



## Family violence exposure and associated risk factors for child PTSD in a Mexican sample<sup>☆, ☆☆</sup>



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### ABSTRACT

This study was undertaken in an effort to help illuminate the deleterious effects of traumatic stress on children and families in Mexico. Rates of exposure to traumatic events, family and community violence, and posttraumatic stress disorder (PTSD) were investigated in 87 school-age children and their mothers. Binary logistic regression analysis was performed to examine potential family and ecological risk factors for the presence of child PTSD. A total of 51 children (58.6%) reported an event that met the DSM-IV A criteria, and 36 children (41.4%; 20 boys and 16 girls) met criteria for full PTSD. Traumatic exposure in this sample was considerable, particularly intense, and chronic as a result of interpersonal violence in the home and community. Results support the need for preventive systemic interventions targeting the individual level, parent–child dyadic level, and the larger cultural and community context.

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### Introduction

Researchers have recognized the importance of a multidisciplinary and multisystemic approach to assessing and treating traumatized children and families, with coordinated services at the individual parent and child level, in addition to the parent–child dyadic level (Appleyard & Osofsky, 2003; Cicchetti & Toth, 1995). A large body of knowledge exists regarding the epidemiology of psychological trauma and posttraumatic stress disorder (PTSD) in industrialized countries. However, our understanding of traumatic stress in economically developing countries is limited. For example, De Girolamo and McFarlane reported in 1996 that only 6% of studies on the prevalence of PTSD had been conducted in developing countries.

The paucity of research in developing countries is a concern because these populations appear to be at increased risk for PTSD (Keane, Marshall, & Taft, 2006). For example, reported PTSD rates in the general adult population in Sarajevo (18.6%; Rosner, Powell, & Butollo, 2003) and Afghanistan (20.4%; Scholte et al., 2004) were considerably higher than those in the United States (6.8%) overall (10.4% in women, 5% in men; Kessler et al., 2005) and in other industrialized countries such as Australia (1.5%; Creamer, Burgess, & McFarlane, 2001) and Iceland (0.6% in women, no men met criteria; Lindal & Stefansson, 1993). Furthermore, de Jong et al. (2001) conducted an epidemiological survey in adult survivors of armed conflict, refugees,

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and displaced persons in four post-conflict, low-income areas and found elevated PTSD prevalence in these areas (Algeria, 37%; Cambodia, 28%; Gaza, 18%; Ethiopia, 16%).

Studies of traumatic stress in children show high rates of trauma exposure in non-Western developing countries. For example, lifetime rates of trauma exposure in South African children and adolescents ranged from 40% to 100% in several community samples of South African children and adolescents (Suliman, Kaminer, & Seedat, 2005), and a rate of 77% lifetime exposure to war related trauma and family violence was found in a sample of children aged 7–15 years in Afghanistan (Catani et al., 2009).

To our knowledge, no epidemiological study has reported rates of exposure to traumatic events and PTSD or associations between PTSD and family or ecological risk factors in school age children in Mexico. However, such information is critical for policy makers and mental health providers in Mexico tasked with developing a local infrastructure to meet the needs of children and families affected by PTSD, particularly because narcotic-related violence has resulted in Mexico's current status as one of the most dangerous countries in the world. Gaining an understanding of PTSD in Mexico is also relevant to U.S. policymakers and mental health providers because of the large influx of documented and undocumented immigrants from Mexico into the United States. If we are to provide valid assessment and effective clinical services on this side of the border, it is necessary to know how exposure rates and traumatic stressors prior to immigration contribute to Mexican immigrants' mental health.

### *Risk Factors for Child PTSD*

Although we know little about trauma exposure in children in Mexico, epidemiological research on childhood traumatic stress in other countries supports a positive dose–effect relationship between the experience of multiple traumas and adverse outcomes, including the development of PTSD (e.g., Catani, Jacob, Schauer, Kohila, & Neuner, 2008). The risk of PTSD in children is greater after exposure to interpersonal violence in the home and the community than after non-interpersonal traumatic events (McCloskey & Walker, 2000). Lehmann (2000) evaluated 28 studies published from 1980 through 1999 to determine risk factors influencing PTSD symptomatology in children aged 8 months to 9 years. Findings indicated that 85% of children with PTSD had histories of exposure to multiple traumas (physical and sexual abuse, family and community violence, war). Female gender has frequently been linked to increased risk for PTSD (e.g., Cauffman, Feldman, Waterman, & Steiner, 1998; Udwin, Boyle, Yule, Bolton, & O'Ryan, 2000), particularly in children who have been sexually abused (Davis & Siegel, 2000). This has been attributed to a tendency of females to internalize psychological distress, leading to higher rates of mood and anxiety symptoms, contrasting with a tendency of males to exhibit externalizing symptoms (Pine & Cohen, 2002). Additionally, female children may experience more intense reactions to a traumatic event than males. Although female gender is a relatively consistent predictor of PTSD diagnosis in children, the effects are small (Cox, Kenardy, & Hendrikz, 2008; Trickey, Siddaway, Meiser-Stedman, Serpell, & Field, 2012).

Parental psychological distress and poor family functioning have been shown to be predictors of child psychopathology (Cox et al., 2008; Trickey et al., 2012). Associations between parental experience of trauma and secondary traumatization of children have been found in studies of war veterans (Dekel & Goldblatt, 2008) and in samples of parents and children who have both been exposed to a range of traumas (Scheeringa & Zeanah, 2001). Lambert, Holzer, & Hasbun, 2014 performed the first meta-analysis examining the association between parents' PTSD symptoms and children's psychopathology in 42 studies (34 peer-reviewed journal articles, eight dissertations). The researchers compared studies in which only the parent experienced trauma ( $n = 18$ ) with studies in which both the parent and the child had a history of trauma exposure ( $n = 24$ ). A moderate effect size was found for the association between parental PTSD and child distress/behavior problems ( $r = .35$ ,  $p < .001$ ), regardless of who experienced the traumatic event(s). This association was significantly stronger for parent–child dyads with a history of interpersonal trauma compared with other event types ( $r = .46$ ,  $p < .001$ ).

In cases where only the child was exposed to trauma, parental support after the trauma has been found to be one of the most critical factors related to child outcome (Cox et al., 2008; Saile, Neuner, & Catani, 2014; Sriskandarajah, Neuner, & Catani, 2014; Trickey et al., 2012). Parent and family functioning may worsen the impact of a traumatic event on children by serving as proximal reminders and secondary stressors of the trauma. Parents' reactive behavior after a traumatic event may be more critical to child adjustment than direct exposure to the event (Cox et al., 2008). Parental modeling of maladaptive and avoidant coping strategies may negatively affect a child's adaptive functioning and may result in less effective parenting skills and decreased ability to provide monitoring and support for the child's needs.

Economic hardship appears to be a significant ecological variable associated with negative responses to trauma and the development of PTSD. The effects of trauma in developing areas of the world are of great concern because these populations may be particularly susceptible to adverse outcomes due to poverty and lack of resources. Norris et al. (2003) identified several risk factors associated with poor countries, including crowded and substandard housing; physically demanding and dangerous work; lack of access to medical and professional care; and enhanced power differentials between rich and poor, adults and children, and men and women.

### *Trauma and PTSD in Mexico*

Poverty is pervasive throughout Mexico, negatively influencing peoples' lives in multiple ways. Mexican women and children in particular live in impoverished conditions, which may affect their abilities to cope with traumatic stressors.

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