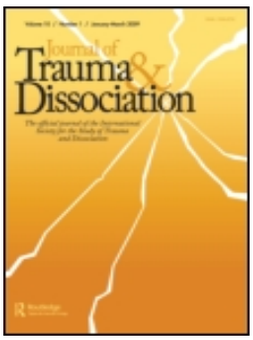

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ARTICLE

Matched trauma: The role of parents' and children's shared history of childhood domestic violence exposure in parents' report of children's trauma-related symptomatology

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ABSTRACT

Parents' childhood experiences of trauma may influence their reports of their children's behavior, and this may be particularly true when children are also traumatized. The present study proposed and tested a matched trauma hypothesis, positing that compared to parents without a childhood history of witnessing domestic violence (DV), parents with a childhood history of witnessing DV may report their children's trauma-related symptomatology differently following children's exposure to DV. Of 137 included parents (*M* age = 32 years; 93% mothers), 81 reported witnessing childhood DV (matched group), whereas 56 reported no childhood DV exposure (nonmatched comparison group). All parents reported on their 3- to 6-year-old children's dissociation and posttraumatic stress symptoms following children's DV exposure. An analysis of covariance controlling for parental life stress, dissociation symptoms, and other childhood traumatic events revealed that parents who witnessed childhood DV reported significantly fewer child dissociation symptoms than comparison parents. No difference was found for parents' reports of children's posttraumatic stress symptoms. Exploratory analyses on a subsample of children with teacher reports of child dissociation symptoms (n = 75) revealed that the strength of the association between parent and teacher reports of dissociation symptoms was moderated by matched versus nonmatched group membership. Findings suggest the importance of considering a parent's history of trauma when using parents as informants for children's trauma symptoms.

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There is extensive evidence that children exposed to domestic violence (DV) are at increased risk for developing psychological problems, with children younger than the age of 6 being particularly vulnerable (Howell, 2011; Kitzmann, Gaylord, Holt, & Kenny, 2003). Young children may exhibit a wide range of behaviors following DV exposure that include tantrums,

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crying, avoiding comfort from caregivers, possessiveness, despondency, nightmares, and somatic problems (e.g., enuresis, stomachaches; Fantuzzo, Boruch, Beriama, Atkins, & Marcus, 1997; Holt, Buckley, & Whelan, 2008; Levendosky, Huth-Bocks, Shapiro, & Semel, 2003). Young children may also develop posttraumatic stress (PTS) symptoms (Cunningham & Baker, 2004; Lundy & Grossman, 2005; Martin, 2002) or dissociation symptoms (American Psychiatric Association, 2000; Ogawa, Sroufe, Weinfield, Carlson, & Egeland, 1997) following exposure to DV. Although approximately 15.5 million American children live in dual-parent families in which some form of DV has occurred in the past year (McDonald, Jouriles, Ramisetty-Mikler, Caetano, & Green, 2006), the consequences of exposure and associated functional impairment in children often go undetected or underestimated.

In this vein, children exposed to DV have been called "hidden victims" because many parents are unaware of the psychological impact of DV exposure on young children (Groves, Zuckerman, Marans, & Cohen, 1993, p. 1). It has also been suggested that parents' ability to identify trauma symptoms in their DV-exposed children may be influenced by their own history of trauma exposure and subsequent posttrauma symptomatology (Lieberman & Van Horn, 2008). In addition, it has been suggested that different types of symptoms may be differentially recognized by parents, and, given the range of symptomatology children may exhibit following exposure to DV, parents may not detect them all equally. Moreover, not all parents seek treatment for their children following child exposure to DV (Stover, Hahn, Im, & Berkowitz, 2010), and even among treatment-seeking parents, ratings of children's trauma-related symptoms vary significantly (Perlstein, 2004). Given that parents typically serve as the primary reporters of symptoms in young children, it is critical to identify factors that influence how parents perceive and report their children's trauma-related symptoms.

One factor that may affect parents' reports of their child's trauma symptoms is parental history of DV exposure in childhood. There is evidence that parents' childhood trauma exposure has long-term repercussions for parents' perceptions of their children's functioning (Bailey, DeOliveira, Wolfe, Evans, & Hartwick, 2012; Moran, Bailey, Gleason, DeOliveira, & Pederson, 2008). Specifically, a parent may be especially vulnerable to inaccuracies in detecting his or her child's trauma-related symptomatology in cases in which the parent and child have matched histories of childhood exposure to DV. In the present study, *matched trauma* is defined as a traumatic event that the parent and child both experienced in their respective childhoods. We propose and test a matched trauma hypothesis, such that we expect that parents who have a matched trauma with their children will exhibit differential reporting of children's trauma symptoms compared to parents who do not have a matched trauma. We focus on the common experience of childhood

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DV exposure because childhood DV exposure is highly prevalent, yet the resulting child symptomatology is susceptible to being inaccurately detected or reported (American Psychiatric Association, 2000; Fantuzzo et al., 1997; McDonald et al., 2006; Zuckerman et al., 1995).

A number of compatible theoretical perspectives provide a rationale for why parents' and children's matched histories of DV exposure may influence parental reports of children's trauma symptomatology. According to emotional security theory and the developmental psychopathology perspective (Cicchetti & Valentino, 2006; Davies & Cummings, 1994; Rutter & Sroufe, 2000), parents' exposure to DV in their families of origin may have occurred in the absence of their own parents' ability to soothe them or to engage in coregulation of emotions (Davies & Cummings, 1994; Davies & Woitach, 2008). As children, they may have developed internalized expectations that their emotions and behaviors would go unnoticed or unsupported (Davies & Cummings, 1994; McIntosh, 2002; Osofsky, 2003). Later in life, following their own transition to parenthood, such expectations may impair their ability to identify or attend to their children's emotions or to engage in empathic responses or appropriate perspective taking (Cicchetti & Valentino, 2006). In cases in which their child then experiences trauma, limited parental attunement to child emotions may affect the accuracy of parental reports of children's trauma-related symptoms.

Furthermore, parental reports of children's trauma symptomatology may be particularly vulnerable to inaccuracies when the child's traumatic experience *matches* the parent's own childhood trauma exposure. For instance, caring for a child who has witnessed DV could be a triggering experience for parents who also witnessed DV in their own childhood (Dannlowski et al., 2012). Their children's experience may not only be a painful reminder of their own DV exposure but may also signal to the parents that they are unable to protect their child from the very trauma that they experienced in childhood. Although there has been limited research on how parental *childhood DV exposure* may affect parenting or parental functioning, extensive attention has been paid to how parental histories of trauma may interfere with the development of a healthy parent–child relationship and attunement to a child's emotional experiences (Moran, Neufeld Bailey, Gleason, Deoliveira, & Pederson, 2008; Fonagy, Steele, Moran, Steele, & Higgitt, 1993; George & Solomon, 2008; Hesse & Main, 1999). Despite this evidence, it remains unclear whether a parent's childhood history of *matched* trauma may ultimately affect his or her report of children's trauma-related symptoms.

The present study aimed to fill this gap in the literature by performing a preliminary test of the hypothesis that parents who *match* their children in childhood DV exposure will differ in their reports of children's trauma-related symptoms compared to parents who do not match their children in childhood DV exposure. We examined parental reports of children's PTS

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symptomatology and trauma-related dissociation due to the fact that they are both commonly observed in children exposed to interpersonal trauma (Hagan, Hulette, & Lieberman, 2015; Rutter & Sroufe, 2000). Whereas PTS in young children involves intrusive trauma-related thoughts, avoidance of trauma-related stimuli, alterations to cognition and mood, and hyperarousal, dissociation reflects a disruption of the normal integration of consciousness, memory, identity, emotion, perception, and behavior (American Psychiatric Association, 2013). Although related, PTS and dissociation have been established as distinct constructs, with individuals who only exhibit PTS requiring different treatments from those of people who exhibit either only dissociation or both PTS and dissociation (Foa, 1998; Lanius, Brand, Vermetten, Frewen, & Spiegel, 2012). Given this, we examined parental reports of children's dissociation and PTS symptoms separately.

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Method

Participants

The current study included 137 parents (93% mothers) referred for services at a university-affiliated clinical research program because of their child's exposure to trauma. Families were included in the current study if (a) the caregiver was the biological parent of a child between 3 and 6 years old, (b) the child had been exposed to DV, and (c) the parent had completed measures of child and parent exposure to traumatic life events and child trauma symptoms. The current sample consisted of an ethnically diverse group of parents (*M* age = 32 years, *SD* = 6.93; 54% Latina/o, 14% Caucasian, 12% African American, 12% mixed) and their young children (*M* age = 47 months, *SD* = 12.75; 50% female; 50% Latina/o, 12% African American, 10% Caucasian, 23% mixed). The majority of parents reported being either single (30%) or separated (35%), and 49% of parents reported speaking primarily Spanish in the home. The average monthly income across all families was less than $1,900, and almost 60% of parents reported having 12 years of education or less.

Procedure

Families were referred for clinical services to a university program for traumatized young children as the result of experiencing any type of interpersonal trauma. During the initial intake phone call, parents were invited to participate in a study to assess the effectiveness of an intervention for young children exposed to trauma and their caregivers. Parents completed an informed consent process and participated in an extensive baseline psychosocial assessment with their children. Measures and interviews were conducted in the child's or parent's

preferred language (Spanish or English). All consent and assessment procedures were approved by an institutional review board.

Measures

Child exposure to trauma and trauma-related symptoms

Childhood DV exposure. The 24-item Traumatic Events Screening Inventory–Parent Report Revised (Ippen et al., 2002) assesses a range of lifetime trauma exposure in children and was administered to the parent in an interview format, with responses coded as 0 (not exposed) or 1 (exposed). This inventory has been validated against other measures of children's violence exposure (Berent et al., 2008). The item "Has your child ever seen or heard about people in your family physically fighting, hitting, slapping, kicking, or pushing each other or shooting with a gun or stabbing, or using any other kind of dangerous weapon?" was used to identify children who had been exposed to DV. In addition, a total trauma score was constructed by summing all items to be included as a covariate in analyses.

Parent-reported PTS and dissociation symptoms. Parents were administered the Trauma Symptom Checklist for Young Children (Briere et al., 2001), a 90-item parent-report measure of trauma-related symptoms in children ages 3–12. Parents rated items on a scale of 1 (*not at all*) to 4 (*very often*). The 10-item Dissociation subscale (α = .84) and the 27-item Posttraumatic Stress Symptoms subscale (α = .90) were included in the current study. Both scales have demonstrated reliability and predictive validity in a large sample of traumatized children (Briere et al., 2001).

Teacher-reported dissociation symptoms. The Caregiver-Teacher Report Form (C-TRF) was completed by children's preschool teacher or day care provider to obtain a nonparent report of child behavior (Achenbach & Rescorla, 2001). Specific items from this instrument were used in a post hoc exploratory analysis of potential differences in parent and teacher reports of child dissociative symptoms among the subsample of children who had a completed C-TRF (n = 75). Although the C-TRF does not include trauma subscales, there have been similar efforts to use items from the corresponding older child version (i.e., the Teacher Report Form of the Child Behavior Checklist for Ages 6–18 [C-TRF]) to assess for dissociative symptoms (e.g., Shields & Cicchetti, 1998; Sim et al., 2005). For example, based on a factor analysis of C-TRF items, Shields and Cicchetti (1998) selected four items from the C-TRF to create a subclinical dissociation score that captured blank stares, daydreaming, and confusion. Based on this precedent, three items from the C-TRF were used in the current study to capture teachers' ratings of dissociative symptomatology

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in children and used in the exploratory analysis. Because of differences in the item content across the Child Behavior Checklist and C-TRF, we included items that were as congruent as possible to those used in previous investigations: "stares into space," "doesn't answer when people talk to him/her," and "daydreams." These items were rated on a 3-point scale from 0 (*not true*) to 2 (*very true or often true*) and were summed to create a composite of teacher-rated dissociation-type symptoms (Cronbach's α = .70).

Parental history of DV exposure and mental health symptoms

Parental history of childhood DV exposure. Parents' experiences of lifetime traumatic events (e.g., abuse, neglect, accidental injury, loss) were assessed using the 30-item Life Stressor Checklist–Revised (Wolfe, Kimerling, Brown, Chrestman, & Levin, 1996), which was administered in an interview format. One item was used to identify parents who had been exposed to DV in childhood: "When you were young [before age 16] did you ever see violence between family members, for example, hitting, kicking, slapping, punching?" Previous studies have found that the Life Stressor Checklist–Revised has adequate test–retest reliability (McHugo et al., 2005), and it has demonstrated good concurrent validity with other measures of traumatic exposure (Ungerer, Deter, Fikentscher, & Konzag, 2010). The sum of all events endorsed throughout the parent's lifetime was used as a covariate in the analyses.

PTS symptoms. The 17-item Davidson Trauma Scale (DTS) (Davidson et al., 1997) was used to assess the frequency (on a scale from 0 = *not at all* to 4 = *every day*) and severity (on a scale from 0 = *not at all distressing* to 4 = *extremely distressing*) of parents' past-week trauma symptoms (e.g., intrusion, avoidance, hyperarousal) in relation to a self-identified traumatic event. The DTS has demonstrated good internal consistency, validity, and strong test–retest reliability (Davidson et al., 1997). Cronbach's α was .89 for the DTS severity and frequency score. In the current study, the DTS total score was used as a covariate (α = .94).

Dissociation symptoms. The Traumatic Dissociation Scale (TDS) Carlson, Waelde, Palmieri, Smith, McDade-Montez, & Gautier, 2011 is a self-report measure of past-week disruptive dissociative symptoms in adults (e.g., derealization, depersonalization, gaps in awareness and memory, and gaps filled with reexperiencing). The TDS includes 24 statements rated on a 4-point scale from 0 (*not at all*) to 4 (*more than 10 times*). The TDS has demonstrated high internal validity and correlates with other measures of dissociation in both clinical and nonclinical populations (Carlson et al., 2011). Cronbach's α for the TDS in the current study was .91. In the current

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study, the parental dissociation score was used as a covariate given previous findings that maternal dissociation was related to greater child dissociation scores (Hagan, et al., 2015).

Data analysis and results

Parent–child dyads were first categorized according to whether parents had experienced childhood DV using responses on the Life Stressor Checklist-Revised. (All 137 children in the current study had been exposed to DV because of the nature of the referral.) Of the 137 parent–child dyads, 56 reported no parental DV exposure in childhood (nonmatched group) and 81 reported parental DV exposure in childhood (matched group). To ensure that any differences were due to a matched DV history rather than a matched history of other types of trauma, we examined the prevalence of other matches in our sample. Fourteen parents reported physical abuse in their own childhood and in their child's lifetime, and four parents reported sexual abuse in their own childhood and in their child's lifetime. These 18 other matched dyads were evenly distributed between the DV matched and non-matched groups. Excluding these families did not change the pattern of results; therefore, they were retained in all analyses. In addition, fathers (n = 10) were evenly distributed between the matched and nonmatched trauma groups, and excluding fathers from analyses did not affect results. Given that the amount of missing data across the entire data set was very low (less than 2%), analyses to compensate for missing data were not deemed to be necessary.

Descriptive statistics for the matched and nonmatched groups are shown in Table 1. There were no significant differences between the groups in terms of family average monthly income; parent age, sex, or mental health problems; or child age, sex, number of traumas experienced, or internalizing or externalizing problems. To examine mean differences in parent-reported child PTS and dissociation symptoms, we conducted two separate analyses of covariance

Table 1. Means (*SD*) for demographic and mental health variables by group membership.

Variable	Nonmatched group	Matched group
Child age (months)	47.77 (11.78)	46.62 (13.42)
Parent age (years)	33.07 (7.94)	31.35 (6.07)
Parent lifetime traumatic events	12 (4.74)	13.31 (4.20)
Monthly income ($)	1,740.22 (1,715.41)	2,017.85 (2,193.32)
Child externalizing	57.36 (13.23)	56.97 (12.15)
Child internalizing	60.79 (12.01)	59.03 (11.92)
Parent depression	18.79 (12.27)	17.70 (9.68)
Parent PTS trauma symptoms	54.10 (33.61)	44.42 (27.44)
Parent dissociation	8.6 (12.35)	8.73 (9.83)

Notes: The groups were not significantly different at the $p < .05$ level on any of the variables (ps = .10–.95). PTS = posttraumatic stress.

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(ANCOVAs), each adjusting for overall child exposure to traumatic events and parental lifetime exposure to other traumatic events. Although there were fewer child PTS symptoms reported in the matched group (M = 41.46, SD = 11.11) compared to the nonmatched group (M = 44.82, SD = 11.74), the difference was not significant, $F(1, 133) = 2.74$ $p = .10$. In contrast, matched/nonmatched group membership significantly predicted child dissociation symptoms, $F(1, 133) = 8.96$, $p = .003$. Parents in the matched group reported significantly fewer symptoms of dissociation in their children (M = 11.77, SD = 3.18) compared to parents in the nonmatched group (M = 13.64, SD = 4.71).

To bolster the accuracy of the observation that mean differences in children's dissociation symptoms were due to parent–child matched DV exposure rather than parents' childhood trauma history in general, we conducted several additional analyses. We examined whether parental history of maltreatment in childhood (physical and sexual abuse before age 16) accounted for the mean differences in child dissociation symptoms, rather than matched versus nonmatched group. In all, 74 parents (54%) reported experiencing either physical or sexual abuse before the age of 16. We ran the exact same ANCOVA, with the same covariates, replacing the matched/nonmatched grouping variable with presence versus absence of parental childhood maltreatment (physical or sexual abuse). Presence or absence of maltreatment before age 16 (0 = no childhood physical or sexual abuse, 1 = childhood physical and/or sexual abuse) was not a significant predictor of child dissociation symptoms, $F(1, 133) = 0.00$, $p = .98$. However, it is noteworthy that parents who reported childhood maltreatment (n = 74) were 2.7 times more likely to be in the matched group than in the nonmatched group than parents without childhood maltreatment, χ^2 (1) = 8.727, $p < .001$. Thus, the original ANCOVA test of matched group status predicting children's dissociation symptoms was also conducted with the inclusion of parental childhood maltreatment as an additional covariate. The results did not change, and parental childhood maltreatment still did not predict child dissociation symptoms, $F(1, 132) = 0.029$, $p = .512$.

Finally, in order to rule out the possibility that parental trauma-related symptomatology accounted for matched versus nonmatched group membership, we tested the original models using a subsample for which parental trauma symptomatology (i.e., PTS and dissociation symptoms) data were available (n = 113) to use as covariates in the ANCOVA model predicting child dissociation. Parental PTS and dissociation symptoms were examined as covariates given previous findings that parental history of traumatic events and subsequent revictimization experiences are related to increases in parental symptoms (Hulette, Kaehler, & Freyd, 2011) and that parental symptoms are related to child trauma symptoms (Hagan, Hulette, & Lieberman, 2015). When parental dissociation and parental PTS symptoms were added to the original models, the results did not change.

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Post hoc exploratory analyses

As an additional exploratory test of differential parental reports of child dissociation symptoms between the matched and nonmatched groups, we examined preschool teacher/day care provider reports of dissociation-type symptoms using three specific items from the C-TRF (see the Method section). Of the 137 children included in the current study, 75 had a completed C-TRF (matched group, n = 41; nonmatched group, n = 34).[1] Children with a C-TRF did not differ from children without a C-TRF in terms of age, sex, family income, child trauma exposure, or child symptomatology.

First, mean differences in teacher-reported dissociation symptoms between the matched and nonmatched groups were examined. A one-way analysis of variance indicated that C-TRF dissociation scores were not significantly different between the matched (M = 1.22, SD = 1.31) and nonmatched (M = 1.76, SD = 1.94) groups, $F(1, 73) = 2.09$, p = .15. Next, the strength of agreement between parents' and teachers' reports of child dissociation symptoms for both groups was examined. To do this, we conducted a multiple linear regression analysis to examine whether the association between parent and teacher reports of dissociation was moderated by matched versus nonmatched group membership. Mean-centered parent-reported child dissociation symptoms were regressed onto mean-centered teacher-reported dissociation scores, group membership, and the interaction between mean-centered teacher-reported dissociation symptoms and group membership. Main effects of teacher-reported dissociation symptoms and group membership were not significant, but the interaction term was significant (B = −.41), $t(74) = -2.94$, p = .004, indicating that the association between parent and teacher reports of dissociative symptoms varied depending on group membership. The simple slopes representing the association between teacher and parent reports were plotted and tested for each group (Figure 1). There was a significant positive association between teacher-reported and parent-reported dissociation symptoms for the nonmatched group (B = .37), $t(74) = 2.63$, p = .01. In contrast, the association between parent and teacher reports in the matched group was negative and did not reach significance (B = −.32), $t(74) = -1.70$, p = .09.

Discussion

Focusing on the match between parent and child exposure to childhood DV, the current study proposed and tested a matched trauma hypothesis. Specifically, we hypothesized that parents who matched their children in having childhood DV exposure would report their children's trauma-related symptomatology differently than parents who did not have a history of

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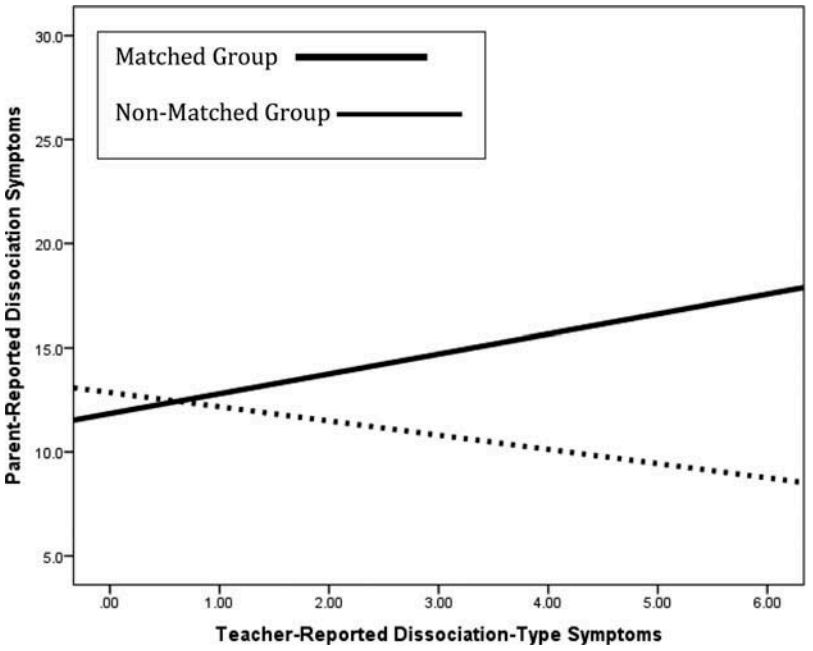

Figure 1. Relation between parent and teacher reports of child dissociation symptoms by group membership (matched vs. nonmatched).

childhood DV exposure. The hypothesis was partially supported. No differences in parent reports of PTS symptoms were found; however, parents with childhood DV exposure reported significantly fewer dissociative symptoms in their DV-exposed children than parents without childhood DV exposure. Moreover, the difference in child dissociation symptoms was not accounted for by parents' cumulative trauma exposure, specific parental exposure to maltreatment (i.e., physical or sexual abuse), or child exposure to other traumatic events. This finding provides preliminary support for the hypothesis that parents who share a history of witnessing childhood DV with their children may underestimate their children's dissociation symptomatology.

Post hoc exploratory analyses using teacher reports of dissociative symptoms among a subsample of children offered additional preliminary evidence for the matched trauma hypothesis. Whereas child dissociation symptoms rated by parents without childhood DV exposure (nonmatched group) were significantly positively related to teacher reports of child dissociation-type symptoms, there was a nonsignificant negative association between parent and teacher reports for children whose parents had childhood DV exposure (matched group). This suggests that parents who match their children in having childhood DV exposure may perceive their children's dissociation symptoms more disparately from teachers compared to parents who do not have this match. Given the nature of the measure of teacher-reported dissociation (three items from a checklist not specifically designed to measure

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dissociation), we are careful not to overinterpret this result; however, the lack of agreement between parents in the matched group and teachers on similar symptomatology further strengthens the interpretation that a matched childhood history of parent and child DV exposure affects the way in which parents report their children's dissociation symptoms.

Although in the same direction as child dissociation, group membership did not significantly predict child PTS stress symptoms. Child PTS symptoms such as hyperarousal and reexperiencing may be more observable than dissociative symptoms, making PTS symptoms less susceptible to bias. The evidence in favor of differential reporting of child dissociation but not child PTS stress may be due to general difficulties in accurately identifying dissociative symptomatology in young children (S. M. Carlson, Tahiroglu, & Taylor, 2008) and to chronically traumatized parents' misattunement to the full range of their children's emotional states (DeOliveira, Bailey, Moran, & Pederson, 2008; George & Solomon, 2008). The measure used to identify dissociative symptoms in children exposed to DV (the Trauma Symptom Checklist for Young Children) required the rating of items such as "living in a fantasy world" and "staring off into space." These items may be difficult for any parent to identify as either trauma induced or developmentally typical in preschool-age children, but this effect may be exacerbated for parents who are less attuned to their child's emotional states because of their own history of childhood adversity (Becker-Blease, Freyd, & Pears, 2004).

Although not statistically significant, teacher-rated dissociation symptoms in the matched group were also lower than teacher-rated symptoms in the nonmatched group. This suggests the possibility that dissociation symptoms were truly lower in the matched group, yet this study likely could have been underpowered to detect such differences given the lower return rate of teacher reports compared to parent reports. Although we cannot rule out this alternative explanation, testing and replicating this teacher-report analysis in a larger sample would have two main, opposing implications. If the difference still remained nonsignificant, this would suggest that parents in the matched group not only inaccurately report their children's dissociation symptoms but also underreport them. Alternatively, if teacher reports of child dissociation were indeed lower in the matched group in a larger sample, this would suggest that children of parents with matched childhood DV exposure may actually manifest fewer dissociation symptoms. Given the small sample size in the present study, future studies should pursue this replication to determine whether and to what extent teacher reports of children's dissociation symptoms differ depending on matched versus nonmatched group status.

From a clinical perspective, the potential for parents with a matched history of witnessing DV to misreport any type of trauma symptoms in their young children is problematic. Many parents are called on to be the primary, and often sole, reporter of their children's functioning. Underestimating or

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underreporting dissociation symptoms, especially those that signal significant disturbance in the child, may hinder teachers, doctors, mental health providers, and interventionists from reaching children and families in need. These parents may need additional support in detecting and responding to their children's varying trauma-related symptoms beyond services to ameliorate parental trauma. In light of the results of the present study, parental reports of children's dissociative symptoms may also need to be probed to a greater degree than other aspects of trauma symptomatology. Given that the current study included a sample of treatment-seeking parents, it is important to consider that the observed findings may be stronger in a sample of non-treatment-seeking parents (who may have less awareness of their children's trauma symptoms).

Limitations

Several limitations must be considered when interpreting the present findings. Due to the fact that the current sample of families was clinically referred for child exposure to trauma, we could not test the possibility that findings may be stronger in a sample of non-treatment-seeking parents because we did not have a sample of dyads composed of parents with a history of witnessing DV and children without DV exposure. Future work would add to our understanding of the matched trauma hypothesis by examining whether parental history of exposure to DV in childhood more generally affects parents' report of children's trauma symptoms regardless of whether the children's trauma reflects a matched experience and whether the matched trauma hypothesis applies to other types of child trauma exposure, such as physical and sexual abuse.

In addition, the study design precluded the ability to distinguish whether the observed parental underreporting of child dissociative symptoms was due to parents' matched history of childhood DV or because parents were revictimized during their child's exposure to DV. Although the current study controlled for parents' current trauma symptoms and found no evidence that parental history of other childhood trauma (physical or sexual abuse) influenced parental report of child symptoms, the study did not account for characteristics of DV experiences to which children were exposed, such as the severity, chronicity, or frequency of such incidents. Furthermore, for parents, children's experience of DV exposure may have represented an important recurring experience; parents who were once witnesses of DV now became victims as their child bore witness. Thus, parents' reports of their children's symptoms may have been inaccurate because DV was threaded throughout parents' lives from childhood to parenthood, because parents had firsthand experience of childhood DV exposure, or because their DV experiences in parenthood were particularly traumatic.

Similarly, although our results held when we controlled for parental dissociation and PTS symptoms, we cannot rule out the possibility that parents with

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a childhood history of DV exposure may have reported fewer dissociation symptoms in their children. Parents' frame of reference with regard to violence in the home and associated psychological distress may be altered by the continuity of violence in their lives, and therefore they may generally report fewer dissociation symptoms than parents without this continuity. Although the current study was unable to parse these alternative explanations, future studies that account for specific characteristics of DV experiences or that include an additional group of parents exposed to DV in childhood but not during parenthood could provide clarifying information on how parental reports of child symptomatology are linked to prior experiences of parental trauma. The availability of an externally rated (i.e., teacher-report) measure of child dissociation for only a subset of the sample is an additional limitation, as is the variability in teacher familiarity with the child depending on the time of year or length in day care. In addition, the externally rated measure of child dissociation was not designed specifically to assess trauma symptoms such as dissociation. However, the precedent for using the C-TRF and Child Behavior Checklist to derive clinically relevant dissociation scales in a trauma-exposed population of children (Shields & Cicchetti, 1998; Sim et al., 2005) and the face validity of the items selected for use in this scale strengthen confidence in the finding of differential associations between parent and teacher reports depending on matched versus nonmatched group status.

In summary, findings indicated that a matched parent–child history of witnessing DV in childhood may affect parents' reports of children's trauma symptoms and specifically may contribute to underestimations of dissociation symptoms. In addition, parents with a matched childhood DV history may also be particularly likely to report their children's dissociation differently than teachers, an observation that warrants future research. Broadly speaking, findings emphasize that parents whose childhood trauma experiences match their children's experiences may need additional support in detecting and reporting on their children's trauma-related dissociation symptoms.

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Note

1. The percentage of children with a C-TRF was consistent with standard return rates for this measure in the clinic where study was conducted, partially because of parents' unwillingness to disclose the child's engagement in trauma-related services to teachers or other caregivers.

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