; Haden & Scarpa, 2008; Rosenthal & Wilson, 2003; Scarpa & Ollendick, 2003; Scarpa, 2001; Scarpa et al, 2002) university counseling personnel are strategically placed to identify and respond to the mental health needs of community violence exposed students. Impactful interventions are predicated on a thorough grasp of the risk factors and consequences of exposure (Fowler et al, 2009). University mental health personnel routinely conduct initial and ongoing assessments, develop case conceptualizations, do treatment planning, and provide referral information. A comprehensive understanding of community violence concerns can enhance the efficacy of treatment (DeCou & Lynch, 2015). This preparation can help university counselors identify clients who are at risk for mental health difficulties associated with community violence exposure and devise appropriate prevention and treatment strategies. The succeeding paragraphs enumerate the consequences of community violence and the risk and protective factors that increase vulnerability to or buffer the consequences of exposure.

Firstly, there is a small and relatively dated body of research, which documents the consequences of direct and indirect community violence among college students. Community violence victimization and or witnessing has been linked to increased psychological distress (Rosenthal & Wilson, 2003), aggression (Scarpa, 2001; Scarpa & Ollendick, 2003, Banerjee et al, 2015), depression (Haden & Scarpa, 2008, Banerjee et al, 2015), interpersonal problems (Scarpa et al, 2002), posttraumatic stress disorder (PTSD) (Scarpa et al, 2002; Khan et al, 2015) and substance use and risky driving and sexual behaviors (Brady, 2006).

High levels of community violence victimization has also been linked to aggression and depression. Scarpa (2001) was the first to examine community violence with a post adolescent sample. She used a modified version of the Survey of Exposure to Community Violence (SECV; Richters & Saltzman, 1990) to screen and classify 476 university students attending a rural western state university based on reports of low and high community violence victimization and witnessing. A modified version of the Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock & Erbaugh, 1961), the Self-Rating Anxiety Scale (SAS; Zung, 1971) and the Aggression Questionnaire (AQ; Buss & Perry, 1992) were subsequently administered to the remaining 54 students to determine the consequences of community violence exposure. Scarpa (2001) found that students within the high exposure group reported greater levels of depression and aggression.

Results from the study conducted by Scarpa et al. (2002) provide additional support for the link between exposure and emotional and relational difficulties. They used the Survey of Exposure to Community Violence (SECV; Richters & Saltzman, 1990), VLES (Vrana & Lauterbach, 1994), Beck Depression Inventory-II (BDI-II; Beck, Steer, & Brown, 1996), State Trait Anxiety Inventory (STAI-Form Y-2; Spielberger, Gorush, & Lushene, 1983), Aggression

Questionnaire (AQ; Buss & Perry, 1992) and the Interpersonal Problems–Personality Disorders Scale (IIP-PD; Pilkonis, Kim, Proietti, & Barkham, 1996) with 518 predominantly White university students to assess the relationship between exposure to violence and difficulties in psychological adjustment. They reported that individuals with high community violence exposure reported greater depression, aggression, interpersonal problems, and post-traumatic stress disorder symptoms (Scarpa et al, 2002).

Scarpa and Ollendick (2003) extended the research on community violence exposure and aggression by examining how physiological factors such as heart rate and stress response influenced the relationship between aggression and community violence exposure. Scarpa and Ollendick (2003) screened four hundred 76 students at a rural western state university and identified 47 participants who were victims and non-victims of community violence. Scarpa and Ollendick (2003) examined whether reduced resting heart rate (HR) and increased baseline heart rate variability (HRV) related to aggression in students who were not victims of community violence and whether increased post stressor cortisol related to aggression in victims. They administered the Survey of Exposure to Community Violence—Self-Report Version (SECV; Richters & Saltzman, 1990), the Aggression Questionnaire (AQ; Buss & Perry, 1992), and psychophysiological measures of stress reactivity, cortisol and heart rate. Scarpa and Ollendick (2003) found that increased HRV was associated with aggression only in nonvictims and increased cortisol only in victims of community violence. They also reported that reduced resting HR was associated with aggression in both victims and non-victims.

The studies cited above looked at the relationships between community violence victimization and witnessing and a variety of negative emotional and adjustment outcomes. Haden and Scarpa (2008) went beyond those studies by focusing on the consequences of

community violence victimization while examining how the relationship between exposure and negative outcomes were influenced by two hypothesized moderating variables. Haden and Scarpa (2008) conducted hierarchical regression analyses with a predominantly White sample of five hundred fifty college students to examine the relationships among lifetime community violence victimization, coping behavior, social support, and depressed mood. The Survey of Exposure to Community Violence–Self-Report Version (SECV; Richters & Saltzman, 1990), Beck Depression Inventory-II (Beck, Steer, & Brown, 1996), Events Scale (Lauterbach & Vrana, 1996), Purdue Posttraumatic Stress Disorder scale (PPTSD-R; Lauterbach & Vrana, 1996), Multidimensional Scale of Perceived Social Support (Zimet, Dahlem, Zimet, & Farley, 1988) and COPE Inventory (Carver, Scheier, & Weintraub, 1989) were used in the study. Haden and Scarpa (2008) reported a positive relationship between community victimization and depressed mood and indicated that avoidant coping and low perceived social support from friends strengthened the relationship between community violence and depression. They found that depression scores increased when problem-focused coping and social support was low and disengagement coping was high. They also reported the relationship between community violence and depressed mood was strengthened when disengagement coping was high (Haden & Scarpa, 2008).

The previously mentioned studies investigated community violence, aggression and depression with predominantly White students in the United States. Rosenthal and Wilson (2003), Banerjee and colleagues (2015) and Khan and associates (2015) expanded the literature by investigating the consequences of community violence exposure with more diverse university student samples. Banerjee and colleagues (2015) examined the perspectives of Students of Color based on cultural socialization and Rosenthal and Wilson (2003) explored the experiences of

Students of color who were attending university in a large city. Khan and associates (2015) investigated the prevalence of PTSD in a non-Western sample of university students.

Banerjee and colleagues (2015) investigated the relationships between community violence victimization and witnessing, racial socialization and psychological well-being in a sample of 281 predominantly female African American Midwestern University students. The Survey of Exposure to Community Violence (SECV; Richters & Saltzman, 1990), the Racial Socialization Questionnaire–Teen (RSQ; Lesane-Brown, Brown, Caldwell & Sellers, , 2005), Aggression Questionnaire (AQ; Buss & Perry, 1992), the Center of Epidemiological Studies Depression scale (CES-D; Radloff, 1977) and author developed measures of cultural socialization and preparation of bias were used to collect data. Banerjee and colleagues (2015) found that community violence victimization was associated with higher levels of aggression and depression and determined that community violence witnessing was linked to higher levels of aggression.

Rosenthal and Wilson (2003) used longitudinal data during high school and the first semester of college to examine the associations among chronic community violence**,** psychological distress and academic performance using an adapted version of the Survey of Exposure to Community Violence (SECV; Richters & Saltzman, 1990), the Trauma Symptom Inventory (TSI; Briere, 1995), attendance records, grade point average. The sample consisted of 385 students of color (50% were Black/African American, 25% Latino/Hispanic, 9% Asian, 3% White, and 13% other) who were attending a public, nonresidential, four-year college in New York City. They found that community violence exposure and psychological distress were related and concluded that psychological distress meditated the effects of exposure to community violence on academic performance (Rosenthal & Wilson, 2003).

Khan and colleagues' (2015) cross-sectional study investigated the prevalence of Post-Traumatic Stress Disorder secondary to community violence among 320 university students at four private institutions in Karachi, Pakistan. The researchers examined lifetime exposure to traumatic events and PTSD symptoms with a modified version of the Composite International Diagnostic Interview for stressful events (CIDI; Andrews & Peters, 1998) and Post-Traumatic Stress Disorder Checklist–Civilian Version (PCL-C; Weathers et al, 1993) and used a PCL-C score that was equal to or greater than 44 to indicate a potential PTSD diagnosis. Khan and collegueas (2015) reported positive association between physical attacks and motor vehicle accidents and PTSD and indicated that more than twenty-five percent of the university students in the sample met criteria for a probable diagnosis of PTSD based on the research determined cut of scores.

Although most of the studies on correlates of community violence victimization and/or witnessing in college populations have focused on emotional or interpersonal difficulties, one study examined risky behaviors that are developmentally salient to college populations. Brady (2006) investigated risky sexual behaviors, substance use and driving practices and community violence. Brady (2006) examined whether lifetime community violence exposure was associated with lifetime and 30-day substance use, lifetime sexual risk-taking, and 30-day risky driving practices with a sample of 319 students attending a northeastern public university.

Brady (2006) used the 2001 Youth Risk Behavior Survey (YRBSS; http://www.cdc.gov/HealthyYouth/yrbs/index.htm),the Community Experiences Questionnaire (CEQ; Schwartz & Proctor, 2000), the Risk and Reckless Behavior Questionnaire (RRBQ; Bradley & Wildman, 2002), a substance use measure that was developed by the researchers, the Aggression Questionnaire (AQ; Buss & Perry, 1992), Barratt Impulsiveness Scale (Patton,

Stanford, Barratt, 1995), the Behavioral Inhibition System and Behavioral Activation System scale (Carver,White,1994), Reactive Responding Scales developed by the MacArthur Research Network (http://www.macses.ucsf.edu/Research/Psychosocial/notebook/ReacResp.html), Reasons for Living Inventory for Adolescents (Osman et al, 1998) and the Collective Efficacy scale (Sampson, Raudenbush, Earls,1997). Brady (2006) found that lifetime community violence exposure was associated with greater lifetime substance use and sexual risk-taking, greater 30-day substance use, and risky driving practices. She indicated that these significant relationships persisted even after controlling for gender, ethnic minority status, personality characteristics, aggression, family socioeconomic status, family support, and neighborhood collective efficacy (Brady, 2006).

The existing empirical data confirms that university students who have witnessed or been victims of violence in community settings are at increased risk for overall psychological distress, depression, aggression, interpersonal difficulties, posttraumatic stress disorder, substance use, risky sexual, and driving behaviors. College mental health personnel may find it helpful to screen for general community violence exposure and be especially alert to these emotional and adjustment difficulties when working with those who have been previously exposed to community violence. It may also be helpful for mental health practitioners to note how community violence victimization may exacerbate the developmental demands and adjustment difficulties of chronically exposed students.

It is also important for university mental health practitioners to understand the nuanced nature of community violence exposure. Despite the prevalence of community violence experiences and the associated increases in vulnerability for psychopathology, a substantial percentage of university students exhibit resilient functioning following a history of

victimization and witnessing (Scarpa, 2001; Scarpa et al, 2002; Borsari, Read & Campbell, 2008). Clinical practice in university settings will therefore be enhanced by an understanding the factors that increase vulnerability to and protect against negative outcomes associated with exposure. Several risk and protective factors have been identified.

Community violence exposure varies along demographic characteristics. Male gender, racial minority status, residence in urban and inner city communities, and low socio-economic status have been repeatedly identified as significant risk factors for the negative consequences associated with chronic community violence victimization and witnessing in child and adolescent samples (Fowler et al, 2009). Although college students in urban residence, racial minority status, and lower socioeconomic statuses are assumed to be at high risk for community violence victimization and witnessing (Scarpa, 2001), the data on adult risk factors is still emerging. There is some dispute about whether male gender increases vulnerability for community violence victimization and or witnessing. Scarpa et al. (2002) and Banerjee and colleagues (2015) suggested that males have higher rates of community violence victimization and witnessing but Scarpa (2008) did not find gendered differences in hearing about community violence. In fact, the existing data suggests that although college students with urban, racial minority, low socio-economic backgrounds reported more instances of community violence victimization that are life threatening, college students from rural, non-minority statuses reported surprisingly high levels of victimization and witnessing (Haden & Scarpa, 2008).

The literature on the negative psychopathological and adjustment sequalea associated with community violence exposure and the factors that increase vulnerability in adulthood is much more developed than the data on protective factors. The scholarship on resilience factors is in its infancy but there are several factors that have been found to buffer community violence in

childhood and adolescence. These protective factors highlighted in the child and adolescent literature are maternal relationship and family support (Hammack, Richards, Luo, Edlynn & Roy, 2004; White, Bruce & Farrell, 1998), family relationships, environment or climate (Kliewer et al, 2004; Gorman-Smith, Henry & Tolan, 2004; Barr et al, 2012), maternal relationship (Bailey, Hannigan, Delaney-Black, Covington & Sokol, 2006), youth cognitions (Brookmeyer, Henrich, Schwab- Stone; 2005), religiousness (Pearce, Jones, Schwab-stone & Ruchkin, 2003), perceived school safety and lower constraints for discussing violence (Ozer & Weinstein, 2004), preferred coping strategies (Edlynn, Gaylord-Harden, Richards & Miller, 2008), and school support (O'Donnell, Schwab-Stone & Muyeed, 2002).

Although there is limited research documenting protective factors in community violence exposed adults, the existing data is consistent with research with children. The developing data suggests that social support and coping strategies reduce the negative impact of exposure for community violence in college students. Haden and Scarpa (2008) found that low levels of avoidant coping and high levels of friend support among traumatized college students protect them from the negative consequences of high community violence victimization. Racial socialization was also found to moderated negative outcomes for university students who were victims or witnesses of community violence.

Banerjee and colleagues (2015) found that cultural socialization buffered the effects of community violence exposure on psychological functioning. They reported that African American undergraduate students who endorsed higher levels of cultural socialization within the context of high community violence victimization and witnessing reported better psychosocial outcomes. High scores on cultural socialization were associated with lower levels of depressive symptomatology and aggression with individuals reporting exposure to community violence

victimization and witnessing. Cultural socialization was conceptualized as parental engagement in race related behaviors and messages about ethnic pride or heritage (Banerjee et al, 2015).

Although protective factors within the context of community violence exposure in college settings are just now being identified, university mental health practitioners are encouraged to evaluate the salience of racial and cultural identity development factors in their therapeutic work with clients who may be at risk for or have a history of community violence victimization and witnessing. Mental health practitioners may find that therapeutic work that includes racial and cultural identity processes are beneficial for some violence exposed clients. Additionally, mental health practitioners interventions geared at strengthening social support networks and expanding coping strategies may be helpful. Future research should center on replicating these studies and examining whether the protective factors identified with child and adolescent samples such as family closeness, support and environment, religiousness, school safety and climate persist in college populations. It may be useful to explore how developmentally salient adult relationships (i.e. intimate partners, work colleagues), statuses (i.e. caregiving and parenting roles, university and community leadership roles) and membership and participation in valued groups buffer the effects of community violence victimization and witnessing who present for services at university counseling centers.

Although current research confirms that community violence victimization and witnessing can have serious mental health implications Banerjee et al, 2015; Brady, 2006; Haden & Scarpa, 2008; Rosenthal & Wilson, 2003;Scarpa, 2001; Scarpa et al, 2002; Scarpa & Ollendick, 2003), relatively little effort has been dedicated to understanding the factors that influence the variability in responses to community violence exposure or the processes that contribute to or buffer against negative outcomes in college populations. The bio-ecological

framework can be used to explore the dynamic factors that influence responses to community violence exposure in college students.

Bio-ecological Model and the Consequences of Community Violence

The bio-ecological model captures the dynamic interactions between the systems that are particularly relevant to development, well being and community violence exposure with an emerging adult population. The model is salient because it attends to the nuanced, bidirectional relationships among individual, family, community, and societal variables and violence exposure (Hoffman & Kruczek, 2011) within a university context. The approach is a worthy conceptual frame because it can be used to provide insights around predicting risk and resilience with a violence exposed population (Afolabi, 2015; Weems, 2015; Ungar, 2015). The bio-ecological model can be used to identify the proximal and distal factors that may intersect to influence college students' response to community violence (Williams & Gardell, 2012). Bronfenbrenner's (2006) bio-ecological model frames developmental outcomes by attending to the interplay of individual characteristics such as biological and personal history factors and the proximal environment which includes family members, partners and close peers. The model also gives attention to social relationships that may be less close such as those that develop in schools, workplaces, and neighborhoods and then culminates with the wider social context such as broad societal factors such as social and cultural norms and values, health, economic, educational and social policies (Bronfenbrenner & Morris, 2006; Williams & Gardell, 2012). Developmental responses are viewed through embedded, bidirectional relationships which begin with the environment in which the individual directly and frequently interacts and extends to those systems where contact is indirect and less frequent across time (Bronfenbrenner & Morris, 2006;Williams & Gardell, 2012; Ben-David & Nel, 2013).

The approach asserts that although most developmental processes initially occur within the immediate family settings, other extra-familial factors increasingly exert influence by indirect contact through important family processes (Afolabi, 2015). The bio-ecological model asserts that extra-familial contactt may expand over time as developmental priorities shift (Bronfenbrenner & Morris, 2006). Extrafamilial factors may become more pertinent as college students navigate new roles and become more independent of their families of origin (Brunner, Wallace, Reymann, Sellers & McCabe, 2014).

The bioecological model can be used to analyze the proximal and distal factors that influence the adjustment and responses of community violence exposed college students (McLinden, 2016). Community violence can be viewed as an ecological stressor which interacts with and is influenced by individual, family, community and wider societal level variables (Afolabi, 2015; Hoffman & Kruczek, 2011; Weems, 2015; Ungar, 2015). Community violence has the potential to infiltrate many ecological levels including the home, the school, the workplace, the neighborhood, and the larger social culture (Bronfenbrenner & Morris, 2006) and its influence on these individual, family and cultural factors can jeopardize or provide protection for psychological functioning (Hoffman & Kruczek, 2011). The specificity of individual adult outcomes will depend on the particular effects of changes produced by violence exposure in the communities (the exosystem), families (the microsystem), and other social contexts in which individual lives, as well as in adult's psychological processes (Hoffman & Kruczek, 2011). The model suggests that there are risk and protective factors at each of these levels and may work independently or in concert to create experiences that may influence outcomes at other levels (Bronfenbrenner & Morris, 2006).

The negative mental health sequelae of violence exposure stems from the unique features of the violent encounter, subsequent disclosures and help seeking, the sociocultural norms that influence responses to these events and the available familial and community resources (Campbell, Dworkin & Cabral, 2009; Chen, Corvo, Lee & Hahm, 2017; Kohli et al, 2015; Ogle, Rubin, Berntsen & Siegler, 2013; Turner et al, 2016). Although Experiences of community violence typically occur within the individual's immediate environment (Fowler et al, 2009; Scarpa et al 2002), these encounters may alter or become the catalyst for changes within peer, school, vocational and family systems and can further inform neighborhood culture and reactionary processes (Chen & Lee, 2017; Hoffman & Kruczek, 2011; Patton, Miller, Garbarino, Gale & Kornfeld, 2016). Community violence can directly influence the college student's emotional, academic and relational functioning but it can also indirectly affect college student's behavior by interfering with the quality and quantity of support they receive from partners, family members, and their school, religious and neighborhood groups (Banerjee et al, 2015**;** Chen & Lee, 2017; Haden & Scarpa, 2008; Hoffman & Kruczek, 2011; Patton et al, 2016). The inter-related nature of responses within and between systems and the quality of the connections will influence individual, familial, and community outcomes (Hoffman & Kruczek, 2011). The interactions between these systems can intensify or modulate risk for mental health outcomes secondary to community violence exposure.

The case below will illustrate how university mental health practitioners can utilize the bio-ecological model as an organizing framework as they conduct initial assessments and formulate case conceptualizations and treatment planning. This hypothetical case example provides guidance on how a university mental health practitioner might utilize this approach when conducting assessments with community violence exposed students.

The Case of the Community Violence Exposed College Student

Rashane is a 23 year old female, Afro-Caribbean American, first generation, freshman student at a large urban, southeastern university in the United States. She self-referred to counseling because of sleep disturbance, reduced appetite, fatigue, anxiety, problems staying focused during classes, and deteriorating academic functioning. Rashane reported that these symptoms began approximately three weeks ago and indicated she was robbed of personal items while on her way home from classes about a month ago. Rashane described increased hypervigilance and feelings of guilt and shame about her academic difficulties. Rashane lives with two female college students and she described these relationships as somewhat distant. She reported that her mother and 15-year-old sister live about two hours away and she expressed concerns for their family's safety because of increased incidents of crime in their neighborhood.

Case Conceptualization and Assessment

The case of Rashane illustrates the potential consequences of community violence exposure. The paragraphs below provide an introduction to how the bioecological approach could be used as an organizing framework when completing initial assessments and treatment planning with a college student who has been a victim of community violence.

Although an intake interview is necessary to augment to complete the clinical picture and provide insights on prognosis, the available data can be used to create a provisional conceptualization and treatment plan using the bio-ecological model. Rashane is displaying range of PTSD symptoms subsequent to exposure. Based on the bio-ecological model, Rashane's presenting symptoms have emerged out of a dynamic interplay between her individual characteristics and the multiple environments with which she has had contact. These experiences

and contacts have overlapped to influence Rashane's vulnerability to community violence victimization and PTSD symptom development.

Rashane developed PTSD symptoms after at least one instance of direct community violence victimization (i.e. robbery) that was proximal to her home while at college. Additionally, she has at least heard about chronic community violence, given her current anxiety about her family of origin's safety. These community violence exposures seemed to be triggering the range of psychological and physiological stress reactions which she describes. The community violence exposure is being experienced as threatening and they seem to be precipitating neurochemical changes which are increasing Rashane's levels of arousal and vigilance as evidence by changes in her sleep cycle, focus, concentration, and appetite.

The case history suggests that Rashane is a racial minority who has limited income, who attends school and lives in a large metropolitan city and who has lived with her family in violence prone communities. Based on the brief case history, it appears that Rashane has limited peer support and her family physical support may not be consistently available because of distance. She may also still be adjusting to the demands of college and her new school and home environment.

The biophysical elements of Rashane's response to violence exposure should be understood within the social context where the violence occurred and where she developed. Rashane identifies as an Afro-Caribbean American, low income, first generation college student with immediate family members living in a violent prone community. These marginalized identities and experiences increased her vulnerability to exposure and have exacerbated her psychological and adjustment difficulties subsequent to exposure. It is probable that Rashane's family's current exposure to community violence may cause her mother to be more distracted or

less emotionally available. Decreased maternal or family support and changes in the family climate could also have influenced Rashane's developing symptoms subsequent to violent victimization.

There are several factors that may influence Rashane's prognosis. There may also have been aspects of the recent victimization event that may have placed her at increased risk for developing symptoms. The existence of a pre-trauma survivor-offender relationship or additional injury or weapon use, if they existed, may negatively impact Rashane's psychological outcomes (Campbell et al, 2009) but Rashane's university status and her willing to seek mental health care could be resiliency factors. Additionally, Rashane's pre-existing mental health problems, coping strategies, personality style and social support could influence her PTSD symptom course (Campbell et al, 2009).

Mental health intervention should begin with building rapport and normalizing Rashane's current symptoms given her trauma exposure. This first step provides a picture of Rashane's resources and strengths and identifies areas of needed support and clinical intervention. The practitioner should ask questions to rule out and respond to imminent concerns about Rashane's safety within her home and school environment. The university mental health practitioner should also inquire about the dynamics of her current living arrangement, perceived school and neighborhood climate, intentional self-injury, perceived social support, suicidal and homicidal ideation, gestures and plans. The counselor should remain attuned to language which provides indications of Rashane's attitudes, beliefs and cultural norms about violent victimization.

This structured interview would be used to gather comprehensive data about Rashane's occupational status and history, social support and peer network, immediate and extended family relationships. The university mental health practitioner who is providing services to Rashane

should gather details about pre-morbid and current functioning and daily routines. These should include eating patterns, sleeping and self-care routines, academic functioning, substance use, coping strategies, relationship status and quality, and perceptions of her impulse control, and coping capacity. The practitioner should utilize structured tools to gather details about exposure to community violence and other potentially trauma events (i.e. child abuse, intimate partner violence, sexual assault). Surveys that can be used to gather data on violence exposure include Survey of Exposure to Community Violence (SECV; Richters & Saltzman, 1990), the Early Trauma Inventory-Self Report (ETI-SR; Bremner, Bolus & Mayer, 2007) and the Composite Abuse Scale (Hegarty, Bush, Sheehan, 2005). The practitioner should also get a thorough history of the number, duration, frequency, severity and recency of her current and historical violence exposure experiences, and the nature of her relationship with current and past perpetrators.

The university mental practitioner who works with Rashane should utilize standardized mental health measures of to determine the severity of her PTSD symptoms and other mental health concerns. The tools to be included in the assessment may include The Clinician-Administered PTSD Scale for DSM-5 (CAPS-*5;* Weathers et al, 2013), the Beck Depression Inventory –II (BDI-II; Beck, Steer & Brown, 1996), the Beck Anxiety Inventory (BAI ; Beck & Steer, 1993) and the Symptom Checklist-90-R (SCL-90-R; Derogatis, 1994). These measures of mental health functioning and violent exposure will enhance the depth of clinical information that is obtained in the clinical interview. The clinical data that gleaned from these combined methods will provide a good frame for treatment planning.

The bioecological model provides insights about how to organize treatment planning within a college counseling context. The bioeological understanding of impactful treatment is based on multilayer interventions and treatment goals. It is therefore critical that counselors

working with violent exposed clients like Rashane, coin both individual and systemic treatment goals and interventions.

After the initial intake and assessment process has been conducted, the counselor should discuss the diagnostic impressions and findings with Rashane and get her feedback about the findings and process. The case study did not point to any imminent, predicted treats. If this is verified by the intake and assessment data, the counselor can proceed with designing mutually agreed on treatment goals and a tentative schedule for therapy. Given the typical treatment course at most university counseling center and the existing treatment picture, 20 weekly sessions may be scheduled with revisions made as counseling progresses. Some of the treatment goals may be salient to violent exposed college students presenting with the PTSD symptoms endorsed by Rashane may include reducing the impact of the trauma event and help Rashane return to premorbid functioning, implement effective coping skills to support execution of normative daily tasks (i.e. going to class, self-care routines and participation in extracurricular activities). Goals may also include having Rashane recall the robbery without being overwhelmed with negative emotions and ending any behaviors that she uses to reinforce any denial or escape.

The bioecological model posits that development and change are best understood as the interplay of individual and the multiple environments with which the person interfaces over time (McLinden, 2017). This orientation and the treatment goals identified in the preceding paragraph provide the organizing framework for the therapeutic interventions that may be utilized in counseling with Rashane. These therapeutic interventions should be geared at reducing the impact of the individual or systemic factors that combined to increase Rashane's risk for psychological and adjustment difficulties. The counselor should also be intentional about

increasing the individual and collective systems that are likely to foster resilience and better than expected outcomes for Rashane. Rashane endorsed significant biophysical concerns (i.e. deterioration in sleep, concentration, academic functioning and appetite) and so the counselor could explore the potential benefits of and her willingness to receive a medical evaluation from a psychiatrist. This medication support may be needed to help her manage the overwhelming physiological reactions to the trauma. This referral could be done to the resident psychiatrist that offers services through many on-campus health and wellness departments or to an off-campus provider.

There are a variety of in-session therapeutic interventions that can be used with clients like Rashane who endorse PTSD symptoms after community violence. The practitioner should provide psychoeducation on traumatic exposure and PTSD symptoms and sensitively explore Rashane's emotional reaction and responses to the robbery and other experience of violent exposure (i.e negative self talk, feelings of guilt and shame) (Jongsma, Peterson & Bruce, 2014) . The counselor could teach relaxation methods (i.e. deep breathing, positive imagery) and sleep hygiene strategies (Jongsma et al, 2014). These relaxation techniques can be used as Rashane is gradually exposed and encouraged to talk and process the robbery. Rashane may also be referred to group therapy sessions with other survivors of interpersonal violence. The practitioner should monitor Rashane's sleep, substance use, medication compliance and self care routines (i.e. physical exercise, eating) (Jongsma et al, 2014).

Given her clinical presentation, Rashane may benefit from referrals to on-campus and community organizations. The counselor should become aware of the available resources to provide salient referrals. She may be referred to Disability services to explore any academic support options. Rashane may be able to access instrumental and academic services through her

on-campus student services. The student services office may be able to provide guidance on accessing tutorial support for her current academic difficulties

The therapist who is working with racial minority college students presenting with PTSD symptoms secondary to community violence should be attuned to how socio-political realities influence psychological functioning (Sue & Sue, 2016). The socio-political factors that feature in Rashane's case include race, socio-economic status, immigration status and race/ethnicity (Sue & Sue, 2016). The mental health practitioner who is working with Rashane should process the salience of these identities and other invisible ones that she might declare. It may therapeutically impactful to provide a space where Rashane can explore how her intersecting identities may have increased her vulnerability to community violence and exacerbated her psychological and adjustment difficulties subsequent to exposure.

Additionally, the counselor may process how Rashane's salient identities and personal and cultural resources (i.e. peer systems, on-campus resources, and support groups) could be bolstered or accessed to increase resiliency. Since Rashane is a racial minority, first year student with limited social support, the counselor could provide information about on-campus and community multicultural associations, advocacy groups and other extracurricular groups. These contacts could help Rashane feel more embedded and connected to her academic community. Rashane may also be eligible to receive resources and mentorship as a first-generation college student. Since Rashane's family residence, low income status and her school location places her in locales that typically experience high rates of violence, she is at risk for further exposure to community violence experiences. The possibility of recurrent exposure justifies in-session exploration of security specific coping skills (i.e. safety planning and other precautions) and consultation and advocacy work on the part of either or both Rashane and the mental health

provider. Treatment will culminate when mutually agreed treatment goals have been satisfactorily met and her symptoms have abated.

University counseling personnel are strategically placed to respond to the mental health needs of clients who endorse PTSD symptoms after experiences of community violence. The case of Rashane illustrates the usefulness of the bio-ecological framework in organizing the therapeutic process. The preceding paraphrases emphasize the importance of multimodal assessment and the intake process. It is also critical that the counselor attend to both individual and varying levels of context realities in treatment. The case of Rashane demonstrates the value of incorporating multicultural and socio-political realities in treatment planning and counseling intervention. The succeeding section will review the general practice implications of community violence in university settings.

Implications for Clinical Practice

Community violence victimization and witnessing experiences are prevalent among university students but the research on the protective and risk factors associated with such exposure is just emerging. There is also limited research on appropriate interventions and models for responding to community violence exposure with this population. The relative dearth of data with this population is concerning given the current indicators of exposure. Additionally, the negative correlates of community exposure are likely to compromise physical and psychological well-being and exacerbate student's ability to respond to the normative developmental challenges and demands of college life. There is need for increased scholarship focused on how models including the bio-ecological approach could be used to organize and frame initial assessments and guide treatment planning with community violence exposed college students. Developing organizing protocols for screening, assessment and treatment planning are critical

because these could help college mental health providers identify and respond to the psychological needs of students that may be at risk for developing the negative outcomes associated with community violence exposure. The case of Rashane provides an example of how a clinician might using the bio-ecological model as an organizing framework in clinical practice with a college student who self-refers to counseling because of PTSD symptoms after exposure. The presented model and case example provides a foundation for improving service within university counseling settings with violence exposed students. There is need for more scholarship around how clinicians might participate in preventative work particularly with diverse college students who might be less inclined to seek services subsequent to community violent experiences.

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ABSTRACT FOR CHAPTER 2

Community violence exposure is a pervasive public health issue in the United States that has been linked to a range of negative psychological and adjustment outcomes (Fowler et al, 2009; Voisin et al, 2015). Although there is a robust body of literature connecting community violence exposure and posttraumatic stress symptoms, exposure has also been linked with other types of violent victimizations. The research on how exposure in community settings affects psychological functioning within the context of other potentially traumatic experiences is still developing (Finkelhor, Vanderminden, Turner, Shattuck & Hamby, 2016; Kelly, Schwartz, Gorman & Nakamoto, 2008). This research investigated the interrelationships among community violence, school bullying, intimate partner violence, child abuse and Posttraumatic symptoms (PTSD) with a sample of 499 undergraduate students. The study examined how intimate partner, child abuse and bully victimization moderated the relationship between community violence and PTSD. Simultaneous multiple linear regression and hierarchical multiple regression analyses were used to determine the combined relationships between community violence, child abuse, school bullying, and intimate partner violence on PTSD symptoms and verify whether child abuse, intimate partner violence, and school bullying moderate the relationship between community violence and PTSD. Treatment and policy implications, limitations, and directions for future research will be discussed.

INDEX WORDS: Community Violence, PTSD, Intimate Partner Violence, Child Abuse

CHAPTER 2

COMMUNITY VIOLENCE AND TRAUMA: THE INFLUENCE OF CHILD ABUSE, BULLYING, AND INTIMATE PARTNER VIOLENCE

Posttraumatic stress disorder (PTSD) is a ubiquitous and disabling condition that is associated with a range of negative emotional, cognitive, and physiological symptoms, which emerge subsequent to a traumatic event (i.e, death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence) (American Psychiatric Association, 2013). Individuals may experience intrusive, recurrent recollections, flashbacks, nightmares, and stressor specific amnesia. Additional concerns include attempts to avoid trauma-related cues, may experience alterations in thoughts and feelings, and increased arousal mental or physical distress to trauma-related cues (American Psychiatric Association, 2013).

PTSD affects individuals across the developmental lifespan. Approximately four percent of the population within a 12-month period and approximately nine percent of individuals over 75 years in the United States meet criteria for PTSD (American Psychological Association, 2013). These statistics are concerning because of the individual and community costs that are associated with PTSD. PTSD imposes notable individual and societal burdens. The diagnosis is associated with social, educational, vocational and physical impairment, increased medical utilization, and significant economic costs (American Psychological Association, 2013). Individuals with PTSD diagnoses are also more likely to meet criteria for other psychiatric conditions including depression, substance abuse, and anxiety disorders (American Psychological Association, 2013). These concerns are complicated by the observed variability in PTSD symptom duration. Researchers suggest that although 50 percent of patients with PTSD achieve full recovery after three months, others continue to experience unremitting symptoms for

several years (American Psychiatric Association, 2013). There is also a growing body of research that calls for increased clinical and research efforts focused on developing appropriate classifications systems to clarify and develop responsive protocols for sub-threshold PTSD in the general population (Brancu et al, 2016; Korte, Allan, Gros & Acierno, 2016). These prevalence indicators and ongoing discussion on costs and consequences of PTSD have sparked ongoing research and treatment and prevention efforts focused on identifying factors that contribute to and alter the course of PTSD symptom development (Korte et al, 2016). Trauma that is directly experienced or witnessed is a key PTSD diagnostic criterion and researchers have dedicated a significant amount of effort in exploring the types of experiences that are associated with increased risk for PTSD (American Psychological Association, 2013). Community violence, bullying, child abuse, and intimate partner violence all have been conceptualized as potentially traumatic life events, which increase vulnerability to PTSD (Kessler, Sonnega, Bromet, Hughes & Nelson, 1995, Kessler, 2000; Hines & Douglas, 2011; Walling et al, 2011). This dissertation examined the relationship between community violence and PTSD within the context of child abuse, intimate partner violence, and school bullying exposure. In the succeeding paragraphs, the author reviews definitions of community violence, intimate partner violence, and child abuse, and summarizes the consequences of these victimization experiences. The empirical studies in each of these areas of research are outlined and the researcher proposes a research agenda in response to the gaps in the field, and details the methodology that was utilized in service of this research effort.

Shahinfar, Fox, and Leavitt (2000) defined community violence as frequent direct or threatened violence and violence related events that occur within the proximal environment of home, school or neighborhood that encompass known or unknown perpetrators. These

community violent exposures include knowing victims of community violence, witnessing community violence, and being directly victimized (Osofsky, 1995). They list experiences of physical assault, shootings, threats with weapons, muggings or robberies, chasing and beatings, homicides, shoving or grabbing, and hearing gunshots, sexual assault, shootings, knife attacks, robbery, and verbal or symbolic threats of violence (Suglia, Ryan, and Wright, 2008). These experiences of direct and indirect community violence exposure have been linked to PTSD (Fowler et al, 2009; Khan et al, 2016; Smith & Patton, 2016).

There is a robust body of literature confirming that community violence exposure increases the severity of and vulnerability to PTSD symptoms in children (Garrido, Culhane, Raviv & Taussig, 2010; Martin, Revington & Seedat, 2013; Rosenthal & Hutton, 2001). Although there has been relatively less studies with adult populations, the somewhat dated studies that exist indicate that the observed outcomes persist in adulthood (Scarpa, Haden & Hurley, 2006). Higher levels of community violence victimization and exposure have been linked to increased PTSD severity in clinical and community samples. Scarpa, Haden and Hurley (2006) found that higher levels of community violence victimization predicted increased PTSD symptom severity and confirmed that this relationship occurred above and beyond the effects of reference trauma. Khan and colleagues (2015) and Dinan, McCall, and Gibson (2004) found that higher levels of community violence exposure were associated with PTSD symptoms with college students in India and with a community sample in South Africa respectively.

Individuals who witness and directly experience violence in community settings are often vulnerable to exposure to other forms of violence and these potentially trauma events themselves predispose them to PTSD. Community violence exposure correlates with experiences of child abuse and maltreatment (Overstreet & Braun, 2000; Cecil, Viding, Barker, Guiney & McCrory,

2014), school victimization, bullying, and peer rejection (Finkelhoret al, 2016; Kelly, Schwartz, Gorman & Nakamoto, 2008), and intimate partner violence (Kennedy et al, 2014). The paragraphs below will examine the interrelationships among intimate partner violence, child abuse, community violence and PTSD.

Breiding, Basile, Smith, Black and Mahendra (2015) defined intimate partner violence as the threatened or actual sexual or physical violence, or psychological and emotional abuse, directed toward a current or former partner. This conceptualization includes current or former dating, cohabiting, and married partners in heterosexual or same-sex relationships.

Cecil and collegueas (2014) examined the main, cumulative, and interactive influences of childhood maltreatment and community violence on mental health with a sample of 204 inner-city adolescents and young adults and found significant relationships between childhood maltreatment, community violence exposure, and mental health outcomes. Kennedy and associates (2014) found that the women who endorsed community violence exposure also reported instances of child abuse and intimate partner violence. It is important to examine PTSD and community violence within the context of experiences of child abuse and intimate partner violence because they have both been identified as risk factors for PTSD. Gobinand and collegueas (2013) found that both intimate partner violence and childhood maltreatment are positively associated with PTSD severity. They determined that childhood maltreatment had unrelenting effects on the PTSD symptoms of IPV survivors (Gobin et al, 2013).

School bullying is also a potentially traumatic event. In fact, Nielsen and colleagues (2015) likened the elevated mental and physical health difficulties that are endorsed by bully victims with those typically associated with PTSD. The features of the bullying relationship and the bullying situation provide insights around why it might be appropriately characterized in this

manner. Olweus (1995) explained that bullying includes physical, verbal, or psychological attacks or acts of intimidation that are designed to induce fear, distress, or harm to the victim. The bully has greater psychological or physical power and oppresses less powerful ones without any provocation (Olweus, 1995). Olweus (1995) maintained that these disempowering encounters are repeated between the same individuals over a protracted time period. The literature consistently documents an association between bullying victimization and a myriad of negative psychological and adjustment outcomes (Rigby, 2003). These negative outcomes include psychosomatic symptoms and academic difficulties (Due et al, 2005), emotional distress (Turner, Exum, Brame, & Holt, 2013; Zwierzynska, Wolke & Lereya, 2013), social maladjustment, and loneliness (Nansel et al, 2001).

Although most research on bullying has focused on the characteristics of victims in elementary and high school settings, (Holt et al, 2014) researchers have noted that the consequences of school bullying exposure can persist in adulthood. Holt and colleagues (2014) reported that first year college students who were previously exposed to bullying in childhood endorsed comparatively lower levels of mental health functioning and perceptions of physical and mental health compared to their peers, while Chen and Huang (2015) found that Taiwanese college students who reported cyber bullying-victimization experiences before college reported significantly higher health-related quality of life concerns in physical health.

PTSD and community violence are relatively under-researched areas in the adult school bullying literature. Only a handful of studies have explored the link between PTSD and childhood bullying, and childhood bullying and community violence with adult populations. These studies found positive significant associations between recalled experiences of childhood school bullying and PTSD in adult samples (Nielsen, Tangen, Idsoe, Matthiesen & Mageroy,

2015; Sesar, Barišic´, Pandza & Dodaj, 2012). Nielsen and associates' (2015) metaanalytic study established a strong, positive association between bullying and adult PTSD symptomology, but the data included assessment of both school and work bullying experiences. Sesar and colleagues (2012) found that adults who were exposed to school bullying had significantly higher levels of dissociative and traumatic symptoms compared to those who were not exposed to bullying.

The data on retrospective school bullying and community violence is equally sparse. Finkelhor and colleagues (2016) investigated exposure to school victimizations among a representative sample of 3,391 children and youth and reported that features of community crime and disorder were related to school victimization. Kelly, Schwartz, Gorman and Nakamoto (2008) completed a short term longitudinal study with 199 children to examine the relationship between community violence victimization and peer rejection. They reported that community violence victimization was related to bullying and peer rejection (Kelly et al, 2008).

The preceding review summarized the data that links community violence, child abuse, school bullying, and intimate partner violence with PTSD as discrete, distinct relationships. The data suggests that community violence exposed individuals are also likely to have experienced child abuse, intimate partner violence, and school bullying. Potentially traumatic events are prevalent in both clinical and non-clinical populations (Moser, Hajcak, Simons, & Foa, 2007; Schnider, Elhai, & Gray, 2007; Smyth, Hockemeyer, Heron, Wonderlich, & Pennebaker, 2008; Ogle, Rubin, Berntsen & Siegler, 2013), and trauma survivors are typically exposed to a variety of potentially traumatic experiences across multiple settings over their lifetime (Margolin, Vickerman, Oliver & Gordis, 2010;Resnick, Kilpatrick, Dansky, Saunders, & Best, 1993). The literature also documents links between community violence, child abuse, intimate partner violence, school bullying, and PTSD.

Although researchers have established a clear link between community violence and PTSD (Garbarino, Kostelny, & Dubrow, 1991, Rosenthal & Hutton, 2001, Garrido et al, 2010; Scarpa, Haden & Hurley, 2006), the concurrence between community violence and other types of victimization such as school bullying, child abuse, and intimate partner violence suggests that the main effects of community violence may be influenced by other victimization experiences. The frequently referenced associations between community violence exposure may be conflated by other victimization experience. These varied violent experiences may accumulate and jointly influence PTSD outcomes (Finkelhor et al, 2011). This observation provides the rationale for assessing violence exposure across multiple interpersonal domains and across time. There is value in exploring how lifetime community violence, childhood abuse, school bullying, and intimate partner violence differentially and cumulatively influence PTSD symptom development.

Fortunately, there is an emerging body of research that links community violence and other types of violence exposure with PTSD. Denson, Marshall, Schell and Jaycox (2007) found that demographic characteristics, pre-traumatic psychological factors, characteristics of the trauma, and reactions to trauma predicted PTSD symptom severity for survivors of community violence. Walling and colleagues (2011) found that adverse childhood experiences (ACEs) and indirect adulthood community violence exposure were significantly positively related to the severity of PTSD symptoms severity with 284 urban community development workers located in five U.S. cities. Kennedy and associates (2014) found that family and community violence and stigma was associated with elevated posttraumatic stress disorder (PTSD) symptoms in a sample of high-risk young women.

Therefore, as shown above, there is robust research linking community violence and PTSD but the studies have predominantly been done with children and adolescence and have

frequently not examined other experiences of violence in school and family settings. Since peer victimization and bullying and violence in care-giving and romantic relationships may also associated with elevated PTSD risk, the addictive and moderating roles of these typically co-occurring experiences need to be considered (Karam et al, 2014; Kennedy et al, 2014). Additionally, the research on school bullying and community violence and PTSD with adult populations is still emerging (Nielsen et al, 2015). The community violence research with relatively low risk samples would be enhanced by examining how exposure in community settings affects psychological functioning while noting other potentially traumatic experiences. The present paper addresses the gap in the literature by investigating the relative contributions of bully victimization, child abuse, and intimate partner violence within the context of the relationship between community violence exposure and PTSD. This study will add to the literature by examining the interrelationships between community violence, school bullying, intimate partner violence, child abuse, and PTSD with an adult low risk sample and will examine how intimate partner, child abuse, and bully victimization exacerbate or mitigate the relationship between community violence and PTSD.

Research Questions

In this study, the researcher examined the impact of community violence, child abuse, school bullying, and intimate partner violence on PTSD symptoms in an emerging adult population and determined the extent to which trauma symptoms will be predicted by community violence, child abuse, school bullying, and intimate partner violence. The study examines the extent to which child abuse, school bullying, and intimate partner violence moderate the relationship between community violence and PTSD.

Method

Design

The methodology involved a correlational design (Lomax & Hahs-Vaughn, 2012). Participants reported retrospective experiences of community violence, school bullying, intimate partner violence, child abuse, and current PTSD symptoms. The author acknowledges that a longitudinal design would be preferred because it affords rich data on causality but correlational design was utilized because of pragmatic considerations. The empirical literature also confirms that cross sectional data can provide rich exploratory data (Lomax & Hahs-Vaughn, 2012). These designs have been repeatedly used to gather data on the long term effects of childhood bullying (Chapell et al., 2006) and violence exposure. Additionally retrospective studies have been shown to provide stable indicators of victimization (Rivers, 2001).

Participants and Procedure

Participants were undergraduates (N = 499) enrolled in introductory counseling courses at a southeastern American university. A total of 74 participants were excluded from the study because of pervasive missing items on two or more scales or random responding (Beach, 1989; Meade & Craig, 2012). Thirteen participants were excluded from the analysis because they responded to less than 75% of items on two or more of the questionnaires (Arbuckle, 1996) and sixty-one participants were dropped because they incorrectly responded to two or more of the four validity items that were incorporated in the survey to detect random responding (Beach, 1989; Meade & Craig, 2012). The final sample consisted of 425 participants.

Preliminary analyses were conducted to identify outliers and check the assumptions of multiple regression. Eighteen responses were identified as outliers on the variables. The cases were reviewed and retained because exclusion of these participant responses did not alter the

regression findings of the study. The responses were retained in the dataset because they were thought to mirror actual experiences of participants. This course of action was also thought to be justified based on the empirical data provided by Tabachnick and Fidell (2012) which supports the retention of outliers.

The data were examined for normality and multicollinearity. The data demonstrated acceptable levels of normality as the absolute values of skewness and kurtosis were below two for most variables (Tabachnick & Fidell, 2012). Intimate partner violence (IPV) and community violence exposure (CVE) were notable exceptions. Community violence had acceptable skewness but elevated kurtosis and IPV had elevated skewness and kurtosis. It is likely that the non-normal distributions reflect absolute differences in IPV and CVE exposure. The observed differences in IPV are thought to mirror actual differences in relationship status of a subsample of participants who reported never being in an intimate relationship. Bivariate correlations indicate that variables did not demonstrate concerning levels of overlap consistent with multicollinearity. Pearson's correlation coefficients were all below.40. Additionally, Variance Inflation Factors (VIF) was significantly less than the recommended cut off. Variance Inflation Factors of between 1.182 and 1.397 were obtained for all variables.

Of the 420 participants who reported their gender, 268 were cisgender female, 129 were cisgender male, 11 identified as transgender or gender non-conforming and 12 reported additional gender classifications. Participants' ages ranged from 19 to 51 with a mean age of 23.66 (Standard deviation 5.48). The majority were seniors (57.5% Seniors) with 34.4% Juniors, 6.6% Sophomore, 8%). With regard to ethnicity, African Americans were the majority (46% African American/Black) and the rest of the sample broke down as 21% White/Euro-American, Asian/Pacific Islander 18.7%, 8.3% Latino/a, 5.2% Biracial or Multiracial and 0.9 % identified

as having additional racial and ethnic identities. Eighty-four percent were single, and the remainders were either married/partnered (14%), separated (.2%), widowed (.2%) or divorced (1.2%). Approximately 69% identified as Christian, 1.7% as Hindu, 6.4% as Muslim, 3.8% as Buddhist, 1.4% as Jewish, 7.3% as Agnostic, 4.5% as Atheist and 6.1% as none of the named religious/spiritual identities. Eight percent identified as a sexual minority and 23.5% reported having a chronic illness or disability. Eighty-four percent of participants spent most of their lives in the southeastern United States and 18.1% described themselves as first generation college students. With regards to family income, 45% reported income between $20,000 and $60,000. Fourteen percent reported income of less than $20,000 and 6.4% indicated having an annual family income of over $150,000.

The study utilized online recruitment of research participants by faculty and graduate students within a counseling program. Students completed online surveys for credit for participating courses in the department. After indicating consent, participants completed a series of online questionnaires on demographic data, child abuse, school bullying, intimate partner violence, trauma symptoms, and community violence exposure. It took approximately 60 minutes for each participant to complete the survey packet. Participants were advised of their right to skip items or discontinue at any time. Participants were given contact information for the University Counseling Center and advised about the possibility of receiving additional counseling referrals on request. The questionnaires were administered and analyzed electronically and stored on computers that were firewall protected. The online data was stored in a password protected qualtrics account and exported to SPSS for analysis. Participants were awarded one research credit for their participation.

Materials

The measures included a demographic questionnaire, the Trauma Symptom Checklist -40 (Briere & Runtz, 1989), the Survey of Exposure to Community Violence (SECV; Richters & Saltzman, 1990), the Retrospective Bully Questionnaire (RBQ; Schäfer, Korn, Smith, Hunter, Mora-Merchán, Singer, & Van der Meulen, 2004), the Composite Abuse Scale (Hegarty, Bush, Sheehan, 2005) and the Early Trauma Inventory-Self Report (ETI-SR; Bremner, Bolus & Mayer, 2007). Five special items were inserted into the study questionnaire to detect a tendency towards inattentive or careless responding across the entire survey. These items were instructed response items (e.g., "If you are still reading, please respond with C for this item").

The Demographic Questionnaire was used to collect data on participants' gender, age, race/ethnicity, relationship/partner status, sexual orientation, level of education, familial college background and annual household income. The measure also included information on chronic illnesses, disability status and religion/spirituality.

The Trauma Symptom Checklist -40 (TSC-40; Briere & Runtz, 1989) was used to measure trauma symptoms. The TSC-40 is a research measure that evaluates posttraumatic stress and other symptom clusters typically associated with childhood or adult traumatic experiences. The TSC-40 is a self- report instrument consisting of six subscales: Anxiety, Depression, Dissociation, Sexual Abuse Trauma Index (SATI), Sexual Problems, and Sleep Disturbance, as well as a total score (TSC-40; Briere & Runtz, 1989). Each symptom item is rated according to its frequency of occurrence over the prior two months, using a four point scale ranging from 0 ("never") to 3 ("often"). The TSC-40 has predictive validity with reference to a wide variety of traumatic experiences and has been shown to discriminate victims of childhood sexual abuse

from non-victimized respondents for both females (Briere & Runtz, 1989) and males (Briere, 1992).

The TSC–40 has demonstrated adequate psychometric properties in assessing adult adjustment in trauma survivors, discriminating abused and non-abused respondents (Elliot & Briere, 1992) and indexing the traumatic sequelae of childhood sexual and physical abuse in a college student sample of both men and women (Neal & Nagle, 2013). Neal and Nagle (2013) found alpha coefficients were acceptable for the total score (.92), Sexual Problems (.83), Anxiety (.77), Sleep Disturbance (.76), Dissociation (.74), and Depression (.70) scales. Other studies have found subscale alphas typically ranging from .66 to .89 (Briere & Runtz, 1989) and .62 to .90 (Elliott & Briere, 1992). Alphas of .939 for the whole scale, .739 for Dissociation, .767 for Depression, .771 for Anxiety, .726 for Sexual Trauma .788 and .799 were obtained for Sleep Disturbance and Sexual Problems respectively in this study.

The Survey of Exposure to Community Violence (SECV; Richters & Saltzman, 1990) was used to assess lifetime frequency of being a witness or a victim of violence in community settings. This exposure includes being chased, robbed, threatened, punched, mugged, sexually assaulted, exposure to a weapon, seriously wounded by violence, stabbed, shot, and exposed to a dead body. Respondents indicate their relationship to the perpetrator (i.e., adult or youth stranger, adult or youth family member, adult or youth acquaintance, and other) and the location (i.e., near home, in home, near school, in school, and other) of the event (Scarpa, Fikretoglu, & Luscher, 2000). The SECV comprises 52 items: 14 items for being victimized, 21 items for witnessing, and 17 items for hearing about violence. The answer choices for each item are displayed on a 9-point scale, ranging from 0 (never) to 8 (almost every day). Only items assessing the frequency of direct victimization and witnessing were included in this study. The

items on hearing about violence, relationship to the perpetrator and recency of exposure will be excluded.

Although the SECV was originally designed as an interview for children, a modified version that allows for self-report and provides frequency data has been used in other studies with children and adults (Kliewer et al., 1998; Richters & Martinez, 1993) and adults alone (Scarpa, Fikretoglu, Bowser, Hurley, Pappert, Romero and Van Voorhees, 2002; Scarpa, 2006, Scarpa, Fikretoglu, & Luscher, 2000, Hassan, Mallozzi, Dhingra & Haden, 2011). The SECV has demonstrated test-retest reliability of r = .81 (Richters & Martinez) among African American middle school age youth (Overstreet & Braun, 2000). Scarpa, Fikretoglu, Bowser, Hurley, Pappert, Romero and Van Voorhees (2002) found internal consistency of .83 and .72 for victimization witnessing scores respectively. Reliability coefficients of .863, .902 and .937 were obtained for community violence victimization, witnessed community violence and the total community violence exposure scales respectively.

The Retrospective Bullying Questionnaire (Shäfer et al., 2004) was used to measure bullying experiences. The questionnaire has 44 items assessing the respondent's role as a bully, victim, or both by referencing experiences in elementary, middle/high school and college settings (Shäfer et al., 2004). The instrument uses multiple choice and five point Likert scales and examines the types (physical, verbal and direct), frequency, duration, and seriousness of bullying exchanges (Shäfer et al., 2004). It also examines the gender and the number of bullies encountered. The questionnaire progresses from primary or elementary school experiences and culminates with questions about college and work place experiences (Shäfer et al., 2004). The measure also includes a five-item trauma subscale which explores the presence of intrusive and

recurrent recollections of bully victimization on a 5-point scale and a question on suicidal ideation (Shäfer et al., 2004).

The Retrospective Bullying Questionnaire (RBQ; Shäfer et al., 2004) was originally written in English and was subsequently translated into German and Spanish. The measure was normed using data that was collected across three European countries (Germany, Spain, and the United Kingdom). The measure has been used with high school (Martinelli, Brondino, Rossi, Panigati, Magnani, Cappucciati & Politi, 2011), college aged (Janzter et al., 2006; Sesar, Barišic´, Pandza & Dodaj, 2012), community (Cooper & Nickerson, 2013) and clinical populations (Valmaggia, Day, Kroll, Laing, Byrne, Fusar-Poli, & McGuire, 2015).

The RBQ has been used worldwide and is the only retrospective bully measure that assesses involvement as a bully, victim, or bystander (Cooper & Nickerson, 2013). The RBQ has been found to have good test-retest reliability with r = .88 for elementary school victimization and r = .87 for middle/high school victimization (Schafer et al., 2004). Reliability coefficients of .761, and .746 were obtained for elementary school and middle/high school victimization respectively. An alpha of .892 was obtained for combined victimization experiences across elementary, high school and college settings in this study.

The Early Trauma Inventory-Self Report (ETI-SR; Bremner, Bolus & Mayer, 2007) was used to measure childhood abuse experiences. The Early Trauma Inventory-Self Report (ETI-SR; Bremner, Bolus & Mayer, 2007) is a 62-item questionnaire that assesses four domains of childhood trauma including; general trauma (31 items - which includes experiences ranging from parental loss to natural disaster**)**, physical abuse (9 items), emotional trauma (7 items) and sexual abuse (15 items) before 18 years. Each item on the ETI inquires about the frequency of the abuse or trauma, the age when the trauma began and ended (0-5 year, 6-11, 12-18), the

perpetrator of the abuse/trauma and how the trauma has affected on the individual (Bremner, Bolus & Mayer, 2007). The full questionnaire can be completed in approximately 30 minutes and individual items converge around each of the four domains, which can be further combined into a global trauma composite (Bremner, Bolus & Mayer, 2007). The general trauma subscale was excluded from the measure. This adjusted version of the ETI was completed in approximately 15 minutes.

The ETI has been translated into many languages, including German (Heim, 2000), Chinese (Wang, Du, & Chen, 2008), and Polish (Bozena, Makara, Chuchra, & Grzywa, 2005). The ETI-Self Report (ETI-SR) has demonstrated good psychometric properties with clinical and non-clinical populations. Bremner, Bolus and Mayer (2007) found that the ETI-SR distinguished typically functioning adults and those with known trauma histories such as those with posttraumatic symptom disorder and bipolar personality disorder diagnoses. The findings also suggest that ETI-Self Report (ETI-SR) was positively correlated with other measures of trauma symptom severity such as the Clinician Administered PTSD Scale (CAPS; Blake et al., 1995). The ETI-SR domains were found to be internally consistent with alpha coefficients ranging from 0.78 to 0.90 (Bremner, Bolus & Mayer, 2007). They obtained alphas of 0.83, 0.78, 0.87 and 0.91 for general trauma, physical abuse, emotional abuse and sexual abuse respectively (Bremner, Bolus & Mayer, 2007). Schoedl, Costa, Mari, Mello, Tyrka, Carpenter and Price (2010) obtained Cronbach alpha of 0.878 for the total ETI. Reliability coefficients of . 0.845, 0.650, 0.796 and 0.817 for combined child abuse, physical abuse, emotional abuse and sexual abuse respectively for the current study.

The Composite Abuse Scale (CAS; Hegarty, Bush & Sheehan, 2005) was used to measure intimate partner violence. The CAS consists of 30 items which are presented in a six

point format ranging from “never”, “only once”, “several times”, “monthly”, “weekly” or “daily” in a twelve month period and comprises four domains of intimate partner violence including; Severe Combined Abuse, Emotional Abuse, Physical Abuse, and Harassment (Hegarty, Bush & Sheehan, 2005). The Severe Combined Abuse Factor has 8 items that represent severe physical abuse items, all sexual abuse items, and physical isolation aspects of emotional abuse. The Emotional Abuse factor has 11 items that encompass verbal, psychological, dominance and social isolation abuse items while the Physical Abuse factor has 7 of the less severe physical abuse items and the Harassment factor has 4 items that are about actual harassment (Hegarty, Bush & Sheehan, 2005).

The original normative sample of Composite Abuse Scale was composed of a sample of Australian nurses. The measure was further validated with a sample of 1836 female patients and caregivers of children patients (16 years and over) who were asked to participate in a women's health project while consulting with doctors at 20 randomly selected general practice physician offices across Australia (Hegarty, Sheehan & Schonfeld, 1999). The CAS has also been used in a variety of primary care settings and with pregnant women (Gartland, Hemphill, Hegarty, Brown, 2011) and has been used in the Russia (Lokhmatkina,Kuznetsova, Feder, 2010), the Netherlands (Prosman, Jansen, Lo Fo Wong, Lagro-Janssen, 2011; Rietveld, Lagro-Janssen, Vierhout, Lo Fo Wong, 2010; Lo Fo Wong, Wester, Mol, Römkens, Hezemans, 2008), Canada (MacMillan, Wathen, Jamieson, Boyle, Shannon, 2009; MacMillan, Wathen, Jamieson, Boyle, McNutt, 2006; Wathen, Jamieson, MacMillan; McMaster Violence Against Women Research Group, 2008; Wathen, Jamieson, Wilson, Daly, Worster, 2007) and the United Kingdom (Sohal, Eldridge, Feder 2007).

The CAS has been used in clinical and research settings and was originally designed to be used with women over 16 years but a male version has been subsequently been developed (Hegarty, Bush & Sheehan, 2005). CAS has been translated into Vietnamese, Arabic, Dutch, Bengali, Russian, Spanish, Malaysian, Japanese and German. Factor analytic studies have confirmed the four identified dimensions and these four factors has exhibited good internal consistency with cronbach alpha greater than 0.85 (Hegarty, Bush & Sheehan, 2005). Cronbach alphas of .90, .93, .94, .87 were obtained for the Severe Combined Abuse, Emotional Abuse, Physical Abuse, and Harassment domains respectively. Reliability coefficients of .836, .881, .912, .773 were obtained for the Severe Combined Abuse, Emotional Abuse, Physical Abuse, and Harassment respectively for the current study. An alpha of .943 was obtained for the total measure.

Research Questions

The research questions are outlined below.

1. What is the relationship between community violence, child abuse, school bullying, and intimate partner violence?
2. Does community violence, child abuse, school bullying, and intimate partner violence predict PTSD symptom? Do these findings vary with demographic variables such as gender, race/ethnicity and sexual orientation?
3. Does child abuse, intimate partner violence, and school bullying independently moderate the relationship between community violence and PTSD?
4. Does the additive experiences of child abuse, intimate partner violence, and school bullying cumulatively moderate the relationship between community violence and PTSD?

Hypotheses

The study investigated the following hypotheses:

1. Experiences of community violence, child abuse, school bullying and intimate partner violence will be positively and significantly related.
2. Participants who report more experiences of community violence, child abuse and intimate partner violence will endorse more trauma symptoms. These findings will not vary with demographic variables such as gender, race/ethnicity and sexual orientation.
3. School bullying, child abuse and intimate partner violence will act as independent moderators of the relationship between community violence and trauma symptoms. This means that participants who have high exposure to community violence and low child abuse, school bullying or intimate partner violence will report lower symptoms of trauma than participants who have high exposure to community violence and high child abuse, school bullying or intimate partner violence.
4. Combined experiences of school bullying, child abuse and intimate partner violence will serve as a moderator of the relationship between community violence and trauma symptoms. This means that participants who have high exposure to community violence and low levels of other violence exposure such as child abuse, school bullying and intimate partner violence will report lower symptoms of trauma than participants who have high exposure to community violence and high exposure to child abuse, school bullying and intimate partner violence.

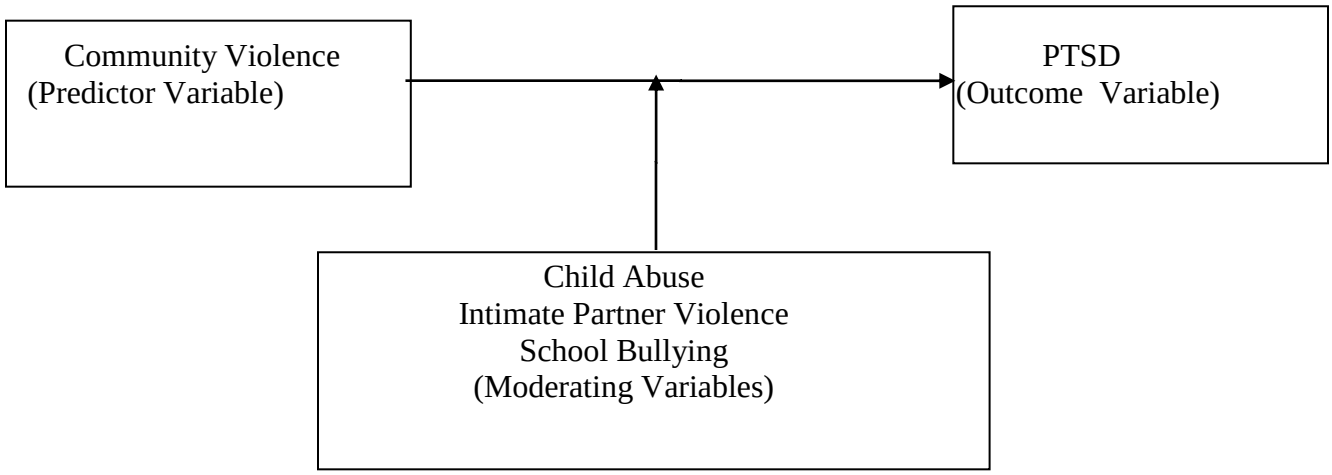

Figure 1: Model of Hypothesized Moderation Effects

Power Analysis

The researcher selected a sample size that will be large enough to provide an adequate probability of finding an effect if an effect exists without wasting resources or placing unnecessary demands on respondents' privacy and time (Dattalo, 2008). A sample size of 500 was chosen based on the anticipated analytical framework, the level of precision and the risk of mistakenly rejecting the null hypothesis (Cohen, 1992). A power analysis was conducted using G*Power to determine the total sample needed to produce a prediction equation that has generalizability, given estimated effect size (f^2), alpha level (α), desired power and the number of predictors. The researcher followed Cohen's (1998) convention for a moderate effect size (r^2 = .35). Given the number of predictors (4), the alpha level of 0.05 and a medium effect size (f^2=.15), to achieve power of .95 a sample size of at least 130 is required to detect a significant model (F (4,125) = 2.444). Additional participants were recruited to offset drop-out and incomplete protocols.

Analytic Procedure

Data analysis was conducted using SPSS 24 version for Windows. Bivariate correlations were conducted to examine the relationships among the outcome and predictor variables. Analyses of variance tests were conducted for community violence exposure and trauma symptoms to detect the presence of confounding demographic variables such as gender, age, sexual orientation and race/ethnicity. A simultaneous multiple linear regression was used to determine the combined relationships between community violence, child abuse, school bullying, and intimate partner violence on PTSD symptoms. A simultaneous multiple linear regression analysis was chosen to ensure all of the independent variables (i.e. community violence, child abuse, school bullying and intimate partner violence) were selected concurrently and were placed on an equal footing (Lomax, 2015). This multiple regression strategy was used because there was no theoretical justification for considering any of the variables a priori (Lomax, 2015).

The hierarchical regression menu item in the Statistical Package for the Social Sciences was used to examine moderation effects (Baron & Kenny, 1986) with the use of the Hayes Macro (Hayes, 2013). The Hayes Macro (Hayes, 2013) was used because it calculates the moderation effect while automatically centering and calculating interaction.

Hierarchical multiple linear regression models were chosen because the study was focused on building successive linear regression models by adding predictors to the relationship between PTSD and community violence (Lomax, 2015). The study investigated whether the size and direction of the relationship between community violence and PTSD depended on the moderator variables which were child abuse, school bullying, intimate partner violence or total interpersonal violence (combined child abuse, school bullying and intimate partner violence. The

hierarchical multiple linear regression analysis was chosen because a priori sequence had been previously selected for the independent variables based on theory (Lomax, 2015). Four different models were selected and in each instance community violence was selected first before the other variables were included in the model. The first model looked at community violence, child abuse and PTSD, the second model involved community violence, intimate partner violence and PTSD, the third model evaluated community violence, school bullying and PTSD and the final model evaluated community violence and composite interpersonal trauma (combined scores for child abuse, school bullying and intimate partner violence) and PTSD. The moderation effect for child abuse, intimate partner violence and school bullying was confirmed if the models were significant and the amount of variance accounted for in models that include the interaction effects of child abuse, intimate partner violence were significantly more than community violence and PTSD alone. Internal consistency reliabilities for the instruments used in this study were also computed.

Results

The preliminary statistics and the findings associated with the research hypotheses are summarized below.

Prevalence of Violence Exposure

Prevalence rates were calculated to capture the extent of violence exposure for the sample. The results revealed notable rates of potentially traumatic events. The rates for community violence exposure, child abuse, intimate partner violence, and school bullying are summarized in Table 1. The prevalence rates for at least one instance of community violence victimization ranged from 7.5% to 71.1% compared to 1.5% to 55.2% observed by Scarpa (2001). The most frequently reported type of community violence victimization in this study,

was being pressured to use drugs (71.1%), followed by being slapped, punched or hit (61.6%), being threatened with serious physical harm (52%), and being a victim of a serious accident (46.8%) respectively. The least frequently reported types of victimization included being shot with a gun (7.5%), being attacked or stabbed with knife (10.8%), and being beaten or mugged (19.8%) (see Table 1). Sixty-four percent of respondents had witnessed others selling or distributing drugs and 67.3% had heard gunfire outside when they were inside or near their homes. The rates of trauma symptoms ranged from 5.4% to 80.7%. The most frequently reported trauma symptoms were headaches (80.7%), insomnia (70.5%), restless sleep (69.2%) and "spacing out" (68.7%) and sadness (61.2%). The least frequent trauma symptoms endorsed were sexual problems (5.4%), fear of women (5.9%), dizziness (11.6%), uncontrollable crying (11.8%) and passing out (12%). Table 1 also provides descriptive information related to the key variables.

Basic Statistics

A series of one-way analyses of variances (ANOVAs) and Bonferroni post hoc tests were used to assess differences in community violence exposure and total trauma symptoms by gender, sexual orientation and racial and ethnic identity. Table 3 outlines the findings of the one-way ANOVAs. There were statistically significant differences in the mean total trauma scores by gender ($F = 4.768$, df = 3, 371, $p < .01$) and sexual orientation ($F = 6.334$, df = 5, 370, $p < .01$). Female identified participants ($M = 67.914$, $SD = 18.812$, n = 243) endorsed higher levels of trauma symptoms compared to participants who identified as male (M = 60.991, SD = 17.979, n = 113). Total trauma scores varied significantly by by sexual orientation ($F = 6.334$, df = 5, 370, $p < .01$). Participants who identified as Queer or Asexual (M = 95.500, SD = 26.395, n = 6) endorsed statistically significant scores compared to participants who identified as Lesbian (M =

51.167, SD = 11.374, n = 6), Heterosexual (M = 64.031, SD = 17.463, n = 328) or with those who had additional sexual identities (M = 67.188, SD = 26.141, n = 16). Participants who identified as Queer or Asexual endorsed higher levels of trauma symptoms compared to those previously mentioned. No significant mean differences were noted in total trauma scores across racial and ethnic groups (F = .416, df = 5, 373, p >.01).

There were no statistically significant differences in community violence exposure across gender and sexual identity statuses. Significant differences in community violence levels were noted for race and ethnicity (F = 5.171, df = 5, 384, p <.01), with African American participants (M = 77.640, SD = 32.233, n = 175) scores being significantly higher than those endorsed by Asian Americans (M = 58.389, SD = 29.890, n = 72).

One-way analyses of variances (ANOVAs) and bonferroni post hoc tests were used to assess differences in school bullying, intimate partner violence and child abuse by gender identity, sexual orientation and racial and ethnic identity. No significant differences were noted in reports of child abuse by gender, race and ethnicity and sexual orientation. Statistically significant differences were noted in rates of intimate partner violence (F = 3.495, df = 5, 302, p <.05) by sexual orientation. Participants who identified as Queer or Asexual (M = 53.333, SD = 27.890, n = 6) reported higher levels of intimate partner violence compared to those who were heterosexual (M = 35.260, SD = 10.949, n = 269) or had additional sexual orientation identities (M = 34.364, SD = 6.169, n = 11). No significant differences were noted for bullying and intimate partner violence across gender and race and ethnicity.

Bivarate correlations were used to assess the relationships between age and exposure to community violence and trauma symptoms. No significant relationship was found between age and community violence (r = .039, p > .05) and age and trauma symptoms (r = .039, p > .05).

Hypothesis One: Correlations among community violence, school bullying, child abuse, and intimate partner violence

Bivarate correlations were conducted to evaluate the first hypothesis, which examined the interrelationships among community violence, child abuse, school bullying, and intimate partner violence. Table 2 presents the correlations among the predictor and outcome variables. Exposure to community violence was linked to higher levels of general and specific trauma symptoms. Total community violence exposure was significantly and positively associated with total trauma symptoms ($r = .264$, $p < .01$), dissociation ($r = .240$, $p < .01$), depression ($r = .242$, $p < .01$), anxiety ($r = .173$, $p < .01$), sexual trauma ($r = .286$, $p < .01$), sexual problems ($r = .306$, $p < .01$) and sleep disturbance ($r = .198$, $p < .01$) (see Table 2). Both community violence victimization and witnessing were significantly and positively associated with trauma symptoms. Higher rates of total trauma symptoms, dissociation, depression, anxiety, sexual problems, sexual trauma symptoms and sleep difficulties were endorsed by participants who experienced and witnessed more instances of violence in their communities (see Table 2).

School bullying, intimate partner violence, and child abuse were positively associated with trauma symptoms. Total school bullying was significantly and positively associated with total trauma symptoms ($r = .242$, $p < .01$), dissociation ($r = .165$, $p < .01$), depression ($r = .225$, $p < .01$), anxiety ($r = .230$, $p < .01$) , sexual trauma ($r = .239$, $p < .01$), sleep disturbance ($r = .217$, $p < .01$) and sexual problems ($r = .268$, $p < .01$). Intimate partner violence was significantly and positively associated with total trauma symptoms ($r = .327$, $p < .01$), dissociation ($r = .295$, $p < .01$), depression ($r = .309$, $p < .01$), anxiety ($r = .244$, $p < .01$), sexual trauma ($r = .337$, $p < .01$), sleep disturbance ($r = .190$, $p < .01$) and sexual problems ($r = .292$, $p < .01$). Child Abuse was significantly and positively associated with total trauma symptoms ($r = .292$, $p < .01$),

dissociation (r = .200, p < .01), depression (r = .252, p < .01), anxiety (r = .215, p < .01) , sexual trauma (r = .269, p < .01), sleep disturbance (r = .241, p < .01) and sexual problems (r = .321, p < .01). As levels of school bullying, intimate partner violence, and child abuse increase, trauma symptoms increase.

Hypothesis Two: Community violence, child abuse and intimate partner violence, gender, sexual orientation, and PTSD

A simultaneous multiple regression analysis was conducted to evaluate the second hypothesis. This research hypothesis is geared at determining whether trauma symptoms could be predicted from total community violence, school bullying, child abuse, intimate partner violence, gender and sexual orientation. Table 4 presents the simultaneous multiple regression findings for total trauma symptoms. A significant proportion of the total variance in trauma symptoms is predicted by the combination of community violence, school bullying, intimate partner violence, child abuse, gender and sexual orientation ($F(211) = 8.067$, $p < .01$, $R^2 = .192$). This combined model accounted for 19.2% of the variability in total trauma symptoms.

Community violence, school bullying, gender and sexual orientation did not independently predict trauma symptoms. Only intimate partner violence (β = .231, t (221) = 3.368, p < .01) and child abuse (β = .230, t (221) = p < .01) had significant partial effects in the full model. Higher levels of reported intimate partner violence and experiences of child abuse predict higher levels of total trauma symptoms.

Hypothesis Three: Child abuse, school bullying and intimate partner violence moderate the relationship between community violence and PTSD

The Hayes Macro (Hayes, 2013) was used with the hierarchical regression menu item in SPSS 24 to investigate the third hypothesis. Hypothesis three evaluates whether the magnitude of the relationship between community violence and PTSD is affected by levels of child abuse, intimate partner violence, or school bullying. Three different moderation models were evaluated for hypothesis three. The first model evaluated whether the relationship between community violence and PTSD was moderated by child abuse while the second model examined whether the relationship between community violence and PTSD was moderated by intimate partner violence. The third model investigated whether the relationship between community violence and PTSD was moderated by school bullying. Tables 5 through 7 detail the moderation findings.

For the first model, community violence and child abuse was selected in the first step of the regression analysis. In the second step, the interaction term between community violence and child abuse was selected. This overall model which included child abuse, community violence, and the interaction between child abuse and community violence significantly predicted the variance in PTSD symptoms, $F(3,307) = 14.872$, $p < .001$, $R^2 = .115$. This overall model explained 11.54% of the variance in PTSD symptom scores. Although child abuse ($b = 1.130$, $t(307) = 3.996$, $p < .01$) was a significant predictor, neither community violence ($b = .1080$, $t(307) = 1.399$, $p > .05$) nor the interaction between child abuse and community violence ($b = .0034$, $t(307) = 022$, $p > .05$) were significant predictors in the model.

For the second model, community violence and intimate partner violence were selected in the first step of the regression analysis. In the second step, the interaction term between community violence and intimate partner violence was selected. This overall model which

included intimate partner violence, community violence and the interaction between intimate partner violence and community violence significantly predicted the variance in PTSD symptoms, $F(3,256) = 8.41$, $p < .001$, $R^2 = .125$. This overall model explained 12.5% of the variance in PTSD symptom scores. Although intimate partner violence ($b = .419$, t (256) = 2.88, $p < .01$) was a significant predictor, neither community violence ($b = .096$, t (307) = 1.31, $p > .05$) nor the interaction between intimate partner violence and community violence ($b = .002$, t (307) = .489, $p > .05$) were significant predictors in the model.

For the third model, community violence and school bullying were selected in the first step of the regression analysis. In the second step, the interaction term between community violence and school bullying was selected. This overall model which included school bullying, community violence, and the interaction between school bullying and community violence significantly predicted the variance in PTSD symptoms, $F(3,332) = 10.28$, $p < .01$, $R^2 = .099$. This overall model explained 9.9% of the variance in PTSD symptom scores. Although school bullying ($b = 1.14$, t (332) = 2.81, $p < .01$) was a significant predictor, neither community violence ($b = .13$, t (307) = 1.81, $p > .05$) nor the interaction between intimate partner violence and community violence ($b = .005$, t (332) = .239, $p > .05$) were significant predictors in the model.

Although the overall models that include community violence, child abuse, and the interaction term, community violence, intimate partner violence and the interaction term and community violence, school bullying and the interaction term predicted significantly PTSD symptoms, non-significant interaction terms suggest that the relationship between community violence and trauma does not depend on child abuse, intimate partner violence or school bullying.

Hypothesis Four: Child abuse, school bullying and intimate partner violence as a combined moderator between community violence and PTSD

The Hayes Macro (Hayes, 2013) was used with the hierarchical regression menu item in SPSS 24 to investigate the fourth research hypothesis. Hypothesis four evaluated the moderation effects of the combined experiences of child abuse, school bullying and intimate partner violence to evaluate the additive effect of child abuse, intimate partner violence and school bullying on community violence and trauma symptoms. Participants' combined violence exposure experience were obtained by calculating a composite score. This composite score was created by adding scores obtained on the child abuse, intimate partner violence, and school bullying measure for each participant. This method of creating an aggregate score by adding scores from different questionnaires is consistent with previous violence exposure literature (Finkelhor et al, 2007; Turner et al, 2010). For the this model, community violence and the aggregate score which included indictors of child abuse, school bullying, and intimate partner violence was selected in the first step of the regression analysis. In the second step, the interaction term between community violence and the aggregate score was selected. This overall model which included the aggregate violence score, community violence and the interaction between the aggregate violence and community violence significantly predicted the variance in PTSD symptoms, $F(3,212) = 8.12$, $p < .001$, $\Delta R^2 = .157$. This overall model explained 15.7% of the variance in PTSD symptom scores. Although aggregate violence ($b = .477$, $t\ (212) = 3.66$, $p < .001$) was a significant predictor, neither community violence ($b = .020$, $t\ (212) = .265$, $p > .05$) nor the interaction between child abuse and community violence ($b = .00$, $t\ (212) = -.027$, $p > .05$) were significant predictors in the model. This suggests the relationship between community

violence and trauma does not depend on the additive effects of child abuse, school bullying, and intimate partner violence.

Discussion

The purpose of the study was to examine the relationships among child abuse, intimate partner violence, school bullying, community violence, and PTSD and investigate whether child abuse, intimate partner violence, and school bullying moderated the relationship between community violence and PTSD with a college population. To date, no study has investigated the relative contributions of bully victimization, child abuse, and intimate partner violence within the context of the relationship between community violence exposure and PTSD. The present study was unique in its attempt to examine how community violence affects psychological functioning while noting other potentially traumatic experiences with an emerging adult population. It was predicted that child abuse, intimate partner violence, school bullying, community violence, and PTSD would be related. It was hypothesized that participants with high exposure to community violence and high levels of child abuse, school bullying, and intimate partner violence would report higher symptoms of trauma than participants who had high exposure to community violence and low exposure to child abuse, school bullying, and intimate partner violence.

The study hypotheses were partially supported. In this study, all violence exposure scores were positively and significantly associated and the full model, which included community violence, child abuse, school bullying, and intimate partner violence significantly predicted trauma symptoms. The results were congruent with the data that confirms that individuals who are at risk for experiencing violence in one setting are at risk for exposures in other contexts (Brown et al,2005; Finkelhor et al, 2011). The findings supported the hypothesis that combined experiences of interpersonal violence across community, intimate relationships, and family

contexts predict PTSD symptom severity. This vulnerability to violence exposure across settings was found to be associated with increased PTSD symptom severity. This result suggests that when emerging adults are exposed to violence in community, school, and relationship contexts, this poly-victimization predicts PTSD symptom severity (Kennedy et al, 2014). The findings align well with the established body of data, which links child abuse and intimate partner violence with PTSD symptoms in adulthood (Brewin, Andrews, & Valentine, 2000; Kennedy et al, 2014; Messman-Moore, Long, & Siegfried, 2000; Walling et al, 2011). This finding reiterates the importance of attending to the mental health consequences of cumulative and poly violence exposure (Kennedy et al, 2014; (Margolin et al, 2010).

Although combined experiences of violence in community, school, family, and intimate relationship was found to significantly predict PTSD, community violence did not independently predict PTSD in any of the proposed multiple regression models. This finding diverges from the body of literature that identifies lifetime community violence exposure as a predictor of PTSD symptoms (Kennedy et al, 2014; Khan et al, 2016; Leshem, Haj-Yahia & Guterman, 2016; Scarpa, Haden & Hurley, 2006). Although studies have identified community violence exposure as a predictor of PTSD symptoms, there is some evidence that there might be some variability in how and when community violence exposure independently predicts PTSD symptoms across adult populations. There are adult studies that detail non-significant findings when examining community violence and trauma symptoms. Bogat and colleagues (2005) reported that community violence did not make a significant contribution to trauma symptoms in a sample of women exposed to domestic violence while Walling and colleagues (2011) determined that witnessing and hearing about community violence but not direct community violence victimization was related to PTSD symptom severity. Wilson and colleagues (2012) found that

community violence was negatively correlated with intimate partner violence related PTSD symptom severity. The scholarship on community violence with adults is developing. The conflicting findings about the links between community violence and PTSD in adulthood suggest that there is need for more focused research across diverse adult populations.

Diversity factors of gender, race, and sexual orientation were noted in the current study. The study found that trauma symptoms varied by gender and sexual orientation and determined that community and intimate partner violence differed by race/ethnicity and sexual orientation respectively. In the current study, female and queer or asexual identified participants endorsed higher rates of PTSD symptoms compared to males and those who identified as heterosexual. African Americans reported higher rates of community violence exposure compared to Asian Americans. Participants who identified as queer or asexual endorsed higher rates of interpersonal violence as compared to those who identified as heterosexual.

The gendered nature of PTSD symptom severity has been reported in previous studies (Avant et al, 2011; Guina, Nahhas, Kawalec & Farnsworth, 2016; Silove et al, 2017) and the observed racial/ethnicity differences in the current study are congruent with previous studies which indicated that African Americans tended to endorse higher and lower rates of community violence exposure compared to other racial/ethnicity minority groups (Kennedy & Ceballo, 2016; Voisin, Chen, Fullilove & Jacobson, 2015; Weist, Acosta & Youngstrom, 2001). These observed differences may be related to the finding that women endorse more experiences of assaultive violence such as sexual trauma and intimate partner violence as compared to their male counterparts (Breslau, 2009; Centers for Disease Control and Prevention, 2014). The racial disparities in community violence exposure that were observed in this study may be related to findings that African Americans tend to be disproportionately represented in low income, urban

communities characterized by violence (Selner-O'Hagan, et al., 1998; United States Census Bureau, 2015). The sexual orientation findings are consistent with the empirical data which suggests that sexual minority individuals are at increased risk for PTSD and intimate partner violence (D'Augelli, Grossman & Starks, 2006; Roberts et al, 2010; Weiss, Garvert & Cloitre, 2015). These findings are concerning because sexual minority individuals are also at increased risk for other types of violence and a myriad of psychological difficulties across the lifespan (Plöderl & Tremblay, 2015; Roberts et al, 2010). Although the research specifically focused on experiences of intimate partner violence for sexual minorities is developing, there are indications that LGBTQ+ identified individuals may be at high risk for violence in intimate relationship contexts (Edwards, Littleton, Sylaska, Crossman & Craig, 2016; Jacobson, Daire & Abel, 2015). There may be unique experiences that place individuals who identify as queer and asexual at greater risk for violence in relationship contexts. The findings should however be interpreted with caution given the small sample size.

The study also examined how other experiences of interpersonal trauma buffered the relationship between community violence and PTSD. Four separate moderation models were examined to determine whether child abuse, intimate partner violence, and school bullying independently or cumulatively (additive experience of child abuse, intimate partner violence, and school bullying) moderated the relationship between community violence and PTSD symptoms. The four overall models which included child abuse, community violence, and the interaction, intimate partner violence, community violence, and the interaction, school bullying, community violence and the interaction and the composite interpersonal violence score (child abuse, intimate partner violence and school bullying), community violence and the interaction significantly predicted the variance in PTSD symptoms. The results of the current study did not support the

moderation hypotheses that child abuse, intimate partner violence, school bullying independently or cumulatively moderate the relationship between community violence and PTSD. This is noteworthy given that this is the first study to examine community violence through the lens of exposures to other related violent victimization experiences such as school bullying, intimate partner violence and intimate partner violence. Community violence, school bullying, intimate partner violence and child abuse have been independently linked to PTSD and a small number of studies have been begun to examine the combined relationships of community violence, school bullying, intimate partner violence and PTSD (Gobin et al, 2013; Kennedy et al, 2014; Nielsen et al, 2015). The interrelationships among these variables remain somewhat unclear. There is need for additional research to clarify the potentially interlocking dynamic relationships between these variables.

The current findings and the variable empirical picture confirm that the community violence literature is nuanced. The non-significant moderation findings of this study are consistent with the bio-ecological model. This model asserts that violence that occurs in environments that are more proximal to the individual have the greatest impact on functioning, while events that take place in more distal contexts have less of an impact. This assertion was observed in this study since proximal violence exposure in the family (child abuse) and relationships (intimate partner violence) significantly predicted PTSD symptom severity. The non-significant moderation findings that were obtained in this study may also be related to other factors. The factors of note may include limited variability in responses to community violence exposure. This limited variability in responses could have reduced the contribution of CVE to the prediction of PTSD symptoms over and above other variables in study. The non-significant moderation findings observed in this study may also be related to the salience of community

violence exposure and perception and meaning making associated with community violent events within this population.

Additionally, it is possible that there were unique resilience features of the sample that were not observed or measured and these variables may have caused participants who were exposed to community violence and school bullying to develop adaptive responses which altered PTSD symptom development (Wilson et al, 2012). Most of the community violence and school bullying empirical literature has been done with children and adolescents and the emerging body of community violence literature that utilizes adult samples has been done with non-diverse university samples or specialized community samples (i.e community workers, domestic violence exposed women). Similar deficits are also noted in the retrospective school bullying literature with adults. The empirical data on the correlates of recalled experiences of childhood school bullying is not as expansive as the literature which documents childhood outcomes and there are few adult specific measures of retrospective school bullying for adults (Blood & Blood, 2016; Cooper & Nickerson, 2013; Espelage, Hong & Mebane, 2016).

This study utilizes a diverse, urban, mixed gendered, convenience sample and examined violence exposure across multiple contexts. It is possible that the mixed results may be reflecting the unique differences among these populations that have been studied. The variable findings may also reflect the complexities that are inherent the phenomena under study. The differences observed across studies may also be remnants of the lack of uniformity in the definition and measurement of community violence and retrospective school bullying.

Conclusion

The empirical literature documents an established link between community violence exposure and negative psychological functioning and adjustment difficulties. However, most of this data has not incorporated other experiences of violence in home and school settings (Finkelhor, Vanderminden, Turner, Shattuck & Hamby, 2016; Kelly, Schwartz, Gorman & Nakamoto, 2008). The study addressed this research gap by investigating the interrelationships among community violence, school bullying, intimate partner violence, child abuse and Posttraumatic symptoms (PTSD) and by exploring how intimate partner, child abuse and school bully victimization moderate the relationship between community violence and PTSD. The study found that violence exposure experiences were related and that these combined experiences predicted PTSD. No moderating effect was noted. The succeeding paragraphs outline the study strengths and limitations and highlight the clinical and research implications of the study.

Limitations and Strengths

The research findings outlined should be reviewed within the context of the limitations of the study. Methodological factors such as instrumentation and sample characteristics are the most salient. Although the Survey of Exposure to Community Violence (SECV; Richters & Saltzman, 1990) has been utilized in previous studies with adults, it was developed for children and adolescents. Additionally, it is difficult to compare findings across studies because researchers often administer modified versions of the instrument across different studies. Similar themes are noted within the school bulling literature. Most of the school bullying measures have been normed with children and adolescents, the Retrospective Bullying Questionnaire (RBQ; Shäfer et al., 2004) is one of the few questionnaires that were designed for adults. Nonetheless, most of the empirical data on its use has been with non-American samples. There are also

concerns with the measure of intimate partner violence. Historically, most of the empirical data on intimate partner violence has been focused predominantly on female populations. The Composite Abuse Scale (CAS; Hegarty, Bush & Sheehan, 2005) is one of the few available instruments that comprehensively examine intimate partner violence but the measure was normed for use with women.

The sample characteristics and questionnaire format should also be noted. Participants' lifetime experiences of community violence exposure, school bullying, child abuse, intimate partner violence and past-month trauma symptoms were obtained through self reports and may have been compromised by recall inaccuracies or over or under estimations of symptom and incident frequency and severity. Additionally the study utilized a correlational design with a conveniently accessed sample of university students enrolled in online courses at a southern American university. Students voluntarily chose to participate in this study as opposed to others for course credit. Dynamic or and intrapersonal variables may have influenced the eventual sample by impacting motivations for study participation. It is possible that potential participants declined to participate in the study because anticipated study and responses to potentially traumatic experiences. Sample characteristics may have also influenced participants' reports of the frequency and severity of incidents and symptoms. The non-random sample design means that the results cannot be generalized across other populations. The correlational research design precludes cause-effect interpretations.

The study provides insights despite the previously referenced limitations. Victimization statistically influenced trauma symptoms even though the research sample included a relatively low-risk population with relatively low levels of community violence exposure. This observation suggests that the results are salient across a range of violence exposure experiences. Overall the

research finding suggests that trauma symptoms are predicted by combined experiences of community violence, intimate partner violence, school bullying and child abuse.

The current findings expand the literature on violence exposure and PTSD with an emerging adult population and illustrate the appropriateness of investigating the link between community violence and PTSD within the context of cumulative violence exposure by incorporating experiences of child abuse, school bullying and intimate partner violence.

Clinical and Research Implications

Although community violence and school bullying were not found to independently predict PTSD, polyvictimization experiences which included community violence, school bullying, child abuse and intimate partner violence were significant. This supports the notion that PTSD is best understood through a cumulative model that incorporates a range of experiences across multiple settings and developmental periods.

There is need for future research focused how these lived experiences of community violence, school bullying, intimate partner violence, child abuse may be related to PTSD symptoms particularly with women and racial/ethnic and sexual minority individuals. This is crucial because these identities appear to introduce additional risk that may make these individual vulnerable to the negative effects of violence exposure. Although gender, race and ethnicity were not found to independently predict PTSD in the model, it is important to explore the line of research that examines how these identities may intersect with other lived experiences to indirectly impact different violence exposure experiences and PTSD symptom severity. Future research should be focused on exploring intimate partner violence and PTSD within the context of community violence with Queer identified individuals in particular.

The findings also have practice implications for mental health particularly with emerging adults. The study confirms the interrelationship between different types of violence exposures and PTSD symptom severity. It is therefore important that mental health practitioners within university settings attend to the cumulative experience of violence victimization as they conduct assessments and psychotherapy and participate in preventative efforts. The onerous but developmentally expected mental and physical demands of university are especially troublesome to students with a history of violent victimization but limited supports reference. It is critical that mental health and student service personnel dedicate efforts focused on expanding preventative and intervention efforts focused on screening for experiences of sexual, emotional, physical and community violence victimization, bullying and PTSD symptoms among college aged populations

The relationship between community violence and PTSD is nuanced and the empirical data with adults are still emerging. Future research should be focused on developing more psychometrically sound measures of violence exposure for use across gender, race, sexual orientation and age groups. Future studies should also examine other types of violence exposures by utilizing multiple informants with varied assessment tools.

This paper adds to the body of work by underlying the value of ongoing therapeutic and public policy work with both clinical and non-clinical populations to respond to and buffer the effects of violence exposure across community, school and relational contexts. Community violence and PTSD are public health concerns and the rates and consequences of violence exposure and PTSD are concerning. Reducing exposure and improving PTSD prevention efforts and treatment outcomes are contingent on a fulsome understanding of these constructs. The findings suggest that it critical that researchers and practitioners continue to examine cumulative

exposure and gender, race and sexuality to further disentangle the effects of potentially traumatic events.

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Table 1

Population Characteristics and Descriptive Statistics for Covariates (N=425)

Variables	N	Frequencies (%)	Mean	Standard Deviation
Total Trauma Symptoms	**380**		**65.16**	**18.667**
Dissociation Index	421		10.16	3.725
Depression Index	417		15.01	4.951
Anxiety Index	408		14.24	4.289
Sexual Abuse Trauma Index	418		10.41	3.522
Sleep Disturbance Index	417		12.88	4.896
Total Early Trauma	**366**		**36.17**	**4.360**
Childhood Sexual Abuse	394		16.06	1.981
Childhood Physical Abuse	406		11.37	1.758
Childhood Emotional Abuse	410		8.67	1.941
Total School Bullying	**399**		**16.05**	**2.889**
Indirect School Bullying	414		5.36	1.434
Physical School Bullying	414		4.49	0.866
Verbal School Bullying	417		5.16	1.227
Combined Intimate Partner Violence	**312**		**35.94**	**12.067**
Intimate Partner Emotional Abuse	334		14.39	6.046
Intimate Partner Physical Abuse	337		8.22	3.246
Intimate Partner Harassment	338		4.98	2.366

Intimate Partner Severe Combined Abuse	333		8.44	2.027
Community Violence Victimization	**408**		**23.99**	**11.141**
Chased	425	20.5	1.41	1.059
Drug Sale & Distribution	422	33.6	1.98	1.766
Drug Use	422	71.1	3.88	2.496
Serious Accident	425	46.8	1.98	1.430
Home Break-in, Present	423	27.5	1.56	1.247
Home Break-in, Absent	421	35.1	1.59	1.030
Picked up or Arrested	424	23.8	1.42	0.939
Threatened with Physical Harm	423	52	2.28	1.626
Slapped, Punched or Hit	422	61.6	2.65	1.776
Beaten or Mugged	424	19.3	1.35	0.954
Sexually Assaulted	422	27.3	1.51	1.094
Knife Attack	424	10.8	1.21	0.783
Shot	422	7.5	1.17	.790
Witnessed Community Violence	403		48.80	20.564
Chased	425	40	1.98	1.497
Drug Sale & Distribution	424	64	3.39	2.427
Drug Use	424	85	5.36	2.680
Serious Accident	424	67.8	2.65	1.682
Attempted Home Break-in	422	23.5	1.45	1.032
Arrested	422	77.2	3.68	2.205
Threatened with Physical Harm	423	65.2	2.85	1.831

Slapped, Punched or Hit, family member	422	61.4	2.84	1.978
Slapped, Punched or Hit, non-family member	422	65.2	3.10	2.048
Beaten or Mugged	423	36.9	2.00	1.604
Sexually Assaulted	422	14.1	1.26	0.824
Possession of Gun or Knife	423	71.8	3.53	2.408
Gunfire outside, in/near home[a]	425	67.3	3.35	2.300
Gunfire outside, in/near school[a]	424	30	1.72	1.479
Gunfire in home[a]	423	17.4	1.40	1.151
Someone wounded [b]	423	35.8	1.86	1.512
Someone attacked with a knife	424	15.1	1.31	.941
Someone Shot	424	16.7	1.34	1.005
Dead Body[c]	423	22.8	1.43	1.037
Suicide	423	12	1.22	0.787
Homicide	424	9.6	1.18	0.717

a.Other than hunting related gunfire

b.By an act of violence

c. Other than funerals or wakes

Table 2

Correlations Among Variables (N =425)

Variables	TTS	DIS	DEP	ANX	SAT	SLD	SEX
CVV	.259**	.219**	.244**	.186**	.278**	.153**	.294**
WCV	.242**	.231**	.217**	.163**	.266**	.207**	.290**
TCV	.264**	.240**	.242**	.173**	.286**	.198**	.306**
TSB	.262**	.165**	.225**	.230**	.239**	.217**	.268**
INSB	.252**	.158**	.223**	.239**	.219**	.220**	.253**
PHYSB	.139**	.093	.117*	.108*	.136**	.122*	.144**
VBSB	.201**	.129**	.162**	.165**	.184**	.158**	.207**
TIPV	.327**	.295**	.309**	.244**	.337**	.190**	.292**
SCIPV	.181**	.172**	.147**	.131*	.240**	.060	.279**
EMIPV	.326**	.283**	.299**	.246**	.310**	.201**	.255**
PHYIPV	.250**	.252**	.233**	.211**	.248**	.131*	.193**
HARIPV	.230**	.202**	.235**	.182**	.282**	.160**	.240**
TCHAB	.292**	.200**	.252**	.215**	.269**	.241**	.321**
PHYCHAB	.216**	.143**	.175**	.142**	.181**	.176**	.250**
EMCHAB	.319**	.233**	.286**	.287**	.298**	.295**	.248**
SEXCHAB	.153**	.091**	.128*	.112*	.152**	.122*	.220**

**. Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

CVV - Community Violence Victimization, WCV-Witnessed Community Violence, TCV- Total Community Violence, TSB-Total School Bullying, INSB-Indirect School Bullying, PHYSB –

Physical School Bullying, VBSB- Verbal School Bullying, TIPV-Total Interpersonal Violence, Severe Combined Interpersonal Violence, EMIPV-Emotional Interpersonal Violence, PHYIPV-Physical Interpersonal Violence, HARIPV-Intimate Partner Harassment, TCHAB-Total Child Abuse, PHYCHAB-Physical Child Abuse, EMCHAB-Emotional Child Abuse, SEXCHAB-Childhood Sexual Abuse, , TTS- Total Trauma Symptoms, DIS-Dissociation, DEP-Depression, ANX-Anxiety, SAT-Sexual Abuse Trauma, SLD- Sleep Disturbance, SEX-Sexual Difficulties

Table 3

ANOVAs Examining Sociodemographic Differences in Community Violence and Trauma Symptoms (N=425)

	Community Violence		Trauma Symptoms	
	M	SD	M	SD
Gender				
Cisgender Female (n = 268)	70.660	25.305	67.914	18.812**
Cisgender Male (n = 129)	76.966	38.161	60.991	17.979
Transgender and Gender Non-conforming (n = 11)	71.455	27.038	63.444	16.697
Additional Gender Identity (n = 12)	72.167	43.348	55.000	13.589
Sexual Orientation				
Gay (n = 6)	82.000	25.219	77.667	11.219
Lesbian (n = 7)	72.571	23.881	51.167	11.374**
Bisexual (n = 14)	79.462	22.184	77.929	22.872
Heterosexual (n = 369)	71.456	30.803	64.031	17.463**
Queer or Asexual (n = 7)	101.571	29.613	95.500	26.395**
Additional Sexual Orientation (n = 16)	62.933	30.310	67.188	26.141**
Race and Ethnicity				
African American/ Black (n = 195)	77.640**	32.233	65.306	18.525
Latino/Latina or Hispanic (n = 35)	69.265	31.026	67.241	21.233
Asian American (n = 77)	58.389**	29.890	63.233	18.994
European American/White (n = 89)	71.714	24.139	66.563	19.616

Biracial or Multiracial (n = 22)	77.905	24.255	62.550	11.790
Native Hawaiian/Pacific Islander or Additional Racial and Ethnic Identity	98.750	21.654	68.250	11.087

* $p < .01$.

Table 4

Summary of Multiple Regression Analyses for Variables Predicting Trauma Symptoms (N = 211)

Variable	*B*	*SE B*	*β*	*t*
Total School Bullying	.374	.494	.056	.757
Total IPV	.368	.109	.231**	3.368
Total Child Abuse	1.098	.357	.230**	3.077
Total Community Violence	.021	.048	.032	.438
Gender	3.497	2.435	.098	1.436
Sexual Orientation	-.040	1.553	-.002	-.026
R^2	.192			
F	8.067			

**$p < .01$.

Table 5

Summary of Multiple Regression Analyses for Variables Predicting Trauma Symptoms (N = 311)

Variable	*B*	*SE B*	*t*
Total Child Abuse	1.130	.282	3.996**
Community Violence	.108	.283	1.399
Interaction: Child Abuse x Community Violence	.003	.016	.2182
R^2	.115		
F	14.872		

**$p < .01$

Table 6

Summary of Multiple Regression Analyses for Variables Predicting Trauma Symptoms (N = 260)

Variable	*B*	*SE B*	*t*
Intimate Partner Violence	.419	.146	2.878**
Community Violence	.096	.073	1.310
Interaction: Intimate Partner Violence x Community Violence	.002	.004	.489
R^2	.125		
F	8.411		

**$p < .01$

Table 7

Summary of Multiple Regression Analyses for Variables Predicting Trauma Symptoms (N = 336)

Variable	*b*	*SE B*	*t*
School Bullying	1.143	.407	2.81**
Community Violence	.130	.072	1.806
Interaction: School Bullying x Community Violence	.005	.020	.239
R^2	.099		
F	10.276		

**$p < .01$

Table 8

Summary of Multiple Regression Analyses for Variables Predicting Trauma Symptoms (N = 336)

Variable	*B*	*SE B*	*t*
Aggregate Violence Exposure	.477	.130	3.70**
Community Violence	.020	.076	.265
Interaction: Aggregate violence x Community Violence	-.000	.004	-.027
R^2	.157		
F	8.117		

**$p < .01$

APPENDICES

APPENDIX A: Informed Consent

Title: Community Violence and Trauma: The Influence of Child Abuse, Bullying, and Intimate Partner Violence

Principal Investigator: Greg Brack, PhD
Student Investigator: Claudine Anderson, MSc.

I. Purpose:

You are invited to participate in a research study. You are invited to take part because you are currently a college student. The purpose of the study is to understand the relationships between community violence exposure, school bullying, child abuse, intimate partner violence and trauma symptoms. A total of 500 participants will be recruited for this study. Participation will take about 60 minutes of your time.

II. Procedures:

If you decide to participate, you will complete 5 surveys. The surveys will take 60 minutes. The surveys will ask you questions about experiences with community violence, school bullying, child abuse, sexual abuse, intimate partner violence and trauma symptoms. You will also be asked questions about your age, ethnicity and academic standing. You will take the surveys through Georgia State University online system. You will only complete the surveys once. No identifying information will be requested or collected. You will not be contacted by the researchers after you have completed the surveys. Your decision to participate or not participate will not affect your academic progress. If you choose to participate you will receive research credits for participation. You will earn 1 research credit for an hour of research participation.

III. Risks:

It is possible that you may experience some emotional discomfort as a result of answering survey questions. If as a result of completing these surveys you experience emotional discomfort, distressing memories, or feel the need to talk to a mental health professional, you may contact Claudine Anderson, the student investigator at (404) 542-7792 to receive a referral. As a student at Georgia State University, you may also be eligible for free individual and group counseling at the GSU Counseling Center. The Counseling Center is located in the Citizens Trust Building (next to the University Commons) at 75 Piedmont Avenue, N.E., Suite 200A. To arrange for an initial appointment, please call (404) 413-1653.

IV. Benefits:

Participation in this study may not benefit you personally. Overall, we hope to gain information about the effects of interpersonal and community violence exposure.

V. Voluntary Participation and Withdrawal:

Participation in research is voluntary. You do not have to be in this study. If you decide to be in the study and change your mind, you may stop at any time. You may skip questions. Whatever you decide, you will not lose any benefits to which you are otherwise entitled. Your instructors will not have access to your survey results and your academic progress will not be affected no matter your decision about participation

VI. Confidentiality:

We will keep your records private to the extent allowed by law. Only the Principal Investigator and Student Researcher will have access to the information you provide.
Information may also be shared with those who make sure the study is done correctly (GSU Institutional Review Board, the Office for Human Research Protection (OHRP)).
We will use a code number rather than your name on study records. Only the primary researcher and student researchers will have access to the information you provide. It will be stored electronically. Your name and other facts that might point to you will not appear when we present this study or publish its results. The data that will be stored on computers are firewall protected. The findings will be summarized and reported in group form. You will not be identified personally.

VII. Contact Persons:

Contact Greg Brack and Claudine Anderson at (404) 413-8165 or gbrack@gsu.edu and (404) 542-7792 or canderson63@student.gsu.edu if you have questions, concerns, or complaints about this study. You can also call if you think you have been harmed by the study. Call Susan Vogtner in the Georgia State University Office of Research Integrity at 404-413-3513 or svogtner1@gsu.edu if you want to talk to someone who is not part of the study team. You can talk about questions, concerns, offer input, obtain information, or suggestions about the study. You can also call Susan Vogtner if you have questions or concerns about your rights in this study.

VIII. Copy of Consent form to Subject:

Please print a copy of this consent form for your records.

If you are willing to volunteer for this research, please click “I agree” below. (You must indicate consent in order to go on to the next page).

I agree to participate in this study.

APPENDIX B: Demographic Questionnaire

Q2 If you are willing to volunteer for this research, please click "I agree" below. (You must indicate consent in order to go on to the next page).

- ❍ I agree to participate in this study. (1)
- ❍ I do not agree to participate in this study (2)

If I do not agree to participa... Is Selected, Then Skip To End of Survey

Q3 Please complete this survey in a private location where others can't see the screen.

Q4 Age

Q5 Gender (please choose an answer that best describes you) (Cisgender : Someone whose internal sense of gender corresponds with the biological sex the person was identified as having at birth)

- ❑ Cisgender Male (1)
- ❑ Cisgender Female (2)
- ❑ Transgender (3)
- ❑ Gender non-conforming (4)
- ❑ None of the above. I identify as (5) _____

Q9 Race or Ethnicity (please choose an answer that best describes you):

- ❍ African American or Black (1)
- ❍ Latino/Latina or Hispanic (2)
- ❍ Asian/Asian American (3)
- ❍ Native Hawaiian or Pacific Islander (4)
- ❍ American Indian or Alaska Native (5)
- ❍ White or European American (6)
- ❍ Biracial or Multiracial (7)
- ❍ None of the above. I identify as (8) _____

Q10 Sexual Orientation (please choose an answer that best describes you):

- ❍ Gay (1)
- ❍ Lesbian (2)
- ❍ Bisexual (3)
- ❍ Heterosexual (4)
- ❍ Queer (5)
- ❍ Asexual (6)
- ❍ None of the above. I identify as (7) _____

Q11 Do you have a chronic illness/disability that impacts your daily functioning? (please check all that apply)

- ❑ Not applicable. I do not experience a disability (1)
- ❑ Chronic/other medical health (e.g. HIV, diabetes, hypertension) (2)
- ❑ Hearing (3)
- ❑ Intellect (4)
- ❑ Learning (5)
- ❑ Mobility (6)
- ❑ Motor Activity (7)
- ❑ Psychological/psychiatric (8)
- ❑ Speaking (9)
- ❑ Vision (10)
- ❑ None of the above. The chronic illness/disability that impacts daily functioning is (11) _____

Q10 Religion/Spirituality (please choose an answer that best describes you):

- ❍ Hindu (1)
- ❍ Muslim (2)
- ❍ Buddhist (3)
- ❍ Christian (4)
- ❍ Jewish (5)
- ❍ Pagan (6)
- ❍ Atheist (7)
- ❍ Agnostic (8)
- ❍ None of the above, I identify as (9) _____

Q11 Geographic region where you have spent the majority of your life:

- ❍ • Southeastern US (AL, AR, FL, GA, KY, LA, MS, NC, SC, TN, VA, WV) (1)
- ❍ • Southwestern US (AZ, NM, OK, TX) (2)
- ❍ • Northeastern US (CT, DE, ME, MD, MA, NH, NJ, NY, PA, RI, VT) (3)
- ❍ • Western US (CA, CO, ID, MT, OR, UT, WA, WY) (4)
- ❍ • Midwestern US (IL, IN, IA, KS, MI, MN, MO, NE, ND, OH, SD, WI) (5)
- ❍ • Hawaii or Alaska (6)
- ❍ • Outside the US (7)

Q12 Please indicate your level in school:

- ❍ Freshman (1)
- ❍ Sophomore (2)
- ❍ Junior (3)
- ❍ Senior (4)
- ❍ Graduate Student (5)

Q16 How many online courses have you taken?

Q278 How many face to face courses have you taken?

Q13 Are you the first person in your family to attend college?
- ❍ Yes (1)
- ❍ No (2)

Q14 Please indicate your family's estimated current household annual income:
- ❍ • Less than $20,000 (1)
- ❍ • $20,000-$40,000 (2)
- ❍ • $40,000-$60,000 (3)
- ❍ • $60,000-$80,000 (4)
- ❍ • $80,000-$100,000 (5)
- ❍ • $100,000-$150,000 (6)
- ❍ • Over $150,000 (7)

Q15 What is your current relationship status?
- ❍ Single (1)
- ❍ Married/partnered (2)
- ❍ Separated (3)
- ❍ Divorced (4)
- ❍ Widowed (5)

APPENDIX C: Survey of Exposure to Community Violence (SECV; Richters & Saltzman, 1990)

Listed below are various kinds of violence and things related to violence that you may have experienced, seen, or heard about. For each question circle the letter that best describes your experience. DO NOT INCLUDE IN YOUR ANSWERS THINGS YOU MAY HAVE SEEN OR HEARD ABOUT ONLY ON TV, RADIO, THE NEWS, OR IN THE MOVIES.

	Never (1)	1 Time (2)	2 Times (3)	3 or 4 Times (4)	5 or 6 Times (5)	7 or 8 Times (6)	At least monthly (7)	At least weekly (8)	Almost every day (9)
How many times have you yourself been chased by gangs or individuals? (1)	❍	❍	❍	❍	❍	❍	❍	❍	❍
How many times have you seen someone else get chased by gangs or individuals? (2)	❍	❍	❍	❍	❍	❍	❍	❍	❍
How many times have you only heard about someone being chased by gangs or individuals? (3)	❍	❍	❍	❍	❍	❍	❍	❍	❍
How many times have you seen other people using or selling illegal drugs? (4)	❍	❍	❍	❍	❍	❍	❍	❍	❍
How many times have you yourself	❍	❍	❍	❍	❍	❍	❍	❍	❍

actually been asked to get involved in any aspect of selling or distributing illegal drugs? (5)									
How many times have you yourself actually been asked to use illegal drugs? (6)	❍	❍	❍	❍	❍	❍	❍	❍	❍
How many times have you seen someone else being asked to get involved in any aspect of selling or distributing illegal drugs? (7)	❍	❍	❍	❍	❍	❍	❍	❍	❍
How many times have you only heard about someone else being asked to get involved in any aspect of selling or distributing illegal drugs? (8)	❍	❍	❍	❍	❍	❍	❍	❍	❍
How many times have you yourself actually been in a serious accident where you	❍	❍	❍	❍	❍	❍	❍	❍	❍

thought that you or someone else would get hurt very badly or die? (9)									
How many times have you seen someone else have a serious accident where you thought the person would get hurt very badly or die? (10)	❍	❍	❍	❍	❍	❍	❍	❍	❍
How many times have you only heard about someone else having a serious accident where you thought the person could have been hurt very badly or died? (11)	❍	❍	❍	❍	❍	❍	❍	❍	❍
How many times have you yourself actually been at home when someone has broken into or tired to force their way into your home? (12)	❍	❍	❍	❍	❍	❍	❍	❍	❍
If you are still reading check	❍	❍	❍	❍	❍	❍	❍	❍	❍

the third option (13)									
How many times has your house been broken into when you weren't home? (14)	❍	❍	❍	❍	❍	❍	❍	❍	❍
How many times have you seen someone trying to force their way into somebody else's house or apartment? (15)	❍	❍	❍	❍	❍	❍	❍	❍	❍
How many times have you only heard about someone trying to force their way into somebody else's house or apartment? (16)	❍	❍	❍	❍	❍	❍	❍	❍	❍
How many times have you yourself actually been picked up, arrested or taken away by the police? (17)	❍	❍	❍	❍	❍	❍	❍	❍	❍
How many times have you seen someone else being picked up, arrested or	❍	❍	❍	❍	❍	❍	❍	❍	❍

taken away by the police? (18)									
How many times have you only heard about someone else being picked-up, arrested or taken away by the police? (19)	❍	❍	❍	❍	❍	❍	❍	❍	❍
How many times have you yourself actually been threatened with serious physical harm by someone? (20)	❍	❍	❍	❍	❍	❍	❍	❍	❍
How many times have you seen someone else being threatened with serious physical harm by someone? (21)	❍	❍	❍	❍	❍	❍	❍	❍	❍
How many times have you only heard about someone else being threatened with serious physical harm by someone? (22)	❍	❍	❍	❍	❍	❍	❍	❍	❍
How many times have	❍	❍	❍	❍	❍	❍	❍	❍	❍

you yourself actually been slapped, punched or hit by someone? (23)									
How many times have you seen someone else being slapped, punched or hit by a member of their family? (24)	❍	❍	❍	❍	❍	❍	❍	❍	❍
How many times have you only heard about someone else being slapped, punched or hit by a member of their family? (25)	❍	❍	❍	❍	❍	❍	❍	❍	❍
How many times have you seen another person being slapped, punched or hit by someone who is not a member of their own family? (26)	❍	❍	❍	❍	❍	❍	❍	❍	❍
How many times have you only heard about someone else being slapped, punched or hit by someone who is not a	❍	❍	❍	❍	❍	❍	❍	❍	❍

member of their own family? (27)									
How many times have you yourself actually been beaten up or mugged? (28)	❍	❍	❍	❍	❍	❍	❍	❍	❍
How many times have you seen someone being beaten up or mugged? (29)	❍	❍	❍	❍	❍	❍	❍	❍	❍
How many times have you only heard about someone else being beaten up or mugged? (30)	❍	❍	❍	❍	❍	❍	❍	❍	❍
How times have you yourself been sexually assaulted, molested or raped? (31)	❍	❍	❍	❍	❍	❍	❍	❍	❍
If you are still reading please check the fifth option (32)	❍	❍	❍	❍	❍	❍	❍	❍	❍
How times have you seen someone else being sexually assaulted, molested or raped? (59)	❍	❍	❍	❍	❍	❍	❍	❍	❍
How times have you only	❍	❍	❍	❍	❍	❍	❍	❍	❍

heard about someone else being sexually assaulted, molested or raped? (34)									
How many items have you actually seen someone carrying or holding a gun or knife (do not include the police, military or security officers)? (35)	❍	❍	❍	❍	❍	❍	❍	❍	❍
How many times have you only heard about someone carrying or holding a gun or knife (do not include military, security forces or police)? (37)	❍	❍	❍	❍	❍	❍	❍	❍	❍
How many times have you yourself heard the sound of gun fire when you were in or near your home? (38)	❍	❍	❍	❍	❍	❍	❍	❍	❍
How many times have you yourself heard the sound of gun	❍	❍	❍	❍	❍	❍	❍	❍	❍

fire when you were in or near school? (39)									
How many times have you actually seen or heard a gun fired in your home? (40)	❍	❍	❍	❍	❍	❍	❍	❍	❍
How many times have you seen a seriously wounded person after an incident of violence? (41)	❍	❍	❍	❍	❍	❍	❍	❍	❍
How many times have you only heard about a person being seriously wounded after an incident of violence? (42)	❍	❍	❍	❍	❍	❍	❍	❍	❍
How many times have you actually been attacked or stabbed with a knife? (43)	❍	❍	❍	❍	❍	❍	❍	❍	❍
How often have you seen someone else being attacked or stabbed with a knife? (44)	❍	❍	❍	❍	❍	❍	❍	❍	❍
How many times have	❍	❍	❍	❍	❍	❍	❍	❍	❍

you only heard about someone else being attacked or stabbed with a knife? (45)									
How many times have you yourself been actually shot with a gun? (46)	❍	❍	❍	❍	❍	❍	❍	❍	❍
How often have you seen someone else get shot with a gun? (47)	❍	❍	❍	❍	❍	❍	❍	❍	❍
How many times have you only heard about someone else getting shot with a gun? (48)	❍	❍	❍	❍	❍	❍	❍	❍	❍
How many times have you actually seen a dead person somewhere in your community (do not include wakes and funerals)? (49)	❍	❍	❍	❍	❍	❍	❍	❍	❍
If you are still reading please check the first option (50)	❍	❍	❍	❍	❍	❍	❍	❍	❍
How many times have	❍	❍	❍	❍	❍	❍	❍	❍	❍

you only heard about a dead body being somewhere in your community (do not include wakes and funerals)? (51)									
How many times have you actually seen someone committing suicide? (52)	❍	❍	❍	❍	❍	❍	❍	❍	❍
How many times have you only heard about someone committing suicide? (53)	❍	❍	❍	❍	❍	❍	❍	❍	❍
How many times have you actually seen someone being killed by another person? (54)	❍	❍	❍	❍	❍	❍	❍	❍	❍
How many times have you only heard about someone being killed by another person? (55)	❍	❍	❍	❍	❍	❍	❍	❍	❍
How many times have you been in any kind of situation not already	❍	❍	❍	❍	❍	❍	❍	❍	❍

described where you were extremely frightened or thought that you would get hurt very badly or die? (56)									
How many times have you yourself been the victim of any type of violence such as those described in this questionnaire? (64)	❍	❍	❍	❍	❍	❍	❍	❍	❍
How many times you seen someone else being victimized by some form of violence such as those described in this questionnaire? (58)	❍	❍	❍	❍	❍	❍	❍	❍	❍

How many times have you only heard about someone else being victimized by some form of violence such as those described in this questionnaire? (60)	❍	❍	❍	❍	❍	❍	❍	❍	❍

Q264 The Counseling Center is located in the Citizens Trust Building (next to the University Commons) at 75 Piedmont Avenue, N.E., Suite 200A. To arrange for an initial appointment, please call (404) 413-1653.

APPENDIX D: Trauma Symptom Checklist -40 (TSC-40; Briere & Runtz, 1989)

How often have you experienced each of the following in the last two months? (0 = Never..... 3 = Often)

	0 (1)	1 (2)	2 (3)	3 (4)
Headaches (1)	❍	❍	❍	❍
Insomnia (trouble getting to sleep) (2)	❍	❍	❍	❍
Weight loss (without dieting) (3)	❍	❍	❍	❍
Stomach problems (4)	❍	❍	❍	❍
Sexual problems (5)	❍	❍	❍	❍
Feeling isolated from others (6)	❍	❍	❍	❍
"Flashbacks" (sudden, vivid, distracting memories) (7)	❍	❍	❍	❍
Restless sleep (8)	❍	❍	❍	❍
Low sex drive (9)	❍	❍	❍	❍
Anxiety attacks (10)	❍	❍	❍	❍

Sexual overactivity (11)	❍	❍	❍	❍
Loneliness (12)	❍	❍	❍	❍
Nightmares (13)	❍	❍	❍	❍
"Spacing out" (going away in your mind) (14)	❍	❍	❍	❍
Sadness (15)	❍	❍	❍	❍
Dizziness (16)	❍	❍	❍	❍
Not feeling satisfied with your sex life (17)	❍	❍	❍	❍
Trouble controlling your temper (18)	❍	❍	❍	❍
Waking up early in the morning and can't get back to sleep (19)	❍	❍	❍	❍
Uncontrollable crying (20)	❍	❍	❍	❍
Fear of men (21)	❍	❍	❍	❍
Not feeling rested in the morning (22)	❍	❍	❍	❍

Having sex that you didn't enjoy (23)	❍	❍	❍	❍
Trouble getting along with others (24)	❍	❍	❍	❍
Memory problems (25)	❍	❍	❍	❍
Desire to physically hurt yourself (26)	❍	❍	❍	❍
Fear of women (27)	❍	❍	❍	❍
Waking up in the middle of the night (28)	❍	❍	❍	❍
Bad thoughts or feelings during sex (29)	❍	❍	❍	❍
Passing out (30)	❍	❍	❍	❍
Feeling that things are "unreal” (31)	❍	❍	❍	❍
Unnecessary or over-frequent washing (32)	❍	❍	❍	❍
Feelings of inferiority (33)	❍	❍	❍	❍
Feeling tense all the time (34)	❍	❍	❍	❍
Being confused about your sexual feelings (35)	❍	❍	❍	❍

Desire to physically hurt others (36)	❍	❍	❍	❍
Feelings of guilt (37)	❍	❍	❍	❍
Feelings that you are not always in your body 38)	❍	❍	❍	❍
Having trouble breathing (39)	❍	❍	❍	❍
Sexual feelings when you shouldn't have them (40)	❍	❍	❍	❍

APPENDIX E: Composite Abuse Scale (CAS)

In this section we ask about your relationships because it is an important part of your life that may influence your health. We ask you about your experiences in adult intimate relationships. By adult intimate relationship we mean husband/wife, partner or boy/girl friend for longer than 1 month.

Q22 Have you ever been in an adult intimate relationship? (Since you were 16 years of age)
- ❍ Yes (1)
- ❍ No (2)

If No Is Selected, Then Skip To Early Trauma Inventory Some people ca...

Q24 Are you currently in a relationship?
- ❍ Yes (1)
- ❍ No (2)

If No Is Selected, Then Skip To Have you ever been afraid of any part...

Q25 Are you currently afraid of your partner?
- ❍ Yes (1)
- ❍ No (2)

Q25 Have you ever been afraid of any partner?
- ❍ Yes (1)
- ❍ No (2)

Q26 We would like to know if you experienced any of the actions listed below and how often it happened during the past twelve months. If you were not with a partner in the past twelve months, could you please answer for the last partner that you had. Please circle the number, which matches the frequency, over a 12-month period, that it happened to you.

Q27 My Partner ;

	Never (1)	Only Once (2)	Several times (3)	Once Monthly (4)	Once a week (5)	Daily (6)
Told me that I wasn't good enough (1)	❍	❍	❍	❍	❍	❍
Kept me from medical care (2)	❍	❍	❍	❍	❍	❍
Followed me (3)	❍	❍	❍	❍	❍	❍
Tried to turn my family, friends and children against me (4)	❍	❍	❍	❍	❍	❍
Locked me in the bedroom (5)	❍	❍	❍	❍	❍	❍
Slapped me (6)	❍	❍	❍	❍	❍	❍
Raped me (7)	❍	❍	❍	❍	❍	❍
Told me that I was ugly (8)	❍	❍	❍	❍	❍	❍
Tried to keep me from seeing or talking to my family (9)	❍	❍	❍	❍	❍	❍
Threw me (10)	❍	❍	❍	❍	❍	❍
Hung around outside my house (11)	❍	❍	❍	❍	❍	❍
Blamed me for causing their violent behavior (12)	❍	❍	❍	❍	❍	❍
Harassed me over the telephone (13)	❍	❍	❍	❍	❍	❍
Shook me (14)	❍	❍	❍	❍	❍	❍
Tried to rape me (15)	❍	❍	❍	❍	❍	❍
Harassed me at work (16)	❍	❍	❍	❍	❍	❍
Pushed, grabbed or shoved me (17)	❍	❍	❍	❍	❍	❍
Used a knife or gun or other weapon (18)	❍	❍	❍	❍	❍	❍

Became upset if dinner/housework wasn't done when they thought it should be (19)	❍	❍	❍	❍	❍	❍
Told me that I was crazy (20)	❍	❍	❍	❍	❍	❍
Told me that no one would ever want me (21)	❍	❍	❍	❍	❍	❍
Took my wallet/purse and left me stranded (22)	❍	❍	❍	❍	❍	❍
Hit or tried to hit me with something (23)	❍	❍	❍	❍	❍	❍
Did not want me to socialize with my female friends (24)	❍	❍	❍	❍	❍	❍
Put foreign objects in my vagina/anus (25)	❍	❍	❍	❍	❍	❍
Refused to let me work outside the home (26)	❍	❍	❍	❍	❍	❍
Kicked me, bit me or hit me with a fist (27)	❍	❍	❍	❍	❍	❍
Tried to convince my friends, family or children that I was crazy (28)	❍	❍	❍	❍	❍	❍
Told me that I was stupid (29)	❍	❍	❍	❍	❍	❍
Beat me up (30)	❍	❍	❍	❍	❍	❍

APPENDIX F: Early Trauma Inventory-Self Report

Some people can talk about these things without much trouble, but some people may find it hard. Some people may find it so hard that they keep these things that hurt them secret for years. We have learned that from talking with people about these things that have happened to them, that it may also make them feel bad feelings when they become adults. So, it is really important to understand how it was for you when you were growing up. Do the best you can. This is not a test and there are no wrong answers.

Q362 Physical Punishment Sometimes people get spanked a lot, physically punished, or disciplined in a very strict way when they are growing up. Before the age of 18, did you ever experienced any of the following things. For each event you experienced before the age of 18, circle yes and the number that best corresponds to the number of times you experienced the event.

Q30 Were you ever spanked with a hand?
- ❍ Yes (1)
- ❍ No (2)

If No Is Selected, Then Skip To Were you ever slapped in the face wit...

Q31 How old were you the first time it occurred?
- ❍ Age 0-5 (1)
- ❍ Age 6-12 (2)
- ❍ Age 13-18 (3)

Q32 In general, how often did this occur?
- ❍ 1 time a year (1)
- ❍ 2-11 times a year (2)
- ❍ 1-3 times a month (3)
- ❍ 1-6 time a week (4)
- ❍ Once a day (5)
- ❍ More than 1 time a day (6)

Q39 Who was the person that most commonly did this?
- ❍ Mother/ Female Primary Caregiver (1)
- ❍ Father/Male Primary Caregiver (2)
- ❍ Other Female Adult (3)
- ❍ Other Male Adult (4)
- ❍ Brother (5)
- ❍ Sister (6)
- ❍ Male Stranger (7)
- ❍ Female Stranger (8)

Q34 What kind of effect did this have on you emotionally at the time it occurred?
- ❍ Extremely Negative (1)
- ❍ Moderately negative (2)
- ❍ Slightly negative (3)
- ❍ Neither (4)
- ❍ Slightly positive (5)
- ❍ Moderately positive (6)
- ❍ Extremely positive (7)

Q35 Were you ever slapped in the face with an open hand?
- ❍ Yes (1)
- ❍ No (2)

If No Is Selected, Then Skip To Were you ever burned with hot water, ...

Q37 How old were you the first time it occurred?
- ❍ Age 0-5 (1)
- ❍ Age 6-12 (2)
- ❍ Age 13-18 (3)

Q38 In general, how often did this occur?
- ❍ 1 time a year (1)
- ❍ 2-11 times a year (2)
- ❍ 1-3 times a month (3)
- ❍ 1-6 time a week (4)
- ❍ Once a day (5)
- ❍ More than 1 time a day (6)

Q282 Who was the person that most commonly did this?
- ❍ Mother/ Female Primary Caregiver (1)
- ❍ Father/Male Primary Caregiver (2)
- ❍ Other Female Adult (3)
- ❍ Other Male Adult (4)
- ❍ Brother (5)
- ❍ Sister (6)
- ❍ Male Stranger (7)
- ❍ Female Stranger (8)

Q40 What kind of effect did this have on you emotionally at the time it occurred?
- ❍ Extremely Negative (1)
- ❍ Moderately negative (2)
- ❍ Slightly negative (3)
- ❍ Neither (4)
- ❍ Slightly positive (5)
- ❍ Moderately positive (6)
- ❍ Extremely positive (7)

Q41 Were you ever burned with hot water, a cigarette or something else?
- ❍ Yes (1)
- ❍ No (2)

If No Is Selected, Then Skip To Were you ever punched or kicked?

Q43 How old were you the first time it occurred?
- ❍ Age 0-5 (1)
- ❍ Age 6-12 (2)
- ❍ Age 13-18 (3)

Q44 In general, how often did this occur?
- ❍ 1 time a year (1)
- ❍ 2-11 times a year (2)
- ❍ 1-3 times a month (3)
- ❍ 1-6 time a week (4)
- ❍ Once a day (5)
- ❍ More than 1 time a day (6)

Q45 Who was the person that most commonly did this?
- ❍ Mother/ Female Primary Caregiver (1)
- ❍ Father/Male Primary Caregiver (2)
- ❍ Other Female Adult (3)
- ❍ Other Male Adult (4)
- ❍ Brother (5)
- ❍ Sister (6)
- ❍ Male Stranger (7)
- ❍ Female Stranger (8)

Q46 What kind of effect did this have on you emotionally at the time it occurred?
- ❍ Extremely Negative (1)
- ❍ Moderately negative (2)
- ❍ Slightly negative (3)
- ❍ Neither (4)
- ❍ Slightly positive (5)
- ❍ Moderately positive (6)
- ❍ Extremely positive (7)

Q52 Were you ever punched or kicked?
- ❍ Yes (1)
- ❍ No (2)

If No Is Selected, Then Skip To Were you ever hit or spanked with an ...

Q75 How old were you the first time it occurred?
- ❍ Age 0-5 (1)
- ❍ Age 6-12 (2)
- ❍ Age 13-18 (3)

Q76 In general, how often did this occur?
- ❍ 1 time a year (1)
- ❍ 2-11 times a year (2)
- ❍ 1-3 times a month (3)
- ❍ 1-6 time a week (4)
- ❍ Once a day (5)
- ❍ More than 1 time a day (6)

Q77 Who was the person that most commonly did this?
- ❍ Mother/ Female Primary Caregiver (1)
- ❍ Father/Male Primary Caregiver (2)
- ❍ Other Female Adult (3)
- ❍ Other Male Adult (4)
- ❍ Brother (5)
- ❍ Sister (6)
- ❍ Male Stranger (7)
- ❍ Female Stranger (8)

Q78 What kind of effect did this have on you emotionally at the time it occurred?
- ❍ Extremely Negative (1)
- ❍ Moderately negative (2)
- ❍ Slightly negative (3)
- ❍ Neither (4)
- ❍ Slightly positive (5)
- ❍ Moderately positive (6)
- ❍ Extremely positive (7)

Q73 Were you ever hit or spanked with an object like a fly–swatter, a belt or a ruler?
- ❍ Yes (1)
- ❍ No (2)

If No Is Selected, Then Skip To Were you ever hit with an object that...

Q48 How old were you the first time it occurred?
- ❍ Age 0-5 (1)
- ❍ Age 6-12 (2)
- ❍ Age 13-18 (3)

Q275 In general, how often did this occur?
- 1 time a year (1)
- 2-11 times a year (2)
- 1-3 times a month (3)
- 1-6 time a week (4)
- Once a day (5)
- More than 1 time a day (6)

Q50 Who was the person that most commonly did this?
- Mother/ Female Primary Caregiver (1)
- Father/Male Primary Caregiver (2)
- Other Female Adult (3)
- Other Male Adult (4)
- Brother (5)
- Sister (6)
- Male Stranger (7)
- Female Stranger (8)

Q51 What kind of effect did this have on you emotionally at the time it occurred?
- Extremely Negative (1)
- Moderately negative (2)
- Slightly negative (3)
- Neither (4)
- Slightly positive (5)
- Moderately positive (6)
- Extremely positive (7)

Q57 Were you ever hit with an object that was thrown at you?
- Yes (1)
- No (2)

If No Is Selected, Then Skip To Were you ever choked?

Q53 How old were you the first time it occurred?
- Age 0-5 (1)
- Age 6-12 (2)
- Age 13-18 (3)

Q54 In general, how often did this occur?
- 1 time a year (1)
- 2-11 times a year (2)
- 1-3 times a month (3)
- 1-6 time a week (4)
- Once a day (5)
- More than 1 time a day (6)

Q55 Who was the person that most commonly did this?
- ❍ Mother/ Female Primary Caregiver (1)
- ❍ Father/Male Primary Caregiver (2)
- ❍ Other Female Adult (3)
- ❍ Other Male Adult (4)
- ❍ Brother (5)
- ❍ Sister (6)
- ❍ Male Stranger (7)
- ❍ Female Stranger (8)

Q56 What kind of effect did this have on you emotionally at the time it occurred?
- ❍ Extremely Negative (1)
- ❍ Moderately negative (2)
- ❍ Slightly negative (3)
- ❍ Neither (4)
- ❍ Slightly positive (5)
- ❍ Moderately positive (6)
- ❍ Extremely positive (7)

Q58 Were you ever choked?
- ❍ Yes (1)
- ❍ No (2)

If No Is Selected, Then Skip To Were you ever pushed or shoved?

Q59 How old were you the first time it occurred?
- ❍ Age 0-5 (1)
- ❍ Age 6-12 (2)
- ❍ Age 13-18 (3)

Q60 In general, how often did this occur?
- ❍ 1 time a year (1)
- ❍ 2-11 times a year (2)
- ❍ 1-3 times a month (3)
- ❍ 1-6 time a week (4)
- ❍ Once a day (5)
- ❍ More than 1 time a day (6)

Q61 Who was the person that most commonly did this?
- ❍ Mother/ Female Primary Caregiver (1)
- ❍ Father/Male Primary Caregiver (2)
- ❍ Other Female Adult (3)
- ❍ Other Male Adult (4)
- ❍ Brother (5)
- ❍ Sister (6)
- ❍ Male Stranger (7)
- ❍ Female Stranger (8)

Q62 What kind of effect did this have on you emotionally at the time it occurred?
- ❍ Extremely Negative (1)
- ❍ Moderately negative (2)
- ❍ Slightly negative (3)
- ❍ Neither (4)
- ❍ Slightly positive (5)
- ❍ Moderately positive (6)
- ❍ Extremely positive (7)

Q63 Were you ever pushed or shoved?
- ❍ Yes (1)
- ❍ No (2)

If No Is Selected, Then Skip To Were you ever tied up or locked in a ...

Q64 How old were you the first time it occurred?
- ❍ Age 0-5 (1)
- ❍ Age 6-12 (2)
- ❍ Age 13-18 (3)

Q65 In general, how often did this occur?
- ❍ 1 time a year (1)
- ❍ 2-11 times a year (2)
- ❍ 1-3 times a month (3)
- ❍ 1-6 time a week (4)
- ❍ Once a day (5)
- ❍ More than 1 time a day (6)

Q66 Who was the person that most commonly did this?
- ❍ Mother/ Female Primary Caregiver (1)
- ❍ Father/Male Primary Caregiver (2)
- ❍ Other Female Adult (3)
- ❍ Other Male Adult (4)
- ❍ Brother (5)
- ❍ Sister (6)
- ❍ Male Stranger (7)
- ❍ Female Stranger (8)

Q67 What kind of effect did this have on you emotionally at the time it occurred?
- ❍ Extremely Negative (1)
- ❍ Moderately negative (2)
- ❍ Slightly negative (3)
- ❍ Neither (4)
- ❍ Slightly positive (5)
- ❍ Moderately positive (6)
- ❍ Extremely positive (7)

Q68 Were you ever tied up or locked in a closet?
- ❍ Yes (1)
- ❍ No (2)

If No Is Selected, Then Skip To Did you endorsed "yes" to any of thes...

Q69 How old were you the first time it occurred?
- ❍ Age 0-5 (1)
- ❍ Age 6-12 (2)
- ❍ Age 13-18 (3)

Q70 In general, how often did this occur?
- ❍ 1 time a year (1)
- ❍ 2-11 times a year (2)
- ❍ 1-3 times a month (3)
- ❍ 1-6 time a week (4)
- ❍ Once a day (5)
- ❍ More than 1 time a day (6)

Q71 Who was the person that most commonly did this?
- ❍ Mother/ Female Primary Caregiver (1)
- ❍ Father/Male Primary Caregiver (2)
- ❍ Other Female Adult (3)
- ❍ Other Male Adult (4)
- ❍ Brother (5)
- ❍ Sister (6)
- ❍ Male Stranger (7)
- ❍ Female Stranger (8)

Q72 What kind of effect did this have on you emotionally at the time it occurred?
- ❍ Extremely Negative (1)
- ❍ Moderately negative (2)
- ❍ Slightly negative (3)
- ❍ Neither (4)
- ❍ Slightly positive (5)
- ❍ Moderately positive (6)
- ❍ Extremely positive (7)

Q81 Did you endorsed "yes" to any of these events involving being spanked, sternly disciplined or physically punished.
- ❍ Yes (1)
- ❍ No (2)

If No Is Selected, Then Skip To Emotional Abuse before the age of 18

Q86 Think about what effect these events may have on you today. Do you believe these events have an effect on you emotionally today?
- ❍ Yes (1)
- ❍ No (2)

If No Is Selected, Then Skip To Do you believe these events affect yo...

Q83 What kind of effect did these experiences have on you emotionally?
- ❍ Extremely Negative (1)
- ❍ Moderately negative (2)
- ❍ Slightly negative (3)
- ❍ Neither (4)
- ❍ Slightly positive (5)
- ❍ Moderately positive (6)
- ❍ Extremely positive (7)

Q87 Do you believe these events affect your current functioning at school or work?
- ❍ Yes (1)
- ❍ No (2)

If No Is Selected, Then Skip To Do you believe these events have an e...

Q84 What kind of effect ?
- ❍ Extremely Negative (1)
- ❍ Moderately negative (2)
- ❍ Slightly negative (3)
- ❍ Neither (4)
- ❍ Slightly positive (5)
- ❍ Moderately positive (6)
- ❍ Extremely positive (7)

Q88 Do you believe these events have an effect on your current social or family relationships?
- ❍ Yes (1)
- ❍ No (2)

If No Is Selected, Then Skip To Emotional Abuse before the age of 18

Q91 If yes what kind of effect?
- ❍ Extremely Negative (1)
- ❍ Moderately negative (2)
- ❍ Slightly negative (3)
- ❍ Neither (4)
- ❍ Slightly positive (5)
- ❍ Moderately positive (6)
- ❍ Extremely positive (7)

Q92 Emotional Abuse Sometimes while growing up people feel as if they can't do anything right in their parent's eyes. Their parents were always putting them down, yelling at them or telling them that they were no good. Do you recall whether anything like this happened to you before the age of 18? Before the age of 18, did you ever experience any of the following things. For each event you experienced before the age of 18, indicate yes and the number best corresponds to the number of times you experienced the event.

Q90 Were you often put down or ridiculed?
- ❍ Yes (1)
- ❍ No (2)

If No Is Selected, Then Skip To Were you often ignored or made to fee...

Q99 How old were you the first time it occurred?
- ❍ Age 0-5 (1)
- ❍ Age 6-12 (2)
- ❍ Age 13-18 (3)

Q102 In general, how often did this occur?
- 1 time a year (1)
- 2-11 times a year (2)
- 1-3 times a month (3)
- 1-6 time a week (4)
- Once a day (5)
- More than 1 time a day (6)

Q110 Who was the person that most commonly did this?
- Mother/ Female Primary Caregiver (1)
- Father/Male Primary Caregiver (2)
- Other Female Adult (3)
- Other Male Adult (4)
- Brother (5)
- Sister (6)
- Male Stranger (7)
- Female Stranger (8)

Q131 What kind of effect did this have on you emotionally at the time it occurred?
- Extremely Negative (1)
- Moderately negative (2)
- Slightly negative (3)
- No effect (4)
- Slightly positive (5)
- Moderately positive (6)
- Extremely positive (7)

Q123 Were you often ignored or made to feel that you didn't count?
- Yes (1)
- No (2)

If No Is Selected, Then Skip To Were you often told you were no good?

Q133 How old were you the first time this occurred?
- 0 to 5 years (1)
- 6 to 12 years (2)
- 13 to 18 years (3)

Q125 In general how often did this occur?
- 1 time a year (1)
- 2 to 11 times a year (2)
- 1 to 3 times a month (3)
- 1 to 6 times a week (4)
- once a day (5)
- More than once a day (6)

Q127 Who was the person that most commonly did this?
- ❍ Mother/ Female Primary Caregiver (1)
- ❍ Father/Male Primary Caregiver (2)
- ❍ Other Female Adult (3)
- ❍ Other Male Adult (4)
- ❍ Brother (5)
- ❍ Sister (6)
- ❍ Male Stranger (7)
- ❍ Female Stranger (8)

Q119 What kind of effect did this have on you emotionally at the time it occurred?
- ❍ Extremely Negative (1)
- ❍ Moderately negative (2)
- ❍ Slightly negative (3)
- ❍ Neither (4)
- ❍ Slightly positive (5)
- ❍ Moderately positive (6)
- ❍ Extremely positive (7)

Q135 Were you often told you were no good?
- ❍ Yes (1)
- ❍ No (2)

If No Is Selected, Then Skip To Were you often shouted or yelled at?

Q124 How old were you the first time this occurred?
- ❍ 0 to 5 years (1)
- ❍ 6 to 12 years (2)
- ❍ 13 to 18 years (3)

Q134 In general how often did this occur?
- ❍ 1 time a year (1)
- ❍ 2 to 11 times a year (2)
- ❍ 1 to 3 times a month (3)
- ❍ 1 to 6 times a week (4)
- ❍ once a day (5)
- ❍ More than once a day (6)

Q252 Who was the person that most commonly did this?
- ❍ Mother/ Female Primary Caregiver (1)
- ❍ Father/Male Primary Caregiver (2)
- ❍ Other Female Adult (3)
- ❍ Other Male Adult (4)
- ❍ Brother (5)
- ❍ Sister (6)
- ❍ Male Stranger (7)
- ❍ Female Stranger (8)

Q276 What kind of effect did this have on you emotionally at the time it occurred?
- ❍ Extremely Negative (1)
- ❍ Moderately negative (2)
- ❍ Slightly negative (3)
- ❍ Neither (4)
- ❍ Slightly positive (5)
- ❍ Moderately positive (6)
- ❍ Extremely positive (7)

Q122 Were you often shouted or yelled at?
- ❍ Yes (1)
- ❍ No (2)

If No Is Selected, Then Skip To Most of the time were you treated in ...

Q111 How old were you the first time it occurred?
- ❍ Age 0-5 (1)
- ❍ Age 6-12 (2)
- ❍ Age 13-18 (3)

Q112 In general, how often did this occur?
- ❍ 1 time a year (1)
- ❍ 2-11 times a year (2)
- ❍ 1-3 times a month (3)
- ❍ 1-6 time a week (4)
- ❍ Once a day (5)
- ❍ More than 1 time a day (6)

Q118 Who was the person that most commonly did this?
- ❍ Mother/female primary caregiver (1)
- ❍ Father/Male primary caregiver (2)
- ❍ Other female Adult (3)
- ❍ Other Male Adult (4)
- ❍ Brother (5)
- ❍ Sister (6)
- ❍ Male Stranger (7)
- ❍ Female Stranger (8)

Q137 What kind of effect did this have on you emotionally at the time it occurred?
- ❍ Extremely Negative (1)
- ❍ Moderately negative (2)
- ❍ Slightly negative (3)
- ❍ Neutral (4)
- ❍ Slightly positive (5)
- ❍ Moderately positive (6)
- ❍ Extremely positive (7)

Q113 Most of the time were you treated in a cold, uncaring way or made to feel like you were not loved?
- ❍ Yes (1)
- ❍ No (2)

If No Is Selected, Then Skip To Did your parents or caretakers usuall...

Q114 How old were you the first time it occurred?
- ❍ 0 to 5 years (1)
- ❍ 6 to 12 years (2)
- ❍ 13 to 18 years (3)

Q104 In general, how often did this occur?
- ❍ 1 time a year (1)
- ❍ 2-11 times a year (2)
- ❍ 1-3 times a month (3)
- ❍ 1-6 time a week (4)
- ❍ Once a day (5)
- ❍ More than 1 time a day (6)

Q138 Who was the person that most commonly did this?
- ❍ Mother/Female Primary Caregiver (1)
- ❍ Father/Male primary caregiver (2)
- ❍ Other Female Adult (3)
- ❍ Other Male Adult (4)
- ❍ Brother (5)
- ❍ Sister (6)
- ❍ Male Stranger (7)
- ❍ Female Stranger (8)

Q139 What kind of effect did this have on you emotionally at the time it occurred?
- ❍ Extremely Negative (1)
- ❍ Moderately negative (2)
- ❍ Slightly negative (3)
- ❍ Neither positive nor negative (4)
- ❍ Slightly positive (5)
- ❍ Moderately positive (6)
- ❍ Extremely positive (7)

Q140 Did your parents or caretakers usually control areas of your life (e.g. clothing, activities etc.) that other kids handled on their own?
- ❍ Yes (1)
- ❍ No (2)

If No Is Selected, Then Skip To Did your parents or caretakers often ...

Q141 How old were you when this first occurred?
- ❍ 0 to 5 years (1)
- ❍ 6 to 12 years (2)
- ❍ 13 to 18 years (3)

Q105 In general, how often did this occur?
- ❍ 1 time a year (1)
- ❍ 2-11 times a year (2)
- ❍ 1-3 times a month (3)
- ❍ 1-6 time a week (4)
- ❍ Once a day (5)
- ❍ More than 1 time a day (6)

Q143 Who was the person that most commonly did this?
- ❍ Mother/Female Primary Caregiver (1)
- ❍ Father/Male Primary Caregiver (2)
- ❍ Other Female Adult (3)
- ❍ Other Male Adult (4)
- ❍ Brother (5)
- ❍ Sister (6)
- ❍ Male Stranger (7)
- ❍ Female Stranger (8)

Q144 What kind of effect did this have on you emotionally at the time it occurred?
- ❍ Extremely Negative (1)
- ❍ Moderately negative (2)
- ❍ Slightly negative (3)
- ❍ Neither positive nor negative (4)
- ❍ Slightly positive (5)
- ❍ Moderately positive (6)
- ❍ Extremely positive (7)

Q145 Did your parents or caretakers often fail to understand you or your needs?
- ❍ Yes (1)
- ❍ No (2)

If No Is Selected, Then Skip To If you endorsed "yes" for any of thes...

Q149 How old were you when this first occurred?
- ❍ 0 to 5 years (1)
- ❍ 6 to 12 years (2)
- ❍ 13 to 18 years (3)

Q106 In general, how often did this occur?
- ❍ 1 time a year (1)
- ❍ 2-11 times a year (2)
- ❍ 1-3 times a month (3)
- ❍ 1-6 time a week (4)
- ❍ Once a day (5)
- ❍ More than 1 time a day (6)

Q146 Who is the person that most commonly did this?
- ❍ Mother/Female Primary caregiver (1)
- ❍ Father/Male Primary caregiver (2)
- ❍ Other female Adult (3)
- ❍ Other male adult (4)
- ❍ Brother (5)
- ❍ Sister (6)
- ❍ Male Stranger (7)
- ❍ Female Stranger (8)

Q148 What kind of effect did this have on you emotionally at the time it occurred?
- ❍ Extremely Negative (1)
- ❍ Moderately negative (2)
- ❍ Slightly negative (3)
- ❍ Neither positive nor negative (4)
- ❍ Slightly positive (5)
- ❍ Moderately positive (6)
- ❍ Extremely positive (7)

Q150 Did you endorse "yes" for any of these events such as being put down, mistreated, or in other ways emotionally mistreated? If yes think about what effects these may have on you today.
- ❍ Yes (1)
- ❍ No (2)

If No Is Selected, Then Skip To Sexual Events Before the age of 18

Q151 Do you believe that these events have an effect on you emotionally today?
- ❍ Yes (1)
- ❍ No (2)

If No Is Selected, Then Skip To Do you believe that these events affe...

Q152 If yes what kind of effect?
- ❍ Extremely Negative (1)
- ❍ Moderately negative (2)
- ❍ Slightly negative (3)
- ❍ Neither positive nor negative (4)
- ❍ Slightly positive (5)
- ❍ Moderately positive (6)
- ❍ Extremely positive (7)

Q153 Do you believe that these events affect your current functioning at school or work?
- ❍ Yes (1)
- ❍ No (2)

If No Is Selected, Then Skip To Do you believe these events affect yo...

Q154 If yes, what kind of effect?
- ❍ Extremely Negative (1)
- ❍ Moderately negative (2)
- ❍ Slightly negative (3)
- ❍ Neither positive nor negative (4)
- ❍ Slightly positive (5)
- ❍ Moderately positive (6)
- ❍ Extremely positive (7)

Q155 Do you believe these events affect your current social or family relationships?
- ❍ Yes (1)
- ❍ No (2)

If No Is Selected, Then Skip To Sexual Events While growing up people...

Q156 If yes, what kind of effect?
- ❍ Extremely Negative (1)
- ❍ Moderately negative (2)
- ❍ Slightly negative (4)
- ❍ Neither positive nor negative (5)
- ❍ Slightly positive (6)
- ❍ Moderately positive (7)
- ❍ Extremely positive (8)

Q157 Sexual Events While growing up people may have had sexual experiences that they didn't want to have or that made them uncomfortable. Sometimes these experiences are with people they know and sometimes with strangers. Do you recall whether anything like that ever happened to you before the age of 18? Before the age of 18, did you ever experienced any of the following things. For each event you experienced before the age of 18, circle yes and the number that best corresponds to the number of times you experienced the event.

Q147 Were you ever exposed to inappropriate comments about sex or sexual parts as a child?
- ❍ Yes (1)
- ❍ No (2)

If No Is Selected, Then Skip To Were you ever exposed to someone "fla...

Q159 How old were you the first time it occurred?
- ❍ 0 to 5 years (1)
- ❍ 6 to 12 years (2)
- ❍ 13 to 18 years (3)

Q279 In general how often did this happen?
- 1 time a year (1)
- 1 to 11 times a year (2)
- 1 to 3 times a month (3)
- 1 to 6 times a week (4)
- once a day (5)
- more than 1 time a day (6)

Q103 Who was the person that most commonly did this?
- Mother/ Female Primary Caregiver (1)
- Father/Male Primary Caregiver (2)
- Other Female Adult (3)
- Other Male Adult (4)
- Brother (5)
- Sister (6)
- Male Stranger (7)
- Female Stranger (8)

Q158 What kind of effect did this have on you emotionally at the time it occurred?
- Extremely Negative (1)
- Moderately negative (2)
- Slightly negative (3)
- Neither positive nor negative (4)
- Slightly positive (5)
- Moderately positive (6)
- Extremely positive (7)

Q94 Were you ever exposed to someone "flashing" or exposing their sexual parts to you?
- Yes (1)
- No (2)

If No Is Selected, Then Skip To Did anyone ever spy on you or watch y...

Q278 How old were you the first time it occurred?
- 0 to 5 years (1)
- 6 to 12 years (2)
- 13 to 18 years (3)

Q160 In general how often did this happen?
- 1 time a year (1)
- 1 to 11 times a year (2)
- 1 to 3 times a month (3)
- 1 to 6 times a week (4)
- once a day (5)
- more than 1 time a day (6)

Q161 Who was the person that most commonly did this?
- ❍ Mother/Female Primary Caregiver (1)
- ❍ Father/Male Primary Caregiver (2)
- ❍ Other female Adult (3)
- ❍ Other Male Adult (4)
- ❍ Brother (5)
- ❍ Sister (6)
- ❍ Male Stranger (7)
- ❍ Female Stranger (8)

Q162 What kind of effect did this have on you emotionally at the time it occurred?
- ❍ Extremely Negative (1)
- ❍ Moderately negative (2)
- ❍ Slightly negative (3)
- ❍ Neither positive nor negative (4)
- ❍ Slightly positive (5)
- ❍ Moderately positive (6)
- ❍ Extremely positive (7)

Q254 Did anyone ever spy on you or watch you while you were bathing, dressing or using the bathroom?
- ❍ Yes (1)
- ❍ No (2)

If No Is Selected, Then Skip To Were you ever forced or coerced to wa...

Q255 How old were you the first time it occurred?
- ❍ 0 to 5 years old (1)
- ❍ 6 to 12 years old (2)
- ❍ 13 to 18 years old (3)

Q256 In general how often did it occur?
- ❍ 1 time a year (1)
- ❍ 2 to 11 times a year (2)
- ❍ 1 to 3 times a month (3)
- ❍ 1 to 6 times a week (4)
- ❍ once a day (5)
- ❍ more than 1 time a day (6)

Q257 Who was the person that most commonly did this?
- ❍ Mother/Female Primary caregiver (1)
- ❍ Father/Male Primary Caregiver (2)
- ❍ Other Female Adult (3)
- ❍ Other Male Adult (4)
- ❍ Brother (5)
- ❍ Sister (6)
- ❍ Male Stranger (7)
- ❍ Female Stranger (8)

Q258 What kind of effect did this have on you emotionally at the time it occurred?
- ❍ Extremely Negative (1)
- ❍ Moderately negative (2)
- ❍ Slightly negative (3)
- ❍ Neither positive nor negative (4)
- ❍ Slightly positive (5)
- ❍ Moderately positive (6)
- ❍ Extremely positive (7)

Q283 Were you ever forced or coerced to watch sexual acts including masturbation and/or sex between other people?
- ❍ Yes (1)
- ❍ No (2)

If No Is Selected, Then Skip To Were you ever touched in an intimate ...

Q163 How old were you the first time it occurred?
- ❍ 0 to 5 years (1)
- ❍ 6 to 12 years (2)
- ❍ 13 to 18 year (3)

Q164 In general how often did this occur?
- ❍ 1 time a year (1)
- ❍ 2 to 11 times a year (2)
- ❍ 1 to 3 times a month (3)
- ❍ 1 to 6 times a week (4)
- ❍ once a day (5)
- ❍ more than 1 time a day (6)

Q165 Who was the person that most commonly did this?
- ❍ Mother/Female Primary Caregiver (1)
- ❍ Father/Male Primary Caregiver (2)
- ❍ Other Female Adult (3)
- ❍ Other Male Adult (4)
- ❍ Brother (5)
- ❍ Sister (6)
- ❍ Male Stranger (7)
- ❍ Female Stranger (8)

Q259 What kind of effect did this have on you emotionally at the time it occurred?
- ❍ Extremely Negative (1)
- ❍ Moderately negative (2)
- ❍ Slightly negative (3)
- ❍ Neither positive nor negative (4)
- ❍ Slightly positive (5)
- ❍ Moderately positive (6)
- ❍ Extremely positive (7)

Q260 Were you ever touched in an intimate or private part of your body (e.g. breast, thighs, genitals) in a way that surprised you or made you feel uncomfortable?
- ❍ Yes (1)
- ❍ No (2)

If No Is Selected, Then Skip To Did you ever experience someone rubbi...

Q261 How old were you the first time it occurred?
- ❍ 0 to 5 years (1)
- ❍ 6 to 12 years (2)
- ❍ 13 to 18 years (3)

Q168 In general how often did this occur?
- ❍ 1 time a year (1)
- ❍ 2 to 11 times a year (2)
- ❍ 1 to 3 times a month (3)
- ❍ 1 to 6 times a week (4)
- ❍ once a day (5)
- ❍ more than 1 time a day (6)

Q263 Who was the person that most commonly did this?
- ❍ Mother/Female Primary Caregiver (1)
- ❍ Father/Male Primary Caregiver (2)
- ❍ Other Female Adult (3)
- ❍ Other Male Adult (4)
- ❍ Brother (5)
- ❍ Sister (6)
- ❍ Male Stranger (7)
- ❍ Female Stranger (8)

Q264 What kind of effect did this have on you emotionally at the time it occurred?
- ❍ Extremely Negative (1)
- ❍ Moderately negative (2)
- ❍ Slightly negative (3)
- ❍ Neither positive nor negative (4)
- ❍ Slightly positive (5)
- ❍ Moderately positive (6)
- ❍ Extremely positive (7)

Q166 Did you ever experience someone rubbing their genitals against you?
- ❍ Yes (1)
- ❍ No (2)

If No Is Selected, Then Skip To Were you ever forced or coerced to to...

Q167 How old were you the first time it occurred?
- ❍ 0 to 5 years (1)
- ❍ 6 to 12 years (2)
- ❍ 13 to 18 years (3)

Q262 In general how often did this occur?
- ❍ 1 time a year (1)
- ❍ 2 to 11 times a year (2)
- ❍ 1 to 3 times a month (3)
- ❍ 1 to 6 times a week (4)
- ❍ once a day (5)
- ❍ more than 1 time a day (6)

Q169 Who was the person that most commonly did this?
- ❍ Mother/Female Primary Caregiver (1)
- ❍ Father/Male Primary Caregiver (2)
- ❍ Other Female Adult (3)
- ❍ Other Male Adult (4)
- ❍ Brother (5)
- ❍ Sister (6)
- ❍ Male Stranger (7)
- ❍ Female Stranger (8)

Q170 What kind of effect did this have on you emotionally at the time it occurred?
- ❍ Extremely Negative (1)
- ❍ Moderately negative (2)
- ❍ Slightly negative (3)
- ❍ Neither positive nor negative (4)
- ❍ Slightly positive (5)
- ❍ Moderately positive (6)
- ❍ Extremely positive (7)

Q96 Were you ever forced or coerced to touch another person in an intimate or private part of their body?
- ❍ Yes (1)
- ❍ No (2)

If No Is Selected, Then Skip To Did anyone ever have genital sex with...

Q171 How old were you the first time it occurred?
- ❍ 0 to 5 years (1)
- ❍ 6 to 12 years (2)
- ❍ 13 to 18 years (3)

Q176 In general how often did this occur?
- ❍ 1 time a year (1)
- ❍ 2 to 11 times a year (2)
- ❍ 1 to 3 times a month (3)
- ❍ 1 to 6 times a week (4)
- ❍ once a day (5)
- ❍ more than 1 time a day (6)

Q177 Who was the person that most commonly did this?
- ❍ Mother/Female Primary Caregiver (1)
- ❍ Father/Male Primary Caregiver (2)
- ❍ Other Female Adult (3)
- ❍ Other Male Adult (4)
- ❍ Brother (5)
- ❍ SIster (6)
- ❍ Male Stranger (7)
- ❍ Female Stranger (8)

Q178 What kind of effect did this have on you emotionally at the time it occurred?
- ❍ Extremely Negative (1)
- ❍ Moderately negative (2)
- ❍ Slightly negative (3)
- ❍ Neither positive nor negative (4)
- ❍ Slightly positive (5)
- ❍ Moderately positive (6)
- ❍ Extremely positive (7)

Q97 Did anyone ever have genital sex with you against your will?
- ❍ Yes (1)
- ❍ No (2)

If No Is Selected, Then Skip To Were you ever forced or coerced to pe...

Q253 How old were you the first time it occurred?
- ❍ 0 to 5 years (1)
- ❍ 6 to 12 years (2)
- ❍ 13 to 18 years (3)

Q179 In general how often did this occur?
- ❍ 0 to 5 years (1)
- ❍ 6 to 12 years (2)
- ❍ 13 to 18 years (3)

Q180 Who was the person that most commonly did this?
- ❍ Mother/Female Primary caregiver (1)
- ❍ Father/Male Primary Caregiver (2)
- ❍ Other Female Adult (3)
- ❍ Other Male Adult (4)
- ❍ Brother (5)
- ❍ Sister (6)
- ❍ Male Stranger (7)
- ❍ Female Stranger (8)

Q181 What kind of effect did this have on you emotionally at the time it occurred?
- ❍ Extremely Negative (1)
- ❍ Moderately negative (2)
- ❍ Slightly negative (3)
- ❍ Neither positive nor negative (4)
- ❍ Slightly positive (5)
- ❍ Moderately positive (6)
- ❍ Extremely positive (7)

Q265 Were you ever forced or coerced to perform oral sex on someone against your will?
- ❍ Yes (1)
- ❍ No (2)

If No Is Selected, Then Skip To Did anyone perform oral sex on you ag...

Q266 How old were you the first time it occurred?
- ❍ 0 to 5 years (1)
- ❍ 6 to 12 years (2)
- ❍ 13 to 18 years (3)

Q267 In general, how often did this occur?
- ❍ 1 time a year (1)
- ❍ 2 to 11 times a year (2)
- ❍ 1 to 3 times a month (3)
- ❍ 1 to 6 times a week (4)
- ❍ once a day (5)
- ❍ more than 1 time a day (6)

Q268 Who is the person that most commonly did this?
- ❍ Mother/Female Primary Caregiver (1)
- ❍ Father/Male Primary Caregiver (2)
- ❍ Other Female Adult (3)
- ❍ Other Male Adult (4)
- ❍ Brother (5)
- ❍ Sister (6)
- ❍ Male Stranger (7)
- ❍ Female Stranger (8)

Q275 What kind of effect did this have on you emotionally at the time it occurred?
- ❍ Extremely Negative (1)
- ❍ Moderately negative (2)
- ❍ Slightly negative (3)
- ❍ Neutral (4)
- ❍ Slightly positive (5)
- ❍ Moderately positive (6)
- ❍ Extremely positive (7)

Q291 Did anyone perform oral sex on you against your will?
- ❍ Yes (1)
- ❍ No (3)

If No Is Selected, Then Skip To Did anyone ever have anal sex with yo...

Q302 How old were you the first time it occurred?
- ❍ 0 to 5 years (1)
- ❍ 6 to 12 years (2)
- ❍ 13 to 18 years (3)

Q301 In general how often did this occur?
- ❍ 1 time a year (1)
- ❍ 2 to 11 times a year (2)
- ❍ 1 to 3 times a month (3)
- ❍ 1 to 6 times a week (4)
- ❍ once a day (5)
- ❍ more than one time a day (6)

Q300 Who was the person that most commonly did this?
- ❍ Mother/Female Primary caregiver (1)
- ❍ Father/Male Primary caregiver (2)
- ❍ Other female Adult (3)
- ❍ Other Male Adult (4)
- ❍ Brother (5)
- ❍ Sister (6)
- ❍ Male Stranger (7)
- ❍ Female Stranger (8)

Q299 What kind of effect did this have on you emotionally at the time it occurred?
- ❍ Extremely Negative (1)
- ❍ Moderately Negative (2)
- ❍ Slightly Negative (3)
- ❍ No effect (4)
- ❍ Slightly Positive (5)
- ❍ Moderately Positive (6)
- ❍ Extremely Positive (7)

Q172 Did anyone ever have anal sex with you against your will?
- ❍ Yes (1)
- ❍ No (2)

If No Is Selected, Then Skip To Did anyone ever try to have any type ...

Q189 How old were you the first time it occurred?
- ❍ 0 to 5 years (1)
- ❍ 6 to 12 years (2)
- ❍ 13 to 18 years (3)

Q188 In general how often did this occur?
- ❍ 1 time a year (1)
- ❍ 2 to 11 times a year (2)
- ❍ 1 to 3 times a month (3)
- ❍ 1 to 6 times a week (4)
- ❍ once a day (5)
- ❍ more than 1 time a day (6)

Q187 Who was the person that most commonly did this?
- ❍ Mother/Female primary caregiver (1)
- ❍ Father/Male primary caregiver (2)
- ❍ Other Female Adult (3)
- ❍ Other Male Adult (4)
- ❍ Brother (5)
- ❍ Sister (6)
- ❍ Male Stranger (7)
- ❍ Female Stranger (8)

Q190 What kind of effect did this have on you emotionally at the time it occurred?
- ❍ Extremely Negative (1)
- ❍ Moderately negative (2)
- ❍ Slightly negative (3)
- ❍ Neither positive nor negative (4)
- ❍ Slightly positive (5)
- ❍ Moderately positive (6)
- ❍ Extremely positive (7)

Q186 Did anyone ever try to have any type of sex with you (oral, anal, genital) against your will but did not actual do so?
- ❍ Yes (1)
- ❍ No (2)

If No Is Selected, Then Skip To Were you ever made to pose for sexy o...

Q191 How old were you the first time this occurred?
- ❍ 0 to 5 years (1)
- ❍ 6 to 12 years (2)
- ❍ 13 to 18 years (3)

Q192 In general how often did this occur?
- 1 time a year (1)
- 2 to 11 times a year (2)
- 1 to 3 times a month (3)
- 1 to 6 times a week (4)
- once a day (5)
- more than 1 time a day (6)

Q193 Who was the person that most commonly did this?
- Mother/Female Primary Caregiver (1)
- Father/Male Primary Caregiver (2)
- Other Female Adult (3)
- Other Male Adult (4)
- Brother (5)
- Sister (6)
- Male Stranger (7)
- Female Stranger (8)

Q194 What kind of effect did this have on you emotionally at the time this occurred?
- Extremely Negative (1)
- Moderately negative (2)
- Slightly negative (3)
- Neither positive nor negative (4)
- Slightly positive (5)
- Moderately positive (6)
- Extremely positive (7)

Q173 Were you ever made to pose for sexy or suggestive photographs?
- Yes (1)
- No (2)

If No Is Selected, Then Skip To Were you ever forced or coerced to pe...

Q195 How old were you the first time it occurred?
- 0 to 5 years (1)
- 6 to 12 years (2)
- 13 to 18 (3)

Q196 In general how often did this occur?
- 1 time a year (1)
- 2 to 11 times a year (2)
- 1 to 3 times a month (3)
- 1 to 6 times a week (4)
- once a day (5)
- more than 1 time a day (6)

Q197 Who was the person that most commonly did this?
- ❍ Mother/Female Primary Caregiver (1)
- ❍ Father/Male Primary Caregiver (2)
- ❍ Other Female Adult (3)
- ❍ Other Male Adult (4)
- ❍ Brother (5)
- ❍ SIster (6)
- ❍ Male Stranger (7)
- ❍ Female Stranger (8)

Q198 What kind of effect did this have on you emotionally at the time it occurred?
- ❍ Extremely Negative (1)
- ❍ Moderately negative (2)
- ❍ Slightly negative (3)
- ❍ Neither positive nor negative (4)
- ❍ Slightly positive (5)
- ❍ Moderately positive (6)
- ❍ Extremely positive (7)

Q270 Were you ever forced or coerced to perform sexual acts for money?
- ❍ Yes (1)
- ❍ No (2)

If No Is Selected, Then Skip To Were you forced or coerced to kiss so...

Q274 How old were you the first time it occurred?
- ❍ 0 to 5 years (1)
- ❍ 6 to 12 years (2)
- ❍ 13 to 18 years (3)

Q273 In general how often did this occur?
- ❍ 1 time a year (1)
- ❍ 2 to 11 times a year (2)
- ❍ 1 to 3 times a month (3)
- ❍ 1 to 6 times a week (4)
- ❍ Once a day (5)
- ❍ more than 1 time a day (6)

Q272 Who was the person that most commonly did this?
- ❍ Mother/Female Primary Caregiver (1)
- ❍ Father/Male Primary Caregiver (2)
- ❍ Other Female Adult (3)
- ❍ Other Male Adult (4)
- ❍ Brother (5)
- ❍ Sister (6)
- ❍ Male Stranger (7)
- ❍ Female Stranger (8)

Q271 What kind of effect did this have on you emotionally at the time it occurred?
- ❍ Extremely Negative (1)
- ❍ Moderately Negative (2)
- ❍ Slightly Negative (3)
- ❍ Neutral (4)
- ❍ Slightly positive (5)
- ❍ Moderately positive (6)
- ❍ Extremely positive (7)

Q199 Were you forced or coerced to kiss someone in a sexual rather than an affectionate way?
- ❍ Yes (1)
- ❍ No (2)

If No Is Selected, Then Skip To If you endorsed "yes" for any of thes...

Q201 How old were you the first time it occurred?
- ❍ 0 to 5 years (1)
- ❍ 6 to 12 years (2)
- ❍ 13 to 18 years (3)

Q200 In general how often did this occur?
- ❍ 1 time a year (1)
- ❍ 2 to 11 times a year (2)
- ❍ 1 to 3 times a month (3)
- ❍ 1 to 6 times a week (4)
- ❍ once a day (5)
- ❍ more than 1 time a day (6)

Q202 Who was the person that most commonly did this?
- ❍ Mother/Female Primary caregiver (1)
- ❍ Father/Male Primary caregiver (2)
- ❍ Other Female Adult (3)
- ❍ Other Male Adult (4)
- ❍ Brother (5)
- ❍ Sister (6)
- ❍ Male Stranger (7)
- ❍ Female Stranger (8)

Q174 What kind of effect did this have on you emotionally at the time it occurred?
- ❍ Extremely Negative (1)
- ❍ Moderately negative (2)
- ❍ Slightly negative (3)
- ❍ Neutral (12)
- ❍ Slightly positive (13)
- ❍ Moderately positive (14)
- ❍ Extremely positive (15)

Q175 Did you endorsed "yes" for any of these events reviewed above involved sexual activities?
- ❍ Yes (1)
- ❍ No (2)

If No Is Selected, Then Skip To End of Block

Q303 Think about what effects these experiences may have had on you today. Do you believe these events have an effect on you emotionally today?
- ❍ Yes (1)
- ❍ No (3)

If No Is Selected, Then Skip To Do you believe these events affect yo...

Q206 If yes, what kind of effect are you experiencing?
- ❍ Extremely Negative (1)
- ❍ Moderately negative (2)
- ❍ Slightly negative (3)
- ❍ Neutral (4)
- ❍ Slightly positive (5)
- ❍ Moderately positive (6)
- ❍ Extremely positive (7)

Q204 Do you believe these events affect your current functioning at school or at work?
- ❍ Yes (1)
- ❍ No (2)

If No Is Selected, Then Skip To Do you believe these events affect yo...

Q207 If yes, what kind of effect are you experiencing?
- ❍ Extremely Negative (1)
- ❍ Moderately negative (2)
- ❍ Slightly negative (3)
- ❍ Neutral (4)
- ❍ Slightly positive (5)
- ❍ Moderately positive (6)
- ❍ Extremely positive (7)

Q205 Do you believe these events affect your current social or family relationships?
- ❍ Yes (1)
- ❍ No (2)

If No Is Selected, Then Skip To End of Block

Q208 If yes, what kind of effect are you experiencing?
- ❍ Extremely Negative (1)
- ❍ Moderately negative (2)
- ❍ Slightly negative (3)
- ❍ Neutral (4)
- ❍ Slightly positive (5)
- ❍ Moderately positive (6)
- ❍ Extremely positive (7)

Q363 The Counseling Center is located in the Citizens Trust Building (next to the University Commons) at 75 Piedmont Avenue, N.E., Suite 200A. To arrange for an initial appointment, please call (404) 413-1653.

APPENDIX G: Retrospective Bullying Questionnaire

The following questions are about bullying. Bullying is intentional hurtful behavior. It can be physical or psychological. It is often repeated and characterized by an inequality of power so that it is difficult for the victim to defend him/herself.

Q334 Please think back to your school days. You may have seen some bullying at school, and you may have been involved in some way. Indicate the choice which best describes your own experiences at school.

- ❍ I was not involved at all, and I never saw it happen (1)
- ❍ I was not involved at all but I saw it happen sometimes (2)
- ❍ I would sometimes join in bullying others (3)
- ❍ I would sometimes get bullied by others (4)
- ❍ At various times, I was both a bully and a victim (5)

Q335 PRIMARY/ELEMENTARY SCHOOL This part deals with experiences at primary school (age 4- 11 years).

Q336 Primary School Experiences

	Detested (1)	disliked (2)	Neutral (3)	Liked a bit (4)	Liked a lot (5)
Did you have a happy time at primary school? (1)	❍	❍	❍	❍	❍
Did you have a happy time at home with your family while in primary school? (2)	❍	❍	❍	❍	❍

Q337 THE NEXT QUESTIONS ARE ABOUT PHYSICAL FORMS OF BULLYING - HITTING, KICKING, AND HAVING THINGS STOLEN

Q338 Were you physically bullied at primary school?

	Yes (1)	No (2)
Hit or punched (1)	❍	❍
Stolen from (2)	❍	❍

Q339 How often did this occur?

	Never (1)	Rarely (2)	Sometimes (3)	Frequently (4)	Constantly (5)
This happened (1)	❍	❍	❍	❍	❍

Q340 Seriousness of bullying attacks

	I was not physically bullied in primary school (1)	Not at all (2)	only a bit (3)	Quite serious (4)	Extremely Serious (5)
How serious did you consider these bullying attacks to be at that time? (1)	❍	❍	❍	❍	❍

Q341 Were you verbally bullied at primary school?

	Yes (1)	No (2)
Called names (1)	❍	❍
Threatened (2)	❍	❍

Q342 How often did this occur?

	Never (1)	Rarely (2)	Sometimes (3)	Frequently (4)	Constantly (5)
These acts happened... (1)	❍	❍	❍	❍	❍

Q343 Perceived seriousness of bully attacks

	I wasn't bullied (1)	Not at all (2)	Only a bit (3)	Quite serious (4)	Extremely Serious (5)
How seriously did you consider these bullying-attacks to be at that time? (1)	❍	❍	❍	❍	❍

Q344 If you are reading choose C

- ❍ A (1)
- ❍ B (2)
- ❍ C (3)
- ❍ D (4)

Q345 THE NEXT QUESTIONS ARE ABOUT INDIRECT FORMS OF BULLYING - HAVING LIES OR NASTY RUMORS TOLD ABOUT YOU BEHIND YOUR BACK, OR BEING DELIBERATELY EXCLUDED FROM SOCIAL GROUPS.

Q346 Were you indirectly bullied at primary school?

	Yes (1)	No (2)
Had lies told about you (1)	❍	❍
Was excluded (2)	❍	❍

Q347 How often did this occur?

	Never (1)	Rarely (2)	Sometimes (3)	Frequently (4)	Constantly (5)
These attacks happened .... (1)	❍	❍	❍	❍	❍

Q348 Seriousness of bully victimization

	I wasn't bullied (1)	Not at all (2)	Only a bit (3)	Quite serious (4)	Extremely Serious (5)
How seriously did you consider these bullying-attacks to be at that time? (1)	❍	❍	❍	❍	❍

Q349 THE NEXT QUESTIONS ARE ABOUT BULLYING IN GENERAL

Q350 How long did the bullying attacks usually last?
- ❍ I wasn't bullied (1)
- ❍ Just a few days (2)
- ❍ Weeks (3)
- ❍ Months (4)
- ❍ A year or more (5)

Q351 How many pupils bullied you in primary school?
- ❍ I wasn't bullied (1)
- ❍ Mainly one boy (2)
- ❍ By several boys (3)
- ❍ Mainly by one girl (4)
- ❍ By several girls (5)
- ❍ By both boys and girls (6)

Q352 If you were bullied, why do you think this happened?

Q353 SECONDARY SCHOOL. Experiences at secondary school (ages 11-18 years)

Q355 Overall Secondary school experience

	Detested (1)	Disliked (2)	Neutral (3)	Liked a bit (4)	Liked a lot (5)
Did you have a happy time at secondary school? (1)	❍	❍	❍	❍	❍
Did you have a happy time at home with your family while in secondary school? (2)	❍	❍	❍	❍	❍

Q356 THE NEXT QUESTIONS ARE ABOUT PHYSICAL FORMS OF BULLYING - HITTING AND KICKING, AND HAVING THINGS STOLEN FROM YOU

Q357 Were you physically bullied at secondary school?

	Yes (1)	No (2)
Hit or punched (1)	❍	❍
Stolen from (2)	❍	❍

Q358 How often did this occur?

	Never (1)	Rarely (2)	Sometimes (3)	Frequently (4)	Constantly (5)
These acts happened .... (1)	❍	❍	❍	❍	❍

Q359 Seriousness of bully attacks

	I wasn't bullied (1)	Not at all (2)	Only a bit (3)	Quite serious (4)	Extremely Serious (5)
How seriously did you consider these bullying-attacks to be at that time? (1)	❍	❍	❍	❍	❍

Q360 THE NEXT QUESTIONS ARE ABOUT VERBAL FORMS OF BULLYING - BEING CALLED NASTY NAMES , AND BEING THREATENED

Q361 Were you verbally bullied at secondary school?

	Yes (1)	No (2)
Called names (1)	❍	❍
Threatened (2)	❍	❍

Q362 How often did this occur?

	Never (1)	Rarely (2)	Sometimes (3)	Frequently (4)	Constantly (5)
These bullying attacks happened .... (1)	❍	❍	❍	❍	❍

Q363 Seriousness of bully attacks

	I wasn't bullied (1)	Not at all (2)	Only a bit (3)	Quite serious (4)	Extremely Serious (5)
How seriously did you consider these bullying-attacks to be at that time? (1)	❍	❍	❍	❍	❍

Q364 THE NEXT QUESTIONS ARE ABOUT INDIRECT FORMS OF BULLYING - HAVING LIES OR NASTY RUMORS TOLD ABOUT YOU BEHIND YOUR BACK, OR BEING DELIBERATELY EXCLUDED FROM SOCIAL GROUPS

Q365 Were you indirectly bullied at secondary school?

	Yes (1)	No (2)
Had lies told about you (1)	❍	❍
Excluded (2)	❍	❍

Q366 How often did this occur?

	Never (1)	Rarely (2)	Sometimes (3)	Frequently (4)	Constantly (5)
These attacks happened ... (1)	❍	❍	❍	❍	❍

Q367 Seriousness of bully attacks

	I wasn't bullied (1)	Not at all (2)	Only a bit (3)	Quite serious (4)	Extremely Serious (5)
How seriously did you consider these bullying-attacks to be at that time? (1)	❍	❍	❍	❍	❍

Q368 THE NEXT QUESTIONS ARE ABOUT BULLYING IN GENERAL

Q369 How long did the bullying attacks usually last?
- ❍ I wasn't bullied (1)
- ❍ Just a few days (2)
- ❍ Weeks (3)
- ❍ Months (4)
- ❍ A year or more (5)

Q370 How many pupils bullied you in primary school?
- ❍ I wasn't bullied (1)
- ❍ Mainly one boy (2)
- ❍ By several boys (3)
- ❍ Mainly by one girl (4)
- ❍ By several girls (5)
- ❍ By both boys and girls (6)

Q371 If you were bullied, why do you think this happened?

Q372 GENERAL EXPERIENCES AT SCHOOL

Q373 When you were being bullied what consequences did you think bullying had for you?
- ❍ I wasn't bullied at school (1)
- ❍ I would learn how to deal with bullying in the future (2)
- ❍ I would become socially isolated (3)
- ❍ That I would be physically hurt or injured (4)
- ❍ I would learn to not bullying others (5)
- ❍ That I would become a bully (6)
- ❍ There would be negative psychological consequences (e.g. losing confidence, reducing self-esteem (7)
- ❍ There would be beneficial psychological consequences (e.g. gaining confidence, becoming a "better" person (8)
- ❍ Other (9)

Q374 Perceived influence in bullying situation

	I wasn't bullied (1)	No (2)	Not without help (3)	With a little help (4)	Yes, on my own (5)
Did you feel that you could change, or do something about, the bullying situation? (1)	❍	❍	❍	❍	❍

Q375 Which were the main ways you used to cope with the bullying? Please check one or more options.
- ❑ I wasn't bullied at school (1)
- ❑ I talked to the bullies (2)
- ❑ I tried to make fun of it (3)
- ❑ I tried to avoid the situation (4)
- ❑ I tried to stay away from school (5)
- ❑ I tried to ignore it (6)
- ❑ I fought back (7)
- ❑ I got help from friends (8)
- ❑ I got help from a teacher (9)
- ❑ I got help from family/parents (10)
- ❑ I did not really cope (11)
- ❑ Other (please specify) (12) _____

Q376 Which of the above strategies do you think was most effective in coping with bullying?
- ❍ I wasn't bullied at school (1)
- ❍ I talked to the bullies (2)
- ❍ I tried to make fun of it (3)
- ❍ I tried to avoid the situation (4)
- ❍ I tried to stay away from school (5)
- ❍ I tried to ignore it (6)
- ❍ I fought back (7)
- ❍ I got help from friends (8)
- ❍ I got help from a teacher (9)
- ❍ I got help from family/parents (10)
- ❍ I did not really cope (11)
- ❍ Other (please specify) (12) _____

Q377 Did you ever take part in bullying anyone while you were in school?

	Yes (1)	No (2)
Hit or punch others (1)	❍	❍
Stole from others (2)	❍	❍
Called others names (3)	❍	❍
threatened others (4)	❍	❍
told lies (5)	❍	❍
excluded others (6)	❍	❍

Q378 How often did this occur?

	Never (1)	Rarely (2)	Sometimes (3)	Frequently (4)	Constantly (5)
These attacks happened ... (1)	❍	❍	❍	❍	❍

Q379 When you were being bullied, did you ever, even for a second, think about hurting yourself or taking your life?
- ❍ I wasn't bulied (1)
- ❍ No, never (2)
- ❍ Yes, once (3)
- ❍ Yes, more than once (4)

Q380 RECOLLECTIONS OF BEING BULLIED AT SCHOOL (Only answer these questions, if you were bullied)

Q381 Reactions to bullying situations

	No never (1)	Not often (2)	Sometimes (3)	Often (4)	Always (5)
Do you have vivid memories of the bullying event (s) which keep coming back causing you distress? (1)	❍	❍	❍	❍	❍
Do you have dreams or nightmares about the bullying event (s)? (2)	❍	❍	❍	❍	❍
Do you ever feel like you are re-living the bullying event(s) again? (3)	❍	❍	❍	❍	❍
Do you ever have sudden vivid recollections or "flashbacks" to the bullying event(s)? (4)	❍	❍	❍	❍	❍
Do you ever feel distressed in situations which remind you the bullying event(s)? (5)	❍	❍	❍	❍	❍

Q382 If you were bullied, do you feel it had any long-term effects? If so, please describe below

Q383 THE NEXT QUESTIONS ARE ABOUT BULLYING AFTER SECONDARY SCHOOL.

Q384 Have you ever experienced bullying at college or university?
❍ Yes (1)
❍ No (2)
If No Is Selected, Then Skip To The Counseling Center is located in t...

Q385 Have you been bullied at college or university over the last six months?
❍ No (1)
❍ Yes, very rarely (2)
❍ Yes, now and then (3)
❍ Yes, several times per month (4)
❍ Yes, several times per week (5)
❍ Yes, almost daily (6)

Q386 If you have been bullied in college or university, when did the bullying start?
❍ Within the last 6 months (1)
❍ Between 6 months and 12 months (2)
❍ Between 1 and 2 years (3)
❍ More than 2 years ago (4)

Q387 If you have been bullied, what did you do? Please tick one or more options

- ❑ Tried to avoid the situation (1)
- ❑ Tried to ignore it (2)
- ❑ Confronted the bully (3)
- ❑ Went to the Student's Union (4)
- ❑ Talked to my tutor/a member of staff (5)
- ❑ Discussed it with other students (6)
- ❑ Saw my doctor (general practitioner) (7)
- ❑ I went for counseling (8)
- ❑ I got psychiatric help (9)
- ❑ Made use of the college or university's grievance procedure (10)
- ❑ I left the college (11)
- ❑ Did not really cope (12)
- ❑ Other (please specify) (13) _____

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