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The Relationship Between Community Violence Exposure and Psychological Well-Being

Among Latino Adolescents

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Abstract

Adolescents living in poor, urban neighborhoods are placed at an extremely high risk for witnessing community violence as well as being personally victimized by community violence. Such exposure to community violence increases the likelihood of adolescents developing adverse psychological outcomes such as depression, anxiety, and posttraumatic stress disorder (PTSD). With a sample of 223 Latino ninth grade students, this study examines three potential moderators between the relation of community violence exposure and adverse psychological outcomes: gender, parent-child closeness, and religiosity. The results demonstrate that being male, having greater closeness with one's mother, and exhibiting higher rates of religiosity are protective factors against developing negative psychological symptoms in the face of community violence.

Keywords: adolescents, anxiety, community violence, depression, Latino, posttraumatic stress, PTSD

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Community violence is a serious public health problem in low-income, urban neighborhoods across the United States (Dempsey, 2002; Gorman-Smith, Henry, & Tolan, 2004). As of 2008, the national prevalence of witnessing community violence is estimated to be 38% among adolescents (Zinzow, Ruggiero, Resnick, Hanson, Smith, Saunders, & Kilpatrick, 2009). When focusing on at-risk populations, that prevalence increases. One study found that of the 2,248 adolescents surveyed from an urban public school system, more than 40% reported witnessing a shooting or stabbing in the previous year, and 74% reported feeling unsafe in their daily environments such as homes, schools, and neighborhoods (Schwab-Stone, Ayers, Kaspro, Voyce, Barone, Shriver, & Weissberg, 1995). Another study that examined a broader classification of violence (as opposed to just stabbings and shootings) revealed that among adolescents from nine urban middle schools, 76% reported witnessing or being victimized by at least one violent act in the six month period prior to being surveyed (Hammack, Richards, Luo, Edlynn, & Roy, 2004).

Children and adolescents in poor, dangerous communities face elevated risks for experiencing violence, both as witnesses and victims. At-risk communities are characterized by high rates of poverty, high unemployment levels, neighborhoods that have ethnic diversity, and neighborhoods populated at high density (Esbensen & Huizinga, 1991; Salzinger, Feldman, Stockhammer, & Hood, 2001). These communities usually experience violence in recurring patterns, putting children and adolescents who reside in such neighborhoods at risk for chronic exposure to violence. In these communities, prior victimization is the best predictor of later exposure to violence (Esbensen, Huizinga, and Menard, 1999). A study exploring the different

types of violence experienced in at-risk neighborhoods found that children who witnessed a killing were likely to have witnessed other less severe forms of violence as well, such as robberies, non-fatal shootings, and non-fatal stabbings (Selner-O'Hagan, Kindlon, Buka, Raudenbush, & Earls, 1998).

Certain ethnic minorities are also at a higher risk for experiencing community violence. In a multiethnic study, White public school students witnessed less community violence, on average, than ethnic minority students (Schwab-Stone et al., 1995). Crouch and colleagues (2000) found that among their sample, African American and Latino youth reported witnessing more violence than did White youth. Another study similarly found that African American and Latino students were exposed to significantly more community violence than White and Asian American students (O'Keefe & Amit, 1997). Sixty percent of African Americans and Latinos had reported witnessing a shooting or drive-by shooting in their community compared to only 18% of White and Asian American students (O'Keefe & Amit, 1997). While ethnic minorities are at a higher risk for witnessing community violence, there is also some evidence suggesting that minorities fare worse in resulting psychological outcomes. In a meta-analysis of several independent studies, Latino samples yielded the strongest effect sizes for PTSD and levels of Latinos' symptomology were significantly higher than those of mixed race samples (Fowler, Tompsett, Braciszewski, Jacques-Tiura, & Baltes, 2009). However, this meta-analysis involved a relatively small number of Latino samples, so further research on specifically Latino populations is needed.

The Psychological Effects of Exposure to Community Violence

The higher prevalence of exposure to violence among ethnic minority youth is concerning as research has linked several adverse psychological effects to community violence

exposure. Adolescents are at a critical stage in development, making them especially vulnerable to stress (Berton & Stabb, 1996). Adolescents' repeated exposure to community violence, either as witnesses or as victims, is linked to a host of negative psychological outcomes including anxiety, depressive symptoms, symptoms of posttraumatic stress disorder (PTSD), and school behavior problems (Fowler et al., 2009; Ozer & Weinstein, 2004; Scarpa, Haden, & Hurley, 2006). Three major pervasive symptoms are worth exploring in further depth: depression, anxiety, and PTSD.

The relations between exposure to community violence and symptoms of both depression and anxiety have been demonstrated in various studies of children and adolescents (Freeman, Mokros, & Poznanski, 1993; Hill, Levermore, Twaite, & Jones, 1996; Kliwer, Lepore, Oskin, & Johnson, 1998; Lynch & Cicchetti, 1998). Witnessing community violence was associated with depressed mood in multiethnic samples of over two thousand public school children (Schwab-Stone et al., 1995; Schwab-Stone et al., 1999). Gorman-Smith and Tolan (1998) found that exposure to violence was associated with an increase in depressive symptoms over a one-year period in Latino and African American inner-city adolescents. In a sample of 3,735 adolescents, Singer, Anglin, Song, and Lunghofer (1995) found that exposure to community violence was also related to anxiety.

Similarly, numerous studies document that exposure to community violence is associated with PTSD (Berton & Stabb, 1996; Fitzpatrick & Boldizar, 1993; Jenkins & Bell, 1994; Mazza & Reynolds, 1999; Overstreet, Dempsey, Graham, & Moely, 1999; Singer et al., 1995). A strong positive relation between elevated rates of violence exposure and PTSD was identified in children and adolescents; youth who were exposed to violence were more likely to exhibit post-traumatic stress symptoms and were also more likely to experience those symptoms at a

debilitating level, warranting a clinical diagnosis of PTSD (Fowler et al., 2009). Another study with urban high school students revealed that 34.5% of those exposed to violence met DSM-III-R criteria for PTSD, again warranting a clinical diagnosis (Berman, Kurtines, Silverman, & Serafini, 1996).

The outcome of an adolescent's psychological well-being after experiencing stress can be positively or negatively mediated by coping methods (Aldwin, 1994; Boekaerts, 1996; Brodzinsky et al., 1992; Grant et al., 2000; Lazarus, 1993; Rudolph, Dennig, & Weisz, 1995; Spaccarelli, 1994). Among 120 inner city, African American adolescents aged 10 to 14 years, Dempsey (2002) examined whether negative coping mechanisms mediated the relation between exposure to violence and psychological outcomes. Past research showed associations between violence exposure and negative coping as well as associations between negative coping and psychological difficulties (Berman et al., 1996; Ebata & Moos, 1991; Springer & Padgett, 2000). Psychological well-being was classified as negative if participants displayed clinical levels of posttraumatic stress symptoms, depression, or anxiety. Three negative coping strategies were measured as mediators: avoidance (i.e. ignoring the problem), aggression (i.e. yelling, hitting, or fighting), and internalizing behaviors (i.e. self-criticism). The results revealed that chronic exposure to violence was indeed associated with the use of negative coping strategies such as avoidance, aggression, and internalizing behaviors (Dempsey, 2002). Further, these negative coping strategies mediated the relation between violence and all three psychological well-being measures (post-traumatic stress symptoms, depression, and anxiety). Since negative coping methods can be harmful to psychological well-being, it is important to identify positive coping methods that may help adolescents process stressors in a healthy way. Identifying specific protective factors for adolescents exposed to community violence will suggest what coping

strategies should be taught and modeled for adolescents at risk.

Community Violence Exposure and Gender

Patterns in research illustrate gender differences in children's exposure to community violence. Numerous studies suggest that boys are more likely than girls to experience community violence (Schwab-Stone et al., 1995; Selner-O'Hagan et al., 1998). In a multiethnic sample of fourth- and fifth-grade children, boys reported witnessing greater amounts of community violence than girls (Ceballo, Dahl, Aretakis, & Ramirez, 2001). Research also indicates that boys are more likely than girls to be victimized by community violence by being robbed, shot or beaten. However, girls were more likely to be victimized by being raped (Bell & Jenkins, 1993; Freudenberg et al., 1999, Jenkins & Bell, 1994; Malik et al., 1997; O'Donnell, 1995; Sheley, McGee, & Wright, 1992).

Despite males' higher risk of exposure to community violence, research suggests that female adolescents are more likely to express symptomology of psychological stress as a result of witnessing violence and victimization (Foster, Kuperminc, & Price, 2004). A study conducted with young adolescents reported that more female participants expressed general distress than did male participants in response to witnessing a peer become victimized by violence (Paquette & Underwood, 1999). More specific symptoms, such as depression, anxiety, and PTSD symptoms, had a higher prevalence in female samples when compared to male samples. In one study of young adolescents, exposure to violence was significantly related with anxiety in girls but not in boys (White, Bruce, Farrell, & Kliewer, 1998). Further, females who had been victimized by violence were more likely to report depressive symptoms than victimized males (Fitzpatrick, 1993). Victimized females also displayed more severe PTSD symptoms in comparison to victimized males (Fitzpatrick & Boldizar, 1993; Jenkins & Bell, 1994). In a meta-

analysis, Fowler et al. (2009) found that female samples yielded stronger effects than male samples for internalizing behaviors in response to violence. In sum, research consistently demonstrates that male children and adolescents are at higher risk for experiencing violence as both victims and witnesses, while female children and adolescents are at a higher risk for displaying more prevalent and more severe adverse psychological outcomes.

Parent-Adolescent Closeness

Research on the changing nature of parent-child relationships reveals a certain amount of disruption in cohesion during the transition into adolescence (Collins & Russell, 1991; Paikoff & Brooks-Gunn, 1991). Developmental psychologists have attributed these changes in cohesion to the development of adolescent autonomy, citing an adolescent's growing desire for autonomy as associated with small to moderate increases in parent-child conflict along with decreases in parent-child cohesion. In a sample of sixth, eighth, and tenth graders, researchers examined adolescents' self-reported relationships with their parents based on their perceived family cohesion and solidarity (Fulgini, 1998). Findings revealed that while parental conflict was present in all age groups, a greater prevalence was reported with each increasing grade level, suggesting that conflict between parents and children progresses throughout the adolescence period. However, despite reporting conflict in their relationships, a majority of participants viewed parents as a source of support and advice. This suggests that parent-child relationships in adolescence, while somewhat turbulent, are still valuable for adolescents' sense of well-being.

Further, parent-adolescent relationships may manifest differently from culture to culture. Fulgini (1998) explains that if, indeed, the cause of the shift in the parent-child relationship during adolescence is a result of adolescents' increased desire for autonomy, then individual cultures must be studied because emphasis on autonomy varies among cultural groups. Most

research on the changing nature of parent-child relationships in adolescence has been conducted with European American families and does not take cultural variation into account. For instance, Mexican, Chinese, and Filipino families are all characterized as respecting parental authority, downplaying individual autonomy, and placing more of an emphasis on family cohesion and solidarity (Chilman, 1993; Harrison, Wilson, Pine, Chan, & Buriel, 1990; Ho, 1981; Shon & Ja, 1982; Uba, 1994). Accordingly, on questionnaires regarding beliefs about parental authority and relationships with parents, Mexican-American, Chinese-American, and Filipino-American adolescent respondents demonstrated a greater respect for authority and less emphasis on autonomy when compared to their European American classmates (Fuligni, 1998).

Latino families, in particular, have shown high degrees of cohesion and hierarchical organization within the family structure (Falicov, 1982). Interactions common among Latino families revealed generational interdependence and loyalty to family members, with high levels of affective resonance (emotionally attuned reciprocal relationships), interpersonal involvement, and internal [familial] control. The different prioritizing of family values and the varying types of interactions characteristic of different ethnicities may influence the nature of changing parent-adolescent relationships.

Moderators of the Effects of Community Violence

Gender. As explained previously, gender may moderate the effects of community violence. Although boys have been shown to experience more community violence than girls (Ceballo et al., 2001; Schwab-Stone et al., 1995; Selner-O'Hagan et al., 1998), numerous studies suggest that girls are more likely to express symptoms of psychological distress as a result of witnessing violence and victimization, such as general distress, depression, anxiety, and PTSD symptoms (Fitzpatrick & Boldizar, 1993; Jenkins & Bell, 1994; Paquette & Underwood, 1999).

In sum, research suggests that being male attenuates the negative psychological outcomes that accompany community violence exposure while being female increases negative psychological outcomes.

Family cohesion and conflict. Families with high levels of conflict place their children at a higher risk for exposure to violence, both as witnesses and victims. Adolescents who report feeling socially isolated from their families are at an increased risk for exposure to violence (Esbensen et al., 1999). Adolescents who feel so isolated that they decide to leave home because of an abusive family are even more susceptible to community violence and victimization (Whitbeck & Simons, 1990). Violence within the family is also associated with an increased risk that children and adolescents will witness neighborhood shootings or stabbings (Bell & Jenkins, 1993). Parental involvement in violent behavior, as well as negative family interaction quality, are related to greater risk for adolescent criminal victimization (Esbensen et al., 1999). The risk for witnessing community violence also increases drastically in families with high levels of reported conflict (Osofsky, Wewers, Hann, & Flick, 1993). Severe conflict, such as parental maltreatment, predicts both witnessing of community violence and personal victimization over one year (Lynch & Cicchetti, 1998). Taken together, these findings support the broader claim that family functioning plays a role in adolescents' exposure to community violence in the first place.

Additionally, some studies found that family cohesion and perceived familial support moderate the relations between exposure to community violence and negative psychological outcomes (Kliewer et al., 1998; Kliewer et al., 2004, Kuther & Fisher, 1998; Ozer & Weinstein, 2004). Family functioning plays a role in resulting psychological outcomes, with negative familial relationships linked to a higher likelihood of developing adverse symptoms. In one

study, boys in less cohesive families suffered more depression and anxiety following exposure to community violence (Gorman-Smith & Tolan, 1998). Another study revealed that increased family conflict mediated the impact of violence exposure on children's PTSD symptoms (Overstreet & Braun, 2000). These findings indicate that family conflict may further exacerbate adverse symptoms that appear in relation to community violence.

Inasmuch as negative family dynamics are a risk factor for witnessing and experiencing violence and developing distress once violence is experienced, positive family traits can be a protective factor against violence exposure as well as against consequential negative psychological outcomes that may result from violence exposure. Family cohesion serves to buffer the relation between stress and negative outcomes, such as antisocial behavior, in adolescents (Tolan, 1988). African American and Latino male youth living in inner-city neighborhoods who come from families that were identified as well-functioning, across multiple dimensions of parenting and family relationship characteristics, were less likely to be exposed to community violence and also less likely to later perpetuate violence when compared to youth from lower functioning families who were exposed to similar amounts of violence (Gorman-Smith, Henry, & Tolan, 2004). Parent-adolescent relationships can also be a potential source of support and guidance for at-risk adolescents. A healthy attachment to parents is associated with a reduced risk for adolescent victimization, and good parental discipline and monitoring practices have been identified as protective factors against victimization (Esbensen et al., 1999). Both parental monitoring and support have been associated with lower levels of witnessing violence (Sullivan, Kung, & Farrell, 2004). Parental monitoring has also been found to moderate the relations between experiencing violence (as a witness or a victim) and both depression and hopelessness (Ceballo, Ramirez, Hearn, & Maltese, 2003). Further, closeness to mothers and

time spent with family moderated the relations between experiencing violence (both victimization and witnessing violence) and psychological symptoms, specifically anxiety and depression, such that those who were closer to their mothers experienced fewer symptoms after exposure to violence (Hammack et al., 2004).

Religiosity. In addition to parent-child relationships, religiosity is another potential moderating factor between adolescents' exposure to community violence and the consequential effects on psychological well-being. However, research on the impact of religiosity has yielded mixed results. Some aspects of religiosity moderate the relationship between stressors and depressive symptoms. A meta-analysis of 147 independent investigations with adults found that across all studies, greater religiosity was mildly associated with fewer depressive symptoms. This association was stronger in studies involving people who were undergoing stress due to recent life events, suggesting that religiosity may serve as a buffer to stressful events. However, this meta-analysis identified two specific aspects of religion that were harmful to psychological well-being: extrinsic religious orientation (involving oneself in religion strictly for self-seeking ends) and negative religious coping (e.g. avoiding difficulties through religious activities or blaming God for difficulties). These behaviors were associated with higher levels of depressive symptoms, demonstrating the opposite direction of the overall findings. Yet aspects of religion, such as God-concept (belief in a higher being) and intrinsic religious orientation (involvement in religion based on a genuine interest in religion rather than for self-seeking ends), yielded significant negative associations between religiosity and depressive symptoms, such that higher levels of God-concept and intrinsic religious orientation yielded lower levels of depressive symptoms (Smith & Poll, 2003). One explanation for this buffer effect is that religious people may experience life events as less threatening and stressful if they believe that their lives are

controlled by a higher power or that negative life events happen for a reason (George, Larson, Koenig, & McCullough, 2000).

Researchers who study religiosity among children and adolescents have also found that religiosity demonstrates protective effects. Among African American children living in a high-crime community, religiosity (measured as spirituality) served as a protective factor that contributed to resilience in those exposed to community violence (Jones, 2007). Another study that examined the effects of religiosity on the development of conduct problems among adolescents exposed to violence found that religiosity buffered the negative effects of violence exposure; religiosity served as a moderator of the relation between violence exposure and conduct problems (Pearce, Jones, Schwab-Stone, Ruchkin, 2003). However, not all research has demonstrated protective effects of religiosity among youth. A study conducted with urban middle-school children found that the relation between community violence exposure and poor academic functioning was stronger for children in families with high levels of religious emphasis (Overstreet & Braun, 1999). Mixed findings on religion indicate that “religion” is too complex to be considered alone since there are varying behaviors and beliefs that fall under the category of religiosity, some of which appear to be risk factors and some of which appear to be protective factors.

The effects of religiosity do not only vary by different religious behaviors, but they also vary among different populations. A study examining racial differences in the relationship between community violence exposure and public and private religiosity in predicting externalizing problems revealed different effects between African American and European American at-risk adolescents (Fowler, Ahmed, Tompsett, Jozefowicz-Simbeni, & Toro, 2008). In both populations, community violence exposure was related to more externalizing problems.

Public religious affiliation showed benefits for both populations; in both the African American adolescents and the European American adolescents, greater public religious affiliation buffered the relationship between community violence exposure and substance abuse. However, the effects of private religiosity differed. Whereas greater private religiosity was a protective factor for African American adolescents in the relationship between community violence and deviant behavior, in European American adolescents no protective benefits were shown. Again, this shows that religiosity is a complex measure, with varying components within and varying effects among different populations.

Current Study

According to data from the US census, Latino youth represent the fastest growing group of youth in the country and they are likely to live in urban areas with high crime rates (Macartney, 2011). This makes Latino youth a population worthy of attention in our understanding of risk and protective factors regarding exposure to community violence and the resulting psychological implications. A recent study on low-income, urban, Latino adolescents found that symptoms of post-traumatic stress and depression were prevalent in a majority of participants who reported exposure to community violence (Kennedy & Ceballo, 2013). Symptoms of posttraumatic stress in adolescents can include problems with memory, concentration, planning for the future, and chronic feelings of fear or anxiety (Perrin, Smith, & Yule, 2000). A range of past research gives insights into the effects of chronic community violence exposure on children and adolescents, but far less information exists on Latino adolescents.

As previously discussed, research on the role of gender with regard to community violence has yielded consistent patterns. Trends strongly indicate that male children and

adolescents are more likely to experience community violence (both as victims or witnesses) than females, while female adolescents, upon exposure to community violence, are more likely to develop adverse psychological symptoms. This study will examine the relation of gender with both rates of exposure to community violence and resulting psychological outcomes to see if previous findings will be replicated among Latino adolescents and to determine if gender is indeed a moderator between community violence exposure and adverse psychological outcomes for this population.

Parent-child relationships should also be examined as a moderator of the relation between community violence exposure and psychological well-being among Latino adolescents. Research has repeatedly illustrated a changing nature of parent-child relationships as children enter adolescence, such as declines in cohesion and rises in conflict. However, studying family closeness and cohesion should be examined specifically with attention to culture, since research has demonstrated that there are unique family dynamics and values among different ethnicities. In particular, Fuligni (1998) demonstrated that Latino families are uniquely characterized by greater respect for authority and less emphasis on children's autonomy. Studies suggesting that Latino families display higher levels of cohesion indicate that parent-child cohesion in adolescence may play an important role in developing resilience against violence (Chilman, 1993; Harrison et al., 1990; Ho, 1981; Shon & Ja, 1982; Uba, 1994).

Religiosity is another possible moderator that should be studied particularly with regard to Latino adolescents. The findings of existing research have been mixed, showing that religion interacts differently in relations between community violence exposure and psychological well-being based on different behaviors of religiosity and different family ethnicities. Recognizing the importance of specifically defining religious behavior or beliefs, this study proposes to examine

the role of reported spirituality in the relation between community violence exposure and adolescents' psychological well-being. In one study, Latino college students scored higher on a measure of spirituality when compared to non-Latino college students (Campesino & Schwartz, 2009). This may demonstrate that the spirituality aspect of religion plays an important part in the lives of young Latinos, however much more research is needed. A major gap in the literature currently is the lack of research on Latino adolescents' spirituality, and this study will attempt to address that gap.

This study will address the following research questions:

- (1) Do male and female Latino adolescents experience similar amounts of community violence exposure?
- (2) Do the relations between violence exposure and psychological well-being as assessed by symptoms of depression, anxiety, and PTSD, vary by gender?
- (3) Is the relation between community violence exposure and psychological well-being moderated by parent-child closeness and cohesion?
- (4) Is the relation between community violence exposure and psychological well-being moderated by adolescents' religiosity?

The following hypotheses address each research question in the order previously presented:

- (1) I hypothesize that Latino adolescent males will experience more community violence than Latino adolescent females.
- (2) I expect that the relations between community violence exposure and indicators of psychological well-being, specifically depression, anxiety, and PTSD, will be stronger for Latino adolescent females than for Latino adolescent males, such that females are more likely to

experience symptoms of depression, anxiety, and PTSD.

(3) Similarly, I hypothesize that more cohesion and closeness between parents and adolescents will serve as a moderator between exposure to community violence and psychological well-being, such that family cohesion buffers the relation between community violence exposure and negative symptoms.

(4) Finally, I expect the relation between community violence exposure and psychological well-being to be moderated by adolescents' religiosity, with higher levels of religiosity buffering the relation between community violence exposure and negative psychological well-being.

Method

Sample

This study used data from the Latino Family Study that was collected from 223 ninth grade students attending three high schools located in two impoverished, Northeastern cities (Kennedy & Ceballo, 2013). The sample included 137 females and 86 males with a mean age of 14.5 years ($SD = .69$). All participating adolescents self-identified as Latino with the largest ethnic group represented being Dominican Americans (62.8% of respondents) and the second largest group represented being Puerto Rican Americans (17.7% of respondents). Seventy-six percent of participants were born in the United States and 85% spoke both English and Spanish at home. Eighty-nine percent of participants were eligible for free or reduced lunch at school, signifying their lower socioeconomic status. When asked about religious affiliation, a majority of participants (65%) identified as Catholic. The remaining participants were distributed fairly evenly between Orthodox Christian, Protestant, other, and no religion. A majority of participants were involved in at least some aspect of organized religion, such as attending services (85%), taking part in other religious activities (71%), and participating in church-based clubs such as a choir (63%).

Procedures

Data were collected via self-report surveys administered at school. All ninth-grade students at each of the three participating schools were given recruitment letters and consent forms to take home to their parents. Both English and Spanish versions were sent home with students. Students who received parental consent went on to participate in the study.

Questionnaires were completed in a quiet classroom during the school day, and several breaks were given. Participants had the option to complete the questionnaires in English or Spanish; however, only seven students chose to complete the questionnaire in Spanish. For these participants, bilingual research assistants were available to provide assistance. Students took approximately two hours to complete the questionnaire. Afterwards, each participant received a \$30 gift card to a local movie theater or shopping mall to thank them for their time and cooperation.

Measures

Community violence exposure. Community violence exposure was assessed using the Survey of Exposure to Community Violence (Richters & Martinez, 1993). The survey asked how often certain violent incidents had been experienced in the adolescent's lifetime using a 9-point Likert scale ranging from (1) *never* to (9) *almost every day*. The scale contained 20 items, with ten items pertaining to personal victimization and ten items pertaining to witnessing violence. An example question for personal victimization was, "How many times have you yourself been chased by gangs or individuals?" whereas an example question for witnessing violence was, "How many times have you seen *someone else* attacked or stabbed with a knife?" Responses to items were summed, resulting in a total victimization score for each participant. Higher scores reflected greater exposure to community violence. Cronbach's alpha for the personal

victimization subscale was .80 in our sample. Cronbach's alpha for witnessing violence was .84 in this sample.

Parent-child closeness and cohesion. Parent-child closeness and cohesion was assessed in relation to mothers. Mother-child cohesion was measured using the Family Adaptation and Cohesion Evaluation Scales (Chao, 2001; Fuligni, 1998). Participants completed 10 items regarding relationships with their mothers. The scale included statements such as, "My mother and I feel very close to each other," and, "My mother and I like to spend our free time with each other." Responses to the items ranged from (1) *almost never* to (5) *almost always*. Higher scores indicated greater parental-child relationship closeness. Cronbach's alpha for this scale was .86 in our sample.

Religiosity. This study focused on subjective aspects of religiosity such as higher self-reported levels of spirituality; for example, finding greater strength, solace, and help in God or a higher being. This was measured using the Fetzer Institute's (1999) "Multidimensional Measurement of Religiousness/Spirituality for Use in Health Research." Participants responded to seven items reflecting aspects of subjective religiosity, with responses ranging from (1) *not at all* to (4) *a great deal*. The scale included questions such as, "Do you believe in a spiritual power?", "Do you feel close to God?", and, "Do you believe God watches over you?" Higher scores reflected greater religiosity and/or spirituality. Cronbach's alpha for this scale was .88 in our sample.

Depressive symptoms. Levels of depressive symptoms were assessed using the Children's Depression Inventory (CDI; Kovacs, 1985). The CDI measured participants' depressive symptoms within the two weeks prior to taking the survey. One item regarding suicidal ideation was omitted from the measure per the request of one of the participating

schools, resulting in a 26-item scale. For each item, a cluster group of three statements is presented and participants are asked to choose which statement best describes how they feel. A sample cluster of statements is, “I am sad once in a while” (0), “I am sad many times” (1), and “I am sad all the time” (2). Scores were summed to produce a total individual score ranging from 0 to 52, such that higher scores indicated greater depressive symptoms. Cronbach’s alpha for this scale was .82 in our sample.

Anxiety. Anxiety symptoms were assessed using Reynolds and Richmond’s (1978) Revised Measure of Children’s Manifest Anxiety. Anxiety was divided into three subscales: physiological anxiety, worry/over-sensitivity anxiety, and concentration anxiety. Data on the three subscales was collected with the 28-item “What I Think and Feel” scale, with 10 items pertaining to physiological anxiety, 11 items pertaining to worry/over-sensitivity anxiety, and 7 items pertaining to concentration anxiety. An example of an item pertaining to physiological anxiety is, “How often do you have trouble catching your breath?” Responses to items ranged from (1) *never* to (5) *most of the time*. Responses to this subscale were averaged; higher scores indicated greater frequency of physiological anxiety. Cronbach’s alpha for this subscale was .84 in our sample. An example of an item pertaining to worry/over-sensitivity anxiety is, “How often do you worry about what’s going to happen?” Responses to this subscale were averaged, and higher scores indicated greater frequency of worrying anxiety. Cronbach’s alpha for this subscale was .93 in our sample. An example of an item pertaining to concentration anxiety is, “How often is it hard to keep your mind on your schoolwork?” Responses to this subscale were averaged, and again, higher scores indicated greater frequency of concentration anxiety. Cronbach’s alpha for this subscale was .87 in our sample. The means of each anxiety subscale were then summed to create a score for general anxiety. Higher scores indicated a greater frequency of overall

anxiety. Cronbach's alpha for this scale was .95 in our sample.

Post-traumatic stress. Posttraumatic stress symptoms were assessed using the Child Posttraumatic Stress Reaction Index (Pynoos & Nader, 1993). The measure is comprised of 19 items on a Likert scale ranging from (1) *never* to (5) *most of the time*. This scale included questions such as, "How often do you get tense or upset when something reminds you about something bad that happened in the past?" and, "How often do you have thoughts about something bad that happened in the past even when you don't want to?" Responses were summed to create a total score, such that higher scores indicated more PTSD symptoms. Responses ranged from 19 to 95. Cronbach's alpha for this scale was .93 in our sample.

Results

Many participants in this study reported exposure to community violence, both via witnessing violence and via personal victimization. Lifetime exposure rates to specific types of violence are presented in Table 1. A majority of participants reported witnessing violent events such as seeing someone carrying a gun or a knife (71%), seeing someone using or selling drugs (70%), seeing someone threatened with physical harm (67%), and seeing someone beaten up or mugged (65%). A majority of participants had personally been hit, punched, or slapped by someone else (71%), as well as heard gunfire while in or near their homes (69%). Overall, there was a higher prevalence of witnessing community violence than personal victimization.

Table 2 displays the correlations found among all independent and dependent variables. There was a strong correlation between witnessing violence and personal victimization ($r = .77$, $p < .001$). Correlations were also found between all independent variables and dependent variables such that an increased rate of community violence exposure was associated with an increased prevalence of adverse psychological symptoms: witnessing violence and depression ($r = .22$, $p < .01$); witnessing violence and anxiety ($r = .22$, $p < .01$); witnessing violence and PTSD ($r = .26$, $p < .001$); personal victimization and depression ($r = .23$, $p < .01$); personal victimization and anxiety ($r = .26$, $p < .001$); and personal victimization and PTSD ($r = .30$, $p < .001$); Further, all three psychological well-being variables were correlated with one another, suggesting comorbidity in many participants: anxiety and depression ($r = .58$, $p < .001$); PTSD and depression ($r = .55$, $p < .001$); and PTSD and anxiety ($r = .83$, $p < .001$).

Research Question 1: Do Latino boys and girls experience similar amounts of community violence exposure?

To address the hypothesis that Latino adolescent males would experience more

community violence than Latino adolescent females, a t-test was performed to compare the two groups. Three independent samples t-tests revealed that males and females experienced similar amounts of community violence exposure. There was no significant difference between males ($M = 22.5$, $SD = 11.93$) and females ($M = 22.46$, $SD = 11.31$) in rates of witnessing violence [$t(221) = .03$, $p = .98$]. Similarly, there was no significant difference between males ($M = 18.45$, $SD = 8.20$) and females ($M = 17.48$, $SD = 9.01$) in rates of personal victimization [$t(221) = .81$, $p = .42$]. When overall community violence exposure was measured, there was still no significant difference between males ($M = 40.95$, $SD = 19.21$) and females ($M = 39.94$, $SD = 19.02$) in rates of community violence exposure [$t(221) = .39$, $p = .70$].

Research Question 2: Do the relations between community violence exposure and psychological well-being, as assessed by symptoms of anxiety, depression, and PTSD, vary by gender?

Witnessing violence. Two moderation analyses using hierarchical regression examined the role of gender as a moderator of the link between witnessing violence and well-being (Table 3) and the link between personal victimization and well-being (Table 4). In the first regression, predicting depressive symptoms, demographic control variables (age, school, ethnicity, and low socioeconomic status) were entered in the first step. Ethnicity was significantly associated with depression, such that both Puerto Rican participants and Dominican participants experienced more depressive symptoms than participants of other ethnicities, on average. In the second step, witnessing violence and sex were entered to investigate main effects. Witnessing, but not sex, was positively and significantly related to more depressive symptoms such that higher rates of witnessing violence were associated with greater depressive symptoms. In the third step, the interaction term was entered to assess whether sex moderated the effect of witnessing violence

on depressive symptoms. The interaction was not significantly associated with depressive symptoms. The third model accounted for 16% of the variance in depressive symptoms.

In the second regression, predicting anxiety symptoms, the same procedure was followed as above. In the second step, witnessing violence and sex were entered to investigate main effects. Both witnessing violence and sex were positively and significantly related to anxiety such that higher rates of witnessing violence were associated with more anxiety symptoms and being female was associated with greater anxiety symptoms. Once again, the interaction was not significant. The third model accounted for 22% of the variance in anxiety symptoms.

In the third regression, addressing PTSD symptoms, both witnessing violence and sex were positively and significantly related to more PTSD symptoms such that a higher frequency of witnessing violence was associated with a higher prevalence of PTSD symptoms and being female was associated with a higher prevalence of PTSD symptoms. As before, the interaction term was not significant, and the third model accounted for 19% of the variance in PTSD symptoms.

Personal victimization. In the first regression, predicting depressive symptoms, demographic control variables were entered in the first step. Both ethnicity control groups were significantly associated with depression, such that Dominican participants and Puerto Rican participants experienced more depressive symptoms than participants of other ethnicities. In the second step, personal victimization and sex were entered to investigate these main effects. Victimization, but not sex, was positively and significantly related to more depressive symptoms. In the third step, the interaction term was entered to assess whether sex moderated the effect of personal victimization on depressive symptoms. The interaction was significantly associated with depressive symptoms. The third model accounted for 21% of the variance in depressive

symptoms, which was significantly more than the variable accounted for by previous main effects model [$\Delta R^2 = .03$, $\Delta F(1, 155) = 6.14$, $p < .05$]. Sex interacted significantly with personal victimization such that the relation between personal victimization and depression was attenuated for males. These relations are depicted in Figure 1, demonstrating that at high rates of victimization, females exhibit significantly higher rates of depression when compared to males.

In the second regression, predicting anxiety symptoms, the same procedure was followed as above. In the second step, personal victimization and sex were entered to investigate main effects. Both personal victimization and sex were positively and significantly related to more anxiety such that a higher frequency of personal victimization was associated with more anxiety symptoms, and being female was associated with a higher prevalence of anxiety symptoms. The interaction term was not significant. The third model accounted for 25% of the variance in anxiety symptoms.

In the third regression, predicting PTSD symptoms, both personal victimization and sex were positively and significantly related to more PTSD symptoms such that a higher frequency of personal victimization was associated with more PTSD symptoms, and being female was associated with more PTSD symptoms. This third model accounted for 23% of the variance in PTSD symptoms, and the interaction term was, again, not significant.

Research Question 3: Is the relation between community violence exposure and psychological well-being moderated by mother-child cohesion?

To address this question, two moderation analyses using hierarchical regressions examined the role of cohesion as a moderator of the link between witnessing violence and well-being, shown in Table 5, and the link between personal victimization and well-being, displayed in Table 6.

Witnessing violence. In the first regression, predicting depressive symptoms, demographic control variables (age, school, ethnicity, low socioeconomic status, and sex) were entered in the first step. In the second step, witnessing violence and mother cohesion were entered to investigate these main effects. Witnessing violence was positively and significantly related to more depressive symptoms, such that greater frequencies of witnessing violence were associated with a greater prevalence of depressive symptoms. Mother-child cohesion was inversely related to depressive symptoms, such that higher levels of closeness were associated with lower levels of depressive symptoms. In the third step, the interaction term was entered to assess whether mother cohesion moderated the relation between witnessing violence and depressive symptoms. The interaction was significantly associated with depressive symptoms. The third model accounted for 30% of the variance in depressive symptoms, significantly more than the previous main effects [$\Delta R^2 = .02$, $\Delta F(1, 154) = 4.38$, $p < .05$]. Mother cohesion interacted significantly with witnessing violence, such that the relation between witnessing violence and depression was attenuated by mother cohesion. As illustrated in Figure 2, at high rates of witnessing violence, adolescents who reported higher levels of closeness with their mothers displayed lower rates of depression compared to adolescents who reported lower levels of mother-child cohesion.

In the second regression, predicting anxiety symptoms, the same procedure was followed as above. In the second step, witnessing violence and mother cohesion were entered to investigate these main effects. Witnessing violence, but not mother cohesion, was positively and significantly related to more depressive symptoms, such that greater frequencies of witnessing violence were associated with a greater prevalence of depressive symptoms. The interaction term was not significant, and the third model accounted for 24% of the variance in anxiety symptoms.

In the third regression, addressing PTSD symptoms, the same procedure was followed as above. In the second step, witnessing violence and mother cohesion were entered to investigate these main effects. Witnessing violence was positively and significantly related to more PTSD symptoms, such that greater frequency of witnessing violence was associated with a greater prevalence of PTSD symptoms, while mother cohesion was inversely related to PTSD symptoms, such that higher levels of mother cohesion were associated with lower levels of PTSD symptoms. The interaction term was not significant. The third model accounted for 22% of the variance in PTSD symptoms.

Personal victimization. In the first regression, predicting depressive symptoms, demographic control variables were entered in the first step. In the second step, personal victimization and mother cohesion were entered to investigate these main effects. Victimization was positively and significantly related to more depressive symptoms, such that greater frequencies of personal victimization were associated with higher levels of depressive symptoms, whereas mother cohesion was inversely related to depressive symptoms, such that greater levels of cohesion were associated with fewer depressive symptoms. In the third step, the interaction term was entered to assess whether mother cohesion moderated the effect of personal victimization on depressive symptoms. The interaction was not significantly associated with depressive symptoms. The third model accounted for 31% of the variance in depressive symptoms.

In the second regression, addressing anxiety symptoms, the same procedure was followed as above. In the second step, personal victimization and mother cohesion were entered to investigate these main effects. Personal victimization, but not mother cohesion, was positively and significantly related to more anxiety, such that greater frequencies of personal victimization

were associated with a greater prevalence of anxiety symptoms. The interaction term was not significant. The third model accounted for 25% of the variance in anxiety symptoms.

In the third regression, addressing PTSD symptoms, the same procedure was followed as above. In the second step, personal victimization and mother cohesion were entered to investigate these main effects. Personal victimization, but not mother cohesion, was positively and significantly related to more PTSD, such that greater frequencies of personal victimization were associated with higher levels of PTSD symptoms. The interaction term was not significant. The third model accounted for 25% of the variance in PTSD symptoms.

Research Question 4: Is the relation between community violence exposure and psychological well-being moderated by adolescents' religiosity?

Higher levels of religiosity were expected to be associated with higher levels of resilience in the face of violence exposure. To address this question, two moderation analyses using hierarchical regressions were conducted in order to examine the role of religiosity on moderating the link between witnessing violence and well-being, displayed in Table 7, and the link between personal victimization and well-being, shown in Table 8.

Witnessing violence. In the first regression, predicting depressive symptoms, demographic control variables were entered in the first step. In the second step, witnessing violence and religiosity were entered to investigate these main effects. Witnessing violence, but not religiosity, was positively and significantly related to more depressive symptoms, such that higher frequencies of witnessing violence were associated with higher levels of depressive symptoms. In the third step, the interaction term was entered to assess whether religiosity moderated the effect of witnessing violence on depressive symptoms. The interaction was significantly associated with depressive symptoms. The third model accounted for 21% of the

variance in depressive symptoms, significantly more than the previous main effects model [$\Delta R^2 = .05$, $\Delta F(1, 151) = 9.83$, $p < .01$]. Religiosity interacted significantly with witnessing violence such that higher levels of religiosity attenuated the relation between witnessing violence and depression. This interaction is similar to the one depicted in Figure 3: at high rates of witnessing violence, a greater level of religiosity is protective such that participants who reported high levels of religiosity demonstrated fewer depressive symptoms.

In the second regression, addressing anxiety symptoms, the same procedure was followed as above. In the second step, witnessing violence and religiosity were entered to investigate these main effects. The second step yielded similar results to the previous regression. The third model accounted for 27% of the variance in anxiety symptoms, which was significantly more than the previous main effects model [$\Delta R^2 = .05$, $\Delta F(1, 151) = 9.33$, $p < .01$]. Religiosity interacted significantly with witnessing violence such that higher levels of religiosity attenuated the relation between witnessing violence and anxiety. This interaction is also similar to the one depicted in Figure 3: at high rates of witnessing violence, higher levels of religiosity were associated with less anxiety.

In the third regression, addressing PTSD symptoms, the same procedure was followed as above. The second step yielded similar results to the previous regressions. The third model accounted for 22% of the variance in PTSD symptoms, which was significantly more than the previous main effects model [$\Delta R^2 = .04$, $\Delta F(1, 149) = 6.69$, $p < .05$]. Religiosity interacted significantly with witnessing violence such that higher levels of religiosity attenuated the relation between witnessing violence and posttraumatic stress symptoms. Figure 3 depicts this interaction, showing that at a high frequency of witnessing violence, higher levels of religiosity were associated with fewer post-traumatic stress symptoms.

Personal victimization. Similar patterns were revealed when substituting personal victimization for witnessing violence: religiosity was never significant as a main effect predicting any dependent variable, yet the interaction terms were always significant. In the first regression, predicting depressive symptoms, the third model accounted for 22% of the variance in depressive symptoms, which was significantly more than the previous main effects model [$\Delta R^2 = .04$, $\Delta F(1, 151) = 7.99$, $p < .01$]. Religiosity interacted significantly with personal victimization such that higher levels of religiosity attenuated the relation between personal victimization and depressive symptoms. This interaction is shown in Figure 4, which illustrates that at high frequencies of personal victimization, greater religiosity predicts fewer depressive symptoms.

In the second regression, addressing anxiety symptoms, the third model accounted for 29% of the variance in anxiety symptoms, which was significantly more than the previous main effects model [$\Delta R^2 = .04$, $\Delta F(1, 151) = 9.08$, $p < .01$]. Religiosity interacted significantly with personal victimization such that higher levels of religiosity attenuated the relation between personal victimization and anxiety symptoms. This interaction is similar to the one depicted in Figure 4: at high frequencies of personal victimization, greater religiosity is associated with less anxiety.

In the third regression, addressing PTSD symptoms, the third model accounted for 24% of the variance in PTSD symptoms, which was significantly more than the previous main effects model [$\Delta R^2 = .03$, $\Delta F(1, 149) = 6.68$, $p < .05$]. Religiosity interacted significantly with personal victimization such that higher levels of religiosity attenuated the relation between personal victimization and PTSD symptoms. This interaction is also similar to the one depicted in Figure 4: at high frequencies of personal victimization, greater religiosity predicts fewer PTSD

symptoms.

Discussion

This study investigated: (1) gender as a predictor of community violence exposure; and (2) the roles of gender, cohesive mother-child relationships, and religiosity as moderators of the relation between community violence exposure and psychological well-being among poor, urban Latino adolescents. Overall, participants in this sample reported extremely high frequencies of community violence exposure, confirming that Latino adolescents from impoverished neighborhoods constitute an at-risk population in need of interventions to attenuate the relation between community violence exposure and poor psychological outcomes.

The first hypothesis was not supported by the results, which instead demonstrated that males and females experienced similar amounts of community violence exposure: both witnessing violence as well as personal victimization. This contradicts previous research indicating that male children and adolescents are more likely than female children and adolescents to experience community violence, both as victims and witnesses (Ceballo, Dahl, Aretakis, & Ramirez, 2001; Schwab-Stone et al., 1995; Selner-O'Hagan et al., 1998). One possible understanding is that gender differences in exposure to violence may dissipate as males and females begin to spend more time together outside of school in adolescence. Although previous studies have shown gender differences in younger children (Ceballo, Dahl, Aretakis, & Ramirez, 2001), this study reflects the lives of adolescents who, in high school, may have begun to spend more time in coed groups. If indeed male and female adolescents spend more time together than do male and female children, their shared experiences would predict similar amounts of exposure to community violence.

The second hypothesis, that gender would moderate the relation between community

violence exposure and psychological well-being, was partially supported. In line with the hypothesis, being male demonstrated significant buffering effects between personal victimization and psychological well-being, specifically depressive symptoms. This supports existing literature suggesting that female adolescents are more likely to express symptomology of psychological stress as a result of exposure to community violence (Foster, Kuperminc, & Price, 2004; Fitzpatrick, 1993). However, gender did not serve as a significant moderator of the relation between witnessing violence and adverse psychological symptoms. One possible interpretation as to why gender served as a moderator when discussing personal victimization but not witnessing violence is that females may experience different types of personal victimization that trigger different types of psychological reactions. Although the previous hypothesis reveals that males and females experience similar amounts of community violence, this finding only takes into account the specific types of community violence measured in this study. The measure used to collect information on community violence exposure does not include sexual assault or harassment, a category of violence that females are especially susceptible to. Because this study did not gather data on personal victimization in the form of sexual assault or threats of sexual assault, an important confounding factor may have contributed to females' higher levels of depressive symptoms even though males and females reported similar amounts of community violence exposure.

Results also partially supported the third hypothesis that cohesion and closeness between mothers and adolescents served as a moderator between community violence exposure and psychological well-being, but only for witnessing violence and not for personal victimization. The protective effect of cohesion with one's mother supports previous research that demonstrated maternal closeness as a moderator on the relation between experiencing violence

and psychological symptoms (Hammack, et al., 2004). A cohesive relationship with one's mother conferred a protective effect against depressive symptoms but did not have a significant effect on anxiety or PTSD symptoms. One explanation as to why the protective effects were isolated to depressive symptoms and did not expand to anxiety and PTSD symptoms is that the relation between violence exposure and PTSD is so strong that even high levels of maternal closeness and cohesion could not ameliorate adolescents' automatic posttraumatic stress responses, including anxiety responses (Kennedy & Ceballo, 2013). Previous research suggests that Latino youth are at a significantly higher risk of developing PTSD symptoms in response to community violence exposure when compared to non-Latino youth. Because of the strength of this association, posttraumatic stress symptoms may be more resistant to buffers than depressive symptoms, which are less common in reaction to community violence (Fowler et al., 2009).

In line with the fourth hypothesis, results indicated that higher levels of religiosity buffered the effects of exposure to community violence across all three measures of psychological well-being. That is, religiosity attenuated the relationship between community violence exposure and negative psychological outcomes (depressive symptoms, anxiety symptoms, and PTSD symptoms) for both witnessing violence and personal victimization. There is a substantial lack of literature addressing religiosity as a moderator between violence exposure and psychological well-being. These findings are especially important because they indicate the significance of religiosity for Latino adolescents' psychological well-being.

The significant effects of religiosity found in this study are vital because they present implications about future research and steps toward improving intervention work. The buffering effect of religiosity among all three measures of psychological well-being suggests that these protective benefits may carry over into other realms of mental health as well. Ideally,

interventions aimed at ameliorating the adverse effects of exposure to community violence would make fostering religiosity a primary goal. Understanding that, in this study, religiosity demonstrated many benefits for a sample of Latino adolescents, promoting spirituality with Latino adolescents who are at risk for community violence exposure could help individuals increase resilience. Future research should explore other adverse situations in which religiosity may prove to be a protective factor amongst the Latino adolescent population.

Limitations to the present study should be taken into account. First, the study's cross-sectional design limited internal validity. Second, the sample was limited in size and scope, focusing solely on ninth graders from urban Northeastern neighborhoods. A larger and more geographically diverse sample is needed to generalize findings to other Latino adolescents in America. A third important limitation to this study is that data was not collected on instances of sexual violence or threats of sexual violence. Although females and males reported similar levels of personal victimization on all items in the measure, it is possible that certain types of violence included in the measure are associated with sexual violence, which went unreported. If this is the case, females may in fact be experiencing more personal victimization than males. This potential confounding factor must be addressed before we can state that females exhibit higher levels of depressive symptoms than males when exposed to similar amounts of personal victimization.

Future research should address these limitations by capturing a more representative sample of Latino American youth as well as a larger sample of Latino youth. Future studies should also examine associations between the types of violence explored in this paper and sexual assault. Finally, this study has made an important contribution toward recognizing the importance of religiosity for Latino adolescents from urban neighborhoods in the Northeast. Future studies should try to replicate these findings in a wider and more diverse sample of Latino

participants. Campesino & Schwartz (2009) showed that Latino college students scored higher on a measure of spirituality when compared to non-Latino college students, indicating that spirituality plays an important role in the lives of Latino college students. Studies addressing religiosity should be expanded to sample sets of college students, adults, and children to explore its protective effects. Religiosity's buffering effects on depressive symptoms, anxiety symptoms, and PTSD symptoms suggest a wide range of protective effects. Future research should explore religiosity as a moderator on relations between other adverse life situations that Latinos may face and psychological well-being.

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Table 1

Percentage of Children Reporting Exposure to Community Violence (n = 223)

Percentage	Type of Violence
Witnessing violence	
71	Seen someone carrying a gun or knife
70	Seen someone using or selling drugs
67	Seen someone threatened with physical harm
65	Seen someone beaten up or mugged
48	Seen someone seriously wounded
29	Seen someone attacked with a knife
23	Seen a dead person (not at a funeral or wake)
22	Seen someone shot with a gun
12	Seen someone killed
6	Seen someone commit suicide
Personal Victimization	
71	Hit, slapped, or punched by someone
69	Heard gunfire when in or near home
36	Threatened with serious physical harm
31	Been asked to help sell drugs
26	Chased by gangs or individuals
20	Home during break-in or attempted break-in
14	Personally beaten up or mugged
11	Gun fired inside their home
8	Personally attacked with a knife
3	Personally shot with a gun

Table 2

Correlations with Means and Standard Deviations for All Variables

Variable	<i>M</i>	<i>SD</i> ^a	1	2	3	4	5	6	7	8	9	10	11	12
1. Student's Sex	—	—	—											
2. Free/Reduced Lunch	—	—	.02	—										
3. Student's Age	14.5	.69	-.01	-.02	—									
4. Dominican Dummy	.63	.48	0	.01	-.03	—								
5. Puerto Rican Dummy	.18	.38	.08	.01	.07	-.6***	—							
6. Personal Victimization	17.86	8.70	-.06	-.06	.13*	.01	.08	—						
7. Witnessing Violence	22.48	11.53	0	0	.07	.07	.06	.77***	—					
8. Mother Cohesion	3.41	.79	-.02	-.03	-.05	.09	.03	-.13*	-.15*	—				
9. Religiosity	2.69	.74	.08	-.01	-.09	-.05	-.01	0	-.03	.21**	—			
10. Depression	10.57	7.28	.18**	.05	.09	.01	.08	.23**	.22**	-.41***	-.15*	—		
11. Anxiety	7.13	2.21	.37***	-.01	-.01	.13	0	.26***	.22**	.20**	-.01	.58***	—	
12. PTSD ^b	24.53	14.35	.29***	-.04	-.06	.09	-.02	.30***	.26***	-.18**	.02	.55***	.83***	—

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

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

***. Correlation is significant at the 0.001 level (2-tailed)

^aSD = standard deviation^bPTSD = posttraumatic stress disorder symptoms

Table 3

*Hierarchical Regression Analyses Predicting Well-Being from Witnessing Violence:
Moderating Role of Sex*

Predictor	Depressive Symptoms			Anxiety Symptoms			PTSD Symptoms		
	ΔR^2	β	SE B	ΔR^2	β	SE B	ΔR^2	β	SE B
Step 1	.07			.06			.04		
Age		.04	.83		-.05	.23		-.08	1.65
School Dummy 1 ^a		.19	1.94		-.13	.55		-.04	3.84
School Dummy 2		-.09	1.69		-.10	.48		-.09	3.36
School Dummy 3		.04	1.69		.04	.48		.03	3.40
Dominican Dummy		.25*	1.72		.17	.49		.16	3.41
Puerto Rican Dummy		.19*	1.86		.13	.53		.04	3.68
Free/reduced lunch		.02	1.96		.00	.55		-.02	3.88
Step 2	.08**			.16***			.15***		
Witnessing		.26**	.05		.27***	.01		.28***	.10
Sex		.12	1.22		.30***	.33		.29***	2.32
Step 3	.02			.00			.00		
Witnessing		.08	.09		.19	.02		.24	.17
Sex		-.15	2.71		.18	.74		.22	5.23
Witnessing x Sex		.35	.11		.16	.03		.08	.21
Total R^2	.16**			.22***			.19***		
n	166			166			163		

Note: Beta coefficients are reported from the step at which the variable was entered.

PTSD = posttraumatic stress disorder

^aDummy coded school variables compared to parochial school

*** $p < .001$, ** $p < .01$, * $p < .05$

Table 4

*Hierarchical Regression Analyses Predicting Well-Being from Personal Victimization:
Moderating Role of Sex*

Predictor	Depressive Symptoms			Anxiety Symptoms			PTSD Symptoms		
	ΔR^2	β	SE B	ΔR^2	β	SE B	ΔR^2	β	SE B
Step 1	.07			.06			.04		
Age		.04	.83		-.05	.23		-.08	1.65
School Dummy 1 ^a		.19	1.94		-.13	.55		-.04	3.84
School Dummy 2		-.09	1.69		-.10	.48		-.09	3.36
School Dummy 3		.04	1.69		.04	.48		.03	3.40
Dominican Dummy		.25*	1.72		.17	.49		.16	3.41
Puerto Rican Dummy		.19*	1.86		.13	.53		.04	3.68
Free/reduced lunch		.02	1.96		.00	.55		-.02	3.88
Step 2	.11***			.18***			.19***		
Victimization		.32***	.07		.32***	.02		.34***	.13
Sex		.14	1.19		.33***	.32		.31***	2.27
Step 3	.03*			.01			.01		
Victimization		.08	.11		.22	.03		.25*	.22
Sex		-.27	2.80		.15	.77		.14	5.41
Victimization x Sex		.49*	.14		.21	.04		.20	.27
Total R^2	.21***			.25***			.23***		
n	166			166			163		

Note: Beta coefficients are reported from the step at which the variable was entered.

PTSD = posttraumatic stress disorder

^aDummy coded school variables compared to parochial school

*** $p < .001$, ** $p < .01$, * $p < .05$

Table 5

*Hierarchical Regression Analyses Predicting Well-Being from Witnessing Violence:
Moderating Role of Mother Cohesion*

Predictor	Depressive Symptoms			Anxiety Symptoms			PTSD Symptoms		
	ΔR^2	β	SE B	ΔR^2	β	SE B	ΔR^2	β	SE B
Step 1	.08			.15**			.11*		
Age		.04	.83		-.05	.22		-.08	1.59
School Dummy 1 ^a		.23	1.97		-.05	.53		.04	3.76
School Dummy 2		-.05	1.75		.01	.48		.01	3.36
School Dummy 3		.04	1.69		.05	.46		.05	3.27
Dominican Dummy		.25*	1.71		.18	.46		.16	3.29
Puerto Rican Dummy		.18	1.86		.09	.51		.01	3.56
Free/reduced lunch		.02	1.96		-.01	.53		-.04	3.74
Sex ^b		.12	1.26		.31***	.34		.29***	2.41
Step 2	.20***			.09***			.10***		
Witnessing		.18*	.05		.25**	.01		.25**	.10
Mother Cohesion		-.38***	.71		-.13	.21		-.17*	1.45
Step 3	.02*			.01			.01		
Witnessing		.80*	.21		.54	.06		.63	.43
Mother Cohesion		.08	1.64		.02	.48		.02	3.37
Witnessing x Mother Cohesion		-.65*	.06		-.31	.02		-.40	.13
Total R^2	.30***			.24***			.22***		
n	166			166			163		

Note: Beta coefficients are reported from the step at which the variable was entered.

PTSD = posttraumatic stress disorder

^aDummy coded school variables compared to parochial school

^bmale = 0, female = 1

*** $p < .001$, ** $p < .01$, * $p < .05$

Table 6

*Hierarchical Regression Analyses Predicting Well-Being from Personal Victimization:
Moderating Role of Mother Cohesion*

Predictor	Depressive Symptoms			Anxiety Symptoms			PTSD Symptoms		
	ΔR^2	β	SE B	ΔR^2	β	SE B	ΔR^2	β	SE B
Step 1	.08			.15**			.11*		
Age		.04	.83		-.05	.22		-.08	1.59
School Dummy 1 ^a		.23	1.97		-.05	.53		.04	3.76
School Dummy 2		-.05	1.75		.01	.48		.01	3.36
School Dummy 3		.04	1.69		.05	.46		.05	3.27
Dominican Dummy		.25*	1.71		.18	.46		.16	3.29
Puerto Rican Dummy		.18	1.86		.09	.51		.01	3.56
Free/reduced lunch		.02	1.96		-.01	.53		-.04	3.74
Sex ^b		.12	1.26		.31***	.34		.29***	2.41
Step 2	.22***			.11***			.13***		
Victimization		.23**	.07		.30***	.02		.31***	.13
Mother Cohesion		-.37***	.70		-.11	.20		-.14	1.43
Step 3	.01			.00			.01		
Victimization		.62*	.24		.43	.07		.59*	.50
Mother Cohesion		-.16	1.55		-.04	.45		.01	3.15
Victimization x Mother Cohesion		-.41	.08		-.14	.02		-.30	.16
Total R^2	.31***			.25***			.25***		
n	166			166			163		

Note: Beta coefficients are reported from the step at which the variable was entered.

PTSD = posttraumatic stress disorder

^aDummy coded school variables compared to parochial school

^bmale = 0, female = 1

*** $p < .001$, ** $p < .01$, * $p < .05$

Table 7

*Hierarchical Regression Analyses Predicting Well-Being from Witnessing Violence:
Moderating Role of Religiosity*

Predictor	Depressive Symptoms			Anxiety Symptoms			PTSD Symptoms		
	ΔR^2	β	SE B	ΔR^2	β	SE B	ΔR^2	β	SE B
Step 1	.08			.15**			.12*		
Age		.05	.82		-.04	.22		-.06	1.56
School Dummy 1 ^a		.21	1.96		-.06	.53		.01	3.71
School Dummy 2		-.05	1.74		.01	.47		.00	3.30
School Dummy 3		.04	1.69		.05	.46		.03	3.23
Dominican Dummy		.27*	1.71		.18	.47		.18	3.24
Puerto Rican Dummy		.20*	1.86		.10	.51		.04	3.51
Free/reduced lunch		.01	1.94		-.01	.53		-.04	3.67
Sex ^b		.13	1.26		.32***	.34		.29***	2.39
Step 2	.07**			.07**			.06**		
Witnessing		.24**	.05		.27***	.01		.26**	.10
Religiosity		-.14	.78		-.01	.21		-.03	1.48
Step 3	.05**			.05**			.04*		
Witnessing		.96***	.16		.94***	.05		.85**	.32
Religiosity		.32	1.67		.42**	.46		.35*	3.22
Witnessing x Religiosity		-.85**	.06		-.80**	.02		-.70*	.12
Total R^2	.21***			.27***			.22***		
n	163			163			161		

Note: Beta coefficients are reported from the step at which the variable was entered.

PTSD = posttraumatic stress disorder

^aDummy coded school variables compared to parochial school

^bmale = 0, female = 1

*** $p < .001$, ** $p < .01$, * $p < .05$

Table 8

*Hierarchical Regression Analyses Predicting Well-Being from Personal Victimization:
Moderating Role of Religiosity*

Predictor	Depressive Symptoms			Anxiety Symptoms			PTSD Symptoms		
	ΔR^2	β	SE B	ΔR^2	β	SE B	ΔR^2	β	SE B
Step 1	.08			.15**			.12*		
Age		.05	.82		-.04	.22		-.06	1.56
School Dummy 1 ^a		.21	1.96		-.06	.53		.01	3.71
School Dummy 2		-.05	1.74		.01	.47		.00	3.30
School Dummy 3		.04	1.69		.05	.46		.03	3.23
Dominican Dummy		.27*	1.71		.18	.47		.18	3.24
Puerto Rican Dummy		.20*	1.86		.10	.51		.04	3.51
Free/reduced lunch		.01	1.94		-.01	.53		-.04	3.67
Sex ^b		.13	1.26		.32***	.34		.29***	2.39
Step 2	.10***			.09***			.09***		
Victimization		.28***	.07		.31***	.02		.30***	.14
Religiosity		-.15	.77		-.02	.21		-.04	1.46
Step 3	.04**			.04**			.03*		
Victimization		.93***	.23		.97***	.06		.89***	.43
Religiosity		.31	1.82		.45*	.50		.38*	3.47
Victimization x Religiosity		-.80**	.09		-.82**	.02		-.73*	.17
Total R^2	.22***			.29***			.24***		
n	163			163			161		

Note: Beta coefficients are reported from the step at which the variable was entered.

PTSD = posttraumatic stress disorder

^aDummy coded school variables compared to parochial school

^bmale = 0, female = 1

*** $p < .001$, ** $p < .01$, * $p < .05$

COMMUNITY VIOLENCE EXPOSURE AND PSYCHOLOGICAL WELL-BEING

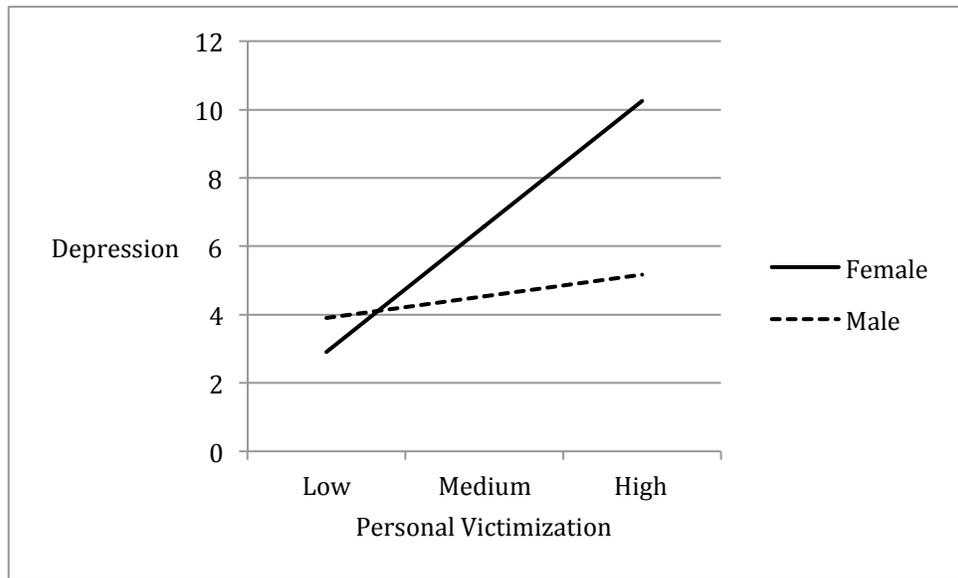


Figure 1. Effects of moderation between sex and personal victimization.

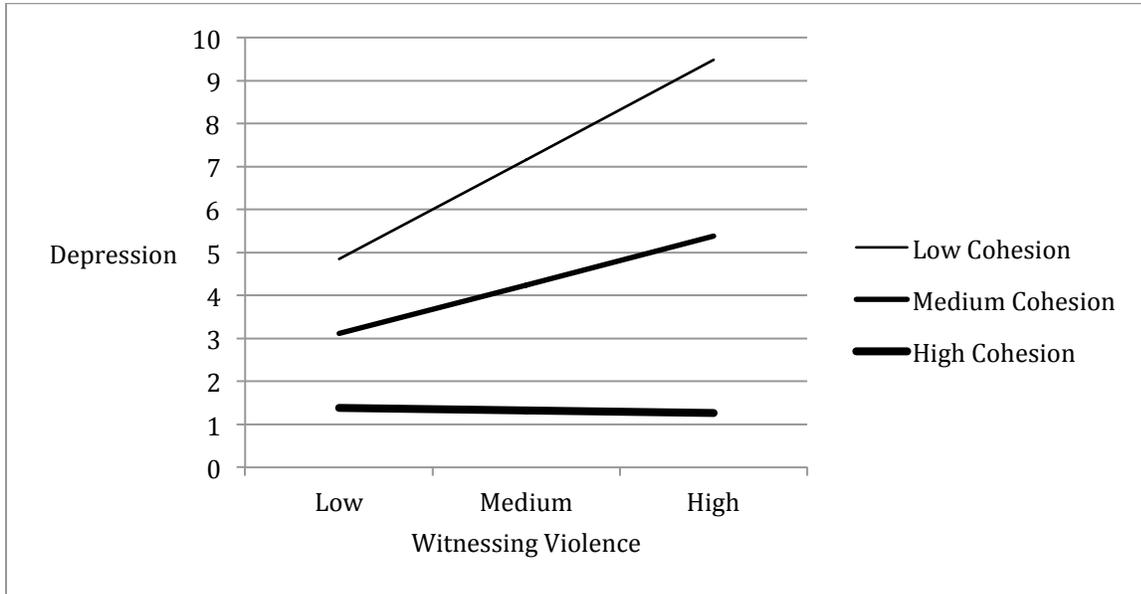


Figure 2. Effects of moderation between mother cohesion and witnessing violence.

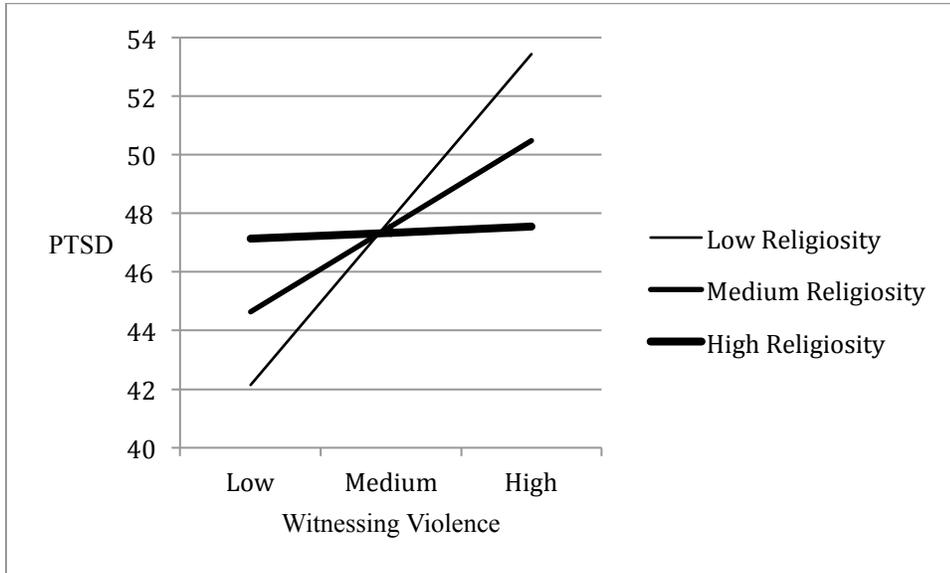


Figure 3. Effects of moderation between religiosity and witnessing violence.

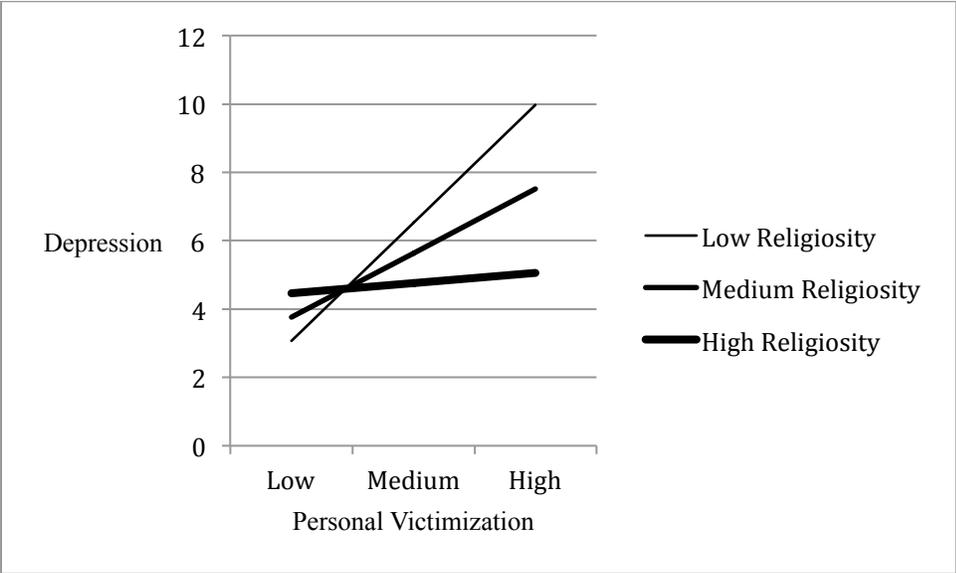


Figure 4. Effects of moderation between religiosity and personal victimization.