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MATERNAL RESPONSES TO CHILDREN'S EXPOSURE TO VIOLENT/TRAGIC NEWS
MEDIA IN A SAMPLE OF MULTIPLY-TRAUMATIZED, AFRICAN-AMERICAN, LOW-
INCOME YOUTH

by

SUSANNA CROWELL MCQUARRIE

Under the Direction of Erin Tone, PhD

ABSTRACT

Given children's ready access to media, particularly to sensationalized media reports of violent/tragic news (Pew Research Center, 2013), it is important to understand whether and how exposure to this news affects children's psychological functioning. Studies in the general population have found that media exposure to violence correlates positively with anxiety and posttraumatic stress (PTS) symptoms in children (Becker-Blease, Finkelhor, & Turner, 2008). However, little is known about the impact such exposure may have on children who are vulnerable to myriad health and mental health problems as a consequence of multiple traumas (Fowler, Tompsett, Braceiszewski, Jaques-Tiura, & Baltes, 2009). Moreover, given evidence

that parents may be able to influence children's responses to media and, possibly, to soften the impact of exposure (Otto et al., 2007), it is important to delineate caregiver practices that may have a buffering effect, particularly for youths from vulnerable groups. In the present study I assessed, in an urban sample of 66 Black mothers and their children (ages 8-12), the relationship among caregiver practices regarding violent news media exposure (i.e., Reassuring Realistically, Controlling Contact, and Scaring for Safety), child anxiety, and frequency of violent news media exposure. Controlling Contact was a significant moderator of the relationship between frequency of violent news media exposure and child anxiety, such that higher amounts of control were associated with lower rates of anxiety. Also, results indicated that Reassuring Realistically and Scaring for Safety caregiver practices were not significantly associated with children's anxiety. This study provides one step toward a better understanding of the roles that parenting practices regarding children's violent news media exposure play in promoting child mental health in highly traumatized families.

INDEX WORDS: violent/tragic news, media, parenting, trauma, children, African American

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SUSANNA CROWELL MCQUARRIE

A Dissertation Submitted in Partial Fulfillment of the Requirements for the Degree of

Doctor of Philosophy

in the College of Arts and Sciences

Georgia State University

2018

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Susanna Jane Crowell McQuarrie
2018

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August 2018

DEDICATION

To my husband, thank you for your never-ending love and support. To my mother for believing in me and encouraging me to accomplish my dreams, no matter what.

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Thank you to Dr. Tone for your support, encouragement, and constructive feedback to ensure the success of this project. And thank you to Drs. Bradley, Cohen and Swartout invaluable edits and contributions to this project. A special thank you to the staff and researchers of Grady Trauma Project for ensuring the completion of this project. Finally, I give my heartfelt gratitude to the families who participate in Grady Trauma Project. Thank you for being open to sharing the details of the most difficult days of your life in an effort to hopefully reduce others' suffering in the future.

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1 INTRODUCTION

Maternal Responses to Children's Exposure to Violent/Tragic News Media in a Sample of Multiply-Traumatized, African-American, Low-Income Youth

Children exposed to trauma are at a higher risk than non-traumatized children for developing a host of emotional difficulties, including anxiety and posttraumatic stress (PTS) symptoms (Saigh, 1989). A subset of these children will experience multiple traumas throughout their lives; repeated trauma exposure is especially common among youths who live in areas with high rates of community violence (Buka, Stichick, Birdthistle, & Earls, 2001; Margolin & Gordis, 2000; see review by Osofsky, 1995; Paxton, Robinson, Shah, & Schoeny, 2004), which are often urban and low-income (Stein, Jaycox, Kataoka, Rhodes, and Vestal, 2003). For such multiply traumatized children, repeated exposure to traumatic experiences heightens vulnerability to developing mental health problems in childhood and adulthood (see Pine & Cohen, 2001 for a review). Given that children from urban, low-income, minority communities tend to face disproportionately elevated exposure to community violence, as well as to other types of trauma (e.g., Buka et al., 2001; Gillespie et al., 2009; see review by Osofsky, 1995), they are at especially high risk for negative trauma-related emotional outcomes.

In addition to experiencing trauma in their own lives, children may witness traumatic events that are shown or described in the popular media. Such events include violent interactions (e.g., murders, assaults, or kidnappings), tragic events (e.g., hurricanes, floods, or tornadoes), and mass casualties like those that follow terrorist attacks. In recent years, children's access to media, delivered via smartphones, television, and other technological devices, has increased markedly (Gutnick, Robb, Takeuchi, & Kotler, 2010; Leiner et al., 2016). This increased access has coincided with a rise in the number of media reports of violent and tragic news (Pew

Research Center, 2013) and with a parallel increase in violence in popular films that target youth (Bushman, Jamieson, Weitz, & Romer, 2013). As a consequence of these changes, it is likely that today's children are exposed to traumatic events in the media at a higher rate than were those in past generations.

Given that media reports of violent and tragic news disproportionately focus on—and commonly misrepresent (Klein & Naccarato, 2003)—members of minority groups, the association between exposure to trauma through the news and psychological functioning warrants particular attention for children from urban, low-income, minority communities. These youths are especially vulnerable to mental health problems due to multiple trauma exposure. Moreover, they are also likely to be raised by caregivers who have experienced trauma themselves (Cross, Crow, Powers, & Bradley, 2015), which may further increase their vulnerability to psychopathology.

Studies in the general population have found that media exposure to violent and tragic news events, like real-life exposure to similar events, correlates positively with anxiety and PTS symptoms in children (Becker-Blease, Finkelhor, & Turner, 2008; Leiner et al., 2016). In the small existing literature, however, findings are mixed regarding how real-life trauma exposure, exposure to violence in the media, and other salient variables may interact to predict patterns of response to distress (Busso, McLaughlin, & Sheridan, 2014; Weems, Scott, Banks, & Graham, 2012). Further, little is known about associations between media exposure to violence/tragedy and both anxiety and PTS symptoms in youths who have experienced high levels of real-life violence or tragedy and may thus be either sensitized or inured to trauma-inducing images and narratives (Comer & Kendall, 2007; Madan, Mrug, & Wright, 2014). These patterns of association warrant study.

In addition to identifying adverse outcomes associated with exposure to violent or tragic media, it is important to clarify factors that might promote resilience in the face of exposure to violent and tragic news. Caregivers can behave in ways that may protect their children against developing mental health problems in response to trauma exposure, whether that exposure is direct or through the media. For example, some evidence suggests that parents can influence children's processing of and responses to negative or violent media and may thus be able to soften its impact (Otto et al., 2007). Caregivers report using a variety of practices to modulate their children's experiences of and responses to violent media images; for instance, parents commonly report restricting children's access to media, discussing media with their children, avoiding talking about the media, or co-viewing media with their children (Letiecq & Koblinsky, 2004; Spano, Rivera, & Bolland, 2011). In a recent study, when asked explicitly about how they respond when their child is exposed to violent or tragic *news* media in particular, a large sample of caregivers ($n=702$) endorsed additional practices that include reassuring the child realistically and scaring the child with an eye to ensuring safety, along with the previously documented practice of controlling the child's contact with the media (McQuarrie & Caporino, 2017).

It remains unclear, however, whether and how use of these practices in the context of media viewing relates to psychological functioning, particularly for youths from vulnerable groups. More specifically, we do not know a) whether and how often caregivers of trauma-exposed children use these practices to respond to their children's exposure to violent/tragic news media, and b) whether children whose caregivers rely on different practices for protecting their offspring from possible distress vary according to their anxiety and PTS symptoms.

The current study is designed as an initial step toward addressing questions regarding associations among a) violent/tragic news media exposure and both anxiety and PTS symptoms

in youths who have experienced high levels of real-life violence, and b) caregiver behaviors intended to protect their children from negative outcomes related to violent/tragic media. Due to the cross-sectional nature of the current study, it is impossible to determine the direction or causal nature of any relationship between child distress and exposure to traumatic media content based on the findings. It is possible that children or parents in distress may seek out violent/tragic media as a function of hypervigilance, rather than that the media exposure causes their distress. It may also be that some children and parents show blunted, rather than amplified, emotional responses to any potentially distressing content in the media because of prior real-life trauma exposure.

To lay groundwork for this research, I first define childhood trauma (experienced both in real life and through the media) and examine the research on its correlates and effects. I then discuss caregiver responses to their children's exposures to both real-life trauma and violent/tragic news media. I focus in particular on these literatures as they pertain to urban, low-income African American children exposed to community violence and trauma, who may be at especially high risk for negative outcomes.

1.1 Childhood Trauma Exposure

About two out of every three children will be exposed to a traumatic event before age 18 (Copeland, Keeler, Angold, & Costello, 2007). Most research on trauma-exposed children has focused on trauma that is experienced firsthand, or "real-life" trauma exposure. The term "real-life trauma exposure" refers to any Criterion A trauma as defined by the American Psychiatric Association's *Diagnostic and Statistical Manual, 5th Edition* (DSM-5; APA, 2013). This category encompasses all instances in which a person experiences, witnesses, or is otherwise exposed to the details of traumatic events such as natural disasters or interpersonal violence (e.g.,

abuse, rape, murder). An event can be traumatic whether it directly affected the individual, or it affected a person close to that individual.

A substantial subset of trauma-exposed children will experience negative psychological consequences that include anxiety disorders, post-traumatic stress disorder (PTSD), PTS symptoms, attention-deficit/hyperactivity disorder, and oppositional defiant disorder (see reviews by Comer & Kendall, 2007; Fowler et al., 2009; Pine & Cohen, 2001;). Indeed, a recent meta-analysis of studies investigating rates of childhood PTSD found that 16% of children exposed to a Criterion A trauma (according to DSM-IV criteria) develop PTSD (Alisic, et al., 2014) and even more exhibit subthreshold PTS symptoms (Silva et al., 2000).

Notably, exposure to violence and tragedy through the media, or “media trauma exposure,” can have a similar impact on children’s psychological well-being to that observed in association with real-life trauma exposure (Lengua, Long, Smith, & Meltzoff, 2005). Comer and Kendall (2007) defined media exposure to violent/tragic news as a type of secondhand trauma that can have negative consequences, even if an individual is not physically present during the events being covered. Media exposure to trauma encompasses exposure to community violence, terrorism, or natural disasters through the TV, internet (e.g., news sites and social media), radio, or print media (e.g., newspapers, magazines).

The literatures on real-life and media-based trauma exposure, for the most part, have developed independently from each other, and many fewer studies have focused on media-based traumas and their potential consequences than on real-life trauma. Because there is some evidence that these types of exposure contribute to similar outcomes (Comer & Kendall, 2007; Lengua, Long, Smith, & Meltzoff, 2005), the significantly larger literature on children’s exposure to real-life violent/tragic events and trauma can help inform research on media-based

trauma. Consequently, I briefly review the literatures regarding both children's real-life and media-based trauma exposure, covering their psychopathological correlates.

1.1.1 Real-life Trauma Exposure and Psychopathology

Children exposed to real-life trauma—such as witnessing or experiencing interpersonal violence or abuse, or surviving natural disasters—are at elevated risk during both childhood and adulthood for mental health problems that range from anxiety, depression, and PTSD to psychosis (see review by Pine & Cohen, 2001; Read, van Os, Morrison, & Ross, 2005). Further, trauma appears to play a causal role in the development of psychopathology among youths; prospective longitudinal studies have indicated that exposure to trauma is related to subsequent internalizing and externalizing symptoms (e.g., Fergusson, McLeod, & Horwood, 2013; Schwab-Stone et al., 1999). Although an individual traumatic experience can precipitate distress and dysfunction, risk for both internalizing problems—such as depression, anxiety, and PTSD symptoms (e.g., Greeson et al., 2011)—and externalizing problems—such as substance use disorders, ADHD, and aggressive behaviors (e.g., Khoury, Tang, Bradley, Cubells, & Ressler, 2010; Kilpatrick et al., 2003)—increases with recurrent real-life trauma exposures, whether direct or indirect (Zimmerman & Posick, 2016). Moreover, the more trauma exposure that a child accumulates, the more symptoms that individual is likely to experience (Briere, Kaltman, and Green, 2008).

Although much research has focused on individually-experienced traumatic events, such as childhood abuse or crime victimization (Paolucci, Genuis, & Violato, 2001; Yehuda, Halligan, & Grossman, 2001), community violence exposure has also been shown to relate to adverse outcomes. Indeed, youths exposed to community violence are at elevated risk for a broad range of both internalizing and externalizing mental health difficulties (Fowler et al., 2009). These

include aggressive behavior, delinquency, attention problems, substance use problems, depression, suicidality, anxiety, hypervigilance, thought problems, somatic symptoms, strained peer interactions, emotional numbing and stress related disorders (Buka, Stichick, Birdthistle, & Earls, 2001; Farver, Natera, & Frosch, 1999; Gaylord-Harden, Dickson, & Pierre, 2016; Gorman-Smith & Tolan, 1998). In some cases, chronic violence exposure has been associated with shockingly high levels of risk for psychological problems. For example, children who grew up in Northern Ireland during its most violent period of terrorism were 15 times more likely to endorse suicidal ideation and behaviors than were children who grew up in the same region during a less violent period (McLafferty et al., 2016).

Children living in low-income urban areas are at very high risk both for experiencing interpersonal violence (e.g., physical abuse, assault) and for witnessing community violence (e.g., stabbings, shootings; Buka, Stichick, Birdthistle, & Earls, 2001; see review by Osofsky, 1995; Paxton, Robinson, Shah, & Schoeny, 2004). Indeed, at least one study comparing urban, suburban, and rural adolescents found the highest rates of victimization among urban non-White youths, although rates among non-White youths in suburban and rural areas were also elevated (Johnson et al., 2008). Remarkably, in one study of Black youth in urban neighborhoods of Baltimore, all participants had been exposed to at least one Criterion A trauma (Smith & Patton, 2016).

As a consequence of such cumulative trauma exposure, low-income, minority children are at elevated risk for developing internalizing and externalizing psychological conditions (Fowler et al., 2009) such as depression (Kilpatrick et al., 2003), anxiety (Kennedy & Ceballo, 2016), emotion dysregulation (Powers, Cross, Fani, & Bradley, 2015), substance use disorders (Khoury et al., 2010), aggressive behavior (Guerra, Huesmann, & Spindler, 2003), and attention-

deficit hyperactivity disorder (Graham-Bermann & Seng, 2004). Low-income, minority youth exposed to trauma are also likely to develop at least some symptoms of PTSD. All participants in one study that sampled from this population, for example, had at least one symptom of the six required for a diagnosis of PTSD, 73% had at least two PTS symptoms, and 19% met diagnostic criteria for the condition (Smith & Patton, 2016). Risk may be especially high for youths who represent racial minorities that commonly are relegated to low social status. For example, findings from several studies suggest that a backdrop of stress associated with racism and discrimination leaves urban African American youth particularly vulnerable to internalizing problems after exposure to trauma, both immediately (Alegría et al., 2013; Garbarino, 1995), and later in life (Gillespie et al., 2009). Moreover, in a study of PTSD rates in a sample composed only of low-income, African American youth, 27% of participants met full criteria for the disorder (Fitzpatrick & Boldizar, 1993), which is much higher than rates in samples drawn from the general population (i.e., 1-2% of general population meet criteria for PTSD; Perkonig, Kessler, Storz, & Wittchen, 2000).

1.1.2 Media Trauma Exposure and Psychopathology

Research interest in potential associations between media-based trauma exposure and youth psychopathology has grown in recent years, which is not surprising, given that children consume media more frequently and at earlier ages than they did in past decades (Chassiakos, Radesky, Christakis, Moreno, & Cross, 2016; Dyer, 2018; Shema, 2018). The small, but growing, literature on media trauma exposure and its potential consequences provides convincing evidence that both frequency and duration of media exposure to violence correlate positively with anxiety, PTS symptoms, depression, separation anxiety, sleep problems, and aggressive behaviors in children (e.g., Becker-Blease, Finkelhor, & Turner, 2008; Collimore,

McCabe, Carleton, & Asmundson, 2008; Comer & Kendall, 2007; Johnson et al., 2008; Leiner et al., 2016; Owens et al., 1999). Indeed, in a survey of family media habits, approximately 62% of parents of 2- to 17-year-old youths reported that their child had been frightened and anxious about media content at some point, and 61% of parents reported that frightening media exposure had affected their children negatively (Gentile & Walsh, 2002).

Most studies that have examined the psychological impact of violent/tragic news events (rather than fictional violence) have assessed children's responses to news coverage of the September 11 terrorist attacks (see review by Comer & Kendall, 2007; Lengua, Long, Smith, & Meltzoff, 2005; Saylor, Cowart, Lipovsky, Jackson, & Finch, 2003). Media 2003). These studies each found positive correlations between frequency of exposure to the news stories and stress-related symptoms. Further, their findings indicated that distance from the traumatic event itself was unrelated to the severity of symptoms (Lengua et al., 2005). Other studies have investigated the effects of exposure to media coverage of natural disasters on children's anxiety and PTS symptoms (Fremont, 2004; Ortiz, Silverman, Jaccard, & La Greca, 2011; Weems, Scott, Banks, & Graham, 2012). For example, children shown a media clip of a natural disaster (i.e., a hurricane) reported significantly more state anxiety than did children who watched a neutral weather clip (Ortiz et al., 2011). The finding that exposure to violent/tragic news media is associated with negative mental health outcomes for children has been strikingly consistent, regardless of the type of violence or trauma (e.g., man-made versus natural disasters) that is receiving coverage.

Some studies have suggested that the negative effects of media exposure can be enduring, lasting upwards of 15 years (Harrison & Cantor, 1999; Johnson et al., 2002). Indeed, in a retrospective study that sampled 138 college students, 26% of participants reported still feeling

anxious about some sort of media that they had viewed during childhood or adolescence (Harrison & Cantor, 1999). Fear and anxiety are common reactions to media exposure during childhood; however, the content that evokes such a response may change over time, too (see review by Wilson, 2008).

Even media coverage of violent/tragic news events that occur far away from a child can have a lasting adverse impact (Shema, 2018). Two years after the Oklahoma City bombing, Pfefferbaum and colleagues (2003) investigated the emotional responses of 88 sixth graders who attended school 100 miles away and had not been not directly affected by the attack (i.e., the child did not know anyone harmed in the attack). The amount of broadcast exposure and children's emotional reactions at the time of viewing the broadcast coverage combined to explain about a quarter of the variance in children's PTS symptoms two years after the event (although no contrast tests were reported to assess if the difference in variance was statistically significant); the impact of children's amount of exposure on their PTS symptoms was dependent upon the children's initial emotional reaction to the event.

Further, experimental and longitudinal evidence indicates that media exposure to violent/tragic events can be a cause—not simply a correlate—of children's mental health outcomes. Hopwood and Schutte (2017) conducted a meta-analysis of 18 experimental studies investigating a causal link between media exposure to violent or tragic events and mental health symptoms in children, with a focus on anxiety, perceived threat, or other negative mental health problems as outcomes. Results indicated large effects of media exposure on negative psychological outcomes, particularly for children in the geographical areas closest to violent/tragic incidents, as well as those living in communities that had recently experienced threats similar to those portrayed.

Preexisting vulnerabilities may amplify children's risk for internalizing problems following exposure to violent/tragic news, though findings are mixed. In a study of children's responses following a series of hurricanes, Weems et al. (2012) found that the association between television viewing of hurricane coverage and current PTS symptoms was stronger among children who had already developed PTS symptoms before the hurricane. Findings from at least one study, however, suggest that amount of media exposure is a less critical contributor to adverse psychological outcomes for youth at high risk for psychopathology (defined as high physiological sensitivity to stress cues/ANS reactivity) than for lower-risk youths (Busso, McLaughlin, & Sheridan, 2014). Busso and colleagues (2014) found that media exposure was significantly and positively associated with the number of self-reported PTS symptoms among adolescents who were not present at the Boston Marathon bombing and who had high autonomic nervous system (ANS) reactivity (measured approximately one year prior to the bombings). Notably, the association between media exposure and PTS symptoms was not significant for youths with low ANS reactivity.

Taken together, the findings from these two studies suggest that violent media exposure may be more tightly associated with psychological problems in individuals who have previously been sensitized to respond adversely to stressful stimuli, either via earlier traumatic experiences (Weems et al., 2012) or via elevated baseline physiological reactivity (Busso et al., 2014). Findings are less consistent, however, regarding whether and how other patterns of reaction to violence or trauma exposure, such as blunted physiological responding, relate to elevated or attenuated risk for mental health problems in association with violent media viewing. In a series of studies, Madan, Mrug and colleagues (Madan, Mrug, & Wright, 2014; Mrug, Madan, Cook, & Wright, 2015) exposed college students to either violent media or non-violent high action media

and measured their emotional and physiological responses. In the first study (Madan et al., 2014), participants who viewed violent clips reported more anxiety after viewing than did those who had viewed non-violent action clips. However, among those who viewed violent clips, those with high levels of prior real-life violence exposure also showed attenuated physiological responses relative to students who had low levels of previous violent exposure. In subsequent research (Mrug et al., 2015), distress levels and blood pressure (after an initial rapid increase) quickly declined over time during viewing of violent clips for male participants who had been exposed to high levels of real-life violence, but not for other participants. This evident desensitization to violent images among those, particularly males, who had experienced real-life violence, however, appears to relate to risk for externalizing behavior problems rather than internalizing conditions such as anxiety or PTSD (Mrug, Madan, & Windle, 2016).

Limited research has explicitly investigated effects of media exposure on urban African American children (Bryant-Davis, Adams, Alejandre, and Gray, 2017). However, parents of these youths report changing their parenting approaches in the wake of coverage of police shootings of Black men (Thomas & Blackmon, 2015; Threlfall, 2016). For example, in two studies conducted after highly-profiled acts of violence against Black men, African American parents reported fear for their sons and a belief that Black youth need protection (Thomas & Blackmon, 2015; Threlfall, 2016). Although these studies do not focus explicitly on responses to *media exposure* to violence against Black men, it seems likely that violent media events may serve as one prompt for parents to engage in particular practices with their children.

Parents in these studies reported using varied strategies to protect their children from potential violence and discrimination. For example, some parents reported that they teach their children behaviors aimed at helping them rise above violence and “not [be] like” those who

engage in it (Threlfall, 2016, p. 10). Such behaviors included not wearing hooded sweatshirts in dark places or stores, keeping one's hands visible at all times, and running from danger in a zig-zag fashion to reduce risk of being injured if under fire. Other African American parents endorsed teaching their children to behave irreproachably in public, particularly in situations where conflict is likely, to reduce the likelihood that they will be viewed as threatening or criminal (Thomas & Blackmon, 2015). Parents noted that these guidelines are especially important for Black boys, whom they considered more likely than Black girls to be perceived as threatening.

1.2 Caregiver Influence on Child's Response to Trauma Exposure

Given the evidence that trauma exposure in real life and through the media relates to adverse consequences for children (Schwab-Stone et al., 1999), researchers have invested considerable effort into identifying factors that might protect against these negative effects (Kilpatrick et al., 2003). Children who receive social support, who have adaptive coping skills, and who are able to regulate their affect effectively, for instance, tend to show enhanced resiliency following traumatic exposure (Agaibi & Wilson, 2005; Coker, Weson, Creson, Justice, & Blakeney, 2005). In addition, youths whose caregivers engage in a variety of practices, including—but not limited to—providing emotional support, may enjoy protection from negative trauma-related outcomes (Berman, Kertines, Silverman, & Serafini, 1996; Cohen, Mannarino, & Murray, 2011; Ozer, Richards, & Kliewer, 2004).

1.2.1 Real-life Trauma

Parents protect their children from the harmful effects of real-life trauma in a number of ways (Cohen, Mannarino, & Murray, 2011; Ozer, Richards, & Kliewer, 2004), and a good child-caregiver relationship appears to be helpful in this regard (Ozer et al., 2004). More specifically,

the degree to which children perceive their parents and families as offering social support has been shown to protect youths from developing negative emotional responses to varied types of trauma exposure (Berman, Kertines, Silverman, & Serafini, 1996; Jain, Buka, Subramanian, & Molnar, 2012; Krenichyn, Saegert, & Evans, 2001). Social support may even buffer the effects of multiple risk factors. For instance, in a study investigating protective factors for urban youth exposed to crime and violent trauma, the availability of social support moderated the association between negative coping practices and PTS symptoms, such that negative coping practices (e.g., criticizing self, blaming others) were more weakly associated with PTS symptoms among youths who perceived that social support was available to them than among peers who felt unsupported (Berman et al., 1996).

Notably, how parents convey their support appears to matter. If parents encourage self-efficacy after trauma exposure, for example, their children may benefit (Agaibi & Wilson, 2005). Parent-child discussions following a trauma have also been shown to help reduce the likelihood that a child will develop PTSD (Berkowitz, Stover, & Marans, 2011). This finding suggests that openness to talking about potentially painful or disturbing topics may be useful for caregivers who want to help their children cope effectively with a traumatic experience.

Some caregivers may be better equipped than others to offer their children helpful support. Caregivers who have experienced trauma themselves, for instance, may have difficulty providing optimal care for their children, given that trauma and PTS can negatively impact family functioning and parenting (Borre and Kliwer, 2014; Compas et al., 2001; Kiser & Black, 2005; Otto et al., 2007). For example, mothers who have experienced trauma are more likely to overprotect or parentify their children (Bar-On et al., 1998); they are also more likely to use physical discipline (Newcomb & Locke, 2001) with their children than are non-traumatized

mothers. Further, in research conducted in communities with high rates of poverty and violence, parental strain (defined as victimization within a community violence context and life stressors) predicted parenting practices (knowledge of their children and child disclosure to parents) a year later (Borre & Kliwer, 2014). Higher levels of parental strain were associated with compromised parenting.

1.2.2 Media Exposure Trauma

Only a small body of research has examined parenting practices that are specific to indirect trauma exposure via the media and the degree to which parent behaviors are protective or problematic for children who are exposed in this way. The majority of the literature on parental guidelines for children's violent news exposure is based on studies of exposure to fictional violent media, rather than violent news media (Reich, 2018). Broadly, however, the literature suggests that caregivers can influence the emotional impact of media exposure on children (Buijzen, van der Molen, & Sondij, 2007) via a number of practices. These include restrictive parenting, active monitoring, deference (i.e., caregivers purposefully avoid involvement in their children's media viewing/access), explaining to the child whether the media presentation is accurate or unbiased, reassuring them realistically about their own risk related to the portrayed events, and scaring them with an eye to ensuring their safety (Buijzen et al., 2007; McQuarrie & Caporino, 2017; Nathanson & Yang, 2003; Padilla-Walker, Coyne, Fraswer, Dyer, & Yorgason, 2012). It remains unclear, however, whether particular practices are better than others for preventing or managing child distress associated with viewing media violence.

One of the better-studied practices that caregivers use to protect their children from the emotional impact of media exposure is restricting the time that children spend in contact with media (Padilla-Walker, Christensen, & Day, 2011; Padilla-Walker, & Coyne, 2011; Valkenberg

et al., 1999). Buijzen, van der Molen, and Sondij (2007), for instance, examined associations between child emotional responses (e.g., anxiety) to media exposure and each of three types of parenting practice: restrictive parenting, defined as simply limiting the child's exposure to media, active parenting, defined as talking with the child about what he/she had viewed, and deference. High levels of active parenting accounted for more variance in children's fearful and worried responses to violent/tragic news media than did restrictive parenting; the more actively engaged parents were in helping their children cope with violent/tragic news exposure, the less fearful and worried their children reported feeling.

The extent to which parents engage in one strategy or the other appears to change over the course of a child's development, although little research has focused explicitly on parent management of exposure to violent/tragic media. Results of at least one study, for instance, suggest that parents of preschoolers rely primarily on restriction to manage their children's overall media consumption (Thompson et al., 2016). Parental use of restriction then appears to decline over time and by the time children reach adolescence, parents have broadened their repertoire of monitoring practices. Padilla-Walker et al. (2012), for example, tracked mothers' approaches to monitoring general media use in a sample of 276 11- to 13-year-olds over a three-year period. Mothers relied most heavily on active practices, followed by restriction, and then deference to manage their children's media viewing during the first two years of the study. Over time, however, the participating mothers (particularly those who reported a more autonomy-granting parenting style), became less restrictive and also exhibited more deference. By the third year, mothers used active and deferent practices with equal frequency and relied much less heavily on restriction.

Many parents also engage in media co-viewing with their children (Valkenburg, Kramar, Peeters, & Marseille, 1999), particularly when images are violent or potentially frightening. For example, in a sample of 179 5- to 11-year-olds and their parents who were surveyed one month after the September 11, 2001 terrorist attacks, 76% of participating children had viewed media coverage of the event with their parents (Saylor et al., 2003). It was not clear how much of this co-viewing was coincidental/passive (e.g., due to shared living space) as opposed to a deliberate caregiver strategy for mediating children's responses to media exposure; either way, however, it may have provided opportunities for discussions of the attacks.

Such caregiver-child discussions of violent news media can be beneficial and may lessen the likelihood of negative outcomes, such as PTS symptoms, for children. Research on caregiver-child discussions of the violent news media coverage of the 2013 Boston Marathon bombing, for instance, showed that caregiver displays of confidence in the family's safety and open parent/child discussion of news media coverage of the bombing predicted lower rates of child PTS symptoms (Carpenter et al., 2015). Parents may need to approach these discussions differently depending on the ages of their children. One study compared the impact of mediating questions (e.g., asking if the children thought people in real life would act that way) and statements (e.g., explaining that the clip was factually or socially unrealistic) about the realism of violent fictional media clips on children's self-reported post-viewing orientation to violence. Whereas younger children (ages 5-8 years) benefited most from mediation statements, older children (ages 9-12 years) benefited more from mediation questions or from no mediation at all (Nathanson & Yang, 2003). Notably, this study focused on the impact of parenting practices on children's opinions about violence rather than their anxious responses to violence. The findings nevertheless provide evidence that parent behaviors during exposure can alter the ways in which

their children react to violent media.

Some evidence suggests that adaptive parent responses can be learned; Comer et al. (2008), for example, taught mothers an approach to processing news information and images with their children. The approach was designed to help parents minimize anxious responses by modeling coping thoughts, positively reinforcing children's use of coping thoughts, and helping children to better understand the media (e.g., comparing the disproportionately extreme violence presented in the news to the actual levels of violence that children were likely to encounter in day to day life). When the researchers compared children whose mothers learned this approach to children whose mothers spoke to them as they normally would, the children whose mothers received the intervention were less likely to report feeling threatened by violent media information and images.

Specific Factors for African American Children and Caregivers. Previous studies have investigated parenting practices that are more likely to be common in communities or cultures with specific needs or experiences (e.g., groups that have experienced racial discrimination; Neblett et al., 2008). For example, minority parents may utilize racial socialization (Neblett et al., 2008), instillation of racial pride (Hughes et al., 2006; Phinney & Chavira, 1995), and spirituality in the face of adversity as means for helping their children to cope with racial discrimination (Howard, Rose & Barbarin, 2013; Lamis, Wilson, Tarantino, Lansford, & Kaslow, 2014). I could not locate published research that investigated culturally-bound parenting practices applied in the context of violent/tragic news media exposure. However, two studies conducted shortly after high-profile police shootings of Black men examined African American caregivers' general responses to their children following these events. African American participants reported preparing their children to anticipate racism and discrimination

(Thomas & Blackmon, 2015), as well as a widespread perception of young Black men as dangerous (Threlfall, 2016). Additionally, African American parents taught their children to rise above the violence and “not [be] like them” (Threlfall, 2016, p. 10). These findings provide suggestive evidence that parents of children from minority groups may use culturally-specific practices that are less likely to be observed in majority culture families; identifying parenting practices in the context of violent/tragic media viewing that may be particularly salient for such families would provide a useful extension to the existing literature on childrearing in different cultural contexts.

Summary. Children exposed to trauma, especially if they also live in low-income neighborhoods with high rates of community violence, are at risk for developing internalizing problems such as anxiety and PTS symptoms. Violent/tragic news media exposure is also associated with poor outcomes in children’s mental health. Some evidence indicates that caregivers may engage in behaviors that can mitigate the negative impact of exposure to trauma, both in reality and via the media. We know relatively little, however, about how specific parenting practices relate to adaptive functioning in children (e.g., low anxiety and PTS symptoms). The proposed study was designed as an initial step toward addressing questions regarding associations among violent/tragic news media exposure, PTS symptoms in youths who have experienced high levels of real-life violence, and caregiver behaviors intended to protect their children from negative outcomes related to violent media. Specific study aims were as follows:

Aim 1: To characterize patterns of association among frequency of violent/tragic news media exposure and child *PTS symptoms* in children at a high risk of exposure to real-life trauma while controlling for real-life trauma/violence exposure.

Hypothesis: Parent-reported frequency of violent/tragic news media exposure will account for a significant proportion of the variance in child-reported child PTS symptoms when real-life trauma/violence exposure is controlled.

Aim 2: To characterize patterns of association among frequency of violent/tragic news media exposure and child *anxiety* in children at a high risk of exposure to real-life trauma while controlling for real-life trauma/violence exposure.

Hypothesis: Parent-reported frequency of violent/tragic news media exposure will account for a significant proportion of the variance in self-reported child anxiety symptoms when real-life trauma/violence exposure is controlled.

Aim 3: To characterize patterns of association among real-life trauma/violence exposure, frequency of media trauma exposure, and PTS symptoms.

Hypothesis: Child PTS symptoms will be highest for children who have combined high rates of trauma exposure from media and real-life.

Aim 4: To test a model of associations among parenting practices (Reassuring Realistically, Controlling Contact, and Scaring for Safety), frequency of the child's violent/tragic news media exposure, and *child PTS symptoms* (see Figures 1 and 2). I aimed to test the same model with *child anxiety symptoms* as the outcome variable.

Hypothesis: Two parenting practices will moderate the relationship between child's violent/tragic news media exposure and child PTS symptoms and, in a subsequent test, anxiety. The interactions between the frequency of the child's violent/tragic news media exposure and caregiver use of Reassuring Realistically and Scaring for Safety practices will account for a significant proportion of variance in self-reported child PTS or anxiety symptoms, such that at higher levels of use of each strategy, the expected

negative association between media exposure and PTS or anxiety symptoms will be weaker than at lower levels of use. Use of a third practice, Controlling Contact, will account independently for a significant proportion of variance in child PTS or anxiety symptoms; however, the association is expected to be positive, such that higher levels of Controlling Contact will be associated with higher levels of PTS or anxiety symptoms. Real-life trauma/violence exposure served as a covariate in tests of this hypothesis.

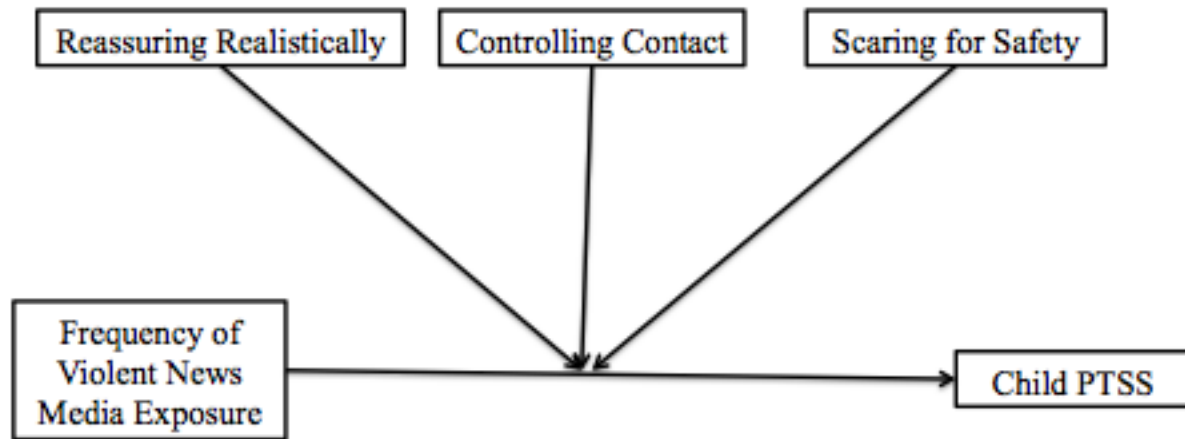


Figure 1. Parenting practices moderate the relationship between frequency of child's violent/tragic news media exposure and child PTS symptoms.

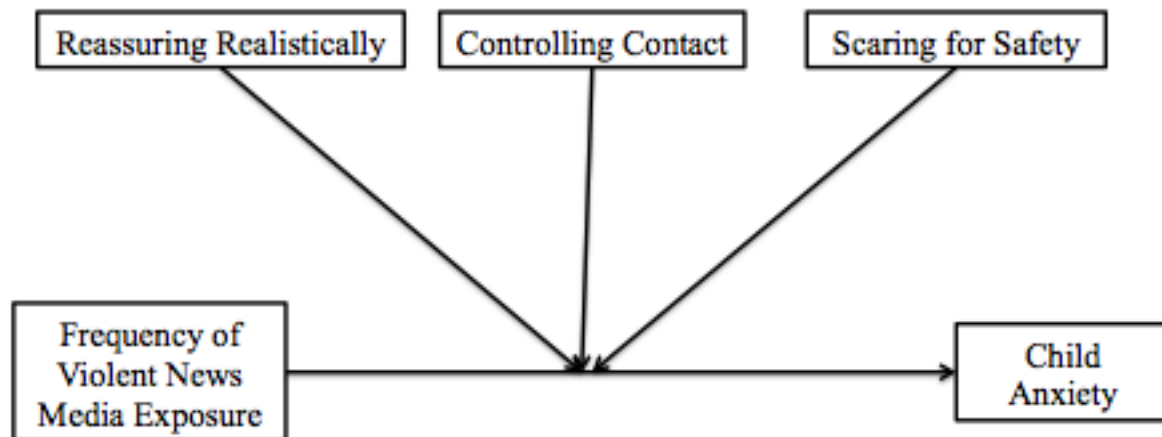


Figure 2. Parenting practices moderate the relationship between frequency of child's violent/tragic news media exposure and child anxiety.

2 METHODS

2.1 Participants

Participants were recruited via the NIH-funded Grady Trauma Project (GTP; 2007 to present), which aims to document factors that underlie risk for and resilience to PTSD (Binder et al., 2008; Bradley et al., 2008; Gillespie et al., 2009). The GTP served as a parent study for the current study. The final sample comprised 66 African American women over the age of 18 who reported being a primary caregiver for a child between the ages of 8 and 12. Given that participants were seeking services at a publicly-funded, nonprofit healthcare system that serves a low-income population, the majority of the participants reported having a low income, consistent with participants in prior research on the same population over the past decade (over 50% of past participants in the GTP reported less than \$1,000 in monthly household income; Powers, Cross, Fani, & Bradley, 2015). In the current sample, 56% of the participants reported less than \$1,000 in monthly household income and 83.3% reported less than \$2,000 monthly.

Rates of trauma in the current sample were high. Specifically, 97% of mothers endorsed having experienced at least one criterion A trauma, and 98% of their children had also had one or more traumatic experiences. Cumulative trauma was more the norm than the exception in this population; participant report indicated that 89.9% of mothers and 86.3% of children had experienced more than three traumas (see *Table 2*). Not surprisingly, given their high rates of trauma, most of the participating mothers met criteria for current (39%) or lifetime (23%) PTSD. Diagnostic data were not available for the remaining five participants.

Table 1 Demographic makeup

	Mean	SD	n	Range
Child Age	9.77	1.48	66	8-13
Child Gender			31 (female)	
Mother Age	38.65	8.88	66	25-59

Note. All participants identified as Black/African-American.

2.2 Procedure

Consistent with standard GTP practice, participants were recruited from the General Medical, Diabetes, Pharmacy, and Obstetric/Gynecological Clinics at a publicly funded, nonprofit healthcare system that serves a low-income population in Atlanta, Georgia. Researchers approached adults waiting for their medical appointments and invited them to participate in the GTP. Those who expressed interest first completed consent procedures. After an individual provided consent to participate in the GTP, a trained interviewer read that person the questions in a battery of self-report measures assessing trauma history, childhood abuse, and associated symptoms including PTS and depression, and recorded his or her responses onto a tablet computer. This battery of questions served as a screening interview to determine eligibility for further research studies, including the “Mom & Kids” study—a parent/child-focused portion of the GTP—to which measures for the current research were added. Data collection for the Mom & Kids study had been underway for approximately 5 years when the present study began. The entire screening interview took 45–75 minutes per participant to complete (dependent in large part on the extent of the participant's trauma history and symptoms). Each person was paid \$15 for participation in this portion of the study. The only eligibility requirement for screening was the ability to give informed consent.

Any screened participant who was a female primary caregiver for a child between the ages of 8 and 12 was invited to participate in the Mom & Kids arm of the GTP study. In this study, mothers and their children came to a research lab for 4-5 hours to complete a battery of questionnaires that focus on parent-child interactions and child trauma exposure, as well as other measures not relevant to the present study. The standard method of data collection for the GTP study is in-person interviewing. However, because recruitment for the Mom & Kids portion of the broader GTP study slowed after I began collecting data, I also administered measures regarding child media violence exposure and associated parenting practices via telephone to mothers who had already completed other Mom & Kids measures. This approach helped to maximize the sample size.

A total of 350 mothers had participated in the Mom & Kids portion of the GTP study and had complete baseline data when I began the current project. Of note, however, because the battery administered to participants had evolved over the course of this longitudinal study, not all mothers had completed the same set of baseline measures. I attempted to contact all 350 mothers who had participated; I was only, however, able to reach 50 mothers via phone, because 225 mothers' contact information was not available in the Redcap digitized record system, 1 mother declined participation via phone, 24 phone numbers had changed, and 34 with assumed accurate numbers were unreachable after 4 attempts to contact via phone and text. Data from the remaining 16 mother-child dyads included in the present study were collected via in-person interviews. All procedures in the GTP study (including the Mom & Kids portion) were approved by the Emory University's Institutional Review Board and the Grady Health Care System Research Oversight Committee. An inter-institutional agreement between Georgia State

University and Emory was completed to allow use of the Mom & Kids data for the present dissertation.

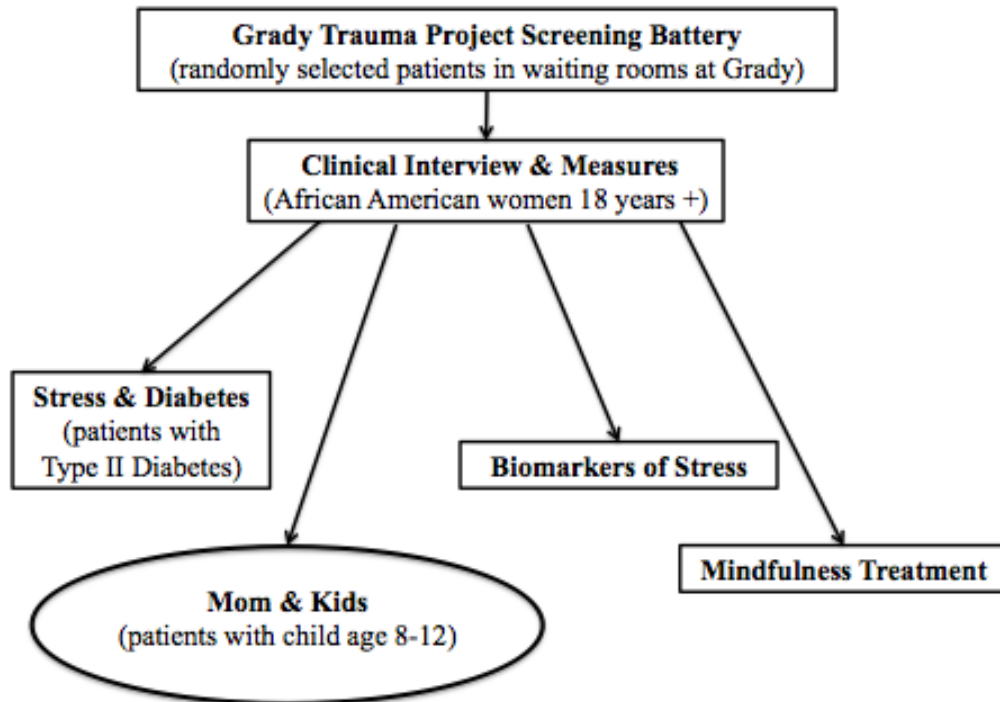


Figure 3. Grady Trauma Project participant flow.

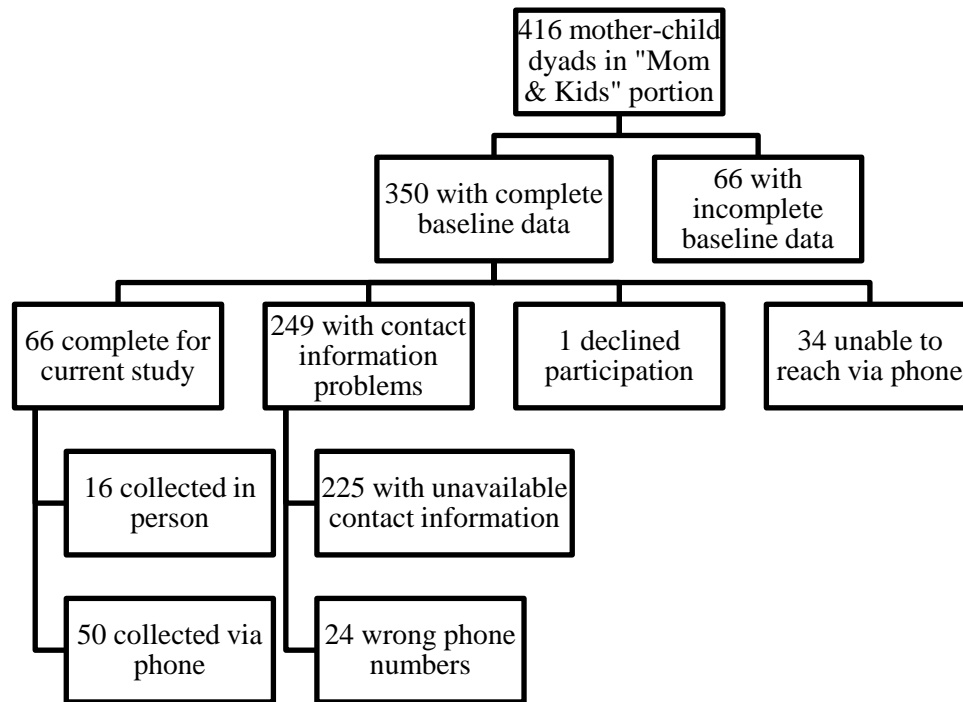


Figure 4. Current study participant flow.

2.3 Measures.

2.3.1 Descriptive Measures.

To assist with characterization of the sample, I used participants' demographic data (e.g., age, income, education, etc.), as well as their responses on the Clinician Administered PTSD Scale-5 (CAPS-5; Weathers et al., 2016) and the Trauma Events Inventory (TEI; Gillespie et al., 2009), which yielded information about caregiver PTSD diagnosis and parent trauma exposure, respectively. Total TEI scores also served as covariates in core study analyses, as described below.

2.3.1.1 Clinician Administered PTSD Scale-5.

The CAPS-5 (Weathers et al., 2016) is a 30-item clinician-administered measure of the frequency and severity of PTS symptoms in adults (Weathers, et al., 2013). Participating mothers were asked to report whether they experienced each of 20 PTS symptoms; based on follow-up questions, clinicians rated each endorsed symptom's severity on a scale from 0 (absent) to 4 (extreme). Severity scores of 2 or higher indicate that the symptoms meet "threshold" for clinical levels of PTSD. The CAPS-5 yields scores for the total number of symptoms endorsed within each DSM-5 criterion domain (i.e., Intrusion, Avoidance, Cognitions/Mood, Arousal/Reactivity), as well as total severity scores for symptoms within each domain.

The CAPS-5 has demonstrated strong interrater reliability ($K = .78$ to 1.00) and test-retest reliability ($K = .83$) for PTSD diagnosis (Weathers, et al., 2017), as well as good internal consistency ($\alpha = .88$). Results from at least one study indicated that the measure's convergent and discriminant validity are good (Weathers, et al., 2017). For example, scores on the CAPS-5 correlated ($r = .66$) with scores on a similar measure of PTSD symptoms (i.e., the PTSD Checklist-5). Correlations with measures expected to yield divergent scores (e.g., Patient Health Questionnaire-Alcohol Abuse, Psychopathic Personality Inventory) ranged from $r = .02$ to $.54$ in predicted directions. In the present study, the CAPS-5 was used to yield a dichotomous outcome (PTSD present/current, lifetime or absent) for each mother. In the current sample, 57% of mothers met criteria for PTSD either currently (36%), or at some point in their lifetime (21%).

2.3.1.2 Traumatic Events Inventory (TEI)

The Traumatic Events Inventory (TEI; Gillespie et al., 2009) is a 14-item self-report measure that assesses whether an individual has experienced or witnessed each of 14 Criterion A

traumatic events during childhood or adulthood. This measure is intended to be used with adults and was administered to mothers only. If a participant endorses either experiencing or witnessing a traumatic event, a researcher asks follow-up questions to assess the frequency of that type of trauma exposure (e.g., multiple incidences of abuse versus a single incident). For the purposes of this study, I used the total traumatic experiences score as a covariate in analyses.

2.3.2 Measures for Hypothesis Tests

2.3.2.1 Child Behavior Checklist (CBCL) for ages 6-18.

The CBCL is a 138-item parent-report measure of child behavioral problems (118 items) and social competencies (20 items) (Achenbach & Rescorla, 2001). The behavioral problems that the CBCL encompasses can be divided into two broad-band scales (Internalizing and Externalizing) and eight narrow-band scales (Rule Breaking, Aggressive Behavior, Withdrawn-Depressed, Somatic Complaints, Anxious Depressed, Social Problems, Thought Problems, and Attention Problems). Respondents rate the target child on each item, using a scale of 0 (not true) to 2 (very true or often true). Responses are summed to yield broad-band, narrow-band, and total raw scores, which are typically converted to age- and gender-based standard scores.

Several studies have yielded evidence of good validity, internal consistency, and test-retest reliability for the CBCL (Achenbach & Edelbrock, 1983). The measure has been validated across a broad range of youth and is widely used in both clinical and research settings (Achenbach & Edelbrock, 1983). It demonstrates good inter-parent and inter-interviewer reliability, as well as good test-retest reliability at .80 to .94 after one week (Achenbach & Edelbrock, 1983). Kendall et al. (2007) established reliability and validity for a set of 16 items from the CBCL that yield a better and more specific estimate of anxiety than the CBCL anxious depressed narrow band scale. The total score from these 16 items served as the dependent

variable in tests of the hypothesis for the second proposed aim. Internal consistency as measured by Cronbach's alpha for the present sample was .83 for the 16 items yielding a measure of anxiety.

2.3.2.2 Behavior Assessment System for Children (BASC)

The BASC (Reynolds & Kamphaus, 1992) is a 139-item measure of emotional and behavioral disorders in children and adolescents. The measure includes three versions: parent, teacher, and self-report. Only data from the parent-report version were used in the present study. The BASC comprises three internalizing scales (anxiety, depression, somatization), three externalizing scales (hyperactivity, aggression, conduct problems), three behavioral scales (school problems, atypicality, withdrawal), and six adaptive scales (adaptability, social skills, leadership, study skills, functional communication). T scores are calculated based on norms for age and gender. The BASC-PR has shown good internal consistency (averaged alpha = .85) and one-month test-retest reliability. For the current study, the anxiety t score (one of the internalizing scales) from the parent report of symptoms was used as the outcome variable in the regression models. Prior research found convergent validity of the BASC-PR anxiety scale with the CBCL anxious/depressed scale to be acceptable ($r = .54$; Doyle, Ostrander, Skare, Crosby, & August, 1997). The mean score for current sample was within the typical range (T scores below 60); only seven children in the current sample scored in the clinical range for anxiety (70 or above), and 10 children scored in the "at risk" range (60 to 69).

2.3.2.3 UCLA Child PTSD Reaction Index.

The UCLA Child PTSD Reaction Index (UCLA Child PTSD-RI; Steinberg, Brymer, Decker, & Pynoos, 2004; Elhai et al., 2013; Steinberg et al., 2013) is a 44-item, clinician-administered questionnaire regarding trauma exposure and PTS for children ages 6-18 years.

The measure was originally developed to align with DSM-IV criteria for PTSD; an updated version of this measure that corresponds to the DSM-5 was used in the current study. The administering clinician first assesses a child's exposure to Criterion A traumas; responses yield dichotomous (either present or absent) scores regarding exposure to specific types of Criterion A trauma. The second part of the measure assesses PTS symptoms and yields a total symptom score.

A confirmatory factor analysis of the measure revealed strong support for a five-factor model; subscales constructed to reflect each factor were labeled Reexperiencing, Avoidance, Numbing, Dysphoric Arousal, and Anxious Arousal (Elhai et al., 2013). For three of the five scales (Re-experiencing, Avoidance, and Numbing), internal consistency was good, with alpha values that ranged from $\alpha = .68$ to $.82$; the remaining two scales (Dysphoric Arousal and Anxious Arousal) had less adequate internal consistency with $\alpha = .48$ to $.60$. The total score from the UCLA Child PTSD-RI has shown good internal consistency (.90) and good convergent validity with other measures of PTSD (Steinberg et al., 2013). In addition, research has found evidence of discriminant validity from measures of anxiety, depression, and dissociation (Steinberg et al., 2013). Internal consistency for the current sample was $.87$. The total PTS symptom score served as a continuous dependent variable in hypothesis tests for the first and third aims.

2.3.2.4 Violence Exposure Scale for Children-Revised (VEX-R).

The Violence Exposure Scale for Children-Revised (VEX-R; Fox & Levitt, 1995) is a 12-item cartoon-based interview used to assess children's self-reports of exposure to violence (both as a victim and as a witness). For each item, children indicate the number of times they have experienced what the child, "Chris" (a boy or a girl, depending on the gender identity of the

participant), is experiencing in the cartoon (i.e., never, once, twice, three times, or many times). Internal consistency estimates range from 0.80-0.86 (Fox & Levitt, 1995); alpha was .90 for the current sample. Total number of criterion A traumas endorsed on this measure served as a covariate in analyses under the third aim.

2.3.2.5 Caregiver Responses to Youth Media Exposure (CRYME).

The Caregiver Responses to Youth Media Exposure (CRYME; McQuarrie & Caporino, in press) is a 35-item self-report measure of how caregivers might respond before, during, and after a child's exposure to violent/tragic news through the media. Participants respond to each question using a 0-4 Likert-type scale with the following options: *never, rarely, sometimes, often, and almost always*. A factor analysis of the measure revealed three distinct patterns of caregiver responses to children's violent/tragic news media exposure; the authors thus constructed a subscale for each of these factors based on the results of the EFA, which they labeled Reassuring Realistically, Controlling Contact, and Scaring for Safety (McQuarrie & Caporino, 2017).

The Reassuring Realistically subscale includes items that assess such behaviors as reassuring the child of his/her safety, explaining violent/tragic news events in a developmentally appropriate way, and/or encouraging the child to not let violent/tragic news affect his/her daily life and routine. The Controlling Contact subscale measures caregiver behavior related to limiting a child's access to the violent/tragic news media either before or during the exposure, minimizing conversations with the child about the events, and/or sheltering the child from knowledge of the violent/tragic news events portrayed in the media. The Scaring for Safety subscale assesses caregiver use of violent/tragic news media as a teaching mechanism to prevent the child from engaging in dangerous activities or to instill fear of similar situations.

Cronbach's alpha for the CRYME as a whole in the initial validation study was .90 (McQuarrie & Caporino, 2017) and .89 for the current sample. However, although the high internal consistency for the full measure suggests that the CRYME total score provides a reliable measure of caregiver attention to the possible impact of media, the scale's authors recommend scoring the three subscales separately in order to capture meaningfully distinct sets of parenting behaviors. Responses for each subscale (i.e., Reassuring Realistically, Controlling Contact, and Scaring for Safety) of the CRYME were summed, yielding three total scores per participant. The ranges of total scores per subscale in the current sample were as follows: Reassuring Realistically 0-56 ($\alpha = .93$), Controlling Contact 0-40 ($\alpha = .90$), and Scaring for Safety 0-44 ($\alpha = .82$). Each subscale total served as a moderating independent variable in analyses.

2.3.2.6 Frequency of media use.

In line with prior studies regarding children's media exposure (e.g., Busso, McLaughlin, & Sheridan 2014; Comer et al., 2008b; Gentile, Nathanson, Rasmussen, Reimer, & Walsh, 2012; Owens et al., 1999), participating mothers were asked to answer six questions regarding how frequently their children have access to visual media and the types of media to which they are exposed. Caregivers were asked to indicate whether their child had access to each of several media sources—television, Internet (e.g., news sites, blogs, etc.), social media (e.g., Facebook, Twitter, etc.), and print media (e.g., magazines, newspaper, etc.)—and the number of hours per week spent on each. In this sample, ranges of time spent on each type of media varied widely (television 0-70 hours, internet 0-84 hours, social media 0-98 hours, and print media 0-15 hours). Hours spent consuming media of any type were summed to yield a total score; hours for some children exceeded the number of hours per week, presumably because those children used multiple types of media at a time (range for current sample 1-210 hours). Thus, the individual

tallies for different types of media are more meaningful. More details regarding the potential limitations of this measure will be discussed. Caregivers also provided information about total hours of media exposure to violent/tragic news per week, regardless of the media source (range for current sample 0-83 hours); this variable served as an independent variable in analyses for all study aims.

2.3.3 Power analysis.

To ensure recruitment of a large enough sample for the proposed analyses, I conducted a power analysis using the G Power program. As an estimate of the smallest anticipated effect to be detected, I used the average of effect sizes (ranging from .04 to .28) from three studies assessing whether parenting/family variables moderated associations between violence exposure and child psychopathology (Forehand & Jones, 2003; Kliwer & Kung, 1998; Kliwer et al., 2001). More conservative estimates indicated that a sample size of 111 would be necessary to find a small to medium effect ($f^2 = .12$), with up to 4 predictors, at a level of power equal to .95 ($1 - \beta$) and an alpha value of .05. Liberal calculations of power equal to .80 indicated that a sample of 68 would be sufficient. To increase the likelihood of detecting effects, I proposed to recruit a sample of 111 participants; however, only 66 mother-child dyads completed at least one measure of each construct under study. A post hoc power analysis with a sample of 66 participants indicated that power to find a small to medium effect size ($f^2 = .12$) in an analysis that included up to 4 predictors would equal .79 ($1 - \beta$) with an alpha value of .05.

3 RESULTS

3.1 Data Cleaning and Preliminary Analyses

Prior to conducting analyses, I cleaned the data in accordance with procedures outlined in Tabachnik and Fidell (2013). I also conducted preliminary analyses to ensure that the data met

assumptions for the planned multiple regression analyses. In addition to inspecting descriptive statistics and distribution of scores on each measure (see *Table 2*), I checked residual scatterplots for all dependent variables to evaluate their normality, linearity, skewness/kurtosis and homoscedasticity.

Table 2 Variable means and standard deviations

	Mean	SD	n	range
BASC-PR Child Anxiety	50.69	13.09	66	32-81
VEX-R Child Trauma	5.30	3.21	66	0-15
CRYME Reassuring (raw)	41.23	11.94	66	0-56
CRYME Reassuring (transformed)	3.69	1.47	66	1-7.5
CRYME Controlling	14.21	10.36	66	0-34
CRYME Scaring	17.45	8.96	66	0-36
Media (hours)	53.00	42.69	66	1-210
Television (hours)	16.59	1.69	66	0-70
Internet (hours)	23.17	2.61	66	0-84
Social Media (hours)	12.20	2.50	66	0-98
Print Media (hours)	1.05	.34	66	0-15
Violent News (hours)	13.85	17.95	66	0-83
TEI Mother Trauma	6.88	3.72	66	0-15

Note. BASC-PR = Behavioral Assessment System for Children-Parent Report; VEX-R = Violence Exposure Scale for Children-Revised; CRYME = Caregiver Responses to Violent News Media; Total media hours variable is a sum of viewing times for each of the four types of media (television, internet, social media, and print media); the range for total media hours was 0-

267 but truncated to 0-210 due to extreme outliers; TEI = Trauma Events Inventory; Mother traumas is a total count of Criterion A trauma count per child measured by the TEI.

Data were complete for the VEX-R measure of child trauma, both media-related measures (CRYME and frequency of media access), and mother's trauma as assessed via the CAPS-5. Only 25 participants in the 66-participant sample, however, had completed the UCLA Child PTSD-RI, and only 53 of the 66 participants had completed the CBCL. These measures had been added to the parent study battery after a large number of participants had already completed participation. Because an inadequate number of participants provided data regarding PTS symptoms, analyses in which UCLA Child PTSD-RI scores served as the dependent variable were necessarily exploratory. I also conducted analyses with child anxiety as the outcome variable to provide more adequately powered tests of associations with similar, yet distinct symptoms. Further, to maximize power for analyses focused on child anxiety as the primary outcome, I used the BASC-2 parent-report Anxiety scale T score as a dependent variable, rather than the CBCL Anxiety scale score, as originally proposed. Exploratory analyses with the CBCL Anxiety scale are detailed in *Appendices F* through *H*. These analyses are underpowered but show patterns of association that resemble those from similar analyses using the BASC Anxiety T-score.

Although most variables met the assumptions of regression analysis, two variables were non-normally distributed. First, the distribution of CRYME scores for the parenting practice "Reassuring Realistically" was leptokurtic (kurtosis = 3.76) and negatively skewed (skewness = -1.69). Second, the distribution of child-reported PTSD symptoms on the UCLA Child PTSD-RI was leptokurtic (kurtosis = 7.54) and positively skewed (skew = 2.57). In line with published recommendations to transform variables with skewness or kurtosis higher than 2 or lower than -2

(West, Finch, & Curran, 1995), I applied the reflect-and-square-root method, which is the most conservative transformation appropriate for negatively skewed and leptokurtic data.

Transformation of the CRYME Reassuring Realistically score yielded a distribution that met the assumption of normality (skewness = .28; kurtosis = .73). Transformation of the UCLA Child PTSD-RI symptoms score required the square-root method (without reflection due to the positive nature of the skew) and also yielded a distribution that met the assumption of normality (skewness = .39; kurtosis = -.31).

For each planned hierarchical linear regression model, I first examined Pearson's product-moment correlations among all independent and dependent variables to assess for multicollinearity, or excessively high correlations among independent variables (see *Table 3*). No correlations exceeded .90 or were otherwise indicative of multicollinearity. Next, I assessed for extreme outliers through the analysis of a standardized residual plot. Tabachnick and Fidell (2013) recommend removing datapoints that are ± 3.3 standard deviations away from the mean for each variable. Two cases had scores that were extreme outliers on the "total violent news hours exposure" variable. The values of these two data points were 83 hours and 77 hours. I truncated these two outliers to 55, as this was the highest value still within 2 standard deviations from the mean. There was one extreme outlier (> 3.3 standard deviations from the mean) on the UCLA Child PTSD-RI measure; I truncated this value of 60 to 37, which was the next highest value within 2 standard deviations from the mean. For less extreme outliers (i.e., ± 2 standard deviations away from the mean), I used Cook's Distance to assess whether they had undue influence on the outcome of the analyses. No Cook's Distance values were higher than 1, indicating that no individual data point had a higher than average influence on results.

Table 3 Correlations among variables included in analyses

	1	2	3	4	5	6	7	8	9	10	11	12
1. mother age	-											
2. TEI mother trauma	.06	-										
3. CAPS mother PTSD	.03	.31	-									
4. child age	.08	.10	.02	-								
5. child gender	.12	.05	.10	.00	-							
6. CRYME Reassuring Real.	.10	-.10	.12	.15	.14	-						
7. CRYME Controlling Contact	.00	-.04	.03	-.20	-.08	-.12	-					
8. CRYME Scaring for Safety	.00	.10	.07	-.11	-.16	-.38**	.08	-				
9. VEX-R child trauma	-.13	.06	-.03	.23	.02	-.14	-.02	-.03	-			
10. BASC-PR child anxiety	-.19	.26*	.11	.00	-.06	.08	.01	.04	-.10	-		
11. violent news hours	-.13	-.05	-.03	.14	-.33**	-.08	-.11	.01	-.05	.04	-	
12. total media hours	.08	-.11	-.10	.05	.16	.22	-.23	.01	.04	-.09	.27*	-
Mean	38.65	6.88	.64	9.77	.47	3.69	14.21	17.45	5.30	50.69	13.09	53.00
SD	8.88	3.72	.48	1.48	.50	1.47	10.36	8.96	3.21	13.09	15.46	42.69

Note. * $p < .05$; ** $p < .01$; TEI = Trauma Events Inventory; Mother traumas is a total count of Criterion A trauma count per child measured by the TEI; CAPS = Clinician Administered PTSD Scale; CRYME = Caregiver Responses to Violent News Media; VEX-R = Violence Exposure Scale for Children-Revised; BASC-PR = Behavioral Assessment System for Children-Parent Report.

To facilitate interpretation of findings for the parenting practices scores measured by the CRYME, I compared the present sample's means and standard deviations (see *Table 4*) to those for both Black and non-Black participants from the sample on which the measure was validated (McQuarrie & Caporino, 2017). Results of one-way ANOVAs showed significant differences among the current sample and the other two groups for two of the three practices. The current sample obtained higher scores on the Reassuring Realistically scale ($F(2, 759) = 13.25, p < .001$) than did members of the other two groups. In contrast, scores for the current sample were lower than those for either validation group on the Controlling Contact scale ($F(2, 766) = 11.88, p < .001$). There were no significant differences among groups for Scaring for Safety ($F(2, 763) = 2.23, p = .11$).

Table 4 Means and standard deviations of parenting practices

Parenting Practice	Validation Sample (all non-Black) $n = 647$		Validation Sample (Black only) $n = 55$		Current Sample $n = 66$	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Reassuring Realistically	34.53 ^a	± 9.98	34.04 ^a	± 9.90	41.23 ^b	± 11.94
Controlling Contact	19.76 ^a	± 8.77	20.36 ^a	± 8.59	14.21 ^b	± 10.36
Scaring for Safety	16.45 ^a	± 7.80	18.87 ^a	± 8.46	17.45 ^a	± 8.96

Note. Ranges for all scales: Reassuring Realistically 0-56, Controlling Contact 0-40, Scaring for Safety 0-44.

3.2 Linear multiple regression analyses

Insufficient UCLA Child PTSD-RI data were available to allow for adequately-powered multiple regression tests of hypotheses regarding relationships among real-life trauma exposure, media violence exposure, parenting practices, and child PTS symptoms. Thus, I used BASC anxiety T scores as the dependent variable in primary analyses and CBCL anxiety scores as

exploratory analyses. I also, however, conducted exploratory analyses with the UCLA Child PTSD-RI total score as the dependent variable to provide information that might help guide future research with larger samples. I originally proposed to use mother's trauma and/or mother's PTSD diagnosis as a covariate in the regression models; however, research published during the completion of the current study indicates that this covariate may be unnecessary to the model. Specifically, in a sample drawn from the same population as the present sample, findings indicate that neither maternal trauma nor maternal PTSD predicted child symptoms of PTSD (Cross et al., 2017). Given the lack of significance in the correlational analyses and recently published research, I excluded these covariates to conserve power.

3.2.1 *Aim 1*

Aim 1: To characterize patterns of association among frequency of violent/tragic news media exposure and child PTS symptoms in children at a high risk of exposure to real-life trauma while controlling for real-life trauma/violence exposure.

I first examined associations between frequency of violent/tragic news media exposure and child PTS symptoms in children at a high risk of exposure to real-life trauma. I covaried real-life trauma/violence exposure. This test was necessarily exploratory, due to the large amount of missing data for the UCLA Child PTSD-RI. Exposure to real life trauma and violent news trauma exposure accounted for a non-significant 1% of the variance in child PTSS, $R^2 = .10$, $F(2, 24) = 1.27$, $p = .30$ and adjusted $R^2 = .10$ (see *Table 5*).

Table 5 Multiple regression predicting child PTSS

	B	SE	β	Adjusted R^2	ΔR^2
Child PTSS					
Step 1				.06	.10
Child Trauma	.96	.61	.31		
Step 2				.02	.01
Child Trauma	1.02	.64	.33		
Total hours of Violent News Media	-.08	.19	-.09		

Note. $N = 25$; * $p < .05$; ** $p < .01$; $R^2 = .10$; $p = .30$; outcome variable = UCLA Child PTSD-RI

3.2.2 Aim 2

Aim 2: To characterize patterns of association between frequency of violent/tragic news media exposure and child anxiety in children at a high risk of exposure to real-life trauma while controlling for real-life trauma/violence exposure.

Next, I examined the degree to which children's exposure to violent/tragic news media predicted anxiety symptoms when exposure to real-life trauma was covaried. I entered child trauma exposure (i.e., number of Criterion A traumas) at the first step and violent news media exposure hours at the second step. Exposure to real life trauma and violent news trauma exposure accounted for a non-significant 1% of the variance in child anxiety after controlling for child trauma, $R^2 = .01$, $F(3, 63) = .34$, $p = .72$ and adjusted $R^2 = -.02$, see Table 6.

Table 6 Multiple regression predicting child anxiety

	B	SE	β	Adjusted R^2	ΔR^2
Child Anxiety					
Step 1				-.01	.01
Child Trauma	-.40	.51	-.10		
Step 2				-.02	.00
Child Trauma	-.39	.52	-.09		
Total Hours of Violent News Media	.03	.11	.04		

Note: $N = 66$; * $p < .05$; ** $p < .01$; $R^2 = .01$; $p = .72$; outcome variable = BASC-PR

3.2.3 Aim 3

Aim 3: To characterize patterns of association among real-life trauma/violence exposure, frequency of media trauma exposure, and PTS symptoms.

For the third aim, I conducted a multiple regression analysis to assess associations among child psychopathology (anxiety or PTSS) and both frequency of violent news media viewing and real-life trauma. Tolerance and VIF values were within acceptable limits (Tolerance $< .10$, VIF < 10) for all variables. I centered all variables around their means. Main effects were entered in the first step, followed by an interaction term in the second step. The model that included the interaction between exposure to real life trauma and violent news trauma exposure accounted for a non-significant 3% of the variance in child anxiety, $R^2 = .03$, $F(3, 63) = 1.10$, $p = .62$ and adjusted $R^2 = -.02$, see Table 7.

Table 7 Multiple regression predicting child anxiety

	B	SE	β	Adjusted R^2	ΔR^2
Child Anxiety					
Step 1				-.02	.01
Child Trauma	-.39	.52	-.09		
Total hours of Violent News Media	.03	.11	.04		
Step 2				-.02	.02
Child Trauma	-.63	.57	-.15		
Total hours of Violent News Media	-.01	.11	-.01		
Trauma x Violent News	-.05	.05	-.15		

Note: $N = 66$; * $p < .05$; ** $p < .01$; $R^2 = .03$; $p = .62$; outcome variable = BASC-PR.

In the exploratory test of this hypothesis, the model that included the interaction between exposure to real life trauma and violent news trauma exposure accounted for a non-significant 10% of the variance in child PTSS, $R^2 = .10$, $F(2, 24) = .82$, $p = .50$ and adjusted $R^2 = -.02$, see Table 8. Given the non-significant findings in both regressions predicting child anxiety and child PTSS, I did not conduct simple slopes analyses.

Table 8 Multiple regression predicting child PTSS

	B	SE	β	Adjusted R^2	ΔR^2
Child PTSS					
Step 1				.02	.10
Child Trauma	1.02	.64	.33		
Total hours of Violent News Media	-.08	.19	-.09		
Step 2				-.02	.01
Child Trauma	1.08	.78	.35		
Total hours of Violent News Media	-.08	.19	-.09		
Trauma x Violent News	.01	.09	.03		

Note: $N = 25$; * $p < .05$; ** $p < .01$; $R^2 = .01$; $p = .72$; outcome variable = UCLA Child PTSD-RI; variables were all centered around their means

3.2.4 Aim 4

Aim 4: To test a model of associations among parenting practices (Reassuring Realistically, Controlling Contact, and Scaring for Safety), frequency of the child's violent/tragic news media exposure, and child PTS symptoms (see Figures 1 and 2). I aimed to test the same model with child anxiety symptoms as the outcome variable.

The proposed hypotheses for Aim 4 included Child PTSS as the outcome variable. Again, due to concerns about power, these analyses are exploratory in nature. To provide a better-powered test with a related construct as the dependent variable, I conducted additional analyses, replacing the child PTSS outcome variable with the child anxiety outcome variable.

First, I entered variables in the hierarchical regression predicting PTSS in the following order: Step 1) mean centered variables for each parenting scale on the CRYME and frequency of

exposure to violent/tragic news media, and Step 2) interaction terms for frequency of media violence exposure and each of the three CRYME subscales (Reassuring Realistically, Controlling Contact, and Scaring for Safety). Because real life trauma was not a significant predictor in the first regression model, I omitted it from subsequent analyses to conserve power. As shown in *Table 9*, the first step yielded non-significant results ($F = .78, R^2 = .14, p = .55$), with no parenting practice making significant independent contributions to variability in child PTSS (i.e., Reassuring Realistically $\beta = -.13, t = -.59, p = .57$; Controlling Contact $\beta = .34, t = 1.57, p = .13$; Scaring for Safety $\beta = .20, t = .88, p = .39$). The second step yielded similarly non-significant results ($F = 1.24, R^2 = .34, p = .33$) for all parenting strategies (i.e., Reassuring Realistically $\beta = -4.69, t = -2.02, p = .06$; Controlling Contact $\beta = -1.14, t = -1.79, p = .09$; Scaring for Safety ($\beta = .42, t = 1.04, p = .31$) and the interaction with the frequency of exposure to violent/tragic news media.

Table 9 Hierarchical multiple regression analysis to test moderation effects of three parenting practices predicting child PTSS.

	B	SE	β	Adjusted R^2	DR ²
Child PTSS					
Step 1				-.04	.14
Reassuring Realistically	-.02	.04	-.13		
Controlling Contact	.06	.04	.34		
Scaring for Safety	.04	.04	.20		
Hours of Violent News	.02	.03	.15		
Step 2				.07	.20
Reassuring Realistically	-.20	.09	-1.11		
Controlling Contact	-.15	.12	0.89		
Scaring for Safety	.02	.06	.12		
Hours of Violent News	.72	.34	4.65		
Reassuring x News	-.02	.01	-4.69		
Controlling x News	-.02	.01	-1.14		
Scaring x News	.01	.01	.42		

Note. $N = 25$; dependent variable = child PTSS; * $p < .01$; ** $p < .001$. All variables were centered at their means.

Finally, I tested the same model with child anxiety as the outcome variable. I conducted a moderated regression analysis with four predictor variables (frequency of media exposure,

Reassuring Realistically, Controlling Contact, and Scaring for Safety) and three interaction terms (Reassuring Realistically x Exposure, Controlling Contact x Exposure and Scaring for Safety x Exposure) as predictors of child anxiety symptoms. For this analysis, I mean centered all predictor variables by subtracting the variable mean from each participant's individual value. I created an interaction term for each parenting scale on the CRYME and frequency of media exposure by multiplying the centered parenting scale on the CRYME variable by the centered frequency of media exposure variable.

VIF and Tolerance values indicated that multicollinearity was present (tolerance > .10 or VIF values greater than 10); the interaction term between Reassuring Realistically parenting practice and violent news media exposure had a VIF score of 30.20 and Tolerance score of .03. I thus removed this interaction term and conducted a third linear multiple regression analysis.

I entered variables in the hierarchical regression in the following order: Step 1) mean centered variables for each parenting scale on the CRYME and frequency of exposure to violent/tragic news media, and Step 2) frequency by Reassuring Realistically, frequency by Controlling Contact, and frequency by Scaring for Safety. Real life trauma was again excluded from analyses to conserve power. As shown in *Table 10*, the first step yielded non-significant results ($F = .12$, $R^2 = .01$, $p = .97$), with no parenting practice making significant independent contributions to variability in child anxiety (i.e., Reassuring Realistically $\beta = -.08$, $t = -.52$, $p = .60$; Controlling Contact $\beta = .02$, $t = .18$, $p = .86$; Scaring for Safety $\beta = .07$, $t = .49$, $p = .62$). The second step yielded similar results, in that the overall model was non-significant ($F = 1.80$, $R^2 = .18$, $p = .10$).

Table 10 Hierarchical multiple regression analysis to test moderation effects of three parenting practices

	B	SE	β	Adjusted R^2	DR^2
Child anxiety					
Step 1				-.06	.01
Reassuring Realistically	-.08	.16	-.08		
Controlling Contact	.03	.17	.02		
Scaring for Safety	.11	.21	.07		
Hours of Violent News	.05	.11	.06		
Step 2				.08	.17
Reassuring Realistically	-.11	.18	-.10		
Controlling Contact	-.13	.16	-.10		
Scaring for Safety	.14	.20	.10		
Hours of Violent News	.13	.55	.15		
Reassuring x News	.00	.01	.04		
Controlling x News	-.05	.02	-.46**		
Scaring x News	.01	.01	.04		

Note: $N = 66$; dependent variable = child anxiety; * $p < .01$; ** $p < .001$. All variables were centered at their means.

In the third regression, to correct for multicollinearity in the second regression, I entered variables in the hierarchical regression in the following order: Step 1) mean-centered variables for Controlling Contact, Scaring for Safety and frequency of exposure to violent/tragic news media, and Step 2) frequency by Controlling Contact and frequency by Scaring for Safety. As shown in *Table 11*, the first step yielded non-significant results ($F = .07$, $R^2 = .01$, $p = .97$), with neither parenting practice making significant independent contributions to variability in child anxiety (i.e., Controlling Contact $\beta = .02$, $t = .12$, $p = .91$; Scaring for Safety $\beta = .04$, $t = .30$, $p = .77$). The second step yielded a significant model ($F = 2.46$, $R^2 = .17$, $p = .04$). The only significant predictor in the second model was the interaction between frequency of exposure to violent/tragic news and Controlling Contact ($\beta = -.45$, $t = -3.47$, $p = .001$).

Table 11 Hierarchical multiple regression analysis to test moderation effects of two parenting practices

	B	SE	β	Adjusted R^2	ΔR^2
Child Anxiety					
Step 1				-.05	.00
Controlling Contact	.02	.16	.02		
Scaring for Safety	.06	.19	.04		
Hours of Violent News	.04	.11	.05		
Step 2				.10	.17*
Controlling Contact	-.14	.16	-.11		
Scaring for Safety	.08	.18	.05		
Hours of Violent News	.14	.11	.17		
Controlling X News	-.05	.02	-.45**		
Scaring X News	.01	.01	.07		

Note. $N = 66$; dependent variable = child anxiety; * $p < .01$; ** $p < .001$. All variables were centered at their means.

I decomposed the significant interaction using simple slopes analysis. Specifically, I compared slopes for participants who scored at a high level (one standard deviation above the mean), the mean, and a low level (one standard deviation below the mean) of the moderator (parenting behaviors measured by the CRYME). I assessed the interaction using the regression

method and the Johnson-Neyman method, and also evaluated it graphically. Results are depicted in *Tables 12 and 13*, and *Figure 5*.

For both low and high levels of Controlling Contact, the slope was positive for the relationship between violent news media exposure and child anxiety. However, the association between violent news media exposure and child anxiety was significantly more positive when mothers used low levels of Controlling Contact ($\beta = .18, p = .10$) than when they reported using high levels ($\beta = .08, p = .43$). Even though slopes were not significantly different from zero, the significant overall interaction ($B = -.05, p = .001$) indicated that these slopes were significantly different from each other.

Table 12 Regression method for simple slopes with high Controlling Contact

	B	SE	β	Adjusted R^2	DR^2
Step 1				-.03	.00
Hours of Violent News	.04	.11	.05		
Controlling Contact (high)	.02	.16	.02		
Step 2				.13	.16**
Hours of Violent News	.08	.10	.09		
Controlling Contact (high)	-.14	.16	-.11		
Controlling (high) X News	-.05	.02	-.43**		

Note: * $p < .01$; ** $p < .001$

Table 13 Regression method for simple slopes with low Controlling Contact

	B	SE	β	Adjusted R^2	DR^2
Step 1				.00	.00
Hours of Violent News	.04	.11	.05		
Controlling Contact (low)	.02	.16	.02		
Step 2				.13	.16*
Hours of Violent News	.18	.11	.22		
Controlling Contact (low)	-.14	.16	-.11		
Controlling (low) X News	-.05	.02	-.46**		

Note: * $p < .01$; ** $p < .001$

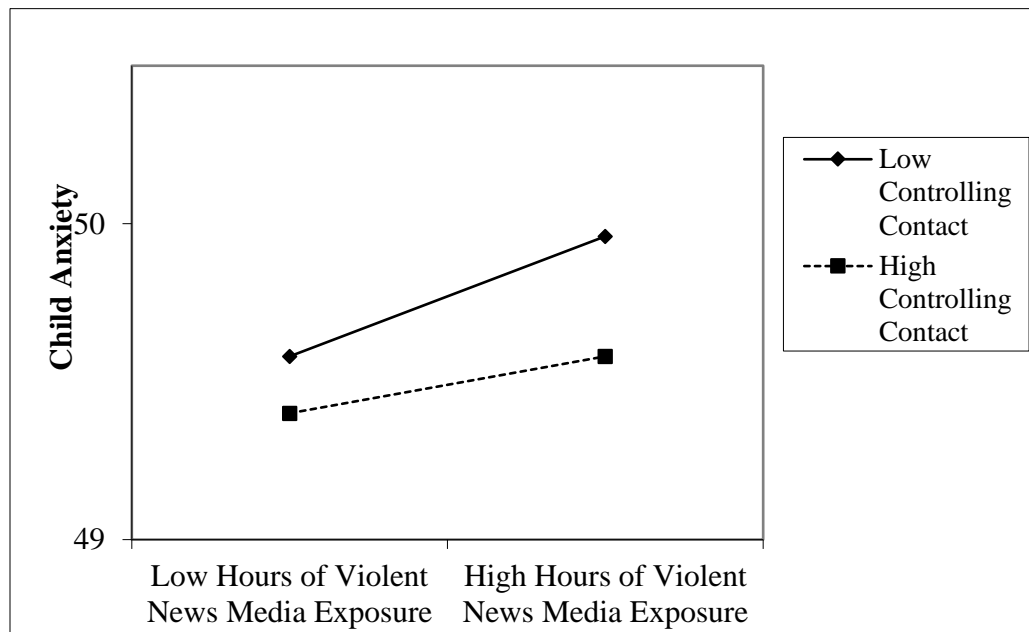


Figure 5 Controlling Contact moderates the association between hours of violent news media exposure and child anxiety.

3.2.5 *Additional Exploratory Analyses*

Although 16 of the study's participants provided data in face-to-face interviews, consistent with standard practice for the GTP study—I collected CRYME and frequency of media use data from the remaining 50 participants (who had already completed most study measures) via phone interview, which was necessary in order to maximize the sample size. It is possible that mothers interviewed in person responded differently to key study measures than did those interviewed by phone. To better understand any potential limitations to the data collection method, I conducted independent samples t-tests comparing the means and standard deviations of mothers who completed measures via in-person interview versus phone. Although underpowered, exploratory results indicated significant differences between the data collection methods; specifically, mothers reporting parenting practices in person reported significantly higher use of Controlling Contact and lower use of Scaring for Safety. Via phone, mothers reported significantly higher amounts of total hours of media exposure compared to mothers reporting in person. There were no significant differences between total hours of violent news exposure and the Reassuring Realistically parenting practice by data collection method. See *Appendix I* for full details.

4 DISCUSSION

This study provides a first step toward addressing questions regarding violent/tragic news media exposure and how it relates to distress in youths who have experienced high levels of real-life violence/trauma. In addition, it provides insight into putative associations between caregiver behaviors intended to protect their children from negative outcomes related to violent/tragic media and child psychological health. Although I originally designed the study to include both child anxiety and PTS symptoms as dependent variables, an inadequate number of participants completed the UCLA Child PTSD-RI, which served as the primary measure of PTS.

Consequently, my planned analyses focused exclusively on child anxiety symptoms as an outcome, and I limited examination of PTS symptoms to exploratory analyses that must be interpreted cautiously due to lack of power.

Contrary to predictions, two of the three measured parenting practices—Reassuring Realistically and Scaring for Safety—were not significant moderators of the relationship between children’s exposure to violent news media and their anxiety. Controlling Contact, however, significantly moderated the relationship between the number of hours a child was exposed to violent news media and their anxiety. More precisely, for children of mothers who endorsed high levels of control over their child’s access to violent news media, anxiety was more weakly associated with amount of viewing time than it was for children of mothers who reported using lower levels of control.

I based my hypotheses for this study off of a small existing literature, and the current findings conflict with the available theories, empirical data and previous research. Therefore, these results should be interpreted cautiously and replicated before making strong inferences about their clinical implications. Viewed with this caveat in mind, however, the present findings provide a potentially useful perspective from which to examine past research; they also point to possible new approaches for future studies.

In particular, this study contributes novel information to the literature regarding how parenting practices around violent news media exposure might relate to childhood mental health by extending research on media parenting practices to a heavily trauma-exposed population. Of note, practices previously found to be effective at reducing adverse emotional responses did not show expected associations with child symptoms in this all-minority, low-income, traumatized sample. Indeed, findings suggest that we may need to refine recommendations for parenting

practices for managing children's experiences of violent news in the media by considering the specific contexts of trauma, income, and minority status.

4.1 Mental Health and Media Parenting Practices.

The body of research informing the current study's hypotheses was conducted using mostly majority (i.e., ~70% White), non-traumatized samples. Findings from extant work indicate that "active parenting" (commonly defined as talking with a child about what he/she had viewed) is associated with more positive outcomes than is "restrictive parenting" (limiting a child's access to the media) (Padilla-Walker, Christensen, & Day, 2011; Padilla-Walker, & Coyne, 2011). The Reassuring Realistically and Scaring for Safety parenting practices examined in the current study appear to represent behaviors that fall under the auspices of "active parenting," in that both share the core feature of speaking openly with the child about media content. The Controlling Contact parenting practice more closely maps onto the "restrictive" form of parenting that has been previously identified in research.

Unexpectedly, in the current sample of Black and trauma-exposed mothers and children, although mothers reported using both Reassuring Realistically and Scaring for Safety practices as often or more often than did parents in the CRYME validation sample, neither practice significantly moderated associations between violent media exposure and child anxiety. Qualitative research, examining the content of both reassuring and scaring discussions might help elucidate this pattern of findings. For example, it would be useful to explore the possibility that, for families coping with both racism and trauma exposure, the content of "Reassuring Realistically" conversations, much like the content of "Scaring for Safety" conversations, is necessarily more about realistic expectations and less about reassurance regarding safety. In

other words, both reassurance and scaring practices may, for parents who have faced many real threats, be aimed at maintaining a level of anxiety that is adaptive in a hostile environment.

A small body of research suggests that this hypothesis may be viable. African American parents, regardless of their direct experiences with trauma, commonly report that they talk with their children about racism, the dangers associated with it, and ways to keep themselves safe (Thomas & Blackmon, 2015). Given recent increases in coverage of violence that appears to be racially motivated (Klein & Naccarato, 2003), it seems likely that African-American parent-child conversations following child exposure to violent/tragic news in the media similarly reference racism and its consequences, as well as self-protective strategies, although data supporting this idea are sparse. It is thus plausible that the “Reassuring Realistically” conversations that mothers in the present study, who were contending with multiple interacting factors, including racial minority status and low socioeconomic status that confer vulnerability (McLoyd & Randolph, 1985), have had with their children reflect a belief based in life experiences that their environments are not safe and that hypervigilance to the inevitable risks in their environment is necessary. Given this context, practices aimed at keeping children appropriately on guard and teaching them how to stay safe might be an appropriate response when children view violence in the news media (Thomas & Blackmon, 2015).

It is also important to consider the possibility that the multiply-traumatized children in this study were inoculated to or numbed by violence exposure, and thus that their mothers may have been using practices aimed at keeping them vigilant out of concern that they might not be adequately frightened by real threats. A past study of college students found a “numbing” or reduced physiological response to violence in the media in participants who had been exposed to high levels of real-life violence during childhood (Madan, Mrug, & Wright, 2014). In related

findings, multiply-traumatized youth exposed to terrorism in Israel showed declining emotional responses to terrorist attacks over a 44-month period of time (Bleich, Gelkopf, Melamed, & Solomon, 2006). Clarifying in more detail how children with trauma histories experience violent media will be important in future research, as there are multiple possible paths they could follow to adverse outcomes.

The one practice to interact significantly with violent media exposure to predict child anxiety was Controlling Contact. Although the cross-sectional nature of the present study precludes directional interpretations of this relationship, anxiety was lower for children whose mothers reported using more restricting/controlling behaviors around violent media viewing. This finding is consistent with those from previous cross-sectional studies in largely White, middle- to upper-middle class families. This body of research indicates that restricting or controlling a child's access to the media, although not as effective as "active" strategies, protects against adverse mental health outcomes, like anxiety and PTSS (Buijzen, van der Molen, and Sondij, 2007; Padilla-Walker, Christensen, & Day, 2011; Padilla-Walker, & Coyne, 2011; Valkenberg et al., 1999).

It is important to note that the present data are correlational, and thus preclude assertions about directionality. It is therefore possible that children with high levels of anxiety evoke different behaviors from their caregivers in association with media viewing than do children who are less anxious. For example, caregivers may accommodate anxious children by facilitating their avoidance of anxiety-provoking situations and providing repeated reassurance that feared outcomes will not occur (e.g., Caporino et al., 2012; Lebowitz et al., 2012). Thus, in order to accommodate a child's anxious responses, parents may restrict a child's media exposure or provide excessive reassurance that the child will not be affected by violent events in the news.

Paradoxically, however, these efforts to reduce a child's distress in the short term are likely to maintain or exacerbate anxiety in the long run (e.g., Caporino et al., 2012; Lebowitz et al., 2012; Storch, et al., 2007).

Studies of observed parental control—encouragement of dependency on parents that can lead children to perceive themselves as lacking in mastery or control and that has been linked to high levels of anxiety in children (e.g., van Brakel, Muris, Bogels, & Thomassen, 2006; Wood, McLeod, Sigman, Hwang, & Chu, 2003)—suggest that the relationship between child anxiety and parenting behavior is dynamic and reciprocal. Thus, it is possible that restrictive parenting in the context of violent news media exposure contributes to child anxiety by communicating to children that they cannot cope independently with violent news. Research is needed that examines the interplay of parenting practices around media viewing and child characteristics and behaviors over time, as well as whether and how these dynamic interactions vary as a function of family trauma exposure.

Notably, the current findings provide suggestive evidence that an intense focus on protecting children from risk of harm, a practice that is common in high-trauma families (Bar-On et al., 1998), may relate to *lower* child anxiety in this population. This contrasts with findings in non-traumatized samples that link overprotection or parental control to high levels of anxiety in children (e.g., van Brakel, Muris, Bogels, & Thomassen, 2006; Wood et al., 2003). It is possible that in highly traumatized families, protective behaviors provide a much-needed sense of safety and adult support, given children's awareness that risks are real and serious.

The literature on authoritarian parenting also provides a useful context for thinking about the Controlling Contact parenting practice. It has been well established that authoritarian parenting (defined as firm limit setting within in the context of warmth and responsiveness) is

more common among Black/African American parents than White/European American parents (Lansford et al. 2011; LeCuyer et al. 2011; Reitman, Rhode, Hupp, & Altobello, 2002).

Moreover, there is some evidence from observational research that higher levels of authoritarian parenting are associated with better self-regulation in children from racial minority groups (LeCuyer & Swanson, 2016). The current study's findings that parental limit-setting around violent media viewing relates to lower child anxiety raise the possibility that this practice also contributes to better emotional self-regulation in children at high risk for distress as a function of trauma.

4.2 Usage Frequency for Media Parenting Practices.

Although assessing the frequency of use among mothers in this highly traumatized population of the three parenting practices measured was not one of the main study aims, it is an important factor to consider. Mothers in the current sample reported using the Controlling Contact practice much less frequently than did both Black and non-Black participants in the validation sample for the CRYME measure (McQuarrie & Caporino, 2017); Scaring for Safety was used with about the same frequency, and Reassuring Realistically was used more often in this sample than the validation sample of mothers.

Differences between the present sample and the validation sample scores on these measures could reflect, at least in part, the ages of the children whose media use mothers are managing, given that the literature to date suggests that parents vary their strategies for managing media exposure depending on how old their children are. There is evidence, for instance, that parents of young children rely primarily on restriction to manage their children's overall media consumption (Thompson et al., 2016). Parental use of restriction then appears to decline over time, with a shift to more active strategies when children reach adolescence (Padilla-Walker et

al., 2012). In the current study, however, mothers endorsed less use of this practice with their 8- to 12-year-old children than did parents of children in a wider age range (6-17 years) in the CRYME validation sample. This raises the possibility that this practice, while of potential utility in protecting trauma-exposed children from negative effects of indirect exposure to violence, may be underused in this population.

The present findings also suggest that, in addition to endorsing less control of their children's media exposure, trauma-exposed mothers report using more realistic reassurance than do mothers in the general population. This is at least superficially inconsistent with prior research that found trauma-exposed mothers to use parenting practices that appear less engaged and potentially more neglectful than trauma-free mothers (Banyard, Williams, & Siegel, 2003), and that has shown that the amount of trauma that mothers have experienced predicts a lack of engagement (Cohen, Hien, & Batchelder, 2008). Research focused on examining in detail the content of conversations between trauma-exposed mothers and their children about media violence might be useful for resolving or clarifying this inconsistency.

4.3 Implications for Refining Parental Recommendations

While there are extensive practice guidelines regarding children's access to media violence, there is much less guidance available in the literature regarding children's access to violent *news* media (Reich, 2018). The National Association for School Psychologists (nasponline.org, 2006) has recommended minimizing negative impacts of violence exposure on children by reassuring them that they are safe, making time to talk, keeping explanations developmentally appropriate, reviewing safety procedures, observing children's emotional state, limiting television viewing of these events, and maintaining a normal daily routine. Other organizations, such as the National Child Traumatic Stress Network (NCTSN; nctsn.org, 2006)

and the Substance Abuse and Mental Health Services Administration (SAMHSA; samhsa.gov, 2012), have offered similar instructions for parents. However, the efficacy of such guidelines for minimizing distress reactions to violent/tragic news has not been fully examined, and in light of recent findings, there may be value in careful consideration of whether they are universally useful. For example, alternate or additional guidelines may be helpful for parents in highly traumatized families, particularly those who are members of minority groups that have historically experienced discrimination.

One point that warrants further consideration is the value of reassuring children about their safety when such reassurance may be inaccurate. The current data appear to contradict the concept that reassuring a child about safety is more effective for reducing anxiety than is limiting their access to the media (Padilla-Walker, Christensen, & Day, 2011; Padilla-Walker, & Coyne, 2011). However, it is unclear how widely the present findings can be generalized, and it is possible that practices associated with low child anxiety differ between members of the general population and highly traumatized populations.

A second idea that warrants attention is that parenting practices that are adaptive for majority groups may be less useful for at least some highly traumatized, low-income, Black families. Research indicates that African American caregivers face particular challenges in parenting minority youth (Lamis et al, 2014), who are vulnerable to negative treatment because of their race. For example, unlike most majority parents, parents of children from minority groups may need to teach their children to anticipate being treated poorly because of their race (Agnew, 2015). Given the frequency with which the media depicts violence against Black people (McLaughlin, 2015), reassurance about safety may be less accurate and useful than is acknowledgement of real risks and instructions about how to keep oneself safe. There is

evidence that honest education about discrimination may help reduce the negative impact of discriminatory experiences (Agnew, 2015); there may be similar value in honest parent-child conversations regarding violent news media exposure.

4.4 Limitations

This study had several limitations. First, the sample was relatively small. Based on a conservative power analysis, I needed a sample of 111 to be able to detect significant moderately-sized effects; a less conservative analysis recommended 68 participants. The final sample, however, comprised only 66 participants. It is therefore unclear whether non-significant findings regarding Reassuring Realistically and Scaring for Safety reflect effects that were simply too small for me to detect without more participants.

Second, the responses for parent-reported frequency of media use were questionable. The data collected using this measure should be evaluated with caution given that some parents reported that their children consumed media at a level of frequency that exceeds the total number of hours in a week. While this is theoretically possible, given that a child could be using two types of media simultaneously, it is unlikely. Unfortunately, well-validated and reliable self-report measures of child media consumption are not yet available, and most studies rely on retrospective self-reports that are likely to be biased or inaccurate. An important next step in the study of children's violent media viewing and its impacts will be to develop measures that more effectively capture actual behaviors. Ecological momentary assessment tools are of potential utility in this regard.

Third, I was unable to test hypotheses regarding child PTS because a large number of participants had not completed the UCLA Child PTSD Reaction Index (UCLA Child PTSD-RI; Steinberg, Brymer, Decker, & Pynoos, 2004). Exploratory analyses using the sample of 25

families who had completed this measure yielded no significant findings. Replication in a larger sample would thus be useful for clarifying whether and how parenting practices function similarly with regard to child anxiety and PTSS.

Fourth, mothers who provided data regarding media exposure in person and those who provided data over the phone differed in their reports regarding parenting practices and child overall media exposure. Specifically, over the phone, reported less Controlling Contact, more Scaring for Safety, and higher rates of media exposure (including violent news media) compared to mothers interviewed in person. Previous studies comparing phone and in-person interviewing found that those interviewed over the phone provided less honest answers than those interviewed in person, possibly because rapport was harder to build in the absence of in-person contact (Anquilino, 2009). There would thus be value in ensuring that data collection practices are as uniform as possible in future studies of parenting and media violence.

The cross-sectional nature of the current data makes it impossible to discern if mothers use specific behaviors with children because they are already anxious or if these behaviors facilitate or ameliorate anxiety. Parental responses to violent news could potentially exacerbate its negative impact on children with preexisting anxiety. Longitudinal research would be helpful in efforts to address causal questions on this topic.

Finally, I did not measure social desirability, a variable that may have influenced participants' patterns of response. It is likely difficult for mothers to estimate how much media and media violence their children have been exposed to; consequently, they may be inclined to under-report in order to make a positive impression on the interviewer. This inclination towards positive impression management may have been magnified given that participants were all African American and the interviewer was White. In a study investigating the effects of

interviewer race on disclosure of information about daily hassles and interpersonal violence histories, low-income African American women were less likely to disclose information to interviewers outside of their own race than to interviewers whom the women perceived as being from their own race (Samples et al., 2014).

4.5 Clinical and Practical Implications

The results of the current study offer new information that could help inform our approaches to helping children after exposure to violent/tragic media. First, there may be value in tailoring parenting recommendations so that they provide specific guidance for parents who must help their children understand and prepare for real and serious risks in their environments that other children may not face. Disseminating such recommendations, as well as education about risks associated with media violence exposure, during pediatric primary care visits would capitalize on a growing trend to integrate mental and physical health care (Asarnow, Rozenman, Wiblin, & Zeltzer, 2015) and might help ensure that parents receive information that they might not otherwise have access to.

There may also be value in expanding the use of parental guidance ratings, which have preceded screening of television show episodes and movies since 1997, when the Federal Communications Commission responded to viewer concerns about the content of some material being displayed on television (Valenti, FCC, 1997). Notably, commercials, sports, and news shows are not required to provide such ratings, even though they may present graphic and disturbing material. Although news anchors and reporters sometimes issue statements warning viewers of disturbing content, this is not a required practice. Requiring newscasts to provide guidelines prior to each news segment in order to help parents determine if the material about to

be shown is appropriate for whomever is in earshot or view of the media content could be helpful.

4.6 Conclusions and Future Directions

While the current study adds to the research on how mothers respond to their children viewing violent news in the media, more research is needed regarding the effectiveness of particular parenting practices for children in different contexts. It will be important to conduct longitudinal research to test for causal relationships among violent news media exposure, parenting practices, and child mental health.

Research targeting special populations, such as those with preexisting mental health diagnoses and more culturally sensitive parenting practices is critical. These populations require different considerations given the vulnerability and pre-existence of mental health symptoms. A more culturally-bound parenting practice that is not measured by the CRYME, similar to those identified in Threlfall (2016) may be present in the families of the current sample. Limited research has been conducted on specific parenting practices for minority youth and parents in response to youth's violent/tragic news media exposure, and the majority of this work has been in response to the coverage of violence against Black men. Future research should expand on this work and aim to focus on particular cultural and family contexts that may require special consideration beyond what is appropriate in majority samples.

While the current study only investigated mothers' parenting practices regarding youth's violent news media exposure, there is research to indicate in homes with two parents that the best outcomes are associated with consistency between parents. For example, in homes where parents disagreed on media restriction, children viewed more media violence than in homes where parents agreed on the amount of restriction to enforce (Mares, Stephenson, Martins, &

Nathanson, 2018). Future research should include analyses of other potential caregivers in the home, as this may play an important role in the child's experience and interaction with media exposure.

Finally, resilience is a relevant phenomenon that should be further investigated in relation to the effects of violent media. Given the present study's null findings regarding "active parenting" practices, there may be other important factors, such as resilience, to consider when measuring the association between parenting practices and children's anxiety and PTSS.

Bonanno (2004) argues that resiliency is distinct from recovery; there may be factors that researchers are missing by only looking at symptoms being present or absent. He argues that a lack of symptoms is different than the existence of resiliency; rather, resiliency is the ability to maintain emotional stability. In a study of 9- to 11- year old Black youth living in an urban setting with exposure to frequent community violence found that spirituality and high social support were the best predictors of resiliency from PTSS (Jones, 2007). Future research should integrate resiliency factors into models.

The current study takes one step toward a better understanding how caregivers respond to their children's media violence exposure and how these responses relate to children's emotional well-being. Findings of the current study expand the extant literature, indicating it is likely that multiple factors—parent, child, and environmental—contribute to a child's response to violent news media exposure, specifically in minority and trauma-exposed populations. Future research should continue to investigate ways to best prevent or address "second hand trauma" from children's exposure to violent/tragic media.

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APPENDICES

Appendix A: Violence Exposure Scale for Children-Revised (VEX-R)

I am going to show you some pictures that tell about a child whose name is Chris. I will show you one picture at a time and tell what is happening in that picture. Afterwards, I will ask you questions about things you may have seen that are like what Chris saw or things that may have happened to you that are like what happened to Chris.

For each question, I want you to pick one answer: I mean, never, one time, a few times, or lots of times. **SHOW SCALE TRAINING PAGE.**

During the summer, how many times do you eat ice cream? Never- 0, One time- 1, A few times- 2, Lots of times-

Now, I am going to show you some pictures of things that Chris really saw or that really happened to Chris. They are not things that Chris imagined or made up. They are not stories that Chris heard or things that Chris saw on TV or in the movies or on the Internet. The pictures show things that Chris really saw or that really happened to Chris.

NOTE: THE INTERVIEWER SHOULD EMPHASIZE WITH THE FIRST FEW PICTURES THAT CHRIS REALLY SAW THESE THINGS HAPPEN, AND THEY ARE NOT THINGS THAT CHRIS WATCHED IN A MOVIE OR ON VIDEO OR TV.

SHOW INTRODUCTION PAGE. This is Chris.

Show Page A. Chris sees a kid sitting on Santa's lap. How many times have you seen a kid sitting on Santa's lap?

1. Chris sees a person yell at another person. How many times have you seen a person yell at another person?
2. A person yells at Chris. How many times has a person yelled at you?
3. Chris sees a person throw something at another person. How many times have you seen a person throw something at another person?
4. A person throws something at Chris. How many times has a person thrown something at you?
5. Chris sees a person push or shove another person really hard. How many times have you seen a person push or shove another person really hard?
6. A person pushes or shoves Chris really hard. How many times has person pushed or shoved you really hard

7. Chris sees a person chase another person. The person who is being chased looks scared and the other person looks angry. How many times have you seen an angry person chase a scared person

8. A person chases Chris. Chris looks scared and the other person looks angry. How many times has an angry person chased you?

Show Page B. Chris watches cartoons on TV. How many times have you watched cartoons on TV?

9. Chris sees a person slap another person really hard. How many times have you seen a person slap another person really hard?

10. A person slaps Chris really hard. How many times has a person slapped you really hard?

11. Chris sees a person beat-up another person. How many times have you seen a person beat up another person?

12. A person beats Chris up. How many times has a person beat you up?

13. Chris sees a person steal stuff from another person. How many times have you seen a person steal stuff from another person?

14. A person steals stuff from Chris. How many times has a person stolen stuff from you?

15. Chris sees a person point a knife or a real gun at another person. How many times have you seen a person point a knife or a gun at another person?

16. A person points a knife or a real gun at Chris. How many times has a person pointed a knife or a real gun at you?

Show Page C. Chris goes shopping. How many times have you gone shopping?

17. Chris sees a person stab another person with a knife. How many times have you seen a person stab another person with a knife?

18. Chris sees a person shoot another person with a real gun. How many times have you seen a person shoot another person with a real gun?

19. Chris sees a person being arrested. How many times have you seen a person being arrested?

20. Chris sees a person dealing drugs. How many times have you seen a person dealing drugs?

21. Chris sees a kid getting spanked. How many times have you seen a kid getting spanked?
22. A person spanks Chris. How many times has a person spanked you?
23. Chris sees someone being bitten by a dog. How many times have you seen someone being bitten by a dog?
24. Chris gets bitten by a dog. How many times has a dog bitten you?
25. Chris knows someone who was killed by someone else. Have you ever known someone who was killed? How many times?
26. Chris sees a house or building on fire. How many times have you seen a house or building on fire?
27. Chris sees a really bad storm, like a tornado, hurricane, or earthquake. How many times have you seen a really bad storm like that?
28. Chris sees adults in his/her home yelling at each other. How many times have you seen adults in your home yell at each other?
29. Chris sees adults in his/her home fighting or pushing each other with their hands. How many times have you seen adults in your home fight or push each other with their hands?
30. Chris is told by his/her parents (or caregivers) to go away and live somewhere else. How many times have you been told by your parents (or caregivers) to go away and live somewhere else?
31. Chris is told that his/her parents (or caregivers) are going to leave him/her. How many times have you been told that your parents (or caregivers) are going to leave you?

Appendix B: UCLA Child PTSD Reaction Index (UCLA Child PTSD-RI)

Sometimes people have scary or violent thing that happen to them where someone could have been or was badly hurt or killed. We have talked about some of those things today. Of all the things we talked about, which one **BOTHERS YOU THE MOST NOW?**

Describe index trauma queried here.

Interviewer, read these directions verbatim:

I'm going to read a list of problems people can have after bad things happen. Please think about the bad thing that happened to you that bothers you the most now. For each problem, tell me how often it has happened to you **IN THE PAST MONTH**, even if the bad thing happened a long time ago. Use the Frequency Rating Sheet to help you decide how often the problem happened in the past month. You can say None, A Little, Some, Much, or Most.

1. I am on the lookout for danger or things that I am afraid of (like looking over my shoulder even when nothing is there).
2. I have thoughts like, "I am bad."
3. I try to stay away from people, places, or things that remind me about what happened.
4. I get upset easily or get into arguments or physical fights.
5. I feel like I am back at the time when the bad thing happened, like it's happening all over again.
6. I feel like what happened was sickening or gross.
7. I don't feel like doing things with my family or friends or other things that I liked to do.
8. I have trouble concentrating or paying attention.
9. I have thoughts like, "The world is really dangerous."
10. I have bad dreams about what happened, or other bad dreams.
11. When something reminds me of what happened I get very upset, afraid, or sad.
12. I have trouble feeling happiness or love.
13. I try not to think about or have feelings about what happened.

14. When something reminds me of what happened, I have strong feelings in my body, like my heart beats fast, my head aches, or my stomach aches.

15. I am mad with someone for making the bad thing happen, not doing more to stop it, or to help after.

16. I have thoughts like, "I will never be able to trust other people."

17. I feel alone even when I am around other people.

18. I have upsetting thoughts, pictures, or sounds of what happened come into my mind when I don't want them to.

19. I think that part of what happened was my fault.

20. I hurt myself on purpose.

21. I have trouble going to sleep, wake up often, or have trouble getting back to sleep.

22. I feel ashamed or guilty over what happened.

23. I have trouble remembering important parts of what happened.

24. I feel jumpy or startle easily, like when I hear a loud noise or when something surprises me.

25. I feel afraid or scared.

26. I do risky or unsafe things that could really hurt me or someone else.

27. I want to get back at someone for what happened.

DISSOCIATIVE SYMPTOMS

28. I feel like I am seeing myself or what I am doing from outside my body (like watching myself in a movie).

29. I feel not connected to my body, like I'm not really there inside.

30. I feel like things around me look strange, different, or like I am in a fog.

31. I feel like things around me are not real, like I am in a dream.

SYMPTOM DURATION

32. Have some of these reactions lasted AT LEAST ONE MONTH?

Yes

No

CLINICALLY SIGNIFICANT DISTRESS

33. Do these reactions bother or upset you a lot?

Yes

No

CLINICALLY SIGNIFICANT FUNCTIONAL IMPAIRMENT

34. Do these reactions make it harder for you to get along with people at home?

Yes

No

35. Do these reactions get you into trouble at home?

Yes

No

36. Do these reactions cause some other problem at home?

Yes

No

37. Do these reactions make it harder for you to do well in school?

Yes

No

38. Do these reactions cause other problems at school?

Yes

No

39. Do these reactions make it harder for you to get along with your friends or to make new friends?

Yes

No

40. Do these reactions make it harder for you to do activities that other kids your age are doing?

Yes

No

Appendix C: Anxiety Items from Child Behavioral Checklist (CBCL)

- 50. Too fearful or anxious
- 112. Worries
- 45. Nervous, high-strung, or tense
- 56c. Nausea, feels sick
- 71. Self-conscious or easily embarrassed
- 56b. Headaches
- 32. Feels he/she has to be perfect
- 56f. Stomachaches or cramps
- 75. Shy or timid
- 11. Clings to adults or too dependent
- 56a. Aches or pains
- 9. Cannot get his/her mind off certain thoughts
- 30. Fears going to school
- 31. Fears he/she might think or do something bad
- 29. Fears certain animals, situations, or places other than school
- 46. Nervous moments or twitching

Appendix D: Caregiver's Response to Youth Media Exposure (CRYME)

Please circle never, rarely, sometimes, often, or almost always for each of the following questions. All of the questions refer specifically to violent or tragic news in the media (terrorist attacks, school shootings, bombings, natural disasters, fires, etc.).

With regard to what your child sees on TV, the internet (news sites, social media, etc.), or in print media (magazines, newspapers, etc.), how often do you...

Never Rarely Sometimes Often Almost Always

1. try to help your child make sense of the violent/tragic news by talking to him/her in a way that s/he can understand?
2. explain the violent/tragic news in a way that s/he can understand?
3. talk with your child about aspects of the violent news that bother him/her the most?
4. reassure your child that you (his/her caregiver) are safe in spite of the violent/tragic news?
5. reassure your child that s/he is safe in spite of the violent/tragic news?
6. explain to your child that you personally feel safe despite the violent/tragic news?
7. ask your child how s/he feels about the violent/tragic news?
8. encourage your child not to let the violent news change his/her day-to-day actions?
9. teach your child that what s/he sees in the news cannot control how s/he lives his/her life?
10. point out something reassuring about the violent/tragic news (for example: no deaths, the perpetrator was caught, etc.)?
11. explain ways in which the government, police, or other officials addressed the situation?
12. talk to your child about how this news event affects him/her personally?

13. point out something positive about the violent/tragic news (for example: humanity, sense of community, heroism)?
14. explain the likelihood of this event happening again?
15. interrupt your child's exposure to the media because it's not appropriate for his/her age?
16. keep your child from learning about violent/tragic news you believe would scare or worry your child?
17. ask your child to leave the room when violent/tragic news is displayed in the media?
18. forbid your child to watch certain programs, avoid certain Internet sites, or read certain print material (for example: books, magazines, newspapers) regarding violent/tragic news?
19. interrupt your child's exposure to the media (for example, by telling him/her to turn off the TV)?
20. specify in advance the TV programs, Internet sites, or specific print media your child can view/use in order to limit access to violent/tragic news?
21. leave out details of the violent/tragic news when discussing it with your child to protect him/her?
22. purposefully leave out details of the violent/tragic news when discussing it with your child?
23. set parental controls on devices in your home that enable blocking certain TV channels, Internet sites, etc. to limit access to violent/tragic news?
24. avoid talking to your child about the violent/tragic news?
25. use the violent/tragic news to scare your child with the purpose of protecting him/her from harm?
26. use the violent/tragic news to scare your child away from participating in dangerous activities?
27. use the violent/tragic news as a way to teach your child to fear similar situations?
28. scare your child into being cautious in similar situations?

29. express that you are fearful or worried about the violent/tragic news when with your child?
30. explain to your child how the violent/tragic event could happen to you or another person in a close relationship to your child?
31. watch or view the violent/tragic news together because of a shared curiosity?
32. emphasize that violent/tragic news is a reality in an effort to protect your child from harm?
33. ask your child if s/he thinks about the event even when s/he is not actively viewing it?
34. ask your child if s/he has trouble sleeping at night because of the violent/tragic news?
35. openly, without restraint, express your emotions about the violent/tragic news around your child?

Appendix E: Frequency of Media Use

Considering the various forms of media that your child accesses, please answer the following:

1. How many days each week does your child have contact with media?

- television _____ (number of days)
- internet (e.g., news sites, blogs, etc.) _____ (number of days)
- social media (e.g., Facebook, Twitter, etc.) _____ (number of days)
- print media (e.g., magazines, newspaper, etc.) _____ (number of days)

2. How many hours per week does your child spend using/viewing media?

- television _____ (number of hours)
- internet (e.g., news sites, blogs, etc.) _____ (number of hours)
- social media (e.g., Facebook, Twitter, etc.) _____ (number of hours)
- print media (e.g., magazines, newspaper, etc.) _____ (number of hours)

3. How many hours per week does your child have access to media that might show/expose VIOLENT news?

- television _____ (number of hours)
- internet (e.g., news sites, blogs, etc.) _____ (number of hours)
- social media (e.g., Facebook, Twitter, etc.) _____ (number of hours)
- print media (e.g., magazines, newspaper, etc.) _____ (number of hours)

4. What is the most frequent type of media that your child uses? Please rank 1 – 4, 1 being the most highly used and 4 being the least frequently used.

- television _____ (number 1 - 4)
- internet (e.g., news sites, blogs, etc.) _____ (number 1 - 4)
- social media (e.g., Facebook, Twitter, etc.) _____ (number 1 - 4)
- print media (e.g., magazines, newspaper, etc.) _____ (number 1 - 4)

5. How often do you place restrictions on your child's media use?

- television
Never Rarely Often Almost Always
- internet (e.g., news sites, blogs, etc.)
Never Rarely Often Almost Always
- social media (e.g., Facebook, Twitter, etc.)
Never Rarely Often Almost Always
- print media (e.g., magazines, newspaper, etc.)
Never Rarely Often Almost Always

Appendix F: Multiple regression model testing child trauma and violent news media exposure predicting child anxiety

	B	SE	β	Adjusted R^2	ΔR^2
Child Anxiety					
Step 1				.00	.01
Child Trauma	-.21	.19	-.15		
Total Hours of Violent News Media	.04	.04	.12		

Note: $N = 52$; $R^2 = .04$; $p = .38$. Exposure to real life trauma and violent news trauma exposure accounted for a non-significant 4% of the variance in child anxiety, $R^2 = .03$, $F(3, 49) = .98$, $p = .38$ and adjusted $R^2 = -.001$. The partial correlation of total violent news media exposure and child trauma was $r = .13$, $t = .89$, $p = .38$, indicating that exposure to violent news did not make a significant independent contribution to the model.

Appendix G: Hierarchical multiple regression analysis testing moderation of three parenting practices predicting child anxiety

Variable	Model 1			Model 2		
	B	SE	β	B	SE	β
Reassuring Realistically	-.04	.06	-.10	-.01	.07	-.01
Controlling Contact	-.05	.06	-.11	-.10	.06	-.23
Scaring for Safety	.01	.07	.03	.05	.07	.09
Hours of Violent News	.04	.04	.13	-.08	.20	-.27
Reassuring X News				.00	.01	.61
Controlling X News				-.02	.01	-.44*
Scaring X News				.00	.01	.12
R^2		.04			.17	
F for change in R^2		.45		2.35		

Note: $N = 52$; dependent variable = child anxiety; * $p < .01$; ** $p < .001$. All variables were centered at their means. As shown, the first step yielded non-significant results ($F = .45$, $R^2 = .04$, $p = .77$), with no parenting practice making significant independent contributions to variability in child anxiety (i.e., Reassuring Realistically $\beta = -.10$, $t = -.67$, $p = .51$; Controlling Contact $\beta = -.11$, $t = -.80$, $p = .43$; Scaring for Safety $\beta = .03$, $t = .19$, $p = .85$). The second step yielded similar results, in that the overall model was non-significant ($F = 1.28$, $R^2 = .17$, $p = .28$).

Appendix H: Hierarchical multiple regression analysis testing moderation of two parenting practices as predictors of child anxiety

Variable	Model 1			Model 2		
	B	SE	β	B	SE	β
Controlling Contact	-.05	.06	-.11	-.09	.06	-.21
Scaring for Safety	.01	.07	-.01	.02	.07	.05
Hours of Violent News	.03	.04	.11	-.09	.05	.31
Controlling X News				.00	.00	-.41*
Scaring X News				-.02	.00	.13
R^2		.03			.15	
F for change in R^2		.45		3.32		

Note: $N = 52$; dependent variable = child anxiety; * $p < .01$; ** $p < .001$. All variables were centered at their means. As shown, the first step yielded non-significant results ($F = .45$, $R^2 = .03$, $p = .72$), with neither parenting practice making a significant independent contribution to variability in child anxiety (i.e., Controlling Contact $\beta = -.11$, $t = -.76$, $p = .45$; Scaring for Safety $\beta = -.01$, $t = -.07$, $p = .95$). The second step yielded a similarly non-significant model ($F = 1.63$, $R^2 = .15$, $p = .17$); specifically, results were similar for the main effect of Scaring for Safety ($\beta = .13$, $t = .81$, $p = .42$) and the interaction with the frequency of exposure to violent/tragic news media. However, frequency of exposure to violent/tragic news significantly interacted with Controlling Contact ($\beta = -.41$, $t = -2.58$, $p = .01$) to predict child anxiety. Because no model

including interaction terms contributed significantly to variance in the dependent variable, I did not conduct simple slopes analyses.

Appendix I: Independent Samples t-test comparing data collection methods

	In-person		Phone		<i>t</i>	<i>df</i>
	Mean	SD	Mean	SD		
	<i>n</i> = 50		<i>n</i> = 16			
Reassuring Realistically	40.06	10.44	41.63	12.50	-.47*	64
Controlling Contact	18.94	8.35	12.57	10.55	2.25*	64
Scaring for Safety	13.76	9.19	18.73	8.61	-2.02*	64
Media Hours	35.24	32.16	59.16	44.41	-2.04*	64
Violent Media Hours	9.88	17.87	14.20	14.57	-.99*	64

Note. * $p < .05$; ** $p < .01$.

Appendix J: Correlations to assess Frequency of Media Use questions

	1	2	3	4	5	6	7
1. CRYME Controlling Contact	-						
2. TV restriction	.26*	-					
3. Internet Restriction	.23	.71**	-				
4. Social Media Restriction	.26*	.63**	.81**	-			
5. Print Media Restriction	.31*	.46*	.36**	.42**	-		
6. Total Hours Media	-.11	-.22	-.12	-.20	-.18	-	
7. Total Hours Violent News	-.23	-.28*	-.22	-.18	-.15	.27*	-

Note. * $p < .05$; ** $p < .01$.