
Assessment of Posttraumatic Stress Disorder
Presented by National Center for PTSD U.S. Department of
Veterans Affairs



**VA/DoD CLINICAL
PRACTICE GUIDELINES
FOR PTSD (2010)**

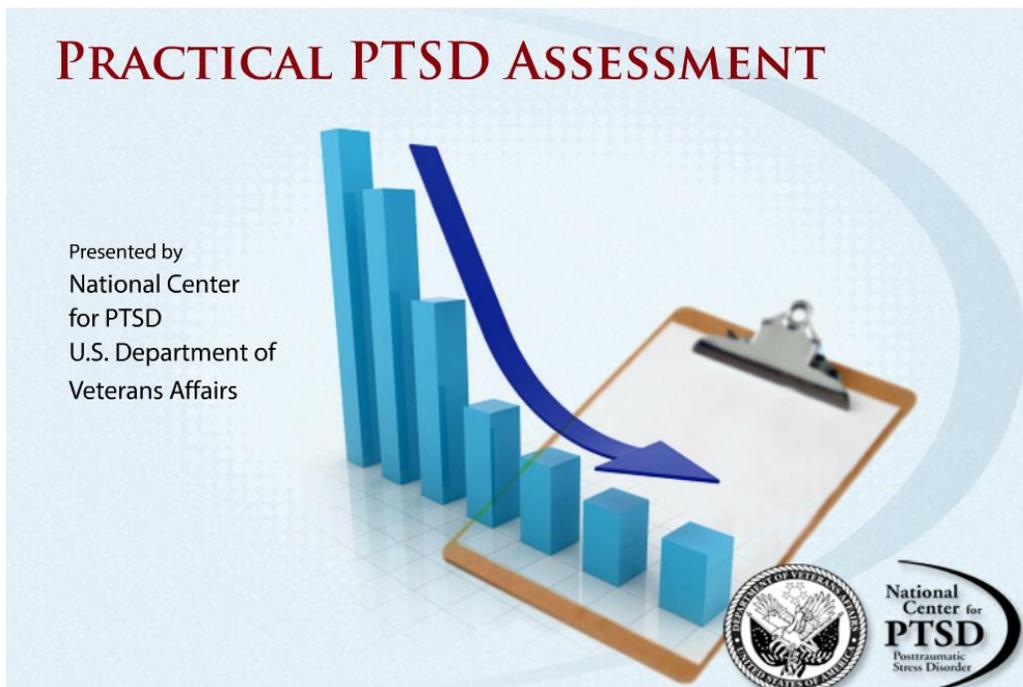
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PRACTICAL PTSD ASSESSMENT



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Welcome to today's lecture on the assessment of Posttraumatic Stress Disorder. I'm Brian Marx, staff psychologist at the VA National Center for Posttraumatic Stress Disorder, and a professor of Psychiatry at the Boston University School of Medicine.

OBJECTIVES

1. Describe the purpose of screening for PTSD and a practical screening measure
2. Understand the importance of monitoring treatment outcomes and how to do so
3. Review the best tools for diagnosing PTSD

Today, I have three objectives for our lecture. First, I'll describe the purpose of screening for PTSD, and also, provide some information about a practical screening measure. I'll also, then, provide an understanding of the importance of monitoring treatment outcomes, and how to do so. And, finally, we'll review the best tools for diagnosing PTSD.

PSYCHOLOGICAL ASSESSMENT

- ▶ More than testing
 - *"An extremely complex process of solving problems (answering questions) in which psychological tests are often used as one of the methods of collecting relevant data"*
- ▶ Collecting data from different sources that must be evaluated and integrated
- ▶ Flexible and individualized

Maloney & Ward, 1976

Before we get into those objectives, I'd like to begin by discussing a few things about assessment more generally. And, I want to emphasize the point that psychological assessment is much more than testing. And Maloney and Ward's quote nicely captures this sentiment, and they wrote that psychological assessment is "an extremely complex process of solving problems (answering questions) in which psychological tests are often used as one of the methods of collecting relevant data."

The complex process of which Maloney and Ward speak usually involves collecting data from different sources. These data must be evaluated and integrated to produce a complete picture of an individual. This process should be flexible and individualized. The point of assessment is often diagnosis or classification of an individual. But, this is not always the case. Sometimes, we might just be interested in predicting a particular outcome or just observing a clinical phenomenon without necessarily being interested in diagnosis.

PROCESS OF ASSESSMENT

- Identifying the problem
- Selecting and implementing methods to obtain information
- Integrating data
- Deriving and reporting conclusions



The process of psychological assessment generally involves four steps. The first step is identifying the problem. The second is selecting and implementing methods to obtain information. The third is integrating the data that you collect. And, the fourth is deriving and recording your conclusions. In this lecture today, we will just be discussing the first two of these processes.

In the first step, in terms of identifying the problem, what we're really talking about here is something that's basic to a clinician's role in many contexts. But in our case, today, we're generally interested to know if someone has Posttraumatic Stress Disorder, or if their symptoms are changing as a result of the treatment in which they are engaged. Fundamentally, psychological assessment boils down to the task of measuring and classifying observations. The selection and implementation of methods will affect our ability to collect the information necessary to answer questions or identify the problem.

PROCESS OF ASSESSMENT

- ▮ Identifying the problem
 - Does the patient have PTSD? Are there symptoms responding to treatment?
- ▮ Selecting and implementing methods to obtain information



In the first step, in terms of identifying the problem, what we're really talking about here is something that's basic to a clinician's role in many contexts. But in our case, today, we're generally interested to know if someone has Posttraumatic Stress Disorder, or if their symptoms are changing as a result of the treatment in which they are engaged. Fundamentally, psychological assessment boils down to the task of measuring and classifying observations. The selection and implementation of methods will affect our ability to collect the information necessary to answer questions or identify the problem.

ASSESSMENT METHODS

- Diagnostic interviewing
- Self-report questionnaires
- Behavioral observation
- Psychophysiological monitoring



There are numerous methods that we can use to collect the data in which we're interested in during a psychological assessment. Some of the more commonly used methods include diagnostic interviewing, and the use of self report questionnaires. But, we can use other methods as well.

For example, sometimes we might be interested to collect behavioral data through observation, or we might be interested in collecting data on how one physiologically reacts to stimuli that might be pertinent to someone's condition. So, for example, we might be interested to see if a patient responds, physiologically speaking, to stimuli that might remind him or her of their trauma. And, we would be looking at changes in heart rate, or sweat response, or respiration, or blood pressure to see if those indicate a physiological reactivity.

DIAGNOSTIC INTERVIEWS

- ▶ Help clinicians determine diagnosis
- ▶ Questions ask about the nature, severity and frequency of symptoms
- ▶ Types of Diagnostic Interviews
 - Unstructured - vary greatly, no standard format, responses not compared to norms, allows for flexibility
 - Structured - specific questions, topics, signs, and symptoms
 - Semistructured - structured but allows for clinician queries when needed

The interview method is the one that's used most frequently in clinical practice. Questions in the clinical interview generally focus on the nature, frequency, and severity of symptoms. Interviews generally vary along a continuum of structure. Some interviews are highly structured, and other interviews are unstructured. With respect to unstructured interviews, these interviews vary greatly by clinician, patient, and context. There may be no standard format and the responses that are obtained from a patient are not usually compared to norms. In other words, the content and the format of an unstructured interview is totally up to the clinician.

One thing that, perhaps, many clinicians like about the unstructured interview is that it allows for maximal flexibility. On the other hand, a structured interview requires the clinician to ask questions that cover specific topics and address a finite list of signs and symptoms associated with various disorders. Somewhere in between a structured and an unstructured interview is a semi-structured interview.

A semi-structured interview, perhaps, combines the best features of both of these kinds of approaches. A semi-structured interview is structured, in that, it asks the clinician to ask for specific information regarding a condition of interest, but it also allows the clinician to make additional queries whenever he or she might feel it to be necessary.

STRENGTHS AND LIMITATIONS OF STRUCTURED INTERVIEWS

- ▮ Strengths: thorough; help with differential diagnosis
 - Semi-structured also allows clinicians to make queries to obtain additional information

- ▮ BUT...timely and usually require training

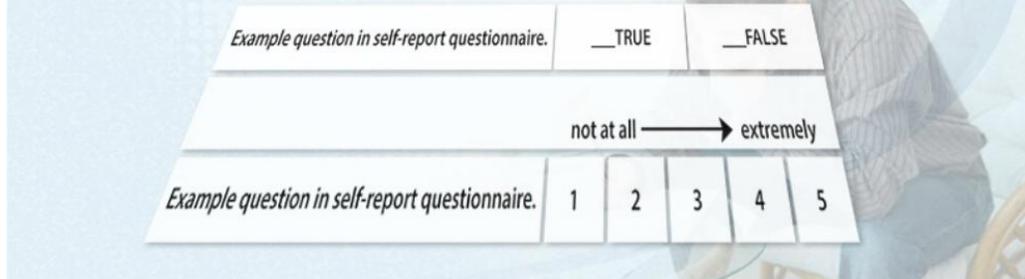
Structured interviews, generally speaking, are preferred to unstructured interviews and that's because they have some important strengths. Number one, they are thorough. And their thoroughness ensures that all diagnostic criteria and associated phenomena of interest are covered. Because they are thorough, they can also help the clinician with differential diagnosis, being able to tell whether or not the individual has PTSD, or some other anxiety disorder, or major depression, can be important from a treatment perspective, as well as from other perspectives too. And so, the structured interview is better at allowing for differential diagnosis.

With respect to the semi-structured interview, as I mentioned before, because it's somewhat more flexible, it will allow the clinician to make additional queries regarding information that may be useful in terms of formulating a coherent clinical picture of a patient.

However, there are some limitations of the structured interview. First and foremost, the structured interview can be timely in terms of administration and scoring. And also, another limitation of the structured interview is that they usually require some training before they can be used with a patient.

SELF-REPORT QUESTIONNAIRES

- Individual responds about him or herself
- Some correspond to DSM criteria, some do not
- Vary by format, response options
- Choose one appropriate for the intended purpose



Another widely-used method of assessment is the self-report questionnaire. This instrument consists of questions to which an individual responds usually about him or herself. These instruments can augment the information that's obtained through the clinical interview. And, oftentimes, the intervention, or the information, requested will pertain to DSM-type symptomatology, but in other times, that may not be the case. So, for example, there are questions that you may want to ask about a patient's coping style, or emotion regulation style, and there are questionnaires that can be used to cover that content.

The manner in which the questions are asked can vary, as can the manner in which the responses are provided by the patient. So, for example, there are some questionnaires that have a true/false format, and there are other questionnaires that have more of a 5-point Likert type scale.

The most important point, however, about self-report questionnaires is to choose the measure that matches your intended purpose. And, this is a very important, because there are, literally, there may be dozens of measures to choose from. And so, I would just recommend that you pick the one that best suits the intended purpose.

STRENGTHS AND LIMITATIONS OF SELF-REPORT QUESTIONNAIRES

- ▶ Brief, easy to use, reliable/valid
- ▶ Interviewer ratings are similar to self-report when capturing clinical change
- ▶ BUT, can yield inaccuracies
 - Response bias, responding randomly, exaggerate, minimize

Monson, 2008

Self-report questionnaires are very popular, and there are good reasons for their popularity. Number one, they are brief. Oftentimes, they don't take very long to complete. They are easy to administer. Self-report questionnaires are very popular, and there are good reasons for their popularity. Number one, they are brief. Oftentimes, they don't take very long to complete. They are easy to administer and score. And, even with all of that, you don't sacrifice much, if anything at all, with respect to the reliability and validity of these self-report measures.

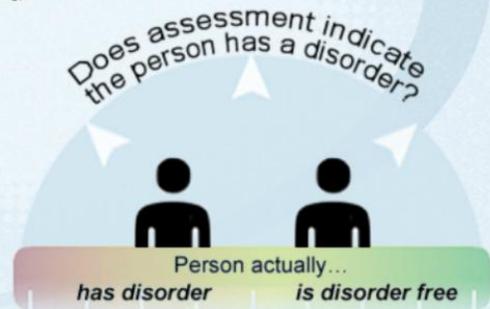
I think it's important to point out that sometimes the information that is obtained through a self-report questionnaire may be different from the information that's obtained through a clinical interview. And, that may or may not be good but, it's important to recognize that you may end up with that kind of a data.

In terms of tracking clinical outcome, however, there are some data that suggest that self-report ratings of changing symptoms over time are not inferior to ratings of clinical change captured by a clinician. So, if you're looking to use self-report measures to monitor treatment outcome, those measures are completely appropriate to use.

Perhaps the biggest drawback of the self-report questionnaire is that, perhaps sometimes, they can yield some inaccuracies due to response bias. Sometimes, respondents may respond in a random fashion, or they may exaggerate their responses on the questionnaire. Or conversely, they might minimize their concerns or their problems on a self-report questionnaire, and so it's important to be cognizant of that possibility.

SENSITIVITY AND SPECIFICITY

- ▮ Sensitivity - probability that a person has the disorder when in fact they do
- ▮ Specificity - probability that a person does not have the disorder when in fact they don't
- ▮ False Positive – positive result for a person who is disorder free
- ▮ False Negative – negative result for a person who has the disorder



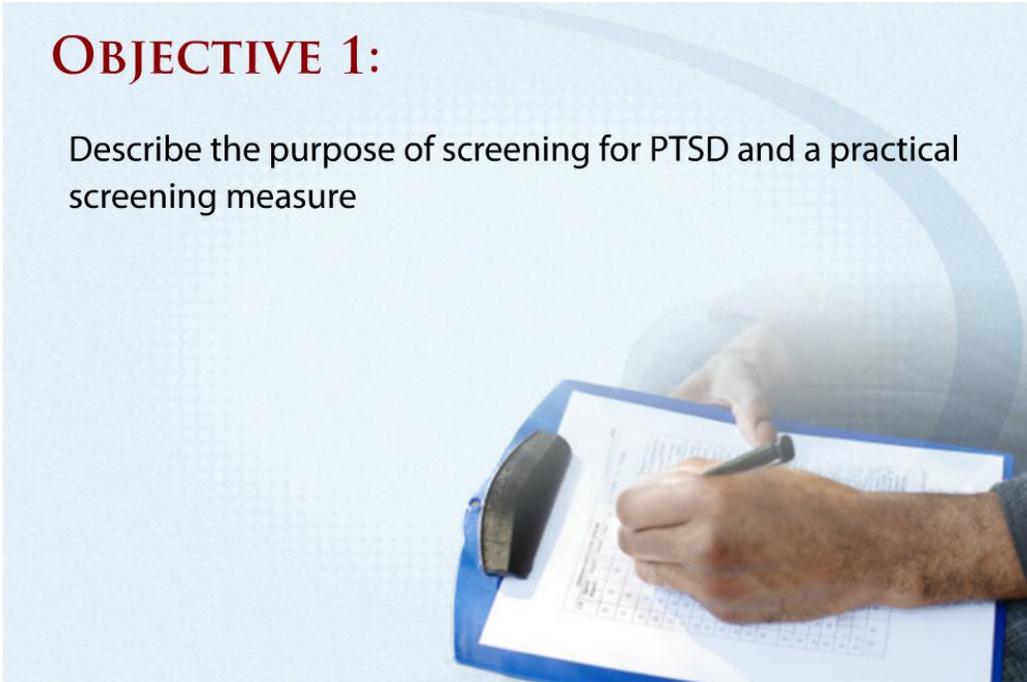
Obviously, we want to select measures that are both reliable and valid. But, there are other indicators of instrument performance, particularly when we're interested in knowing how well it diagnoses an individual with a particular condition, like Posttraumatic Stress Disorder, that we should be interested in.

For example, when we choose a measure, we should be looking at its sensitivity and specificity. Sensitivity is the measure's ability to detect a disorder when a person has it. And, specificity is the ability of the measure to detect that a person doesn't have the disorder, when in fact he or she doesn't have it.

We should also be concerned about rates of false positives and false negatives. False positives, when we talk about false positives, we're talking about a positive result for a person, who in fact is disorder free. And, false negatives refer to when we find a negative result on the test for a person who actually has a disorder. Obviously, we'd like to choose measures that minimize both false positives and false negatives, and provide accurate diagnosis.

OBJECTIVE 1:

Describe the purpose of screening for PTSD and a practical screening measure

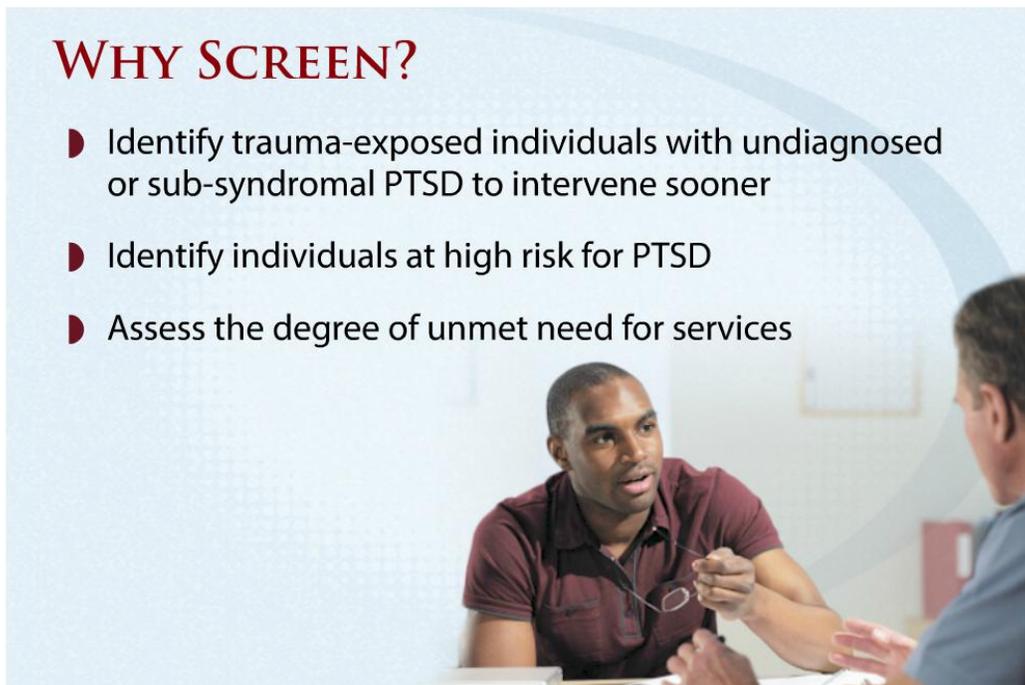


Okay, so, now with all of that in mind, let's turn our attention to the first objective of the talk, which is to describe the purpose of screening for PTSD, and give some information about a practical screening measure.

High estimates of PTSD among personnel deployed to Iraq and Afghanistan have led to increased efforts to screen Veterans for PTSD and other disorders. So, because of that, it's obviously important to choose a screening instrument that is reliable and valid, doesn't, perhaps yield too many false positives or false negatives.

WHY SCREEN?

- ▶ Identify trauma-exposed individuals with undiagnosed or sub-syndromal PTSD to intervene sooner
- ▶ Identify individuals at high risk for PTSD
- ▶ Assess the degree of unmet need for services



Why should we screen? Well, there are several important reasons to do. First and foremost, screening offers an opportunity to identify trauma exposed individuals with undiagnosed or sub-syndromal PTSD, so that we can intervene as soon as possible.

Screening also allows for an opportunity to identify individuals who may be at high risk for PTSD, but who have not yet manifested the disorder. And, finally, screening allows us to assess the degree of unmet need of services among Veterans and other populations in which we're interested in.

FALSE NEGATIVES vs. FALSE POSITIVES

- ▶ Consequences depend on disorder, setting, and cost
- ▶ In a screening context, we are more tolerant of false positives
- ▶ In a context where an important decision is made based on the assessment, less tolerance for false positives



The discussion of false positives and false negatives is a particularly important one in the context of screening. There are, depending on the assessment context, there may be different costs associated with each situation.

So, for example, in a screening context, because we're interested in just simply identifying people, perhaps who may have PTSD, or who are at risk for PTSD, we may be more tolerant of higher levels of false positives than we would perhaps in a context like a disability assessment in which the assessment will yield a decision, perhaps, about whether or not someone should be compensated for their PTSD. In that kind of a situation, we wouldn't want high levels of false positives. Instead, we would want lower levels of false positives.

PTSD SCREENING MEASURES

- ▶ Most assess DSM symptoms, but not all do
 - some focus on risk factors in hopes of preventing PTSD
- ▶ Vary by number of items and response scales, scoring
- ▶ Choose one that makes sense for the context and for the population of interest

Brewin, 2005

In terms of the available PTSD screening measures most assessed, some of the DSM symptoms of PTSD, but not all of them do. For example, there are some screening instruments that have been developed that don't focus on the DSM symptoms of PTSD, but rather focus on the risk factors for PTSD, with the thought being that if you had someone who has all of the risk factors for PTSD, but perhaps hasn't manifested the disorder you can catch someone before they develop it and intervene in a prevention manner, rather than an intervention manner.

Screeners come in all shapes and sizes and, they may vary by the number of items and the scales that are used. The main thing to remember, again, is to pick one that makes sense for the context and for the population with which you are working. So, if you are working with Veterans, then it's important to choose a screening device that has been validated for use with Veterans.

PTSD SCREENING MEASURES

- ▶ **Primary Care Posttraumatic Stress Disorder Screen (PC-PTSD)** (Prins et al., 2003)
- ▶ **Startle, Physiological arousal, Anger, and Numbness (SPAN)** (Meltzer-Brody et al., 1999)
- ▶ **Short Screening Scale for PTSD** (Breslau, 1999)
- ▶ **The Short Post-Traumatic Stress Disorder Rating Interview (SPRINT)** (Connor and Davidson, 2001)

Some of the most widely used screening instruments include: the Primary Care Posttraumatic Stress Disorder screen, the Startle, Physiological arousal, Anger and Numbness scale, the Short Screening Scale for PTSD, and the Short Posttraumatic Stress Disorder Rating Interview.

These scales are all relatively short. They take no more than 2 to 3 minutes to complete. They range in size from 4 to 10 items. And, these particular measures ask about some of the PTSD related symptoms..

PRIMARY CARE-PTSD SCREEN (PC-PTSD)

- ▶ 4-item screen designed for use in primary care and other settings outside of specialty mental health (but can be used in these settings)
- ▶ Used to screen for PTSD in Veterans at the VA and Department of Defense (DoD) post-deployment assessments

I'd like to focus now on the primary care PTSD screener. It's a 4-item screen designed for use in primary care and other settings outside of specialty mental health clinics. But, it can be used in specialty mental health clients as well.

The PC-PTSD has been used to screen for PTSD among Veterans at the VA and it's also been used to screen for PTSD by the Department of Defense (DoD) within the post-deployment assessment. The scale includes an introductory sentence that cues the individual's response to the traumatic event that he or she may have experienced.

PC-PTSD

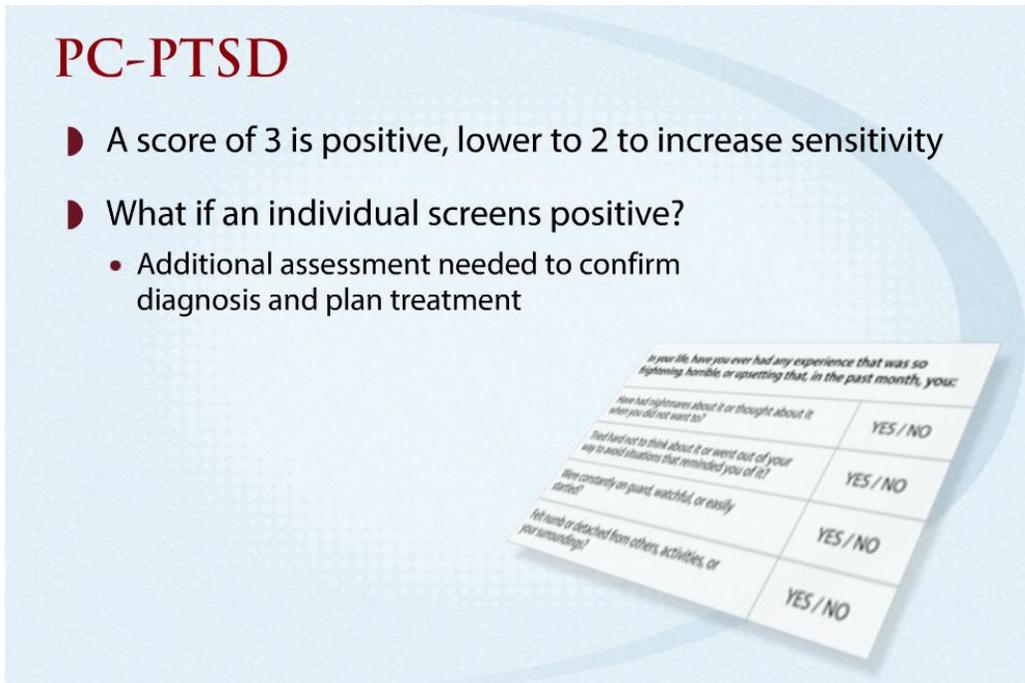
In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:

Have had nightmares about it or thought about it when you did not want to?	YES / NO
Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?	YES / NO
Were constantly on guard, watchful, or easily startled?	YES / NO
Felt numb or detached from others, activities, or your surroundings?	YES / NO

On this slide, you see the actual PC-PTSD screening measure itself. And, you can see at the top the introductory statement which reads, "In your life have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month you:", and then it moves down to the 4 questions in the PC-PTSD which are answered in a yes or no fashion.

PC-PTSD

- ▶ A score of 3 is positive, lower to 2 to increase sensitivity
- ▶ What if an individual screens positive?
 - Additional assessment needed to confirm diagnosis and plan treatment



The authors of the PC-PTSD suggest that, in most cases, results should be considered positive for PTSD if the individual answers yes to any 3 of the 4 items. The sensitivity and specificity of a cutoff score of 3 is actually quite good. However, if you want to increase the sensitivity, in other words, perhaps capture more individuals whom may be at risk for PTSD, or may partially have PTSD, it is acceptable to reduce the cutoff score to 2.

Now, what happens if an individual screens positive on the PC-PTSD? In that case, I would recommend following up the PC-PTSD with a more thorough and comprehensive assessment to confirm the diagnosis of Posttraumatic Stress Disorder.

OTHER PTSD QUESTIONNAIRES USED TO SCREEN

- ▶ PTSD Checklist (PCL; Weathers et al., 1993)
- ▶ Posttraumatic Stress Diagnostic Scale (PDS; Foa et al., 1997)
- ▶ Davidson Trauma Scale (DTS; Davidson, 1996)

Now, in some cases, it might be beneficial to a clinician to use a more thorough measure to screen for PTSD. More specifically, they might choose to use a measure that assesses all of the 17 cardinal symptoms of Posttraumatic Stress Disorder. And, some of these measures include the PTSD Checklist, or the PCL, the Posttraumatic Stress Diagnostic Scale, or PDS, and the Davidson Trauma Scale (DTS).

PCL

- ▶ 17-item self-report measure of PTSD symptoms
- ▶ Items correspond to the DSM diagnostic criteria
- ▶ Respondents rate symptoms over past month on a scale from 1 to 5
- ▶ Yields continuous measure of symptom severity
- ▶ Takes 5-10 minutes
- ▶ Variety of cutoff scores

The PCL is a 17 item self-report measure of PTSD symptoms. And, the items on the PCL correspond to, as I mentioned, the DSM diagnostic criteria for PTSD. Respondents rate the symptoms over the past month on a scale from 1 to 5. And, the PCL yields a continuous score of PTSD symptom severity that ranges from a low of 17 to a high of 85.

The PCL takes approximately 5 to 10 minutes to complete and, there have been some recommended cutoff scores for screening for PTSD. But, there are a variety of cutoff scores.

I think it depends, again, on your use of the measure and whether or not you're willing to tolerate higher rates of false positives that would determine whether or not you used a more liberal cutoff of 30, or a more stringent cut off of 50. And again, that just simply depends on your use and the context.

PCL EXAMPLE ITEMS

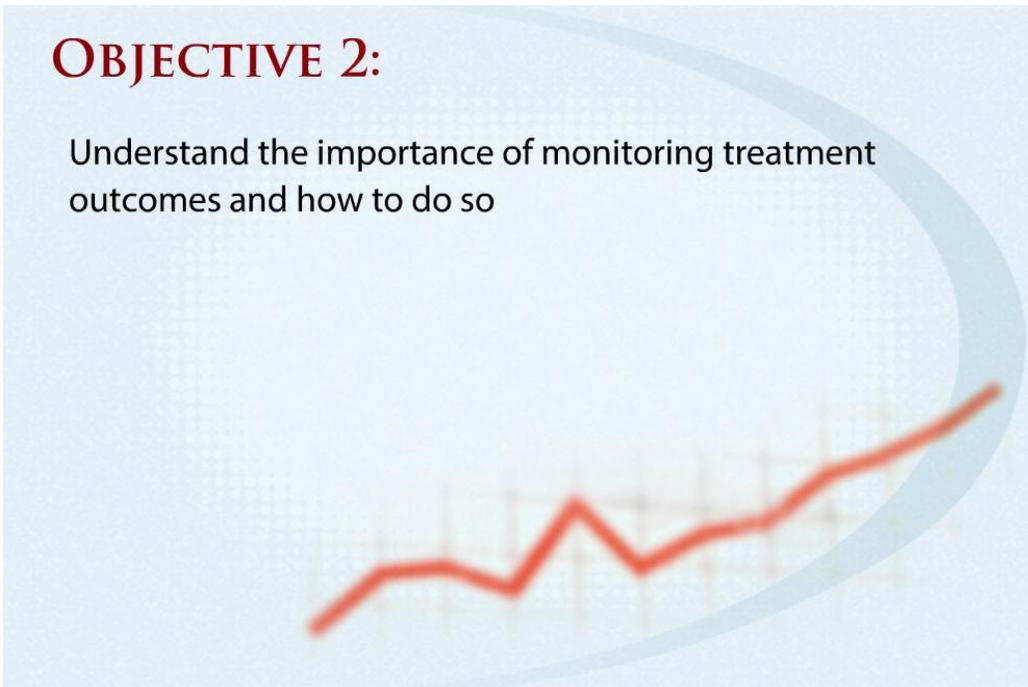
INSTRUCTIONS: Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each one carefully, then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing <i>memories, thoughts, or images</i> of a stressful experience from the past?	1	2	3	4	5
2. Repeated, disturbing <i>dreams</i> of a stressful experience from the past?	1	2	3	4	5
3. Suddenly <i>acting or feeling</i> as if a stressful experience from the past <i>were happening again</i> (as if you were reliving it)?	1	2	3	4	5
4. Feeling <i>very upset</i> when <i>something reminded you</i> of a stressful experience from the past?	1	2	3	4	5
5. Having <i>physical reactions</i> (e.g., heart pounding, trouble breathing, sweating) when <i>something reminded you</i> of a stressful experience from the past?	1	2	3	4	5

This slide shows some of the actual items from the PCL and the rating scale that respondents use to answer the actual items on the PCL, and you can see the scoring, or the scale, ranges from not at all to extremely.

OBJECTIVE 2:

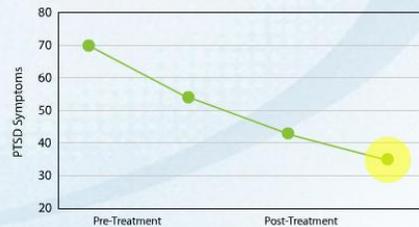
Understand the importance of monitoring treatment outcomes and how to do so



Let's move now to talking about using measures to determine treatment outcome for individuals with Posttraumatic Stress Disorder. We don't talk about using assessment instruments in this manner very frequently, although this is a really important thing to do.

WHY MONITOR TREATMENT OUTCOMES?

- ▶ Is treatment working?
- ▶ Has outcome been achieved and/or maintained?
- ▶ Is a change in approach needed?
- ▶ Discuss care and progress with patients
- ▶ Outcomes improve with monitoring



And, there are several good reasons to monitor treatment outcomes. First and foremost, it's important to know whether or not treatment is working. Secondly, it's important to know when the desired outcome has been achieved and whether or not any treatment gains have been maintained over time.

Monitoring treatment outcome is good also because it may be helpful in terms of knowing whether or not, or how, to tweak a particular treatment to address concerns as the treatment is in progress. Another good reason to monitor treatment outcomes is to just simply be able to talk with patients about their progress.

It's very helpful, rather than just simply talking about, and just sort of subjectively telling a patient that you think they're making progress; it's much more impactful if you can actually show data to patients when they've made progress, so they can sort of track their own progress over time, so you can say, "Here's where you started at, and now here's where you're at with your PTSD symptoms." And, that can be very, very important and encouraging for patients as they perhaps move through treatment, and even when treatment becomes difficult for them.

And, related to this point, we know, from research, that monitoring treatment outcomes actually improves the efficacy of treatment itself. There's something important in that feedback that we give to patients and telling them and, in fact, even maybe displaying for them, the progress that they've made over time. And, that can be reinforcing.

MONITORING TREATMENT OUTCOMES

- ▮ Assess at baseline and then intermittently during treatment
- ▮ Post-treatment
- ▮ Follow-up
- ▮ Look for change in symptoms over time
- ▮ Self-report measures are most efficient method of monitoring change

When you do monitor treatment outcomes, obviously it's important to assess symptoms before treatment starts, and then again every so often during treatment. Sometimes, it may be a good idea to assess symptoms at the beginning of every treatment session, but that is not always required.

Once treatment is over, it's important to assess PTSD symptomatology. And, it's also important to follow up, maybe a month or three months later, to see if treatment gains have been sustained over time. While one could use a diagnostic interview to monitor changes in symptoms over time, that's probably too burdensome for both the clinician and the patient.

And, as I mentioned earlier, it is absolutely appropriate and reasonable to use self-report measures to track changes in symptoms over the course of treatment, because they are brief, they are easy to use, and they just are not burdensome too much to either the clinician or the patient.

MEASURES FOR TREATMENT MONITORING

- ▶ PTSD Checklist (PCL; Weathers et al., 1993)
- ▶ Posttraumatic Stress Diagnostic Scale (PDS; Foa et al., 1997)

And just like the screening measures, there are many self-report scales to choose from for the purposes of monitoring treatment. Once again, you can use the PCL or the PDS. And, as I mentioned before, both of those measures ask specifically about the 17 symptoms of PTSD. But, perhaps, there are other measures that could be used, too.

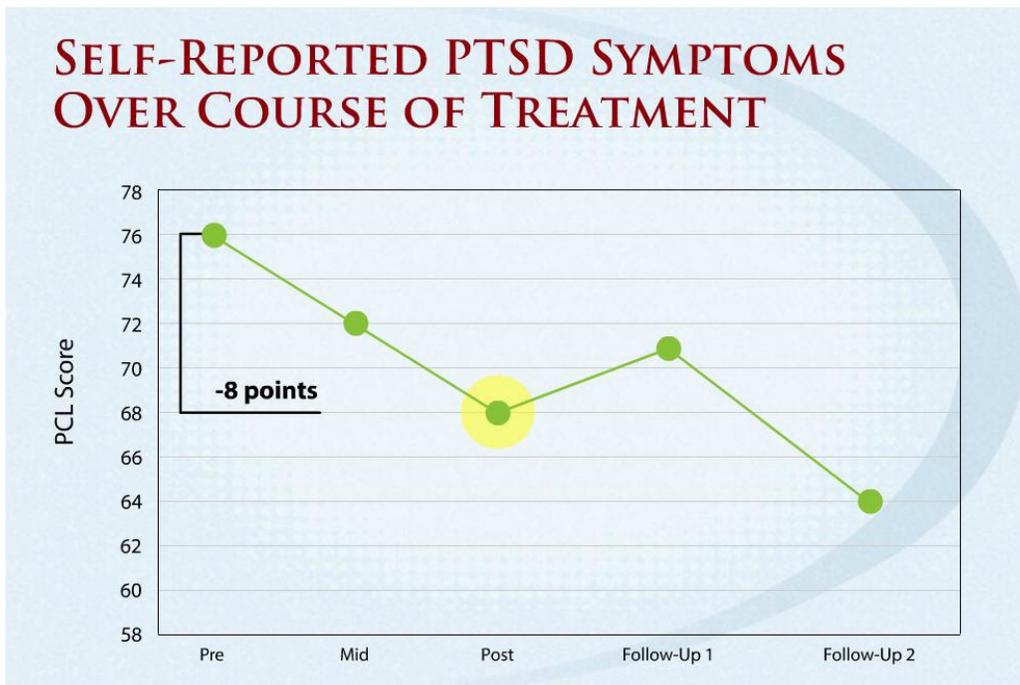
For example, the Detailed Assessment of Posttraumatic Stress, or the DAPS, the Impact of Event Scale, the IES, or the Mississippi Scale, are all appropriate to use for monitoring treatment outcome. But, they are a little bit different than the PCL and the PDS, in that they may cover PTSD symptoms, but they also cover other associated phenomena like guilt and disassociation, as well.

PCL

- ▶ 5-10 point change represents reliable change (treatment response)
- ▶ >10 point change represents clinically significant change (clinically meaningful)

Monson et al., 2008

With respect to the PCL, there is some evidence that shows that a 5 to 10 point change in PCL scores represents a reliable change, meaning that the change is not due to chance. And, a 10 to 20 point change in PCL scores represents a clinically significant change in PTSD symptom severity. Thus, when it comes to the PCL, I recommend using 5 points as a minimum threshold for determining if someone has responded to treatment, and 10 point change as a minimum threshold for determining whether or not the change is clinically meaningful.



Now, on this slide you can see an example of how the PCL was used to monitor treatment for a real patient. And, you can see here the decrease in PCL scores over time. The change in PCL score from Pre- to Post-treatment is 8 points and represents a reliable change. And, the change from Pre- to Follow-Up 2 is 12 points, and that represents a clinically significant change.

Now, due to the up and down nature, fluctuation of symptoms following treatment, it would be advisable to do more follow-up assessments with this patient just to make sure that the treatment gains that are observed are sustained over time.

PTSD COACH

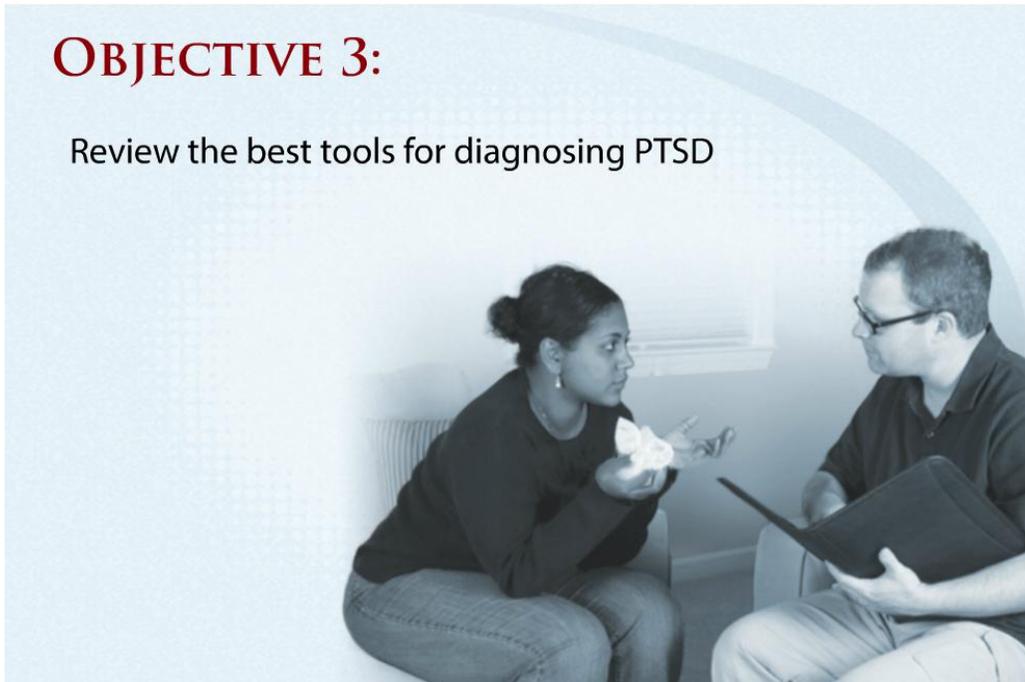
- ▶ Smart phone application
- ▶ Can help learn about and manage PTSD symptoms
- ▶ Lets user assess and track symptoms using the PCL
- ▶ Adjunct to professional medical treatment



Now, one new and interesting development is the use of handheld devices to both manage PTSD symptoms and assess PTSD symptoms over time.

The PTSD Coach is a smart phone application that has been developed by the National Center for PTSD in conjunction with others. And, the PTSD Coach can be used to help learn about and manage one's PTSD symptoms. But, in the context of this discussion here, it's important to point out that the PTSD Coach can allow the individual to assess and track his or her PTSD symptoms using the PCL.

The PCL is part of the PTSD Coach, and that's a very nice feature that they've included in this application. I also want to point out, however, that the PTSD Coach should not be used as a stand alone treatment. We don't have any evidence to suggest that it should be used in that way. But rather, it should be used as an adjunct to professional treatment..



Let's now turn to the last portion of our discussion, and here is where we'll talk about some of the best tools for diagnosing PTSD.

MULTIMETHOD ASSESSMENT OF PTSD

- ▶ Clinical diagnostic structured interviews
- ▶ Self-report measures
- ▶ Behavioral observation
- ▶ Psychophysiological testing (reactivity measures)

"All are imperfect and require clinical judgment in their use"



Keane & Barlow (2002)

Before we talk about the actual instruments themselves, I want to take a little time to talk about best practices for assessment. And, it's important to mention that, perhaps, the best practice is to employ a multi-method approach. And, what that means is you use multiple methods, for example, diagnostic interviews, self-report measures, behavioral observation, psychophysiological monitoring to answer questions about diagnosis.

And, the reason for this is simple. By themselves each one of these measures could be fallible. No single measure is definitive, but using multiple methods to collect information can allow you to be more confident about the conclusions that you might draw from the data.

TRAUMA EXPOSURE ASSESSMENT

- ▶ Document whether individual was exposed to traumatic event of sufficient magnitude to meet DSM stressor criterion
- ▶ Use multiple sources of information
 - Combine objective reports (e.g., military records) with subjective reports (e.g. self report) when possible
- ▶ Record a detailed narrative of trauma
- ▶ Use suggested standardized self-report measures
 - e.g. Life Events Checklist, Combat Experiences Scale, Deployment Risk and Resilience Inventory

Part of any assessment for PTSD should include a thorough assessment of trauma exposure. During the assessment, you should document whether the individual was exposed to an event that meets the DSM's definition of a stressor event. And, you would document this using multiple sources of information, for example, you would use information perhaps for military records or police records, as well as subjective reports from the individual him or herself.

It may also be a good idea to have the person write down a detailed narrative of their traumatic experience. It's good to get exactly what happened to the person in his or her own words, particularly for the purpose of using that narrative in treatment. And, with respect to a subjective self-report, there are several well validated measures that can be used to record someone's trauma history. So, for example, the Life Events Checklist, the Combat Experience Scale, and the Deployment Risk and Resilience Inventory are all reliable and valid measures of a traumatic exposure.

MULTIMETHOD ASSESSMENT OF PTSD

- ▶ Trauma exposure
- ▶ PTSD symptoms
- ▶ Comorbid conditions
- ▶ Associated features (guilt, dissociation)
- ▶ Response bias



Now, in addition to collecting data on the individual's trauma history and their PTSD symptoms, a proper evaluation would also include an assessment of comorbid conditions. So, for example, it would be advisable to collect information about whether or not the person was feeling depressed, or whether or not they were experiencing other symptoms of anxiety. Substance use, traumatic brain injury, all of these conditions are frequently co-occurring with PTSD, and thus it's important to get a sense of whether or not the individual might be experiencing those things as well.

It's also a good idea to assess for features that, again, occur quite frequently with PTSD. For example, you may want to get a sense of whether not the individual has feelings of guilt related to their traumatic event. For example, someone might be feeling intense survivor guilt because he may have survived a car accident, when, in fact, the passenger that he was traveling with, did not. And, that would be important information to have for treatment purposes.

Likewise, dissociation may be something that was experienced at the time of the trauma, or may be experienced frequently, more currently, by the person, and that would be something to assess for as well, because if someone is highly dissociative, that may have implications for a treatment strategy.

Finally, it's also a good idea to include an assessment of response bias in any assessment of Posttraumatic Stress Disorder. As I mentioned before, individuals may respond in random fashion. They may respond in an exaggerated fashion. Or, conversely, in an attempt to minimize their pain and suffering, and it would be important information to have, from the standpoint of assessment, but also from the standpoint of treatment as well.

DIAGNOSTIC STRUCTURED INTERVIEWS

- ▶ Clinician-Administered PTSD Scale (CAPS)
- ▶ PTSD Symptom Scale-Interview
- ▶ Structured Interview for PTSD
- ▶ PTSD Interview
- ▶ PTSD Module of SCID

Keane, Brief, Pratt, Miller (2006)

For diagnosing PTSD, structured interviews are the gold standard. And some of the more common structure interviews are the Clinician-Administered PTSD Scale, the PTSD Symptom Scale-Interview, the Structured Interview for PTSD, the PTSD Interview, and the PTSD Module from the Structured Clinical Interview for the DSM.

CAPS

- ▶ The “gold standard” for PTSD diagnosis
- ▶ Assesses PTSD diagnostic criteria
 - Criterion A – trauma exposure
 - Criterion B - re-experiencing
 - Criterion C – avoidance and numbing
 - Criterion D – hyperarousal
 - Criterion E - chronicity
 - Criterion F – clinical significance (distress/dysfunction)
- ▶ Associated features



CAPS

- ▶ Yields current or lifetime diagnosis
- ▶ Can assess PTSD for more than one trauma
- ▶ Takes 45-60 minutes



Let's take a closer look at the CAPS, which is generally considered to be the go-to structured diagnostic interview for PTSD. The CAPS is a 30-item interview that assesses trauma exposure as well as all of the other core parts of the DSM diagnosis for PTSD. It also assesses for other associated features, such as guilt and association. The CAPS can be used to make either current, or lifetime, diagnosis, and can be used to assess PTSD for more than one trauma. The full interview takes between 45 and 60 minutes to complete.

CAPS

- Frequency and intensity of symptoms rated along 5-point ordinal scales

Frequency	Intensity
<p>Have you ever had unpleasant dreams about (EVENT)? Describe a typical dream. <i>(What happens in them?)</i></p> <p>How often have you had these dreams in the past month (week)?</p> <p>0 Never 1 Once or twice 2 Once or twice a week 3 Several times a week 4 Daily or almost every day</p> <p>Description/Examples</p>	<p>How much distress or discomfort did these dreams cause you? Did they ever wake you up? <i>[IF YES:] (What happened when you woke up? How long did it take you to get back to sleep?) [LISTEN FOR REPORT OF ANXIOUS AROUSAL, YELLING, ACTING OUT THE NIGHTMARE] (Did your dreams ever affect anyone else? How so?)</i></p> <p>0 None 1 Mild, minimal distress or disruption of activities 2 Moderate, distress clearly present but still manageable, some disruption of activities 3 Severe, considerable distress, difficulty dismissing memories, marked disruption of activities 4 Extreme, incapacitating distress, cannot dismiss memories, unable to continue activities</p>

CAPS

- Frequency and intensity of symptoms rated along 5-point ordinal scales
- Total score for the ratings (frequency + intensity) range from 0 to 136
- Cutoffs can be adjusted for more or less stringent criteria
- Also yields a dichotomous (i.e., present or absent) rating for the disorder as a whole

Each question on the CAPS consists of two parts, a frequency part and an intensity part. The interviewer asks questions regarding each symptom with respect to frequency, and intensity, and then makes a rating using a 5-point ordinal scale. These ratings are then summed to produce a total score on the CAPS which ranges from 0 to 136.

These scores can also be used to form a cut-off from which a PTSD diagnosis can be given. And, the diagnostic cut off for the CAPS score can be adjusted in order to make the decision-making process either be more stringent or more lenient. The authors of the CAPS have also developed a set of scoring rules that can help clinicians and researchers make this dichotomous determination of PTSD diagnosis.

CAPS SCORING RULES

- ▶ The “1/2” rule - a core PTSD symptom is counted as present when its frequency is rated as a ‘1’ or greater and its intensity is rated as a ‘2’ or greater
 - 1 re-experiencing, 3 avoidance/numbing, 2 hyperarousal using the 1/2 rule is sufficient for a diagnosis
- ▶ Total CAPS severity ≥ 45
- ▶ Individuals who meet criteria by lenient rules may be less symptomatic and less impaired relative to those who meet criteria by more stringent rules

Weathers, Ruscio & Keane (1999)

One of the more common rules for determining PTSD diagnosis is called the 1 - 2 rule. In this rule, a PTSD symptom is counted towards the diagnosis if its frequency is 1 or greater and, its intensity rating is a 2 or greater.

And, so, if a person has at least one re-experiencing symptom rated at a frequency of 1 or higher and an intensity of 2 or higher, three avoidance and numbing symptoms, with a frequency of 1 or higher and an intensity of 2 or higher, and two hyperarousal symptoms rated at a frequency rated at 1 or higher and the intensity at a 2 or higher, then this would be sufficient for making a diagnosis of Posttraumatic Stress Disorder.

Another commonly used scoring rule for diagnosing PTSD is to just simply use a total score on the CAPS of 45. Individuals with a score of 45 or higher using this rule would be considered to have Posttraumatic Stress Disorder, whereas, those who were under a total score of 45 would be considered not to have Posttraumatic Stress Disorder.

Both of the scoring rules that I've described here are pretty lenient, and so people who are diagnosed with PTSD using these scoring rules may be less symptomatic or less dysfunctional than others who are given PTSD using a more stringent scoring rule.

CAPS EXAMPLE ITEMS

<p>What happened? <i>(How old were you? Who else was involved? How many times did this happen? Life threat? Serious injury?)</i></p>	<p>Describe (e.g., event type, victim, perpetrator, age, frequency):</p>
<p>How did you respond emotionally? <i>(Were you very anxious or frightened? Horrified? Helpless? How so? Were you stunned or in shock so that you didn't feel anything at all? What was that like? What did other people notice about your emotional response? What about after the event - how did you respond emotionally?)</i></p>	<p>A. (1) _____</p> <p>Life threat? NO YES [self__ other__]</p> <p>Serious injury? NO YES [self__ other__]</p> <p>Threat to physical integrity? NO YES [self__ other__]</p> <p>A. (2) _____</p> <p>Intense fear/help/horror? NO YES [during__ after__]</p> <p>Criterion A met? NO PROBABLE YES</p>

On this slide, you see a portion of the CAPS, and in this portion it's assessing the individual's trauma history, both criterion A1 and A2, for PTSD. The first part asks the individual about their trauma and what happened, who was there, who was involved, how many times it happened, whether or not life threat was involved, was the individual injured during the experience, and then how did the person respond emotionally during the event. If they responded with fear, helplessness, or horror, then that would fulfill criterion A2 for PTSD.

CAPS EXAMPLE ITEMS

<i>Frequency</i>	<i>Intensity</i>
<p>In the past month, have you had any unwanted memories of (EVENT)? What were they like? <i>(What did you remember?)</i> [IF NOT CLEAR:] <i>(Did they ever occur while you were awake, or only in dreams?)</i> [EXCLUDE IF MEMORIES OCCURRED ONLY DURING DREAMS]</p> <p>How often in the past month?</p> <p>0 Never 1 Once or twice 2 Once or twice a week 3 Several times a week 4 Daily or almost every day</p> <p>Description/Examples</p>	<p>How much distress or discomfort did these memories cause you? Were you able to put them out of your mind and think about something else? <i>(How hard did you have to try?)</i></p> <p>How much did they interfere with your life?</p> <p>0 None 1 Mild, minimal distress or disruption of activities 2 Moderate, distress clearly present but still manageable, some disruption of activities 3 Severe, considerable distress, difficulty dismissing memories, marked disruption of activities 4 Extreme, incapacitating distress, cannot dismiss memories, unable to continue activities</p> <p>QV (specify) _____</p>

This next slide shows how the CAPS queries about intrusive thoughts related to the trauma. On the left side, you can see how the CAPS asks questions about frequency of intrusive memories and thoughts. And, on the right side, you can see how the CAPS asks questions with a respect to the intensity of these intrusive thoughts.

CASE EXAMPLE

- ▶ Deployed to Kuwait in 1st Gulf War
- ▶ Trauma exposure: Missile launches, shot at
- ▶ Veteran reported intense distress at trauma-related cues, physiological reactivity at reminders
- ▶ Endorsed daily efforts to avoid thoughts or feelings about those events, some avoidance of situations
- ▶ 15 year-old daughter didn't like spending time with him because "he's always angry"



At this point, I wanted to provide a brief case example in which the CAPS was useful in, both determining diagnosis, but also helpful in setting targets for treatment. This is a Veteran who was deployed to Kuwait in the first Persian Gulf War, and during his CAPS, he reported experiencing several traumatic events during his deployment to Kuwait, including SCUD missile launches, being shot at, etc.

And, he reported numerous PTSD symptoms during his CAPS interview. But, some of the more prominent symptoms that he reported were intense distress at trauma related cues, and physiological reactivity to reminders of his trauma. He also endorsed daily efforts to avoid thoughts or feelings about the events that he experienced, as well as avoidance of situations that reminded him of the traumas.

He also reported extreme anger and irritability to the point where his young daughter didn't like to spend time with him because he was always angry. He reported that these were the symptoms that were the primary cause of his distress and dysfunction, and so these were the symptoms that were the target of treatment.

CASE EXAMPLE

- ▶ Total CAPS score = 67
- ▶ Using 1 / 2 rule
 - Cluster B – 2 symptoms
 - Cluster C – 4 symptoms
 - Cluster D – 4 symptoms

And, in terms of his overall CAPS, his total score was 67, which was certainly well above the cutoff score of 45, that I gave you earlier. It's actually above some of the more stringent cut offs for PTSD, as well. And, using the 1 - 2 rule, he would also meet diagnostic criteria for PTSD, as he reported 2 Cluster B re-experiencing symptoms that met this criteria, 4 Cluster C or avoidance and numbing symptoms that met this criteria, and 4 Cluster D symptoms that met this 1 - 2 rule criteria as well.

USING THE PCL TO AID IN DIAGNOSING

INSTRUCTIONS: Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each one carefully, then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing <i>memories, thoughts, or images</i> of a stressful experience from the past?	1	2	3	4	5
2. Repeated, disturbing <i>dreams</i> of a stressful experience from the past?	1	2	3	4	5
3. Suddenly <i>acting or feeling</i> as if a stressful experience from the past <i>were happening again</i> (as if you were reliving it)?	1	2	3	4	5
4. Feeling <i>very upset</i> when something reminded you of a stressful experience from the past?	1	2	3	4	5
5. Having <i>physical reactions</i> (e.g., heart pounding, trouble breathing, sweating) when something reminded you of a stressful experience from the past?	1	2	3	4	5

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5. Having <i>physical reactions</i> (e.g., heart pounding, trouble breathing, sweating) when something reminded you of a stressful experience from the past?	1	2	3	4	5



USING THE PCL TO AID IN DIAGNOSING

- ▶ Symptoms rated as “Moderately” or above are counted as present. DSM criteria then used.
- ▶ Total score exceeds a cutoff
- ▶ Combining methods 1 and 2



Now, the PCL can also be used to aid in diagnosing PTSD. If there's one thing to pick up from this talk is that the PCL can be a rather helpful tool. It's very flexible. It can be used for screening purposes. It can be used for monitoring treatment outcome. It can also be helpful as an aide for diagnosing PTSD.

I want to point out that, you should never diagnose PTSD based solely on the PCL, but it can be potentially helpful in terms of identifying someone that may meet criteria, and that should be followed up with a CAPS or other structured interview.

And, so, in terms of how you would use the PCL to diagnose PTSD, symptoms rated as moderately or above are counted as present and towards the DSM PTSD criteria, and you would use the DSM algorithm of 1 re-experiencing, 3 avoidance and numbing, and 2 hyperarousal symptoms.

You can also use the PCL score just by using a designated cut off score. So, a score that fell above a designated cut off would be potentially indicative of someone with Posttraumatic Stress Disorder.

And then, finally, another manner in which the PCL is used to help with diagnosing PTSD is if both of those methods are combined. So, the individual would first have to have 1 re-experiencing, 3 avoidance and numbing, and 2 hyperarousal symptoms rated as at least moderately or higher, to be considered to have probable PTSD.

EVALUATION FOR COMPENSATION AND PENSION (C&P) VS. TREATMENT

- ▶ C&P: Provides diagnostic and other evidence for the severity of a disability needed by Veterans Benefits Administration to determine entitlement to benefits for an individual
- ▶ Report is for primarily regional office adjudicative staff, lawyers, and judges

As we bring this presentation to a close, I'd like to say a few things about PTSD assessment in the context of a compensation and pension examination. This context is very different from treatment. Specifically in a comp and pen context, an assessment is used to provide evidence for the severity of a disability needed by the Veterans Benefits Administration to determine entitlement to benefits for an individual.

And, the report that is generated from this assessment is not for clinicians; instead, it is for regional office adjudicative staff, lawyers, and judges. So, the content of the report is going to be much different.

EVALUATIONS FOR C&P VS. TREATMENT

- Treatment: Provides a diagnosis and for treatment planning and outcome purposes
- Report written primarily for clinicians

Now, this is in contrast to a psychological assessment that's done more for the purposes of treatment and establishing a diagnosis. In treatment, we're providing a diagnosis for treatment planning and outcome purposes, and the report is written primarily for other clinicians in order to communicate the nature of the disturbance, or the disorder, and other associated features and their dysfunction and other problems that the individual may be experiencing.

FUNCTIONAL IMPAIRMENT AND DISABILITY EXAMINATIONS

- ▶ Determining the extent of impairment and its association with PTSD
 - important in determining disability in work with Veterans and non-Veterans applying for compensation

- ▶ Important to use evidence-based assessment methods



Now, as I mentioned before, a comp and pen examination is important because not only are you assessing PTSD, but you're also assessing associated dysfunction or disability. So, it's very important, from that standpoint, to use evidence-based methods to assess for functional impairment or issues related to quality of life, and other things that can be brought to bear on understanding the extent to which PTSD, or other mental disorders, may be negatively affecting one's life.

SUMMARY

- ▶ Measures can be used to screen, monitor treatment outcomes, and diagnose PTSD
- ▶ PC-PTSD for screening
- ▶ PCL for screening, monitoring, and aiding in diagnosis

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:

Have had nightmares about it or thought about it when you did not want to?	YES / NO
Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?	YES / NO
Were constantly on guard, watchful, or easily startled?	YES / NO
Felt numb or detached from others, activities, or your surroundings?	YES / NO



SUMMARY

- ▶ Measures can be used to screen, monitor treatment outcomes, and diagnose PTSD
- ▶ PC-PTSD for screening
- ▶ PCL for screening, monitoring, and aiding in diagnosis
- ▶ Best to use a multimethod approach
- ▶ All methods have their strengths and weaknesses
- ▶ CAPS is gold standard for diagnosing



So, in summary, there are several strong methods, and measures that we can use to screen for PTSD, monitoring treatment outcomes, and diagnosing Posttraumatic Stress Disorder.

The PC-PTSD screen is a reliable and valid measure that can be used, as are other measures for screening for PTSD. The PCL can also be used to screen for PTSD. In terms of monitoring treatment outcomes, the PCL can also be a very valuable tool.

Both screening and monitoring treatment outcomes are important endeavors that we should give time and consideration to. When it comes to diagnosing Posttraumatic Stress Disorder, the best approach is to use a multimethod approach – one that includes diagnostic interviews, self-report questionnaires, behavioral observations, psychophysiological assessment, if, and when, possible.

Using a multitude of measures within those methods are also a good idea, because all methods and measures have their strengths and weaknesses. And, again, it's important because of that to collect as much information as you possibly can to come to a reasonably sound conclusion about whether not someone has PTSD.

The CAPS is a reliable and valid instrument that has become the gold standard for diagnosing PTSD. And, it will continue to be so, and I recommend its use.

FOR FURTHER INFORMATION

- ▶ VA intranet <http://vaww.ptsd.va.gov/>
- ▶ Assessment request form on www.ptsd.va.gov



For additional information within the department of Veterans Affairs, you can check the VA intranet. If you're not within the VA, then you can go to the National Center for PTSD website and request assessment information using the assessment request form. The web site address is PTSD.VA.gov. Thank you for your time.