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Alytia A. Levendosky, G. Anne Bogat and Cecilia Martinez-Torteya

*Violence Against Women* 2013 19: 187 originally published online 17 February 2013

DOI: 10.1177/1077801213476458

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# PTSD Symptoms in Young Children Exposed to Intimate Partner Violence

Violence Against Women

19(2) 187–201

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DOI: 10.1177/1077801213476458

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## Abstract

Intimate partner violence (IPV) places infants and young children at risk for development of trauma symptoms. However, this is an understudied consequence of IPV because young children pose particular difficulties for assessment of trauma symptoms. The authors collected maternal reports on mothers' and children's posttraumatic stress disorder (PTSD) symptoms and IPV yearly, from ages 1 to 7. Approximately half of the children exposed to IPV at each time period developed some trauma symptoms, and frequency of IPV witnessed was associated with PTSD symptoms. Maternal and child PTSD symptoms were correlated, suggesting that young children may be particularly vulnerable to relational PTSD due to their close physical and emotional relationship with their parents.

## Keywords

childhood exposure, intimate partner violence, PTSD, trauma

There is a dearth of research on posttraumatic stress disorder (PTSD) in young children that occurs as a result of exposure to intimate partner violence (IPV; defined here as male violence against a female romantic partner). This is unfortunate, as young children are at high risk for exposure to IPV. Families in which IPV occurs are more likely than the general population to have children under the age of 5 (Fantuzzo, Boruch, Beriama, Atkins, & Marcus, 1997). Also, young children are likely to witness the violence directly (i.e., see or hear it) because they are often in the presence of their mothers (DeJonghe, von Eye, Bogat, & Levendosky, 2006; Fantuzzo et al., 1997). Between 20% and 25% of school-age children

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living in homes with IPV report that they directly witness it (McCloskey, Figueredo, & Koss, 1995; McCloskey & Walker, 2000; O'Brien, John, Margolin, & Erel, 1994). When IPV episodes involve law enforcement, the rate of child witnessing at all ages increases to 95% (Fusco & Fantuzzo, 2009).

Exposure to IPV results in an increased risk of behavioral and emotional problems among children, as demonstrated by recent meta-analyses (e.g., Chan & Yeung, 2009; Evans, Davies, & DiLillo, 2008; Sternberg, Baradaran, Abbott, Lamb, & Guterman, 2006). The problems include externalizing (e.g., Davis & Carlson, 1987; Fantuzzo et al., 1991; Hughes, 1988; Graham-Bermann & Levendosky, 1998a) and internalizing symptoms (e.g., Grych, Jouriles, Swank, McDonald, & Norwood, 2000; Hughes, 1988), such as PTSD and dissociative symptoms (Bogat, DeJonghe, Levendosky, Davidson, & von Eye, 2006; Graham-Bermann & Levendosky, 1998b; Levendosky, Huth-Bocks, Semel, & Shapiro, 2002).

The extant literature provides only a broad, generic understanding of the effects of IPV on children's PTSD symptoms. The current research focused on children exposed to IPV during the time they were aged 1 to 7 years. The number of children exposed to IPV varied from 29 to 48 across these ages. Our unique, longitudinal data set allowed us to elucidate developmental differences in the symptom picture of these children. In addition, we examined why, because IPV is a unique interpersonal stressor, it is important to understand the child's trauma symptoms in the context of the mother's traumatic response as well as the severity of the IPV she experiences.

## Problems Diagnosing PTSD in Young Children

A significant difficulty in accurately diagnosing very young children stems from their inability to report on their psychological symptoms (Scheeringa, Zeanah, Myers, & Putnam, 2003; Stover & Berkowitz, 2005); thus, children's symptoms are generally assessed through parental report. However, because PTSD symptoms are more likely to be on the internalizing rather than the externalizing spectrum (e.g., feeling confused about the event) and, thus, not "visible" to the parent, there are inevitably problems with reliability. For example, all of the reexperiencing symptoms cannot be assessed by an external observer (parent or otherwise) in children below the age of 1 (e.g., bad dreams [with or without clear content] or flashbacks about the traumatic event) as, without significant language skills, the child cannot describe the content of his or her dreams. It is really only at age 3 that clinicians and researchers can begin to have more confidence in parental assessment of PTSD reexperiencing symptoms.

There are two current sets of diagnostic criteria for PTSD in young children: the *DSM-IV-TR* (*Diagnostic and Statistical Manual of Mental Disorders*, text rev., American Psychiatric Association, 2000) and DC: 0-3R (*Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood*, rev. ed.; Zero to Three, 2005). The *DSM-IV-TR* criteria require A1 (exposure to trauma) and A2 (reaction of fear, helplessness, or horror) as well as one reexperiencing symptom, three avoidance symptoms, and two arousal symptoms (same as for adults). Some guidance is given for modifications of symptoms that are useful when diagnosing children. The major difference in the

two diagnostic systems is that the DC: 0-3R diagnosis of PTSD excludes the A2 criteria and reduces the number of criteria needed for the avoidance/numbing symptom cluster to one symptom. In addition, it eliminates some criteria that are clearly inappropriate for young children (“intense psychological distress at exposure to internal or external cues that symbolize or resemble the trauma” and “inability to recall an important aspect of the trauma”) and adds one new avoidance/numbing symptom (i.e., “social withdrawal”). The DC: 0-3R diagnosis shows predictive validity of children’s problems in functioning and is reliable over time (Meiser-Stedman, Smith, Glucksman, Yule, & Dalgleish, 2008; Scheeringa, Zeanah, Myers, & Putnam, 2005).

However, some research indicates that very young children may experience additional/different trauma symptoms that are not contained within either the *DSM-IV-TR* or the DC: 0-3R (Scheeringa & Zeanah, 1995, 2001). These include constriction of play, regression to earlier functioning (such as loss of toilet training), aggression, separation anxiety, and development of new fears (Scheeringa & Zeanah, 1995). This symptom cluster, called “New Symptoms,” was included in the diagnosis of Traumatic Stress Disorder (TSD) in the original DC: 0-3 (*Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood, Zero to Three, 1994*). Thus, if using the *DSM-IV-TR* or the DC: 0-3R, the more constricted range of symptoms that exclude those most applicable to young children may limit the clinician and researcher from diagnosing PTSD symptoms in young children.

Assessment of PTSD symptoms needs to be developmentally sensitive. Recent studies suggest that the DC: 0-3R is the superior system for children aged 0 to 6 (Meiser-Stedman et al., 2008; Scheeringa, 2008); however, in our opinion, children under the age of 1 year cannot be reliably diagnosed. The data are unclear whether the criteria for the DC: 0-3R diagnosis of PTSD is the superior diagnostic system for childhood through adolescence (Scheeringa, Wright, Hunt, & Zeanah, 2006) or whether current *DSM-IV-TR* criteria are better (see Kearney, Wechsler, Kaur, & Lemos-Miller, 2010, for a review).

It is difficult to ascertain the most accurate diagnostic system for specific age groups because most research is cross-sectional and thus it aggregates data from children of a wide variety of ages. A recent meta-analysis that examined 96 studies of children aged 3 to 18 found that exposure to traumatic events was significantly associated with both posttraumatic symptoms and PTSD and that there were no age effects in this association (Furr, Comer, Edmunds, & Kendall, 2010). However, the data were analyzed by comparing those children aged 3 to 12 with children older than age 12. This procedure did not allow for examination of the potential developmental differences between infants, preschoolers, and school-age children. Our longitudinal data provided a unique opportunity to examine these differences.

There are few studies solely focused on trauma symptoms of very young children. Research finds that young children exposed to single event or chronic traumatic events (e.g., IPV) exhibit symptoms that fit the three *DSM-IV-TR* clusters (see Coates & Gaensbauer, 2009, for a review). However, the rates of PTSD diagnosis in trauma-exposed young children are only consistent with rates of older children when developmentally sensitive versus *DSM-IV-TR* criteria are used (25%-69% vs. 0%-20%,

respectively; Ghosh-Ippen, Briscoe-Smith, & Lieberman, 2004; Levendosky et al., 2002; Meiser-Stedman et al., 2008; Ohmi et al., 2002; Scheeringa, Peebles, Cook, & Zeanah, 2001; Scheeringa, Zeanah, Drell, & Larrieu, 1995; Scheeringa & Zeanah, 2008; Scheeringa et al., 2003). A similar pattern of results is found in the few studies that have specifically examined PTSD symptoms and diagnoses in children exposed to IPV.

## Research on PTSD in Young Children Exposed to IPV

Extant studies find that, among young children, witnessing IPV is associated with PTSD symptoms (e.g., Jarvis, Gordon, & Novaco, 2005; Kilpatrick & Williams, 1997). However, while these studies generally find that mothers and/or children report high rates of symptoms, low rates of PTSD diagnosis are reported for children, particularly when *DSM-IV* (American Psychiatric Association, 1994) criteria are used. Across studies of young children (including studies that assessed PTSD symptoms in both younger and older children exposed to IPV), the rates of children who endorsed symptoms in each of the criteria sets were as follows: 52% to 85% for reexperiencing, 3% to 98% for avoidance, and 31% to 73% for arousal, while the rates of *DSM-IV-TR* PTSD reported were between 3% and 25% (Graham-Bermann, DeVoe, Mattis, Lynch, & Thomas, 2006; Graham-Bermann & Levendosky, 1998; Levendosky et al., 2002; Mertin & Mohr, 2002; Rossman, Bingham, & Emde, 1997). The large discrepancies in percentages of symptoms in each of the PTSD clusters that different researchers find are probably due to the cross-sectional nature of the research methods that assessed children from a wide age range (e.g., young childhood to middle childhood or adolescence; Graham-Bermann et al., 2006; Mertin & Mohr, 2002; Rossman et al., 1997). Across ages, reexperiencing symptoms seem to be most prevalent, with avoidant symptoms least prevalent. In addition, the discrepancy between the large percentages of children who have symptoms of PTSD and the much lower percentages of children who meet diagnostic criteria for PTSD suggests that PTSD criteria as defined by the *DSM-IV-TR* are not as valid for young children as they are for adolescents and adults.

Finally, when examining PTSD diagnoses or symptoms in young children, it is important to also examine the mother's symptoms in order to understand fully the child's symptom picture. For example, prior research with infants in the current study revealed that while mothers reported that more than one third of the infants who witnessed IPV had at least one symptom of PTSD, these symptoms of PTSD were associated with maternal PTSD symptoms, especially when mothers had been exposed to severe IPV (Bogat et al., 2006).

## IPV and PTSD in Mothers

In very young children there is some evidence that the mother's trauma symptoms are associated with those of her child (e.g., Bogat et al., 2006; Scheeringa & Zeanah, 2001). This is significant because rates of PTSD across studies of women experiencing IPV typically range from 31% to 84% (Golding, 1999). Scheeringa and Zeanah propose that in situations where mothers experience trauma, relational PTSD can result—a situation in

which the emotional relationship between the mother and child causes an enhancement of the trauma symptoms of each of them. Young children, compared to older children, are considered to be particularly vulnerable to the effects of the mother's trauma response due to their increased physical proximity to and more significant emotional dependence on the mother. Thus, for young children, trauma symptoms may be more highly related to the severity of the mother's trauma symptoms, rather than the frequency of witnessing IPV (or other traumas), compared with older children and adults. Current research has not examined developmental changes in relational PTSD, nor has it examined whether specific symptom clusters of mothers and children are more likely than others to be related. Again, longitudinal data allowed us to examine changes in relational PTSD over time.

## The Current Study

The data from the current longitudinal study allowed for a fine-grained description of the PTSD symptom clusters at six different ages. At each age, we measured PTSD symptoms using developmentally appropriate criteria. In contrast to most studies, we chose to examine symptoms for each of the six age groups separately because of the significant developmental changes that occur over the course of 1 year during early childhood. This allowed us to examine variation in symptom picture across age groups. We addressed the following research questions. First, does age influence the types of symptoms and symptom clusters that children exhibit? Second, do the three different diagnostic schemes (*DSM-IV-TR*, DC: 0-3R, and DC: 0-3) show age differences in rates of diagnosis? Third, is the frequency of witnessed IPV related to children's PTSD symptoms? Fourth, controlling for frequency of witnessed IPV, is there a significant relationship between maternal and child PTSD symptoms, and does this change as a function of the child's age?

## Method

### Participants

The participants were drawn from the Mother-Infant Study (Bogat, Levendosky, & Davidson, 1999; Levendosky, Bogat, Davidson, & von Eye, 2000). Two hundred and six women were interviewed during the last trimester of their pregnancy. After the child was born, they were assessed yearly at the child's birthday through age 7. In the current study, we are presenting data from ages 1, 2, 3, 4, 5 and 7. We did not collect data on the children's PTSD symptoms at age 6. The demographics for the full sample are shown in Table 1. The children in the current research are those whose mothers reported that they witnessed IPV at any age. For each data collection, if the mother reported that her child had witnessed IPV (note, the mother may have experienced IPV but the child did not witness it), then she was asked to report on her child's symptoms of PTSD. Because in any given year the women may not have experienced IPV or the child may not have witnessed what occurred, the data at each time point are not necessarily for the same children (see Table 1 for the children witnessing IPV each year and the percentage with any PTSD symptoms and full diagnosis).

**Table 1.** Children Who Witnessed IPV With PTSD Symptoms at Ages 1 to 7.

	Age of Child					
	1	2	3	4	5	7
IPV, <i>n</i>	77	83	55	65	51	47
Witness, <i>n</i>	48	43	29	38	33	29
PTSD symptoms, <i>n</i>	18	26	23	29	16	17
Percentage of witnessing with any symptoms	38	60	79	76	48	86
Percentage of witnessing with DSM-IV-TR diagnosis	N/A	0	0	2	2	4
Percentage of witnessing with DC: 0-3R diagnosis	N/A	1	9	14	6	21
Percentage of witnessing with DC: 0-3 diagnosis	N/A	4%	12%	17	N/A	N/A

Note: DSM-IV-TR = *Diagnostic and Statistical Manual of Mental Disorders* (text rev.); DC: 0-3R = *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* (rev. ed.).

## Measures

**IPV.** IPV was assessed with the Severity of Violence Against Women Scales (SVAWS; Marshall, 1992), a 46-item questionnaire that measures the frequency of threats of violence, actual physical violence, and sexual violence during the past year. A total frequency score at each time point was used. Mothers also indicated whether their children witnessed the violence. Marshall reported coefficient alphas among a community sample ranging from .86 to .96 for the subscales.

**Maternal PTSD.** This was assessed using the Posttraumatic Stress Disorder Scale for Battered Women (Saunders, 1994). This self-report questionnaire asks women to endorse how often they experience 17 symptoms that are consistent with the *DSM-IV-TR* symptom list (Criteria B-D) for PTSD. A total score as well as scores for the individual cluster symptoms were used in these analyses. Saunders reported a .94 reliability coefficient, and a high correlation ( $r = .58$ ) with other PTSD scales.

**Child PTSD.** This was assessed with maternal report on three different measures, based on the appropriateness of the measure for the developmental level of the child. The infants were assessed with a measure developed for this study based on the DC: 0-3 criteria (Zero to Three, 1994)—the Infant Traumatic Stress Questionnaire (ITSQ; Bogat, 1999). The preschool children (ages 2-4) were assessed with a measure based on the *DSM-IV-TR* and DC: 0-3 (Zero to Three, 1994) criteria—the Child Traumatic Stress Questionnaire (CTSQ; Bogat & Levendosky, 2002). The 5- and 7-year-old children were assessed with the Child Domestic Violence PTSD scale (Pynoos, Rodriguez, Steinberg, Stuber, & Frederick, 1998), a measure based on the *DSM-IV* (American Psychiatric Association, 1994) criteria. All of these measures yielded symptoms for the three clusters



of reexperiencing, avoidance, and arousal, with the exception of the ITSQ, which did not assess reexperiencing. The ITSQ and the CTSQ also assessed symptoms in the new fears category from the DC: 0-3R.

## Procedures

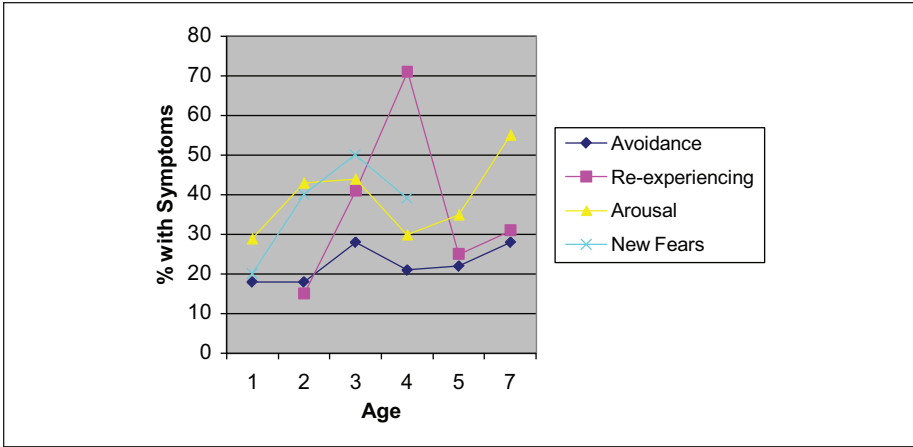
Women were recruited into this study during their pregnancy. We oversampled for women who had experienced IPV so that more than half of them had experienced IPV during the pregnancy (see Huth-Bocks, Levendosky, Bogat, & von Eye, 2004) for a detailed description of recruitment and screening. The current study analyzes data collected when the children were ages 1, 2, 3, 4, 5 and 7. At each wave, data include only those children whose mothers indicated that they witnessed IPV during the past year. Interviews were scheduled near the child's birthday. Women were paid for their time, and children were given a small gift.

## Results

The children who witnessed IPV at each of the six ages were assessed for their PTSD symptoms and whether they met criteria for PTSD. There was no linear developmental pattern to the number of children who lived in homes where IPV occurred or to the number of children who witnessed the IPV (see Table 1). At ages 1 and 2, children were more likely to have IPV in their homes and to witness it compared to children at other ages. Across the different ages, there was a general rise in the percentage of children witnessing IPV who experienced symptoms, with the exception of age 5 when there was a decline. The percentage of children diagnosed with PTSD based on the DC: 0-3 or DC: 0-3R criteria was higher at all ages compared to when the *DSM-IV-TR* diagnostic criteria were used (see Table 1).

There were developmental patterns in the three PTSD clusters of symptoms: reexperiencing, avoidance, and arousal (see Figure 1). Arousal was the most frequently endorsed at all ages, except age 4. At age 4 reexperiencing was the most highly endorsed symptom. The percentage of children with reexperiencing symptoms peaked at age 4 and then declined. The percentage of children who experienced avoidance rose from ages 1 to 3 and then stayed fairly stable, with mild fluctuation between ages 4 and 7. The percentage of children who experienced arousal symptoms increased from ages 1 to 3, dropped at ages 4 and 5, and was then fairly stable until age 7, when it increased dramatically. In addition, the percentage of new symptoms (a category of symptoms unique to DC: 0-3 diagnostic criteria) also showed a nonlinear pattern (see Figure 1). The percentage of children with these symptoms was similar at ages 1 and 2, more than doubled at age 3, and then declined at age 4, but to levels higher than ages 1 and 2. These symptoms were not measured at ages 5 and 7.

Frequency of IPV witnessed by the children influenced the relationship between symptoms and the age at which they were expressed (see Table 2). Again, though, the results were not consistent. Frequency of IPV was significantly related to total PTSD symptoms at



**Figure 1.** Percentage of Children Experiencing the Four Types of Symptoms at Each Age.  
 Note: Figure is available in full color in the online version at [vaw.sagepub.com](http://vaw.sagepub.com)

**Table 2.** Relationship Between Frequency of IPV Witnessed and Child PTSD Symptoms.

	Age of Child					
	1	2	3	4	5	7
Total PTSD	.46*	.24*	.70*	.48*	.72*	.48*
Reexperiencing	N/A	-.15	.04	.16	.34*	.41*
Avoidance	.28*	-.02	.08	.21	.36	.36*
Arousal	.30*	.17	.36*	.29*	.52*	.23
New symptoms	.09	.17	.44*	.35*	N/A	N/A

Note: IPV = intimate partner violence; PTSD = posttraumatic stress disorder.  
 \* $p < .05$ .

all ages. None of the symptom clusters follows this pattern. Reexperiencing was only associated with severity of IPV at age 7. Avoidance was only associated with frequency of IPV at ages 1, 5, and 7. Arousal was associated with frequency of IPV at ages 1, 3, 4, and 5. The new symptoms cluster from the DC: 0-3 (Zero to Three, 1994) was associated with frequency of witnessing IPV at ages 3 and 4.

Finally, we examined the relationship between mothers' and children's PTSD symptoms, controlling for frequency of witnessed IPV (see Table 3). These revealed inconsistent significant relationships across ages without a clear developmental pattern. In fact, the patterns that existed seemed to be related to symptom clusters rather than to age. The most consistent relationships were found for arousal symptoms across ages, showing significance for ages 1, 2, 4, and 7. In contrast, there were no significant relationships between reexperiencing symptoms for mothers and children.

**Table 3.** Relationship Between Child and Maternal PTSD Symptoms Controlling for Frequency of IPV Witnessed.

	Age of Child					
	1	2	3	4	5	7
Total PTSD	.47*	.19	.25	.43*	.44*	.13
Reexperiencing	N/A	.15	.01	.17	-.02	.28
Avoidance	.44*	.18	.04	.45*	.44*	.07
Arousal	.39*	.32*	.21	.44*	.19	.31*

Note: IPV = intimate partner violence; PTSD = posttraumatic stress disorder.  
 \**p* < .05.

### Discussion

Overall, our findings indicate that children are affected by the IPV they witness and often show a traumatic response. The likelihood of traumatic symptoms increases as children age; this is consistent with the trajectory of other anxiety disorders and internalizing disorders generally (Kovacs, Feinberg, Crouse-Novak, Paulauskas, & Finkelstein, 1984; Leve, Kim, & Pears, 2005). In addition, maternal report of child PTSD symptoms changes across development such that some symptoms are more likely to be endorsed in infancy and others during preschool. The “new symptoms” category in the original DC: 0-3 (Zero to Three, 1994) was relatively highly endorsed by the mothers in our sample, and the correlations with frequency of witnessing IPV were in the same direction and generally of the same strength as the other three groups of symptoms. In addition, these symptoms contributed to several additional cases of diagnosed TSD in ages 2 to 4. One possible interpretation is that these symptoms are in fact other ways of responding to trauma and a comprehensive assessment of early childhood traumatic responses should include these symptoms.

Rates of diagnosed PTSD were low in this study, compared with studies of older children exposed to trauma (Graham-Bermann et al., 2006; Lehmann, 1997). Only the PTSD diagnosis rate of 21% in the 7-year-olds (using the DC: 0-3R criteria) approaches rates typical of older children reported in the literature (i.e., 25%-69%; Ghosh-Ippen et al., 2004; Levendosky et al., 2002; Meiser-Stedman et al., 2008; Ohmi et al., 2002; Scheeringa et al., 2001, 1995; Scheeringa & Zeanah, 2008; Scheeringa et al., 2003). It may be that young children rarely meet all criteria for a PTSD diagnosis, similar to the low rates for other anxiety and internalizing disorders. The low rates of PTSD diagnosis, even using the DC: 0-3R or DC: 0-3 criteria suggest that young children witnessing IPV do not fit the same profile of responses to IPV as older children and adults. Their high rates of symptoms suggest that they do experience affective and behavioral dysregulation but that it is not adequately captured with the various instruments that assess PTSD diagnoses. Our findings suggest that alternative conceptions of posttraumatic consequences for young children are important to consider, such as the Developmental Trauma Disorder (DTD), currently under

development by van der Kolk and colleagues (see van der Kolk, Roth, Oelcovitz, Sunday, & Spinazzola, 2005).

Another explanation for the low rates of PTSD diagnosis among the young children in our sample may relate to the difficulty mothers have reliably reporting internalizing symptoms. At this stage of development, mothers may have underestimated the symptoms, thus depressing the rates of PTSD. Consistent with this hypothesis is the finding that arousal symptoms were generally the most frequently endorsed by mothers. Arousal symptoms are more amenable to external observation than are reexperiencing and avoidance symptoms.

The total number of children's symptoms was related to the frequency of IPV that they witnessed. This is consistent with previous findings (e.g., Graham-Bermann et al., 2006; Levendosky et al., 2002; Rossman et al., 1997) and suggests that young children are directly affected by witnessing violence, even if most of them do not meet criteria for PTSD. Arousal was significantly associated with witnessing IPV for ages 1 to 5 (with the exception of age 2). In contrast, avoidance was only associated with witnessing IPV at ages 5 and 7, and reexperiencing was only associated at age 7. This may indicate a developmental shift such that in the youngest children, affective dysregulation is the most dominant response to witnessing IPV, but as children get older, more cognitive and behavioral dysregulation as a response to witnessing IPV become prominent, as seen in reexperiencing and avoidance. This may reflect the increasing differentiation of symptoms of emotional distress that occur with development and are associated with particular psychopathologies (Carter, Briggs-Gowan, Jones, & Little, 2003; Eisenberg et al., 2001). Age 2 was an exception to the trend, with no specific symptom clusters related to witnessing IPV. The inconsistency of the age 2 data may be a valid finding. This is the age when children first attempt to separate and develop independence; this may be a particularly trying and conflictual experience in families where IPV takes place. A mother may be unable to distinguish her toddler's traumatic response from other difficult behaviors.

Our findings also indicated a high co-occurrence of maternal and child PTSD symptoms, controlling for frequency of IPV witnessed, across all the ages. One interpretation of these findings is support for relational PTSD. Young children who are likely to be in close physical and emotional proximity to their mothers are likely to influence and be influenced by her traumatic response to the IPV. In particular, maternal symptoms of arousal were associated with children's arousal symptoms. This suggests young children are responding directly to their mothers' affective dysregulation in reaction to IPV as well as demonstrating similar affective dysregulation. In contrast, maternal reexperiencing symptoms were not related to those of the children. This may be due to children's lack of awareness of maternal reexperiencing symptoms or that these symptoms in their mothers may be less distressing to children than their mother's arousal symptoms. Finally, the lack of a significant relationship also may be due to the difficulty mothers have in ascertaining children's reexperiencing symptoms, as noted above.

There are several limitations to this study. The first is the reliance on the mother as the sole reporter of her experiences of IPV as well as her and her child's trauma symptoms. Mothers may underreport witnessing of IPV because, at the time it is occurring, their involvement in the episode may have distracted them from attending to whether or not their

child heard or saw the IPV. In addition, they may defensively imagine that they protect their children from exposure to IPV. The second limitation is related to the size of the sample. Our sample was sufficient to allow for examination of symptoms at each age, rather than aggregating different age children as prior studies have done. However, our study method was to assess PTSD symptoms at each age only for those children whose mothers reported that they witnessed IPV. Thus, we could not examine whether and how PTSD symptoms change throughout an individual child's development. Unfortunately, because women's experiences of IPV are rarely consistent (e.g., overall rates of IPV decrease as women and men age, women often leave and return to abusive partners multiple times) an enormous epidemiological sample would be necessary to track children's trauma symptoms over time.

In summary, similar to other studies, the ratio between children who had symptoms of PTSD in response to witnessing IPV, compared with those who met criteria for PTSD under any of the diagnostic schemes, was low. This adds evidence to the growing movement to include DTD in the *DSM-5* (van der Kolk et al., 2005). This disorder is designed to address the very significant problem that most children exposed to traumatic events, including witnessing IPV, do not meet criteria for PTSD, even the modified criteria by Scheeringa et al. (2003) for younger children. Van der Kolk et al. argue that many children who have a posttraumatic disorder are not currently diagnosed, with the implication that children often do not get services they need. Many of these children, instead, may be receiving treatment for other disorders, such as ADHD (attention-deficit hyperactive disorder) or depression, rather than the treatment they need. Among children who witness IPV, DTD may better capture the posttraumatic problems than current diagnostic schemas.

Future studies should continue to examine the trajectories of symptoms of PTSD in response to trauma across children's ages. Our study suggests that children may exhibit different PTSD symptom clusters across development in response to witnessing IPV. Finally, there are some clinical implications from the current study. It is critical that assessment instruments used by clinicians and researchers with young children exposed to IPV include developmentally sensitive symptom items. Physicians and mental health professionals should assess young children exposed to IPV for trauma symptoms and consider the consequences for children's functioning and development, even when children do not fit criteria for the *DSM-IV* PTSD diagnosis. Finally, this study highlights the importance of clinicians being aware of the differences in the types of posttraumatic symptoms across early childhood.

### **Declaration of Conflicting Interests**

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

### **Funding**

The authors disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This study was supported by grants from the National Institute of Justice (8-7958-MI-IJ) and the Centers for Disease Control (RO1/CCR518519-01) to the first and second authors.

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