

University of New Orleans  
**ScholarWorks@UNO**

---

University of New Orleans Theses and  
Dissertations

Dissertations and Theses

---

12-15-2006

## Which Events Constitute Criteria A1 of PTSD? The Phenomenology of Psychological Trauma in Youth

Leslie Katherine Taylor  
*University of New Orleans*

Follow this and additional works at: <https://scholarworks.uno.edu/td>

---

### Recommended Citation

Taylor, Leslie Katherine, "Which Events Constitute Criteria A1 of PTSD? The Phenomenology of Psychological Trauma in Youth" (2006). *University of New Orleans Theses and Dissertations*. 505.  
<https://scholarworks.uno.edu/td/505>

This Thesis is protected by copyright and/or related rights. It has been brought to you by ScholarWorks@UNO with permission from the rights-holder(s). You are free to use this Thesis in any way that is permitted by the copyright and related rights legislation that applies to your use. For other uses you need to obtain permission from the rights-holder(s) directly, unless additional rights are indicated by a Creative Commons license in the record and/or on the work itself.

This Thesis has been accepted for inclusion in University of New Orleans Theses and Dissertations by an authorized administrator of ScholarWorks@UNO. For more information, please contact [scholarworks@uno.edu](mailto:scholarworks@uno.edu).

**Which Events Constitute Criteria A1 of PTSD?  
The Phenomenology of Psychological Trauma in Youth**

**A Thesis**

**Submitted to the Graduate Faculty of the  
University of New Orleans  
in partial fulfillment of the  
requirements for the degree of**

**Master of Science  
in  
Applied Developmental Psychology**

**by**

**Leslie Katherine Taylor**

**B.S., University of Georgia 2002**

**December 2006**

## Table of Contents

List of Tables .....	iii
Abstract.....	iv
Introduction.....	1
Traumatic Experiences in Youth.....	3
The Impact of Traumatic Experiences in Youth .....	7
The Proposed Investigation.....	10
Hypotheses of the Investigation .....	12
Method .....	12
Results .....	18
Discussion.....	23
References.....	30
Tables .....	36
Appendix A .....	53
End Notes.....	60
Vita .....	61

**List of Tables**

<b>Table 1.....</b>	<b>36</b>
<b>Table 2.....</b>	<b>37</b>
<b>Table 3.....</b>	<b>38</b>
<b>Table 4.....</b>	<b>39</b>
<b>Table 5.....</b>	<b>40</b>
<b>Table 6.....</b>	<b>41</b>
<b>Table 7.....</b>	<b>42</b>
<b>Table 8.....</b>	<b>43</b>
<b>Table 9.....</b>	<b>44</b>
<b>Table 10.....</b>	<b>45</b>
<b>Table 11.....</b>	<b>46</b>
<b>Table 12.....</b>	<b>47</b>
<b>Table 13.....</b>	<b>48</b>
<b>Table 14.....</b>	<b>49</b>
<b>Table 15.....</b>	<b>50</b>
<b>Table 16.....</b>	<b>51</b>
<b>Table 17.....</b>	<b>52</b>

## Abstract

The aim of this study was to explore the phenomenology of psychological trauma in youth. It was hypothesized that events reported as traumatic could be classified into one of seventeen trauma categories, that levels of impairment in traumatized youth would be higher than levels of impairment in non-traumatized youth, and that traumatic events reported would be differentially related to Posttraumatic Stress Disorder (PTSD) symptoms and types of cognitive errors. Information regarding traumas and PTSD symptoms was collected through The *Child PTSD Checklist* from a sample of youth aged 6 to 17. A coding system was developed for classification of traumatic events. The expression symptom and impairment levels were evaluated through parent and child report. The coding system had Cohen's Kappas ranging from .78-1.00. Findings indicate that traumatized youth demonstrate higher levels of impairment than non-traumatized youth, and that traumatic events are not differentially related to PTSD symptoms or cognitive errors.

## Introduction

Research suggests that traumatic events are prevalent in youth (Costello, Erkanalli, Fairbank, & Angold, 2002; Cuffe et al., 1998). As an example, findings from a sample of youth (N=1420) aged 9 to 16 indicate that 25% of youth have experienced an exceptionally stressful event (e.g. death of a loved one, rape, or serious illness) by the time they reach 16, and that 30% experienced a substantially stressful event (e.g. parental divorce, changed schools, loss of best friend as a result of moving) within three months of being surveyed (Costello et al., 2002). Research suggests that experiences specified as exceptionally stressful (e.g. death of a loved one, rape, or serious illness) by Costello and colleagues (2002) are similar to those considered traumatic by adolescents and young adults. Findings from a sample (N=490) of youth aged 16 and 22 suggest that the experience of specific events (i.e., experiencing rape or sexual abuse, witnessing a serious accident, medical emergency) are associated with increased risk of developing Posttraumatic Stress Disorder (Cuffe et al., 1998).

Posttraumatic Stress Disorder (PTSD) manifests in response to the experience of a traumatic event [*The Diagnostic and Statistical Manual of Mental Disorders* (4<sup>th</sup> edition, text revision) *DSM-IV-TR*, American Psychiatric Association, 2000]. The *DSM-IV-TR* (2000) text revision characterizes a traumatic event as an experience that involves threatened death or severe injury to an individual, or witnessing an individual experience threatened death or severe injury (Criterion A1). The *DSM-IV-TR* (2000) text revision also specifies that an individual must respond to that event with intense fear, helplessness, or horror (Criterion A2). Criteria B, C, and D are the three symptom clusters for the disorder. Symptoms from Cluster B include re-experiencing or intrusive remembering of the traumatic event, symptoms from Cluster C include avoidance and numbing of responsiveness, and symptoms from Cluster D include increased

arousal (e.g. difficulty concentrating or an exaggerated startle response). An individual has to evidence one symptom from Cluster B, three symptoms from Cluster C, and two symptoms from Cluster D for at least a month (Criterion E) and experience distress or impairment as a result of these symptoms (Criterion F) in order to meet diagnostic criteria for PTSD.

Research indicates that symptoms of PTSD manifest differently in children and adolescents than in adults (Cohen & Mannarino, 2004; Shaw, 2000; Yule, 2001). For example, research regarding PTSD symptoms in adults suggests that individuals demonstrating partial PTSD, or fewer symptoms from each symptom cluster than necessary for The *Diagnostic and Statistical Manual of Mental Disorders* (4<sup>th</sup> ed. [DSM-IV], American Psychiatric Association, 1994) diagnosis of the disorder, display a lesser degree of impairment than those meeting full criteria for PTSD (Breslau, Lucia, & Davis, 2004). However, research indicates that children and adolescents having sustained a trauma and experiencing PTSD symptoms but not meeting full criteria for the disorder [i.e. two of the three symptom clusters required for *DSM-IV* (1994) fourth edition diagnosis of PTSD] report levels of impairment from PTSD symptoms similar to youth reporting symptoms from all three clusters (Carrion, Weems, Ray, & Reiss, 2002).

The *DSM-IV-TR* (2000) text revision offers consideration for children's responses to traumatic events through notations within Criteria A and B. Specifically, *DSM-IV-TR* (2000) text revision notation within Criterion A2 specifies that children may respond to traumatic events through disorganized or agitated behavior. Notation within Criteria B indicates that children's re-experiencing symptoms may manifest through repetitive play which reenacts the traumatic event, or through recurrent upsetting dreams about the traumatic event. Although the *DSM-IV-TR* (2000) text revision specifies developmental differences in terms of reactions to traumatic events or expression of re-experiencing symptoms, it does not provide consideration for children

with respect to Criterion A1, which is the experience of a traumatic event. Notation within the *DSM-IV-TR* (2000) indicates specific types of events that might be found traumatic in adulthood (e.g. violent personal assault, motor vehicle accidents, witnessing death); however, no specification is offered regarding the types of events that might constitute Criterion A1 stressors in youth. Given that meeting Criterion A1 is essential for a diagnosis of PTSD, this raises the question, “Which types of events do children and adolescents find traumatic?” Garnering information about types of events experienced as traumatic by youth might help develop an empirical definition of events that are traumatic and associated with the expression of PTSD symptoms in this population. In the following section, types of events that research suggests as “traumatic” in youth are reviewed.

### **Traumatic Experiences during Childhood**

Research suggests that specific types of events are traumatic in youth. For example, experiences of sexual or physical abuse during childhood have been widely researched as traumatic events and abused children are considered to be at high risk for developing PTSD (Cohen, Berliner, & Mannarino, 2003; Davis & Siegel, 2000; Shaw, 2000). In a clinical sample of children and adolescents (N=163) with histories of either physical abuse, sexual abuse, or both, Kiser and colleagues report (1991) that 55% of these youth develop symptoms of posttraumatic stress (Kiser, Heston, Millsap, & Pruitt, 1991). Findings by Ackerman and colleagues (1998) further suggest that forms of abuse can constitute a Criterion A1 stressor for PTSD in youth (Ackerman, Newton, McPherson, Jones, & Dyman, 1998). Ackerman et al. (1998) sampled children aged 7 to 13 (N=204) with past histories of abuse. From this sample, 23% of boys and 42% of girls with past histories of sexual abuse (n=127) met criteria for PTSD based on their scores on the revised Diagnostic Interview for Children and Adolescents (DICA).



Twenty-seven percent of boys and 40% of girls with histories of physical abuse (n=43) met diagnostic criteria for PTSD based on their DICA scores. Children with past histories of sexual and physical abuse (n=34) demonstrated the highest incidence rates for PTSD. For children with past histories of both forms of abuse, 46% of boys and 30% of girls met diagnostic criteria for PTSD based on DICA scores (Ackerman et al., 1998). In sum, results reported by Kiser et al. (1991) and Ackerman et al. (1998) suggest that the experience of one or more forms of abuse constitutes a traumatic event in childhood, and that a history of abuse is associated with the phenomenology of PTSD in youth.

Other events types of events researched as traumatic for youth include exposure to community violence (Stein et al., 2003; Berton & Stabb, 1996; Seedat, Njeng, Vythilingum, & Stein, 2004). When Stein and colleagues (2003) interviewed six graders (N=127) from an inner city area about the prevalence of violent events in their community, 76% of the children reported witnessing violence that involved weapons (e.g. knives or gun), and the sample reported scores on The *Child PTSD Symptom Scale* indicative of moderate to severe levels of posttraumatic stress (Stein et al., 2003). Research suggests that high school aged youth exposed to the same forms of community violence as the six graders from the Stein et al. (2003) study also report high PTSD symptom levels (Berton & Stabb, 1996; Seedat, Njeng, Vythilingum, & Stein, 2004). Sixty percent of South African youth (N=2041) aged 14 to 22 reported witnessing violence in the street, in their neighborhood, or at school (Seedat et al., 2004). In addition, 34% of these youth reported being robbed or mugged, and 22% of youth sampled met full *DSM-IV* (1994) fourth edition diagnostic criteria for PTSD (Seedat et al., 2004). Taken together, findings by Stein et al. (2003) and Seedat et al. (2004) suggest that witnessing violence events or being directly victimized by violent events can constitute a Criterion A1 event across a wide age range youth.

Surviving natural disasters in childhood or adolescence is also associated with the development of posttraumatic stress symptoms in youth. For example, findings suggest that youth displaced from their homes as a result of hurricanes evidence high levels of PTSD symptoms (Lonigan, Shannon, Taylor, Finch, & Sallee, 1994; La Greca, Silverman, Vernberg, & Prinstein, 1996). As an example, Lonigan et al. (1994) surveyed youth aged 9 to 16 (N=) and found that those who were displaced from their homes as a result of Hurricane Hugo were at increased risk for expressing PTSD symptoms from more than one of the *DSM-III-R* (1987) third edition, revised, PTSD symptom clusters than youth who were not displaced. Findings also suggest that factors such as loss and disruption following natural disasters are associated with the sequelae of posttraumatic stress symptoms (LaGreca et al., 1996). La Greca and colleagues (1996) sampled third-, fourth-, and fifth-graders (N=442) surviving Hurricane Andrew and found that loss and disruption as a result of the storm were associated with the expression of PTSD symptoms up to ten months after the disaster.

With respect to other types of disastrous events, refugee youth are report high PTSD symptom levels. Papageorgiou and colleagues (2000) examined levels of PTSD symptoms in a sample (N=95) of young refugees from the Bosnian War between aged 8 to 13. Roughly 30% of youth report scores on the Impact of Events Scale indicative of PTSD diagnoses, and 64% of youth sampled reported separation from their families during the war as a traumatic experience (Papageorgiou et al., 2000). Ajdukovic (1998) reports similar findings from a sample (N=45) of refugees between the ages of 14 and 19. Posttraumatic stress reactions were intensely present in 28.6% of youth sampled. In addition, 66.7% of the sample reported having a family member sent to fight in the war as a traumatic event (Ajdukovic, 1998). Taken together, findings by Papageorgiou et al. (2000) and Ajdukovic (1998) indicate that exposure to war and factors

precipitated by war (i.e., displacement from family members) are potentially traumatic events in youth.

Motor vehicle accidents have been examined as potentially traumatic events in youth. McDermott and Cvitanovich (1999) interviewed children surviving motor vehicle accidents aged 8 to 13 (N=26). Twenty-two percent of youth sampled reported scores on the Posttraumatic Stress Disorder-Reaction Index (PTSD-RI) suggesting a clinical diagnosis of PTSD according to *DSM-IV* (1994) fourth edition criteria for the disorder (McDermott & Cvitanovich, 1999). Findings by Keppel-Benson et al. (2002) further suggest that experience of motor vehicle accidents as potentially traumatic in youth (Keppel-Benson, Ollendick, & Benson, 2002). In a sample of motor vehicle accident survivors aged 7 to 16 (N=50), Keppel-Benson et al. found that 14% of children met full criteria for PTSD nine months after the accidents, and 96% of the children met criteria for at least one *DSM-III-R* (1987) third edition symptom cluster for the disorder. Findings from this sample also suggest that severity of physical injuries sustained as a result of the motor vehicle accident (i.e. the more severe the physical injury) predict expression of more post-traumatic stress symptoms (Keppel-Benson et al., 2002).

In sum, research suggests that types of experiences or events during youth such as abuse, exposure to community violence, natural disasters, and separation or loss of family members can result in the expression of PTSD symptoms (Ackerman et al., 1998; Kiser et al., 1991; Berton & Stabb, 1996; Seedat et al., 2004; Lonigan et al., 1994; LaGreca et al., 1996; Papageorgiou et al., 2000; Ajdukovic, 1998). In addition, a number of other events have also been hypothesized as potentially traumatic events in youth. These events include physical neglect (i.e. denying the child shelter or proper medical care), physical trauma (i.e. being burned, breaking a limb, sprains), emotional abuse (i.e. belittling the child or denying s/he affection), and other types of

potentially traumatic events (Rodriguez-Srednicki & Twaite, 2004a, Richmond, Thompson, Deatrick, & Kauder, 2000; Blakeney, Robert, & Meyer, 1998; Rodriguez-Srednicki & Twaite, 2004b). However, less is known about the relative impact of physical neglect, physical trauma, or emotional abuse as potentially traumatic events compared to events more generally considered as traumatic, and as meeting Criterion A1. For example, the *DSM-IV-TR* (2000) makes a distinction between types of traumas; implying that certain forms of trauma might be more likely to result in PTSD than others. It is not clear if these types of traumas are associated with similar or different levels of trauma related impairment. The type of trauma experienced might be differentially related to the expression of PTSD symptoms and impairment. In the next section, levels of impairment associated with different types of traumatic events in youth are reviewed.

### **The Impact of Traumatic Experiences in Youth**

Experiencing a traumatic event may lead to other symptoms or impairment; not just PTSD symptoms. Specifically, the impact of trauma during youth is associated with symptoms or diagnoses of other psychiatric disorders. Findings from a sample of traumatized youth aged 7 to 16 suggest that the expression of posttraumatic stress symptoms is often associated with symptoms or diagnoses of separation anxiety or specific phobia (Keppel-Benson et al., 2002). Research regarding youth with histories of abuse also supports the association between PTSD symptoms and symptoms of other anxiety disorders. Examination of the prevalence of psychiatric disorders in a sample of youth with histories of physical abuse, sexual abuse, or both, suggests that approximately 50% of these youth (N=204) report high symptom levels of separation anxiety disorder (Ackerman et al., 1998).

In addition to displaying anxious and depressive symptoms, youth with PTSD symptoms demonstrate impaired ability to function in academic and social settings when compared to their

non-traumatized contemporaries. Findings by Saigh and colleagues (2002) suggest differences in the prevalence of specific behaviors and levels of impairment in a sample of traumatized and nontraumatized youth aged 7 to 19. This sample was divided into of three groups: youth who had experienced traumatic events and displayed PTSD symptoms (PTSD positives, N=24), youth who had experienced traumatic events and did not display PTSD symptoms (PTSD negatives, N=50), and youth who had not experienced traumatic events and did not display PTSD symptoms (controls, N=30). Participants' scores on the Child Behavioral Checklist (CBCL) suggested that youth who had experienced traumatic events and displayed PTSD symptoms evidenced higher scores on the Social Problems, Attention Problems, and Other Problems subscales when compared to the other two groups. In addition, youth who had experienced a traumatic event and displayed PTSD symptoms scored higher on the Aggressive Behaviors scale of the CBCL when compared to the remainder of the sample. Moreover, traumatized youth displaying symptoms of PTSD reported higher levels of impairment as well as a variety of other symptoms compared to traumatized youth without symptoms of the disorder or to non-traumatized contemporaries.

The *DSM-IV-TR* (2000) text revision suggests that manifestation of PTSD symptoms is related to changes in cognitive processes. For example, the *DSM-IV-TR* (2000) text revision describes the phenomena of “omen formation,” or the ability to foresee the occurrence of future untoward events, and the belief that one will not reach adulthood, as characteristics of childhood PTSD (p. 466). The *DSM-IV-TR* (2000) text revision indicates that intrusive cognitions or thought patterns are associated with re-experiencing symptoms. Notation within the *DSM-IV-TR* (2000) text revision implies that the experience of traumatic events and the expression of PTSD symptoms during youth might be associated with impaired cognitive functioning. In addition,

research suggests that traumatized youth do not perform as well on cognitive tasks as non-traumatized youth. As an example, Moradi and colleagues (1999) examined differences in cognitive factors in a sample of traumatized (N=18) and non-traumatized (N=22) youth aged 11 to 17. Participants were administered a memory task (i.e. *The Rivermead Behavioral Memory Test*) originally used to identify memory deficits in patients with brain injuries. From this sample, 78% of youth with a diagnosis of PTSD reported scores on *The Rivermead Behavioral Memory Test* suggesting impaired memory compared to 13% of contemporaries without the disorder (Moradi, Neshat-Doost, Taghavi, Yule, & Dalgleish, 1999). Although the *DSM-IV-TR* (2000) suggests that changes in cognition may manifest with onset of PTSD, and research has examined the extent of memory impairment in youth with PTSD, the extent to which different types of traumas are differentially associated with cognitive impairment in youth has been less widely researched.

Researchers have examined the extent to which certain cognitive processes predict aspects of childhood internalizing symptoms (Leitenburg; Yost, Carroll-Wilson; 1986; Weems, Berman, Silverman, & Saavedra, 2001; Weems, Silverman, Rappee, & Pina, 2003). For example, findings suggest that catastrophizing, a specific type of cognitive error, was the strongest predictor of anxiety in a sample of youth aged 6 to 17 (N=251) whereas selective abstraction was more predictive of depressive symptoms (Weems et al., 2001). A trend in this research is to focus upon the relationship between certain cognitive processes and their differential relation with anxiety versus depression in youth. This research implies differential associations among anxious and depressive symptoms and various cognitive processes. Given that trauma is associated not only with PTSD symptoms, but with symptoms of anxiety and depression, different types with traumatic experiences may be differentially related to anxious

and depressive symptoms and possibly different cognitive processes. For example, the death of a loved one might be relatively more associated with depressive symptoms and cognitive errors such as selective abstraction, whereas surviving a natural disaster might be relatively more associated with anxious symptoms and catastrophizing. Exploring differential associations among types of traumatic events and cognitive errors might therefore provide important information about the impact of certain events.

### **The Proposed Investigation**

The *DSM-IV-TR* (2000) text revision as well as findings by Costello et al. (2002) implies that there are differences in the magnitude of various types of traumatic events. Specifically, the *DSM-IV-TR* (2000) text revision indicates intensity and an individual's physical proximity to the potential stressor as factors that contribute to the likelihood of developing PTSD. Costello et al. (2002) posits developmental differences as the determinants of the magnitude of potentially traumatic events. For example, Costello and colleagues (2002) points toward the idea that events widely researched as Criterion A1 stressors in adulthood might not encompass the types of events constituting Criterion A1 stressors in youth. Although Costello et al. (2002) examined the prevalence of potentially traumatic events in youth, these researchers did not investigate how the experiences of these different types of events relate to the phenomenology of PTSD in terms of expression of PTSD symptoms, or symptoms associated with the phenomenology of the disorder. Moreover, the sample employed by Costello and colleagues (2002) for conducting their investigation offers limited generalizability of findings. Given that the sample used for this study was primarily composed of rural youth, and included little representation of minority groups, further examination of the types of traumatic events prevalent in a more ethnically

diverse sample is in order; as this sample would offer a more comprehensive depiction of traumatic events prevalent in youth.

The aim of this study was to expand upon findings such as those by Costello et al. (2002) by examining the phenomenology of traumatic events in an ethnically diverse sample of urban youth. Specifically, the overall purpose of this study was to garner information about the types of experiences youth report as traumatic in order to develop a more empirical definition of trauma within this population. Information about these types of traumatic experiences was collected through self report. A coding system was devised as a means of classifying the types of traumatic events reported. Independent coders classified types of traumatic events through this coding system, and the inter-rater reliability of these coders was assessed.

Additional aims of this study were to expand upon findings by Saigh et al. (2002) by examining the relationship between traumatic experiences and the degree of impairment expressed by youth reporting traumatic experiences. Specifically, youth sampled were evaluated for the presence of internalizing and externalizing behaviors, anxious and depressive symptoms, academic and social problems, and cognitive biases.

In sum, the aims of this study were the following: (1) to examine the types of experiences reported as traumatic by youth and formulate a coding system by which these events could be categorized, (2) to evaluate the level of impairment experienced by youth reporting traumatic events through replication of findings by Saigh et al. (2002), and (3) to investigate the differential association among traumatic events and the presence of PTSD symptoms, and the differential association among traumatic events and cognitive errors.



## **Hypotheses of the Investigation**

1. Experiences youth report as traumatic can be reliably classified into one of seventeen proposed categories. Analyses of the psychometric properties of the Child PTSD Checklist are presented with findings regarding coding reliability.
2. Youth reporting traumatic events and meeting symptom cluster criteria for PTSD (i.e. PTSD positives) will demonstrate higher levels of impairment than youth reporting trauma who do not meet criteria for the disorder (i.e. PTSD negatives) or non-traumatized youth (i.e. controls).
3. Various types of traumatic experiences will be differentially related to PTSD symptoms and cognitive errors.

## **Method**

### Participants

Data was collected for this study as part of the Youth and Family, Anxiety Stress, Phobia Laboratory. Data was drawn from 211 parents and their children. Participants received a small monetary reward for each child who participated in the study. The sample was composed of 107 females and 104 males (N=211) between the ages of 6 and 17 with a mean age of 11.43. In terms of ethnicity, 46% of sample was Caucasian, 39.3% African American, 7.1% Hispanic, 1.7% Asian, and 4.7% were of other ethnic backgrounds. Twenty-eight percent of the sample reported household incomes ranging from 0-11,999; 13.8%, 12,000-20,999; 8.9%, 21-30,999; 5.7%, 31,000-40,999; 19.5%, 41,000-50,999; and 24.4% over 51,000.

### Measures

**Demographics.** The parent/legal guardian was asked to report demographic information on themselves and their children. Questions asked included the child and parent's age, gender,

ethnicity, socioeconomic status, and education level. Information was also collected on the participating child's family (e.g., age and gender of any siblings, parental marital status, and parental work status).

**Measurement of Traumatic Experiences and Posttraumatic Stress Symptoms.** The *Child PTSD Checklist* was used to record self-reported traumas and PTSD symptoms (Amaya-Jackson, McCarthy, Newman, & Cherney, 1995). The questionnaire records up to three self-reported traumas and includes a 28-item checklist for assessment of PTSD symptoms. Checklist items are based upon symptom criteria (e.g. symptoms for clusters B, C, and D) specified in *DSM-IV* (1994) fourth edition. The rating scale for prevalence of symptoms is as follows: “not at all,” “some of the time,” “most of the time,” or “all of the time.” Evidence of good test-retest reliability, internal consistency, and construct validity has been reported by Amaya-Jackson and colleagues (2000). Coefficient alphas have been reported ranging from 0.91-0.72 (Amaya-Jackson et al., 2000). In terms of reliability analyses, internal consistency estimates of the *Child PTSD Checklist* for our sample (n=123), by age group, and gender are presented in Table 1. Cronbach's alpha for the total number of items on the questionnaire range from .88 to .90 across gender and groups and are in within the range of estimates reported by Amaya-Jackson and colleagues (2000).

**The Coding of Self-Reported Traumatic Experiences.** Types of traumatic experiences were recorded through The *Child PTSD Checklist*. A copy of coding instructions and category descriptions can be found in Appendix A.

Given that *DSM-IV-TR* (2000) text revision points toward intensity of and physical proximity to a traumatic event as factors predicting the development of PTSD, coders were required to provide ratings for the psychological intensity and physical severity of events

reported. Coding instructions include directions for how to assign intensity and severity ratings and provide example ratings for particular events. Intensity and severity ratings were assigned to each reported trauma (see Table 2 for reliability estimates).

A group of coders was provided with instructions for coding traumas and trained on which types of events belong to particular categories. Coder agreement was examined through Cohen's Kappa, and the data files were examined for accuracy of placement of events into categories. Kappa coefficients for youth reporting traumatic events are presented in Table 3.

The *Child PTSD Checklist* records up to three self-reported traumas (Amaya-Jackson et al., 1995). Two independent coders were given one data file with the first self-reported traumas to be coded. Another pair of independent coders was given two data files to code: (1) a data file with the second self reported trauma and (2) a data file with the third self reported trauma. Coder agreement was analyzed every forty cases. Meetings were held with coders when discrepancies in category agreement for specific events occurred, and decisions were made regarding appropriate categorization of events. Inter-rater reliability of coders is presented in the result section.

The rating scale for responses to the checklist is “not at all,” “some of the time,” “most of the time,” or “all of the time,” and evidence of a symptom was considered to be a response of “most of the time” or “all of the time” to a questionnaire item. Given that an aim of this study is to replicate findings by Saigh et al. (2002) regarding comparison of traumatized and non-traumatized youth, The *Child PTSD Checklist* was also used to delineate three groups of individuals in this sample (1) youth reporting traumatic events and PTSD symptoms (i.e. if the child reported experiencing the symptom “most” or “all of the time”), (2) PTSD negatives (i.e. if the child reported a traumatic event, but reported experiencing symptoms “none” or “some of the

time”), and (3) controls (i.e. the child reporting neither a traumatic event nor PTSD symptoms occurring “none,” “some,” “most,” or “all of the time”). Thus, PTSD positives reported at least one trauma classified in trauma categories other than miscellaneous, and met *DSM-IV-TR* (2000) symptom criteria by reporting symptom prevalence of “most of the time” or “all of the time” for one symptom from Cluster B, three symptoms from Cluster C, and two symptoms from Cluster D. PTSD negatives reported a traumatic event, but did not report symptom prevalence required for a *DSM-IV-TR* (2000) diagnosis of the disorder. Control participants did not report traumas or presence of PTSD symptoms.

**Measurement of Anxious and Depressive Symptoms.** The *Revised Child Anxiety and Depression Scale* (RCADS) is a 47-item adaptation of the Spence Children’s Anxiety Scale and was used to assess symptoms of anxiety disorders other than Posttraumatic Stress Disorder (RCADS; Chorpita, Yim, Moffitt, Umemoto, & Francis 2000; Spence, 1997). The RCADS is comprised of subscales assessing symptoms of Separation Anxiety Disorder, Generalized Anxiety Disorder, Panic Disorder, Specific Phobia, Obsessive-Compulsive Disorder, and Major Depression. A total anxiety score is computed from all the items assessing symptoms of anxiety disorders. The RCADS has good reliability and validity estimates (Chorpita, et al., 2000). Internal consistency estimates for the RCADS range from .92 to .97 (Weems, Zakem, Costa, Cannon, & Watts, 1996). Estimates from this sample fall within this range, .93-.94. Convergent validity estimates of the RCADS with the RCMAS have been shown to range from .77-.94 (Weems et al., 2006). As presented in Table 4, convergent validity estimates for the RCADS and RCMAS from our sample are below this range, .62-.72, but correlations among the RCADS and RCMAS are significant at  $p < .05$ . For the purposes of this study, the RCADS was employed as

a means of assessing symptoms associated with various anxiety disorders across reported traumatic experiences. Symptoms were recorded through child and parent report.

The *Revised Children's Manifest Anxiety Scale* (RCMAS; Reynolds & Richmond, 1978) was used to assess trait anxiety. The RCMAS is a widely used and well researched 37-item scale designed to assess general anxiety in children. Responses to twenty-eight of the items on the scale are summed to yield a Total Anxiety score. The RCMAS includes three factor sub-scales: Worry-Oversensitivity, Physiological, and Concentration. The other nine items comprise the social desirability or "lie" sub-scale. The RCMAS has been found to have satisfactory reliability and validity estimates (Reynolds & Richmond, 1978). Internal consistency estimates range from 0.83-0.87. The parent version of the RCMAS (RCMAS-P) has similar validity estimates (Pina, Silverman, Saavedra, & Weems, 2001). For the purposes of this study, the three factor subscales of the RCMAS were employed as a means of assessing child anxiety across trauma categories. Symptoms were recorded through child and parent report.

**Measurement of Other Symptoms.** The *Child Behavioral Checklist* (CBCL; Achenbach, 1991) is a caregiver report measure that consists of rating scales used to assess symptoms of behavioral and emotional problems in children and adolescents. In addition to providing a total problems score, this measure provides subscale scores for internalizing symptoms and other specific behavior problems. The CBCL has been found to have extensive reliability and validity estimates (Achenbach, 1991; 2001). Coefficient alphas have been reported ranging from 0.96 and 0.89 for the Internalizing, Externalizing, and Total scales, respectively. Coefficient alphas have been reported ranging from 0.70-0.92 for the syndrome scales (Achenbach, 1991). With respect to this research design, the CBCL was used as a means

of assessing parent report of child aggressive, academic and social behaviors; anxious and depressive symptoms; and withdrawn, internalizing, externalizing symptoms.

**Measurement of Cognitive Sequelae.** The *Children's Negative Cognitive Error Questionnaire* was used to assess cognitive errors (CNCEQ; Leitenberg, Yost, & Carroll-Wilson, 1986). The CNCEQ is a 24-item questionnaire which has been designed to assess cognitive distortions. This questionnaire includes subscales for each of the four major forms of distortions (i.e. catastrophizing, overgeneralization, personalizing, and selective abstraction). Each subscale consists of six questions. Items on the questionnaire are composed of hypothetical vignettes as well as a possible negative interpretation of events described in the vignette. Individuals evaluate their responses to questions by indicating how closely events described coincide with their own thought processes. Good internal consistency, test-retest reliability, and construct validity estimates of the CNCEQ have been reported (Leitenberg et al., 1986; Thurber, Crow, Thurber, & Woffington, 1990). Coefficient alphas have been reported ranging from 0.60- 0.71 for Total scores and Subscale Scores, respectively. This measure was used to assess the extent to which traumatic events were differentially related to cognitive errors.

### Procedure

Participants were recruited through psychology classes at the University of New Orleans. Participant interviews took place at the Youth Anxiety, Stress, and Phobia Laboratory, located on campus at the University of New Orleans. Parents completed questionnaires regarding demographic information, their child's levels of anxiety and depression, and their child's behavior. Children completed questionnaires regarding traumatic experiences and PTSD symptoms, levels of anxiety and depression, and their behavior. In order for both parties to feel comfortable providing honest and accurate responses to questionnaires, parents and children

completed interviews in separate areas of the lab. Research assistants read questionnaires to children who did not know how to read or had difficulty reading. Research assistants were in the laboratory during assessments in order to answer questions pertinent to the measures employed.

## **Results**

### *Hypothesis 1*

Kappa coefficients (Cohen, 1960) were computed to estimate the inter-rater reliability for the categories. From the total sample (N=211), 67 females and 59 males (n=123) reported experiencing a traumatic event. Kappa coefficients for the portion of the sample reporting traumas (n=123) are presented in Table 3 (i.e. the first reported experience, the second reported experience, the third reported experience). Kappa coefficients ranged from .78-1.00, with percent agreement ranging from 95-100% across the three reported traumas. Categories for which five or more events were reported are presented by age group in Table 5. Reliability coefficients ranged from .69-1.00 with percent agreement ranging from 93-100% youth between the ages 6-12. The range of coefficients for youth between the ages of 13 and 17 is .77-1.00, and percent agreement ranges from 95-100%. The difference in coefficient range across age groups may be due to ambiguity of event reporting by younger children. Kappa coefficients are presented by gender in Table 6. Kappa coefficients across girls range from .77-1.00 with percent agreement among coders ranging from 94-100%. Kappa coefficient's across for boys range from .86-1.00 with percent agreement among coders ranging from 95-100%. Across age and gender, Kappa coefficients and percent agreement indicate good estimates of inter-rater reliability.

Inter-rater agreement for physical severity and psychological intensity ratings were analyzed through intraclass coefficient correlations (ICCs). Ratings for the youth reporting trauma (n=123), by age group, and gender are presented in Table 2. Overall ICCs across age and

gender evidence good reliability estimates for physical severity and psychological intensity ratings.

Investigation of the psychometric properties of the *Child PTSD Checklist* symptom items was performed through reliability and validity analyses. Reliability analysis by age and gender for symptom cluster items and total items indicate good internal consistency estimates overall and point toward relative developmental sensitivity of the measure.

With respect to the convergent validity of the checklist, correlation coefficients were computed among the *Child PTSD Checklist* and measurement of symptoms associated with the phenomenology of PTSD (e.g. anxious, depressive, internalizing and externalizing symptoms). Correlation coefficients for the youth reporting traumatic events (n=123) are presented in Table 4. Results indicate that levels of PTSD symptoms assessed by the checklist are significantly associated with parent and child report of anxious and depressive symptoms. Results from analyses by age group indicate that total checklist scores for children in both age groups are significantly correlated with child report of anxious and depressive symptoms as presented in Table 7 (ages 6-12) and Table 8 (ages 13-17). Results from analyses by gender indicate that total checklist scores are correlated with measures of manifest anxiety, symptoms of other anxiety disorders and depression (see Table 9 for girls and Table 10 for boys).

### *Hypothesis 2*

It was hypothesized that youth reporting trauma and meeting *DSM-IV-TR* (2000) text revision symptom cluster criteria for PTSD would report higher levels of impairment compared to traumatized youth not meeting *DSM* criteria for the PTSD and non-traumatized youth. Prior to testing this hypothesis, the sample was divided into three groups of individuals: (1) PTSD positives (i.e. reported a trauma and met *DSM* criteria for the disorder by reporting the



experience of one symptom “most” or “all of the time,” from Cluster B, three symptoms from Cluster C and two symptoms from Cluster D), (2) PTSD negatives (i.e. youth reporting traumas, but reporting the experience of symptoms “none” or “some of the time”), and (3) controls (i.e. youth reporting neither trauma nor symptoms occurring “none,” “some,” “most,” or “all of the time”). Chi square analyses were conducted on each of the demographic variables across the three groups and are presented in Table 11. Results indicated no differences across groups in terms of gender or ethnicity among the three groups, but revealed significant differences for income ( $X^2 = 19.16, p < .05$ ) and age [ $F(2, 193) = 6.78, p = 0.001$ ]<sup>1</sup>.

The means of CBCL total and subscales across groups are presented in Table 12. The differences in means of CBCL scores indicate differences in impairment level across PTSD positives, PTSD negatives, and the control group. To further investigate the differences across the three groups, a series of one way analyses of variances (ANOVAs), were conducted with group (i.e. PTSD positives, negatives, and controls) as the independent variables and CBCL total and subscale scores as the dependent variables performed separately. As shown by Table 12, there were significant differences between the groups on Total Problems scores [ $F(2, 193) = 8.82, p < 0.05$ ], Internalizing [ $F(2, 193) = 6.05, p < 0.05$ ], Externalizing [ $F(2, 193) = 4.84, p < 0.05$ ], Somatic Complaints [ $F(2, 193) = 7.14, p < 0.05$ ], Anxious/Depressed [ $F(2, 193) = 3.07, p < 0.05$ ], Social Problems [ $F(2, 193) = 3.61, p < 0.05$ ], Thought Problems scores [ $F(2, 193) = 14.68, p < 0.05$ ], Attention Problems [ $F(2, 193) = 5.10, p < 0.05$ ], and Delinquent Behaviors [ $F(2, 193) = 4.83, p < 0.05$ ] subscales. Independent samples *t* tests were run to further examine significant differences between groups and are presented in Table 13. As shown by Table 13, the tests indicate that PTSD positives evidence significantly higher Total Problems, Internalizing, Externalizing, Somatic Complaints, Social Problems, Thought Problems, Attention Problems,

and Delinquent Behaviors subscales than PTSD negatives. Tests indicate that PTSD positives evidenced significantly higher scores on Total Problems, Internalizing, Externalizing, Anxious/Depressed, Thought Problems, Attention Problems, and Delinquency Behaviors than controls. Tests further indicate no significant differences between PTSD negatives and control groups on Total Problems, Internalizing, Externalizing, Anxious/Depressed, Attention Problems, and Delinquent Behaviors subscale scores. Results indicate significant differences [ $t(172) = 2.82, p = .005$ ] between PTSD negative and control groups on Thought Problems subscales of the CBCL.

To further investigate impairment level across groups, additional ANOVAs with parent and child measures of anxious and depressive symptoms were performed separately. Means scores on these measures are presented in Table 14. There were significant differences between groups on scores of RCADS Child Anxiety [ $F(2, 186) = 10.25, p < .05$ ], RCADS Child Depression [ $F(2, 186) = 11.18, p < .05$ ], RCADS Parent Anxiety [ $F(2, 197) = 4.45, p < .05$ ], RCADS Parent Depression [ $F(2, 197) = 5.70, p < .05$ ], and the RCMAS Child [ $F(2, 194) = 10.39, p < .05$ ] and RCMAS Parent [ $F(2, 191) = 10.05, p < .05$ ]. Independent samples  $t$  tests were run to further examine significant differences between groups and are presented in Table 15. As shown by Table 15, the tests indicate that PTSD positives evidence significantly higher on parent and child measures of anxious and depressive symptoms than PTSD negatives. Tests indicate that PTSD positives evidenced significantly higher scores on parent and child report measures of anxious and depressive symptoms than controls. Tests further indicate no significant differences between PTSD negatives and control groups on parent and child measures of anxious and depressive scores.

### *Hypothesis 3*

Prior to testing whether or not various types of traumatic experiences were differentially related to PTSD symptoms and cognitive errors, a trauma grouping variable was created. From the traumas reported (the *Child PTSD Checklist* records up to three traumas), the trauma with the highest severity and intensity ratings was grouped into one of the seventeen trauma categories. Categories with at least five cases made up the trauma grouping variable. Chi square analyses were conducted on each of the demographic variables across the categories that made up the trauma grouping variable and are presented in Table 16. Result indicated no differences across categories in terms of gender, ethnicity, or income.

To test whether types of traumatic experiences are differentially related to PTSD symptom expression and cognitive errors, a series of one way analyses of variances (ANOVAs) were conducted with the trauma grouping variable as the independent variable and PTSD total and symptom cluster scores, and CNCEQ total and subscale scores as the dependent variables performed separately. Means and standard deviations for categories are presented in Table 16. As shown by Table 16, there were no significant differences across types of traumas in terms of symptom expression (i.e. Cluster B, C, and D symptoms and total symptoms scores), indicating that type of trauma is not differentially related to the expression of PTSD symptoms. There were no significant differences across types of traumas for cognitive errors (i.e. total and subscale scores on the CNCEQ), indicating that type of trauma is not differentially related to expression of negative cognitive errors.

## Discussion

Findings from this study add to existing research on psychological trauma by indicating the types of events traumatic to youth, the prevalence of posttraumatic stress symptoms in youth reporting traumas, and the prevalence of other associated symptoms evidenced by youth reporting traumatic events. In addition, results indicate that types of events reported as traumatic by youth are not differentially related to expression of posttraumatic stress symptoms or cognitive errors. These findings suggest that the type of traumatic event experienced might not be predictive of the kind of posttraumatic stress symptoms or cognitive errors expressed.

With respect to the types of events reported as traumatic by youth, findings from this study indicate that experiences relative to witnessing community violence, entertainment violence, separation and loss events, and motor vehicle accidents are some of the most prevalent traumas in youth. Given the nature of our sample, types of traumatic events reported were also presented in terms of age and gender. The most frequently reported types of traumatic events (i.e., witnessing community violence, entertainment violence, separation and loss events, and motor vehicle accidents) were prevalent across age and gender. In terms of age related trends in the type of traumatic event reported, physical traumas were more frequently reported by children aged 6 to 12 than by aged 13 to 17. This is consistent with findings regarding the prevalence of younger children being referred to emergency rooms for injuries related to falls while at play (American Academy of Pediatrics, 2001). There were relatively no differences in events reported as traumatic experiences across gender.

Report of experiences categorized by our coding system as miscellaneous events (e.g., nightmares, drug abuse, and psychological problems) were prevalent across youth sampled. The frequency of reported experiences classified in the miscellaneous category suggests that there

might be types of experiences considered as traumatic by youth that have not been widely researched as such events. For example, youth sampled by Costello et al. (2002) reported pregnancy (i.e., either becoming pregnant or getting someone pregnant), changing schools, or parent job loss as traumatic events. According to our coding system, these events would be categorized as miscellaneous events. In as much, this attempt to categorize self-reported traumatic events indicates that experiences of trauma are subjective. Moreover, findings from this sample point toward individual differences in types of events considered traumatic by youth.

Though experiences categorized as miscellaneous events were prevalent across youth sampled for this study, there were trends in the types of miscellaneous events reported relative to age. Children aged 6 to 8 were more likely to report nightmares as traumatic events than older children. Youth aged 13 to 18 were more likely to report psychological problems (e.g., depression, or eating disorders), self-injurious behaviors (i.e., cutting themselves, or suicide attempts), and the effects of experimentation with drugs, or delinquency (e.g., skipping or cutting school, acts of neighborhood vandalism) as traumatic experiences than those below the age of 13.

With respect to further implications of findings regarding the types of events youth perceive as traumatic, it should be noted that exposure to media violence was frequently reported as a traumatic event by youth in our sample. While report of experiencing or witnessing interpersonal violence has been widely researched as a traumatic event in youth, exposure to media violence has not been researched as a Criterion A1 event in childhood. Almost 25% of youth (n=29) from this sample who reported at least one event that could be placed in the media/entertainment violence trauma category. Reports of traumas placed in this trauma category were not dependent upon age. Interestingly, of those youth reporting at least one

media/entertainment trauma, almost half (n=13) were aged 12 or older. A focus of research on the topic of youth and media violence is to examine the relationship of youth exposure to violent television programming, movies, and video games to acts of aggression (Anderson et al., 2003). Findings from this sample suggest that another way to untangle the relationship between exposure to media violence and its effects on children's behavior is to explore the impact of these events as potential psychological traumas in youth.

In addition to indicating the frequency of specific types of potentially traumatic events in youth, the coding system for classifying traumatic events evidences good reliability estimates. Given that many tools (i.e., *PTSD Reaction Index for DSM-IV*; Rodriguez et al., 1999; *Clinician-Administered PTSD Scale for Children and Adolescents*; CAPS-CA; Nader et al., 1996; the *Child PTSD Checklist*; Amaya-Jackson et al., 1995) utilized for assessing levels of posttraumatic stress in youth include a query regarding traumatic events experienced, further use of this coding system offers a way to compile this type of youth self-report data. Coder agreement across physical severity and psychological intensity ratings suggests that the utility of the coding system extends beyond categorization of traumatic events. These rating scales might be helpful in terms of assessing proximity and severity (i.e., Criterion A2) of children to events that may constitute Criterion A1 stressors in youth. Findings from this study also support the clinical utility of The *Child PTSD Checklist* across a wide age range and ethnically diverse sample of youth. Internal consistency estimates of the measure as well as convergent validity of The *Child PTSD Checklist* with parent and child report of anxious and depressive symptoms support clinical efficacy of this measure for assessment of posttraumatic stress symptoms in youth.

Findings from this study are consistent with existing research regarding the phenomenology of PTSD in traumatized youth (Ackerman et al., 1998; Keppel-Benson et al.,

2002; Saigh et al., 2002). Consistent with findings by Saigh et al. (2002), youth in PTSD positive group evidenced significantly higher Total Problems, Internalizing, Externalizing, Somatic Complaints, Social Problems, Thought Problems, Attention Problems, and Delinquent Behaviors scales than PTSD negatives. Although we did not find significant differences between PTSD positives and negatives on the Anxious/Depressed scale, results from our sample indicate that the PTSD positive group demonstrated higher scores on RCADS and RCMAS parent and child report measures of anxious and depressive symptoms than the PTSD negative group. Our findings are in line with existing research which suggests an association between high levels of trait anxiety (i.e., high RCMAS scores) and the development of childhood PTSD (Davis & Siegel, 2000). Moreover, results from this study are consistent with findings regarding the manifestation of associated symptoms with the expression of PTSD symptoms in youth. PTSD positives reported higher levels of anxious and depressive symptoms, and this is line with existing research regarding the phenomenology of PTSD in youth (Ackerman et al., 1998; Davis & Siegel; Keppel-Benson et al., 2002).

In addition, our findings regarding comparison of PTSD negatives and controls (i.e. groups were not significantly different Total Problems, Internalizing, Externalizing, Anxious/Depressed, Attention Problems, and Delinquent Behaviors subscale scores than controls) were similar to those reported by Saigh et al. (2002). Our findings indicate significant differences in scores on the Thought Problems scales of when comparing PTSD negative and control groups. This might be due to fact that our data came from a community sample rather than from a sample of clinically referred youth, and differences in tools used to assess posttraumatic stress symptoms.

An aim of this study was to examine differential relationships among traumatic experiences relative to the phenomenology of PTSD symptoms and changes in cognition. Our findings do not suggest that type of traumatic event experienced results in the specificity of the kind of PTSD symptoms (i.e., those from B, C, or D) or type of cognitive errors expressed by youth who report traumas and evidence PTSD symptoms. Although these results are contrary to our hypothesis, the implications of our findings point toward the idea that level of impairment underscores a possible relationship among type of event experienced and the expression of PTSD symptoms or cognitive errors. In other words, significant levels of impairment (i.e., expression of PTSD symptoms and symptoms of other anxiety disorders and depression) are associated with reactions to psychological trauma in youth, and the impact of these responses psychological trauma effect's children's ability to function.

Findings from this study cannot be considered without limitation. Youth sampled were from the community and were not administered clinical interviews as part of our study. Clinical interviews would have pointed toward and provided more information about why the reported event was traumatic to the child. Although results regarding internal consistency and validity estimates of The *Child PTSD Checklist* indicate utility of this measure for assessing posttraumatic stress levels in youth, the checklist does not indicate the time frame of the reported trauma. Our sample was not queried about the duration of the symptom disturbance, and *DSM-IV-TR* (2000) text revision criteria specify that symptoms persist for at least a month. Given that a response of "some of the time," to a checklist item was not considered symptom presence for the purposes of our study, clinical interviews may have better distinguished youth meeting symptom criteria for the disorder.



Future research regarding childhood trauma might include further exploration of the types of events considered traumatic in youth and the true phenomenology of psychological trauma in youth. Although our results indicate that the coding system developed to classify traumatic events in youth is reliable, events reported as traumatic by youth in our sample might not be reliable. Specifically, given that youth sampled were not extensively queried about the nature of the reported experience, youth might have been reporting cues or events that occurred just prior to or as a response to the actual trauma. However, given that findings by Papageorgiou et al. (2000) suggest a significant association between the number of traumatic events experienced and the number of PTSD symptoms expressed, it might be that youth from our sample reported events that could be considered risk factors for developing the disorder.

For example, it is plausible to consider the types of miscellaneous events reported by adolescents in our sample as evidence of exposure to risk factors for the development of posttraumatic stress symptoms. Research posits poor parental monitoring as a factor that contributes to delinquency in youth (Pettit, Laird, Dodge, Bates, & Criss, 2001; Parker & Benson, 2004; Coley, Morris, & Hernandez, 2004). Given that these youth are left to explore their communities by themselves, it is reasonable to suggest that delinquent youth are at increased risk of being exposed to community violence, becoming part of deviant peer groups, and performing acts of vandalism. In as much, youth from our sample who reported delinquent acts may be at risk for developing the PTSD as a result of the contextual factors.

Other types of miscellaneous events reported by youth as traumatic include experiences of substance use, self-injurious behavior, and psychological problems (i.e., depression, eating disorders). Report of substance use might be another example of youth events associated with the experience of a trauma rather than the experience of the actual trauma. The National Center

for Post-Traumatic Stress Disorder suggests that drug use, cutting, or depression are reactions to trauma, and it is also possible that when asked if they had experienced a traumatic event, youth from this sample reported coping responses to traumatic events (Ruzek, 2006).

Comparison of symptoms across clinical and community samples might further indicate risk factors for PTSD as well as differences in the impact of certain types of events in youth. Existing research suggests that circumstances that occur as a consequence of a traumatic event can also increase the likelihood for developing the disorder. For example, in a sample of children surviving Hurricane Hugo, Lonigan et al. (1994) report that children whose parents lost jobs as a result of the hurricane are more likely to develop PTSD than children of parents who were able to keep their jobs. In as much, it is possible that youth from our sample may have reported cues or consequences of a traumatic experience rather than the actual trauma, and further investigation of traumatic events and events surrounding them might point toward identification of risk factors for developing PTSD in youth.

## References

- Achenbach, T.M. (1991). *Manual for the Child Behavior Checklist/4-18 and 1991 profile*.  
Burlington, VT: University of Vermont Department of Psychiatry.
- Achenbach, T.M., & Rescorla, L.A. (2001). *Manual for ASEBA School-Age Forms and Profiles*.  
Burlington, VT: University of Vermont, Research Center for Youth, Children,  
and Families.
- Ackerman, P.T., Newton, J.E.O., McPherson, W.B., Jones, J.G., & Dykman, R.A. (1998).  
Prevalence of posttraumatic stress disorder and other psychiatric diagnoses in three  
groups of abused children (sexual, physical, and both). *Child Abuse and Neglect*, 22(8),  
759-794.
- Adjudukovic, M. (1998). Displaced adolescents in Croatia: Sources of stress and posttraumatic  
stress reaction. *Adolescence*, 33(129), 209-218.
- Amaya-Jackson, L., McCarthy, G., Newman, E., & Cherney, M.S. (1995). *Child PTSD  
Checklist*: Durham, North Carolina. Duke University Medical Center.
- Amaya-Jackson, L., Newman, E., Lipschitz, D., Davis, K., Billingslea, E., Ymanis, N.  
(2000, October). The Child and Adolescent PTSD Checklist in Three Clinical Populations.  
*New Methods and Practice in Assessing Posttraumatic Stress Disorder*. In V. Carrion  
(Chair). Symposium conducted at the Annual meeting of American Academy of Child and  
Adolescent Psychiatry, New York, NY.
- American Pediatric Association (2001). Fall from heights, windows, roofs, and balconies.  
*Pediatrics*, 107 (5), 1188-1191.
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental  
disorders* (4<sup>th</sup> edition). Washington, DC: Author.

- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4<sup>th</sup> ed., text revision). Washington, DC: Author.
- Anderson, C.A., Berkowitz, L., Donnerstein, E., Huesmann, R. Johnson, J.D., Linz, D. Malamuth, N.M., Wartella, E. (2003). The influence of media violence on youth. *Psychological Science in the Public Interest* 4(3), 81-110.
- Berton & Stabb (1996). Exposure to violence and posttraumatic stress disorder in urban adolescents. *Adolescence*, 122 (31), 489-499.
- Blakeney, P., Robert, R., & Meyer, W. (1998). Psychological and social trauma recovery of children disfigured by physical trauma: Elements of treatment supported by empirical data. *International Review of Psychiatry*, 10 (3), 196.-201.
- Breslau, N., Lucia, V.C., & Davis, G.C. (2004). Partial PTSD versus full PTSD: An empirical examination of associated impairment. *Psychological Medicine*, 34, 1205-1214.
- Carrion, V.G., Weems, C.F., Ray, R., & Reiss, A. (2002). Toward a more empirical definition of pediatric PTSD: The phenomenology of PTSD symptoms in youth. *Journal of the American Academy of Child and Adolescent Psychiatry*, 40(2), 166-173.
- Chorpita, B.F., Yim, L., Moffitt, C., Umemoto, L.A., & Francis, S.E. (2000). Assessment of symptoms of DSM-IV anxiety and depression in children: A revised child anxiety and depression scale. *Behaviour Research and Therapy*, 38(8), 835-855.
- Cohen, J. (1960). A coefficient agreement for nominal scales. *Educational and Psychological Measurement*, 20, 37-46.
- Cohen, J.A., Belinger, L. & Mannarino A.P. (2003). Psychosocial and pharmacological interventions for child crime victims. *Journal of Traumatic Stress*, 16 (2), 175-186.

- Cohen, J.A. & Mannarino, A.P. (2004). Posttraumatic Stress Disorder. In T.H. Ollendick and J.S. March (Eds.), *Phobic anxiety disorders in children and adolescents* (pp. 405-427). New York, NY: Oxford University Press.
- Coley, R.L., Morris, J.E., & Hernandez, D. (2004). Out of care and problem behavior trajectories among low income adolescents: Individual, family, and neighborhood characteristics as added risks, *Child Development* 25 (3), 948-965.
- Costello, J.E., Erkanalli, A., Fairbank, J.A., & Angold, A. (2002). The prevalence of potentially traumatic events in childhood and adolescence. *Journal of Traumatic Stress*, 15(2), 99-112.
- Cuffe, S.P., Addy, C.L., Garrison, C.Z., Waller, J.L., Jackson, K.L., McKeown, R.E. et. al. (1998). Prevalence of PTSD in a community sample of older adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry*, 37, 147-154.
- Davis & Seigel (2000). Posttraumatic stress disorder in children and adolescents: A review and analysis. *Clinical Child and Family Review*, 3 (3), 135-154.
- Keppel-Benson, J.M., Ollendick, T.H., & Benson, M. (2002). Post-traumatic stress in children following motor vehicle accidents. *Journal of Child Psychology and Psychiatry*, 43 (2), 203-212.
- Kiser, L.J., Heston, J., Millsap, P.A., Pruitt, D.B. (1991). Physical and sexual abuse in childhood: Relationship with posttraumatic stress disorder. *Journal of the American Academy of Child and Adolescent Psychiatry*, 30(5), 776-783.
- La Greca, A.M., Silverman, W.K., Vernberg, E.M., & Prinstein, M.J. (1996). Symptoms of posttraumatic stress in children after Hurricane Andrew: A prospective study. *Journal of Consulting and Clinical Psychology*, 64 (4), 712-723.

- Leitenberg, H., Yost, L. W., & Carroll-Wilson, M. (1986). Negative cognitive errors in children: Questionnaire development, normative data, and comparisons between children with and without self-reported symptoms of depression, low self-esteem, and evaluation anxiety. *Journal of Consulting and Clinical Psychology, 54*, 528-536.
- Lonigan, C.J., Shannon, M.P., Taylor, C.M., Finch, A.J., & Sallee, F.R. (1994). Children exposed to disaster: II. Risk factors for the development of the post-traumatic symptomatology. *Journal of the American Academy of Child and Adolescent Psychiatry, 33* (1), 94-105.
- McDermott, B.M. & Cvitanovich, A. (2000). Post-traumatic stress disorder and emotional problems in children following motor vehicle accidents: An extended case series. *Australian and New Zealand Journal of Psychiatry, 34*, 446-452.
- Moradi, A. R., Neshat-Doost, H. T., Taghavi, M. R., Yule, W. & Dalgleish, T. (1999). Everyday memory deficits in children and adolescents with PTSD: Performance on the Rivermead Behavioral Memory Test. *Journal of Child Psychology and Psychiatry, 40*(3), 357-361.
- Nader, K.O., Kriegler, J.A., Blake, D.D., Pynoos, R.S., Newman, E., Weather, F.W. (1996), *Clinician administered PTSD Scale, Child and Adolescent Version*. White River Junction, VT: National Center for PTSD.
- Papageorgiou, V., Frangou-Garunovic, A., Ioranidou, R., Yule, W., Smith, P., & Vostanis, P. (2000). War trauma and psychopathology in Bosnian refugee children. *European Child & Adolescent Psychiatry, 9*, 84-90.
- Parker, J. S. & Benson, M. J. (2004). Parent-adolescent relations and adolescent functioning: Self-esteem, substance abuse, and delinquency. *Adolescence, 39* (155), 519-530.

- Pettit, G.S., Laird, R.D., Dodge, K.A., Bates, J.E., & Criss, M. M. (2001). Antecedents and behavior-problem outcomes of parental-monitoring and psychological control in early adolescence, *Child Development, 72*(2), 583-598.
- Pina, A., Silverman, W.K., Saavedra, L.S., & Weems, C.F. (2001). An analysis of the RCMAS lie scale in a clinic sample of anxious children. *Journal of Anxiety Disorders, 15*, 443-457.
- Reynolds, C. R., & Richmond, B. O. (1978). What I think and feel: A revised measure of children's manifest anxiety. *Journal of Abnormal Child Psychology, 6*, 271-280.
- Richmond, T.S., Thompson, H.J., Deatrck, J.A., Kauder, D.R. (2000). Journey towards recovery following physical trauma. *Journal of Advanced Nursing, 32* (6), 1340-1348.
- Rodriguez-Srednicki, O. & Twaite, J.A. (2004a). Understanding and reporting child abuse: Legal and psychological perspectives: Part One: Physical abuse, sexual abuse, and neglect. *The Journal of Psychiatry and the Law, 32*, 315-359.
- Rodriguez-Srednicki, O. & Twaite, J.A. (2004b). Understanding and reporting child abuse: Legal and psychological perspectives: Part two: Emotional and secondary abuse. *The Journal of Psychiatry and the Law, 32*, 443-481.
- Ruzek, J. (2006). *The national center for PTSD: Coping with PTSD and Recommended Lifestyle Changes for PTSD Patients*. Retrieved October, 26, 2006, from the United States Department of Veterans Affairs, The National Center for PTSD Web site:<http://www.ncptsd.va.gov/index.html>
- Saigh, P.A., Yasik, A.E., Oberfield, R.A., Halamandaris, P.V., & McHugh, M. (2002). An analysis of the internalizing and externalizing behaviors of urban youth with and without PTSD. *Journal of Abnormal Psychology, 111*(3), 462-470.

- Seedat, S., Njeng, N.F., Vythilingum, B., & Stein, D.J. (2004). Trauma exposure and posttraumatic stress symptoms in urban African school. *British Journal of Psychiatry*, *184*, 169-175.
- Shaw, J.A. (2000). Children, adolescents, and trauma. *Psychiatric Quarterly*, *71*(3), 227-243.
- Spence S. H. (1997). Structure of anxiety symptoms among children: A confirmatory factor-analytic study. *Journal of Abnormal Psychology*, *106*, 280-297.
- Stein, B.D., Jaycox, L.H., Kataoka, S.H., Wong, M., Tu, W., Elliot, M.N., & Fink, A. (2003). A mental health intervention for schoolchildren exposed to violence. *Journal for the American Medical Association*, *290* (5), 603-611.
- Thurber, S., Crow, L., Thurber, J.A., & Woffington, L.M. (1990). Cognitive distortions and depression in psychiatrically disturbed adolescent inpatients. *Journal of Clinical Psychology*, *46*(1), 57-60.
- Weems, C.F., Berman, S.L., Silverman, W.K., Saavedra, L.M. (2001). Cognitive errors in youth with anxiety disorders: The linkages between negative cognitive errors and anxious symptoms. *Cognitive Therapy and Research*, *25* (5), 559-575.
- Weems, C.F., Silverman, W.K., Rapee, R. M., & Pina, A. A. (2003). The role of control in childhood anxiety disorders. *Cognitive Therapy and Research*, *27* (5), 557-568.
- Weems, C. F., Zakem, A., Costa, N. M., Cannon, M., & Watts, S. (2006). The role of sympathetic arousal in childhood anxiety: Association with symptoms of childhood anxiety disorders and cognitive bias. *Journal of Clinical Child and Adolescent Psychology*.
- Yule, W. (2001). Posttraumatic stress disorder in children and adolescents. *International Review of Psychiatry*, *13*, 194-200.



Table 1. *Internal Consistency of the Child PTSD Checklist*

	Total Items	Cluster B Items	Cluster C Items	Cluster D Items
<b>Cronbach's Alpha</b>				
Total sample (n=123)	.91	.80	.80	.72
<b>Age</b>				
6-12 (n=62)	.90	.78	.77	.73
13-17 (n=61)	.92	.84	.83	.70
<b>Gender</b>				
Females (n=64)	.93	.83	.85	.74
Males (n=59)	.88	.75	.71	.70

Note: Cluster B: Reexperiencing symptoms; Cluster C: Avoidance and Numbing; Cluster D: Hyperarousal.

Table 2. *Physical Severity and Psychological Severity Ratings, Intraclass Correlation Coefficients*

N	Physical Severity	Psychological Intensity
Trauma (n=123)		
1	.88	.90
2	.80	.77
3	.76	.74
Ages 6-12 (n=62)		
1	.90	.89
2	.79	.81
3	.83	.70
Ages 13-17 (n=61)		
1	.86	.90
2	.80	.72
3	.69	.76
Girls (n=64)		
1	.84	.90
2	.77	.72
3	.78	.79
Boys (n=59)		
1	.90	.91
2	.82	.81
3	.74	.68

Table 3. *Frequency and Category Agreement for Reported Traumas*

Trauma Category	Category <i>N</i>	Percent Reported	Kappa	Percent Agreement
Trauma 1 (n=123)				
Witnessing Violence, Family	6	2.8	.89	99
Witnessing Violence, Non-Family	15	7.1	.92	98
Media/Entertainment Violence	22	10.4	.95	98
Separation and Loss, Family	16	7.6	.96	99
Separation and Loss, Non-Family	5	2.4	1.00	100
Physical Neglect, Family	1	0.5	N/A	100
Physical Trauma	7	3.3	N/A	100
Sexual assault, Non-family	1	0.5	N/A	100
Emotional Trauma	4	1.9	N/A	100
Motor Vehicle Accidents	12	5.7	.91	98
Miscellaneous	37	17.5	.86	94
No Reported Trauma	85	40.3	N/A	N/A
Trauma 2 (n=79)				
Witnessing Violence, Family	2	2.5	N/A	100
Witnessing Violence, Non-Family	6	7.4	.84	98
Media/Entertainment Violence	8	9.9	.80	96
Separation and Loss, Family	15	18.5	.92	97
Separation and Loss, Non-Family	1	1.2	N/A	100
Physical Trauma	11	13.6	.89	97
Sexual assault, Non-family	1	1.2	N/A	100
Emotional abuse, Family	1	1.2	N/A	100
Emotional abuse, Non-Family	1	1.2	N/A	100
Motor Vehicle Accidents	8	9.9	.78	96
Natural Disasters	1	1.2	N/A	100
Miscellaneous	26	32.1	.85	95
No reported Trauma 2	42	51.9	N/A	N/A
Trauma 3 (n=49)				
Witnessing Violence, Non-Family	7	14.6	N/A	100
Media/Entertainment Violence	4	8.3	N/A	100
Separation and Loss, Family	6	12.5	1.00	100
Physical Trauma	5	10.4	1.00	100
Sexual assault, Non-family	1	2.0	N/A	100
Emotional abuse, Family	2	4.2	N/A	100
Motor Vehicle Accidents	2	4.2	N/A	100
Natural Disasters	1	2.1	N/A	100
Miscellaneous	20	41.7	.96	98
No reported Trauma 3	34	70	N/A	N/A

Table 4. *Convergent Validity of the Child PTSD Checklist (n=123)*

	1	2	3	4	5	6	7	8	M	SD
1. Child PTSD Checklist									22.22	13.94
2. RCADS Child Anxiety	.64**								64.33	16.84
3. RCADS Child Major Depression	.52**	.78**							16.78	5.03
4. RCADS Parent Anxiety	.27**	.31**	.24**						52.40	10.89
5. RCADS Parent Major Depression	.32**	.17	.18*	.74**					13.60	3.65
6. RCMAS Total Child	.64**	.68**	.60**	.17	.20*				11.09	6.26
7. RCMAS Total Parent	.35**	.34**	.31**	.76**	.72**	.24*			8.10	5.38
8. CBCL Internalizing	.24**	.21*	.22*	.69**	.63**	.09	.74**		52.75	12.04
9. CBCL Externalizing	.22*	.04	.05	.51**	.56**	.08	.60**	.62**	51.72	10.89

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

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

Table 5. *Coder Agreement for Traumas by Age Group*

Trauma Category	Category <i>N</i>	Percent Reported	Kappa	Percent Agreement
Ages 6-12 (n=62)				
Trauma 1				
Witnessing Violence, Non-Family	9	14.5	.87	97
Media Entertainment Violence	15	24.2	1.00	100
Separation and Loss, Family	7	11.3	.91	98
Miscellaneous	22	30.6	.93	97
Trauma 2				
Media Entertainment Violence	5	12.5	.69	93
Separation and Loss, Family	9	22.5	.86	98
Physical Trauma	6	12.5	1.00	100
Miscellaneous	14	32.5	.82	93
Trauma 3				
Witnessing Violence, Non-Family	5	20.0	1.00	100
Miscellaneous	8	32.0	1.00	100
Ages 13-17 (n=61)				
Trauma 1				
Witnessing Violence, Non- Family	6	9.8	1.00	100
Media Entertainment Violence	7	11.5	.86	97
Separation and Loss, Family	9	14.8	1.00	100
Motor Vehicle Accidents	9	14.8	.93	98
Miscellaneous	15	24.6	.77	95
Trauma 2				
Witnessing Violence, Non- Family	5	12.8	.89	97
Separation and Loss, Family	6	15.4	1.00	100
Motor Vehicle Accidents	5	10.3	1.00	100
Miscellaneous	12	30.8	.94	97
Trauma 3				
Miscellaneous	12	52.2	.92	96

Table 6. *Coder Agreement for Traumas by Gender*

Trauma Category	Category <i>N</i>	Percent Reported	Kappa	Percent Agreement
Girls (n=64)				
Trauma 1				
Witnessing Violence, Non-Family	6	9.4	1.00	100
Media/Entertainment Violence	12	18.8	.95	98
Separation and Loss, Family	10	15.6	.94	98
Motor Vehicle Accidents	6	9.4	.82	97
Miscellaneous	19	29.7	.86	94
Trauma 2				
Witnessing Violence, Non-Family	5	12.5	1.00	100
Separation and Loss, Family	7	17.5	.91	98
Physical Trauma	7	15.0	.80	95
Motor Vehicle Accidents	5	12.5	.77	95
Miscellaneous	11	27.5	.88	95
Trauma 3				
Miscellaneous	8	38.1	1.00	100
Boys (n=59)				
Trauma 1				
Witnessing Violence, Non-Family	9	15.3	.94	98
Media/Entertainment Violence	10	16.9	.94	98
Separation and Loss, Family	6	10.2	1.00	100
Motor Vehicle Accidents	6	10.2	1.00	100
Miscellaneous	15	25.4	.86	95
Trauma 2				
Media/Entertainment Violence	5	12.8	.89	97
Separation and Loss, Family	8	20.5	1.00	100
Miscellaneous	14	35.9	.88	95
Trauma 3				
Witnessing Violence, Non-Family	6	22.2	1.00	100
Miscellaneous	12	44.4	.92	96

Table 7. *Convergent Validity of the Child PTSD Checklist, Ages 6-12 (n=62)*

	1	2	3	4	5	6	7	8	M	SD
1. Child PTSD Checklist									25.14	14.45
2. RCADS Child Anxiety	.52**								69.61	18.20
3. RCADS Child Major Depression	.46**	.82**							17.85	5.47
4. RCADS Parent Anxiety	.23	.39**	.31*						53.67	10.49
5. RCADS Parent Major Depression	.28*	.20	.19	.75**					13.58	3.83
6. RCMAS Total Child	.62**	.72**	.65**	.33**	.27*				11.34	6.13
7. RCMAS Total Parent	.25*	.34**	.28*	.73**	.70**	.32*			9.03	5.28
8. CBCL Internalizing	.14	.21	.16	.69**	.59**	.15	.70**		54.56	11.60
9. CBCL Externalizing	.22	.07	.07	.49**	.58**	.08	.65**	.60**	52.85	10.44

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

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

Table 8. *Convergent Validity of the Child PTSD Checklist, Ages 13-17 (n=61)*

	1	2	3	4	5	6	7	8	M	SD
1. Child PTSD Checklist									19.26	12.85
2. RCADS Child Anxiety	.74**								58.88	13.41
3. RCADS Child Major Depression	.54**	.68**							15.67	4.31
4. RCADS Parent Anxiety	.28*	.17	.11						51.08	11.21
5. RCADS Parent Major Depression	.38*	.16	.20	.75**					13.63	3.49
6. RCMAS Total Child	.67**	.72**	.56**	.01	.13				10.83	6.43
7. RCMAS Total Parent	.40**	.21	.26	.79**	.80**	.13			6.89	5.06
8. CBCL Internalizing	.27*	.10	.22	.67**	.70**	.03	.77**		50.85	12.31
9. CBCL Externalizing	.18	-.10	-.04	.52**	.55**	.08	.56**	.62**	50.53	11.30

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

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



Table 9. *Convergent Validity of the Child PTSD Checklist, Girls (n=64)*

	1	2	3	4	5	6	7	8	M	SD
1. Child PTSD Checklist									23.16	15.38
2. RCADS Child Anxiety	.73**								67.73	17.33
3. RCADS Child MajorDepression	.61**	.85**							17.53	5.37
4. RCADS Parent Anxiety	.23	.20	.18						52.86	10.34
5. RCADS Parent MajorDepression	.30*	.12	.20	.70**					13.77	3.16
6. RCMAS Total Child	.68**	.71**	.61**	.13	.18				11.98	6.45
7. RCMAS Total Parent	.35**	.32*	.32*	.76**	.69**	.26*			8.53	5.06
8. CBCL Internalizing	.16	.09	.14	.63**	.56**	.01	.76**		51.56	12.15
9. CBCL Externalizing	.16	-.03	-.02	.49**	.53**	.04	.63**	.62**	51.58	11.46

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

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

Table 10. *Convergent Validity of the Child PTSD Checklist, Boys (n=59)*

	1	2	3	4	5	6	7	8	M	SD
1. Child PTSD Checklist									21.21	12.25
2. RCADS Child Anxiety	.49**								60.57	15.57
3. RCADS Child Major Depression	.36*	.68**							15.95	4.53
4. RCADS Parent Anxiety	.32*	.44**	.31*						51.85	11.58
5. RCADS Parent Major Depression	.36**	.21	.17	.79**					15.95	4.53
6. RCMAS Total Child	.57**	.62**	.56**	.20	.21				10.07	5.92
7. RCMAS Total Parent	.34*	.36*	.29	.77**	.78**	.20			7.55	5.54
8. CBCL Internalizing	.38**	.45**	.38**	.78**	.73**	.25	.77**		54.18	11.87
9. CBCL Externalizing	.31*	.15	.15	.54**	.62**	.16	.58**	.62**	51.89	10.26

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

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

Table 11. *Demographic Variables across PTSD Positives, PTSD Negatives, and Controls*

Demographic Variables	PTSD Positives	PTSD Negatives	Controls	<i>F/X</i> <sup>2</sup>	<i>P</i>
N	22	102	72		
Age: Mean (SD)	11.22 (4.11)	12.25 (3.33)	10.44 (3.14)	6.78	.001
Gender ( <i>n</i> %)				2.24	.33
Girls	15 (65.2)	51 (48.1)	41 (50.0)		
Boys	8 (38.4)	55 (51.9)	41 (50.0)		
Ethnicity ( <i>n</i> %)				6.01	.82
White	10 (43.5)	48 (45.3)	39 (47.6)		
African American	11 (47.8)	40 (37.7)	32 (39.0)		
Hispanic	1 (4.3)	9 (8.5)	5 (6.1)		
Asian	0	4 (3.8)	0		
Other	1 (4.3)	4 (3.8)	5 (6.1)		
Household income ( <i>n</i> %)					
0-11,999	9 (39.1)	28 (27.2)	11 (13.8)	19.16	.04
12,000-20,999	4 (17.4)	12 (11.7)	14 (17.5)		
21,000-30,999	2 (8.7)	8 (7.8)	17 (21.3)		
31,000-40,999	1 (4.3)	6 (5.8)	7 (8.8)		
41,000-50,999	4 (17.4)	22 (21.4)	9 (11.3)		
Over 51,000	3 (13)	27 (26.2)	22 (27.5)		

Table 12. *Means and Standard Deviations of the CBCL Subscales across Groups*

Scale	PTSD Positives		PTSD Negatives		Controls		Univariate	
	M	SD	M	SD	M	SD	<i>F</i>	<i>p</i>
Total	60.96	8.13	51.84	12.29	48.69	12.52	8.82	.000*
Internalizing	59.36	10.21	51.15	12.06	49.15	12.61	6.05	.003*
Externalizing	57.14	7.85	50.45	10.91	49.18	10.79	4.84	.009*
Withdrawn	58.00	8.41	55.01	8.36	54.46	7.00	1.31	.180
Somatic Complaints	61.27	10.16	55.16	6.82	55.28	6.34	7.14	.001*
Anxious/ Depressed	58.86	8.37	55.50	8.30	54.21	6.61	3.07	.049*
Social Problems	59.18	8.79	55.70	6.84	54.53	6.94	3.61	.029*
Thought Problems	62.91	10.64	56.00	8.01	52.89	5.74	14.82	.000*
Attention Problems	62.36	12.48	56.95	8.84	55.21	8.54	5.10	.007*
Delinquent Behaviors	59.77	6.48	54.91	7.35	54.76	6.65	4.83	.009*
Aggressive Behaviors	56.86	8.05	54.67	6.90	53.69	6.42	1.82	.164

\*Significance levels were set at  $p < .05$ .

Table 13. *Groups Comparisons on CBCL subscales*

Scale	PTSD vs. PTSD Negatives		PTSD vs. Controls		PTSD Negatives vs. Controls	
	<i>t</i> (122)	<i>p</i>	<i>t</i> (92)	<i>p</i>	<i>t</i> (172)	<i>p</i>
Total Problems	3.32	.001*	4.32	.000*	1.65	.100
Internalizing	2.97	.004*	3.46	.001*	1.06	.746
Externalizing	2.72	.007*	3.20	.002*	.76	.448
Somatic Complaints <sup>3</sup>	2.67	.001*	3.33	.051	.12	.906
Anxious/ Depressed	1.72	.088	2.71	.008*	1.10	.274
Social Problems	2.06	.042*	2.58	.011*	1.10	.272
Thought Problems <sup>3,4</sup>	3.45	.008*	5.27	.001*	2.82	.005*
Attention Problems <sup>2,3</sup>	2.41	.018*	3.07	.003*	1.30	.196
Delinquent Behaviors	2.87	.005*	3.11	.003*	.14	.892

\*Significance levels were set at  $p < .05$ .

Table 14. *The Prevalence of Associated Symptoms across Groups*

Measures	PTSD Positives		PTSD Negatives		Controls		Univariate	
	M	SD	M	SD	M	SD	F	<i>p</i>
RCADS								
Child Anxiety	78.43	20.42	61.56	14.20	61.93	17.62	10.25	.000*
RCADS								
Child Depression	21.09	6.16	15.90	4.18	16.53	4.83	11.18	.000*
RCADS								
Parent Anxiety	56.50	11.75	51.52	10.45	49.15	9.48	4.45	.013*
RCADS								
Parent Depression	15.54	4.73	13.12	3.22	12.83	3.12	5.70	.004*
RCMAS								
Child Anxiety	16.90	5.34	9.98	5.86	10.26	6.63	10.05	.000*
RCMAS								
Parent Anxiety	12.40	4.83	7.01	5.00	6.76	5.35	10.39	.000*

\*Significance levels were set at  $p < .05$ .

Table 15. *Groups Comparisons on Associated Symptoms*

Measure	PTSD vs. PTSD Negatives		PTSD vs. Controls		PTSD Negatives vs. Controls	
	<i>t</i> (119)	<i>p</i>	<i>t</i> (88)	<i>p</i>	<i>t</i> (172)	<i>p</i>
RCADS Child Anxiety <sup>2</sup>	4.62	.000*	3.67	.000*	-1.50	.881
RCADS Child Depression	4.80	.000*	3.59	.001*	-.90	.370
RCADS Parent Anxiety	2.00	.049*	3.01	.003*	1.54	.124
RCADS Parent Depression	2.93	.004*	3.15	.002*	.61	.543
RCMAS Child Anxiety	5.11	.000*	4.29	.000*	-.30	.766
RCMAS Parent Anxiety	4.41	.000*	4.29	.000*	.32	.752

\*Significance level was set at  $p < .05$ .

Table 16. *Demographic Variables across Trauma Groups*

Demographic Variables	WVF	WVNF	SLF	SLNF	PT	EV	MVA	MIS	<i>F/X<sup>2</sup></i>	<i>p</i>
N	5	14	20	8	11	8	22	32		
Age: Mean (SD)	14(2)	11.43(2.28)	12.45(3.10)	11.75(2.77)	11.91(3.27)	11.38(4.66)	12.86(3.58)	11.47(3.98)	.69	.68
Gender ( <i>n</i> %)									7.23	.41
Boys	1(20)	8(42.90)	7(35)		7(63.60)	3(37.50)	10(45.50)	15(46.90)		
Girls	4(80)	6(57.10)	13(65)		4(36.40)	5(62.50)	12(54.50)	17(53.10)		
Ethnicity ( <i>n</i> %)									30.41	.69
Caucasian	2(40)	7(50)	7(35)	5(62.5)	4(36.40)	5(62.50)	10(45.50)	13(40.60)		
African American	2(40)	5(35.70)	8(40)	3(37.5)	5(45.50)	3(37.50)	9(40.90)	13(40.60)		
Other	1(20)	2(14.30)	0	0	0	0	1(4.50)	1(3.10)		
Income ( <i>n</i> %)									26.24	.86
0-11,999	1(20)	4(28.60)	9(47.40)	3(37.50)	2(20)	2(25)	4(19)	7(21.90)		
12,000-20,999	1(20)	2(14.30)	2(10.50)	0	2(20)	0	4(19)	6(18.80)		
21,000-30,999	0	1(7.10)	3(15.80)	1(12.50)	0	0	3(14.30)	3(9.40)		
31,000-40,999	0	0	1(5.30)	1(12.50)	0	0	1(4.80)	3(9.40)		
41,000-50,999	2(40)	2(14.30)	2(10.50)	1(12.50)	1(10)	2(25)	5(23.80)	7(21.90)		
Over 51,000	1(20)	5(35.70)	2(10.50)	2(25)	5(50)	4(50)	4(19)	6(18.80)		

Note: WVF is Witnessing Violence, Family; WVNF: Witnessing Violence, Non-family; SLF: Separation and loss, Family; SLNF: Separation and loss, Non-family; PT: Physical Trauma; EV: Entertainment violence; MVA: Motor Vehicle Accidents; MIS: Miscellaneous



Table 17. *The Relationship among Traumas and Associated Symptoms*

Trauma Group	WVF		WVNF		SLF		SLNF		PT		EV		MVA		MIS		Univariate	
	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	F	<i>p</i>
Measure																		
<i>The Child PTSD Checklist</i>																		
B	5.60(4.98)		6.50(3.35)		6.25(3.27)		7.88(5.45)		7.73(6.34)		6.50(4.34)		7.17(5.88)		8.00(6.20)		.35	.93
C	4.38(3.75)		6.79(3.53)		5.75(3.61)		9.13(5.74)		7.91(5.63)		6.38(4.54)		6.54(4.90)		8.32(6.16)		.97	.46
D	5.80(4.15)		5.07(2.87)		6.05(3.52)		6.00(6.23)		6.27(3.71)		6.88(4.29)		7.13(4.22)		7.41(5.52)		.51	.83
Total	16.98(12.84)		19.29(7.59)		19.25(9.73)		24.50(16.49)		23.55(15.67)		21.50(13.55)		22.16(15.09)		25.47(17.55)		.56	.78
<i>The CNCEQ</i>																		
Catastrophizing	9.60(3.78)		10.93(4.86)		11.75(5.21)		15.00(4.81)		13.18(4.79)		10.22(3.36)		14.00(4.46)		12.84(5.44)		1.42	.20
Overgeneralizing	11.00(1.00)		10.79(4.51)		13.70(6.30)		15.13(7.10)		11.91(3.78)		11.29(3.09)		12.68(3.06)		14.50(6.16)		1.29	.26
Selective Abstraction	11.60(2.97)		11.86(4.31)		11.20(4.74)		14.38(3.78)		11.81(4.35)		11.13(3.00)		13.59(3.64)		13.24(5.23)		.99	.44
Personalizing	10.20(2.77)		11.57(3.77)		12.05(4.57)		16.25(7.15)		12.45(5.24)		12.25(2.82)		13.68(4.27)		13.72(5.29)		1.29	.26
Total	42.20(5.90)		45.14(15.19)		48.70(18.69)		60.75(20.32)		49.36(15.88)		44.48(8.71)		53.95(12.91)		54.30(19.13)		1.37	.22

Note: WVF is Witnessing Violence, Family; WVNF: Non-family; SLF: Separation and loss, Family; SLNF: Separation and loss, Non-family; PT: Physical Trauma; EV: Entertainment violence; MVA: Motor Vehicle Accidents; MIS: Miscellaneous.

## Appendix A

### Coding instructions for the *Child PTSD Checklist* using SPSS

- Column 1: Enter the ID number into the “id” column.
- Column 2: Enter the first trauma the child reports into the “trauma1” column.
- Column 3: Enter the physical severity rating of “trauma1” in the “physsev1” column. Rank the physical severity of the trauma using the scale shown below.  
0 1 2 3 4 5 6 7 8  
**None A little Some A lot Very, Very Severe Physical Threat**

**How to assign physical severity ratings:** The *DSM-IV-TR* stressor criterion for a traumatic event includes experiencing or witnessing an event for which the physical integrity of self or others has been threatened (American Psychological Association, 2000). Consider this definition when assigning each trauma a physical severity rating. In other words, the aim of coding the physical severity of a trauma is to assess how much the child’s physical integrity or the physical integrity of others was threatened during the event reported. Thus, if the child reports minimal direct threat to the self or others, for example, “having nightmares,” or “watching scary movies with friends” as traumatic experiences, give the trauma a physical severity rating of 0 or 1. If the child reports severe direct threat to their physical integrity during the trauma, for example: “being shot at in my neighborhood” or “I got hit by a car and had to go to the hospital,” or reports witnessing severe direct threat of another person’s physical integrity; for example: “seeing someone get shot,” or “saw a stranger get murdered by someone,” give the trauma physical severity rating of 7 or 8.

0 1 2 3 4 5 6 7 8  
**None A little Some A lot Very, Very Intense Psychological Response**

- Column 4: Enter the psychological intensity rating of “trauma1” in the “psycint1” column. Rank the psychological intensity of the trauma using the scale shown below.

**How to assign psychological intensity ratings:** *DSM-IV-TR* (2000) criteria also states that an individual’s response to the traumatic event involves intense fear, helplessness, or horror (American Psychological Association, 2000). Consider this when assigning each trauma a psychological intensity rating. In other words, the aim of coding the psychological intensity of the trauma is to assess how much fear, helplessness, or horror was involved in the child’s response. The amount of fear/helplessness/horror indicated through the child’s report of the trauma is used to assess the child’s response to the trauma. Thus, if the trauma reported by the child implies a minimal fear/helplessness/horror response, for example “getting stung by a bee,” or “losing a game,” give the trauma a psychological severity rating of 0 or 1. If the trauma reported by the child implies an intense fear/helplessness/horror response (i.e. the child has little control during the event, and the event is likely to be associated with a fear response), for example; “I saw someone get raped,” or “when I was in the car and another car crashed into us,” give the trauma an intensity rating of 7 or 8.

- Enter the traumatic event, “trauma1,” into one of seventeen proposed categories. Each of the proposed categories of traumatic events has its own column in SPSS, and the top of

each column displays the abbreviation for that category. Code the traumatic event into the most appropriate category (i.e. each event should be coded into only one category). Each trauma category column within the SPSS file should get assigned either a “**1 = yes, this event fits into the category,**” or “**0 = no, this event does not fit into the category.**” Below are names, abbreviations, and descriptions of each category, examples of events that would fit into a particular category, and instructions for how to code categories as **1** or **0**.

- Column 5: Witnessing Violence/Family (fwv)\*: This category includes various violent events that a child would witness among relatives (i.e. parents, siblings, etc.) in the home. Listed below are some examples of events which would be coded as witnessing violence in the home or among family members (*any kind of sexual harassment or sexual victimization should not be coded as witnessing violence; see description of sexual abuse*).
  - a) The child reports having seen a relative, or even seeing a family pet being hit or punched, slapped, pushed, threatened or yelled at, or otherwise hurt by another relative.

✓ **To code an event as “fwv,” code 1 = yes. For events which do not fall into the “fwv” category, code 0 = no.**

\* Categories with an “f” as a prefix to their abbreviation signify that the traumatic event was directly associated with the actions of a family member or relative. Categories with an “nf” as a prefix to their abbreviation signify that the traumatic event was directly associated to the actions of a person outside of the child’s family; for example, friends, classmates, or neighbors.

- Column 6: Witnessing violence/Non-family (nfwv): This category includes various violent events that a child would witness either at school, in their community, or otherwise outside of the home (i.e. non-family witnessing of violence). Listed below (*a* and *b*) are examples of events which would be coded as witnessing school or community violence (*any kind of sexual harassment or sexual victimization should not be coded as witnessing violence; see description of sexual assault*).
  - a) The child reports being shot at, having a knife or other weapon pulled on them, being robbed, threatened or otherwise physically hurt/assaulted by someone in their community.
  - b) The child reports having seen a shooting, seeing someone have a knife or other type of weapon pulled on them, having seen someone being robbed, having seen someone (this includes violence to animals) threatened or otherwise physically hurt/assaulted in their community.

✓ **To code an event as “nfwv,” code 1 = yes. For events which do not fall into the “nfwv” category, code 0 = no.**

- Column 7: Entertainment/Movie/Television Violence (mtv): If child reports media violence as a traumatic event, code the trauma in this category. Listed below (*a, b, c, and d*) are examples of events which would be coded as media violence:
  - a) Scary, frightening, or violent movies or television programs
  - b) Violent video games
  - c) The child reports listening to scary, violent, or frightening music
  - d) The child reports amusement park rides, haunted houses, or other entertainment activities

✓ **To code an event as “mtv,” code 1 = yes. For events which do not fall into the “mtv” category, code 0 = no.**
  
- Column 8: Separation and Loss/Family (fsepls): If the child reports being separated from their primary caregiver/relative or reports an event during which they were unsure if that primary caregiver/relative would return (regardless of time period) due to the separation or loss, code the traumatic experience as separation and loss. Listed below are examples of events which would be coded as separation and loss of family members.
  - a) Child report of parents divorcing or separating
  - b) Child report of a death within the family
  - c) Child report of a family member/relative being kidnapped, or child reports being prevented from seeing or communicating with a particular family member/relative

✓ **To code an event as “fsepls,” code 1 = yes. For events which do not fall into the “fsepls” category, code 0 = no.**
  
- Column 9: Separation and Loss/Non-Family (nfsepls): If the child reports being separated from individuals who are not family members (ex. friends, breakup with girl/boyfriend) and are unsure or doubtful that they will ever see those people again, code as separation and loss, non-family. Listed below are examples of events which would be coded as separation and loss, non-family.
  - a) Child reports removal from friends through moving to a new home or school, or as a result of parents preventing the child from interacting with friends.
  - b) Child (more likely adolescents) reports breakup with boy/girlfriend.
  - c) Child reports death of a friend or other non-relative.

✓ **To code an event as “nfsepls,” code 1 = yes. For events which do not fall into the “nfsepls” category, code 0 = no.**
  
- Column 10: Physical Abuse/Family (fpsa): Physical abuse results from a willful or intentional act during which the child’s primary caregiver or a relative injures the child. Willful or intentional acts resulting in injury can include punishments administered by the primary caregiver/relative. Listed below (*a and b*) are examples of events that would be coded as physical abuse by a family member:
  - a) Child report of intentional physical injury performed by their primary caregiver or another relative (ex. cousin, uncle, sibling) that results from being

- kicked, punched, slapped, bit, burned, or hit (with or without an object).
- b) Child report of punishments administered by a primary caregiver/relative that result in physical injury such as bruises, cuts, scrapes, burns, bites, or broken bones.
- ✓ **To code an event as “fpsa,” code 1 = yes. For events which do not fall into the “fpsa” category, code 0 = no.**
- **Column 11: Physical Neglect/Family (fpsn):** Physical neglect is a form of child abuse performed by the child’s primary caregiver or a relative of the child. Listed below (*a*, *b*, and *c*) are examples of events which would be coded as physical neglect by a family member:
- a) The child reports denial of medical care (ex. the child has been/is sick or injured and receives no medical treatment).
- b) The child reports starvation/denial of food.
- c) The child reports denial of shelter or being kicked out of their home.
- ✓ **To code an event as “fpsn,” code 1 = yes. For events which do not fall into the “fpsn” category, code 0 = no.**
- **Column 12: Physical Trauma (ptr):** Physical traumas are often serious physical injuries that may cause disfigurement, disability, or scaring, and result from accidental circumstances, rather than intentional acts (*intentional acts are the case with witnessing violence or physical abuse categories*). Report of sustaining less severe injuries would also be coded as physical traumas. Listed below (*a* and *b*) are examples of events which would be coded as physical trauma.
- a) The child reports injury from an accidental circumstance such as taking a severe fall and hurting their body, losing or having one of their body parts amputated, or their body being scared or disfigured as a result of being burned during a fire.
- b) The child reports being bitten by animals such as a dog or cat, or being stung by an insect, such as a bee.
- ✓ **To code an event as “ptr,” code 1 = yes. For events which do not fall into the “ptr” category, code 0 = no.**
- **Column 13: Sexual Abuse/Family (fsxa):** Sexual abuse occurs when a child is used for the sexual gratification of an adult, and that adult is the primary caregiver/relative of the child. Listed below (*a* and *b*) are examples of events which would be coded as sexual abuse by a family member:
- a) Child report of being fondled or touched inappropriately by a primary caregiver/relative, or being forced to touch someone else inappropriately, report of nonconsensual intercourse/penetration, or report of exposure to pornography by a primary caregiver/relative.
- b) Child report of sexual harassment by a primary caregiver/relative (someone making inappropriate comments to the child).

✓ **To code an event as “fsxa,” code 1 = yes. For events which do not fall into the “fsxa,” category, code 0 = no.**

➤ Column 14: Sexual Assault (nfsa): Sexual assault may or may not involve force and includes attempted or completed acts of unwanted sexual contact. For coding purposes, the person the child reports as responsible for the assault cannot be a relative (*unwanted sexual contact with a relative would be coded as sexual abuse*). Listed below (*a* and *b*) are examples of events which would be coded as sexual assault:

- a) Child report of attempted or completed, forced or nonforced, unwanted sexual contact toward the child in the form of grabbing or fondling, or being forced to touch someone else inappropriately, or child report of nonconsensual intercourse or penetration by someone.
- b) Child report of unwanted sexual attention, such as someone making repeated negative comments to the child about their sex (as a male or female), or someone relaying sexist remarks in the child’s presence (in the form of jokes or stories), or making any other kind of sexually inappropriate comments to the child (such as verbally threatening to sexually assault the child).

✓ **To code an event as “nfsa,” code 1 = yes. For events which do not fall into the “nfsa,” category, code 0 = no.**

➤ Column 15: Emotional Abuse/Family (femo): Much like physical abuse, the intent behind emotional abuse is to hurt the child, and the abuser is the primary caregiver/relative of the child. Listed below (*a*, *b*, and *c*) are examples of events which would be coded as emotional abuse by a family member:

- a) The child reports being verbally belittled or berated (ex. the parent tells the child they wish the child had never been born, tells the child they are worthless).
- b) The child reports being restrained and/or confined in a closed area (ex. locked in a closet).
- c) The child reports being otherwise rejected (ex. a parent withholding affection to the child, but not to the child’s siblings).

✓ **To code an event as “femo,” code 1 = yes. For events which do not fall into the “femo,” category, code 0 = no.**

➤ Column 16: Emotional Abuse/Non-Family (nfemo): A child may be emotionally abused by individuals who are not related to them such as peers or classmates. Listed below (*a* and *b*) are examples of events which would be coded as emotional abuse/non-family:

- a) The child reports being verbally belittled or berated by non-relatives (i.e. peers or classmates).
- b) The child reports being restrained and/or confined in a closed area by non-relatives (ex. locked in a closet or room).

✓ **To code an event as “nfemo,” code 1 = yes. For events which do not fall into the “nfemo,” category, code 0 = no.**

- Column 17: Emotional Trauma (emotr): Emotional traumas are best described as events that are experienced as emotionally painful or distressing, but that are not necessarily physically traumatic or painful. Listed below (*a* and *b*) are examples of events which would be coded as emotional traumas:
  - a) The child reports being diagnosed with a life threatening disease or illness such as cancer, or juvenile diabetes, etc.
  - b) The child reports that someone close to them (e.g. a caregiver or relative) has been diagnosed with a life threatening disease or illness.

✓ **To code an event as “emotr,” code 1 = yes. For events which do not fall into the “emotr,” category, code 0 = no.**
  
- Column 18: Motor vehicle accidents (mva): This category includes violent or threatening events children report experiencing while in a motorized vehicle, seeing/the motor vehicle accidents as they happen (i.e. they are not inside a vehicle that is in the accident, but view an accident when looking out a window, or see one while playing in their yard, etc.), or the child reports having seen an individual who has been physically injured as a result of being in a motor vehicle accident. Listed below (*a*, *b*, and *c*) are examples of events that would be coded as motor vehicle accidents (*any kind of physical injury that the child reports as a result of being in a car accident should not be coded as mva; see description of physical trauma*):
  - a) the child reports seeing a car accident
  - b) the child reports seeing a person or animal that was hit by vehicle
  - c) the child reports riding in a vehicle with someone who drives erratically/doesn't drive safely

✓ **To code an event as “mva,” code 1 = yes. For events which do not fall into the “mva,” category, code 0 = no.**
  
- Column 19: Natural Disasters (nd): If the child reports natural disasters as the reported trauma code the event in this category. Listed below are examples of events which would be coded as natural disasters:
  - a) The child reports hurricanes, thunderstorms, floods, or tornadoes

✓ **To code an event as “nd,” code 1 = yes. For events which do not fall into the “nd,” category, code 0 = no.**
  
- Column 20: Explosions/War (ew): If the child reports explosions or war as the traumatic experience, code the traumatic event in this category. Listed below (*a* and *b*) are examples of events which would be coded as explosion/war:
  - a) The child reports witnessing bombings or other types of explosions
  - b) The child reports witnessing/surviving war, or being a refugee

✓ **To code an event as “ew,” code 1 = yes. For events which do not fall into the “ew,” category, code 0 = no.**

- Column 21: Miscellaneous (misc): If the reported trauma does not fit into any of the other categories, or the child's self-reported trauma is extremely unclear or ambiguous, code it in the miscellaneous category. Listed below (*a*, *b*, and *c*) are examples of events which would be coded as miscellaneous:
  - a) The child reports witnessing a fire, or other acts of vandalism that are not specified as witnessing violence or explosions/war.
  - b) The child reports self-injurious behaviors such as cutting or suicide attempts.
  - c) The child reports other kinds of mental health or substance abuse problems as the traumatic event, such as anxiety, depression, or eating disorders.
- ✓ **To code an event as “misc,” code 1 = yes. For events which do not fall into the “misc,” category, code 0 = no.**
- Column 21: Enter the second trauma the child reports into the “trauma2” column.
- Column 22: Enter the physical severity rating of “trauma2” in the “physsev2” column. Rank the physical severity of the trauma using the physical severity scale on page one of the coding instructions.
- Column 23: Enter the psychological intensity rating of “trauma2” in the “psycint2” column. Rank the psychological intensity of the trauma using the psychological intensity scale on page one of the coding instructions.
- Enter the traumatic event, “trauma2,” into one of eighteen proposed categories (*see previous pages for descriptions of each category and how to code traumas into categories*).
- Enter the third trauma the child reports into the “trauma3” column. Enter the physical severity and psychological intensity rankings for “trauma3,” and enter “trauma 3” into one of the proposed categories in the same manner as “trauma1” and “trauma2.”



## End Notes

<sup>1</sup>There were significant differences across PTSD positives, PTSD Negatives, and the control group for income ( $X^2 = 19.16, p < .05$ ) and for age [ $F(2, 193) = 6.78, p = 0.001$ ]. Additional analyses were run controlling for age and income. Differences across groups on CBCL total and subscale scores, and scores on measures of anxiety and depression were still significant,  $p < .05$ .

<sup>2</sup>Levene's test indicated inequality of variance between PTSD positive and PTSD negative groups. The  $t$ -value for unequal variances was reported.

<sup>3</sup>Levene's test indicated inequality of variance between PTSD positives and control groups. The  $t$ -value for unequal variances was reported.

<sup>4</sup>Levene's test indicated inequality of variance between PTSD negatives and control groups. The  $t$ -value for unequal variances was reported.

## **Vita**

Leslie K. Taylor is from Greenville, South Carolina and received her B.S. in psychology from the University of Georgia in 2002. She researches the clinical aspects of childhood trauma. Specifically, her efforts involve examining developmental differences in PTSD symptom expression, analyzing the psychometric properties of tools used to assess posttraumatic stress in children and adolescents, and effective treatments for the disorder in this population.