ASSESSMENT: While evaluation may begin with gathering information from family members and other informed adults, children should be evaluated directly and separately from parents. In addition to frequency and intensity of nightmares and levels of motor activity and distractibility, physical examinations to monitor pulse and blood pressure can yield valuable information about the youngster's fluctuating levels of arousal. Techniques of assessment depend on the child's age. Play and art are essential means for interacting with preadolescent children (20). Assessment can include psychological and educational testing, and the use of PTSD scales (46, 69) and semi-structured interviews (12).

In general, since youngsters rarely attribute symptoms to trauma, may be reluctant patients or poor historians, and because post-traumatic symptomatology can be non-specific, superimposed on, or mimic other childhood disorders, it is important to maintain a high level of suspicion regarding the post-traumatic etiology of any presenting symptoms and include the possibility of trauma in differential diagnoses of most childhood symptoms. Thus, even when youngsters present without a history of trauma, it is nevertheless useful to inquire routinely, "Have you ever been hurt by anyone?... touched in a way you didn't like?... treated in a way you didn't like?... seen something that really scared you?... had nightmares?... got real jumpy?" Clinicians should be alert to unexplained regressions, sudden symptoms, or recurrence of direct or disguised traumatic themes or references in play, drawings, stories, dreams, or fantasies. However, suggestible and eager to please young children may be easily led to believe and to convincingly describe a version of an event implied by biased adults because they may not yet grasp notions of a consistent 'truth' independent of their feelings, fantasies or wishes to please examiners or parents. therefore, clinicians should exercise extreme care to avoid inducing "false memories" by structuring any inquiry in a scrupulously open-ended and non-biased manner. Even with such precautions, both adults (78, 16) and children (89, 64) may unintentionally offer distorted recollections of traumatic events. Often, it is impossible to determine the validity of a young child's description. While a detailed accurate description of an event may be essential in forensic situations, it is not as necessary for effective clinical intervention and should not be sought with excessive zeal. Forensic assessments should be rigorously

documented and may require specialized techniques and electronic recording. Because the goals and procedures of forensic and therapeutic activities differ, it is advisable that be conceptualized as separate processes conducted by different clinicians.

As with adults, symptoms deriving from childhood trauma constitute a spectrum. While many children may not meet more stringent PTSD diagnostic criteria, they may nevertheless have significant post-traumatic symptoms, as well as internalizing and externalizing behavior disorders. While DSM-III and DSM-III-R criteria, usually based on self-reports, have been utilized to assess school-age children and adolescents, assessment of younger children usually relies on direct observation and on caretaker reports. Saigh (69) noted PTSD children to be distinct from phobic or normal children. Schwarz & Kowalski (74) showed DSM-III-R to be more stringent than DSM-III or proposed DSM-IV criteria and children to show a range of symptoms similar to adults.