Alternative Criteria for PTSD in Young Children (Scheeringa et al; 1995)

A. (1) The child experienced, witnessed, or was confronted with an event which involves actual or threatened death or serious injury or a threat to the physical integrity of self or others.

B. Re-experiencing. One item needed:
(1) Posttraumatic play; compulsively repetitive, represents part of the trauma.
Fails to relieve anxiety and is less elaborate and imaginative than usual play.
(2) Play re-enactment represents part of the trauma but lacks the monotonous repetition and other characteristics of posttraumatic play.
(3) Recurrent recollections of the traumatic event other than what is revealed in play, and which is not necessarily distressing.
(4) Nightmares: may have obvious links to the trauma or be of increased frequency with unknown content.
(5) Episode with objective features of a flashback or dissociation.

C. Numbing of responsiveness. One item needed:
(1) Constriction of play. Child may have constriction of play and still have posttraumatic play or play re-enactment.
(2) Socially more withdrawn.
(3) Restricted range of affect.
(4) Loss of acquired developmental skills, especially language regression and loss of toilet training,

D. Increased arousal. One item needed:
(1) Night terrors.
(2) Difficulty in going to sleep which is not related to being afraid of having nightmares or fear of the dark.
(3) Night-waking not related to nightmares or night terrors.
(4) Decreased concentration; marked decrease in concentration or attention span compared to before the trauma.
(5) Hypervigilance.
(6) Exaggerated startle response.

E. New fears and aggression. One item needed:
(1) New aggression.
(2) New separation anxiety.
(3) Fear of toileting alone.
(4) Fear of the dark.
(5) Any other new fears of things or situations not obviously related to the trauma.

F, Duration of disturbance greater than one month.

Sheeringa, M. S., Zeanah, C. H., Drell, M. J., & Carrieu, J. A, (1995) Two approaches to the diagnosis of post-traumatic stress disorder in infancy and early childhood. *Journal of the American Academy of Child and Adolescent Psychiatry, 34,* 191-200.

Developmental Trauma Disorder – proposed criteria

Van der Kolk 2005

A. Exposure

- Multiple or chronic exposure to one or more forms of developmentally adverse interpersonal trauma (e.g. abandonment, betrayal, physical assaults, sexual assaults, threats to bodily integrity, coercive practices, emotional abuse, witnessing violence and death).
- Subjective experience (e.g., rage, betrayal, fear, resignation, defeat, shame).

B. Triggered pattern of repeated deregulation in response to trauma cues

Dysregulation (high or low) in presence of cues. Changes persist and do not return to baseline; not reduced in intensity by conscious awareness.

- Affective.
- Somatic (e.g. physiological, motoric, medical).
- Behavioural (e.g. re-enactment, cutting).
- Cognitive (e.g. thinking that it is happening again, confusion, dissociation, depersonalization).
- Relational (e.g. clinging, oppositional, distrustful, compliant).
- Self-attribution (e.g., self-hate, blame).

C. Persistently Altered Attributions and Expectancies

- Negative self-attribution.
- Distrust of protective caretaker.
- Loss of expectancy of protection by others.
- Loss of trust in social agencies to protect.
- Lack of recourse to social justice/retribution.
- Inevitability of future victimization.

D**. Functional Impairment**

- Educational.
- Familial.
- Peer.
- Legal.
- Vocational.

Position statement on Complex Post-Traumatic Stress Disorder

The National Institute of Clinical Excellence (NICE) states that Post-Traumatic Stress Disorder (PTSD) develops following a stressful event or situation of an exceptionally threatening or catastrophic nature, and examples that are given include single events such as assaults or road traffic accidents. For adults, we believe that this refers to "simple" PTSD, which commonly develops following a single traumatic event occurring in adulthood. The recommended treatment is brief, trauma-focused psychological therapy. However, the guideline does not apply to situations involving complex trauma, for example where there is a history of multiple traumatic events, including previous childhood trauma and attachment disorder.

While the ICD-10 (International Classification of Diseases – 10th Revision, 2007) is less specific, the Diagnostic and Statistical Manual of Mental Disorders (4th Edition Text Revision – DSM-IV-TR, 2000) states that an "associated constellation of symptoms may occur and are more commonly seen in association with an *interpersonal stressor* (eg childhood sexual or physical abuse, domestic battering, being taken hostage, incarceration as a prisoner of war or in a concentration camp, torture): impaired affect modulation, self–destructive and impulsive behaviour; dissociative symptoms; somatic complaints; feelings of ineffectiveness; shame, despair or hopelessness: feeling permanently damaged; a loss of previously sustained beliefs; social withdrawal; feeling constantly threatened; impaired relationships with others ; or a change from the individual's previous personality characteristics".

This clinical picture is characterised by extensive co-morbidity, and often referred to in the literature (see e.g. Blum, 1999; Herman, 1992; Van der Kolk et al., 2005) as *"Complex PTSD"*. We propose that this is associated with a very different clinical profile and therefore breadth of treatment needs.

Complex PTSD includes a spectrum of defined disorders, the symptoms of which include those of simple PTSD, but also several other key elements. Opinions vary regarding the age at which traumatic events occur in order to contribute to Complex PTSD – arguments for trauma below the age of 14 years (Cook, Blaustein, Spinazzola & Van der Kolk, 2003) and below the age of 26 years (Luxenberg et al., 2001) exist.

Van der Kolk and colleagues (Van der Kolk, 2005) has developed the concept of Developmental Trauma Disorder for those experiencing the effects of complex trauma. Other relevant literature within the spectrum of Complex PTSD in children and adults covers the contribution of trauma to: attachment disorders, eating disorders, conduct disorders, substance misuse, psychosis, dissociative disorders, borderline personality disorder, disorders of extreme stress (DESNOS), enduring personality change following catastrophe, and survivors of childhood sexual abuse.

NICE recommends 8-12 sessions of trauma-focused psychological treatment for PTSD following single-event trauma. Both simple and complex PTSD can be chronic conditions (and in fact we would argue that Complex PTSD is inherently chronic). NICE acknowledges the existence of chronic PTSD conditions, and recommends "chronic disease management models", and with multiple traumas that psychological treatment is extended. However, NICE does not specify what this encompasses. Literature on effective treatment for complex PTSD is limited, but what there is so far shows that multi-

phasic and multi-modal treatment is indicated for children and adults (e.g. Luxenberg et al., 2001). The literature recommends that the following three stages are included:

1. Establishing stabilisation and safety;
2. Psychological therapy, incorporating trauma-focused elements and some exposure to the trauma;
3. Rehabilitation.

Conclusions

The NICE guidelines do not provide adequate guidance in relations to the assessment and treatment of Complex PTSD. This results in lack of appropriate provision, resources and training to treat people with Complex PTSD, and ensuing limited access to effective treatment services. We propose that a review of the literature on complex PTSD is urgently needed to refine the definition of complex PTSD, and provide more detailed guidance for good practice in the assessment and treatment of complex PTSD. We advise that the multi-phasic treatment recommendations outlined above should be followed as best practice for the treatment of Complex PTSD as we currently understand it.

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CODING MANUAL FOR PTSD SEMI-STRUCTURED INTERVIEW AND OBSERVATIONAL RECORD FOR INFANTS AND YOUNG CHILDREN (0-48 MONTHS)

Version 1.1 (5/14/03)

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This coding manual describes in detail the items used in a set of alternative criteria developed specifically for diagnosing post-traumatic stress disorder in infants and toddlers. The authors have assessed three groups of preschool children in published studies (Scheeringa et al., 1995, 2001, 2003) who suffered severe traumas and found the DSM-IV criteria for PTSD inadequate for this age group. The aim of this effort was to develop criteria that were anchored in observable behaviors and sensitive to developmental differences in young children. The criteria described in this coding manual represent the latest revision of empirically-derived criteria.

A major problem that was discovered in trying to diagnose infants was that they were preverbal or barely verbal. They could not relate their subjective experiences, that is, their thoughts and feelings. Any attempts by a clinician to speculate on subjective experiences of an infant were inferences, and therefore open to bias and error. The DSM-IV criteria for PTSD contained many items concerning subjective experiences. When creating an alternative set of criteria, the authors made the items more behaviorally anchored and objective. Also, items were included that appeared to occur only in infants and toddlers and not in older children and adults (such as loss of toilet

training, separation anxiety, etc.).

The purpose for this coding manual is to elaborate on the diagnostic items to make them as clear as possible to enhance interrater reliability. Examples are provided. We consider this an ongoing effort and welcome input from other investigators and clinicians.

A. The traumatic event

"The individual has experienced an event that was traumatic".

This item is modified from DSM-IV to delete the emphasis on threat of death and physical integrity because younger children may perceive non-life-threatening events as traumatic.

Examples:
Witnessing the murder or assault of a parent, witnessing family violence, attacks by animals, automobile accidents, physical and sexual abuse, or abductions.

B. Reexperiencing the event. One item needed.

B(1) "Play reenactment of the trauma".

Examples:

A 37-month old boy was in a pet store with his father when a leopard escaped by jumping over the top of the cage and attacked them both. Both of them were bitten on the head and neck but were not seriously injured. The boy was assessed five months after the trauma whereupon he began weekly therapy sessions. "One major theme that progressed throughout all of the sessions was the re-enactment in play of the traumatic event. In a myriad of ways, the actual attack of the leopard was re-enacted. Every detail of the trip with father, the interior of the pet store, the attack of the leopard, what was said, where the scratches and cuts occurred, the police, ambulance, and so on, was reviewed over and over again. This re-enactment might consist of a detailed verbal description of the traumatic encounter, or a simple, small part of the entire adventure might be symbolically or directly present in play. For example, in play, a toy rubber tiger might be contained in a small cage, only to escape over the toys...Similarly, a great cage might be built of the toy furniture and blocks to contain the rubber animal, to no avail, for he 'always gets out'. The play room frequently became the pet store or the leopard's cage, and the play centered on that" (MacLean, 1977).

Karen was 30 months old when it was discovered she had been sexually abused by her grandparents. "Karen had brought a knitting needle to her mother saying, 'That belongs to granny and grandpa; they stuck it in my bottom.'...In the playroom, Karen held tightly to her mother and begged her to put all the animal and human toys in the trash 'so they won't stick me.' Later, she was able to throw the grandparent puppets onto the floor repeatedly. In subsequent sessions she made a 'jar full of fire' and jailed the grandparent puppets there." (Goodwin, 1985).

Greg was 3 years old when he saw his mother kill his father. He was brought for evaluation only a few weeks after the trauma. "In his play during the assessment

session with us Greg was preoccupied with the killing. He spontaneously re-enacted it using doll figures to represent his parents. He picked up a toy scalpel belonging to a set of toys we use for children being helped to prepare for a surgical operation and putting it in the hand of the mother doll, he used it as a hammer, repeatedly hitting the face of the father doll....For many of the early sessions, he would choose his 'family', which was the foster-family, and would be incredibly aggressive to each doll, throwing them on the floor and using the surgical knife to kill each one of them. ..." (Hendriks, Black, and Kaplan, 1993).

Jasmine was 19 months old when she witnessed her mother being assaulted and raped by an acquaintance. After Jasmine's mother fought with the man for several minutes, he grabbed Jasmine and held a gun to her head in order to get her mother to do what he said. Shortly following the trauma, Jasmine developed a repetitive sequence in which she threw dolls down on the floor and hit them. She tended to repeat this over and over without elaboration and without obvious affect, according to her mother. She demonstrated this play only at home and not in the examining office (MS).

B(1) "Recurrent recollections of the event"

The main change made in this item from the similar item in DSM-IV is the removal of the requirement that the recollection be distressing. From experience with infants and toddlers, they are often drawn to bringing up the traumatic event more with morbid fascination rather than distress.

Either this item or the item above titled “Play reenactment of the trauma” can be used to code the presence of the DSM-IV item B(1) for recurrent recollections of the event. In the former item, the thoughts are expressed through play, in the latter, through verbalizations. The interview provides a means to code the existence of these two modes of expression separately for research purposes.

Examples:

Gabrielle was 37 months old at the time it was discovered she had been sexually abused. She accused the mother's boyfriend of putting his penis in her mouth. He also allegedly put ketchup on Gabrielle's body and licked it off of her. Within weeks of the abuse, Gabrielle told everyone she saw, even complete strangers, about the sexual abuse. For example, while sitting in a waiting room of a clinic, a policeman walked by, and Gabrielle said, "The police put his thing in my mouth." She made similar references to the aunt about once a week. (MS)

A 16-month-old girl was involved in a plane crash but was not seriously injured. In the first evaluation session, as soon as she entered the playroom, and without the therapist having said a word, she told the therapist about the crash. She then acted out the crash with a toy plane. She did the same thing in the next evaluation session.(Sugar, 1992). In this instance, the verbalization was coded as recurrent recollections (B[2]) and the play with the plane was coded as play reenactment of the trauma (B[1]).

B(2) "Nightmares"

Two main difficulties have been noted with this item. First, an adult observer may not always be awake to observe enough of a night-waking episode to know if the child woke up from nightmares or from other distress. Second, children normally have a

certain number of nightmares. How frequent and how intense do nightmares have to be to be considered positive for this item? We have used the guideline of coding the nightmares if they occurred with a frequency greater than they did prior to the trauma.

B(3) "Episodes with objective features of a flashback or dissociation"

The main difficulty in rating this item is not having access to the subjective experiences of the young child. Flashback and dissociative behavior must often be inferred from behaviors.

Dissociative-like behaviors have been described in infants of maltreating parents when observed in the Ainsworth Strange Situation. Upon reunion, infants became motionless, accompanied by a dazed or trance-like expression. Freezing was defined as the holding of postures that defied gravity. Stilling was distinguished from freezing in that the posture held did not involve defying gravity. Infants also appeared out of touch with reality by showing disoriented facial expressions and disorganized wandering about the room (Main, Solomon, 1990).

Examples:

Eric was 24 months old when he was abducted from his home by his natural mother and taken out-of-state for five weeks. "While the stepmother was in an adjacent room, the natural mother, who was visiting Eric, took him without warning and ran from the house to a waiting vehicle". He developed difficult behavior, which the mother was unable to deal with, and she returned Eric to his father and stepmother after five weeks. The stepmother "related that Eric had a reenactment of the abduction on three occasions - two a few weeks prior to his birthday and one on his brother's birthday. As an example, she reported that while she was with him he would suddenly look away and begin talking loudly, as if his natural mother were in the room, saying, "Go away, you can't take me away."

Brandon, a 22-month-old boy, was referred for psychiatric evaluation by his paternal grandmother five days after he witnessed his mother shoot his father to death. The next day his mother committed suicide. His grandmother reported that the major concern she had was about discrete periods of mute and almost frozen stillness which were precipitated by mention of his parents or mention of the murder. These episodes lasted from 5-25 minutes, and generally Brandon was <u>unresponsive</u> to overtures from anyone during these times. He simply stared into the distance, appearing either blank or wary.

B(4) "Psychological distress at exposure to internal or external reminders of the event"

Rating distress in an infant or preschool child has been difficult at times because of their lack of verbal expressive ability. Scoring this item is mainly dependent on behavioral observations of distress.

This item was often confused with item C(1), avoidance of things that reminded the subject of the traumatic event. When an infant was noted to refrain from certain activities which appeared related to the trauma, the question for raters was, did the infant become distressed at a reminder and then avoid the reminder, or was it avoidance without distress before a distress reaction could be activated?

For the purpose of using these criteria, it is assumed that distress occurs first and then, logically, the child acts to avoid the reminder. However, either item can only be

rated if there is outward evidence of each. Avoidance is considered to be a second-level, or more severe type of reaction. This thinking is consistent with research that has consistently shown that the avoidance and numbing of responsiveness cluster is the one that is relatively more rare, i.e., present in only the most severe subjects. When a child shows outward signs of distress when confronted with a reminder, this item should be rated as present. If a child behaves by avoiding reminders and shows distress, then both this item and the C(1) item are coded. What if a child shows avoidance without showing distress? Then, only C(1), should be rated as present.

Example:

Greg, introduced under item B(1), was three years old when he witnessed his mother kill his father. During a drunken quarrel his mother picked up a hammer and smashed the father's face. Greg went to live with a foster family. "Nine months after the killing, mother stood trial...and was released on probation...When Greg went to live with his mother alone his play became much more disturbed. He indicated his fear and anxiety by re-enacting some of the aggressive games which had been a feature of his early sessions and which had since subsided." In this case, the clinician would need to inquire about the time course as to whether the new presence of his mother served as a reminder of the traumatic event (Hendriks, Black, & Kaplan, 1993).

Emily was 17 months old at the time she was discovered to have been physically abused. She had second degree burns on both feet and lower legs from being lowered into hot water, and fractures of both bones in her right forearm. The perpetrator was a boyfriend of the mother. She was symptomatic from the start but was not assessed until she was 27 months old. One of her symptoms was that she developed a dislike of taking baths. (MS). This case in particular highlights the issue of whether this behavior is "distress at a reminder" or "avoidance." Careful history is needed to know whether Emily avoids the bathroom calmly and consciously versus becomes distressed when her mother tries to bathe her.

B(5) "Physiological reactivity on exposure to internal or external reminders"

The same principles apply as above for B(4). The evidence for this item must come from the typical physiological reactions of sweat, hands or legs shaking, heart pounding, shortness of breath, knot in the stomach, or urinating on oneself. Some of these behaviors can be visually observed, but others can only be known if the caregiver physically touched the child for an examination.

C. Numbing of responsiveness/ Avoidance. One item needed.

C(1) "Avoidance of thoughts or conversations associated with the trauma"

C(2) "Avoidance of activities, places, or persons associated with the trauma"

See also the discussion under item B(4) about the confusion with "distress at reminders".

Examples:

Gabrielle, introduced under item B(1), was a 37-month-old , African-American female at the time it was discovered she had recently been sexually abused. She accused the mother's boyfriend of putting his penis in her mouth. He also allegedly put

ketchup on Gabrielle's body and licked it off of her. Among other symptoms, she frequently asked, "Where's (boyfriend's name)?" Mother's impression was that Gabrielle seemed to be asking because she was anxious and did not want to see him. If she heard someone in the house talk about the abuse, she stopped what she was doing and stared at the talker. Then she held her head down and walked off. Other times she would make a loud noise with a toy to drown out the conversation. This was seen repeatedly in the evaluation sessions. Whenever the topic switched to the abuse, Gabrielle changed what she was doing. She then played with a toy steering wheel that had a siren driven by a hand crank. She wound the hand crank to make the siren sound until the topic was changed (MS).

Antoine and Andre' were 28-month-old identical African-American twins when they witnessed their father shoot and kill their mother. They entered therapy when they were 35 months old for severe behavioral difficulties that had developed after the trauma. On a couple of occasions in therapy sessions, they avoided looking at a photo of their mother when it was presented to them, saying, "No, no", and pushed it away (MS).

C(3) "Inability to recall an important aspect of the trauma"

This item refers to psychogenic amnesia due to psychological blocks to recalling painful memories. This is not coded as present if children with relatively undeveloped verbal or cognitive skills simply cannot relate a coherent narrative of the event. We have never observed this item in preschool children. Our leading hypothesis to explain the absence of this symptom is that it does not occur in this age group due to the still emerging cognitive and language capacities. However, it is plausible that it has existed but could not be detected because it is such an internalized construct and is difficult to assess in this age group.

C(4) "Constriction of play"

This is modified wording of the DSM-IV symptom "loss of interest in significant activities." This has been one of the most infrequently coded items. It is suspected that this may be due to lack of details in the history from the caregiver rather than true absence of the symptom. The child may have constriction of play and still have play reenactment of the trauma.

C(5) "Socially more withdrawn"

This is modified wording of the DSM-IV item "detachment or estrangement from others." This item has been infrequently coded in our cases. It's most likely that it is because of lack of detail in the history taking rather than an absence of the behavior. Clinicians need to gather details about the child's social behavior with multiple interactive partners.

Example:

Isaac was a 38-month-old boy when he witnessed his mother being held at knifepoint and terrorized for several hours by her boyfriend. Mother was cut in the forehead and bled profusely on herself and the sofa. Among other symptoms, he became socially more withdrawn, spending time sitting by himself and not playing with other children (MS).

C(6) "Restricted range of affect"

The same caveat for C(4) applies here, in that the item has so far been infrequently present which may be due more to the lack of detailed observations from the caregiver.

C(7) “Sense of foreshortened future”

Similar to item C(3), this item has never been observed in our samples of young children. We suspect that this is due to the relatively undeveloped capacity to abstractly think of the long-term future in this age group.

D. Increased arousal. Two items needed.

D(1) "Night waking or difficulty going to sleep which is not related to being afraid of having nightmares or fear of the dark"

This item should not be rated if night waking occurs only in the context of nightmares, because nightmares are coded under item B(2).

This item should not be rated if the difficulty going to sleep is due only to fear of the dark.

Night terrors should be coded under this item. Night terrors are distinguished from nightmares in that the child screams in the midst of sleep. The child is virtually inconsolable. The parent may describe the incident as the child "woke up screaming", but careful history would reveal that the child did not actually wake up except perhaps after several minutes of prodding by the parent. The event is not remembered the next day.

D(2) "Increased irritability, fussiness, temper tantrums, or labile affect"

This is rated only if it is a change from behavior before the event.

D(3) "Decreased concentration"

This is a very infrequently rated item so far, probably due to lack of detail in the histories and/or standardized methods for observing concentration abilities in young children. The challenge of this item is to create clear criteria of what constitutes impaired concentration in infants. At this point, no systematic, attempt has been made to clarify this for clinical purposes.

Example:

Jill was a 47-month-old African-American female when she witnessed her father strangle her mother to death. Jill developed a variety of symptoms in the weeks following the murder. Jill spent the first week at a foster home and then started attending a preschool. "During the first few weeks Jill was in school, the teacher felt that her attention span gradually increased, and her activity level diminished into the average range" (Zeanah & Burk, 1984).

Antoine and Andre', the twins introduced under item C(1), manifested their

concentration difficulties in the course of therapy. In the early therapy sessions, they hardly talked, were overly active, and poorly focused in play. As therapy proceeded, they became more focused, and were able to sit and even listen to stories for prolonged periods of time (MS).

D(4) "Hypervigilance"

This is similar to the adult criteria item and is based largely on behavioral observations.

D(5) "Exaggerated startle response"

The same caveat in D(4) applies here.

EXPERIMENTAL SYMPTOMS:

These symptoms were created out of our empirical research that many infants had the fears, anxiety, and aggression noted below. There is no theoretical construct for the clustering of these items together. They don't seem to fit neatly into other clusters. In our study, all of these items had high frequencies and good interrater reliabilities.

(1) "Loss of acquired developmental skills, especially language regression and loss of toilet training".

This item has been one of the most frequently coded and reliable items.

(2) "New fears, e.g. of toileting alone, of the dark, of strangers, etc."

Fear, or avoidance, of toileting alone and of the dark were the two most common new fears. Fear of the dark at bedtime needs to be distinguished from separation anxiety that is manifest when the child doesn't want to be separated from the caregiver to go to bed.

Examples:
Jasmine, the 19-month-old introduced under item B(1), witnessed her mother's rape. After the incident she showed a new tendency to avoid contact with men regardless of whether they appeared to physically resemble the attacker.

Antoine and Andre', the 35-month-old twins introduced under item C(1), witnessed their father murder their mother. Immediately after the shooting the twins stayed with their great aunt, whom they had never met before, for about one week. Then their maternal grandmother picked them up to live with her in another part of the country. The grandmother reported that initially, the twins were terrified of anyone. When persons approached they would put their hands up to ward them off. When new persons entered the house, they huddled together and hid behind things. They asked their grandmother if she was going to whip them. They were frightened taking baths. These behaviors continued in gradually decreasing forms for at least the next 12

months, along with a fear of the dark at night (MS).

A 27-month-old Caucasian boy was in an automobile accident with his father driving. Their car was broadsided, rolled over, and crashed into a light pole. He and the father suffered only fractures and bruises. They spent several hours in the emergency room having x-rays taken. He had been fearful of doctors before the accident and this persisted. However, the fear generalized to his barber after the wreck. He also became very fearful of anyone taking pictures (it was speculated that this resembled the x-ray process in the emergency room) (CZ).

(3) "New separation anxiety"

Example:

Yolanda was 41-months-old when struck on the head by a bullet while she was riding in the car with her family. She was an innocent victim in a drive-by shooting. She was evaluated at 46 months. Yolanda's clingyness was evident by her initial refusal to allow her mother out of the office. At home, if mom left her, she cried. Mom dealt with this simply by never leaving her. Yolanda was still sleeping in mom's bed because of this (MS).

(4) "New aggression"

Example:

Emily, the youngster first introduced under item B(4), was brought to therapy because her caregiver's main concern was her severe aggression. She attacked people in a way that she appeared to be trying to hurt them. She attacked people she knew and total strangers in an unprovoked fashion. She hit, bit, and scratched. For example, she walked up to unfamiliar children or adults on the street and attacked them vigorously. At night when other people were asleep, she would wake up, walk over to them and hit them in the face. She tried to bite her therapist on the hand at the end of one session with no known provocation. In therapy sessions, when limits were put on her destructiveness, she tried to kick and scratch while fighting back (MS).

F. "Duration of the disturbance at least one month".

This is not a change from the DSM-IV duration requirement.

POSSIBLE ASSOCIATED FEATURES:

Many other symptoms have been noted in cases which did not fit into the above categories and which appeared infrequently. These may indicate co-morbid disorders or associated symptoms.

1. Phobias: of going outside (in a boy who was bitten by a dog outside), of picture-taking.
2. Symptoms of disordered attachment: does not cuddle when held, doesn't acknowledge pain or seek comfort when injured
3. Pressured, staccato-like speech
4. Terror-stricken when reprimanded
5. Eating behaviors: food refusal, refusal of solids, regurgitation,

diminished appetite, weight loss

6. Hand sucking
7. Trichotillomania (pulling out hair)
8. Smeared feces and urinated on walls
9. Self-endangering behavior, such as darting out of the house into the street
10. Cries in sleep
11. Won't allow mother into the bathroom while bathing
12. Hypersomnia

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Date _____ Child _____ ID _____

Respondent _____ Interviewer _____

POSTTRAUMATIC STRESS DISORDER SEMI-STRUCTURED INTERVIEW AND OBSERVATIONAL RECORD FOR INFANTS AND YOUNG CHILDREN

(M.S. Scheeringa & C.H. Zeanah, 1994, version 1.2)

The questions in this interview are for the primary caretaker of the child.
Ask if these traumas occurred at any time in the child's life.

_____ 1. Experienced automobile accident, plane crash.

_____ 2. Attacked by a large animal.

_____ 3. Other man-made disasters (witnessed crashes, fires, etc.)

_____ 4. Experienced or witnessed natural disasters (hurricane, tornado.)

_____ 5. Witnessed another person being beaten, raped, threatened with serious harm, shot at seriously wounded, killed etc.

_____ 6. Suffered physical or sexual abuse.

_____ 7. Has the child ever accused someone of physical or sexual abuse?

_____ 8. Other

Ask the parent if he/she considers the event traumatic for the child. Briefly describe each event below.

		Traumatic?	
Event #	**Month/Year**	**Yes/No**	**Brief Description**

POSTTRAUMATIC STRESS DISORDER CRITERIA

		Alternative Criteria			DSM-IV Criteria		
1. Event established on previous page.	**A. (1) The individual has experienced an event that was traumatic.**	**0**	**1**	**2**	**0**	**1**	**2**
2. Did your child respond at the time of the event by looking very afraid, acting helpless, or very disturbed in some way?	**(2) The child's response showed intense fear, helplessness, horror or disorganized or agitated behavior.**				**0**	**1**	**2**
Now I'd like to ask you how your child reacted after the event. For example…	**B. Reexperiencing symptoms.**						
3…did your child reenact some part of the traumatic event?	**(1) Play reenactment of the trauma.**	**0**	**1**	**2**			
(Distinguish between play reenactments and the compulsive, repetitive, and monotonous posttraumatic play.)							
Record Onset:							
Frequency:							
Duration:							
4…has your child made repeated statements or questions about the event? Did he appear distressed by these?	**Recurrent recollections of the event. (Distress not required for alternative symptom)**	**0**	**1**	**2**	**0**	**1**	**2**
Note: For coding DSM-IV, if play reenactment was endorsed then code yes here.							
Record Onset:	Note if child is distressed or not by the recollection.						
Frequency:							
Duration:							
5…has your child had nightmares about it?	**(2) Nightmares.**	**0**	**1**	**2**	**0**	**1**	**2**
Record Onset:							
Frequency:							
Duration:							
6…did your child appear to have flashbacks, that is for a minute or so acting like the event was	**(3) Episodes with objective features of a flashback or dissociation.**	**0**	**1**	**2**	**0**	**1**	**2**

		Alternative Criteria			DSM-IV Criteria		
happening all over again? **Record Onset:** **Frequency:** **Duration:**							
…or, appear to space out in a daze? **Record Onset:** **Frequency:** **Duration:**							
7…has your child looked really upset because he/she saw or heard something that reminded him/her of what happened? **Record Onset:** **Frequency:** **Duration:**	**(4) Psychological distress at exposure to internal or external reminders of the event.**	**0**	**1**	**2**	**0**	**1**	**2**
8…has your child gotten biologically worked up because of a reminder of the event, such as having a fast heart rate, looking shaky, sweaty, or breathing really fast? **Record Onset:** **Frequency:** **Duration:**	**(5) Physiological reactivity on exposure to internal or external reminders.**	**0**	**1**	**2**	**0**	**1**	**2**
Since the event…	**C. Numbing of responsiveness and avoidance**						
9…has your child tried to avoid hearing conversations about it? **Record Onset:** **Frequency:** **Duration:**	**(1) Avoidance of thoughts, feelings, or conversations associated with the trauma.**	**0**	**1**	**2**	**0**	**1**	**2**
10…or tried to avoid places, persons, or things connected to the event? **Record Onset:**	**(2) Avoid activities, places, or people associated with the trauma.**	**0**	**1**	**2**	**0**	**1**	**2**

Frequency:

Duration:

		Alternative Criteria				DSM-IV Criteria			
11…has your child been unable to remember only a certain part of the trauma?	**(3) Inability to recall an important aspect of the trauma.**					**0**	**1**	**2**	
…does your child play less than before?	**(4) Constriction of play. DSM-IV: Markedly diminished interest or participation in significant activities**	**0**	**1**	**2**		**0**	**1**	**2**	
Record Onset:									
Frequency:									
Duration:									
12…has your child been more withdrawn and less sociable than before?	**(5) Socially more withdrawn. DSM-IV: Feelings of detachment or estrangement from others.**			**0**	**1**	**2**		**0**	**1** **2**
Record Onset:									
Frequency:									
Duration:									
13…has your child shown less emotion than usual?	**(6) Restricted range of affect.**			**0**	**1**	**2**		**0**	**1** **2**
Record Onset:									
Frequency:									
Duration:									
14…has your child seemed to you like there was nothing to look forward to in the future?	**(7) Sense of foreshortened future.**					**0**	**1**	**2**	
Record Onset:									
Frequency:									
Duration:									
Since the trauma…	**D. Hyperarousal symptoms.**								
15…has your child had a hard time going to bed or falling asleep?	**(1) Night waking or difficulty going to sleep which are not related to being afraid of having nightmares or**	**0**	**1**	**2**		**0**	**1**	**2**	

fear of the dark.

Record Onset:

Frequency:

Duration:

		Alternative Criteria			DSM-IV Criteria		
16…has your child shown increased irritability, fussiness, extreme mood swings, or temper tantrums?	**(2) Increased irritability, fussiness, labile affect (or temper tantrums for alternative criteria).**	**0**	**1**	**2**	**0**	**1**	**2**
17…has your child had more difficulty concentrating on things than he use to?	**(3) Decreased concentration.**				**0**	**1**	**2**
18…has your child seemed watchful or on guard even when there was no reason to be?	**(4) Hypervigilance.**				**0**	**1**	**2**
19…were there times when your child got scared or very upset when he heard a sudden noise, or if someone came up from behind him when he didn't know they were coming?	**(5) Exaggerated startle response.**	**0**	**1**	**2**	**0**	**1**	**2**

Record Onset:

Frequency:

Duration:

ASSOCIATED SYMPTOMS:

20…did your child lose some skills that he had learned before? Did he lose toileting skills, become	**(1) Loss of acquired developmental skills, especially language regression and loss of toilet training.**	**0**	**1**	**2**			

mute, or lose some speech skills?

Record Onset:

Frequency:

Duration:

		Alternative Criteria			DSM-IV Criteria
21…has your child become afraid of things he didn't used to be afraid of? Such as fear of toileting alone, of the dark, of strangers, or other things?	**(2) New fears.**	**0**	**1**	**2**	

Record Onset:

Frequency:

Duration:

22…has your child been upset when he had to be separated from his mother a lot more than he use to be?	**(3) New separation anxiety.**	**0**	**1**	**2**	

Record Onset:

Frequency:

Duration:

23…has your child been a lot more aggressive than he use to be?	**(4) New aggression.**	**0**	**1**	**2**	

Record Onset:

Frequency:

Duration:

24. Has your child been bothered by most of these things for as long as a month? **0** **2**

DISABILITY AND DISTRESS QUESTIONS

After all those questions, the items that seem to be present include (list all the endorsed symptoms).
Now I'm going to ask you a series of about 5 questions to see if these behaviors get in the way of doing things in everyday life.

25. Because of these behaviors (may need to list them again), do they get in the way of being able to function within your family? I mean, do they prevent your child from being able to do things with the family, like go out to eat, go to the store, go on outings (may use other examples)? Or do they get in the way with activities in the house, like examples may be that they prevent him from doing chores, get dressed, clean up, take baths, or do fun activities with the family?

A lot of the time	**3**
Some of the time	**2**
Hardly ever or none	**1**

26. Because of these behaviors (may need to list them again), does that prevent your child from being able to do things with other children like playing, keeping friends, spend the night, go on outings (may use other examples)?

A lot of the time	**3**
Some of the time	**2**
Hardly ever or none	**1**

27. Because of these behaviors (may need to list them again), do you know if your child's teacher gets annoyed? Has the teacher ever said anything to you about your child being a problem in the class?

A lot of the time	**3**
Some of the time	**2**
Hardly ever or none	**1**
Not applicable	**-8**

28. Do you (the child's caregiver) get annoyed because of these behaviors (may need to list them again)? I mean does it cause you distress? Do they affect the quality of the times you spend with your child?

A lot of the time	**3**
Some of the time	**2**
Hardly ever or none	**1**

29. And last, do you think that these behaviors (may need to list them again) cause your child to feel upset? I mean, do they cause your child to feel emotionally bad inside, like feel bad about himself, or cry, or just seem real upset because of these things?

A lot of the time	**3**
Some of the time	**2**
Hardly ever or none	**1**