Chapter 19
Measures for Acute Stress Disorder and Posttraumatic Stress Disorder

Susan M. Orsillo

Note: Throughout this chapter, reference is made to the various DSM-IV criteria for PTSD (American Psychiatric Association, 1994). Criterion A-1 refers to the occurrence of a traumatic event. Criterion A-2 refers to the presence of intense fear, helplessness, and horror at the time of the traumatic event. Criterion B refers to the presence of symptoms involving reexperiencing the traumatic event. Criterion C refers to symptoms of persistent avoidance of stimuli related to the traumatic event and numbing of general responsiveness. Criterion D includes symptoms of increased arousal since experiencing the trauma. Criterion E refers to the duration of the disturbance (at least 1 month for PTSD). Criterion F refers to the presence of clinically significant distress or impairment.

ACCIDENT FEAR QUESTIONNAIRE (AFQ)

Original Citation

Kuch, K., Cox, B. J., & Direnfeld, D. M. (1995). A brief self-rating scale for PTSD after road vehicle accident. *Journal of Anxiety Disorders*, *9*, 503–514.

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Purpose

To measure PTSD-related phobic avoidance following involvement in a motor vehicle accident.

Description

The AFQ is a self-report scale consisting of an MVA profile that includes 10 yes/no questions about the accident and related anxiety, and 10 phobic avoidance items (AFQ-PA) in which the respondent is asked to rate his or her avoidance on a nine-point scale ranging from 0 (would not avoid it) to 8 (would always avoid it). There are also two descriptive questions about the accident and one question that assesses interference from physical illness (e.g., back pain) using the same nine-point scale.

Administration and Scoring

The AFQ can be administered in 5 to 10 minutes. The AFQ-PA subscale can be scored by summing the 10 items. A cutoff score of 15 on the AFQ-PA may be used to detect the presence of PTSD and/or accident phobia (see below).

Psychometric Properties

Sample Scores and Norms. The mean scores for the AFQ-PA are available from a sample of 54 men and women seeking treatment for pain or some other somatic symptom following a motor vehicle accident (Kuch et al., 1995). Individuals diagnosed with PTSD obtained a mean score of 54.44 ($SD = 11.36$); those diagnosed with accident phobia had a mean score of 34.00 ($SD = 14.77$); those with neither disorder had a mean score of 14.66 ($SD = 12.46$). Lower means were obtained in a sample of 113 accident victims referred to a research study from a rehabilitation center (Asmundson, Cox, Larsen, Frombach, & Norton, 1999). The mean score of individuals diagnosed with PTSD and accident phobia combined was 20.9 ($SD = 14.0$) and the comparison group obtained a mean of 9.0 ($SD = 9.6$). The percentages of respondents by diagnosis who endorsed each item in the accident profile are found in Kuch et al. (1995) and Asmundson et al. (1999).

Reliability. Items making up the MVA profile subscale had fairly low internal consistency ($\alpha = .67$) likely reflecting the divergent nature of the items (Asmundson et al., 1999). In contrast, good internal consistency was demonstrated for the AFQ-PA subscale (αs .80 to .89; Asmundson et al., 1999; Kuch et al., 1995).

Validity. The convergent and discriminant validity of the AFQ-PA was evaluated across a number of measures (Asmundson et al., 1999). The AFQ-PA was moderately associated with measures of anxiety sensitivity (.43), alexithymia (.33), and somatization (.28). The measure was not associated with extraversion and perceived self-control.

Individuals diagnosed with PTSD scored significantly higher than those with accident phobia and those with neither disorder in one sample (Kuch et al., 1995). In another sample, the PTSD and phobia groups did not differ, but these groups combined scored significantly higher than individuals with neither disorder (Asmundson et al., 1999).

The diagnostic efficiency of the AFQ-PA was assessed against a structured clinical interview. A cutoff score of 15 on the AFQ-PA appeared to be the optimal score for screening. However, this score yielded a sensitivity of only .67 and specificity of .78 with 55% of those scoring at or above the cutoff meeting diagnostic criteria for PTSD or accident phobia and 85% of those below the cutoff not meeting criteria for either disorder.

Source

The AFQ is reprinted in the original citation and in Appendix B. More information can be obtained by contacting Klaus Kuch, M.D. Forensic Program (4th Floor), Centre for Addiction and Mental Health, Clarke Institute Division, 250 College Street, Toronto, ON M5T 1R8, Canada; (tel) 705-487-2324; (e-mail) klaus.kuch@sympatico.ca.

ACUTE STRESS DISORDER INTERVIEW (ASDI)

Original Citation

Bryant, R. A., Harvey, A. G., Dang, S. T., & Sackville, T. (1998). Assessing acute stress disorder: Psychometric properties of a structured clinical interview. *Psychological Assessment, 10,* 215–220.

Purpose

To diagnose acute stress disorder.

Description

The ASDI is a clinician-rated scale consisting of 19 items that relate to criterion B (*dissociation*, 5 items), criterion C (*reexperiencing*, 4 items), criterion D (*avoidance*, 4 items), and criterion E (*arousal*, 6 items). Each item is scored dichotomously as 0 (symptom absent) or 1 (symptom present). The ASDI also includes items that assess the *objective and subjective experience of the traumatic event* (criterion A, 3 items), the *duration of each symptom* (criterion F), and *impairment* (criterion G, 4 items).

Administration and Scoring

The ASDI can be administered in 10 minutes. Scoring is according to DSM-IV criteria for ASD (see above).

Psychometric Properties

The psychometric properties of the ASDI were evaluated in a multisample, multistudy paper (Bryant et al., 1998).

Sample Scores and Norms. Thirteen patients out of 56 (23%) patients who were admitted to a hospital following a traumatic event met criteria for ASD. Twenty-four patients out of 60 (40%) who were referred to a PTSD unit following a traumatic event were diagnosed with ASD.

Reliability. The internal consistency for the 19 symptom items of the ASDI was found to be excellent (r = .90) among a sample of 65 patients admitted to a hospital following a traumatic event. The individual symptom clusters were lower: *dissociation* (r = .67), *reexperiencing* (r = .67), *avoidance* (r = .69), and *arousal* (r = .76).

Two- to seven-day test–retest reliability was reported for a sample of 60 adults seeking treatment. Correlations for each of the symptom clusters ranged from .80 to .87. Further, 88% of those who were diagnosed at time 1 were also diagnosed at time 2 and 94% of participants who were not diagnosed at time 1 also did not receive a diagnosis at time 2.

Validity. The items of the ASDI were rated by experts on a five-point scale ranging from 1 (not at all) to 5 (extremely) on their relevance (M = 4.86, SD = 0.93), specificity (M = 4.44, SD = 0.43), and clarity (M = 4.51, SD = 0.27). The content validity of the ASDI was evaluated in a sample of 56 inpatients admitted to a hospital following the occurrence of a traumatic event. The ASDI cluster score for the *dissociation* symptoms was significantly correlated with a measure of dissociation (r = .35), the *reexperiencing* cluster correlated with a measure of intrusion (r = .72), the *avoidance* cluster correlated with an additional measure of avoidance (r = .83), and the *arousal* cluster correlated with a measure of state anxiety (r = .38).

Given the lack of a gold standard measure of ASD, the ASDI was validated against the diagnosis of expert clinicians. The sensitivity of the ASDI was 91% and the specificity was 93%. Kappa values were .75 for the overall diagnosis, .79 for the stressor, .65 for *dissociation*, .61 for *reexperiencing*, .73 for *avoidance*, and .41 for *arousal*.

Alternative Forms

A self-report version of the ASDI, the Acute Stress Disorder Scale (ASDS) has also been developed (Bryant, Moulds, & Guthrie, 2000). Patients diagnosed with ASD scored a mean of 65.11 (SD = 14.74) on the ASDS and patients without ASD scored a mean of 36.97 (SD = 19.54). The internal consistency and test–retest reliability for the ASDS was found to be very good to excellent for the total score and the individual symptom clusters. Convergent validity and predictive validity against the interview version have also been established. The ASDS can be obtained by contacting Dr. Bryant (see source information below) and is reprinted in the original citation (Bryant et al., 2000).

Source

The ASDI can be obtained by contacting Richard A. Bryant, Ph.D., School of Psychology, University of New South Wales, Sydney, NSW 2052, Australia; (e-mail) r.bryant@unsw.edu.au.

CLINICIAN-ADMINISTERED PTSD SCALE (CAPS)

Original Citations

Blake, D. D., Weathers, F. W., Nagy, L. M., Kaloupek, D. G., Klauminzer, G., Charney, D. S., & Keane, T. M. (1990). A clinician rating scale for assessing current and lifetime PTSD: The CAPS-1. *The Behavior Therapist, 13*, 187–188.

Blake, D. D., Weathers, F. W., Nagy, L. M., Kaloupek, D. G., Gusman, F. D., Charney, D. S., & Keane, T. M. (1995). The development of a clinician-administered PTSD scale. *Journal of Traumatic Stress, 8*, 75–90.

Purpose

To diagnose and assess symptoms of PTSD.

Description

The CAPS is a clinician-rated scale. The most up-to-date version includes a checklist of potentially traumatizing events. After it is administered, up to three events are chosen (based on their severity or recency) and a description of the event and the respondent's emotional response at the time of the event are obtained to establish DSM-IV criterion A. These events are referred to in the subsequent questions. Seventeen items directly assess DSM-IV criteria B, C, and D. Each item is rated on a five-point scale to determine the frequency (for most items 0 = never to 4 = daily or almost every day) and intensity (0 = none to 4 = extreme, with additional specific behavioral descriptions to each item). Raters are also permitted to indicate whether they believe each rating is of questionable validity (e.g., whether the patient is over- or underreporting). Criterion E is established by two questions on onset and duration. Criterion F is established by three questions on distress and impairment in functioning. Three items require the interviewer to make global ratings on the validity of responses, severity of PTSD and, if applicable, improvement since the previous assessment. If criteria are met for PTSD, five items tapping into associated features are administered. This version of the CAPS is able to assess symptoms over the past week, past month, and lifetime.

Administration and Scoring

The CAPS can be administered in 45–60 minutes. A total score is obtained by summing the frequency and intensity scores for each of the 17 symptom items. The CAPS can also be used to obtain a dichotomous rating of the presence or absence of PTSD. The psychometric properties of nine scoring rules (e.g., a symptom is present if the frequency rating is at least 1 and the intensity rating is at least 2; a symptom is present if the severity of a symptom {frequency + intensity} is greater than or equal to 4) have been examined (Weathers, Ruscio, & Keane, 1999). These authors concluded that the appropriate scoring rule should be based on the purpose of the assessment (e.g., screening versus differential diagnosis). Thus, it is highly recommended that users of the CAPS obtain this article.

Psychometric Properties

Sample Scores and Norms. In a sample of motor vehicle accident and sexual assault victims, the mean score on the CAPS was 45.9 (*SD* = 29.1; Blanchard, Jones-Alexander, Buckley, & Forneris, 1996).

Reliability. Internal consistency for intensity of PTSD symptom criteria was examined in a sample of 25 veterans (Blake et al., 1990). Cronbach's alpha ranged from .73 to .85. Similar results were found with a larger sample (Weathers & Litz, 1994). Internal consistency was also high within a sample of older veterans (αs range from .87 to .95; Hyer, Summers, Boyd, Litaker, & Boudewyns, 1996). Interrater reliability on the same interview (with both raters present) was established within a sample of seven veterans for criteria B, C, and D (*r*s range from .92 to .99 for frequency and intensity; Blake et al., 1990). Diagnostic agreement within the pairs was perfect.

A more conservative test of interrater reliability was conducted in a larger sample of veterans. Three rater pairs independently interviewed veterans on two occasions 2 to 3 days apart (Weathers & Litz, 1994). The correlations for symptom clusters and total scores ranged from .77 to .98. However, the use of questionable validity ratings for each item was not shown to be reliable (Weathers & Litz, 1994).

Validity. A confirmatory factor analysis was conducted on a sample of 524 service-seeking male veterans to examine the relative fit of a number of models hypothesized to reflect the dimensionality of PTSD (King, Leskin, King, & Weathers, 1998). The model of best fit was a four-factor, first order solution containing correlated factors reflecting the reexperiencing, effortful avoidance, emotional numbing, and hyperarousal symptom clusters of PTSD.

Convergent validity of the CAPS was demonstrated for a sample of 25 veterans (Blake et al., 1990). The CAPS was significantly correlated with self-report measures of PTSD (*r*s range from .70 to .84) and combat exposure ($r = .42$; Blake et al., 1990). In a sample of motor vehicle accident and sexual assault victims, the CAPS was significantly associated with a self-report measure of PTSD ($r = .93$). Within a large service-seeking veteran sample, score on the CAPS was shown to be significantly associated with other self-report measures of PTSD (*r*s range from .77 to .91), depression (*r*s range from .69 to .74), and anxiety (*r*s range from .65 to .76; Weathers & Litz, 1994). In contrast, in the same sample, the CAPS was only weakly associated with a measure of antisocial personality ($r = .14$). Further, when the effects of possible response bias were controlled for, the correlations with measures of PTSD remained strong, whereas the correlations with associated features dropped substantially (Weathers & Litz, 1994). Finally, convergent validity of the symptom subscales of the CAPS was assessed in a large sample of service-seeking veterans (King et al., 1998). A measure of state anxiety was more strongly associated with symptoms of hyperarousal and reexperiencing than the numbing and avoidance clusters. In contrast, numbing and hyperarousal were the symptom clusters most highly associated with depression (King et al., 1998).

The diagnostic utility of nine scoring rules for the CAPS was examined against a diagnosis obtained by structured clinical interview in a sample of service-seeking veterans (Weathers et al., 1999). All nine rules yielded efficiencies ranging from .82 to .87.

Diagnosis based on the CAPS has been shown to be predictive of heart rate reactivity in response to a combat-related priming event (e.g., Litz, Orsillo, Kaloupek, & Weathers, 2000). Treatment sensitivity was demonstrated in a study of trauma management therapy with veterans (Frueh, Turner, Beidel, Mirabella, & Jones, 1996), and in an open trial of exposure therapy with a mixed group of trauma survivors (Thompson, Charlton, Kerry, & Lee, 1995).

Alternative Forms

The CAPS has been translated into several languages including French, Spanish, Japanese, and Russian. A modification of the CAPS for use with Afghan refugees (Pushto and Farsi {Dari} languages) has been demonstrated to have good internal consistency and interrater reliability (Malekzai et al., 1996). The Dutch version has also been psychometrically examined (Hovens, van der Ploeg, Klaarenbeek, Schreuder, & Rivero, 1994a). A computerized version of the CAPS with good validity and reliability has been developed (Neal, Busuttil, Herapath, & Strike, 1994). A child version of the CAPS is available through the National Center for PTSD website. More information on the child version is available by contacting Elana Newman, University of Tulsa, Psychology/Lorton Hall, 600 S. College Ave., Tulsa, OK 74104-3189, USA; (e-mail) newmane@centum.utulsa.edu.

Source

More information about the CAPS, including a request form to obtain a copy of the measure, is available at the National Center for PTSD website (www.ncptsd.org/treatment/assessment/caps.html). In addition, interested readers can contact Carole A. Goguen, Psy.D. at the National Center for PTSD (116D) VA Medical Center & Regional Office Center, 215 North Main St., White River Junction, VT 05009, USA. The CAPS can be obtained through the National Center for PTSD at no cost. In addition, a version of the CAPS is under development with Western Psychological Services. For more information, contact Western Psychological Services, 12031 Wilshire Boulevard, Los Angeles, CA 90025, USA; (tel) 800-648-8857; (fax) 310-478-7838; (e-mail) custsvc@wpspublish.com; (website) www.wpspublish.com.

DAVIDSON TRAUMA SCALE (DTS)

Original Citation

Davidson, J. R. T., Book, S. W., Colket, J. T., Tupler, L. A., Roth, S., David, D., Hertzberg, M., Mellman, T., Beckham, J. C., Smith, R. D., Davison, R. M., Katz, R., & Feldman, M. E. (1997). Assessment of a new self-rating scale for posttraumatic stress disorder. *Psychological Medicine*, *27*, 153–160.

Purpose

To assess symptoms of PTSD among individuals with a history of trauma exposure.

Description

The DTS is a self-report scale comprised of 17 items corresponding to each of the DSM-IV symptoms of PTSD. For each item, the respondent rates frequency and severity for the previous week on a five-point scale. The *reexperiencing* symptoms are tied to a specific traumatic event described by the respondent. However, the *numbing*, *withdrawal*, and *hyper-*

arousal events are not specifically linked to the traumatic event (e.g., the respondent is not asked if these symptoms arose as a result of, or at the time of, the trauma). For frequency, the scale ranges from 0 (not at all) to 4 (every day). For severity, the range is from 0 (not at all) to 4 (extremely distressing).

Administration and Scoring

The DTS takes 10 minutes to administer. A total score can be derived by summing all of the items. Subscale scores can be computed separately for frequency and severity. Subscale scores can also be computed separately for each of the symptom clusters: reexperiencing, avoidance, and hyperarousal.

Psychometric Properties

Sample Scores and Norms.

Respondents derived from studies on veterans and victims of a natural disaster with PTSD obtained a mean score of 62 ($SD = 38.0$) versus a mean of 15.5 ($SD = 13.8$) for respondents without PTSD (Davidson, et al., 1997).

Reliability.

Internal consistency was reported for participants in studies on rape victims, veterans, and victims of a natural disaster (Davidson, Book, et al., 1997). Cronbach's alpha for the combined sample ranged from .97 to .99 for the frequency only, severity only, and total items. Similar internal consistency ratings were found in a sample of survivors of childhood sexual assault (Zlotnick, Davidson, Shea, & Pearlstein, 1996).

Two-week test–retest data were available for 21 participants in a multicenter drug trial for individuals with a variety of trauma histories who were rated with "no change" on an independently derived measure of their symptoms (Davidson, et al., 1997). The test–retest reliability on this subsample was .86.

Factor analysis of a sample of individuals with a history of combat, rape, or natural disaster yielded two factors (Davidson, et al., 1997). The first accounting for 20% of the variance was interpreted as a severity factor. The second accounted for a small amount of the variance and consisted mostly of positive loadings on the *intrusive* items and negative loadings on the *avoidance* and *numbing* items. A factor analysis on only respondents with PTSD yielded six factors, the largest being similar to the severity factor discussed above.

Convergent validity was assessed with the same sample (Davidson, et al., 1997). Individuals diagnosed with PTSD on the basis of a structured clinical interview scored significantly higher than those without PTSD. A score of 40 on the DTS was associated with a sensitivity of 69%, specificity of 95%, and efficiency of 83%. Within the sample of patients treated with an antidepressant, DTS scores were significantly different (in the predicted directions) for five categories of PTSD severity (minimal, subclinical, clinical, severe, and very severe) determined by a physician's rating (Davidson, et al., 1997). Within the rape victim and veteran samples, the DTS was significantly correlated with a self-report ($r = .64$) and an interview ($r = .78$) measure of PTSD. The DTS was also significantly correlated with measures of general psychological distress (rs ranging from .44 to .65), but not with a measure of extroversion ($r = .04$).

In a sample of childhood sexual abuse survivors, DTS scores were significantly correlated with an interview measure of PTSD (rs ranged from .57 to .72 for frequency and severity), a measure of dissociation (rs ranged from .51 to .59), and a measure of affect regulation (rs ranged from .49 to .53; Zlotnick et al., 1996).

Sensitivity to treatment effects was evaluated by comparing the DTS total score in responders versus nonresponders in the antidepressant trial (Davidson, et al., 1997). Responders demonstrated a significant decrease in DTS score, whereas nonresponders did not. Controlling for pretreatment scores, women with a history of childhood sexual assault who received a group treatment demonstrated a nonsignificant trend toward scoring lower on the DTS than individuals in the waitlist control condition (Zlotnick et al., 1996).

Alternative Forms

The DTS is available in French-Canadian and Spanish. A four-item scale called the SPAN (Startle, Physiological arousal, Anger, and Numbness) has been developed as a brief diagnostic screening from the DTS. The psychometric properties of this scale are described in Meltzer-Brody, Churchill, and Davidson (1999). The SPAN is also available from Multi-Health Systems (see below).

Source

The DTS is available through Multi-Health Systems Inc., 908 Niagara Falls Blvd., North Tonawanda, NY 14120-2060, USA; (tel) 800-456-3003 (USA) or 800-268-6011 (Canada); (fax) 416-424-1736; (webpage) www.mhs.com. A kit that contains a manual and 25 scoring forms is available for $47.50 US. More information can also be obtained by contacting Jonathan R. T. Davidson, M.D., Department of Psychiatry, Duke University Medical Center, Box 3812, Durham, NC 27710, USA; (tel) 919-684-2880; (fax) 919-684-8866; (e-mail) tolme@acpub.duke.edu.

DISSOCIATIVE EXPERIENCES SCALE (DES)

Original Citations

Bernstein, E. M., & Putnam, F. W. (1986). Development, reliability and validity of a dissociation scale. *Journal of Nervous and Mental Disease, 174*, 727–735.

Carlson, E. B., & Putnam, F. W. (1993). An update on the Dissociative Experiences Scale. *Dissociation, 6*, 16–27.

Purpose

To measure frequency of dissociative experiences.

Description

The DES has been used in over 400 published studies on a variety of populations. Over 35 studies have been conducted on the psychometric properties of the scale. While the DES appears to be a clinically useful measure of dissociative features, it lacks some clarity because

it does not specify a time period for reporting and because it measures experiences that are reflective of both normal and pathological dissociation. The DES consists of 28 items that describe dissociative experiences including experiences of amnesia, depersonalization, derealization, imaginative involvement, and absorption. Respondents are asked to indicate the frequency (not including drug- or alcohol-related experiences) of these experiences using a 100-point scale. The original version of the DES used a visual analogue response scale consisting of a 100 mm line numerically anchored on the end points. A revised version uses a format of numbers from 0 to 100 (by 10s) and asks the respondent to circle the percentage of time that best reflects how much he or she has each experience in their daily life (no specific time window is indicated).

Administration and Scoring

The DES can be administered in 10 to 15 minutes. On the original version, the scale is scored by measuring the mark made by the respondent to the nearest 5 millimeters. On the revised version, the circled numbers are used. A total score is calculated by adding all of the items and dividing by 28. Subscale means based on a factor analysis (Carlson et al., 1991) can also be obtained, although, there is some debate over the validity of these factors (see psychometric review below). *Amnestic dissociation* is measured by taking the mean of items 3–6, 8, 10, 25, and 26. *Absorption and imaginative involvement* is measured by taking the mean of items 2, 14–18, 20, 22, and 23. *Depersonalization and derealization* is the mean of items 7, 11–13, 27, and 28. A score of 30 is used as a cutoff point for defining a respondent as high in dissociation.

Psychometric Properties

Sample Scores and Norms. Based on a meta-analysis of 85 studies on almost 12,000 respondents, means were derived for individuals with PTSD ($N = 259$, $M = 32.58$), for normal individuals ($N = 1578$, $M = 11.57$), and students ($N = 5676$, $M = 14.27$; van Ijzendoorn & Schuengel, 1996).

Reliability. The meta-analysis conducted by van Ijzendoorn and Schuengel (1996) included 16 studies that examined internal consistency, and the mean alpha across these studies was .93. The test–retest reliability of the DES has been shown to range from .79 to .96 over 4- to 8-week intervals (e.g., Bernstein & Putnam, 1986; Frischholz et al., 1990; Pitblado & Sanders, 1991).

Validity. Fischer and Elnitsky (1990) conducted a factor analysis on the DES in a student sample to determine if the three-factor solution (yielding the three subscales discussed earlier) would emerge. However, they found that a one-factor solution best accounted for the data. In contrast, Ross, Joshi, and Currie (1991) conducted a factor analysis on data derived from a large community sample and obtained the three-factor solution that was hypothesized. Carlson et al. (1991) conducted a factor analysis on DES scores derived from a multicenter study including 1574 individuals with and without a variety of psychological disorders (Carlson et al., 1991) and also obtained the three-factor solution. However, Waller (1995) reanalyzed their data set correcting for skewness and confirmed that one general factor best accounted for the variance.

The meta-analysis conducted by van Ijzendoorn and Schuengel (1996) included 26 studies that allowed for an examination of the convergent validity of the DES. The DES showed excellent convergent validity with other self-report and interview measures of dissociation (combined effect size $d = 1.05$, $N = 1705$), PTSD (combined effect size $d = 0.75$, $N = 1099$), and physical or sexual abuse (combined effect size $d = 0.52$, $N = 2108$).

In contrast, the discriminant validity of the DES is somewhat less well established. DES scores do not seem to be strongly associated with gender (combined effect size $d = -0.01$, $N = 4074$) or age ($d = -0.24$, $N = 2474$). However, DES scores have been shown to be significantly related to a number of measures of general psychological distress (*r*s ranging from .67 to .69; e.g., Walker, Katon, Neraas, Jemelka, & Massoth, 1992; Zlotnick et al., 1995). Although this may indicate that the DES measures general distress, it may also accurately reflect the relationship between general distress level and severity of dissociation.

Alternative Forms

The DES has been translated into at least 17 languages. There is an adolescent DES that is similarly formatted, but that contains different content, and is available through the Sidran Foundation (see below). A brief version of the DES, the DES-T, has been developed to specifically measure pathological dissociation (Waller, Putnam, & Carlson, 1996; Waller & Ross, 1997). A computerized version of the scale is available from Grant Fair, M.S.W., R.S.W., (e-mail) grantf@provcomm.net.

Source

The line version of the DES is reprinted in the Bernstein and Putnam (1986) paper, although the response line is not the correct length and one item is missing. The percentage version of the DES is reprinted in Carlson and Putnam (1993) and in Appendix B. One copy of the instrument (designate the language), a user's manual (the Carlson & Putnam, 1993, article referenced above), and a list of 333 references are available for purchase through the Sidran Foundation, 2328 West Joppa Road, Luterville, MD 21093, USA; (tel) 410-825-8888; (fax) 410-337-0747; (e-mail) sidran@sidran.org; (webpage) www.sidran.org.

DISTRESSING EVENT QUESTIONNAIRE (DEQ)

Original Citation

Kubany, E. S., Leisen, M. B., Kaplan, A. S., & Kelly, M. P. (2000). Validation of a brief measure of posttraumatic stress disorder: The Distressing Event Questionnaire (DEQ). *Psychological Assessment, 12*, 197–209.

Purpose

To assess PTSD and PTSD severity.

Description

The DEQ is a comprehensive measure that has been demonstrated to assess PTSD across a variety of trauma populations. Although the measure does not assess criterion A-1 (the occurrence of a traumatic event), it does assess criterion A-2, with three questions that assess the presence of intense fear, helplessness, and horror at the time of the traumatic event. The DEQ also includes 17 items that assess the diagnostic symptoms of PTSD (criteria B through D). Respondents are asked to indicate the degree to which they experienced each of the symptoms within the last month on a five-point scale ranging from 0 (absent or did not occur) to 4 (present to an extreme or severe degree). Criterion E is assessed by three questions that ask if the respondent had PTSD for more than 30 days, when the symptoms began, and how long they have persisted. Criterion F is assessed by 11 items that measure distress and impairment in various areas of functioning. Additional features associated with PTSD, including trauma-related guilt, anger, and unresolved grief over trauma-related losses, are also assessed.

Administration and Scoring

The DEQ can be administered in 5 to 7 minutes. A PTSD diagnosis can be obtained by following the DSM-IV diagnostic criteria or a symptom severity index can be obtained by summing the appropriate items. Cutoff scores differ for men and women (see below).

Psychometric Properties

Psychometric properties were evaluated in a multisample, multistudy study (Kubany et al., 2000).

Sample Scores and Norms.

None are available.

Reliability.

Reliability was assessed in a sample of male veterans. The internal consistency of the DEQ was excellent for the total score ($\alpha = .93$) and very good to excellent for each of the B, C, and D symptom clusters (αs .88 to .91). Similar results were found for women with histories of sexual assault, abuse by an intimate partner, prostitution, and substance abuse.

Test–retest reliability for a male veteran sample ($M = 17.5$ days, $SD = 12.3$ days) for the overall scale was .95 with reliability coefficients (rs) for the various symptom clusters ranging from .69 to .72. Similar results were found among battered women (test–retest reliability for total score, $r = .83$; for subscales rs range from .76 to .81). Temporal stability of the DEQ for identifying the presence of a PTSD diagnosis was also demonstrated with the battered women. Utilizing all six DSM-IV criteria to establish a diagnosis resulted in 83% diagnostic agreement.

Validity.

Six clinicians who specialize in PTSD rated relevance and representativeness of several aspects of the DEQ (e.g., response format, individual items) for measuring PTSD as defined in DSM-IV . The responses averaged "very well" to "considerably" relevant and representative for all indices.

Convergent validity was assessed in a male veteran sample. A sum of the 20 symptom items of the DEQ was significantly, positively correlated with another measure of PTSD ($r = .83$), a measure of depression ($r = .76$), and hostility ($r = .55$), and was negatively correlated with a measure of self-esteem ($r = -.67$).

In a mixed sample of veterans and women with histories of sexual assault, abuse by an intimate partner, prostitution, and substance abuse, the DEQ was correlated with two other measures of PTSD (*rs* range from .82 to .94) and these correlations remained high across a variety of ethnic groups. Further, the sum of the additional items of the DEQ measuring associated features were also found to correlate significantly with three measures of PTSD, a measure of depression and a measure of guilt (*rs* = .71 to .91 for men and *rs* = .57 to .78 for women). In contrast, the DEQ was uncorrelated with a measure of social desirability in all samples except for within the group of women with a history of prostitution.

The ability of the DEQ to predict diagnostic status as assessed by another self-report measure of PTSD was examined. The percentage of diagnostic agreement between the two scales was 82%. PTSD designation on the DEQ was based on whether DSM-IV criteria B, C, and D were met using a symptom score of 2 (i.e., present to a moderate degree) or higher. The two measures agreed on positive PTSD cases 75% of the time, and agreement regarding the absence of PTSD occurred in 92% of the cases.

The discriminative validity of the DEQ was evaluated against the CAPS. A cutoff score of 26 for a veteran group correctly classified 86% of the sample. A cutoff score of 18 for a group of treatment-seeking women with histories of rape, incest, partner abuse, prostitution, and substance abuse correctly classified 90% of the sample.

Alternative Forms

There are different initial instruction versions of the DEQ depending on the purpose of the assessment and the setting in which it is conducted. Translations are available in Japanese and Tagalog. A computerized version of the scale (which incorporates this scale and the Traumatic Life Events Questionnaire) is currently being validated in a grant-funded study.

Source

The DEQ is available from Edward S. Kubany, Ph.D., National Center for PTSD, Department of Veterans Affairs, 1132 Bishop Street, Suite 307, Honolulu, HI 96813, USA; (tel) 808-566-1651; (fax) 808-566-1885; (e-mail) kubany@pixi.com. A published version of the DEQ is in development with Western Psychological Services, 12031 Wilshire Boulevard, Los Angeles, CA 90025, USA; (tel) 800-648-8857; (fax) 310-478-7838; (e-mail) custsvc@wpspublish.com; (website) www.wpspublish.com.

IMPACT OF EVENT SCALE (IES)

Original Citations

Horowitz, M., Wilner, N., & Alvarez, W. (1979). Impact of Event Scale: A measure of subjective stress. *Psychosomatic Medicine, 41*, 209–218.

Weiss, D. S., & Marmar, C. R. (1997). The Impact of Event Scale-Revised. In J. P. Wilson & T. M. Keane (Eds.), *Assessing psychological trauma and PTSD* (pp. 399-411). New York: Guilford.

Purpose

To measure intrusion and avoidance resulting from exposure to traumatic events.

Description

The IES is a 15-item self-report questionnaire based on Horowitz's (1976) conceptualization of the stress response as including alternating phases of intrusions and avoidance. There are two subscales: *intrusion* and *avoidance* (see discussion below). Respondents are asked to indicate a specific life event and to rate the descriptive statements in response to that event. Respondents rate how frequently they have experienced each of the symptoms during the previous 7 days on a four-point scale. Weighted numerical ratings are assigned to the descriptors (not at all = 0, rarely = 1, sometimes = 3, and often = 5). Item values of 2 and 4 are not used. Although the IES can be used to assess responses to any type of stressful event, it has been widely used to measure symptoms of PTSD. However, the IES does not assess criterion D, hyperarousal symptoms (e.g., difficulty concentrating, exaggerated startle response). A revised version of the IES, discussed below, includes six items to assess this symptom cluster.

Administration and Scoring

It takes 10 minutes to administer the IES. The IES is scored by summing all of the items. Subscale scores can also be derived by summing the items that reflect *intrusion* (items 1, 4–6, 10, 11, 14) and *arousal* (items 2, 3, 7–9, 12, 13, 15). Horowitz (1982) identified total score thresholds for clinical concern as low (< 8.5), medium (8.6–19), and high (> 19). However, these cutoff points are not related to diagnostic status and their utility has been questioned (e.g., Joseph, 2000).

Psychometric Properties

Sample Scores and Norms. There are no published norms on the IES, but some individual studies report mean scores for different groups. For instance, the mean score on the IES in a sample of 130 service seeking veterans was 55.7 (SD = 10.6) for the total score and 27.6 (SD = 6.8) for the *intrusion* subscale and 28.2 (SD = 6.2) for the *avoidance* subscale (McFall, Smith, Roszell, Tarver, & Malas, 1990). Among a sample of survivors of a ferry disaster, the mean score was 35 for total score, 19 for *intrusion*, and 16 for *avoidance* (Joseph, Yule, Williams, & Hodgkinson, 1993). Female bank staff following an armed raid scored an average of 22.57 on the IES total score (Hodgkinson & Joseph, 1995).

Reliability. Good internal consistency for the total and subscale scores on the IES has been demonstrated in a sample of psychotherapy outpatients who had experienced a serious life event (αs range from .78 to .86; Horowitz et al., 1979) and a sample including outpatients and controls who had experienced parental bereavement (total score IES α = .86; Zilberg, Weiss, & Horowitz, 1982).

Test–retest reliability over 1 week for a small sample of students who had recently dissected a cadaver was .87 for the total score, .89 for *intrusion*, and .79 for *avoidance* (Horo-

witz et al., 1979). Despite the fact that the IES is widely used, no other studies have reported test–retest reliability data on the scale, raising the concern that these findings might overestimate the true reliability of the scale (Joseph, 2000).

Validity. Psychotherapy outpatients reflecting on significantly distressing life events scored significantly higher on the *intrusion subscale*, *avoidance subscale*, and the total IES than medical students relating to their first dissection experience, which had occurred during the previous week (Horowitz et al., 1979). Patients seeking therapy for parental bereavement scored significantly higher than individuals recruited from the community who had also lost a parent (Zilberg et al., 1982).

Several factor analyses have confirmed the existence of the two hypothesized factors of the IES (e.g., Hodgkinson & Joseph, 1995; Joseph et al., 1993; Schwarzwald, Solomon, Weisenberg, & Mikulincer, 1987; Zilberg et al., 1982) with minor differences in the item loadings. However, even when the two-factor structure was supported, some of these studies have yielded a weaker, third factor that may in fact reflect the distinction of emotional avoidance or denial from active behavioral avoidance (e.g., Joseph et al., 1993; McDonald, 1997; Schwarzwald et al., 1987). Hodgkinson and Joseph (1995) found a change in the structure of a factor analysis over time. Specifically, they found *intrusion* to be a larger factor immediately posttrauma and *avoidance* to account for more variance at a later follow-up point (Hodgkinson & Joseph, 1995). Finally, other studies with more chronic trauma populations have reported a single factor solution, suggesting that the distinctiveness of intrusion and avoidance lessens over time (Hendrix, Jurich, & Schumm, 1994).

Studies have examined correlations between the subscales of the IES and have, for the most part, supported the notion that they measure separate but related constructs (rs = .40 to .78; Hodgkinson & Joseph, 1995; Horowitz et al., 1979, Neal, Busuttil, Rollins, et al., 1994; Zilberg et al., 1982). There is some evidence that the relationship between the two subscales changes over time (e.g., Zilberg et al., 1982).

The IES has been shown to be associated with another self-report measure of PTSD (rs for the total score and subscales ranged from .44 to .67) and a measure of general distress (rs range from .50 to .60) among women receiving inpatient treatment for trauma-related disorders (Allen, Coyne, & Huntoon, 1998). In a mixed sample of veterans seeking treatment and civilians, the IES was significantly associated with a self-report (rs ranged from .73 to .79) and a structured clinical interview measure of PTSD (rs ranged from .75 to .81; Neal, Busuttil, Rollins, et al., 1994). Further, the IES was significantly associated with general distress (rs ranged from .44 to .63) in a sample of women exposed to an armed raid (Hodgkinson & Joseph, 1995).

Neal, Busuttil, Rollins, et al. (1994) found that an optimum cutoff score of 35 for the total IES yielded a sensitivity of 89%, specificity of 88%, and overall diagnostic efficiency of 88%, relative to a structured clinical interview.

Treatment sensitivity has been demonstrated in several studies (Davidson et al., 1993; Foa, Rothbaum, Riggs, & Murdock, 1991; Horowitz et al., 1979).

The predictive validity of the IES has also been demonstrated. Perry, Difede, Musngi, Frances, and Jacobsberg (1992) found that IES *intrusion* scores 2 months posttrauma significantly predicted PTSD at 6 months and that IES *avoidance* scores at 6 months significantly predicted PTSD at 12 months posttrauma. Shalev, Peri, Canetti, and Schreiber (1996) found that IES scores 1 week posttrauma predicted PTSD 6 months later with 92.3% sensitivity, but only 34.2% specificity.

Alternative Forms

The IES has been translated into several languages including Hebrew and Dutch. A revised version of the IES, which includes seven new items presumed to measure hyperarousal and one that measures flashback-type experiences, has been demonstrated to have very good internal consistency and moderate to good test–retest reliability (Weiss & Marmar, 1997). After collecting these psychometric data, the authors made some additional changes to the IES-R with regard to the instructions and the rating scale, which need to be empirically evaluated.

Source

The IES is reprinted in the original citation and in Appendix B. Additional information can be obtained by contacting Mardi Horowitz, M.D., University of California–San Francisco, P.O. Box 0984, Box F-LPP 357, San Francisco, CA 94142, USA. The IES-R is reprinted in Weiss and Marmar (1997). More information can be obtained by contacting Daniel S. Weiss, Ph.D., Director of PTSD Research, SFVAMC, Department of Psychiatry, University of California–San Francisco, San Francisco, CA 94143, USA; (e-mail) dweiss@itsa.ucsf.edu.

LOS ANGELES SYMPTOM CHECKLIST (LASC)

Original Citation

King, L. A., King, D. W., Leskin, G., & Foy, D. W. (1995). The Los Angeles Symptom Checklist: A self-report measure of posttraumatic stress disorder. *Assessment*, *2*, 1–17.

Purpose

To measure PTSD symptoms from DSM-IV criteria B, C, and D as well as associated features.

Description

The LASC is a 43-item self-report scale. Seventeen of the items correspond fairly closely with the B, C, and D symptoms of PTSD. Each item is a word or phrase that is rated on a five-point scale ranging from 0 (not a problem) to 4 (extreme problem), reflecting the extent to which the symptom is a problem for the respondent. No time frame is established for rating symptoms.

Administration and Scoring

The LASC can be administered in 10 to 15 minutes. It can be scored in several ways. To be considered a positive PTSD case, a respondent must endorse an appropriate combination of symptoms with a rating of two or higher. Following DSM-IV criteria, the diagnosis of PTSD

requires at least one *reexperiencing* (B) symptom (items 5, 23, 28), three *avoidance* (C) symptoms (items 19, 29, 40–43), and two *arousal* (D) symptoms (items 1, 4, 8, 20, 25, 34, 37, 38). A partial PTSD diagnosis may be considered if a respondent endorses two of the three criteria. The LASC may also be scored as a continuous measure of PTSD severity, which requires summing the scores of the 17 items reflecting PTSD symptoms. Finally, the sum of all 43 items provides a global assessment of distress and interference related to traumatic exposure.

Psychometric Properties

Sample Scores and Norms. Normative information is available for a variety of samples that vary across gender, age, and trauma type derived from 10 studies reported by King, King, Leskin, and Foy (1995). *PTSD severity* scores for male veterans have been found to range from 46.94 to 49.82; in the same samples the *LASC total* score ranged from 94.63 to 107.87 (Leskin & Foy, 1993; Pava, 1993). Mean *PTSD severity* scores for help seeking women with a history of childhood sexual assault ranged from 29.57 to 31.18; in the same samples the *total LASC* scores ranged from 56.83 to 64.62 (Lawrence, 1992; Rowan, Foy, Rodriguez, & Ryan, 1994; Ryan, 1992).

Reliability. A data set was formed to assess the psychometric characteristics of the LASC by combining data from 10 studies that had used the measure with clinical samples (King et al., 1995). The samples were derived from a diverse set of populations including Vietnam veterans, battered women, adult survivors of childhood sexual abuse, maritally distressed women, psychiatric outpatients, and high-risk adolescents. The total data set included 874 respondents. Coefficient alpha was .94 for the 17 items specifically assessing PTSD symptoms and .95 for the total score. Test–retest reliability over 2 weeks was available for a sample of 19 Vietnam veterans. The 17-item scores yielded a coefficient of .94 and the total scores yielded a coefficient of .90.

Validity. A factor analysis on the combined data set yielded three factors accounting for a total of 40.8% of the variance in the scale. Factor 1 was represented primarily by items that assessed the specific symptoms of PTSD. Factor 2 included items that tapped into physical manifestations of stress (e.g., severe headaches, abdominal distress, dizziness). Factor 3 included items reflecting issues related to interpersonal functioning (e.g., marked self-consciousness, inability to make and keep same-sex friends).

The LASC PTSD scores have been shown to be moderately but significantly related to measures of combat exposure (*r*s ranging from .30 to .51; Foy, Sipprelle, Rueger, & Carroll, 1984; Lund, Foy, Sipprelle, & Strachan, 1984; Resnick, Foy, Donahoe, & Miller, 1989) and other self-report measures of PTSD symptomatology (*r*s ranging from .38 to .48; Astin, Lawrence, & Foy, 1993). Diagnoses based on LASC scores corresponded to diagnosis based on a structured clinical interview with a sensitivity rate of 70% and a specificity rate of 80% (Housekamp & Foy, 1991).

King et al. (1995) also examined the ability of the LASC to predict PTSD diagnosis derived from a structured clinical interview. Although the 17 items were associated with a PTSD diagnosis (a score of 34 on the LASC is associated with approximately a 75% probability of having PTSD), the additional 26 items did not add to the predictive power of the measure. Thus, although these items may be clinically descriptive, their predictive validity is unproven.

Alternate Forms

An adolescent version of the LASC is available (Foy, Wood, King, King, & Resnick, 1997).

Source

The LASC is reprinted in Appendix B. The primary author of the scale is David W. Foy, Ph.D., Graduate School of Education and Psychology, Pepperdine University Plaza, 400 Corporate Pointe, Culver City, CA 90230, USA; (tel) 310-568-5739; (fax) 310-568-5755. More information can also be obtained by contacting Lynda A. King, National Center for PTSD (116B-3), VA Boston Healthcare System, 150 South Huntington Avenue, Boston, MA, 02130, USA; (tel) 617-232-9500, ext. 4938; (fax) 617-566-8508; (e-mail) lking@world.std.com.

MINNESOTA MULTIPHASIC PERSONALITY INVENTORY PTSD SCALE (MMPI-PTSD)

Original Citation

Keane, T. M., Malloy, P. F., & Fairbank, J. A. (1984). Empirical development of an MMPI subscale for the assessment of combat-related posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology, 52*, 888–891.

Purpose

To detect symptoms of posttraumatic stress disorder.

Description

One of the greatest advantages of the MMPI-PTSD scale is that it is widely available to clinicians who regularly administer the MMPI-2 as part of their practice. The original MMPI-PTSD was a 49-item measure derived from the MMPI. When the MMPI was renamed and revised, the MMPI-PTSD scale also underwent some changes including the deletion of three items, the rewording of one item, and a change in item order (thus the current version has 46 items). The items are answered in a true–false format. Although the scale is typically administered as part of the full MMPI-2, it can be useful as a stand-alone scale. The embedded and stand-alone versions have been shown to be highly correlated ($r = .90$; Herman, Weathers, Litz, & Keane, 1996).

Administration and Scoring

It takes 15 minutes to administer the stand-alone version of the MMPI-PTSD scale. A total score is derived by summing the positive answers to the items. The MMPI-2 PTSD is also

discussed in the MMPI-2 manual and can be scored by the hand or computer method. A cutoff score of 30 was originally suggested for detecting PTSD among veterans; later studies with the MMPI-2 version suggested a cutoff between 24 and 28. The civilian cutoff is in the range of 15 to 19. Scores greater than 38 or 40 may indicate fabrication of symptoms. Additional information about scoring and interpreting the MMPI-PTSD scale in the context of the MMPI-2 is available in the manual.

Psychometric Properties

Sample Scores and Norms. On the original MMPI-PTSD scale, veterans with PTSD have a mean score between 26 and 37 (Keane et al., 1984; Koretzky & Peck, 1990), whereas psychiatric controls have a mean of 20 (Keane et al., 1984) and non-PTSD patients a mean of 12.30 (Koretzky & Peck, 1990). Veterans with PTSD revealed a mean of 31.5 on the revised stand-alone scale whereas those without PTSD had a mean of 15.5 (Herman et al., 1996). Mean scores for the revised, embedded MMPI-PTSD scale have been shown to range from 30.6 to 36.2 for veterans with PTSD (Herman et al., 1996; Litz et al., 1991), and to be 15.5 for veterans without PTSD (Herman et al., 1996), 22.9 for psychiatric controls, 18.3 for substance abusers, and 5.2 for a comparison group (Litz et al., 1991).

Reliability. The internal consistency of the embedded and stand-alone versions of the MMPI-2 PTSD scale has been shown to be excellent in a veteran sample (αs range from .95 to .96; Herman et al., 1996).

The test–retest reliability of the stand-alone version of the MMPI-2 PTSD scale over 2 to 3 days was also excellent in a veteran sample ($r = .95$; Herman et al., 1996).

Validity. Veterans with PTSD have been shown to score significantly higher than psychiatric controls (Keane et al., 1984) and veterans without PTSD (Herman et al., 1996; Scotti, Sturges, & Lyons, 1996). Further, the MMPI-PTSD scale can differentiate veterans with comorbid PTSD and substance abuse from those with substance abuse alone (Kenderdine, Phillips, & Scurfield, 1992).

A score of 30 correctly classified 82% of veterans with and without PTSD (Keane et al., 1984). A score of 19 correctly classified 88% of patients in a psychotherapy clinic (Koretzky & Peck, 1990).

With regard to convergent validity, the original MMPI-PTSD scale was correlated significantly with other self-report measures of PTSD in a sample of veterans (*r*s ranged from .79 to .88; Watson et al., 1994) although another study found the associations to be lower (*r*s ranged from .21 to .71; McFall, Smith, Mackay, & Tarver, 1990). In a sample of battered women, Dutton, Perrin, Chrestman, Halle, and Burghardt (1991) found the MMPI-PTSD scale to be moderately but significantly correlated with other self-report measures of PTSD (*r*s ranged from .33 to .65). Stronger convergent validity with other measures of PTSD was demonstrated in a mixed trauma sample (Neal, Busuttil, Rollins, et al., 1994; *r*s ranged from .79 to .85); however, in this sample, the scale was also highly correlated with a measure of general distress ($r = .92$). Further, the MMPI-PTSD scale was significantly correlated with a number of MMPI scales and subscales in a sample of inpatient alcoholics, again suggesting that the measure may assess general psychological distress (Moody & Kish, 1989).

The embedded and stand-alone versions of the MMPI-2 PTSD scale have been shown to be moderately but significantly associated with a measure of combat exposure (*r*s ranged from .32 to .37), other self-report measures of PTSD (*r*s ranged from .65 to .85), and a structured clinical interview for PTSD (*r*s ranged from .77 to .80; Herman et al., 1996).

Cutoffs of 26 and 28 for the embedded MMPI-2 PTSD scale have been shown to correctly classify 76% of veterans with PTSD (Herman et al., 1996; Munley, Bains, Bloem, & Busby, 1995), whereas a cutoff of 24 on the stand-alone version correctly classified 80% of veterans with PTSD (Herman et al., 1996).

Treatment sensitivity for the MMPI-PTSD has been demonstrated in a number of studies (e.g., Brom, Kleber, & Defares, 1989; Thompson et al., 1995).

Source

Additional information about the MMPI-PTSD scale can be obtained by contacting Terence M. Keane, Ph.D., National Center for PTSD (116B-2), VA Boston Healthcare System, 150 South Huntington Avenue, Boston, MA 02130, USA; (tel) 617-232-9500, ext. 4143; (e-mail) terry.keane@med.va.gov.

MISSISSIPPI SCALE FOR PTSD

Original Citations

Keane, T. M., Caddell, J. M., & Taylor, K. L. (1988). Mississippi Scale for Combat-Related Posttraumatic Stress Disorder: Three studies in reliability and validity. *Journal of Consulting and Clinical Psychology, 56*, 85–90.

Purpose

To measure self-reported symptoms of PTSD.

Description

There are several versions of the Mississippi Scale for PTSD. Among the most widely used include the Mississippi Scale for Combat-Related PTSD and the Civilian Mississippi Scale. The original combat scale consists of 35 items that tap into the presence of symptoms reflecting the three main DSM-IV criteria for PTSD: *reexperiencing* (criterion B), *avoidance and numbing* (criterion C), and *hyperarousal* (criterion D) and associated features (e.g., depression, substance abuse). Items are rated on a five-point scale with anchors that vary depending on the item but include phrases such as "not at all true" to "almost always true." Respondents are asked to rate symptoms over the time period occurring "since the event." The original version of the civilian scale used in the civilian/nonveteran component of the National Vietnam Veterans Readjustment Study (NVVRS) also had 35 items. Eleven of the items were rephrased slightly, changing reference to military service to a more general reference to the past. In both the combat and civilian versions, 4 items were added to make the scale consistent with DSM-IV criteria. These items assess symptoms of reexperiencing, psychogenic amnesia, hypervigilance, and increased arousal when confronted with reminders of the event. However, these items have not been found to increase the discriminative validity of the measure, so they are commonly omitted.

ADMINISTRATION AND SCORING

The full Mississippi Scale takes 10 to 15 minutes to administer. After reversing the positively worded items, a total score is derived by summing all of the items. A cutoff score of 107 was originally established for the combat version, although later studies suggested that a cutoff of 121 allows for better differentiation between veterans with and without PTSD. For the version reprinted in Appendix B, there are 9 positively worded items that should be reversed (items 6, 11, 17, 19, 22, 24, 27, 30, 34).

Psychometric Properties

Sample Scores and Norms. Among a large sample of treatment seeking veterans, the mean score for the 35-item scale was 104.5 (*SD* = 26.2; Keane et al., 1988). Means on the civilian measure for undergraduates ranged from 73.5 to 74.4 on the 35-item scale, and 81.8 to 82.9 on the 39-item scale (Lauterbach, Vrana, King, & King, 1997). The mean score obtained by civilians on the NVVRS was 64.3 (*SD* = 13.2) for the 35-item scale (Vreven, Gudanowski, King, & King, 1995).

Reliability. In a large sample of veterans seeking treatment, the 35-item Mississippi Scale for Combat-Related PTSD was shown to have excellent internal consistency ($\alpha = .94$; Keane et al., 1988). Test–retest reliability over 1 week in a smaller sample of veterans was .97 (Keane et al., 1988).

Internal consistency for the civilian version has also been demonstrated to be very good for both the 35- and 39-item scales (αs from .86 to .89; Lauterbach et al., 1997; Vreven et al., 1995).

Validity. Several factor analyses have been conducted on the 35-item Mississippi Scale for Combat-Related PTSD (e.g., Keane et al., 1988; McFall, Smith, Mackay, & Tarver, 1990). King and King (1994) conducted exploratory and higher order confirmatory factor analysis on the Mississippi Scale for Combat-Related PTSD using data from over 2200 veterans who participated in the NVVRS. The results suggest that the latent structure of this scale is best represented as an overarching single PTSD factor with four subsidiary dimensions: (1) reexperiencing and situational avoidance, (2) withdrawal and numbing, (3) arousal and lack of control, and (4) self-persecution.

Factor analyses on the civilian version have yielded mixed results from study to study and for the 35- versus the 39-item scale (Lauterbach et al., 1997; Vreven et al., 1995).

With regard to convergent validity, scores on the Mississippi Scale for Combat-Related PTSD are significantly associated with combat exposure (*r*s range from .25 to .44; Keane et al., 1988; McFall, Smith, Mackay, & Tarver, 1990; McFall, Smith, Roszell, et al., 1990) and other self-report measures of PTSD (*r*s range from .44 to .88; McFall, Smith, Mackay, & Tarver, 1990; McFall, Smith, Roszell, et al., 1990; Watson et al., 1994).

The convergent validity of the civilian measure has also been examined. Individuals with symptoms of PTSD score significantly higher than those without any PTSD symptoms, and some relationship has been established between exposure to stressful events and score on the Civilian Mississippi Scale (Lauterbach et al., 1997; Vrenen et al., 1995). Also, civilian scores have been associated with sexual abuse-related posttraumatic symptomatology (Gold & Cardeña, 1998). Further, the scores have been significantly but moderately associated with other measures of PTSD (*r*s range from .34 to .52; Lauterbach et al., 1997). However, the

civilian version has also been found to be strongly associated with general distress ($r = .63$; Vrenen et al., 1995), depression ($r = .71$), and anxiety ($r = .70$; Lauterbach et al., 1997). Overall these findings suggest that the civilian version may be more of a general measure of psychopathology than a specific measure of PTSD (Lauterbach et al., 1997; Vrenen et al., 1995).

Compared with a diagnosis derived by structured interview, the diagnostic accuracy of the Mississippi Scale for Combat-Related PTSD with a cutoff score of 107 was 90%, with a sensitivity of 93% and a specificity of 89% (Keane et al., 1988). McFall, Smith, Mackay, and Tarver (1990) found similar diagnostic efficiency with a lower cutoff score. However, Dalton, Tom, Rosenblum, Garte, and Aubuchon (1989) reported that 77% of nonveterans were able to feign a score on the scale exceeding the 107 cutoff. Lyons, Caddell, Pittman, Rawls, and Perrin (1994) also found that the scale was vulnerable to faking and suggested a cutoff of 121. However, although the sensitivity of this cutoff is good (.95), its specificity is relatively low (.45).

The diagnostic accuracy of the civilian version of the scale was examined in a large sample of individuals recruited from an emergency room (Shalev, Freedman, Peri, Brandes, & Sahar, 1997). With a cutoff of 75, the sensitivity of the scale was .87, and the specificity was .51. No cutoff score was found that could optimize both sensitivity and specificity.

Alternative Forms

The Mississippi Scale for Combat-Related PTSD has been translated into Hebrew and Spanish. A short version of the combat-related version, comprised of 11 items, has been shown to have good internal consistency, high sensitivity and specificity against a cutoff derived from the full scale, and good treatment sensitivity (Fontana & Rosenheck, 1994). Norris and Perilla (1996) developed a 30-item Revised Version of the Civilian Mississippi Scale that has demonstrated internal consistency for both an English and a Spanish translation.

Source

The Mississippi Scale for Combat-Related PTSD can be obtained by contacting Terence M. Keane, Ph.D., National Center for PTSD (116B-2), VA Boston Healthcare System, 150 South Huntington Avenue, Boston, MA 02130, USA; (tel) 617-232-9500, ext. 4143; (e-mail) terry.keane@med.va.gov. The 35-item Civilian Mississippi Scale is reprinted in Appendix B.

PENN INVENTORY FOR PTSD (PENN INVENTORY)

Original Citation

Hammarberg, M. (1992). Penn Inventory for Posttraumatic Stress Disorder: Psychometric properties. *Psychological Assessment, 4*, 67–76.

Purpose

To measure severity of PTSD.

Description

The Penn Inventory is a 26-item self-report measure of the severity of PTSD. Each item comprises four sentences modeled after the Beck Depression Inventory. The meanings of the series of sentences measure the presence or absence of PTSD symptoms over the past week in addition to their degree, frequency, or intensity. The respondent chooses the statement that best describes their experience. Each sentence is rated from 0 to 3 with higher scores representing more symptomatology. Items are not keyed to a specific traumatic event.

Administration and Scoring

The Penn Inventory can be administered in 10 to 15 minutes. A score is derived by summing all of the circled values. A cutoff score of 35 can be used to determine the likely presence of PTSD.

Psychometric Properties

Sample Scores and Norms. The mean scores for clinical samples of Vietnam veterans range from 51.1 ($SD = 12.3$) to 54.7 ($SD = 8.7$; Hammarberg, 1992). Veterans without PTSD revealed a mean score of 15.6 ($SD = 9.1$) and a nonveteran community sample had a mean of 15.3 ($SD = 8.4$; Hammarberg, 1992).

Reliability. The Penn Inventory has been demonstrated to have very good to excellent internal consistency (α ranges from .78 to .94) across a variety of clinical and community samples (Hammarberg, 1992). Additionally, test–retest over an average of 5.2 days ranged from .87 to .93 (Hammarberg, 1992).

Validity. Individuals diagnosed with PTSD on the basis of self-report measures and a clinical interview scored significantly higher than those without PTSD (either confirmed by diagnostic interview or assumed based on nonveteran or community status; Hammarberg, 1992).

The overall diagnostic efficiency of the measure against another self-report measure of PTSD among veterans was 94% (Hammarberg, 1992). In a sample of disaster victims, the hit rate was 95% (Hammarberg, 1992).

Scores on the Penn Inventory have been shown to be moderately but significantly associated with exposure to combat ($r = .39$; Hammarberg, 1992). Further, among a group of veterans diagnosed with PTSD, the Penn Inventory was demonstrated to be associated with measures of anxiety (rs ranged from .74 to .82) and depression ($r = .52$). The Penn Inventory was also significantly associated with additional measures of PTSD (rs from .72 to .85).

Treatment sensitivity was demonstrated in a sample of Vietnam veterans treated for PTSD (Hammarberg & Silver, 1994). Patients changed on average from a score of 55 ($SD = 9.2$) to a score of 45.96 ($SD = 16.0$) over a period of 12 weeks, whereas untreated veterans with PTSD and non-PTSD Vietnam era veterans and nonveterans showed no significant symptom change.

Source

The Penn Inventory may be obtained from Melvyn Hammarberg, Ph.D., Department of Anthropology, 325 Museum, University of Pennsylvania, Philadelphia, PA 19104-6398, USA; (tel) 215-898-0981; (fax) 215-898-7462; (e-mail) mhammarb@ecat.sas.upenn.edu. The cost of the measure is $35.00 US.

POSTTRAUMATIC COGNITIONS INVENTORY (PTCI)

Original Citation

Foa, E. B., Ehlers, A., Clark, D. M., Tolin, D. F., & Orsillo, S. M. (1999). The Posttraumatic Cognitions Inventory (PTCI): Development and validation. *Psychological Assessment, 11*, 303–314.

Purpose

To measure trauma-related thoughts and beliefs.

Description

The PTCI is a 36-item self-report questionnaire that taps into three constructs related to trauma-related thoughts and beliefs: *negative cognitions about self, negative cognitions about the world*, and *self-blame*. Each item presents a statement and is followed by a seven-point response scale representing degree of agreement ranging from 1 (totally disagree) to 7 (totally agree). Items are worded so that higher ratings reflect greater endorsement of pathological cognitions.

Administration and Scoring

The PTCI can be administered in 10 minutes. Scoring consists of summing the items that make up each subscale and dividing the sum by the number of items comprising the subscale. *Negative cognitions about self* is derived from items 2–6, 9, 12, 14, 16, 17, 20, 21, 24–26, 28–30, 33, 35, and 36; *negative cognitions about the world* is derived from items 7, 8, 10, 11, 18, 23, and 27; *self-blame* is derived from items 1, 15, 19, 22, and 31. Items 13, 32, and 34 are experimental and are not included in the subscales. The total score is derived by taking the sum of the items that comprise the three subscales.

Psychometric Properties

The psychometric properties are derived from a sample of 601 volunteers, 392 of whom had experienced a traumatic event, and 170 of whom had reported at least moderate PTSD symptomatology on a self-report measure (Foa et al., 1999). Participants were recruited from clinical, community, and undergraduate settings.

Sample Scores and Norms. The median scores for a sample of individuals with PTSD of at least moderate severity were 133 ($SD = 44.17$) for total score, 3.60 ($SD = 1.48$) for *negative cognitions about self*, 5.00 ($SD = 1.25$) for *negative cognitions about the world*, and 3.20 ($SD = 1.74$) for *self-blame*. Median scores derived from a nontraumatized group were 45.50 ($SD = 34.76$) for total score, 1.08 ($SD = 0.76$) for *negative cognitions about self*, 2.07 ($SD = 1.43$) for *negative cognitions about the world*, and 1.00 ($SD = 1.45$) for *self-blame*.

Reliability. Cronbach's alphas for the three PTCI scales and total scales are good to very good (total score, $\alpha = .97$; *negative cognitions about self*, $\alpha = .97$; *negative cognitions about the world*, $\alpha = .88$; *self-blame*, $\alpha = .86$). One-week test–retest reliability on a subsample of the respondents was .74 for the total score and ranged from .75 to .89 for the scales. Three-week test–retest reliability in another subsample was .85 for the total score and ranged from .80 to .86 for the scales.

Validity. Factor analysis confirmed the existence of the three-factor structure. The first factor explained 48.5% of the variance, the second factor accounted for an additional 4%, and the third factor accounted for an additional 3.4%. The stability of the structure was validated across three samples.

PTCI scores were found to correlate with PTSD severity ($r = .79$), depression ($r = .75$), and anxiety ($r = .75$). The scales of the PTCI were significantly associated with similar scales assessing trauma-related cognitions. Traumatized individuals with PTSD scored significantly higher than traumatized individuals without PTSD and nontraumatized individuals on all of the PTCI scales. Further, the PTCI compared favorably with other measures of trauma-related cognitions for predicting PTSD. Scores on the PTCI scales classified 86% of the traumatized individuals correctly into those with and without PTSD with a sensitivity of .78 and a specificity of .93.

Source

The PTCI is reprinted in the original citation and in Appendix B. Additional information about the measure can be obtained by contacting Edna B. Foa, Ph.D., Center for the Study and Treatment of Anxiety, University of Pennsylvania, School of Medicine, 3535 Market Street, 6th floor, Philadelphia, PA 19104, USA; (tel) 215-746-3327; (fax) 215-746-3311; (e-mail) foa@mail.med.upenn.edu.

POSTTRAUMATIC DIAGNOSTIC SCALE (PDS)

Original Citation

Foa, E. B., Cashman, L. A., Jaycox, L., & Perry, K. (1997). The validation of a self-report measure of posttraumatic stress disorder: The Posttraumatic Diagnostic Scale. *Psychological Assessment, 4*, 445–451.

Purpose

To assess the DSM-IV diagnostic criteria and symptom severity of PTSD.

Description

The PDS is a revised version of an earlier self-report scale entitled the PTSD Symptom Scale (Foa, Riggs, Dancu, & Rothbaum, 1993). The PDS consists of 49 items arranged into four sections. Part 1 includes a checklist of 12 traumatic events one could experience or witness. In Part 2, the event causing the most distress in the past month is chosen, described in more detail and referred to in subsequent questions. Criterion A is established via four questions that assess physical threat and feelings of helplessness related to the event. Part 3 includes 17 items corresponding to PTSD criteria B, C, and D that assess the frequency of each symptom in the past month on a four-point scale. Part 4 assesses criterion F with 9 items that determine impairment in major life areas (e.g., work, leisure) using a yes/no format.

Administration and Scoring

The PDS can be administered in 10 to 15 minutes. It may be scored by hand or by computer program. A number of scoring indices can be derived including PDS diagnosis, symptom severity score, number of symptoms endorsed, symptom severity rating, and level of impairment in functioning. Following DSM-IV criteria, the diagnosis of PTSD requires the presence of physical injury or perception of life threat; a sense of helplessness or terror during the event; endorsement of at least one reexperiencing (criterion B) symptom, three avoidance (criterion C) symptoms, and two arousal (criterion D) symptoms; duration of at least 1 month; and impairment in at least one area of life functioning. An index of PTSD severity is obtained by summing the 17 symptom items.

Psychometric Properties

The psychometric properties are derived from a sample of 248 volunteers recruited from several PTSD treatment centers as well as from non-treatment seeking populations who may be at high risk for trauma (e.g., staff at police stations, individuals at women's shelters; Foa et al., 1997).

Sample Scores and Norms. The mean scores for a sample of 128 individuals with PTSD were 33.59 ($SD = 9.96$) for total symptom severity, 8.95 ($SD = 3.68$) for reexperiencing, 13.63 ($SD = 4.76$) for avoidance, and 11.02 ($SD = 3.53$) for arousal. The non-PTSD group ($N = 120$) obtained a mean score of 12.54 ($SD = 10.54$) on the total scale, 3.64 ($SD = 3.18$) on the reexperiencing scale, 4.54 ($SD = 4.83$) on the avoidance scale, and 4.36 ($SD = 3.97$) on the arousal scale.

Reliability. The PDS has been shown to have excellent internal consistency overall ($\alpha = .92$) and very good internal consistency for the symptom subscales (αs ranging from .78 to .84). Additionally, repeated administration over 2 to 3 weeks yielded an 87% agreement rate (kappa = .74) between diagnoses and adequate stability in symptom severity (all rs = .77 to .85).

Validity. Satisfactory agreement was found between the diagnoses derived from the PDS and those obtained from a structured clinical interview (kappa of .65, 82% agreement). Sensitivity of the PDS was .89 and specificity was .75. Scores reflecting symptom severity on

the PDS correlated with another measure of PTSD ($r = .78$), a measure of anxiety (rs range from .73 to .74), and a measure of depression ($r = .79$). These correlations raise the issue of whether the PDS is a specific measure of PTSD or a more general measure of psychological distress. However, given the high comorbidity of PTSD with anxiety and mood disorders, and the symptom overlap between disorders, this pattern of findings is not surprising.

Alternative Forms

The PTSD Symptom Scale Interview (PSS-I) is an interview version of the PTSD Symptom Scale Self-Report Scale that was the predecessor of the PDS. Psychometric properties of this scale are available in Foa et al. (1993).

Source

The PDS is available from National Computer Systems, P.O. Box 1416, Minneapolis, MN 55440, USA; (tel) 800-627-7271; (webpage) www.ncs.com. The PDS on-line version requires the purchase of Microtest Q Assessment Systems Software with an annual licensing fee of $89.00 US. Each assessment profile costs $4.25 US for the first 50 reports. The pencil-and-paper starter kit (including 1 manual, 10 answer sheets, and 1 scoring sheet) is $44.00 US. The reorder kit (50 answer sheets, 50 work sheets, and 1 scoring sheet) is $117.00 US. Additional information about the measure can be obtained by contacting Edna B. Foa, Ph.D., Center for the Study and Treatment of Anxiety, University of Pennsylvania, School of Medicine, 3535 Market Street, 6th floor, Philadelphia, PA 19104, USA; (tel) 215-746-3327; (fax) 215-746-3311; (e-mail) foa@mail.med.upenn.edu.

PTSD CHECKLIST (PCL)

Original Citations

Weathers, F. W., Litz, B. T., Herman, D. S., Huska, J. A., & Keane, T. M. (1993, October). *The PTSD checklist: Reliability, validity and diagnostic utility.* Paper presented at the Annual Meeting of the International Society for Traumatic Stress Studies, San Antonio, TX.

Blanchard, E. B., Jones-Alexander, J., Buckley, T. C., & Forneris, C. A. (1996). Psychometric properties of the PTSD Checklist (PCL). *Behaviour Research and Therapy, 34,* 669–673.

Purpose

To assess PTSD symptom severity.

Description

The PCL is a 17-item inventory that assesses the specific symptoms of PTSD. The respondent is asked to rate how much the problem described in each statement has bothered

him or her over the past month on a five-point scale ranging from 1 (not at all) to 5 (extremely). The authors have also suggested that the time frame (e.g., last week) can be changed to accommodate the goals of the assessment.

Administration and Scoring

The PCL takes 5 to 10 minutes to administer. A total score is an indicator of PTSD symptom severity. Cutoff scores of 50 for military samples and 44 for nonmilitary samples have been proposed (see below). Although the authors originally suggested that a PTSD diagnosis could be derived by considering a score of 3 or higher as reflecting the presence of a particular symptom, and by following the DSM-IV diagnostic rules to determine the appropriate number and pattern of symptoms, Blanchard et al. (1996) caution against this approach (see below).

Psychometric Properties

Sample Scores and Norms.

In a sample of combat veterans, those with a diagnosis of PTSD obtained a mean of 63.58 (SD = 14.14) and those without a diagnosis of PTSD obtained a mean of 34.40 (SD = 14.09; Weathers et al., 1993). Individuals with MVA-related PTSD scored 60.0 (SD = 9.4) and those without PTSD scored 26.6 (SD = 4.6). Sexual assault victims diagnosed with PTSD scored 55 (SD = 16.7) versus 22.8 (SD = 11.8) for the no-PTSD assault group (Blanchard et al., 1996). Additional sample means are available for mothers of cancer survivors (Manne, Du Hamel, Gallelli, Sorgen, & Redd, 1998) and for breast cancer survivors (Andrykowski, Cordova, Studts, & Miller, 1998).

Reliability.

The PCL has been shown to have excellent internal consistency in Vietnam and Persian Gulf veterans, victims of motor vehicle accidents, and sexual assault survivors (rs ranging from .94 to .97; Blanchard et al., 1996; Weathers et al., 1993). Test–retest reliability over 2 to 3 days was .96 for the Vietnam veterans (Weathers et al., 1993).

Validity.

A factor analysis on data derived from the Persian Gulf war veterans suggested that the items are best accounted for by a single factor (Weathers et al., 1993). In a Vietnam veteran sample, the PCL-M was significantly correlated with other measures of PTSD (rs range from .77 to .93) and a measure of combat exposure (r = .46; Weathers et al., 1993). Among Persian Gulf veterans, the PCL-M was significantly associated with another measure of PTSD (.85; Weathers et al., 1993).

Several studies have examined the diagnostic efficiency of the PCL. Weathers et al. (1993) found that at a cutoff of 50, the PCL-M predicted PTSD diagnosis derived from a structured clinical interview with a sensitivity of .82 and a specificity of .84. Blanchard et al. (1996) found the same cutoff yielded a sensitivity of .78 and a specificity of .86, and that a cutoff of 44 improved the sensitivity to .94 and specificity to .86 with an overall diagnostic efficiency of 90%. However, they also found variability in the most efficient cutoff score for each item (3 versus 4), thus they caution against the use of a score of 3 on a sufficient number of criterion B, C, and D symptoms to derive a diagnosis.

Additional diagnostic efficiency for cancer groups is found in Manne et al. (1998) and Andrykowski et al. (1998).

Alternative Forms

There are several versions of the PCL: the PCL-Military, the PCL-S (which is tied to a specified stressor), and the PCL-C (which is not tied to a specific stressful event, but instead asks about "response to stressful life events"). A parent report on child symptoms is also available (PCL-PR).

Source

The PCL-C is reprinted in Appendix B. More information about the scale can be obtained from Frank Weathers, Ph.D., Department of Psychology, 226 Thach Hall, Auburn University, AL 36849, USA, (tel) 334-844-6495; (e-mail) weathfw@mail.auburn.edu.

PURDUE PTSD SCALE-REVISED (PPTS-R)

Original Citation

Lauterbach, D., & Vrana, S. (1996). Three studies on the reliability and validity of a self report measure of posttraumatic stress disorder. *Assessment, 3*, 17–25.

Purpose

To assess the frequency of each PTSD symptom.

Description

The PPTSD-R is a self-report measure comprised of 17 items corresponding to the symptoms found within PTSD criteria B, C, and D. Respondents rate the frequency of occurrence within the previous month of each item on a five-point scale ranging from 1 (not at all) to 5 (often).

Administration and Scoring

The PPTSD-R can be administered in 10 minutes. The scale can be scored to yield a dichotomous index reflecting the presence or absence of PTSD or to yield a continuous measure of severity. Continuous scores are obtained by summing the 17 items. The diagnosis of PTSD requires the endorsement of at least one *reexperiencing* (criterion B) symptom (items 1–4, 8), three *avoidance* (criterion C) symptoms (items 5–7, 9–12) and two *arousal* (criterion D) symptoms (items 13–17).

Psychometric Properties

The psychometric properties reported below are published in a multisample, multistudy paper (Lauterbach & Vrana, 1996).

Sample Scores and Norms. Mean scores for a sample of 440 undergraduate students are 31.5 ($SD = 12.9$) for the total score, 8.5 ($SD = 4.1$) for *reexperiencing*, 12.6 ($SD = 5.5$) for *avoidance*, and 10.4 ($SD = 4.9$) for *arousal*. Within a sample of 35 students receiving psychotherapy at a university-based counseling center the means were 38.7 ($SD = 15.9$) for the total score, 9.5 ($SD = 4.6$) for *reexperiencing*, 15.6 ($SD = 6.7$) for *avoidance* and 13.6 ($SD = 6.3$) for *arousal*.

Reliability. The PPTSD-R has excellent internal consistency overall ($\alpha = .91$) and very good internal consistency for the symptom subscales (αs ranging from .79 to .84). Test–retest reliability for 51 undergraduate students over 2 weeks reflected adequate stability in symptom severity for the total score ($r = .72$); however, stability was somewhat lower for the *avoidance* ($r = .67$), *arousal* ($r = .71$), and *reexperiencing* subscales ($r = .48$).

Validity. The PPTSD-R has been shown to be more strongly correlated with other measures of PTSD symptomatology (rs range from .50 to .66) than measures of anxiety ($r = .37$) and depression ($r = .39$). Further, students who experienced at least one traumatic event scored significantly higher on the PPTSD-R than those who did not report any traumatic events on the total score, *reexperiencing* and *arousal* subscales. Although the traumatized group scored higher on the *avoidance* scale as well, this difference did not reach conventional levels of significance.

Alternative Forms

There is a military and a civilian version of the measure.

Source

The PPTSD-R is reprinted in Appendix B. More information is available from Dean Lauterbach, Ph.D., 350 Sam Sibley Drive, Room 313, Bienvenu Hall, Department of Psychology, Northwestern State University, Natchitoches, LA 71497, USA; (tel) 318-357-5453; (fax) 318-357-6802.

SHORT SCREENING SCALE FOR PTSD

Original Citation

Breslau, N., Peterson, E. L., Kessler, R. C., & Schultz, L. R. (1999). Short screening scale for DSM-IV posttraumatic stress disorder. *American Journal of Psychiatry, 156*, 908–911.

Purpose

To screen for PTSD in persons exposed to a DSM-IV qualifying traumatic event.

Description

The Short Screening Scale for PTSD is a seven-item (yes/no format) clinician-administered interview measure derived from the modified National Institute of Mental Health Diagnostic Interview Schedule and the World Health Organization Composite International Diagnostic Interview developed and used in the Detroit Area Survey of Trauma (Breslau, Kessler, & Peterson, 1998). The majority of PTSD symptom measures ask about symptoms in connection with only one event. Often, respondents have experienced multiple events, but they are asked to choose the worst or most distressing event to complete the measure. The Short Screening Scale for PTSD was developed to enable interviewers to quickly and efficiently assess PTSD in response to a number of traumas.

Administration and Scoring

The Short Screening Scale for PTSD can be administered in less than 3 minutes. Scoring consists of counting the number of positive answers to the seven items. A score of 4 or more seems to be the best cutoff for predicting PTSD diagnosis.

Psychometric Properties

Sample Scores and Norms. None are available.

Reliability. The reliability of the seven-item screening scale has not been directly examined. However, the reliability of the PTSD module from which it was derived has been assessed. A random sample of 32 baseline PTSD cases and 23 noncases was selected to be reassessed 12 to 18 months after the baseline interview (Breslau et al., 1998). There was agreement on 83% of the cases.

Validity. The predictive validity of the Short Screening Scale for PTSD relative to the full diagnostic interview was examined in a representative sample of 1830 men and women who were interviewed as part of the 1996 Detroit Area Survey of Trauma (Breslau et al., 1999). With 4 as a cutoff, the sensitivity was 80.3% and the specificity was 97.3%.

Although this measure appears to be a promising screening tool, particularly for researchers, it is important to note that the validity of the scale has not been examined in a study in which the seven items were administered as a freestanding scale.

Source

The Short Screening Scale for PTSD is reprinted in Appendix B. More information about the scale can be obtained by contacting Naomi Breslau, Ph.D., Henry Ford Health Systems, Psychiatry Service, 3A, Detroit, MI 48202-3450, USA; (tel) 313-876-2516; (fax) 313-874-6221; (e-mail) nbreslal@hfhs.org.

STANFORD ACUTE STRESS REACTION QUESTIONNAIRE (SASRQ)

Original Citation

Cardeña, E., Koopman, C., Classen, C., Waelde, L. C., & Spiegel, D. (2000). Psychometric properties of the Stanford Acute Stress Reaction Questionnaire: A valid and reliable measure of acute stress. *Journal of Traumatic Stress, 13*, 719–734.

Purpose

To assess the psychological symptoms experienced in the aftermath of a traumatic event.

Description

The SASRQ is a 30-item self-report measure of ASD. The instructions allow the administrator to specify the time period during which the respondent's symptoms should be rated. The respondent is asked to describe the stressful event and rate how much disturbance it caused. Then, the respondent rates 30 items on a six-point scale ranging from 0 (not experienced) to 5 (very often experienced). Items tap into dissociation (10 items), reexperiencing (6 items), avoidance (6 items), anxiety and hyperarousal (6 items), and impairment in functioning (2 items). A final question asks the respondent how many days he or she experienced the worst symptoms of distress.

Administration and Scoring

The SASRQ can be administered in 15 minutes. It can be scored continuously by summing all of the items or dichotomously (ratings between 0 and 2 = 0, ratings between 3 and 5 = 1) for the presence of a symptom. To meet criterion B, a respondent must endorse three or more of the symptom criteria for dissociation: numbing (items 20, 28), reduction in awareness of surroundings (items 4, 24), derealization (items 3,18), depersonalization (items 10, 13), dissociative amnesia (items 16, 25). A respondent must endorse a symptom within each of the remaining criterion symptom clusters to obtain an ASD diagnosis: criterion C (items 6, 7, 15, 19, 23, 29), criterion D (items 5, 11, 14, 17, 22, 30), criterion E (items 1, 2, 8, 12, 21, 27), and criterion F (items 9, 26).

Psychometric Properties

The psychometric properties of an earlier version and of the final version of the SASRQ were evaluated together in a multisample, multistudy paper (Cardeña et al., 2000).

Sample Scores and Norms.

In a sample of 43 adult emergency rescue workers the mean score was 26.37 (SD = 25.52). In contrast, within a group of 97 nonexposed rescue workers the mean was 4.91 (SD = 8.34).