

# CHILD STRESS DISORDERS CHECKLIST (CSDC)

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Child's Name (or ID #): \_\_\_\_\_ Age: \_\_\_\_\_ Sex: **M** **F**

Person Completing Questionnaire: \_\_\_\_\_ Date \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Has your child experienced or witnessed an event that caused, or threatened to cause, serious harm to him or herself or to someone else? Please check any and all events (and age(s) of your child at the time of the event or events) below-

- |                                      |  |
|--------------------------------------|--|
| 1) Car Accident _____ Age(s) _____   | 5) Physical Illness _____ Age(s) _____ |
| 2) Other Accident _____ Age(s) _____ | 6) Physical Assault _____ Age(s) _____ |
| 3) Fire _____ Age(s) _____           | 7) Sexual Assault _____ Age(s) _____   |
| 4) Storm _____ Age(s) _____          | 8) Any Other Event _____ Age(s) _____  |

Please provide any details about this (or these) events in the box below. For example- Where did the event occur? Who was with your child? Who hurt your child? How often did this happen? How long did it last? How badly was your child hurt? Did he or she require medical care?

Directions: Below is a list of feelings or behaviors that children sometimes have **immediately after a frightening event (or after he or she regained consciousness from such an event)**. For each item that describes your child **immediately after** the event, please circle **2** if the item is **VERY TRUE** of your child. Circle **1** if the item is **SOMEWHAT TRUE** of your child. If the item is **NOT TRUE** of your child, circle **0**. Please answer all items as well as you can even if some do not seem to apply to your child. For children who have experienced more than one event, choose the event that was **most** distressing to him or her.

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

- 0 1 2** 1) Child felt terrified (extreme anxiety or fear).
- 0 1 2** 2) Child felt horrified (extreme feelings of revulsion, disgust, or shame).
- 0 1 2** 3) Child felt helpless.
- 0 1 2** 4) Child's behavior became agitated. For example, his or her behavior became hyperactive, impulsive, or difficult to control.
- 0 1 2** 5) Child's behavior became disorganized. For example, his or her behavior became very different than is usual, his or her behavior did not make sense.

Directions: Below is a list of behaviors that describe children. For each item that describes your child **NOW** or **WITHIN THE PAST MONTH**, please circle **2** if the item is **VERY TRUE** or **OFTEN TRUE** of your child. Circle **1** if the item is **SOMEWHAT** or **SOMETIMES TRUE** of your child. If the item is **NOT TRUE** of your child, circle **0**. Please answer all items as well as you can even if some do not seem to apply to your child. The term “event” refers to the **most** stressful experience that you have described above.

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

- 0 1 2** 1) Child reports uncomfortable memories of the event.
- 0 1 2** 2) Child startles easily. For example, he or she jumps when hears sudden or loud noises.
- 0 1 2** 3) Child gets very upset if reminded of the event.
- 0 1 2** 4) Child seems numb or distant from his or her feelings.
- 0 1 2** 5) Child avoids doing things that remind him or her of the event.
- 0 1 2** 6) Child seems irritable or angry.
- 0 1 2** 7) Child has difficulty remembering details about the event.
- 0 1 2** 8) Child has difficulty falling asleep or staying asleep.
- 0 1 2** 9) Child seems detached or distant from other people.
- 0 1 2** 10) Child has difficulty getting along with friends, schoolmates or teachers.
- 0 1 2** 11) Child does things that he or she outgrew. For example, thumb sucking, bedwetting, nail biting, or requests to sleep with parents.
- 0 1 2** 12) Child reports feeling as if the event were happening again.
- 0 1 2** 13) Child is restless and doesn't sit still.
- 0 1 2** 14) Child avoids places that remind him or her of the event.

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

- 0 1 2 15) Child has difficulty getting along with family members.
- 0 1 2 16) Child appears confused about things that he or she should know.
- 0 1 2 17) Child seems “on edge” or nervous.
- 0 1 2 18) Child seems “spaced out” or in a daze.
- 0 1 2 19) Child acts as if the event were happening again.
- 0 1 2 20) Child has trouble keeping track of time. He or she may become confused about the time of day, the day of the week, or when something really happened.
- 0 1 2 21) Child avoids talking about the event.
- 0 1 2 22) Child reports bad dreams.
- 0 1 2 23) Child reports more physical complaints when reminded of the event. For example, headaches, stomach aches, nausea, difficulty breathing.
- 0 1 2 24) Child has difficulty performing activities such as schoolwork or chores.
- 0 1 2 25) Child plays about the event (child expresses what happened to him or her with toys, games, drawings, or other fantasy-play).
- 0 1 2 26) Child appears slowed down. It takes him or her a long time to respond to things.
- 0 1 2 27) Child reports that his or her environment seems different than it used to. For example, he or she may report that things look or sound different.
- 0 1 2 28) Child avoids people who remind him or her of the event.
- 0 1 2 29) Child has trouble concentrating
- 0 1 2 30) Child reports that he or she does not want to think about the event.

# SCORING THE CHILD STRESS DISORDERS CHECKLIST

The Child Stress Disorders Checklist (CSDC) assesses a child's post-traumatic symptoms based on observer report. Observers respond to an inventory of symptoms by indicating **0** (Not True), **1** (Somewhat or Sometimes True), or **2** (Very True) based on their observations of their child. Scores are calculated by adding the responses within a variety of dimensions of post traumatic symptoms.

The first page of the CSDC gathers descriptive information about the traumatic event or events. This page is not meant to be scored but yields information about the type(s) of traumatic events that the child may have experienced, his or her age(s) at the time of the event, as well as a qualitative description of the circumstances of the event.

The second to fourth pages of this instrument gather quantitative information about a child's post traumatic symptoms.

The first five items of the CSDC asks about a child's immediate responses to the event. The Immediate Response Score is calculated by adding the scores (0, 1, or 2) for these five items.

The remainder of The CSDC assesses the thirty different post traumatic symptoms on five dimensions- 1) Reexperiencing, 2) Avoidance, 3) Numbing and Dissociation, 4) Increased Arousal, 5) Impairment in Functioning. The items that measure these five dimensions are-

- 1) Reexperiencing- Items 1, 3, 12, 19, 22, 23, 25
- 2) Avoidance- Items 5, 14, 21, 28, 30
- 3) Numbing and Dissociation- Items 4, 7, 9, 16, 18, 20, 26, 27
- 4) Increased Arousal- Items 2, 6, 8, 13, 17, 29
- 5) Impairment in Function- Items 10, 11, 15, 24

The score for each dimension is calculated by adding the responses for each item in that dimension. The total Post Traumatic Symptom Score is calculated by adding the responses for all 30 items.

## SCORES

- 1) **Immediate Response Score:** \_\_\_\_\_
- 2) **Post Traumatic Symptom Scores:**
  - 1) Reexperiencing: \_\_\_\_\_
  - 2) Avoidance: \_\_\_\_\_
  - 3) Numbing and Dissociation: \_\_\_\_\_
  - 4) Increased Arousal: \_\_\_\_\_
  - 5) Impairment in Functioning: \_\_\_\_\_
  - 6) Total Post Traumatic Symptom Score: \_\_\_\_\_