The Validity of the Posttraumatic Stress Disorder Classification as Applied to Preschool Children

by

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Abstract

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The Children's Posttraumatic Stress Disorder Inventory and the Diagnostic Interview for Children and Adolescents - Revised were used to identify three matched groups of preschool children. The first group met diagnostic criteria for Posttraumatic Stress Disorder (n = 15). The second group met criteria for Attention Deficit Hyperactivity Disorder (n = 15) and the third group consisted of non-clinical controls (n = 15). Classroom teachers used the Achenbach Child Behavior Checklist (CBCL) to rate the conduct of the subjects. A MANOVA based on Wilkes Lambda, univariate tests, and Bonneferoni comparisons were used to test the hypotheses that the Posttraumatic Stress Disorder group would have significantly higher scores on the three CBCL subscales that comprise the Internalizing Score and that the Attention Deficit Hyperactivity Disorder group would have significantly higher scores on the two CBCL subscales that comprise the Externalizing Score. Data analysis determined that the CBCL Withdrawn and Internalizing scores of the Posttraumatic Stress Disorder group were significantly greater than the scores of

the Attention Deficit Hyperactivity group. It was also observed that the Aggression and Externalizing scores of the Attention Deficit Hyperactivity group were significantly greater than the scores of the control group. Theoretical and methodological implications relative to the assessment of Posttraumatic Stress Disorder among preschool youth are considered.

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Now comes the hard part. How can words express my deep felt thoughts and feelings about my family? A seed was planted many years ago. It has germinated, blossomed, and bloomed. To my father and mother, Jack and Esther Reiss, who said I should and I could. My parents have always been and continue to be a source of ambition and support to me. May they see continued nachas. To my in-laws, David and Goldie Diamond, much thanks, you are like parents to me. Mimi and Shoshie - I've paved the way, but only with you at my side. To my dear husband, Maiku, thanks and I love you for allowing and encouraging me to realize this dream. We are a great team, and I hope all our future endeavors will be as challenging and fulfilling, if not better. To my children - some of whom never knew that not all mothers go to school - I say not only thanks, but I hope that my educational experience will somehow have a positive impact on your goals, attitudes, and achievements in life. Ephraim, Aliza, Yocheved, Asher, and Sara - your lives certainly give much meaning to mine.

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Chapter 1

History of Posttraumatic Stress Disorder

Traumatic events have been evident throughout recorded history. The clinical symptoms of what came to be called posttraumatic stress disorder (PTSD), however, were not recorded until much later. The 1666 diary of Samuel Pepys alludes to the stressful aftermath of the Great Fire of London, where symptoms of PTSD are chronicled. Writing six months after the fire Pepys observed that, "...until this day I cannot sleep without great terrors of the fire..." (quoted in Daly, 1983, p.66). Much later, war-related symptoms of emotional distress were chronicled during World War I (Saigh, 1992a). For example, Colonel Southard (an American physician) documented the psychopathology of a 27 year old soldier. After having experienced shell-fire, he was unable to continue with active operations. Two years later, he worked with a pioneer battalion whose duties included burying the dead. According to Southard,

> After a month of this pioneer work he became mildly depressed; fatigue set in and now for the first time he began to jump nervously when the shells came over. To

> counteract this nervousness he began to drink and in a fortnight developed insomnia. The Somme front scenes kept constantly in mind as he tried to sleep. He felt as if he had to go up to the trenches next day and that he did not want to go. There were hypnagogic hallucinations of trenches and shells, recognized as imaginary and productive of no fear.... The horror at bloodshed, to which he had long since become accustomed, reappeared." (Southard, 1919, p.457).

World War II led to the opportunity to evaluate and treat thousands of soldiers and civilians who experienced extreme forms of war-related stress. For example, John (1941), studied the effects of evacuation and air-raids on the adjustment of British children aged six months to fourteen years. He concluded that the amount of unsatisfactory adjustment among these children was much greater than stress reactions noted by previous investigators. According to John, "after an interval of six months the effects of the air raids still showed themselves in ways that were often easy to observe. Perhaps the most marked feature of such cases was the increase of ascertainable fears." (John, 1941, p.179). In addition, he also chronicled the development of nightmares and enuresis among these cases.

Bradner (1943) went on to describe the symptoms of Finnish children during the Russo-Finnish war. Bradner

clearly observed that children who had experienced forced evacuations suffered from "mental damage" that persisted after they arrived at their destination. Observed symptoms included amentia, strong depressive reactions, as well as numerous neuropathic symptoms such as anorexia, eneuresis, tics, and pavor nocturnus (i.e. nightmares). In addition, Bradner documented the extreme reactivity to war-related stimuli. Viewed in this context, he indicated that,

> Even a year after the war, the sight of ruins had a profoundly depressing effect upon children, especially girls. War films, saddening war pictures in illustrated magazines, reports of war of any kind, still caused such symptoms of wartime to return at the given moment....the war is still reflected in the play of children, especially of boys. (p. 319).

Mercier and Despert (1943) chronicled the psychological sequelae of war on French children as based on clinical observations that were effected from 1939 to 1941. During the German occupation, children from Paris and its suburbs were observed. Recorded symptoms included sweating and diarrhea along with increased heart-rate, memory impairment, nightmares, eneuresis, and repeated aversive recollections and avoidance. The authors concluded that "...traumatic influences to which the children have been submitted, the disintegration of families, the profound social and moral changes produced by invasion - all these

factors caused modifications of the child's character and mental attitude..." (Mercier & Despert, 1943, p. 272).

In a similar vein, Grinker and Spiegel (1945) described the symptoms of soldiers who were diagnosed as having "combat neurosis". These symptoms included restlessness, aggression, depression, memory impairment, sympathetic overactivity, concentration impairment, alcoholism, nightmares, phobia, and suspicion. Emotional adjustment of repatriated internees during the war was also observed. In a study conducted by Wolf and Ripley (1947) shortly following the surrender of Japan, 34 Allied prisoners who had suffered from inadequate rations, disease, forced labor, beatings, and torture over a three year period consequently presented with war-related nightmares and fears, blunted affect, memory impairment, anger, and depression. Similarly, Eitinger (1962), himself a survivor of Auschwitz, examined 100 Norwegian survivors of the Nazi concentration camps and observed that 85% presented with chronic fatigue, reduced concentration, and increased irritability, as well as "painful associations" that could be aroused through associating innocious scenes with similar stimuli experienced during the war.

Following World War II, the American Psychiatric Association's (APA) Committee on Nomenclature and Statistics included a category of Gross Stress Reaction in its Diagnostic and Statistical Manual of Mental Disorders (DSM

I, 1952). Although the diagnosis pertained to situations involving exposure to "severe physical demands or extreme stress, such as in combat or civilian catastrophe," (p.40), operational criteria were not included.

The 1950's and 1960's were associated with continued research in the area of psychiatric reactions to traumata. The advent of the Korean war further confirmed the clinical composite that had been observed in previous combat veterans. For example, more than 50% of the wounded soldiers that were assessed by Noble, Roudebush, and Prince (1952) experienced startle reactions, nightmares, and general tension.

Bloch, Silber, and Perry (1956) went beyond war-related studies by evaluating the emotional reactions of children who were exposed to a tornado that struck the town of Vicksburg, Mississippi in 1953. The study involved 185 children, aged two years to fifteen years, who were in a theater at the time of the tornado's destruction of the building. Children were assessed through family interviews and questionnaires. Approximately 30% of the traumatized children were diagnosed as having mild or severe emotional disturbance. The authors also made reference to the subjects' overt anxiety, symptom formation or intensification of pathological character traits. Again, documented symptoms included increased dependency needs and reestablishing situations of earlier security; regressive

behaviors such as enuresis and abandonment of previously learned skills; night terrors during which experiences would be relived; tornado games; irritability and sensitivity to noise; and phobic and avoidance symptoms, (i.e. not going to movies even in an open air theater). An interesting and important finding in this study was the observation that not only direct involvement, but vicarious involvement through experiences of friends also induced pathology in children.

Langdon and Parker (1964) examined the symptomology of a sample of adults who experienced the Alaskan earthquake of 1962. As research progressed among non-war populations, the APA revision of the Diagnostic and Statistica Manual of Mental Disorders: II (DSM II, 1968) introduced the category of Transient Situational Disturbance, which included "transient disorders of any severity...that represent an acute reaction to overwhelming environmental stress." (p.48). Here again, operational diagnostic criteria were not provided and the DSM II was severely criticized for this as well as limited reliability and modest coverage of only 108 classifications (Spitzer & Fleiss, 1974).

Ziv, Kruglanski, and Shulman (1974) described the psychological reactions of Israeli children subjected to frequent artillery shellings in the period following the 1967 Arab-Israeli War. It was found that shelled children exhibited a greater degree of covert aggression (e.g. in dreams), and greater appreciation of the personality trait

of courage than did non-shelled controls. The findings were interpreted as reflecting an active process of coping with stress in children.

In 1974, Burgess and Holmstrom coined the term "rape trauma symdrome." In this context, rape victims were said to experience two phases of distress, acute and long-term. The study included 146 women who were raped and were interviewed one year thereafter. Whereas the acute phase was characterized by immediate soreness, lack of sleep, headache, anger, fear, guilt, and gastrointestinal difficulties, the long-term phase was associated with nightmares related to the rape, assault-related ideation, avoidance, fears, and sexual dysfunction. In a similar vein, Kilpatrick, Veronen, and Resick (1979) concluded that rape victims were significantly more fearful of rape-related stimuli up to six months following the rape.

Examined in toto, it is apparent that traumatized individuals may develop extensive and long-lasting emotional problems. Different terms and names, however, have been used to describe this form of morbidity. Unfortunately, the use of various terms to describe the same phenomenon served to confuse, and in some cases retard the practice, of scientists and practitioners in the field (Saigh, 1992a). Kardiner (1969) commented on this nosological confusion, lamenting that the vast store of data lacked continuity and organization. Saigh (1992a) also observed that this

situation was counterproductive and that the need for a well-grounded (operational) and nationally recognized nosology was acutely apparent.

Prompted by the DSM-II's lack of operational criteria, limited reliability, and modest coverage (108 classifications), the APA established a task force in 1975 to update the 1968 taxonomy of mental disorders. In 1980, in response to an outcry for a more organized and operationally-defined nosology (Saigh, 1992a), the DSM III Reactive Disorders Committee (APA, 1980) reviewed clinical experiences and the existing literature. The Reactive Disorders Committee went on to establish the Posttraumatic Stress Disorder category. Criteria were formulated whereby a psychologically traumatic event outside the realm of human experience (including stressors such as combat, rape, or natural disasters) could result in characteristic symptoms (APA, DSM III, 1980). Viewed in this context, the PTSD category consisted of discrete symptoms (i.e., trauma exposure, reexperiencing, avoidance, and emotional constriction), as per the DSM III criteria.

With the publication of the DSM-III-R by the APA in 1987, three types of traumatic experiences were reported to be capable of inducing the disorder: a threat to one's life, observation of traumatic experiences, and/or learning of traumatic experiences to others. The DSM-III-R provides examples of different classes of trauma that could induce

the disorder. The acute subtype was dropped. In its place, one is to indicate the time of onset (delayed six months or more after the trauma). Table 1 presents the DSM-III-R diagnostic criteria for PTSD.

TABLE 1

DSM-III-R Diagnostic Criteria for Posttraumatic Stress Disorder

A. The person has experienced an event that is outside the range of usual human experience and that would be markedly distressing to almost anyone, e.g., serious threat to one's life or physical integrity; serious threat or harm to one's children, spouse, or other close relatives and friends; sudden destruction of one's home or community; or seeing another person who has recently been, or is being, seriously injured or killed as a result of an accident or physical violence.

B. The traumatic event is persistently reexperienced in at least one of the following ways:

(1) recurrent and intrusive, distressing recollections of the event (in young children, repetitive play in which themes or aspects of the trauma are expressed)

(2) recurrent distressing dreams of the event

(3) sudden acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative [flashback] episodes, even those that occur upon awakening or when intoxicated)

Table 1, cont'd.

(4) intense psychological distress at exposure to events that symbolize or resemble an aspect of the traumatic event, including anniversaries of the trauma.

C. Persistent avoidance of stimuli associated with the trauma or numbing of general responsiveness (not present before the trauma), as indicated by at least three of the following:

(1) efforts to avoid thoughts or feelings associated with the trauma

(2) efforts to avoid activities or situations that arouse recollections of the trauma

(3) inability to recall an important aspect of the trauma (psychogenic amnesia)

(4) markedly diminished interest in significant activities (in young children, loss of recently acquired developmental skills such as toilet training or language skills)

(5) feeling of detachment or estrangement from others

(6) restricted range of affect, e.g. unable to have loving feelings

(7) sense of foreshortened future, e.g. does not expect to have a career, marriage, or children, or a long life.

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by at least two of the following:

(1) difficulty falling or staying asleep

(2) irritability or outbursts of anger

(3) difficulty concentrating

Table 1, cont'd.

(4) hypervigilance

(5) exaggerated startle response

(6) physiologic reactivity upon exposure to events that symbolize or resemble an aspect of the traumatic event (e.g. a woman who was raped in an elevator breaks out in a sweat when entering any elevator).

E. Duration of disturbance (symptoms in B, C, and D) of at least one month.

Specify delayed onset if the onset of symptoms was at least six months after the trauma.

Note: Criteria from the American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised.* Washington, D.C., American Psychiatric Association, 1987. Reprinted by permission.

The three dimensions of stress response (re-experiencing, avoidance and numbing, and physiological arousal) are specified. It is also noted that this last revision makes specific reference to symptom presentation in children.

Validity

Morey, Stenner, and Blashfield (1986) provided four reasons to support the use of a model of psychiatric classifications such as the DSM-III-R. Initially, a nosology may provide a basis for accurate communication, facilitation of research, theory formation and proper treatment choices. The empirical validity of a psychiatric

classification should aid in determining its distinction as a classification as well as its singular relationship to other classifications. The validity of a classification should also differentiate its distinct relationship in regard to different variables in other classifications (Quay, 1986).

Several comparative studies were conducted to test the validity of the PTSD category, as reviewed by Saigh (1992a). Roberts et al. (1982) divided a sample of Vietnam veterans with symptoms of PTSD into two groups of high or low incidence, respectively. It was noted that the high-incidence group showed elevated levels on specific scales (0, 4, and 6) of the Minnesota Multiphasic Personality Inventory (MMPI). Similarly, Fairbank, Keane, and Malloy (1983) administered self-report scales to three groups of Vietnam veterans (PTSD group, other diagnostic classifications group, and an asymptomatic control group). In this study, the PTSD group presented with higher scores on all scales of the MMPI, as well as on other relevant diagnostic scales (State Trait Anxiety Inventory, the Beck Depression Inventory, and the Zung Depression Inventory).

Blanchard, Kolb, Pallmeyer, and Gerardi (1982) focused on the psychophysiological aspect of PTSD. In comparing a Vietnam veteran PTSD group to a non-veteran control group, both groups listened to recordings of combat sounds as their blood pressure, skin temperature, forehead muscle activity,

and skin resistance were monitored. The PTSD group's reactions differed consistently from the non-combat veteran's reactions. This paradigm has been followed by others, with similar results (i.e. Blanchard, et. al, 1986; Ornitz and Pynoos, 1989). In a follow-up investigation, Blanchard, et.al. (1986) compared the reactivity of Vietnam veterans with PTSD and those without psychiatric morbidity. The heart rates of the two groups were monitored as a recording of war-related combat sounds was played. Blanchard, et al. (1986) subsequently observed that the PTSD group evinced more heart beats per minute than the non-traumatized group.

Biological differences have also been observed between PTSD and non-PTSD groups. Kudler, Davidson, Meador, Lipper and Ely (1987) contrasted PTSD patients and depressed patients relative to nonsuppression on the dexamethasone suppression test. It was determined that PTSD patients rarely exhibited nonsuppression on the dexamethasone suppression test relative to depressed patients. In addition, a study by Kosten, Mason, Giller, Ostroff, and Harkness (1987) reported that the mean urinary norepinephrine and epinephrine levels of patients diagnosed with PTSD were elevated relative to the levels of patients with other psychiatric disorders (i.e. major depression, bipolar disorder-manic, paranoid schizophrenia, and undifferentiated schizophrenia). In a related study,

Blanchard and his colleagues (1991) compared the norepinephrine levels of Vietnam veterans with PTSD to the norepinephrine levels of combat veterans without psychiatric morbidity. Blanchard, Kolb, Prins, Gates, and McCoy (1991) obtained plasma samples from the veterans both before and after exposure to combat-like stimulii. Whereas the non-clinical group showed no change in the plasma norepinephrine levels pre- and post-exposure to the stimulii, the PTSD group manifested a 30% increase in plasma norepinephrine.

Saigh (1988, 1989b, 1989c) has pioneered PTSD validity studies including children and adolescents. Saigh (1988) first tested three groups of adolescents aged 12-13 years of age (chronic PTSD group, test-phobic group, non-clinical control group). Each group marked the Revised Children's Manifest Anxiety Scale or RCMAS, the Children's Depression Inventory or CDI, and the Test Anxiety Inventory or TAI, and the Conners Teacher Rating Scale or CTRS. It was subsequently observed that the PTSD group had elevated scores on all scales that were administered in comparison to the clinical and nonclinical control groups. In a second study, Saigh (1989c) presented the same scales to three groups of children (PTSD, test-phobic and controls), aged 9-13 years. As in the previous study, the PTSD subjects had significantly higher levels of morbidity. In a third study, Saigh (1991) identified 230 children who met criteria for

PTSD based on the Children's PTSD Inventory (Saigh, 1989b). The children were traumatized by direct exposure to a traumatic event, observation of the event, verbal mediation of the event, or combination of any of the three. Thirty five non-clinical controls were identified using the same inventory. It is interesting to note that although scores for all of the PTSD groups did not differ significantly on the RCMAS, CDI, or CTRS scales, each of the PTSD groups had scores that were significantly higher than the non-clinical controls.

More recently, Saigh and Mrouegh (1993) examined the academic achievement of traumatized adolescents by administering the Vocabulary, Reading Comprehension, Mathematics, Spelling, Language, and Science subtests of the Metropolitan Achievement Test (MAT) as well as the Lebanese General Ability Scale to three groups of Lebanese adolescents. The first group met diagnostic criteria for posttraumatic stress disorder (PTSD). The second group had been exposed to qualitatively and quantitatively similar stressors and did not meet diagnostic criteria for PTSD (traumatized PTSD negatives). The third group consisted of non-traumatized controls. Data analysis, using IQ as a covariate, determined that the MAT scores of the PTSD subjects were significantly lower than the scores of the traumatized PTSD negatives and controls. No significant differences were observed when the MAT scores of the

traumatized PTSD negatives and controls were compared. The authors subsequently concluded that PTSD among adolescents may be associated with significant scholastic impairments. It was also suggessted that PTSD among adolescents may serve as a critical deterrant for entry into professional careers.

Although these reports present a selected review of the literature, it is apparent that the observed levels of morbidity provide support for the validity of PTSD as a unique psychiatric category. In addition, the studies reviewed provide evidence that the disorder may affect adults, adolescents, and children. On the other hand, it is of considerable interest to observe that the validity of the PTSD classification as it applies to younger populations (e.g., preschool children) has not been explored.

Epidemiology

To understand the nature and scope of a psychiatric classification, it is of considerable import to have reliable information regarding the prevalence of a disorder among individuals who are at risk as well as the general population. The accurate quantification of prevalence data is also important for researchers and practitioners who are interested in issues related to the etiology of the condition. Thirdly, the consideration of accurate epidemiological estimates is of import to social policy makers who are in charge of the allocation of funds for prevention and treatment of the disorders (Saigh, 1992a).

PTSD studies originally focused on war veterans and adults who had undergone traumatic stress (see Saigh, 1992a). Although few empirical studies have been carried out with traumatized children, the DSM-III-R recognized that adolescents and children may develop the condition. An expanding literature base clearly indicates a number of studies that have reported and confirmed the incidence of PTSD symptomology and PTSD diagnosis in children and adolescents who are at risk. Despite a strong data base of trauma-related investigations, epidemiologists have failed to reach a consensus about the prevalence of PTSD in children.

Several studies have investigated the prevalence of PTSD in adult populations (Kilpatrick and Resnick, 1993; Kulka, Schelenger, Fairbank, Hough, Jordan,Marmar, & Weiss, 1990). Comparable large-scale investigations have not, however, been effected in regard to school-age populations. It is interesting to note the paucity of information regarding the prevalence of PTSD among children and adolescents, when more than half of the U.S. population reportedly have experienced a traumatic experience in their lifetime (Goodman, Koss, & Russo, 1990). This point is highlighted by the fact that a national telephone survey indicated that childhood sexual abuse was experienced by 27% of the women and 16% of the men that were sampled (Finkelhor, Hotaling, Lewis, & Smith, 1990). In a similar

vein, Breslau, Davis, Andreski and Peterson (1991) assessed the lifetime prevalence of PTSD among a sample of young adults (aged 21-30 years) in the Detroit region using the Diagnostic Interview Schedule (DIS; Robins, Helzer, Croughan, & Ratcliff, 1981). Breslau, et al. (1991) observed that a life threat, observing others being killed or badly injured, and/or physical assault were associated with a lifetime PTSD prevalence of about 25%. On the other hand, rape led to the development of PTSD among 80% of victims and accidental injury induced 12% of the cases. Breslau and colleagues concluded that overall lifetime rate of PTSD in the general population of young adults was approximately nine percent.

Studies Involving At Risk Children and Adolescents

Community data regarding the prevalence of PTSD among school-age populations have not been systematically recorded. However, information is available from studies that have examined children who are at risk (i.e., children or adolescents who were exposed to extreme stress). The bulk of these studies involved school age samples who were either exposed to war-related stressors, criminal victimization, or industrial/natural disasters or accidents. Whereas studies have also been conducted following exposure to different modes of extreme stress that resulted in PTSD, this review will focus on reported estimates according to the above mentioned categories of stressors.

War Related Studies:

As part of a previously described case-control study, Saigh (1989) administered the Children's PTSD Inventory (Saigh, 1989c) to 840 Lebanese children (aged 8-12 years). Children were referred for assessment following exposure to extreme forms of war-related stress by physicians, Red Cross personnel, mental health practitioners, as well as educators. Data was collected from one to two years after the victim's exposure to the traumatic events. As such, 230 subjects (32.50%) of the sample clearly met diagnostic criteria for PTSD. In a related study involving mode of traumatization (i.e. direct experience, observation, information transmission or combinations thereof) Saigh (1991) reported that 25.21%, 55.65%, 5.65%, and 13.48% of the aforementioned victims had PTSD, respectively. Also in relation to war-related PTSD in Lebanon, Saigh (1988) conducted a prospective study that involved 12 female students at the American University of Beirut, aged 18-22 years. Self-reported anxiety, depression, assertion, and PTSD (in accordance with a structured interview authored by Saigh following DSM-III PTSD criteria) were charted 63 days preceeding as well as 8, 37, and 316 days following a devastating artillery bombardment in the area. Whereas a majority of the students reported elevated levels of anxiety and depression and lower levels of assertion after the bombardment, the estimates that were observed 37 and 316

days following the trauma were not significantly different from the estimates that were observed 67 days preceeding the trauma. However, diagnostic assessments revealed that nine of the students, or 75% of the subjects, warranted a diagnosis of acute PTSD 37 days after the bombardment. Only one student (8.33% of the sample) remained symptomatic during the last observation (i.e.,316 days following the trauma).

In a similar vein, Kinzie et al. (1986) conducted a study to assess psychiatric morbidity of adolescents exposed to war trauma and refugee camps, in which 50% of the victims were found to meet criteria for PTSD 2.5 years after the trauma. This study focused on Cambodian children who moved to the United states following the demise of the Pol Pot regime. The children, aged 8-12 years, suffered "catastrophic trauma caused by separation from their families, forced labor, starvation, personal injuries, and the witnessing of many deaths and executions" (Kinzie et al., 1986, p.501). The study involved the administration of the Diagnostic Interview Schedule (DIS) to 40 adolescents approximately two and a half years following immigration to the United States, where 50% met criteria for PTSD. In 1989, or three years later, Kinzie et al. conducted a follow-up study of the same subjects, and reexamined 27 of the adolescents involved in the original study. Of those, 29.6% (8 subjects) continued to meet criteria for PTSD as

measured on the DIS. Eleven subjects (40.8%) never met criteria. Of the final 8 subjects (29.6%), 3 (11.1%) initially did not meet criteria and did so at the follow-up, and the remaining 5 (18.5%) subjects who initially met criteria failed to do so at follow-up.

In a study related to the effects of traumatization on victims from adolescence to early childhood, Sack et al. (1993) administered the Diagnostic Interview for Children and Adolescents (DICA; Welner, Reich, Herjanic, Jung, & Amando, 1987) to 19 of the original Pol Pot survivors. Of these 19 subjects (assessed across all dates), 11 (11.89%) had PTSD in 1984, 9 (47.37%) were PTSD positives in 1987, and 6 subjects, or 31.57%, met criteria for PTSD in 1990. In a similar study, levels of morbidity were observed by Realmuto et al. (1992) in a sample of Cambodian adolescents (aged 14-23 years) who were administered the Reaction Index (Fredrick, 1986; Pynoos, Frederick, Nader, Arroyo, Steinberg, Eth, Nunez, & Fairbanks, 1987). Results were similar to the aforementioned study, as 39% of the 47 subjects involved in the study met criteria for PTSD.

Savin, Sack, Clarke, Nee, & Richart (in press) observed the incidence of war-related PTSD and associated psychopathology among Cambodian refugees without the confounding effects of resettlement stress. They administered the Khmer version of the DICA as well as the Schedule for Affective Disorders and Schizophrenia for

School Age Children (K-SADS, Puig-Antich, Orvaschel, Tabrinzi, & Chambers, 1980) to 99 Khmer young adults (aged 18-25 years). These subjects had fled from Cambodia following childhood experiences of horror of the Pol Pot regime. The authors reported that 26.3% of the subjects met diagnostic criteria for war-related PTSD. It was also indicated that 31.3% had a lifetime prevalence of the disorder despite residence in the relative safety of a refugee camp. The prevalence of PTSD was compared in the following three groups: subjects in the refugee camp, subjects in the Sack et al. (1993) study, and a matched cohort in the United States. The results indicate that whereas the PTSD rate among the Pol Pot survivors who remained in Thailand was somewhat higher than the rates that were observed in the United States, the differences were not statistically significant. Savin concludes that the diagnosis of war-related PTSD may be a direct product of the original trauma and not necessarily a byproduct of contextual stress.

A more recent analysis conducted by Sack, McSharry, Clarke, Kinney, Seeley, and Lewinson (in press) investigated the morbidity of an independent sample (aged 13-25 years) of 209 Khmer survivors of the Pol Pot reign. The DICA and D-SADS were administered to a randomly selected sample to assess for PTSD as well as any co-morbid conditions. Despite residence in the United States for 3-9 years, a

prevalence of 18.2% was observed for PTSD. In addition, a lifetime prevalence of 21.5% was also noted. Co-morbidity in the form of major depression was observed with a current prevalence of 11%, and a lifetime prevalence of 34.9%. Extremely low prevalence rates were evinced for additonal DSM-III-R diagnoses (i.e. 1.0% and 1.9% for current and lifetime prevalence of conduct disorder, respectively; no cases of psychoactive substance use were identified).

Nader, Pynoos, Fairbanks, Al-Ajeel, and Al-Asfour (in press) administered the Reaction Index to 51 Kuwati summer school students (aged 8-21 years) five months after Iraqi forces were driven from their country. Nader et al. reported that 70% of the subjects were positive for PTSD. Another study, conducted by Weisenberg, Schwarzwald, Waysman, Solomon, & Klingman (1993) in the context of the Gulf War involved the administration of a version of the Reaction Index to 492 Israeli children (grades 5-10). In this instance, the children had remained in sealed rooms with their families for four to six weeks, and wore gas masks during Iraqi missile attacks. Assessments were administered three weeks following the war. It was estimated that 25.61% of the children were positive for PTSD symptoms.

Prevalence data for PTSD following exposure to war-related stimuli varied among the groups of children assessed. Point prevalence ranged from 8.3% to 75.0% within

this category. It is evident that this stressor group presented with relatively high estimates of PTSD. It is also interesting to note that the prevalence of the disorder may seemingly decrease over time.

Criminal and Victimization Studies:

Available statistics on crimes involving sexual abuse and physical abuse in which the child is a victim are of great social concern. Current child maltreatment estimates are approximately 1.5 to 2 million (National Center on Child Abuse and Neglect, 1988, cited in Green, 1993). A projection of 150,000 - 200,000 new cases, per annum, of childhood sexual abuse cases has been reported (Finkelhor & Hoteling, 1984). According to the National Child Abuse and Neglect Data System report (1990), 2.4 million reports of suspected child maltreatment were recorded. Of these, 225,000 cases were "substantiated" or "indicated" cases that were sexual in nature (Daro & Mitchel, 1990). This suggests that one out of every 100 children in the United States below the age of 12 has been the subject of an abuse or neglect report. In a review of all the child and adolescent charts regarding mental health services at a clinic it was found that documented histories of physical abuse were noted in 21% of the charts, and suspected abuse in nine percent of the charts (Threlkind & Thyer, 1992). When controlled for sexual abuse, specifically, 19% of the same subjects had documented histories and another 9% were suspected. Male

and female subjects were equally at risk for physical abuse, whereas the rate increased four fold for women in regard to sexual abuse.

Documentation of PTSD has been effected for the above-mentioned population. It is noted at this point that documentation of sexual and/or physical abuse with children and adolescents is generally recorded by clinics or agencies. Children and adolescents are rarely self-referred, so that information in regard to such cases is necessarily transferred via a third party (Saigh, Green, & Korol, in press). Keeping this in mind, McLeer, Deblinger, Atkins, Foa, and Ralphe (1988) observed 31 sexually abused children (aged 3-16 years) at a university-based outpatient child psychiatry clinic and noted that 48% met criteria as per a structured interview developed by the investigators for evaluating child sexual abuse and scored according to a PTSD symptom checklist based on DSM-III-R criteria. Results indicated that 75% of the subjects who had been abused by their parents were PTSD positives, whereas none of those abused by older siblings met criteria. In a follow-up study (1992) conducted by the same authors, McLeer et al. administered the K-SADS (Puig-Antich, Orvaschel, Tabrinzi, & Chambers, 1980) to a similar population of sexually abused children who were receiving psychological services. Fifty four per cent, 42%, and 10% of the children developed PTSD symptoms following abuse by their natural fathers, trusted

adults, and strangers, respectively. However, no manifestation of PTSD was found following sexual abuse by older children.

Two studies were conducted that involved the aftermath of sexual abuse in children. The first (Kiser, Ackerman, Brown, Edwards, McColgan, Pugh, & Pruitt, 1988) was based on clinical interviews with the parents of 10 children who were reportedly abused in a day care setting. The results of the study indicated that 90% of the subjects met DSM-III-R criteria for PTSD. In a similar vein, Kiser, Heston, Millsap, and Pruitt (1991) reviewed 163 consecutive referrals at a children's day treatment center. Of these, 40 had a history of physical abuse, 25 were sexually abused, 24 were both physically and sexually abused, and 74 had no history of abuse. Of the 89 subjects who reported abuse, 55% met criteria for PTSD as per clinical diagnoses by a psychiatrist.

Adams, Everett, and O'Neal (1992) assessed 98 children (aged 4-12 years) at an out-patient program over a six-month period. Exposure to physical and/or sexual abuse was determined by multiple sources. The PTSD diagnosis (positive or negative) was established via clinical criteria. Adams and his colleagues reported that 63.26% of the children did report histories of abuse (20% physically abused, and 43% sexually abused) and subsequently developed PTSD. Children exposed to both forms of abuse, concurrently,

had a point prevalence of 28% for PTSD.

A school shooting incident evolved into an investigation for PTSD, as well. Pynoos, Frederick, Nader, Arroyo, Eth, Nunez, & Fairbanks (1987) evaluated 159 child survivors of the incident (aged 5 - 13 years, mean age 9.2 years) via the Reaction Index. The investigators estimated that 60% of the children were PTSD positive (38% with moderate to severe symptoms, 22% with mild symptoms). Pynoos et al. (1987) theorized that severity of PTSD symptoms varied as a function of exposure to stress. In the follow-up study, Nader, Pynoos, Fairbanks, & Frederick (1990) determined that 74% of the children with high levels of stress exposure continued to manifest symptoms of PTSD 14 months following the school shooting incident, as compared to 19% of the subjects with lower levels of exposure. In a similar study, Schwartz and Kowalski (1991) administered a self-report checklist (based on the Reaction Index) to 64 children (aged 5-14 years) who had been exposed to a school shooting, as well. It was determined that 27% of the children who witnessed the shooting met criteria for PTSD, despite an eight to twelve month lapse between stress exposure and data collection.

Estimates for prevalence of PTSD in children exposed to purposeful crime or victimization incidents were relatively high. In fact, exposure to abuse resulted in PTSD prevalence rates similar to the war-exposed group, if not

higher. Point prevalence ranged from 19.0% to 100% in this stressor category. It is also observed that females may present with higher rates of the disorder than males.

Disaster and Accident Studies:

The occurrence of a natural disasters or accidents can have long-lasting effects on the emotional adustment of victims. Bradburn (1991) administered the Reaction Index to 22 children (aged 10-12 years) six to eight months following the Loma Prieta earthquake. A reported 63% of the children were PTSD positive, as per diagnostic criteria.

The prevalence of PTSD in children who were involved with a technological disaster was observed by Green and her colleagues over two investigations. Initially Green, Korol, Grace, Vary, Leonard, Gleser, and Smitson-Cohen (1991) reviewed the psychiatric reports of 179 children (aged 2-15 years) who had been exposed to the Buffalo Creek dam collapse in 1972. Although the PTSD diagnoses did not exist when the data were originally collected, in retrospective reviews of the records many children presented with PTSD symptoms and may have actually qualified a PTSD diagnosis. In rating reports for probable symptoms of PTSD two years after the disaster, results indicated a "probable" positive diagnosis for 37% of the cases. Fewer PTSD symptoms were evidenced by the younger children (aged two to seven years), and higher symptom levels existed for girls than boys. Degree of life threat, parental adjustment, and family

atmosphere were contributing factors to manifestation of PTSD. In a 17 year follow-up study conducted by Green et al. (in press) involving 99, or 55.30%. of the original subjects (aged 19-32 years), the Structured Clinical Interview for the DSM-III-R (SCID, Spitzer & Williams, 1986) was administered to assess lifetime and current morbidity. It was observed that 32% of this cohort had PTSD at some time in their lifetime, and that 7% were currently positive for PTSD. It was noted that the current PTSD rate in the Buffalo Creek victims (17 years following the disaster) was not significantly different from the PTSD rate of a demographically matched cohort that had not been exposed to the flood.

Hanford, Mayes, Mattison, Humphrey, Bagnato, Bixler, and Kales (1986) devised a questionnaire (TMI questioner) to assess PTSD in victims following the Three Mile Island nuclear disaster. The questionnaire was administered to 35 post-trauma children (aged 6-19 years). Extensive clinical interviews were conducted with the parents of the subjects, as well. It was observed that none of the children evidenced PTSD, but 11% suffered from different psychiatric disorders. Similarly, Earls, Smith, Reich, and Jung (1988) administered the DICA to 32 children and adolescents (aged 6-17 years) one year after they had been exposed to a flood and dioxin contamination. It was noted that none of the victims met criteria for PTSD. On the other hand, 10% of

the sample met criteria for adjustment disorder. Korol (1990) studied the reactions of residents in the Fernald, Ohio community who had experienced nuclear contamination from a weapons facility in the area. The Reaction Index was administered to 120 children (aged 7-15 years) approximately five years following knowledge of the nuclear leak. Six children, or 5% of those questioned, were PTSD positives, as based on self-reports. It is interesting to note that the behaviors and emotional symptoms of the stress exposed subjects did not differ significantly from a non-exposed control group. However, a subsample of children who lived within a 1.5 mile radius of the nuclear weapons accident manifested significantly higher levels of psychiatric morbidity as compared to a cohort that resided within a five mile radius. In this last group, 83% of the PTSD positive subjects were in the oldest age group (13-15 years), none were in the middle aged group (10-12 years), and 17% were in the youngest group (seven to nine years).

Migram, Toubiana, Klingman, Raviv, and Goldstein (1988) determined that 57.1% of the children (11-13 years) in a school bus accident met criteria for PTSD (based on a Hebrew version of the Reaction Index) one week after the incident. They also reported that 16% continued to meet criteria nine months after the accident. 39.9% of the reactions were moderate to severe. Whereas frequency rates are not reported, an ANOVA revealed that females experienced a

higher rate of acute and chronic stress reactions to the trauma than a matched, non-exposed cohort.

Estimates for prevalence of PTSD within the disaster/accident category were inconsistent between groups. Point prevalence rates ranged from 0.0% to 57.1%. It appears as if "silent stressors", or less deliberate acts or events, may be associated with lower levels of psychiatric morbidity.

Summary:

It is apparent that a good deal of variability within and between stressor categories was reported. Despite these variations, it appears that war-related events and criminal victimization were associated with higher estimates of PTSD in children than less deliberate acts or events. It is also of interest to observe that the prevalence of the disorder seemingly decreases over time, and that females may present with higher rates of the disorder than males. It may also be said that "silent" stressors, such as exposure to nuclear or chemical contamination, were associated with lower levels of psychiatric morbidity.

The variability may, in part, be explained by realizing that considerable differences were evident relative to the type, duration, and intensity of the precipitating stressors. Moreover, variations were apparent relative to the interval of time that elapsed between stress exposures and clinical assessments. Finally, considerable variability

was evident in the way PTSD was determined. It is to be noted that the instruments or methods that were used to formulate diagnoses have different or undetermined levels of sensitivity and specificity (Saigh, Green, & Korol, in press). As such, psychometric differences most probably contributed to the epidemiological variability.

Although it is apparent that exposure to a severe and psychologically distressing event was not sufficient to induce the disorder in most of the subjects that were sampled, it is also apparent that the overriding majority of stressors described were capable of inducing clinically significant levels of PTSD among a subset of children and adolescents. Indeed, it may be concluded that children and adolescents (much like adults) experience differential levels of distress after exposures to extremely stressful events.

Statement of Research Problem

The selected review of the literature suggests that there is a good deal of empirical support for the validity of the classification of PTSD as indicated by different self report, behavioral, and psychophysiological indicators; it is recalled that this literature base did not involve preschool populations. It is of interest to note that childhood psychopathology may be evidenced in different ways across developmental levels (Green et al., (1991); Kazdin, 1989; Terr, 1991). It is also of interest to note that

Green et al. 1991, suggested that "separate stage-specific diagnostic symptom criteria may be necessary to adequately describe stress reactions of children of different age groups." (p. 946). In view of these considerations, this investigation presents a case-control analysis of the PTSD classification as indicated by the perceived functioning of traumatized and non-traumatized preschool children.

Chapter Two

Method

This chapter presents information relative to diagnostic measures, dependent variables, subject selection, informed consent, research design, rationale and research hypotheses.

Diagnotic Measures

Children's PTSD Inventory (Saigh, 1989b). The Children's PTSD Inventory was developed on the basis of the DSM-III-R criteria for formulating an Axis I PTSD diagnosis. The measure presents four subtests that are scored on a dichotomous basis (i.e., 1 for presence and 0 for absence of symptoms). The first subtest assesses for traumatization through experiential, vicarious, or verbal mediation (e.g., "Have you had a very bad experience?", "Did you see someone else having a very bad experience?", "Have you heard about someone else who had a very bad experience?"). The second subtest measures unwanted trauma-related ideation (e.g., "Are you having a lot of bad dreams about the experience that you described?"). The third assesses general affect (e.g., "Have you become less interested in seeing friends or doing things that you used to enjoy?") and the fourth measures diverse symptoms that were not apparent before the trauma (e.g., "Difficulty paying attention in class" or "Not being able to sleep well"). Scores on all four subtests qualify a child for a PTSD positive diagnosis. Field trials

determined that the instrument correctly classified 84% of the cases (Kappa = .78, $p < .01$) that had been previously classified as PTSD positives by an expert clinician. Appendix A presents the Children's PTSD Inventory.

Diagnostic Interview for Children and Adolescents-Revised-Parent (DICA-R-P; Reich, Shayka, & Taibleson, 1991). The DICA-R-P is a structured clinical interview that is based on the DSM-III-R criteria. The DICA-R-P consists of a series of modules that are indicative of specific disorders that are evident in childhood or adolescence. The test-retest reliability of the DICA-R-P was based on interviews with 50 children and adolescents. For the purposes of the current study, the DICA-R-P Attention Deficit Hyperactivity (ADHD) and Conduct Disorder modules were used, with reported kappa coefficients of .85 and .83 reported, respectively (Reich, Shayka, & Taibleson, 1994). Appendix B presents the selected DICA-R-P modules.

Dependent Variable

The Child Behavior Checklist (CBCL; Achenbach, 1991). The CBCL (Appendix C) is a norm referenced behavior rating scale that may be marked by teachers or parents. Items are rated for presence/absence of symptoms according to a 0, 1, and 2 point Likert-type scale. Raters are instructed to rate items that describe functioning within the last six months. Scoring is effected by circling 2 if the item is very indicative or often indicative of the examinee's

behavior. If a behavior is somewhat or sometimes indicative of the examinee, a 1 rating is indicated. A 0 rating is specified if the item is not reflective of the examinee's behavior. The CBCL consists of nine orthogonal scales. In addition, the CBCL provides an Internalizing score and Externalizing score. The Internalizing score reflects the sum of scores on the problem items of the Withdrawn, Somatic Complaints, and Anxious/Depressed scales. The Externalizing score includes the sum of scores on the problem items of the Delinquent Behavior and Aggressive Behavior scales. The Internalizing and Externalizing scores represent contrasting kinds of problems, though they are not mutually exclusive. The following CBCL scales were administered:

Withdrawn. This nine item scale involves a series of statements that denote isolating behaviors (e.g., "Would rather be alone than with others"). Achenbach (1991) reported a test-retest correlation coefficient of .95 for this scale. Construct validity was addressed by correlating test scores with Quay and Peterson's (1983) Revised Behavior Problem Checklist Anxiety-Withdrawn scale and a coefficient of .66 was reported.

Somatic Complaints. This scale consists of nine items that reflect physical symptoms or complaints (e.g., "dizzy") as well as physical problems without medical etiology. Achenbach (1991) reported a test-retest correlation coefficient of .95 for this scale. The Somatic Complaints

scale was also correlated with the Connors Parent Rating Scale (1973) psychosomatic scale and a coefficient of .70 was determined.

Anxious/Depressed. This scale presents 14 items that reflect symptoms of anxiety (e.g., "fears he/she might think or do something bad") and depression (e.g., "feels too guilty"). A test-retest correlational coefficient of .86 was determined for the scale. The Anxious/Depressed scale was also correlated with the Connors Parent Rating Scale Anxiety scale and a coefficient of .70 was determined. Likewise, a correlation of .78 was determined when the Anxious/Depressed scale was correlated with Quay and Peterson's (1983) Revised Behavior Problem Checklist Anxiety-Withdrawn scale (Achenbach, 1991).

Social Problems. This scale consists of eight items describing interpersonal problems (e.g., "Acts too young for his or her age"). A test-retest correlational coefficient of .82 was reported by Achenbach (1991) for this index. Discriminate validity was addressed, in part, by comparing the scores of matched clinical and non-clinical (DSM status was not reported) cohorts. Achenbach (1991) reported that clinical subjects had significantly higher scores on the Social Problems scale than matched non-clinical subjects.

Thought Problems. This seven item scale involves a series of statements that denote unwanted thoughts that intrude on daily living (e.g., "Can't get his/her mind off

certain thoughts; obsessions"). A test-retest correlational coefficent of .82 was reported by Achenbach (1991) for this subtest. A Pearson correlation conducted between the CBCL Thought Problems scale and the Thought Problems subscale of the Quay Peterson Revised Behavior Problem Checklist (1983) yielded a reported r of .64.

Attention Problems. This scale presents 11 items that involve a series of statements denoting an inability to attend to tasks (i.e., "Can't concentrate, can't pay attention for long"). Achenbach (1991) reported a test-retest correlation coefficient of .90 for this scale. Construct validity, assessed via correlations with the Impulsive/Hyperactive Scale of the Conners (1973) Parent Questionnaire and the Attention Problems subscale of the Quay-Peterson (1983) Revised Behavior Problem Checklist, yield coefficients of .59 and .77, respectively. Additionally, a correlation of .66 was effected for the Attention Problems Scale of the CBCL (Achenbach, 1991) and the Motor Excess subscale of the Quay-Peterson (1983) Revised Behavior Checklist.

Delinquent Behavior. This scale consists of 13 items describing behaviors that reflect neglectful, offensive, or faulty behaviors (e.g., "Doesn't seem to feel guilty after misbehaving"). A test-retest correlational coefficient of .86 was reported by Achenbach (1991) for this index. The Delinquent Behavior scale was also correlated with the Anti-

social and Conduct Problem subscales of the Conners Scale (1973) effecting coefficients of .77 and .72, respectively. The correlations with the Socialized Aggression and Conduct Disorder subscales of the Quay-Peterson (1983) test yielded coefficients of .59 and .73, respectively.

Aggressive Behavior. This 20 item scale involves a series of statements that denote forceful and unreasonable behaviors (e.g., "Cruelty, bullying or meanness to others," or "Destroys his/her own things"). A test-retest coefficient of .91 was reported by Achenbach (1991). Correlations for validity with the Conduct Problems subscale of the Conners Parent Questionnaire (1973) yield a coefficient of .86. Similarly, validity for the CBCL Aggressive Behavior scale in relation to the Quay-Peterson (1983) Revised Behavior Problem Checklist's Conduct Disorder scale yielded a coefficient of .88.

Other Problems. This 33 item scale includes a broad range of probelms that are reportable by parents/teachers. These items reflect problems that differ from items on the other scales to avoid redundancy among items and to prevent artificial correlations between scales. Examples of problems tapped include sexual problems (i.e., "Plays with own sex parts in public.", or "Sexual problems."); speech problems (to be described by informant); fears (i.e., "Fears going to school.", or "Fears certain animals, situations, or places, other than school [describe]."); eating disorders

(i.e., "Doesn't eat well.", or "Eats or drinks things that are not food - don't include sweets [describe]."); sleep problems (i.e., "Sleeps less than most kids."); or toileting issues (i.e., "Wets self during the day."). A test-retest correlation coefficient of .83 was reported by Achenbach (1991) for this scale. Validity was not reported for this scale.

In addition to the nine scales, the CBCL has an Internalizing and Externalizing scale.

Internalizing Scale. The Internalizing scale reflects the combined scores of the Withdrawn, Somatic Complaints, and Anxious/Depressed Scales. The individual scales have been described above. The pattern of problems tapped with the Internalizing score reflect personality problems, inhibition, or overcontrolled personality traits (Achenbach, 1991, p. 60). A test-retest correlation coefficient of .89 was reported by Achenbach (1991) for this score. Pearson Correlations between the CBCL Internalizing Scores and the Psychosomatic and Anxiety scales of the Connors Parent Questionnaire (1973) yielded coefficients of .56 and .62, respectively. Additionally, a correlation coefficient of .72 is reported with the Quay-Peterson Revised Behavior Problem Checklist (1983) Anxiety-Withdrawn Scale.

Externalizing Score. The Externalizing score is the combined total score of the problems noted on the Delinquent Behavior and Aggressive Behavior Scales. The individual

scales have been described above. Achenbach notes that the Externalizing Score taps conduct problems, aggression and undercontrolled personality traits (1991, p.60). A test-retest correlation coefficient of .93 is reported for the Externalizing Score (Achenbach, 1991). Pearson Correlations between the CBCL Externalizing Score and the Anti-Social and Conduct Problem Scales of the Connor Parent Questionnaire (1973) are .67 and .86, respectively. Additionally, correlation coefficients of .52 and .88 are reported in regard to the CBCL Externalizing Score and the Socialized Aggression and Conduct Disorder Scales of the Quay-Peterson Revised Behavior Problem Checklist (1983), respectively.

Design

Case-control research designs contrast a disorder of interest to a related condition and a non-clinical group (Breslow & Day, 1982; Schlesssman & Stolley, 1982). The selected subjects in this study consisted of three groups of closely matched preschool children (i.e., PTSD, Attention Deficit Hyperactivity Disorder [ADHD], and a non-clinical control group). Groups were matched on the basis of age, gender, and race. More specifically, if a 5-year-old white female met criteria for a PTSD diagnosis, the investigator identified a 5-year-old white female with ADHD and a 5-year-old white female without either condition. Figure 1 presents a schematic representation of the data collection design.

Figure 1

Schematic representation of the research design.

	Diagnostic Group		
CBCL Scales	PTSD (n=15)	ADHD (n=15)	Control(n=15)
Withdrawn			
Somatic Complaints			
Anxious/Depressed			
Social Problems			
Thought Problems			
Attention Problems			
Delinquent Problems			
Aggressive Behavior			
Other Problems			
Internalizing Score			
Externalizing Score			

Procedure

Subject Selection Process

Subjects were referred for assessment from a New York City preschool that provides regular and special education services. This school has a total enrollment of 178 students (101 male, 77 female) of mixed socio-economic status, with an age range of one year 11 months to six years six months. Teachers and administrators were asked to refer cases of suspected or documented child abuse or ADHD to the principal investigator. Non-clinical controls were randomly selected from the preschool's regular education classes. Parents of the referred cases were verbally advised about the purpose of the investigation and permission was sought to test their offspring. Following the provision of informed parental verbal and written consent (see Appendix D) the school psychologist administered the Children's PTSD Inventory to the referred youth. In instances where children did not understand an item on the inventory, the item was rephrased to facilitate comprehension. The DICA-R-P ADHD and Conduct Disorder modules were administered to the teachers of the referred youth and ratings were made on the basis of the teacher's classroom-based observations of the children. School records of referred preschoolers were also reviewed in order to identify individuals with Mental

Retardation, Pervasive Developmental Disorders, Speech Disorders, and individuals who were receiving psychopharmocological medications (i.e., Ritalin).

It is noted that all children who received a psychiatric diagnosis were referred for treatment as indicated by their individual disorders.

PTSD. A total of 24 documented or suspected of child abuse as denoted by the New York State Social Services Law, Section 412 (1994) and the Family Court Act, Section 1012 (1985) were referred for assessment. Inasmuch as earlier research had not examined the reliability of the Children's PTSD Inventory with preschool youth, the instrument was administered on two occasions to the referred youth. Four children received two consecutive PTSD negative diagnoses and were excluded from the study. Two children who initially met PTSD criteria did not meet criteria when they were retested. These children were also excluded. One child without an initial PTSD diagnosis received a subsequent positive PTSD diagnosis and was excluded from the study. Two children who met criteria for PTSD were excluded due to comorbid conditions (one youth met criteria for PTSD and ADHD and another met criteria for PTSD and a Speech Disorder). The remaining 15 children met criteria for PTSD on both administrations of the Children's PTSD Inventory. Two of the PTSD subjects were reported to the New York City Child Welfare Agency (CWA) by the principal investigator and

three were reported to the CWA by the school social worker. Ten others had documented histories of child abuse/neglect with the CWA. Twelve of the PTSD subjects (80% of the cohort) indicated that they had been directly exposed to highly stressful events. In response to questions from the Children's PTSD Inventory, one subject said that, "My mother put my hand in boiling water." Another subject (7%) indicated that she saw her father hitting and kicking her brother until he bled. Two subjects developed PTSD through combinations of intra-familial experiences and observations involving abuse.

ADHD. Ninety-seven children were referred for assessment due to histories of motor excess. Twenty-six met DICA-R-P criteria for ADHD and did not meet criteria for specified comorbid disorders. Eleven of these individuals were excluded due to the fact that their demographic characteristics were inconsistent with the characteristics of the PTSD group relative to age, gender, or race. Thirteen children who met DICA-R-P criteria also presented with comorbid disorders: eight had a Speech Disorder, three met criteria for Pervasive Developmental Disorder, one met criteria for PTSD, and one child was retarded. These children were excluded from the study. Finally, 48 children were excluded because they did not meet DICA-R-P criteria for ADHD or any of the other exclusionary disorders. As such, the ADHD cohort consisted of 15 children without

comorbid conditions.

Controls. Thirty-four children from the preschool's regular education classes were referred for evaluation. None of these children met criteria for PTSD, ADHD, or the other exclusionary conditions. Nineteen of the non-clinical referred youth were excluded from the study because their demographic characteristics were not indicative of the demographic characteristics of the PTSD and ADHD cohorts.

Table 2 presents the demographic composition of the PTSD, ADHD, and non-clinical controls. It is to be noted that each proband consists of eight males and seven females. Each proband includes nine white children, five black children, and one Hispanic child. The mean age for the respective PTSD, ADHD, and non-clinical control groups was 4.5, 4.7, and 4.4 years.

After the selected subjects were identified, 14 classroom teachers with 5 to 25 years of teaching experience rated the selected subjects according the the standardized CBCL directions on the basis of their classroom-based observations.

Table 2

Age, Gender, and Race of Subjects by Diagnostic Group[1]

	GROUPS								
PROBAND	PTSD			ADHD			Control		
	Age	Sex	Race	Age	Sex	Race	Age	Sex	Race
1)	5-0	F	Black	5-2	F	Black	5-6	F	Black
2)	5-0	F	White	4-11	F	White	5-3	F	White
3)	5-6	M	White	5-2	M	White	5-7	M	White
4)	4-10	M	White	5-4	M	White	5-3	M	White
5)	5-8	M	White	5-10	M	White	5-5	M	White
6)	4-11	F	Black	5-1	F	Black	5-6	F	Black
7)	4-6	F	White	4-2	F	White	4-9	F	White
8)	4-0	M	Black	4-8	M	Black	4-9	M	Black
9)	5-1	M	White	4-11	M	White	5-2	M	White
10)	5-4	F	Hisp.	5-5	F	Hisp.	5-8	F	Hisp.
11)	4-10	F	White	5-0	F	White	5-3	F	White
12)	4-10	M	White	4-1	M	White	4-9	M	White
13)	5-9	M	Black	5-7	M	Black	5-2	M	Black
14)	5-4	F	White	5-8	F	White	5-9	F	White
15)	4-3	M	Black	5-0	M	Black	5-1	M	Black

[1]Age reported in years and months; F=Female, M=Male

Rationale and Hypotheses

It is important to note that ADHD is indicated by a number of discrete symptoms that differ from the diagnostic symptoms of PTSD. More specifically, the essential features of ADHD involve developmentally inappropriate levels of inattention, impulsiveness, and hyperactivity (APA, DSM-III-R, 1987). The DSM-III-R indicates that ADHD is manifested in the classroom by "inattention and impulsiveness... by not sticking with tasks sufficiently to finish them and by having difficulty organizing and completing work..." (p. 50). The manual also indicates that an individual who has the disorder "often gives the impression that he or she is not listening...work is often messy and performed carelessly..." (p. 50). In the classroom, impulsiveness is often demonstrated by blurting out answers to questions before they are completed, making comments out of turn, and failure to await one's turn in tasks. The actual DSM-III-R diagnostic criteria for ADHD are stated in Appendix E.

The DSM-III-R further indicates that the associated features of ADHD include "low self-esteem, frustration tolerance, and temper outbursts" (p. 51). The manual also indicates that some of the symptoms of Conduct Disorder (i.e. physical aggression) may be evident.

Given the above, there were a number of reasons to anticipate that the PTSD subjects would have higher CBCL scores on the Withdrawn, Somatic Complaints, and

Anxious/Depressed scales than the ADHD and non-clinical control groups. It was recalled that PTSD is an internalizing condition that is indicated by unwanted and repeated anxiety-evoking thoughts as well as social isolation (APA, DSM-III-R, 1987). It was also recalled that the DSM-III-R lists feelings of depression as an associated feature of PTSD. In addition, earlier case-control studies indicated that children and adolescents who met diagnostic criteria for PTSD had significantly higher levels of anxiety and depression on the Conners Teacher Rating Scale than phobic and non-clinical control groups (Saigh, 1988, 1989c, 1992b). Finally, clinically significant gains on the Conners Teacher Rating Scale were observed after children and adolescents with PTSD received a course of imaginal flooding (Saigh, 1986, 1987a, 1987b, 1987c, 1989a). In contrast, the DSM-III-R criteria for ADHD do not include symptoms of anxiety and depression. Given that PTSD is an internalizing disorder, and the Withdrawn, Somatic Complaints, and Anxious/Depressed scales comprise the Internalizing score on the CBCL, the following hypotheses were tested.

HO1: The CBCL Withdrawn scores of the PTSD group will significantly exceed the scores of the ADHD group.

HO2: The CBCL Withdrawn scores of the PTSD group will signifcantly exceed the scores of the non-clinical control group.

HO3: The CBCL Withdrawn scores of the ADHD and non-clinical control groups will not be signifcantly different.

HO4: The CBCL Somatic Complaints scores of the PTSD group will significantly exceed the scores of the ADHD group.

HO5: The CBCL Somatic Complaints scores of the PTSD group will significantly exceed the scores of the non-clinical controls.

HO6: The CBCL Somatic Complaints scores of the ADHD and non-clinical control groups will not be significantly different.

HO7: The CBCL Anxious/Depressed scores of the PTSD cohort will significantly exceed the scores of the non-clinical cohort.

HO8: The CBCL Anxious/Depressed scores of the PTSD cohort will significantly exceed the scores of the ADHD cohort.

HO9: The CBCL Anxious/Depressed scores of the ADHD and non-clinical cohorts will not be significantly different.

HO10: The CBCL Internalizing Score of the PTSD group will significantly exceed the Internalizing Score of the ADHD group.

HO11: The CBCL Internalizing Score of the PTSD group will significantly exceed the Internalizing Score of the non-clinical control group.

HO12: The CBCL Internalizing Scores of the ADHD and non-clinical control groups will not differ significantly from each other.

As ADHD is an externalizing disorder that is indicated by excessive movement, distractibility, difficulty in adhering to instruction, inability to await one's turn in games, and dangerous play activity (APA, DSM-III-R, 1987; Quay & Werry, 1986; Cantwell, 1980; Safer & Allen, 1976), it was anticipated that the ADHD subjects would present with higher scores on the Delinquent Behavior and Aggressive Behavior scales than the comparison groups. In addition, whereas both PTSD and ADHD are indicated in part by some of the symptoms that comprise the CBCL delinquency measure, it is apparent from the nosology and the published literature that children with ADHD have more pervasive misconduct than children with PTSD (APA, DSM-III-R, 1987; Quay & Werry, 1986; Cantwell, 1980). As the Externalizing Score is comprised of scores from the Delinquent Behavior and Aggressive Behavior scales, it is anticipated that the Externalizing scores of the ADHD group will significantly exceed the scores of the PTSD and non-clinical control groups.

HO13: The CBCL Delinquent Behavior scores of the ADHD cohort will significantly exceed the scores of the PTSD cohort.

HO14: The CBCL Delinquent Behavior scores of the ADHD cohort will significantly exceed the scores of the non-clinical control group.

HO15: The CBCL Delinquent Behavior scores of the PTSD and

non-clinical control groups will not be significantly different.

HO16: The CBCL Aggressive Behavior scores of the ADHD cohort will significantly exceed the scores of the PTSD cohort.

HO17: The CBCL Aggressive Behavior scores of the ADHD cohort will significantly exceed the scores of the non-clinical control group.

HO18: The CBCL Aggressive Behavior scores of the PTSD and non-clinical control groups will not be significantly different.

HO19: The Externalizing Score of the ADHD group will significantly exceed the score of the PTSD group.

HO20: The Externalizing Score of the ADHD group will significantly exceed the score of the non-clinical control group.

HO21: The Externalizing Score of the PTSD and non-clinical control groups will not be significantly different.

Given that the Social Problems, Thought Problems, Attention Problems, and Other Problems CBCL scales reflect items that are indicative of some of the symptoms of PTSD and ADHD, it is anticipated that the scores of the two clinical groups will not appreciably differ. On the other hand, it is expected that the Social Problems, Thought Problems, Attention Problems, and Other Problems scores of the PTSD and ADHD groups will be greater than the scores of

the non-clinical control group. As such, the following hypotheses were tested.

HO22: The CBCL Social Problems scores of the PTSD group will significantly exceed the scores of the non-clinical control group.

HO23: The CBCL Social Problems scores of the ADHD group will significantly exceed the scores of the non-clinical control group.

HO24: The CBCL Social Problems scores of the PTSD group and the ADHD group will not significantly differ from each other.

HO25: The CBCL Thought Problems scores of the PTSD group will significantly exceed the scores of the non-clinical control group.

HO26: The CBCL Thought Problems scores of the ADHD group will significantly exceed the scores of the non-clinical control group.

HO27: The CBCL Thought Problems scores of the PTSD group and the ADHD group will not significantly differ from each other.

HO28: The CBCL Attention Problems scores of the PTSD group will significantly exceed the scores of the non-clinical control group.

HO29: The CBCL Attention Problems scores of the ADHD group will significantly exceed the scores of the non-clinical control group.

HO30: The CBCL Attention Problems Scores of the PTSD group and the ADHD group will not significantly differ from each other.

HO31: The CBCL Other Problems scores of the PTSD group will significantly exceed the scores of the non-clinical control group.

HO32: The CBCL Other problems scores of the ADHD group will significantly exceed the scores of the non-clinical control group.

HO33: The CBCL Other Problems scores of the ADHD group and the PTSD group will not significantly differ from each other.

Chapter III

RESULTS

This chapter describes the data analysis. Descriptive statistics in relation to the dependent variables are also reported. Information involving the reliability of the Children's PTSD Inventory is presented. Data analyses involving a MANOVA, univariate F tests and Bonneferoni comparison are also presented.

Initially, the reliability of the Children's PTSD Inventory (CPTSDI) was calculated based on results that were recorded using a one-to-seven day test-retest procedure. A Cohen's Kappa Coefficient of .92 was observed.

Table 3 presents the means and standard deviations by outcome measure (CBCL scales) for the three comparison groups (PTSD, ADHD, and non-clinical controls).

Table 3

Means and Standard Deviations of the Comparison Groups

	Group					
	PTSD (n=15)		ADHD (n=15)		Control (n=15)	
	Mean	SD	Mean	SD	Mean	SD
Subscale						
Withdrawn	4.93	3.90	1.06	1.75	3.53	4.01
Somatization	0.40	0.74	0.13	0.52	0.40	0.83
Depression	5.33	6.32	2.13	2.45	2.53	2.67
Social	2.67	2.29	7.13	15.28	1.06	1.58
Thought	1.60	2.13	1.13	2.00	0.60	1.06
Attention	6.07	4.18	8.33	3.50	4.13	4.31
Delinquent	1.80	1.42	1.67	1.59	0.53	0.92
Aggression	9.47	9.09	14.53	7.11	5.00	4.68
Other Prob.	2.49	3.33	4.33	2.61	2.34	2.43
Internal	10.67	10.31	3.33	3.56	6.47	6.65
External	11.27	10.14	16.20	7.97	5.53	5.44

A multi-variate analysis of variance (MANOVA) was performed to test for group differences. The null hypothesis of no significant differences was rejected using Wilks Lambda test, $F(18, 68) = 2.56$, $p<.003$. As a statistically significant value was apparent, univariate F tests were effected for each subscale. Table 4 represents the univariate F test results.

Table 4

Univariate Analysis of Variance

Univariate F-tests with (2,42) Degrees of Freedom

Variable	MS Error	F	Sig. of F
Withdrawn	11.467	5.014	.001*
Somatic	0.498	0.713	.496
Depressed	17.686	2.578	.088
Social	80.381	1.845	.171
Thought	3.213	1.169	.321
Attention	16.095	4.119	.023*
Delinquent	1.797	4.044	.025*
Aggression	51.702	6.601	.003*
Other Prob.	7.714	2.958	.063

As may be noted from Table 4, significant variations were apparent on the Withdrawn, Attention Problems, Delinquent, and Aggression subtests. Non-significant differences were observed on the Somatic Problems, Depressed, Social Problems, Thought Problems and Other Problems subtests.

Given this information, a series of Bonneferoni post hoc analyses were conducted. Table 5 presents the Bonneferoni post hoc results.

Table 5

Post Hoc Analysis Using Dunn Bonneferoni Procedure

	Comparisons		
	PSTD vs ADHD	ADHD vs Control	PTSD vs Control
Withdrawn	*		
Somatization			
Depression			
Social			
Thought			
Attention			
Delinquent			
Aggression		*	
Other Prob.			

* = $p < .05$ using the Bonneferoni post hoc correction based on 27 post hoc comparisons. (Bonneferoni correction set at .002).

In effect the Bonneferoni results shown in Table 5 indicate that the Withdrawn subtest scores of the PTSD group were significantly higher than scores of the ADHD group. It is also apparent that the scores of the ADHD group were significantly higher than the scores of the non-clinical

control group on Aggression. The remaining analyses were non-significant.

Univariate F-tests (ANOVA's) were calculated in regard to the Internalizing and Externalizing Scales for the three groups. A significant F (2, 42) = 3.731, $p < .032$ resulted for the Internalizing Scales. A significant F (2, 42) = 6.550, $p < .003$ was also effected in regard to the Externalizing Scale. Since the overall F test was significant, post hoc analyses using the Scheffe method were conducted to further analyze the group differences. The Scheffe results indicate that the Internalizing scores for the PTSD group, F (2,42) = 7.42, $p < .05$, were significantly higher than the Internalizing scores for the ADHD group. Additionally, the Externalizing scores for the ADHD group were significantly higher, F (2,42) = 13.09, $p < .05$, than the Externalizing scores of the control group.

CHAPTER IV

SUMMARY AND CONCLUSIONS

Summary

The present study compared the CBCL scores of three groups of preschool children (PTSD, ADHD, and non-clinical controls). The subject pool consisted of 45 children, aged 4-5 years. Subjects were matched by sex, race, and age. Preschool children with comorbid Conduct Disorder, Mental Retardation, Pervasive Developmental Disorders, and Speech Disorders were excluded from the study. Data analysis evinced significant effects for two directional hypotheses: the PTSD group scored significantly higher than the ADHD group on the Withdrawn subtest, and the ADHD group scored significantly higher than the non-clinical control group in the Aggressive Behaviors subtest. This was confirmed by the significant data for the Internalizing and Externalizing Scores for the different groups. A general discussion regarding the observed results, limitations of the study, and directions for future research will be presented in this chapter.

Discussion

The significant differences that were observed when the CBCL Withdrawn scores of the PTSD group were compared to the Withdrawn scores of the ADHD group provide a modicum of support for the validity of the PTSD classification as reflected by the CBCL teacher ratings of preschool youth.

Recalling that PTSD is an anxiety disorder and that ADHD is an externalizing disorder, the PTSD subjects should have evidenced appreciably more isolating or withdrawn behaviors (e.g., "Would rather be alone than with others") as denoted by the items that make up the Withdrawn scale. The significantly higher PTSD Internalizing score relative to the score of the ADHD group may also be ascribed to the fact that CBCL Internalizing scores are partially calculated on the basis of CBCL Withdrawn scores.

The observation that the Aggression scores of the ADHD group were significantly greater than the scores of the control group may be attributed to the close correspondence between the Aggression scale items and the ADHD symptoms. As in the case of the significant difference that was observed on the Internalizing scale, the significant difference that was observed when the Externalizing scores of the ADHD and control groups were compared may be explained by recalling that Externalizing scores are partially comprised of Aggression scores.

Given that PTSD is manifested in part by irritability (APA, 1980, 1987, 1994) and as earlier research determined that older children (Saigh, 1989a, 1989b) and adolescents (Saigh, 1988) with PTSD had elevated scores on the Connors Teacher Rating Scale (Conners, 1969), the nonsignificant PTSD-ADHD Aggression and Externalizing contrasts may be explained by recalling that ADHD (and to a lesser extent

PTSD) is manifested by acting out behaviors.

The nonsignificant differences that were evident across groups on the CBCL Somatization, Anxiety/Depression, Social, Thought and Other Problems scales are open to several lines of explanation. A comparison of the diagnositic criteria for PTSD and ADHD (as denoted by the Children's PTSD Inventory and DICA-R-P) relative to the item pools for these measures indicates that the diagnostic criteria for PTSD and ADHD is not reflected by the Somatization and Other Problems items (e.g., "Dizzy" or "Cruel to animals"). Although many of the CBCL Anxiety/Depression, Social, and Thought Problems items are concordant with some of the symptoms and associated features of PTSD, a sizable proportion of these items do not relate to PTSD. As such, it may be argued that the CBCL Anxiety/Depression, Social, and Thought Problems items were not sufficiently sensitive to the unique expression of PTSD as denoted by preschool teacher ratings.

Finally, it may be said that many of the items that make up the Anxiety/Depression, Social, and Thought Problems scales do not reflect the way that preschool youth manifest emotional problems. Whereas items that denote guilt, distrust, and loneliness reflect many of the symptoms of PTSD, it should be realized that the selected subjects had an age range of four years zero months to five years ten months and that children in this age range tend not to verbalize feelings of guilt, hypervigilance, or social

estrangement (Schiffer, 1984).

Given that the CBCL Attention and Delinquent scale means of the PTSD and ADHD groups were appreciably greater than the respective means of the control group, and in view of the significant univariate results, it may be argued that a larger sample may have generated the necessary power to reflect significant differences between the comparison groups.

Limitations

These observations must be tempered with the realization that the selected sample was carefully screened to maximize variations in the expression of psychiatric morbidity without the confounding effects of comorbid conditions. Whereas this approach offers considerable merit from a theoretical perspective, it should be recalled that epidemiological research involving PTSD (Sack, et. al., 1993; Saigh, Green, & Korol, in press) and ADHD (Fisher, et. al., 1990; Lahey, et. al., 1994; Schachar & Logan, 1990;) indicates that these disorders frequently occur in conjunction with other disorders (e.g., panic attacks, major depression, or conduct disorder). In view of this, the external validity of the results may be limited to comparison groups without comorbid disorders as described in this report. The observed results should also be viewed with the understanding that they are based on classroom-based ratings and that the teachers who effected the

ratings only observe the subjects in school settings. In view of this and as the expression and intensity of ADHD may vary across settings (Barkley, 1990; Campbell & Werry, 1986), it is possible that different outcomes may have been evident if the selected subjects had been observed in multiple settings.

This investigation did not control for the potentially confounding effects of socio-economic status (SES). As SES has been associated with the prevalence of psychiatric conditions (Kazdin, 1992) and as SES was not taken into consideration, the observed effects may have been influenced by between group SES variations.

Finally, as the principle investigator administered the Children's PTSD Inventory and the DICA-R-P, the possibility of an examiner expectation effect must be considered.

Recommendations

Given the observed results and the need to identify indices that are uniquely sensitive to the expression of PTSD among preschool children, a number of recommendations for future research are indicated. These recommendations are as follows:

1. In view of the significant univariate and nonsignificant Bonneferoni analyses involving the CBCL Attention and Delinquent scales, it is recommended that future researchers should effect a follow-up study with a larger sample. Given additional power, it is conceivable

that a different statistical outcome may be observed.

2. It is also recommended that researchers effect a similar study with a different rating scale such as the Conners Teacher Rating Scale (Conners, 1969).

3. Recalling that the respondents were classroom teachers who were only able to observe the subjects at the preschool, it would be of interest to conduct a similar study using CBCL parental ratings.

4. Clearly, the clinical assessment of preschool youth presents a number of methodological problems. The assessment of young children may be complicated by age-appropriate -but limited: a) attention span, b)receptive and expressive vocabulary, and c) proclivity to endorse different symtpoms across testing sessions (Sattler, 1992). In view of this, it is recommended that future research test the validity of psychophysiological assessment procedures relative to the prediction of PTSD with preschool children. It is recalled that Blanchard, Kolb, Gerardi, Ryan, and Pallmeyer (1986) compared Vietnam veterans with PTSD to a group of Vietnam combat veterans without psychiatric morbidity. In this instance the heart rate of subjects was monitored as they listened to a recording of "emotionally meaningful combat sounds including helicopters, AK-47's firing, mortars, and screaming wounded" (Blanchard, et. al., 1986, p. 597). Blanchard, et. al, (1986) subsequently observed that the PTSD group evinced more heart beats per

minute than the non-traumatized veterans. In view of the inherent problems that are encountered when paper and pencil tests as well as clinical interviews are administered to young children, psychophysiological assessment may present a more viable way to gauge the effects of exposure to highly stressful events among preschool populations.

5. It is also recommended that future investigations test the validity of biological assessment procedures as an indicator of PTSD among young children. Kudler, Davidson, Meador, Liper, and Tim (1987) determined that adult war veterans with PTSD, in contrast to depressed patients, rarely exhibited nonsuppression on the dexamethasone suppression test. Moreover, Kosten, Mason, Giller, Ostroff, and Harkness (1987) observed that the mean urinary norepinephrine and epinephrine levels of PTSD patients were elevated relative to the level of patients with diverse diagnoses (i.e., major depression, bipolar disorder-manic, paranoid schizophrenia, and undifferentiated schizophrenia).

6. As SES is associated with the prevalence of a number of psychiatric conditions (Kazdin, 1992), it is recommended that reliable and valid measures of SES like the Hollingshead (1975) be employed as covariates in future case-control studies of this type.

Appendix A

CHILDREN'S PTSD INVENTORY

Examinee: _____

Sex: M _____ F _____

Address: _____

Telephone: _____

Date Examined: Year _____ Month _____ Day _____

Date of Birth: Year _____ Month _____ Day _____

Age: Years _____ Month _____ Day _____

Examiner: _____

PART I - QUESTIONS

1. SAY: *"Have you had a very bad experience?"*
   CHECK: Yes _____ No _____
   If "Yes" was indicated, SAY: *"Tell me about it."*
   RECORD the Examinee's statement: _____
   _____
   _____
   _____
   SAY: *"When did this happen?"*

   NOTE: Young children may be unable to accurately gauge time. If this occurs, secure an estimate from the referrant after the interview.
   RECORD: Year _____ Month _____
   CHECK: a) Less than six months ago _____
   b) More than six months ago _____

2. SAY: *"Did you see someone else having a very bad experience?"*
   CHECK: Yes _____ No _____
   If "Yes", was indicated, SAY: *"Tell me about it."*
   RECORD the Examinee's statement: _____
   _____
   _____
   _____
   SAY: *"When did this happen?"*
   RECORD: Year _____ Month _____
   CHECK: a) Less than six months ago _____
   b) More than six months ago _____

PTSD INVENTORY Page 2

3. **SAY:** *"Have you heard about someone else who had a very bad experience?"*
CHECK: Yes _____ No _____
If "Yes", was indicated, **SAY:** *"Tell me about it."*
RECORD the Examinee's statement: _____
_____
_____
_____

SAY: *"When did this happen?"*
RECORD: Year _____ Month _____
CHECK: a) Less than six months ago _____
b) More than six months ago _____

PART I - SCORING

1. If the Examinee said "Yes" to Questions 1, 2 or 3 **DETERMINE:**

   a) If the stressor was outside the range of usual human experience Yes _____ No _____

   b) If the stressor was of sufficient intensity as to invoke significant symptoms of distress from almost everyone Yes _____ No _____

2. If a or b were rated as "No", **RECORD** a 0 in the scoring box.

3. If a and b were rated as "Yes", **RECORD** a 1 in the scoring box.

PART I SCORE ☐

PART II QUESTIONS

1. **SAY:** *"Are you having a lot of bad dreams about the experience which you described?"*
RECORD: Yes _____ No _____

2. **SAY:** *"Are you having a lot of unwanted thoughts about this?"*

RECORD: Yes _____ No _____

3. **SAY:** *"Do you sometimes feel that this experience is about to happen again?"*
RECORD: Yes _____ No _____

PART II SCORING

1. If the Examinee said "No" to Questions 1, 2 and 3, **RECORD** a 0 in the scoring box.

2. If the Examinee said "Yes" to Questions 1, 2 or 3, **RECORD** a 1 in the scoring box.

PART II SCORE ☐

PTSD INVENTORY Page 3

PART III QUESTIONS

1. **SAY:** *"Have you become less interested in seeing friends or doing things that you used to enjoy since you: / had / observed / learned about (select appropriate word) this experience?"*
   RECORD: Yes _____ No _____

2. **SAY:** *"Since that time, have you come to feel that you are different from your classmates?"*
   RECORD: Yes _____ No _____

3. **SAY:** *"Since that time, has it become difficult for you to feel things or show other people how you feel?"*
   RECORD: Yes _____ No _____

PART III SCORING

1. If the Examinee said "No" to Questions 1, 2 and 3, **RECORD** a 0 in the scoring box.

2. If the Examinee said "Yes" to Questions 1, 2 or 3, **RECORD** a 1 in the scoring box.

PART III SCORE [ ]

PART IV QUESTIONS

1. **SAY:** *"Have you developed any of the following problems since you: had / observed / learned about (select the appropriate word) the experience which you described?"*

	SYMPTOM	YES	NO
a.	*"Feeling very tense or becoming disturbed by loud noises."*	_____	_____
b.	*"Not being able to sleep well?"*	_____	_____
c.	*"Feeling bad about yourself because you are ok while someone else was not as lucky."*	_____	_____
d.	*"Difficulty remembering things or paying attention in class."*	_____	_____
e.	*"Poor marks in school."*	_____	_____
f.	*"Avoiding people, places, or things that remind you of what happened."*	_____	_____
g.	*"Loosing your temper."*	_____	_____

PTSD INVENTORY Page 4

	YES	NO
SAY: *"Do any of the things which I mentioned get worse when you see or do things that remind you of what happened?"*	_____	_____

PART IV SCORING

1. If the Examinee reported having less than 2 Symptoms, **RECORD** a 0 in the scoring box.

2. If the Examinee reported having more than 2 Symptoms, **RECORD** a 1 in the scoring box.

PART IV SCORE [ ]

DIAGNOSIS

1. Total the scores for **PARTS I - IV** **TOTAL SCORE:** _____

2. If the Total Score was 4 and the trauma occurred less than 6 months ago, an **ACUTE PTSD** diagnosis is warranted.

3. If the Total Score was 4 and the trauma occurred more than 6 months ago, a **CHRONIC PTSD** diagnosis is warranted.

4. If the Total Score was less than 4, a **NEGATIVE** diagnosis is warranted.

5. **CHECK** one:
   a) **ACUTE PTSD** _____
   b) **CHRONIC PTSD** _____
   c) **NEGATIVE** _____

Appendix B

[PARENT]
Deck 02

Coding
NO.....1
RARELY.....2
SOMETIMES OR SOMEWHAT.....3
YES.....5

III. BEHAVIOR DISORDERS

A. ATTENTION DEFICIT - HYPERACTIVITY DISORDER

In this section I will ask you how your child gets along with his family and friends and what school is like for him.

INTERVIEWER:
THE CODING THROUGHOUT THE INTERVIEW IS:
"I DON'T KNOW" = 9 OR 99
"ALWAYS - AS LONG AS I CAN REMEMBER" = 22

STANDARD PROBES:

Does (Did) this happen a lot (over and over)?

Do (Did) he get in trouble for that a lot?

Do (Did) you think this is a big problem for him?

Did the teacher speak with you about this?

ASK LIFETIME FIRST. IF POSITIVE, ASK ABOUT "NOW". "NOW" MEANS THIS ACADEMIC YEAR.

	Third Child LIFE TIME	Third Child NOW	Second Child LIFE TIME	Second Child NOW	First Child LIFE TIME	First Child NOW
21. **Have people ever told him to sit still or to stop fidgeting or squirming about?** (PROBE: FIDGETING IN HIS SEAT, PLAYING WITH HIS HANDS AND FINGERS; RESTLESS - JUST NEVER ABLE TO SIT STILL?)	(05)	(20)	(05)	(20)	(05)	(20)
22. **When your child has been in school has he ever had trouble sitting in his seat for a long time?** (PROBE: IN THE CLASSROOM HAS THE TEACHER EVER HAD TO KEEP TELLING HIM TO GO BACK TO HIS SEAT?)	(06)	(21)	(06)	(21)	(06)	(21)
23. **Has it ever been hard for him to keep his mind on what he was doing when there were other things going on in the same room? For example, someone talking or walking around?** (PROBE: FOR EXAMPLE, WHEN OTHER CHILDREN AROUND HIM WERE TALKING IN CLASS -OR- IF HE HEARD NOISES OUTSIDE.)	(07)	(22)	(07)	(22)	(07)	(22)

Coding
NO.....1
RARELY.....2
SOMETIMES OR SOMEWHAT.....3
YES.....5

	Third Child LIFE TIME	Third Child NOW	Second Child LIFE TIME	Second Child NOW	First Child LIFE TIME	First Child NOW
24. **Has he ever had a hard time waiting his turn when he was playing with other children or waiting in line?** (PROBE: HAS HE GOTTEN VERY RESTLESS WHEN HE HAD TO WAIT? HAS HE STARTED CLOWNING AROUND OR PUSHING AHEAD IN LINE? HAS HE HAD TROUBLE LINING UP TO SEE A MOVIE OR LINING UP FOR CLASS?)	(08)	(23)	(08)	(23)	(08)	(23)
25. **Have you ever found that he started answering questions before you finished asking them, that he blurted out the answers before you finished asking the questions?** (PROBE: HAS HE BEGUN TO TALK BEFORE YOU WERE FINISHED TALKING?)	(09)	(24)	(09)	(24)	(09)	(24)
26A. **When working in school or when doing his homework, has he ever done a lot of daydreaming, or thinking about other things?** (PROBE: HAS THE TEACHER COMPLAINED THAT HE DOESN'T PAY ATTENTION TO HIS WORK?)	(10)	(25)	(10)	(25)	(10)	(25)
B. **When playing by himself or with other kids, has there ever been a time when he got restless pretty quickly and wanted to move on to something else?** (PROBE: HAS HE GOTTEN TIRED OF DOING ONE THING EVEN IF THE OTHER KIDS DIDN'T WANT TO STOP? HAVE YOU OR HIS FRIENDS TOLD HIM THAT HE NEVER STICKS WITH ONE THING?)	(11)	(26)	(11)	(26)	(11)	(26)
27. **Has there ever been a time when he got tired of doing one thing, and then moved on to something else, even if he hadn't finished what he was doing?** (PROBE: HAS HE LEFT THINGS UNFINISHED A LOT OF THE TIME?)	(12)	(27)	(12)	(27)	(12)	(27)
28. **Has it ever been hard for him to play quietly either by himself or with other kids?** (PROBE: HAVE PEOPLE ALWAYS TOLD HIM THAT HE WAS TOO NOISY AND THAT HE WAS ALWAYS RUNNING AROUND, OR THAT HE NEVER PLAYED QUIETLY?)	(13)	(28)	(13)	(28)	(13)	(28)

Coding
NO.....1
RARELY.....2
SOMETIMES OR SOMEWHAT.....3
YES.....5

	Third Child LIFE TIME	Third Child NOW	Second Child LIFE TIME	Second Child NOW	First Child LIFE TIME	First Child NOW
29. **Have people ever told you that he talked all the time or that he never stopped talking?**	(14)	(29)	(14)	(29)	(14)	(29)
30. **Has his teacher or the other kids ever complained that he interrupted them or butted into their conversations or games?** (PROBE: HAVE THE OTHER KIDS COMPLAINED THAT HE BUTTED INTO WHATEVER THEY WERE DOING?)	(15)	(30)	(15)	(30)	(15)	(30)
31. **Have you ever felt that he was not really listening to you?** (PROBE: HAVE THE TEACHERS SPOKEN WITH YOU ABOUT THIS?)	(16)	(31)	(16)	(31)	(16)	(31)
32. **Has there been a time when he was always losing things like pencils, notebooks, or papers from school?** (PROBE: WHEN GETTING READY TO DO HOME-WORK OR SCHOOLWORK, HAS IT SEEMED AS THOUGH HE NEVER HAD ALL THE THINGS HE NEEDED?)	(17)	(32)	(17)	(32)	(17)	(32)
33. **Have people ever gotten upset with him for doing dangerous things, like running out into the street without looking?** (PROBE: CLIMBING UPON THINGS THAT WERE DANGEROUS, WHERE IT WAS EASY TO FALL AND GET HURT; RIDING HIS BIKE IN DANGEROUS PLACES? JUST NOT BEING CAREFUL?)	(18)	(33)	(18)	(33)	(18)	(33)

ELIMINATE THRILL SEEKERS; ASK IF THE CHILD DID THESE THINGS BECAUSE HE DIDN'T THINK ABOUT WHAT MIGHT HAPPEN, WHICH IS THE CRITERIA FOR THE SYMPTOM. WE WANT TO EXCLUDE CHILDREN WHO WERE EXCITED BY THE DANGER, I.E. THE THRILL SEEKERS.

Coding
NO.....1
RARELY.....2
SOMETIMES OR SOMEWHAT.....3
YES.....5

	Third Child		Second Child		First Child	
34. Has he ever had problems in school because even after the teacher explained the lesson to him, he still didn't manage to get it done? Was he the same way with his chores at home? Have you ever told him what to do, and has he just not followed through? (PROBE: HAS THIS HAPPENED A LOT, THAT YOU OR THE TEACHER TOLD HIM TO DO SOMETHING AND HE JUST COULDN'T SEEM TO MANAGE TO GET IT DONE?)	(19)	(34)	(19)	(34)	(19)	(34)

IF NO POSITIVES IN QS.21-34, SKIP TO OPPOSITIONAL /DEFIANT DISORDER, Q.43.
IF ONLY 1 POSITIVE, SKIP TO Q.35B.
IF TWO OR MORE POSITIVES, CONTINUE.

35A. Let's see. You've told me that your child has had problems like_____ _____ (NAME POSITIVES). Have most of these problems happened at about the same time? For example, when he was _____ was he also _____? (PROBE: IN THE SAME SCHOOL YEAR?) RECORD SYMPTOMS THAT CLUSTERED: _____ _____		(35)		(35)		(35)
B. How old was he when he first had these problems that you've just told me about? (PROBE: WAS HE LIKE THAT IN FIRST GRADE? WAS HE ALWAYS LIKE THAT?)		(36 - 37)		(36 - 37)		(36 - 37)

CODE AGE, NOT GRADE.
ALWAYS = 22.
IF BEFORE AGE 7, BUT EXACT AGE UNKNOWN CODE = 33.
IF AGE 7 OR OLDER, BUT EXACT AGE UNKNOWN, CODE = 44.

Coding
NO.....1
RARELY.....2
SOMETIMES OR SOMEWHAT.....3
YES.....5

	Third Child	Second Child	First Child
35C. When was the last time he had any of these problems? Was it ?	(38)	(38)	(38)
within the past two weeks?.....1 within the past month?.....2 within the past six months?....3 within the past year?.....4 over a year ago?.....5			
IF OVER A YEAR AGO, ASK:			
D. How old was he then? (PROBE: WHAT GRADE WAS HE IN?)	(39 - 40)	(39 - 40)	(39 - 40)
E. INTERVIEWER: IN ORDER TO MEET CRITERIA FOR ATTENTION DEFICIT DISORDER, THE SYMPTOMS MUST HAVE LASTED A MINIMUM OF 6 MONTHS. IF OBVIOUS FROM AGES OF ONSET AND RECENCY QUESTIONS, OR FROM INFORMATION IN THE CONTEXT OF THE INTERVIEW, CODE WITHOUT ASKING. OTHERWISE, PROBE FOR A 6 MONTH DURATION.	(41)	(41)	(41)
36. Have these behaviors (ever) caused a problem with how your child gets along with people at home? Not at all.....1 Not too much.....2 Somewhat.....3 Quite a bit.....4	(42)	(42)	(42)
37. Have these behaviors (ever) caused a problem with how your child gets along with his friends? Not at all.....1 Not too much.....2 Somewhat.....3 Quite a bit.....4	(43)	(43)	(43)
38. Have these behaviors (ever) caused a problem for your child with his school work? Not at all.....1 Not too much.....2 Somewhat.....3 Quite a bit.....4	(44)	(44)	(44)

Page 12

[PARENT]
Deck 02

Coding
NO.....1
RARELY.....2
SOMETIMES OR SOMEWHAT.....3
YES.....5

	Third Child	Second Child	First Child
39. Did you ever take him to a doctor because he was having problems like the ones we've been talking about?	(45)	(45)	(45)
IF NO, SKIP TO OPPOSITIONAL DISORDER, Q. 43. IF YES, CONTINUE:			
40. Did the doctor give him any medicine to help him with these problems?	(46)	(46)	(46)
IF NO, SKIP TO OPPOSITIONAL DISORDER, Q. 43. IF YES, CONTINUE:			
41. Do you know the name of the medicine?	(47)	(47)	(47)
RECORD _____			
IF MEDICINE IS RITALIN, CODE 5. ALL OTHER MEDICINE, CODE 6.			
42. After he started taking the medicine, did these problems get better?	(48)	(48)	(48)

Coding

NO.....1
RARELY.....2
SOMETIMES OR SOMEWHAT.....3
YES.....5

III. (continued)
C. CONDUCT DISORDER

Most kids do things that get them in trouble with their parents or teachers. I'm going to name some kinds of trouble that kids get into, and you tell me if your child(ren) has(have) ever been in trouble like that.

	Third Child	Second Child	First Child
56A. **Has he ever been suspended from school?**	(69)	(69)	(69)
IN-SCHOOL SUSPENSIONS COUNT.			
IF NO, THEN SKIP TO Q. 57A. IF YES, CONTINUE:			
B. **How many times has it happened?** 1 TIME.....1 2 TIMES.....2 3-4 TIMES.....3 5-9 TIMES.....4 10+ TIMES.....5	(70)	(70)	(70)
C. **Can you tell me why he was suspended?** RECORD _____			
D. **How old was he when he was first suspended?**	(01 - 02)	(01 - 02)	(01 - 02)
E. **When was the last time he was suspended? Was it** within the past two weeks?.....1 within the past month?.....2 within the past six months?.....3 within the past year?.....4 over a year ago?.....5	(03)	(03)	(03)
IF OVER A YEAR AGO, ASK:			
F. **How old was he the last time he was suspended?**	(04 - 05)	(04 - 05)	(04 - 05)

Coding
NO.....1
RARELY.....2
SOMETIMES OR SOMEWHAT.....3
YES.....5

	Third Child	Second Child	First Child
57A. Has he ever been expelled from school (kicked out for the rest of the year)?	(06)	(06)	(06)
IF NO, SKIP TO Q. 58A. IF YES, CONTINUE:			
B. Can you tell me why he was expelled? RECORD_____ _____			
C. How old was he the first time he was expelled?	(07 - 08)	(07 - 08)	(07 - 08)
D. When was the last time he was expelled? Was it within the past two weeks?.....1 within the past month?.....2 within the past six months?.....3 within the past year?.....4 over a year ago?.....5	(09)	(09)	(09)
IF OVER A YEAR AGO, ASK:			
E. How old was he the last time he was expelled?	(10 - 11)	(10 - 11)	(10 - 11)
58A. Has he ever skipped school? (PROBE: PLAYED HOOKEY;TAKEN A DAY OFF FROM SCHOOL WITHOUT PERMISSION?)	(12)	(12)	(12)
IF NO, THEN SKIP TO Q. 59A. IF YES, CONTINUE:			
B. How often has he skipped school? 1 TIME.....1 2 TIMES.....2 3-4 TIMES.....3 5-9 TIMES.....4 10+ TIMES.....5	(13)	(13)	(13)

Coding
NO.....1
RARELY.....2
SOMETIMES OR SOMEWHAT.....3
YES.....5

	Third Child	Second Child	First Child
58C. Do you remember how old he was the first time he skipped school?	(14 - 15)	(14 - 15)	(14 - 15)
D. When was the last time he skipped school? Was it within the past two weeks?.....1 within the past month?.....2 within the past six months?.....3 within the past year?.....4 over a year ago?.....5	(16)	(16)	(16)
IF OVER A YEAR AGO, ASK:			
E. How old was he the last time?	(17 - 18)	(17 - 18)	(17 - 18)
59A. How about cutting classes - has he ever cut any classes? That is, he was at school, but he just didn't go to certain classes?	(19)	(19)	(19)
IF NO, SKIP TO Q. 60A. IF YES, CONTINUE:			
B. How many days has he cut classes? 1 DAY.....1 2 DAYS.....2 3-4 DAYS.....3 5-9 DAYS.....4 10+ DAYS.....5	(20)	(20)	(20)
C. How old was he the first time he cut classes?	(21 - 22)	(21 - 22)	(21 - 22)
D. When was the last time he cut classes? Was it within the past two weeks?.....1 within the past month?.....2 within the past 6 months?.....3 within the past year?.....4 over a year ago?.....5	(23)	(23)	(23)
IF OVER A YEAR AGO, ASK:			

Coding
NO.....1
RARELY.....2
SOMETIMES OR SOMEWHAT.....3
YES.....5

	Third Child	Second Child	First Child
59E. How old was he then?	(24 - 25)	(24 - 25)	(24 - 25)
60A. Has he ever stolen anything, like money from someone's purse, or has he swiped something that belonged to another kid? (PROBE: DID HE EVER SWIPE ANYTHING FROM SOMEBODY'S LOCKER, OR THEIR DESK?)	(26)	(26)	(26)
B. Has he ever stolen anything else, for instance has he shoplifted items from a store or has he stolen anything from someone's home? (PROBE: LIPSTICKS, MAGAZINES, CLOTHES, JEWELRY, CDS., STEREO, TV) RECORD WHAT WAS TAKEN AND AMOUNT ITEM(S) WAS WORTH: _____ _____	(27)	(27)	(27)
C. Has he ever used a credit card without permission or signed someone else's name on a check? RECORD WHAT WAS CHARGED TO CREDIT CARDS AND/OR AMOUNTS ON FORGED CHECKS: _____ _____	(28)	(28)	(28)

IF NO TO A,B AND C, SKIP TO Q. 61A.
IF ANY POSITIVES, CONTINUE:

D. How many times has he stolen things (or used a credit card or signed someone else's name on a check)? 1 TIME.....1 2 TIMES.....2 3-4 TIMES.....3 5-9 TIMES.....4 10+ TIMES.....5	(29)	(29)	(29)
E. How old was he the first time he _____(NAME WHAT CHILD DID)?	(30 - 31)	(30 - 31)	(30 - 31)

Coding
NO.....1
RARELY.....2
SOMETIMES OR SOMEWHAT.....3
YES.....5

	Third Child	Second Child	First Child
60F. When was the last time he did anything like that? Was it within the past two weeks?.....1 within the past month?.....2 within the past six months?.....3 within the past year?.....4 over a year ago?.....5	(32)	(32)	(32)
IF OVER A YEAR AGO, ASK:			
G. How old was he then?	(33 - 34)	(33 - 34)	(33 - 34)
61A. Does he often lie or make up stories to get out of trouble? (PROBE: LIKE TELLING THE TEACHER THAT HE HAD A BAD HEADACHE AND COULDN'T DO HIS HOMEWORK WHEN HE REALLY JUST HADN'T DONE THE HOMEWORK. OR, TELLING YOU HE WAS ONE PLACE, WHEN HE WAS REALLY SOMEPLACE ELSE.)	(35)	(35)	(35)
B. Does he get into trouble because people say he lies?	(36)	(36)	(36)
IF NO TO A AND B, SKIP TO Q. 62A. IF YES TO EITHER A OR B, CONTINUE:			
C. How old was he when he first started telling lies or when people said he was lying?	(37 - 38)	(37 - 38)	(37 - 38)
D. When was the last time he told a lie? Was it within the past two weeks?.....1 within the past month?.....2 within the past six months?.....3 within the past year?.....4 over a year ago?.....5	(39)	(39)	(39)
IF OVER A YEAR AGO, ASK:			
E. How old was he the last time?	(40 - 41)	(40 - 41)	(40 - 41)

Coding
NO.....1
RARELY.....2
SOMETIMES OR SOMEWHAT.....3
YES.....5

	Third Child	Second Child	First Child
62A. Has he ever set any fires that he wasn't supposed to set?	(42)	(42)	(42)
IF NO, SKIP TO Q. 63A. IF YES, CONTINUE:			
B. How did it happen and what happened because of the fire(s)? RECORD_____	(43)	(43)	(43)
ACCIDENTAL.....1 DELIBERATE.....2 SOME ACCIDENTAL/ SOME DELIBERATE.....3			
IF CODED 1, SKIP TO Q. 63A. IF CODED 2 OR 3, CONTINUE:			
C. How many times has he set fires that he wasn't supposed to set? 1 TIME.....1 2 TIMES.....2 3-4 TIMES.....3 5-9 TIMES.....4 10+ TIMES.....5	(44)	(44)	(44)
D. How old was he the first time he set a fire that he wasn't supposed to set?	(45 - 46)	(45 - 46)	(45 - 46)
E. When was the last time he set a fire that he wasn't supposed to set? Was it within the past two weeks?.....1 within the past month?.....2 within the past six months?.....3 within the past year?.....4 over a year ago?.....5	(47)	(47)	(47)
IF OVER A YEAR AGO, ASK:			
F. How old was he then?	(48 - 49)	(48 - 49)	(48 - 49)

Coding
NO.....1
RARELY.....2
SOMETIMES OR SOMEWHAT.....3
YES.....5

	Third Child	Second Child	First Child
63A. Has he ever run away from home overnight or longer?	(50)	(50)	(50)
MUST HAVE RUN AWAY FROM HOME WITHOUT LETTING PARENT KNOW HIS WHEREABOUTS.			
IF NO, SKIP TO Q. 64A. IF YES, CONTINUE:			
RECORD_____			
B. How many times has he run away like that? 1 TIME.....1 2 TIMES.....2 3-4 TIMES.....3 5-9 TIMES.....4 10+ TIMES.....5	(51)	(51)	(51)
C. How old was he the first time he ran away?	(52 - 53)	(52 - 53)	(52 - 53)
D. When was the last time he ran away? Was it within the past two weeks?.....1 within the past month?.....2 within the past six months?.....3 within the past year?.....4 over a year ago?.....5	(54)	(54)	(54)
IF OVER A YEAR AGO, ASK:			
E. How old was he then?	(55 - 56)	(55 - 56)	(55 - 56)
64A. Has he ever gotten into fights with other kids? (PROBE: FIGHTS IN WHICH THEY REALLY HIT ONE ANOTHER, NOT JUST SCREAMING MATCHES?)	(57)	(57)	(57)
IF NO, SKIP TO Q. 66A. IF YES, CONTINUE:			

Coding
NO.....1
RARELY.....2
SOMETIMES OR SOMEWHAT.....3
YES.....5

	Third Child	Second Child	First Child
64B. Has he ever started any of these fights?	(58)	(58)	(58)
IF NO, SKIP TO Q. 65A. IF YES, CONTINUE:			
C. How often has he started fights with other kids?	(59)	(59)	(59)
1 TIME.....1 2 TIMES.....2 3-4 TIMES.....3 5-9 TIMES.....4 10+ TIMES.....5			
D. How old was he the first time he started a fight?	(60 - 61)	(60 - 61)	(60 - 61)
E. When was the last time he started a fight? Was it within the past two weeks?.....1 within the past month?.....2 within the past six months?.....3 within the past year?.....4 over a year ago.....5	(62)	(62)	(62)
IF OVER A YEAR AGO, ASK:			
F. How old was he the last time he started a fight?	(63 - 64)	(63 - 64)	(63 - 64)
G. Has he ever hurt someone badly in a fight - like giving them a black eye or a bloody nose? (PROBE: WHAT WAS THE WORST INJURY HE EVER GAVE SOMEONE?) RECORD _____	(65)	(65)	(65)
IF NO, SKIP TO Q. 65A. IF YES, CONTINUE:			

Coding

NO.....1
RARELY.....2
SOMETIMES OR SOMEWHAT.....3
YES.....5

	Third Child	Second Child	First Child
64H. How many times has he hurt someone in a fight? 1 TIME.....1 2 TIMES.....2 3-4 TIMES.....3 5-9 TIMES.....4 10+ TIMES.....5	(66)	(66)	(66)
65A. When he's been fighting, has he ever used other things in addition to his hands, such as weapons like sticks, rocks, or sharp objects? (Did he ever use a knife or a gun?)	(67)	(67)	(67)
IF NO, SKIP TO Q. 66A. IF YES, CONTINUE:			
B. How often has he used a weapon in a fight? 1 TIME.....1 2 TIMES.....2 3-4 TIMES.....3 5-9 TIMES.....4 10+ TIMES.....5	(68)	(68)	(68)
C. How old was he the first time he used a weapon in a fight?	(69 - 70)	(69 - 70)	(69 - 70)
D. When was the last time he got into a fight and used a weapon? Was it within the past two weeks?.....1 within the past month?.....2 within the past six months?.....3 within the past year?.....4 over a year ago?.....5	(01)	(01)	(01)
IF OVER A YEAR AGO, ASK:			
E. How old was he the last time he used a weapon?	(02 - 03)	(02 - 03)	(02 - 03)

Coding

NO.....1
RARELY.....2
SOMETIMES OR SOMEWHAT.....3
YES.....5

	Third Child	Second Child	First Child
66A. Has he ever mugged someone or held them up and robbed them? Has he ever bullied other kids until they handed over their lunch money or other possessions?	(04)	(04)	(04)
IF NO, SKIP TO Q. 67A. IF YES, CONTINUE:			
B. How many times has he done that? 1 TIME.....1 2 TIMES.....2 3-4 TIMES.....3 5-9 TIMES.....4 10+ TIMES.....5	(05)	(05)	(05)
C. How old was he the first time this happened?	(06 - 07)	(06 - 07)	(06 - 07)
D. When was the last time? Was it within the past two weeks?.....1 within the past month?.....2 within the past six months?.....3 within the past year?.....4 over a year ago?.....5	(08)	(08)	(08)
IF OVER A YEAR AGO, ASK:			
E. How old was he the last time it happened?	(09 - 10)	(09 - 10)	(09 - 10)
67A. Has he ever injured or killed an animal such as a cat, a dog, a squirrel, a hamster or a gerbil? (PROBE: TORMENTED A LARGER ANIMAL, SUCH AS A HORSE OR COW? DO NOT COUNT ORDINARY INSECT KILLING, SUCH AS SWATTING FLIES OR GETTING RID OF HOUSEHOLD PESTS LIKE ROACHES. DO NOT COUNT LEGITIMATE HUNTING ACTIVITIES.)	(11)	(11)	(11)
IF NO, SKIP TO Q. 68A. IF YES, CONTINUE:			

Coding

NO.....1
RARELY.....2
SOMETIMES OR SOMEWHAT.....3
YES.....5

	Third Child	Second Child	First Child
67B. How did it happen (the death or injury) ?	(12)	(12)	(12)
ACCIDENTAL, UNINTENTIONAL...1 DELIBERATE.....2 SOME ACCIDENTAL/SOME DELIBERATE.....3			
IF CODED 1, SKIP TO Q. 68A. IF CODED 2 OR 3, CONTINUE:			
RECORD _____			
C. How often has he done that?	(13)	(13)	(13)
1 TIME.....1 2 TIMES.....2 3-4 TIMES.....3 5-9 TIMES.....4 10+ TIMES.....5			
D. How old was he the first time it happened?	(14 - 15)	(14 - 15)	(14 - 15)
E. When was the last time? Was it			
within the past two weeks?.....1 within the past month?.....2 within the past six months?.....3 within the past year?.....4 over a year ago?.....5	(16)	(16)	(16)
IF OVER A YEAR AGO, ASK:			
F. How old was he the last time it happened?	(17 - 18)	(17 - 18)	(17 - 18)

Coding

NO.....1
RARELY.....2
SOMETIMES OR SOMEWHAT.....3
YES.....5

	Third Child	Second Child	First Child
68A. Has he ever done anything on purpose to harm another person or to cause them physical pain? (PROBE: SOME EXAMPLES WOULD BE TYING SOMEONE TO A TREE AND LEAVING THEM; TWISTING THEIR ARM BEHIND THEIR BACK SO IT REALLY HURT; SMOTHERING THEM WITH A PILLOW; OR HOLDING THEIR HEAD UNDER WATER; CUTTING THEM WITH A KNIFE, NOT IN A FIGHT, BUT JUST TO HURT THEM.)	(19)	(19)	(19)

IF NO, SKIP TO Q. 69A.
IF YES, CONTINUE:

68B. What did he actually do?

RECORD _____

_____

C. INTERVIEWER: USE YOUR JUDGEMENT; DO NOT ASK RESPONDENT a AND b.
THE HARMING HAS TO BE SERIOUS AND DELIBERATE.

	Third Child	Second Child	First Child
a. WAS THE HARM DONE SERIOUS?	(20)	(20)	(20)
b. WAS IT DELIBERATE?	(21)	(21)	(21)

D. How often has he harmed someone on purpose?

1 TIME.....1	(22)	(22)	(22)
2 TIMES.....2			
3-4 TIMES.....3			
5-9 TIMES.....4			
10+ TIMES.....5			

E. How old was he the first time?

Third Child	Second Child	First Child
(23 - 24)	(23 - 24)	(23 - 24)

Coding
NO.....1
RARELY.....2
SOMETIMES OR SOMEWHAT.....3
YES.....5

	Third Child	Second Child	First Child
68F. When was the last time he did this? Was it within the past two weeks?.....1 Within the past month?.....2 Within the past six months?.....3 within the past year?.....4 over a year ago?.....5	(25)	(25)	(25)
IF OVER A YEAR AGO, ASK:			
G. How old was he the last time?	(26 - 27)	(26 - 27)	(26 - 27)
69A. Has he ever broken into someone's house or car, or has he ever broken into a building?	(28)	(28)	(28)
IF NO, SKIP TO Q. 70A. IF YES, CONTINUE:			
B. How often has he done that? 1 TIME.....1 2 TIMES.....2 3-4 TIMES.....3 5-9 TIMES.....4 10+ TIMES.....5	(29)	(29)	(29)
C. How old was he the first time?	(30 - 31)	(30 - 31)	(30 - 31)
D. When was the last time he did this? Was it within the past two weeks?.....1 Within the past month?.....2 Within the past six months?.....3 within the past year?.....4 over a year ago?.....5	(32)	(32)	(32)
IF OVER A YEAR AGO, ASK:			
E. How old was he the last time?	(33 - 34)	(33 - 34)	(33 - 34)

Coding

NO.....1
RARELY.....2
SOMETIMES OR SOMEWHAT.....3
YES.....5

	Third Child	Second Child	First Child
70A. **Has he ever wrecked someone else's property on purpose?** (PROBE: HERE ARE SOME EXAMPLES: BREAKING WINDOWS IN A SCHOOL OR SOME OTHER BUILDING; SCRATCHING A CAR; THROWING ROCKS AT CARS; "EGGING" CARS).	(35)	(35)	(35)
IF NO, SKIP TO INSTRUCTION AFTER Q. 70E. IF YES, CONTINUE:			
B. **How often has he done things like that on purpose?** 1 TIME.....1 2 TIMES.....2 3-4 TIMES.....3 5-9 TIMES.....4 10+ TIMES.....5	(36)	(36)	(36)
C. **How old was he the first time he did anything like that?**	(37 - 38)	(37 - 38)	(37 - 38)
D. **When was the last time he did that? Was it** within the past two weeks?.....1 within the past month?.....2 within the past six months?.....3 within the past year?.....4 over a year ago?.....5	(39)	(39)	(39)
IF OVER A YEAR AGO, ASK:			
E. **How old was he the last time it happened?**	(40 - 41)	(40 - 41)	(40 - 41)
IF CHILD'S AGE IS 6-12 YEARS, SKIP TO Q. 72A. IF CHILD'S AGE IS 13-17 YEARS, CONTINUE:			
71A. **Has your child ever had sexual relations with anyone?**	(42)	(42)	(42)
IF NO, SKIP TO Q. 72A. IF YES, CONTINUE:			

Coding

NO.....1
RARELY.....2
SOMETIMES OR SOMEWHAT.....3
YES.....5

	Third Child	Second Child	First Child
71B. How many people has he had sexual relations with?	(43 - 44)	(43 - 44)	(43 - 44)
C. How old was he the first time he ever had sexual relations?	(45 - 46)	(45 - 46)	(45 - 46)
72A. Has your child ever forced anyone to do sexual things with him? RECORD WHATEVER PARENT VOLUNTEERS _____	(47)	(47)	(47)
IF NO, SKIP TO Q. 73A. IF YES, CONTINUE:			
B. How old was he the first time?	(48 - 49)	(48 - 49)	(48 - 49)
73A. Has he ever been in trouble with the police?	(50)	(50)	(50)
IF NO, SKIP TO INSTRUCTION AFTER Q. 73H. IF YES, CONTINUE:			
B. How many times has he been in trouble with the police?	(51)	(51)	(51)
1 TIME.....1 2 TIMES.....2 3-4 TIMES.....3 5-9 TIMES.....4 10+ TIMES.....5			
C. Has he ever appeared in juvenile court?	(52)	(52)	(52)
IF NO, SKIP TO F. IF YES, CONTINUE:			
D. How many times has he appeared in juvenile court?	(53)	(53)	(53)
1 TIME.....1 2 TIMES.....2 3-4 TIMES.....3 5-9 TIMES.....4 10+ TIMES.....5			

Coding
NO.....1
RARELY.....2
SOMETIMES OR SOMEWHAT.....3
YES.....5

	Third Child	Second Child	First Child
73E. Can you tell me what happened? (PROBE: WITH POLICE, JUVENILE COURT, OR BOTH.) RECORD_____			
F. How old was he the first time he got in trouble with the police or appeared in juvenile court?	(54 - 55)	(54 - 55)	(54 - 55)
G. When was the last time that happened? Was it within the past two weeks?.....1 within the past month?.....2 within the past six months?.....3 within the past year?.....4 over a year ago?.....5	(56)	(56)	(56)
IF OVER A YEAR AGO, ASK: H. How old was he the last time?	(57 - 58)	(57 - 58)	(57 - 58)

IF NO POSITIVES IN QS. 58-72, SKIP TO ALCOHOL USE/ABUSE, Q. 78.
IF ONLY 1 POSITIVE, SKIP TO Q. 74B.
IF TWO OR MORE POSITIVES, CONTINUE.

74A. Let's see. You've told me that your child has had problems like_____ ____ (NAME POSITIVES). Have most of these problems happened at about the same time? For example, when he was _____ was he also _____? (PROBE: IN THE SAME SCHOOL YEAR?) RECORD SYMPTOMS THAT CLUSTERED:	(59)	(59)	(59)
B. How old was he when he first had these problems that you've just told me about? (PROBE: DO YOU REMEMBER WHAT GRADE HE WAS IN?)	(60 - 61)	(69 - 61)	(60 - 61)

Coding

NO.....1
RARELY.....2
SOMETIMES OR SOMEWHAT.....3
YES.....5

	Third Child	Second Child	First Child
74C. **When was the last time he had any of these problems? Was it**	(62)	(62)	(62)
within the past two weeks?.....1 within the past month?.....2 within the past six months?....3 within the past year?.....4 over a year ago?.....5			
IF OVER A YEAR AGO, ASK:			
D. **How old was he then?** (PROBE: WHAT GRADE WAS HE IN?)	(63 - 64)	(63 - 64)	(63 - 64)
E. INTERVIEWER: IN ORDER TO MEET CRITERIA FOR CHILD CONDUCT DISORDER, THE SYMPTOMS MUST HAVE LASTED A MINIMUM OF 6 MONTHS. IF OBVIOUS FROM AGES OF ONSET AND RECENCY QUESTIONS, OR FROM INFORMATION IN THE CONTEXT OF THE INTERVIEW, CODE WITHOUT ASKING. OTHERWISE, PROBE FOR A 6 MONTH DURATION.	(65)	(65)	(65)
75. **Have these behaviors (ever) caused a problem with how your child gets along with people at home?**	(66)	(66)	(66)
Not at all.....1 Not too much.....2 Somewhat.....3 Quite a bit.....4			
76. **Have these behaviors (ever) caused a problem with how your child gets along with his friends?**	(67)	(67)	(67)
Not at all.....1 Not too much.....2 Somewhat.....3 Quite a bit.....4			
77. **Have these behaviors (ever) caused a problem for your child with his school work?**	(68)	(68)	(68)
Not at all.....1 Not too much.....2 Somewhat.....3 Quite a bit.....4			

Appendix C

CHILD BEHAVIOR CHECKLIST FOR AGES 4-18

CHILD'S NAME

SEX ☐ Boy ☐ Girl | AGE | ETHNIC GROUP OR RACE

TODAY'S DATE Mo. ____ Date ____ Yr ____

CHILD'S BIRTHDATE Mo. ____ Date ____ Yr ____

GRADE IN SCHOOL ____

NOT ATTENDING SCHOOL ☐

Please fill out this form to reflect *your* view of the child's behavior even if other people might not agree. Feel free to write additional comments beside each item and in the spaces provided on page 2.

PARENTS' USUAL TYPE OF WORK, even if not working now. *(Please be specific – for example, auto mechanic, high school teacher, homemaker, laborer, lathe operator, shoe salesman, army sergeant.)*

FATHER'S TYPE OF WORK: ____

MOTHER'S TYPE OF WORK: ____

THIS FORM FILLED OUT BY:

☐ Mother (name): ____

☐ Father (name): ____

☐ Other – name & relationship to child: ____

I. Please list the sports your child most likes to take part in. For example: swimming, baseball, skating, skate boarding, bike riding, fishing, etc.

☐ None

	Compared to others of the same age, about how much time does he/she spend in each?				Compared to others of the same age, how well does he/she do each one?			
	Don't Know	Less Than Average	Average	More Than Average	Don't Know	Below Average	Average	Above Average
a. ____	☐	☐	☐	☐	☐	☐	☐	☐
b. ____	☐	☐	☐	☐	☐	☐	☐	☐
c. ____	☐	☐	☐	☐	☐	☐	☐	☐

II. Please list your child's favorite hobbies, activities, and games, other than sports. For example: stamps, dolls, books, piano, crafts, cars, singing, etc. (Do not include listening to radio or TV.)

☐ None

	Compared to others of the same age, about how much time does he/she spend in each?				Compared to others of the same age, how well does he/she do each one?			
	Don't Know	Less Than Average	Average	More Than Average	Don't Know	Below Average	Average	Above Average
a. ____	☐	☐	☐	☐	☐	☐	☐	☐
b. ____	☐	☐	☐	☐	☐	☐	☐	☐
c. ____	☐	☐	☐	☐	☐	☐	☐	☐

III. Please list any organizations, clubs, teams, or groups your child belongs to.

☐ None

	Compared to others of the same age, how active is he/she in each?			
	Don't Know	Less Active	Average	More Active
a ____	☐	☐	☐	☐
b ____	☐	☐	☐	☐
c ____	☐	☐	☐	☐

IV. Please list any jobs or chores your child has. For example: paper route, babysitting, making bed, working in store, etc. (Include both paid and unpaid jobs and chores.)

☐ None

	Compared to others of the same age, how well does he/she carry them out?			
	Don't Know	Below Average	Average	Above Average
a. ____	☐	☐	☐	☐
b. ____	☐	☐	☐	☐
c. ____	☐	☐	☐	☐

V. 1. About how many close friends does your child have? (Do not include brothers & sisters) ☐ None ☐ 1 ☐ 2 or 3 ☐ 4 or more

2. About how many times a week does your child do things with any friends outside of regular school hours? (Do not include brothers & sisters) ☐ Less than 1 ☐ 1 or 2 ☐ 3 or more

VI. Compared to others of his/her age, how well does your child:

	Worse	About Average	Better	
a. Get along with his/her brothers & sisters?	☐	☐	☐	☐ Has no brothers or sisters
b. Get along with other kids?	☐	☐	☐	
c. Behave with his/her parents?	☐	☐	☐	
d. Play and work by himself/herself?	☐	☐	☐	

VII. 1. For ages 6 and older – performance in academic subjects. If child is not being taught, please give reason _____

	Failing	Below average	Average	Above average
a. Reading, English, or Language Arts	☐	☐	☐	☐
b. History or Social Studies	☐	☐	☐	☐
c. Arithmetic or Math	☐	☐	☐	☐
d. Science	☐	☐	☐	☐
Other academic subjects – for example: computer courses, foreign language, business. Do *not* include gym, shop, driver's ed., etc. e. _____	☐	☐	☐	☐
f. _____	☐	☐	☐	☐
g. _____	☐	☐	☐	☐

2. Is your child in a special class or special school? ☐ No ☐ Yes – what kind of class or school?

3. Has your child repeated a grade? ☐ No ☐ Yes – grade and reason

4. Has your child had any academic or other problems in school? ☐ No ☐ Yes – please describe

When did these problems start?

Have these problems ended? ☐ No ☐ Yes – when?

Does your child have any illness, physical disability, or mental handicap? ☐ No ☐ Yes – please describe

What concerns you most about your child?

Please describe the best things about your child:

Below is a list of items that describe children and youth. For each item that describes your child **now or within the past 6 months**, please circle the **2** if the item is **very true** or **often true** of your child. Circle the **1** if the item is **somewhat** or **sometimes true** of your child. If the item is **not true** of your child, circle the **0**. Please answer all items as well as you can, even if some do not seem to apply to your child.

0 = Not True (as far as you know) **1 = Somewhat or Sometimes True** **2 = Very True or Often True**

0 1 2 1. Acts too young for his/her age
0 1 2 2. Allergy (describe): _____
_____
0 1 2 3. Argues a lot
0 1 2 4. Asthma
0 1 2 5. Behaves like opposite sex
0 1 2 6. Bowel movements outside toilet
0 1 2 7. Bragging, boasting
0 1 2 8. Can't concentrate, can't pay attention for long
0 1 2 9. Can't get his/her mind off certain thoughts; obsessions (describe): _____
_____
0 1 2 10. Can't sit still, restless, or hyperactive
0 1 2 11. Clings to adults or too dependent
0 1 2 12. Complains of loneliness
0 1 2 13. Confused or seems to be in a fog
0 1 2 14. Cries a lot
0 1 2 15. Cruel to animals
0 1 2 16. Cruelty, bullying, or meanness to others
0 1 2 17. Day-dreams or gets lost in his/her thoughts
0 1 2 18. Deliberately harms self or attempts suicide
0 1 2 19. Demands a lot of attention
0 1 2 20. Destroys his/her own things
0 1 2 21. Destroys things belonging to his/her family or others
0 1 2 22 Disobedient at home
0 1 2 23 Disobedient at school
0 1 2 24 Doesn't eat well
0 1 2 25 Doesn't get along with other kids
0 1 2 26 Doesn't seem to feel guilty after misbehaving
0 1 2 27 Easily jealous
0 1 2 28 Eats or drinks things that are not food – *don't* include sweets (describe): _____
_____
0 1 2 29 Fears certain animals, situations, or places, other than school (describe): _____
_____
0 1 2 30. Fears going to school
0 1 2 31. Fears he/she might think or do something bad
0 1 2 32. Feels he/she has to be perfect
0 1 2 33. Feels or complains that no one loves him/her
0 1 2 34. Feels others are out to get him/her
0 1 2 35. Feels worthless or inferior
0 1 2 36. Gets hurt a lot, accident-prone
0 1 2 37. Gets in many fights
0 1 2 38. Gets teased a lot
0 1 2 39. Hangs around with others who get in trouble
0 1 2 40. Hears sounds or voices that aren't there (describe): _____
_____
0 1 2 41. Impulsive or acts without thinking
0 1 2 42. Would rather be alone than with others
0 1 2 43. Lying or cheating
0 1 2 44. Bites fingernails
0 1 2 45. Nervous, highstrung, or tense
0 1 2 46. Nervous movements or twitching (describe):
_____
_____
0 1 2 47. Nightmares
0 1 2 48. Not liked by other kids
0 1 2 49. Constipated, doesn't move bowels
0 1 2 50. Too fearful or anxious
0 1 2 51. Feels dizzy
0 1 2 52. Feels too guilty
0 1 2 53. Overeating
0 1 2 54. Overtired
0 1 2 55. Overweight
56. Physical problems without known medical cause:
0 1 2 a. Aches or pains (*not* headaches)
0 1 2 b. Headaches
0 1 2 c. Nausea, feels sick
0 1 2 d. Problems with eyes (describe): _____
_____
0 1 2 e. Rashes or other skin problems
0 1 2 f. Stomachaches or cramps
0 1 2 g. Vomiting, throwing up
0 1 2 h. Other (describe): _____
_____

Please see other side

0 = Not True (as far as you know) 1 = Somewhat or Sometimes True 2 = Very True or Often True

0 1 2 57. Physically attacks people
0 1 2 58. Picks nose, skin, or other parts of body (describe): _____
_____
0 1 2 59. Plays with own sex parts in public
0 1 2 60. Plays with own sex parts too much
0 1 2 61. Poor school work
0 1 2 62. Poorly coordinated or clumsy
0 1 2 63. Prefers being with older kids
0 1 2 64. Prefers being with younger kids
0 1 2 65. Refuses to talk
0 1 2 66. Repeats certain acts over and over; compulsions (describe): _____
_____
0 1 2 67. Runs away from home
0 1 2 68. Screams a lot
0 1 2 69. Secretive, keeps things to self
0 1 2 70. Sees things that aren't there (describe):
_____
_____
0 1 2 71. Self-conscious or easily embarrassed
0 1 2 72. Sets fires
0 1 2 73. Sexual problems (describe): _____
_____
_____
0 1 2 74. Showing off or clowning
0 1 2 75. Shy or timid
0 1 2 76. Sleeps less than most kids
0 1 2 77 Sleeps more than most kids during day and/or night (describe): _____
_____
0 1 2 78. Smears or plays with bowel movements
0 1 2 79. Speech problem (describe): _____
_____
0 1 2 80. Stares blankly
0 1 2 81. Steals at home
0 1 2 82. Steals outside the home
0 1 2 83. Stores up things he/she doesn't need (describe): _____
_____
0 1 2 84. Strange behavior (describe): _____
_____
0 1 2 85. Strange ideas (describe): _____
_____
0 1 2 86. Stubborn, sullen, or irritable
0 1 2 87. Sudden changes in mood or feelings
0 1 2 88. Sulks a lot
0 1 2 89. Suspicious
0 1 2 90. Swearing or obscene language
0 1 2 91. Talks about killing self
0 1 2 92. Talks or walks in sleep (describe): _____
_____
0 1 2 93. Talks too much
0 1 2 94. Teases a lot
0 1 2 95. Temper tantrums or hot temper
0 1 2 96. Thinks about sex too much
0 1 2 97. Threatens people
0 1 2 98. Thumb-sucking
0 1 2 99. Too concerned with neatness or cleanliness
0 1 2 100. Trouble sleeping (describe): _____
_____
0 1 2 101. Truancy, skips school
0 1 2 102. Underactive, slow moving, or lacks energy
0 1 2 103. Unhappy, sad, or depressed
0 1 2 104. Unusually loud
0 1 2 105. Uses alcohol or drugs for nonmedical purposes (describe): _____
_____
0 1 2 106. Vandalism
0 1 2 107. Wets self during the day
0 1 2 108. Wets the bed
0 1 2 109. Whining
0 1 2 110. Wishes to be of opposite sex
0 1 2 111. Withdrawn, doesn't get involved with others
0 1 2 112. Worries
113. Please write in any problems your child has that were not listed above:
0 1 2 _____
0 1 2 _____
0 1 2 _____

PLEASE BE SURE YOU HAVE ANSWERED ALL ITEMS.

UNDERLINE ANY YOU ARE CONCERNED ABOUT.

Appendix D

Dear Parent:

I am presently working in this school as a school psychologist to fulfill an internship requirement for my doctorate in Educational Psychology at the CUNY Graduate Center. As part of a research project for my dissertation, I am requesting permission to interview your child. Specifically, I am interested in how a stressful event and/or condition impacts on children's social and school development. I hope the results of this study will be helpful in the future planning of treatments for children who have undergone stressful or traumatic events.

If you would like more information, please fell free to contact me, Tuesdays and Wednesdays, at this school.

Sincerely,

Rachel Diamond
School Psychologist

Please sign the following and send it back to school with your child:

I have read and understood your request and am hereby granting permission to have my child, _____, interviewed.

_____
Signature

Appendix E

DSM-III-R Diagnostic Criteria for Attention-deficit Hyperactivitity Disorder

Note: Consider a criterion met only if the behavior is considerably more frequent than that of most people of the same mental age.

A. A disturbance of at least six months during which at least eight of the following are present:
   (1) often fidgets with hands or feet or squirms in seat in adolescents, may be limited to subjective feelings of restlessness)
   (2) has difficulty remaining seated when required to do so
   (3) is easily distracted by extraneous stimuli
   (4) has difficulty awaiting turn in games or group situations
   (5) often blurts out answers to questions before they have been completed
   (6) has difficulty following through on instructions from others (not due to oppositional behavior or failure of comprehension), e.g., fails to finish chores
   (7) has difficulty sustaining attention in tasks or play activities
   (8) often shifts from one uncompleted activity to another
   (9) has difficulty playing quietly
   (10) often talks excessively
   (11) often interrupts or intrudes on others, e.g., butts into other children's games
   (12) often does not seem to listen to what is being said to him or her
   (13) often loses things necessary for tasks or activities at school or at home (e.g., toys, pencils, books, assignments)
   (14) often engages in physically dangerous activities without considering possible consequences (not for the purpose of thrill-seeking), e.g., runs into street without looking

   Note: The above items are listed in descending order of discriminating power based on data from a national field trial of the DSM-III-R criteria for Disruptive Behavior Disorders.

B. Onset before the age of seven.

C. Does not meet the criteria for a Pervasive Developmental Disorder.

Criteria for severity of Attention-deficit Hyperactivity Disorder:

Mild: Few, if any, symptoms in excess of those required to make the diagnosis **and** only minimal or no impairment in school and social functioning.

Moderate: Symptoms or functional impairment intermediate between "mild" and "severe."

Severe: Many symptoms in excess of those required to make the

diagnosis and significant and pervasive impairment in functioning at home and school and with peers.

Note: Criteria from the American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised.* Washington, D.C., American Psychiatric Association, 1987. Reprinted by permission.

Appendix F

An abused child is one who is under 18 years of age whose parent or other person legally responsible for his care inflicts or allows to be inflicted upon the child or creates or allows to be created a physical injury or a substantial risk thereof by other than accidental means which causes or creates a substantial risk of death, serious or protracted disfigurement, or protracted impairment of physical or emotional health or protracted loss or impairment of the functions of a bodily organ.

An abused child also is one whose parents or other person legally responsible for his care commits or allows to be committed a sex offense as defined in Article 130 of the Penal Law; commits incest; allows, permits or encourages such child to engage in prostitution; or allows such child to engage in acts or conduct which constitute a sexual performance.

A maltreated child is one who is under 18 years of age whose physical, mental, or emotional condition has been impaired or is in imminent danger of becoming impaired as a result of the failure of the parent or other person legally responsible for his care to exercise a minimum degree of care: 1) in supplying the child with food, clothing, shelter or compulsory education, or medical, dental, optometrical or surgical care though financially able to do so or offered financial or other reasonable means to do so; or 2) in providing the child with proper supervision or guardianship by unreasonably inflicting or allowing to be inflicted harm or a substantial risk thereof, including the use of excessive corporal punishment, or by misusing drugs or alcohol to the extent that he or she loses self-control of his actions, or by abandoning the child.

In addition, Social Services Law specifically defines abuse and maltreatment as it relates to a child who is living away from his or her home in a residential care program (New York State Social Services Law Section 412 [1994]; New York State Family Court Act Section 1012 [1985]).

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