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Growing Up Under the Gun: Children and Adolescents Coping with Violent Neighborhoods

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Inner-city children are exposed to an environment fraught with violence. They are frequent victims of violence and even more frequent witnesses of violence. Exposure to violence can provoke a variety of responses in exposed children such as crying, tremors, withdrawal, etc. In addition to causing such acute stress reactions, exposure to violence can result in more lasting symptoms—including sleep disturbances, nightmares, anxiety, depression, and recurrent intrusive memories of the traumatic event. In many of these children such symptoms occur in combination and persist for long enough to justify a diagnosis of post-traumatic stress disorder. Children are most likely to cope successfully with community violence if they have an internal locus of control, a strong sense of self-efficacy, and an optimistic and planful attitude toward the future. Parental support is particularly important in helping children to cope with stress. Professional interventions in the family and school can help children to cope with such trauma. Such interventions attempt to help children to cope with violent situations by construing the situations in positive ways, by working toward attainable goals and by not allowing them to be overwhelmed by their fear and frustration, thus preventing the trauma from permanently affecting them.

KEY WORDS: inner-city youth; violence; traumatic events; PTSD; and coping.

"Fear of violence is robbing our children of their childhood."
—President Bill Clinton

In a recent survey of 467 students attending a small rural midwestern high school, Weiler, Sliepcevich and Sarvela (1994) found that 53% of the students worried about being murdered. Sixty-one percent reported that they

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were concerned about crime, 53% about family violence, 42% about terrorism, 37% about gang violence, and 37% about guns in school. And this was in a quiet, rural environment—far from the inner city and its violence.

America is a violent society, with a murder rate ten times higher than that of England and twenty-five times higher than Spain (Wolfgang, 1986). The National Research Council (1993) found that, "compared with 30 other industrialized countries, the United States has the highest rates of sexual assault and assault with force, and is third in homicide." Furthermore, American teenagers are much more likely than adults to be victims of crimes of violence. The National Crime Survey (Whitaker & Bastian, 1991) showed that teenagers experienced 67 violent crimes per 1,000 teens each year, compared to a rate of 26 per 1,000 adults age 20 or older. In other words, teenagers were two-and-one-half times as likely to be victims of violent crimes than were adults.

More than one-third (37%) of the violent crimes experienced by 12- to 15-year-old victims took place at school, and another one-quarter on the street (Whitaker & Bastian, 1991). For victims aged 16 to 19, the most common location was the street (26) followed by the school (17%) and public transit (13%). Bastian and Taylor (1991) report that nearly one student in ten reported being a victim of in-school crime during the six month period of a national survey. Two percent reported a violent victimization and 7% a property crime.

Nearly 4,000 American youths, 18 and younger, die in a shooting each year (Christoffel, 1983). Another 8,000 youths are injured annually by firearms, and 2,000 of those are left with permanent impairments (Rivara & Stapleton, 1982). Youth who live in the inner city, who are male, or who are Black are much more likely to be victims of gunshot injuries and deaths (Abel, 1986; Christoffel, Anziger & Merrill, 1989; Copeland, 1991).

In addition to being victims of violence, children and youth are frequent witnesses of violence in the community they reside in. Shakoor and Chalmers (1991) propose the term "covictimization" for the traumatic experience of witnessing a violet assault on another person. A recent survey of 1,000 elementary and secondary school students in Chicago found that more than one in four students had witnessed a murder, nearly 40% had seen a shooting and more than one-third had seen a stabbing (Garbarino, Dubrow, Kostelny & Pardo, 1992). Bell (1991), in another study of Chicago children, found that 74% had witnessed a murder, a shooting, a stabbing or a robbery and that 47% of these incidents had involved friends, classmates, family members or neighbors.

Not surprisingly, inner-city children know more victims of violence and witness more assaults, rapes and killings than do upper middle class youths (Gladstein & Rusonis, 1992). A survey of inner city first and second graders

by Telljohan and Price (1994) found that 10% of the Black and 1% of the White students reported having seen someone shot. Surprisingly perhaps, that was true for 3% of the boys and 8% of the girls.

In a study of Boston public school students, 37% of the boys and 17% of the girls reported that they had carried a weapon to school at some time, with fear for their own safety as the major reason (Boston Committee on Safe Public Schools, 1983). This compares to national survey results showing that 3% of boys and 1% of girls had done so (Bastian & Taylor, 1991). The national survey showed a 1% rate in rural schools, 2% in suburban schools, and 3% in central city schools.

CHILDREN'S RESPONSES TO STRESS

Traumatic events, such as exposure to violence, may provoke a variety of responses in exposed children such as crying, tremors, withdrawal, etc. In addition to causing such acute stress reactions, exposure to violence can result in more lasting symptoms. These symptoms may include sleep disturbances, nightmares, anxiety, depression, and recurrent intrusive memories of the traumatic event. If enough of these symptoms occur in combination and persist for at least a month, a diagnosis of post-traumatic stress disorder (PTSD) may be applied.

PTSD is described by the American Psychiatric Association's (1994, p. 424) *Diagnostic and Statistical Manual of Mental Disorders*, as being a characteristic set of symptoms following exposure to an extreme traumatic stressor. These characteristic symptoms include persistent reexperiencing of the traumatic experience, persistent avoidance of stimuli associated with the trauma, a paradoxical mixture of numbing of general responsiveness and symptoms of increased arousal, and clinically significant distress or impairment in social, occupational or other important aspects of life. The reexperiencing of the trauma may include nightmares, intrusive memories of the event, or in some cases reliving the experience for anywhere from several minutes to several hours. Other symptoms frequently observed in PTSD victims include: irritability and outbursts of anger, difficulty falling asleep, and a sense of being alienated from those around one.

Terr (1979) studied the twenty-six Chowchilla, California school children whose school bus was hijacked and buried by kidnappers in a much-publicized case. Her study revealed that all of the children were suffering from PTSD. A follow-up four years later (Terr, 1983) still showed signs of PTSD and a preoccupation with death and self-preservation in all twenty-six children.

Pynoos et al. (1987) studied 159 children attending a Los Angeles school that had been attacked by a sniper. They found that one month after the attack more than half of the children showed symptoms of PTSD. At a fourteen month follow-up, those children who were not directly exposed to the shooting showed diminished symptoms, while those children who had been near the shooting or had known one of the victims continued to show severe symptoms. They found that factors which increase the likelihood of PTSD in childhood witnesses of violence include: being physically close to the violence, knowing the victim, and previous exposure to violence.

Susceptibility to PTSD is related to age-specific developmental issues (Lyons, 1987). Adolescents are more susceptible to psychological trauma than are young adults (nan der Kolk, 1987). Pre-adolescents are more vulnerable than are adolescents (Davidson & Smith, 1990), while for preschool children the distress and poor functioning in response to trauma often end once the trauma is over (Maccoby, 1983). For these very young children emotional well-being is so strongly tied to the here-and-now that in most cases once the cause of distress is removed, their distress quickly dissipates (Nolen-Hoeksema, 1992).

Pynoos and Nader (1988) have concluded that the effects of repeated exposures to violence are additive, with each exposure tending to exacerbate or renew symptoms caused by earlier exposures. Chronic trauma, such as that associated with living in a violent neighborhood, can product particularly severe reactions. Even the young child will be likely to develop long term effects if the trauma causing the distress is a chronic situation (Nolen-Hoeksema, 1992).

In addition to PTSD and similar responses, another common outcome is for the child who has been chronically exposed to violence to later become a violent individual. The literature on victimization leading to violence has been reviewed by Widom (1989a & 1989b). Based on visits to war zones around the world and on observations in the inner city of Chicago, Garbarino, Kostelny and Dubrow (1991) identify the common results of children being exposed to chronic violence as being a triad of increased aggressiveness, violent revenge seeking, and apathy and despair about the future.

A cross-sectional study, by DuRant et al. (1994) of the use of violence by Black adolescents in Atlanta, Georgia, showed that previous exposure to violence and victimization was the strongest predictor of use of violence by those teens. The same study also identified resiliency factors which made some violence-exposed youths less likely to engage in violence themselves. These protective factors were: lower levels of hopelessness, a sense of purpose in life, and a belief that they would still be alive at the age of 25. It

might be said that those violence-exposed children who have escaped the third element of Garbarino, Kostelny and Dubrow's (1991) triad of effects are likely to also escape the other two elements.

Shakoor and Chalmers (1991) have hypothesized that poor school performance and impaired learning are symptoms of the trauma children suffer from witnessing violence. They suggest that high dropout rates and poor academic performance among inner-city African-American youth are, in part, a result of such "covictimization." In this view the observation that African-American males suffer greater academic difficulties than do females would be attributable to the fact that males both experience and witness more acts of violence than do females.

CHILDREN'S COPING WITH TRAUMA

While witnessing a shooting or stabbing would be highly upsetting to any child, vulnerability to PTSD and other effects varies from one child to another. Children are most likely to cope successfully if they have an internal locus of control, a strong sense of self-efficacy, and an optimistic and planful attitude toward the future (Bandura, 1986). Children with an external locus of control, low self-efficacy, and a pessimistic outlook are most vulnerable to trauma. Unfortunately, children who are distressed over a period of time become pessimistic in their expectations for themselves and for the future (Nolen-Hoeksema, 1992), thus making them more vulnerable to the effects of further stress.

In her excellent review, Nolen-Hoeksema (1992) identifies three strategies whereby children can cope with uncontrollable stress: (1) Engaging in a cognitive reappraisal or reconstrual of the situation or of the child's role in that situation. (2) Using positive imagery and distraction. (3) Developing reasonable short-term goals.

According to Horowitz (1972) any successful coping with traumatic stress involves both working through feelings about what has happened and developing a cognitive framework that can incorporate and possibly lend some meaning to the events that have occurred. Garbarino, Kostelny, and Dubrow (1991) also emphasize the importance of the child's "processing" of the traumatic experience and developing a cognitive framework which makes sense of that experience. Each of these children needs to arrive at a personal interpretation of events that sustains and supports the child's sense of competence and trust (Anthony & Cohler, 1987; Wallach, 1993).

Studies of Palestinian children affected by the 1987 uprisings indicated that an ideological explanation of the conflict and a sense of being on the "right side" could buffer children from the negative effects of exposure to

the violence (Baker, 1990; Garbarino, Dubrow & Kostelny, 1992). There can be a danger, however, of children who believe they are on the "right side" in ethnic or religious conflicts coming to adopt a fanatical ideology which not only contributes to the community violence but impairs their long-term adjustment to the trauma (Garbarino, Dubrow & Kostelny, 1992). This could be a concern in some American communities where violence occurs between gangs which have become virtual primary groups for their members or between rival ethnic groups.

Garbarino, Dubrow, Kostelny and Pardo (1992) use the term "positive revenge" to describe a commitment to positive change and caring for others that has been observed among some survivors of the "killing fields" of Cambodia. This particular cognitive framework has facilitated the emotional healing of many of the children exposed to the Khmer Rouge atrocities—children who typically have suffered a high prevalence of severe and persistent PTSD.

Another important coping strategy is the use of distraction and positive imagery. Provided that it does not lead to the extreme of complete denial of the stress and resulting emotional distress, temporary escape from the chronic trauma through behavioral distraction or cognitive distraction—doing something else or thinking about something else—can be a very positive strategy. Intense involvement in sports, television, videogames, etc., can help children to dampen the fear arising from life in a violent community.

Children with a rich fantasy life can find escape into fantasy from the violence in their real life, unless that violence is reflected in their fantasies. Even violent fantasies (and violent videogames) have some positive value since the child typically fantasizes being in control of the violence, triumphing over enemies, and thus achieving some sense of mastery and efficacy. Such fantasies may, however, contribute to later violent behavior on the part of some of these children.

Developing realistic plans for dealing with the violence in their lives is another important element in successful coping for children in these communities. These children typically have big, long-term goals. They want to get out of the inner city and live in a big house in the suburbs. They want to become a basketball superstar and buy a better life for themselves and their families. Such goals may be very worthwhile but they can have no immediate resolution and efforts to achieve them may have little immediate impact on the child's emotional adjustment.

These children need to learn how to translate their long-term goals of escape from the community into more limited short-term goals leading toward their ultimate objectives. This will not only increase the likelihood that they will achieve their long-term goals but will build their sense of mastery and self-efficacy as they achieve their short-term goals. The boy

who hopes to escape the inner city by becoming a basketball superstar, for instance, should be encouraged to focus on short-term goals such as getting on a local youth club team and improving his jump shot or passing.

Children can learn coping techniques by which they can deal with uncontrollable stresses such as living amid inner city violence. These are techniques which can be taught and which children may readily learn. Helping children to master the techniques of reconstrual, distraction, and working toward attainable goals can keep them from being overwhelmed by their fear and frustration, and can prevent the community violence from permanently affecting children's sense of themselves.

PARENTAL SUPPORT

A stable and safe—in the sense that the family is not characterized by either violence nor drug abuse—family appears to be a child's best defense against the harms resulting from exposure to violence (Richters & Martinez, 1993). During the World War II bombing of British cities, for instance, it was observed that British children who stayed with their parents in the target cities were less troubled by the air raids than those children who had been sent to the relative safety of rural areas (Freud & Burlingham, 1943). Likewise, a follow-up study of Cambodian children who had survived the Khmer Rouge terror found that those who did not live with a family member were most apt to have developed PTSD as well as other mental disorders (Kinzie et al., 1986).

Studies of children's coping with disasters have shown that open communication in families allows the parents to sympathize with the children's fears, to reassure them that their fears are normal, and to help them to understand the problems in their environment (Bloch, Silber & Perry, 1956; Figley, 1983). The same is likely to be true for children faced with urban violence, but Nolen-Hoeksema (1992) warns that simply getting children to express their feelings may not be helpful if it does not lead to an appropriate parental response. Where the child's parents feel powerless to respond, the child's expression of his or her fears "may not help and could even backfire" (Nolen-Hoeksema, 1992, p. 184).

Parents who perceive themselves as being capable of coping with danger are better able to transmit a sense of security and confidence to their children (Baker, 1990). When parents provide a model of coping with danger, their children are likely to develop higher self-esteem and greater confidence in their own ability to cope (Scheinfeld, 1983). Parents who are involved in political or community action to combat violence, such as the low-income mothers observed by Dubrow and Garbarino (1989) who es-

tablished a neighborhood system of "safe houses" for children, can simultaneously provide models of coping and provide a cognitive framework for dealing with violence.

Figley (1983) found that open, flexible communication could help families to develop such a cognitive framework, which he called a "healing theory"—a rational explanation of the reasons for the traumatic events which gives meaning to those events. Garbarino, Kostelny, and Dubrow (1992), however, warn that if this conceptual framework justifies violence, it may impede the children's moral development. They suggest that parents may facilitate their children's moral development, despite a violent environment, by discussing the moral implications of violent situations, taking into account the maturity of their child, and encouraging the child to move in the direction of such concepts as justice, compassion and responsibility. Promoting altruism and concern for others can simultaneously promote moral development and provide the "healing theory."

Fostering open discussion of neighborhood dangers also gives parents the opportunity to teach safety practices to their children. At the same time they can also enhance their children's self-esteem and self-efficacy by expressing confidence and pride in their children's ability to adopt such practices and take care of themselves.

A further important perspective on this subject is provided by the research of Baldwin et al. (1993). Seeking factors related to resiliency in children raised in high risk environments, they found that the parenting practices which are most effective in advantaged families are not effective in disadvantaged families. They found that African-American families tended to be more controlling, more critical, and more inclined to value conformity in their child-rearing practices than were White families. Furthermore, they found that these practices were associated with more positive life outcomes for disadvantaged children.

BARRIERS TO PARENTAL SUPPORT

There are a variety of reasons why parents may fail to provide the emotional support their children need in order to cope with community violence: Poor communications between parent and child may leave them unaware of the degree to which their children are exposed to violence. Some parents may have a general tendency to downplay the seriousness of their children's concerns. In other cases, parents may overlook their child's emotional needs while focusing exclusively on physical safety issues. Grief over the loss of another family member may paralyze some parents' ability to respond effectively to their children's needs.

Parents who lack a religious, philosophical or political framework for giving meaning to their own experience of urban violence can do little to help their children make sense of the experiences of violence (Dubrow & Garbarino, 1989; Garbarino et al., 1992). Simply put, parents can't share with their children what they lack themselves. If they are still grasping for some means to make sense of the violence in their environment they are less able to help their children find such meaning.

Parental or family pathology may also keep parents from being supportive of their children (Bloch, Silber & Perry, 1956; Pynoos & Nader, 1988). In these situations, family therapy may be necessary before parents can help their children to cope with violence. Patterns of family violence can only compound the negative effects of community violence.

Parents may attempt to protect their children from community violence by adopting very restrictive child rearing strategies. Parents who forbid their children to play outdoors for fear of drive-by shootings may keep their children safer but they also deprive them of normal growth experiences. The result is likely to be both impaired social and emotional growth of the child and evasion of or rebellion against parental authority. In order to maintain this protective restrictiveness, parents often feel compelled to adopt a punitive style of discipline, often including corporal punishment. This unfortunately has the effect of heightening aggression on the child's part and increasing the likelihood that they will be drawn into the community violence of gangs, etc.

FAMILY INTERVENTIONS

The most natural setting for preventive interventions for children is in their own families. Not surprisingly, a variety of family-centered strategies have been developed for these children.

Figley's (1983) approach is typical of family therapy models which treat the whole family. His therapy model initially stresses educating the family about the effects of trauma. He then trains family members to be more effectively supportive of each other.

Lyons (1987) summarizes the elements of child-centered family interventions for children exposed to traumatic events. She notes, however, that systematic research has not yet been conducted that would demonstrate whether these interventions are effective or not. The key elements which she identifies are that:

1. The child is re-exposed in imagination or role play to the traumatic event in a structured and supportive situation.

2. Significant adults in the child's life are taught to discuss the traumatic event openly and honestly with the child.
3. The child is helped to develop strategies for coping with danger and with PTSD symptoms.

Less widely reported are parent group approaches (Pynoos & Nader, 1988; Dubrow & Garbarino, 1989). These involve groups in which parents are taught about the consequences of trauma for their children and can discuss their fears and concerns for them. Effectiveness studies of these groups also are lacking. The effectiveness of such interventions is discussed in the general review of indirect treatment of children via parent training by Wright, Stroud and Keenan (1993).

INTERVENTIONS IN THE SCHOOLS

Schools are in many ways a natural setting for the provision of interventions to help children to cope with the violence in their communities. Schools provide a setting in which professionals can have access to virtually all of the children of a community. The student can find an important support network in their classmates and school personnel.

Programs in the schools have more commonly addressed the primary prevention of violence by students. These efforts have included both educational interventions and environmental modifications. Educational interventions have generally implemented all or part of the practice paradigm developed by Wodarski and Hedrick (1987) which consisted of: conflict resolution skills, cognitive anger control, communication skills, and drug education. Page et al. (1992) review the major curricula which have been developed for such interventions. Effectiveness of these programs has not yet been established. A discussion of the most widely known of these curricula and of a wider context for prevention of violence is provided by Prothro-Stith (1993).

Environmental modifications, such as metal detectors, visitor sign-ins, teachers monitoring halls or security guards, have not been found to reduce violent victimizations significantly compared to those schools not taking such precautions (Bastian & Taylor, 1991). The students in schools with such precautions, however, were more likely to be fearful of school crime—increasing their risk of PTSD-type reactions. This is not unlike the finding of Norris and Kaniasty (1992) that not only do widely advocated community crime prevention measures fail to reduce crime but may also increase fear of crime among residents effected by the prevention efforts.

Those school-based interventions for children exposed to violence that have been reported in the literature have for the most part been based on the assumption that the exposure to violence was a one-time event. Such interventions typically employ techniques of "debriefing" and "anticipatory guidance." Both techniques are typically conducted in a group setting. In debriefing the children are encouraged to discuss the traumatic event in a supportive setting so that the feelings involved can be worked through and a cognitive framework for understanding the event and those feelings can be developed. In anticipatory guidance the children are told what effects they may experience as a result of their traumatic experience and discuss or are advised on means of dealing with those effects.

Developing interventions to address chronic exposure to violence in inner city communities will be much more difficult. Children who are suffering the cumulative effects of ongoing exposure to violence may experience greater difficulty in identifying or discussing the specific events that have placed them under stress. The use of debriefing techniques with such children may arouse intense feelings which cannot readily be dealt with by classroom teachers who are not trained therapists. Such debriefing may even undercut defenses, such as denial or distraction, that the child is using currently to cope with the violent life situation.

More appropriate interventions for these children might be focused on building the children's self-esteem and sense of self-efficacy. The curriculum described by Cowen, Wyman, Work and Iker (1995) is an example of such an intervention that has positive preliminary results. Another approach might be to encourage the children to discuss and develop active strategies for protecting themselves from the dangers in their community.

The experience of groups for children of battered mothers may provide a useful model of groups developed for children suffering the trauma of being exposed to chronic violence. A forthcoming book edited by Peled, Jaffe and Edleson (in press) surveys innovative interventions in this area. They report that most group interventions for these children provide highly structured sessions with specific goals for relatively small numbers of children. Typical groups consisted of three to six children with one or two therapists. Techniques used in the groups include: lectures, discussions, modeling, role-playing, art therapy and "homework" assignments.

The typical goals of groups for children of battered mothers were to help the child participants to: (1) define violence and assign responsibility for violence; (2) express their feelings, including anger; (3) improve communication, problem-solving and coping skills; (4) increase their self-esteem; (5) develop social support networks; (6) develop personal safety plans; and (7) develop feelings of safety and trust in the group sessions. One of the few systematic evaluations of such a group to be found in the

literature is that by Peled and Edleson (1992). They concluded that such a group succeeded in: (1) providing an environment in which the children felt safe; (2) increasing their self-esteem, and (3) allowing them to talk about their experience of violence—breaking the secret of family violence.

Secondary prevention is also an important approach which can be implemented in the schools. Teachers should be trained to identify children suffering from PTSD and related reactions to community violence. The schools should have established referrals for such children.

CONCLUSION

Several million of our children are growing up in communities characterized by gang violence, drug war and drive-by shootings. Exposure to such violence on a chronic basis can produce serious emotional and behavioral problems in these children. Parents and schools can help children to cope with these conditions but many parents and most schools are poorly equipped to provide these children with that help. Preparing parents and teachers to provide that help should be one of the major primary prevention tasks for the decades ahead.

REFERENCES

Abel, E. L. (1986). Childhood homicide in Erie County, New York. *Pediatrics, 77*, 709-713.

Anthony, E., & Cohler, B. (1987). *The Invulnerable Child.* New York: Guilford Press.

Baker, A. M. (1990). The psychological impact of the Intifida on Palestinian children. *American Journal of Orthopsychiatry, 60*, 496-505.

Baldwin, A., Baldwin, C. P., Kasser, T., Zax, M., Sameroff, A., & Seifer, R. (1993). Contextual risk and resiliency during late adolescence. *Development and Psychopathology, 5*, 741-761.

Bandura, A. (1986). *Social Foundations of Thought and Action.* Englewood Cliffs, NJ: Prentice-Hall.

Bastian, L. D., & Taylor, B. M. (1991). *School Crime: A National Crime Victimization Survey Report.* NCJ-131645. Washington, DC: U.S. Government Printing Office.

Bell, C. (1991). Traumatic stress and children in danger. *Journal of Health Care for the Poor and Underserved, 2*, 175-188.

Bloch, D., Silber, E., & Perry, S. (1956). Some factors in the emotional reactions of children to disaster. *American Journal of Psychiatry, 113*, 416-422.

Boston Committee on Safe Public Schools (1983). *Making Our Schools Safe for Learning.* Boston: Boston Public Schools.

Christoffel, K. K. (1983). American as apple pie: Guns in the life of U.S. children and youth. *Pediatrics, 72*, 46-51.

Christoffel, K. K., Anziger, N. K., & Merrill, D. A. (1989). Age-related patterns of violent death, Cook County, Illinois, 1977 through 1982. *American Journal of Diseases of Children, 143*, 1403-1409.

Compas, B. E. (1987). Coping with stress during childhood and adolescence. *Psychological Bulletin, 101*, 393-403.

Copeland, A. R. (1991). Childhood firearms fatalities: The metropolitan Dade County experience. *Southern Medical Journal, 84*, 175-178.

Cowen, E. L., Wyman, P. A., Work, W. C., & Iker, M. R. (1995). A preventive intervention for enhancing resilience among highly stressed urban children. *The Journal of Primary Prevention, 15*, 247-260.

Davidson, J., & Smith, R. (1990). Traumatic experiences in psychiatric outpatients. *Journal of Traumatic Stress, 3*, 459-475.

Dubrow, N., & Garbarino, J. (1989). Living in the war zone: Mothers and young children in a public housing development. *Child Welfare, 58*, 3-20.

DuRant, R. H., Cadenhead, C., Pendergrast, R. A., Slavens, G., & Linder, C. W. (1994). Factors associated with the use of violence among urban Black adolescents. *American Journal of Public Health, 84*, 612-617.

Figley, C. R. (1983). Catastrophes: An overview of family resources. In C. R. Figley and H. I. McCubbin (Eds.), *Stress and the Family: Volume 2 Coping with Catastrophe* (pp. 3-20). New York: Brunner-Mazel.

Freud, A., & Burlingham, D. (1943). *War and Children.* New York: Ernest Willard.

Garbarino, J., Dubrow, N., Kostelny, K., & Pardo, C. (1992). *Children in Danger.* San Francisco: Jossey-Bass.

Garbarino, J., Kostelny, K., & Dubrow, N. (1991). What children can tell us about living in danger. *American Psychologist, 46*, 376-383.

Gladstein, J., Rusonis, E. S., & Heald, F. P. (1992). A comparison of inner-city and upper middle-class youths' exposure to violence. *Journal of Adolescent Health, 13*, 275-280.

Horowitz, M. J. (1972). Phase-oriented treatment of stress response syndrome. *American Journal of Psychotherapy, 27*, 506-551.

Kinzie, J. D., Sack, W., Cangell, R., Manson, S., & Rath, R. (1986). The psychiatric effects of massive trauma on Cambodian children. *Journal of the American Academy of Child Psychiatry, 25*, 370-376.

Koop, C. E., & Lundberg, G. D. (1992). Violence in America: A public health emergency. *Journal of the American Medical Association, 267*, 3076-3077.

Lyons, J. A. (1987). Post traumatic stress disorder in children and adolescents: A review of the literature. *Developmental and Behavioral Pediatrics, 8*, 349-356.

Maccoby, E. E. (1983). Social-emotional development and response to stressors. In N. Garmexy and M. Rutter (Eds.), *Stress, Coping, and Development in Children.* New York: McGraw-Hill.

National Research Council (1993). *Losing Generations: Adolescents in High Risk Settings.* Washington, DC: National Academy Press.

Nolen-Hoeksema, S. (1992). Children coping with uncontrollable stressors. *Applied and Preventive Psychiatry, 1*, 183-189.

Norris, F. H., & Kaniasty, K. (1992). A longitudinal study of the effects of various crime prevention strategies on criminal victimization, fear of crime, and psychological distress. *American Journal of Community Psychology, 20*, 625-648.

Page, R. M., Kitchin-Becker, S., Solovan, D., Golec, T. L., & Hebert, D. L. (1992). Interpersonal violence: A priority issue for health education. *Journal of Health Education, 23*, 286-292.

Peled, E., & Edleson, J. L. (1992). Multiple perspectives on groupwork with children of battered women. *Violence and Victims, 7*, 327-346.

Peled, E., Jaffe, P. G., Edleson, J. L. (in press). *Ending the Cycle of Violence: Community Responses to Children of Battered Women.* Thousand Oaks, CA: Sage.

Prothro-Stith, D. (1993). *Deadly consequences.* New York: Harper Perennial.

Pynoos, R. S., Frederick, K., Nader, K., Arroyo, W., Steinberg, A., Eth, S., Nunez, F., & Fairbanks, L. (1987). Life threat and post-traumatic stress in school-aged children. *Archives of General Psychiatry, 44*, 1057-1063.

Pynoos, R. S., & Nader, K. (1988). Psychological first aid and treatment approach to children exposed to community violence: Research implications. *Journal of Traumatic Stress, 1*, 445-473.

Richters, J. E., & Martinez, P. E. (1993). Violent communities, family choices, and children's chances. *Development and Psychopathology, 5*, 609-627.

Rivara, F. P., & Stapleton, F. B. (1982). Handguns and children: A dangerous mix. *Developmental and Behavioral Pediatrics, 3*, 35-38.

Scheinfeld, D. (1983). Family relationships and school achievement among boys of lower-income urban, Black families. *American Journal of Orthopsychiatry, 53*, 127-143.

Shakoor, B. H., & Chalmers, D. (1991). Co-victimization of African-American children who witness violence: Effects on cognitive, emotional, and behavioral development. *Journal of the National Medical Association, 83*, 233-238.

Sorenson, S. B., & Saftlas, A. F. (1994). Violence and women's health: The role of epidemiology. *Annals of Epidemiology, 4*, 140-145.

Spivak, H., Prothrow-Stith, D., & Hausman, A. J. (1988). Dying is not an accident: Adolescents, violence, and intentional injury. *The Pediatric Clinics of North America, 35*, 1339-1347.

Telljohan, S. K., & Price, J. H. (1994). A preliminary investigation of inner city primary grade students' perceptions of guns. *Journal of Health Education, 25*, 41-46.

Terr, L. (1979). Children of Chowchilla: A study of psychic trauma. *Psychoanalytic Study of the Child, 34*, 547-623.

Terr, L. (1983). Chowchilla revisited: The effects of psychic trauma four years after a school-bus kidnapping. *American Journal of Psychiatry, 140*, 1543-1550.

van der Kolk, B. A. (1987). *Psychological Trauma.* Washington, DC: American Psychological Association Press.

Wallach, L. B. (1993). Helping children cope with violence. *Young Children* (May), 4-11.

Weiler, R. M., Sliepcevich, E. M., & Sarvela, P. D. (1994). Adolescents' concerns as reported by adolescents, teachers and parents. *Health Values, 18*(2), 50-62.

Whitaker, C. J., & Bastian, L. D. (1991). *Teenage Victims: A National Crime Victimization Survey Report.* NCJ-128129. Washington, DC: U.S. Government Printing Office.

Widom, C. S. (1989a). Does violence beget violence? A critical review of the literature. *Psychological Bulletin, 106*, 3-28.

Widom, C. S. (1989b). The cycle of violence. *Science, 244*, 160-165.

Wodarski, J. S., & Hedrick, M. (1987). Violent children: A practice paradigm. *Social Work in Education*, Fall, 24-82.

Wolfgang, M. (1986). Homicide in other industrialized countries. *Bulletin of the New York Academy of Medicine, 62*, 400.

Wright, L., Stroud, R., & Keenan, M. (1993). Indirect treatment of children via parent training: A burgeoning form of secondary prevention. *Applied and Preventive Psychology, 2*, 191-200.