ENHANCING A SOCIAL WORK STUDENT'S EXPERIENCE WITH STANDARDIZED DIAGNOSTIC INSTRUMENTS: COMPARATIVE ADMINISTRATION OF THE CAPS, SCID, AND PCL-M TO ASSESS PTSD

by

EMILY JOY CLARK-NIMZ

Presented to the Faculty of the Graduate School of
The University of Texas at Arlington in Partial Fulfillment
of the Requirements
for the Degree of

MASTER OF SOCIAL WORK

THE UNIVERSITY OF TEXAS AT ARLINGTON
August 2014

Acknowledgements

My thesis is dedicated to my husband, Richard, without whom it might never have come to fruition. Thank you so much for your support and willingness to help make my dreams a reality. I would like to extend a special thank you to my mom for instilling within me a love of learning. Your dedication to my education has led to this moment. I also want to thank all my family for your enthusiasm about my continued academic career; thank you for understanding all the missed family events!

Thank you to Dr. Alexa Smith-Osborne for chairing my thesis committee, involving me in your projects, especially the Student Veterans Project, and for your availability, teaching, and patience for all my questions. To my thesis committee, Dr. Noelle Fields and Dr. Craig Nagoshi, thank you for your time and efforts in walking me through my thinking process when I needed it. Thank you to Dr. Jan Finch for inspiring my project through your passion for working with veterans, current military members, and those with PTSD. Thank you to Mary Kate Kensworthy and the staff at the Center for Clinical Social Work for working with me and allowing me access to your clients. This thesis would not have been possible without your assistance and teaching throughout my learning process.

April 14, 2014

Abstract

ENHANCING A SOCIAL WORK STUDENT'S EXPERIENCE WITH STANDARDIZED DIAGNOSTIC INSTRUMENTS: COMPARATIVE ADMINISTRATION OF THE CAPS, SCID, AND PCL-M TO ASSESS PTSD

Emily Joy Clark-Nimz, MSW

The University of Texas at Arlington, 2014

Supervising Professor: Alexa Smith-Osborne

Multiple assessment tools measure PTSD. Participants used the PCL-M, or the SCID. I used the CAPS to supplement these assessments. None of these is usually taught to graduate social work students despite requirement changes from the NASW and the CSWE (2010, 2012).

I had two aims. The first was to train me in psychometric assessment tools, specifically the CAPS. The second aim was to determine whether participants received a positive diagnosis of PTSD from one measure but not the CAPS, or vice versa.

I learned to confidently give clinical assessments to participants from various demographic backgrounds. Findings in this study determined that participants often received a diagnosis PTSD through the PCL-M or the SCID but did not meet full criteria by the CAPS; they met the criteria for subthreshold

PTSD. While these findings are provocative, further study will be needed to determine whether these results could be generalizable.

Table of Contents

List of Tables

Chapter 1

Nature of the Problem

1.1 Epidemiology of Posttraumatic Stress Disorder

Many different diagnostic tools are available to both adults and children for the diagnosis of Posttraumatic Stress Disorder, but they have not all been tested in a community clinic with social workers as the diagnostician. Military and civilian mental health professionals have recognized the effects of extreme trauma, including those related to war, industrial accidents, and natural disasters, yet the modern understanding of Posttraumatic Stress Disorder (PTSD) only dates from the 1970s in the United States. While PTSD-like symptoms have long been recognized in combat veterans of many military conflicts; they had a variety of names: soldier's heart (Civil War), shell-shock (World War I), and combat fatigue/ combat exhaustion (World War II) (Macleod, 2004). Early clinicians noted that those returning from war were often depressed or highly anxious. They could not concentrate, had nightmares, and were easily startled.

1.1.1 DSM-III and DSM III-R

The specific illness or syndrome related to these posttraumatic symptoms was not defined by the American Psychiatric Association until the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) which was released in 1980 (APA). Originally named Post-Vietnam Syndrome, the syndrome changed names to Posttraumatic Stress Disorder (PTSD) to avoid the

highly political and controversial relationship with the Vietnam War (Fleming, 1985). The DSM Process Group stated that the newly created disorder was characterized by unique symptoms, including nightmares and flashbacks, that could not be covered by anxiety or depression diagnoses alone. PTSD's original definition focused on the precipitating event as life-threatening, such as direct combat, physical assault, or natural disasters (APA, 1980). The DSM-III-R definition added 'vicarious' traumatic events such as witnessing a traumatic event without being in direct harm, or seeing a loved-one exposed to a life-threatening event.

Evaluating individuals who have experienced a traumatic event is challenging and multi-dimensional. Early researchers accomplished this goal by completing a structured clinical interview, psychometric inventories, and biopsychosocial measures (Keane, Wolfe, and Taylor, 1987). The clinical interview or Diagnostic Interview Scale (DIS) has its beginnings in the DSM as a standardized method to review a variety of symptoms (Robins, Helzer, Croughan, and Ratcliffe, 1981). Large discrepancies in prevalence of PTSD appear in various populations (Thompson, Gottesman, and Zalewski, 2006). Early measures, such as the National Vietnam Veteran Readjustment Study (NVVRS) showed a prevalence as high as 15.2% in males returning from combat in Vietnam compared to their male civilian counterparts (Kulka, Schlenger, Fairbank, Hough, Jordan, Marmar, and Weiss, et al, 1990), while the Vietnam

Experience Study (VES) found a prevalence of only 2.2% in the same population (Center for Disease Control and Prevention, 1988). During the 1980s, few specific diagnostic tools were available, and frequently researchers used the MMPI as a diagnostic tool. Unfortunately, researchers found the MMPI to be non-specific to trauma responses (Watson, Juba, Anderson, and Manifold, 1990).

1.1.2 DSM-IV and DSM-IV-T-R

The DSM-IV expanded the definition further to include trauma as "the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury." At the same time, the event must result in "intense fear, helplessness, or horror" (APA, 1994). These important changes broadened the definition each time to include additional events and types of exposure. The DSM-IV (1994) and DSM-IV-TR (2000) changes led to the creation of several different instruments including the Structured Clinical Interview for DSM-IV (First, Spitzer, Gibbon, and Williams, 2002.; First, Spitzer, Gibbon, and Williams, 1995). More recently, instruments including the Clinician Administered PTSD Scales (CAPS) (Blake, Weathers, Nagy, and Kaloupek, 1995) and the Traumatic Events Screening Inventory for Children (TESI-C) (Caliso and Milner, 1992) relate specifically to PTSD.

Clinicians used a variety of new tools to assist in diagnosis including the Mississippi Scale for Combat-related PTSD, the Posttraumatic Stress Disorder Interview (PTSD-I) while continuing to use the Diagnostic Interview Schedule

(DIS) in the DSM and the MMPI-PTSD Scale (Watson, Plemel, DeMotts, Howard, Tuorila, and Moog , 2004*)*. Again, as in the 1980s, the MMPI was not shown to be a reliable or valid measure of PTSD and was soon discontinued as diagnostic tool for it (McFall, Smith, Mackay, and Tarver, 1990).

The expansion also grew to include individuals who experienced vicarious trauma through non-family members, including clinical professionals who treated individuals that experienced trauma. These continued expansions began to take on a life of their own in the late 1990s with the DSM-IV-TR and an ever more relaxed definition of trauma. Some individuals received the PTSD diagnosis due to extramarital affairs (Dattilio, 2004), or seeing the events of September 11, 2001 on television. The expanding definition of trauma created difficulties in measuring trauma in a clinical setting.

1.1.3 DSM-V

With the introduction of new criteria for Posttraumatic Stress Disorder in the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V), current methods of evaluation may not accurately measure all symptoms (APA, 2013). The DSM-V tightened the definition and added additional criteria that must be met. The current DSM has removed vicarious trauma from its definition; according to Criterion A, individuals cannot be diagnosed based on experiences through “electronic media, television, movies, or pictures unless this exposure is work related” (APA, 2013). Of note is that current diagnostic tools,

including the Posttraumatic Stress Disorder Checklist (PCL), the SCID, and the CAP do not directly align with the new criteria.

1.2 Prevalence of PTSD

Prevalence of PTSD varies by age, gender, ethnicity, and military experience. According to the U.S. National Comorbidity Survey Replication, using the DSM-IV criteria in 2001 and 2003, the estimated lifetime prevalence in a general population of adults in the United States was 6.85% (Kessler, Barker, Colpe, Epstein, Gfroerer, Hiripi, and Howes, et al, 2003; Kessler, Berglund, Bruce, Koch, Laska, Leaf, Manderscheid, et al, 2001; Hoge, Castro, Messer, McGurk, Cotting, and Koffman, 2004; Kessler, Berglund, Delmer, Jin, Merikangas, and Walters, 2005). More specifically, the lifetime prevalence for men was 3.6% and 9.7% among women in the United States (Kessler, Berglund, and Delmer, et al, 2005). Within newer populations, such as those who experienced the events of September 11, 2001, rates of PTSD were lower among New York Police members than non-traditional responders, such as volunteers with a range of 5.9% PTSD development by police officers and 23% for volunteers using DSM-IV-TR criteria (Luft, Schechter, Kotov, Broihier, Reissman, Guerrera, Bromet, et al, 2012).

Zimmerman's study evaluating an outpatient psychiatric facility, 14.4% received a PTSD diagnosis of 1000 patients when using the SCID (1999). In Carol North's report on male first responders and male victims of the Oklahoma

City Bombing, 23% of the victims were diagnosed with PTSD while 13% of the first responders were diagnosed with PTSD (2002). The discovery in prevalence indicates that PTSD is not only found in military populations or only in first-responder type roles such as police, fire responders, or paramedics, but in civilians, as well.

Some people receive an initial PTSD diagnosis many years after a traumatic event. Smid's meta-analysis of delayed PTSD, found that lifetime development of PTSD ranged from 1 – 11.2% regardless of when the actual trauma occurred (2009). In one particular case, the trauma occurred at least 15 years before onset of symptoms (Smid, 2009). This significant finding affects the clients who approach the Center for Clinical Social Work (CCSW) with or without an immediate traumatic event, but may have something in their far past that is reawakening. As social workers it is critical to be aware of the full history of clients.

1.2.1 Prevalence among ethnic/ racial minorities

A meta-analysis by Pole, Gone, and Kulkarni (2008), found varied prevalence rates that surprised the researchers between African American and Caucasian veterans. In some studies, such as the NVVRS, a significant difference was found, with 20.6% of African American Vietnam Veterans being diagnosed with PTSD while 13.7% of Caucasian veterans received the same diagnosis (Kulka, Schlenger, Fairbank, Hough, Jordan, Marmar, and Weiss, et al,

1988). However, in non-veteran samples, a difference of only .4% was found in adult males (Pole, Gone, and Kulkarni, 2008). In the same meta-analysis, Latinos/ Hispanics had very low rates of any negative mental condition (Pole, Gone, and Kulkarni, 2008). Adams and Boscarino determined after September 11th that Latino/ Hispanics remained more likely to develop delayed onset PTSD (2006). Interestingly, Puerto Rican Latinos were more susceptible to PTSD during the post-Vietnam war era and September 11th than Mexican Latinos (Ortega and Rosenheck, 2000; Galea, Vlahov, Tracy, Hoover, Resnick, and Kilpatrick, 2004).

Asians and Pacific Islanders tend to have significantly lower rates of PTSD compared to Caucasians, though their symptoms tend to be more severe. Friedman's 2004 Hawaii Vietnam Veterans Project found that lifetime PTSD rates ranged from 1.9% - 8.8% in Japanese Americans and native Hawaiian veterans had similar rates as Caucasian Americans at 11.8% (Friedman, Schnurr, Sengupta, Holmes, and Ashcraft, 2004).

1.2.2 Prevalence rates among women veterans with or without military sexual trauma

All branches of the military are currently working to determine prevalence of military sexual assault (MST). Yaeger, Himmelfarb, Cammack, and Mintz concluded that 41% of women within the military are raped by either a co-worker or superior officer in one year of service (2006). Women with MST had higher

rates of PTSD than women who had not faced MST at a statistically significant level (p=.0001 with MST and .02 without MST) (Yaeger, Himmelfarb, and Cammack, et al, 2006). Of the 196 participants, 39% experienced MST and another trauma; also 62% of those developed PTSD compared to 29% of their female compatriots who experienced trauma but not MST (Yaeger, Himmelfarb, and Cammack, et al, 2006). These women are not only experiencing traumatic events in a war-time situation such as roadside bombs, improvised explosive devices, or close-quarter combat, but also feel isolated from their peers. They are more likely to develop depression and experience higher levels of severity of symptoms than both other women and their male co-workers (Yaeger, Himmelfarb, and Cammack, et al, 2006).

1.2.3 Prevalence among domestic violence, sexual assault, or other assault

PTSD among survivors of domestic violence, sexual assault, or other physical injuries is much higher than the general population. Generally, women have higher rates of PTSD than men in each of these instances. Women were 4.7 times more likely to meet Criterion C and 3.8 times more likely to meet Criterion D after a motor vehicle accident (Fullerton, Ursan, Epstein, Crowley, Vance, Kao, and Dougall, et.al, 2001). In the same study, the rates of re-experiencing Criterion A stayed the same for men and women (2001).

Survivors of rape tend to have the highest levels of prevalence of PTSD (Kessler, Sonnega, and Bromet, et al, 1995) in both in men and women.

Kessler's review article of the National Comorbidity Survey, ascertained that 65% of male and 46% of female survivors of rape develop PTSD (1995). A longitudinal study conducted by Johansen, Wahl, Eilertsen, and Weisaeth determined that over a twelve-month period, more than 30% of men and women had high levels in both prevalence and severity of symptomology after experiencing physical assault that was not domestic violence (2007).

1.2.4 PTSD rates and different disasters

North, Oliver, and Pandya conducted a meta-analysis of ten different disasters, both natural and man-made to determine PTSD risks and prevalence (2012). According to their study, the strongest predictors for developing PTSD were "female, being younger, Hispanic, lesser education, ever-married status, pre-disaster psychopathology, disaster injury, and witnessing injury or death" (North, Oliver, and Pandya, 2012). The highest rates of prevalence related most closely to man-made disasters including a plane crash and the terrorist bombing of Oklahoma City in 1995, rather than natural disasters including major floods, earthquakes, or tornados (North, Oliver, and Pandya, 2012). North, Oliver, and Pandya (2012) determined lower rates of prevalence in cases where some subjects felt as if they had a level of control. Specifically, prevalence rates were very low following two mass shootings in which one or more of the hostages fought back against the perpetrator.

Prevalence rates vary across a multitude of disasters and events, from personal victimization from an assault of any kind, natural disasters, military combat, or man-made disasters such as terrorist actions. It will be crucial for social workers to be aware that Posttraumatic Stress Disorder is not reserved specifically for military personnel or veterans, but can affect people who have experienced any type of life-altering event.

1.3 Subthreshold PTSD

This researcher needs to make an important distinction between clinically significant PTSD and subthreshold PTSD. Subthreshold PTSD means that a person met some or nearly all of the criteria but either their score was not high enough numerically, or they did not endorse enough criteria. As stated earlier, in order for a person to receive a PTSD diagnosis, he/ she is required to have an exposure to a traumatic event, symptoms must have lasted at least 6 months, they must have re-experiencing symptoms, avoidance/ numbing symptoms, and hyperarousal symptoms.

As early as 1988 in the National Vietnam Veterans Readjustment Study (NVVRS) , in additional studies by Kulka, Schlenger, Fairbank, et al (1988), and Weiss, Marmar, Schlenger, Fairbank, Jordan, Hough, and Kulka (1992) researchers noted the prevalence of partial PTSD; a person must endorse at least three symptoms within Criterion C. One recent study suggests that Criterion C is frequently unmet; Kilpatrick, Resnick, Milanak, Miller, Keyes, and

Friedman (2013) found that “97% of a large sample met Criterion B, 63% met Criterion D, but only 39% met Criterion C (p.542).” It is unknown why some people develop only partial PTSD while others develop full PTSD, though Cukor, Wyka, Jayasinghe, and Difede (2010) believe it may have to do with resilience and a reflection of the amount of risk a person actually experienced. A large 2004 study expanded partial PTSD to civilian victims of trauma (Breslau, Lucia, and Davis, 2004).

1.3.1 Prevalence of subthreshold PTSD

In a review of data from the National Epidemiological Survey on Alcohol and Related Conditions, lifetime prevalence of PTSD was 6.4%; rates of subthreshold PTSD were 6.6%. Female rates of both were higher (8.6% for both PTSD and subthreshold PTSD) than men (4.1% and 4.5% respectively) (Pietrzak, Goldstein, Southwick, and Grant, 2011a).

Subthreshold PTSD presents in multiple types of trauma and illnesses including motor vehicle accidents (Blanchard, Hickling, Taylor, Loos, and Gerardi, 1994), eating disorders (Mitchell, Mazzeo, Schlesinger, Brewerton, and Smith, 2012), and heart attacks (Von Känel, Kraemer, Saner, Schmid, Abbas, and Begré, 2010). It was also prevalent in police involved in the events of September 11, 2001 (Pietrzak, Schechter, Bromet, Katz, Reissman, Ozbay, and Southwick, et al, 2012) and World War II veterans exposed to mustard gas (Schnurr, Ford, Friedman, Green, Dain, and Sengupta, 2000).

1.4 Impact on the Profession of Social Work

Social workers interact with a variety of clients, from military veterans, children, married couples, or individuals who have endured a variety of traumatic events. When seeing clients for the first time, social workers must discover whether the client is suffering from a mental illness, including Posttraumatic Stress Disorder (PTSD) (Cicchetti, Fontana, and Showalter, 2008). This study will help determine the most effective method of determining symptomology and diagnosis of PTSD.

Military social work was established in 1926 and includes civilian social workers as well as active military members who are practicing social workers (NASW, 2011b). Prevalence of social workers interacting with the military population – both active and veterans – is extremely high. The VA is affiliated with over 180 graduate schools of social work, including the University of Texas at Arlington, training over 900 students per year (”History of VA Social Work,” 2012). Social workers also offer direct practice in the community for veterans.

Recent literature indicates that many social workers and other workers in the mental health profession suffer from vicarious trauma when working with traumatized victims (Michalopoulos and Aparicio, 2012; Newell and MacNeil, 2010; Pearlman and MacIan, 1995; Schauben and Frazier, 1995). Current studies continue to validate their research and care should be taken to avoid

continued exposure without self-care (Van Deusen and Way, 2006; Zimering, Munroe, and Gulliver, 2003).

1.4.1 NASW and CSWE guidelines for military social work

Using assessment tools is in keeping with the National Association of Social Work guidelines and the *Council on Social Work Education's Guidelines for Military Social Work* (2012). Both guidelines include the goal of additional training in more standardized instruments such as the CAPS. While these guidelines are specifically written for military social work, current Evidence-Based Practice is moving in the direction of additional psychometric measures and fewer purely qualitative or general psychosocial assessments.

The NASW *Standards for Social Work Practice with Service Members, Veterans and Their Families* (2012) states in Standard 4: Assessment:

> Social workers who work with Service Members, Veterans, and their families shall use appropriate theoretically and evidence-based practice models, skills, and interventions that reflect their understanding of the opportunities and challenges facing this population. The depth and breadth of the assessment shall depend on the qualifications of the social work provider.

The NASW interprets their statement as follows:

> Assessment is a fundamental process of social work practice. Treatment and intervention strategies require that social workers both assess and reassess client needs and modify plans accordingly. Social work assessments can facilitate the identification of individuals in need of specific social, health, mental health, and/ or behavioral health services (2012).

Finally, the NASW Standards (2012) encourage social workers to develop the skill of using measurement tools in the areas of mental health and behavioral health, especially for frequently occurring concerns such as PTSD. Social workers will maintain cultural sensitivity to ensure the needs of special populations within the military are met through assessment including the needs of women, LGBT, or those with disabilities.

In the CSWE publication *Advanced Social Work Practice in Military Social Work* (2010), the author states the required educational competencies clearly:

> EP 2.1.10b Assessment: Social workers will: … assess client strengths and limitations; …by "using differential and multi-axial diagnoses that take into consideration signature injuries as well as other military related illnesses and injuries….[Additionally], advanced social work practitioners need to develop knowledge and skills related to the selection … 'best practices' in their work with service members, veterans, families, and communities.

1.5 Purpose of the Study and Research Question

The purpose of this study is to enhance a social work graduate student's clinical skills, to gain additional skills in standardized, psychometric measurement, and to use different instruments in a clinical community population outpatient setting.

The research question seeks to resolve whether CAPS is a more valid diagnostic tool compared to the SCID in a mid-size college environment in the southwest in a community clinic population.

Chapter 2

Literature Review

2.1 Discrepancies in Prevalence Rates

Two large independent studies in 1990 and 1991, funded by the United States government, assessed the prevalence rates of PTSD in US Veterans. These studies specifically targeted veterans to determine if experiences in the Vietnam Conflict inflated rates of PTSD. The first study, the National Vietnam Veterans Readjustment Study (NVVRS) determined that approximately 15.2% of participants met all the PTSD diagnostic criteria (Kulka, Schlenger, and Fairbank, et al, 1988). Meanwhile, the second study, the Vietnam Experience Study (VES) found a prevalence rate among Vietnam veterans of only 2.2% (CDC, 1988). After both studies ended, they used an additional ten years of previous data (from 1980 – 1990) to re-evaluate the results of the two studies (Kessler, Barker, and Colpe, et al, 2003; Kessler, Berglund, and Bruce, et al, 2001). The extreme range found between these two studies conducted in the same year, with the same population, highlights the need to narrow and specify symptoms in formalized evaluation tools for all clients.

The NVVRS study used the MISS-PTSD, the Keane MMPI-PTSD, and a semi-structured diagnostic interview based in part on the SCID, but did not use the actual SCID interview (Kulka, Schlenger, and Fairbank, et al, 1988; Keane, Wolfe, and Taylor, 1987). Additionally, the results were skewed by the number of

veterans versus control subjects, random selection did not occur, but rather they were pre-screened and selected based on the likelihood that they would be classified as having PTSD (Watson, Gottesman, and Zalewski, 2006).

Separately, the VES used a randomly sample of records from the Army databases based on gender, military occupation, a single term of enlistment, and pay grade (CDC, 1988). The control group was also selected from Army records, but participants could never have served in Vietnam. Finally, subjects completed the Diagnostic Interview in the DSM-III and the MMPI (Watson, Gottesman, and Zalewski, 2006).

To attempt to derive current prevalence estimates between the two studies, Watson, Gottesman, and Zalewski (2006), created a composite diagnosis based on multiple assessments and narrowed the selected score to 94 to qualify for PTSD when using the MISS-PTSD. Changing these diagnostic terms and using the narrow definition they created to narrow the focus, altered the prevalence rates of combat-related PTSD to 2.5% and 2.9% on the VES and the NVVRS, respectively. Using a pre-determined, broad, and sensitive set of criteria, prevalence rates of combat-related PTSD for Vietnam veterans ranged from 12.2% and 15.8% on the VES and NVVRS, respectively (Watson, Gottesman, and Zalewski, 2006).

The conclusion reached by Watson's group was that when disparate prevalence rates exist, determining a same definition of the symptoms and using

the same or similar diagnostic tools, can reconcile the results (2006). Watson's study presents valid and concise guidelines to determine prevalence rates when comparing multiple diagnostic tools and will be invaluable to this research project.

2.2 Changes in Test-Retest Validity between the DSM-IV and DSM-V Diagnostic Criteria

Prior to the release of the Diagnostic and Statistical Manual of Psychiatric Disorders V in May 2013, multiple research studies also known as field trials, were conducted to determine the ability of clinicians to accurately diagnose psychiatric illness using the new criteria set forth by the American Psychiatric Association (Regier, Narrow, Clarke, Kraemer, Kuramoto, Kuhl, and Kupfer, 2013). The purpose of these field trials was to measure the degree to which different clinicians could reach similar or the same diagnoses with patients interviewed on separate occasions in clinical settings. Patients were randomly assigned to two different clinicians to conduct diagnostic interview using the standardized approach found in the DSM-V (APA, 2013). Clinicians were also blind to previous diagnoses.

PTSD was found to be in the "Very Good" interpretation range with a kappa coefficient of .69 (Regier, Narrow, and Clarke, et.al, 2013). 79% of the participants in the study received a PTSD diagnosis. DSM-V prevalence estimated that 42% of the participants would be diagnosed at the Houston VA/

Menninger Clinic population site (Regier, Narrow, and Clarke, et.al, 2013). At the Dallas VA site, the kappa coefficient was 0.63, and it also received “Very Good” interpretation score. DSM-IV prevalence was rated at 50% while DSM-V prevalence was rated at 46% (Regier, Narrow, and Clarke, et.al, 2013). These field trials demonstrate the reliability of the DSM-5 criteria when used to diagnose PTSD.

2.3 Convergent Validity between Measures

Watson, Plemel, DeMotts, Howard, Tuorila, Moog, Anderson, et al, compared convergent validities of four commonly used PTSD measures in 80 help-seeking Vietnam veterans (1994). The researchers used the MISS-PTSD, the Posttraumatic Stress Disorder Interview (PTSD-I), the Diagnostic Interview Schedule from the DSM-III (PTSD Module), and the MMPI PTSD Scale. When each scale compared a single symptom, such as the startle reflex or nightmares, the results remained nearly identical in level of intensity, severity, and frequency. However, overall outcomes were widely discordant with no single test identifying the same subjects as having a diagnosis of PTSD. These results suggested that the four measures have similar convergent validities when used simply to identify individual symptomology of PTSD. Two of the assessment tools, the PTSD-I and the MISS-PTSD scale offered better convergent validity than the MMPI or DIS instruments when used as severity measures (Watson, Plemel, DeMotts, Howard, Tuorila, Moog, Thomas, and Anderson, 1994).

Watson's study is crucial to this research project as it demonstrates that reliable and valid measurement tools can vary in diagnostic abilities with specific disorders and can vary even when parsing out specific criteria or symptomology.

2.4 Interrater Reliability between the CAPS and Other Assessment Tools

In a comparison study between the PTSD Symptom Scale-Interview (PSSI), the CAPS, and the SCID, Foa and Tolin's results showed that both tools held high internal consistency and had high interrater reliability (2000). The PSSI was also correlated with the SCID but to a lesser degree. This research demonstrates how and why different tools may be used to reach a similar diagnosis. Some measures may be more effective in a shorter space of time if there are time-limiting factors during the assessment.

Higher reliability describes the phenomenon wherein the same client/ patient/ participant is interviewed by different professionals; these professionals then reach the same diagnostic conclusion at the end of the interview without first discussing it with one another. In Foa and Tolin's study, the same participant was given the CAPS and the SCID and researchers videotaped the interviews. Different evaluators viewed the tapes to determine the participants' diagnoses (2000). Finally, they compared the PSSI scores with the CAPS and the SCID results. The PSSI was determined to be as equally adept at diagnosing PTSD as the CAPS while taking a shorter amount of time ($p=<.001$) (Foa and Tolin, 2000).

2.5 How to Evaluate Multiple Assessments for PTSD Symptoms

Cicchetti, Fontana, and Showalter's work using multiple assessments with a single patient demonstrates concern about interrater reliability is a concern when diagnosing patients (2008). Their specific study evaluated a single participant by twelve separate examiners using the CAPS (2008). Results indicated that the reliability levels of the CAPS consistently and almost exclusively rated in the excellent to perfect levels of inter-examiner agreement, as based upon both global evaluations and on a symptom-by-symptom basis. The results of their investigation were interpreted broadly to apply to determining inter-examiner agreement in clinical trials or other large multi-site studies (Cicchetti, Fontana, and Showalter, 2008).

Cicchetti's work in this area is highly valuable because it demonstrates the reliability of the Clinician Administered PTSD Scale (CAPS) across a variety of examiners, including physicians, social workers, licensed clinical practitioners, and psychologists.

2.6 Importance of Consistent Use of Standardized Assessments

The 2007 Handbook of PTSD makes the argument that the consistent use of standardized measures will lead to better research methodologies, the ability to accomplish meta-analyses, and develop more empirically based treatments, or Evidence Based Practices (EBP) (Keane, Brief, Pratt, and Miller, 2007). In the

advancement of the study of PTSD, it is critical to understand which methods of evaluation work best to conclude whether PTSD is present.

2.7 Method of Literature Review

I reviewed the SCID document, the CAPS document, and the PCL-M. I conducted a search of the National Center for PTSD Published International Literature on Traumatic Stress (PILOTS) database covering 1994-2014. The Social Work Abstracts and Clinical Evidence databases were also explored. Databases were searched using the key words: PTSD, SCID, CAPS, prevalence rates, demographics, reliability and validity, subthreshold, and conducting interviews. All key words were also cross-referenced with Social Work.

Chapter 3

Methodology

This research study is a multi-case study comparison of an assessment tool, the CAPS. The purpose of my study is to compare diagnostic results from the Clinician Administered PTSD Scale (CAPS) to the Structured Clinical Interview for DSM Disorders (SCID) or the Posttraumatic Stress Disorder Checklist for Military Personnel (PCL-M). Participants in the research project will have already completed the SCID with a licensed social worker or the PCL-M with a clinical intern member of the Student Veteran Project, and their scores will be on file. The current study is interested in reviewing each report in a case-study method rather than a statistical analysis.

3.1 Description of Research Design and Procedures

I will draw a sample of participants from 2 groups: those who have been interviewed previously with the SCID while receiving services at the CCSW at the University of Texas in Arlington (UTA), or they will be participants who have previously been evaluated using the PCL-M while receiving services through the Student Veterans Project. I will then administer the CAPS and compare the two results to determine validity of the CAPS using current DSM diagnostic criteria.

Prior to each session, participants will read or have read to them the disclosure and release forms to participate in the study and signed them. The researcher then administered the CAPS to the participants. To preserve study

integrity, the researcher conducting the interviews was continually monitored and received additional training as needed while administering the evaluation. The researcher saw the participants for one hour to complete the CAPS only and she then referred them back to their original counselor for further clinical treatment to the CCSW. If participants were not clients of the CCSW, the researcher gave them a comprehensive list of community and campus resources and referrals

The research design is a case study using the CAPS and SCID or PCL-M assessment tools. The length of time of the evaluation depends on the participants' willingness to speak, but on average, each visit lasts about one hour.

3.2 Description of the Measures

Licensed Clinical Social Workers first gave some participants the Structured Clinical Interview for DSM Disorders (SCID) at the CCSW. The SCID is a diagnostic exam used to determine major mental and personality disorders. It consists of open-ended questions, within nine sections – seven of which represent the Axis I diagnoses (Spitzer, Williams, Gibbon, and First, 1992). The SCID uses a decision tree approach so that if a person answers yes to a question, it leads to other questions while a 'no' response directs the clinician to another section entirely. It can be an extensive process, frequently taking place over multiple sessions if there are several co-occurring conditions. The SCID records the presence or absence of multiple disorders and can be used to rule

out multiple concerns (Spitzer, Williams, and Gibbon, et al, 1992). The SCID has been found to be a valid test measure for determining PTSD and subthreshold PTSD in participants reporting a traumatic event (Franklin, Sheeran, and Zimmerman, 2002).

Other participants volunteered from the Student Veteran Project (SVP). Members of the SVP gave copies of the consent form to the student veterans so they could read it on their own time and decide if they wanted to participate. If the veteran agreed to participate, the researcher set up an independent time to meet with him/ her to administer the CAPS. These student veteran results were compared with the PCL-M instead of the SCID. The Posttraumatic Stress Disorder Checklist for Military personnel (PCL-M) consists of 17 self-report questions that are rated using a Likert Scale. The Likert Scale ranges from 1=Not at all to 5=Extremely. Military veterans are required to score a minimum of 44. The range of scores are 17-33=Low/ not clinically significant, 34-43=Moderate/ nearly clinically significant, and 44-85=High/ clinically significant PTSD (Kimerling, 2009; Blanchard, Jones-Alexander, Buckley, and Forneris, 1996).

The researcher gave participants CAPS in an oral interview. The CAPS (Clinician Administered PTSD Scale) is a “semi-structured interview that is designed to assess the essential features of Posttraumatic Stress Disorder as defined by the DSM-IV” (Blake, Weathers, Nagy, Kaloupek, Klauminzer,

Charney, and Keane, et.al, 2000). It can be used regardless of the amount of time that has passed since the traumatic event. The current CAPS assessment is flexible and is closely aligned with the DSM-IV PTSD criteria. The CAPS also uses frequency and intensity ratings to determine levels of functioning with PTSD.

The CAPS will specifically diagnose Criterion A (whether the event qualifies as traumatic), including guiding questions about lifetime events to which the client may have been exposed (Blake, Weathers, and Nagy, et al, 2000). It has been shown to be reliable and valid in multiple studies (Weathers, Keane, and Davidson, 2000). The CAPS consists of 36 general questions with a Likert scale of 0-4 indicating that an event/ symptoms occurred None of the time, Little of the time, Some of the time, Much of the time, or Most of the time. Each Likert rating also has a descriptor to the side in case a participant cannot between categories. In addition, each of the questions has sections on intensity and frequency of the event or the symptoms. These questions can either be answered with yes/no responses or with open-ended responses from the participant. Participants can also view a visual aid of frequency and intensity.

3.3 Description of the Participants

I recruited research participants from college students at a north Texas university and community members in Arlington, Texas who received treatment from The CCSW located on the University of Texas at Arlington campus. The

CCSW provides clinical services to clients within the community, supports post-graduate education, and provides training to social workers to provide community service. The CCSW conducts clinical research to establish evidence-based practice for social workers (UTA Research Centers, 2013).

Clients volunteered to participate in the evaluation of Posttraumatic Stress Disorder using the CAPS. The age range consisted of adults ages 23 - 49 (Mean= 30, n=6). Three biological males and four biological females participated. Division of the participants into five ethnicity groups broke down as follows: two identified as Hispanic, one as African American, four as Caucasian. Five participants were veterans of the military, with two Army veterans, one Marine, one Air Force, and one Navy veteran. The following marital statuses were reported: four had never been married, two were currently married/ in a domestic partnership, and one participant was divorced. Highest education level completed included: two high school diplomas, three completed a bachelor's degree, and two were currently students and pursuing bachelor's degree. The participants were largely full-time students who were not working, although one was a full time student and fully employed, two people were out of school and working, and one was out of work/ not looking.

3.4 Data Collection

Research data collection began in January 2014 and lasted through March 2014. Data was collected in a single session with each participant lasting approximately 1 hour.

3.5 Data Analysis

Data analysis was conducted by comparing the two methods of assessment with each participant to determine if there was a difference in diagnosis using current criteria. Collected scores for each participant are in Table 4.3.

Chapter 4

Results

4.1 Quantitative Results

Of the four participants who had taken the PCL-M, two did not meet that measure's clinical threshold criteria, but did meet the CAPS criteria. One participant met criteria on both PCL-M and the CAPS. Of the two participants who completed the SCID, rather than the PCL-M, one participant met the SCID but did not meet the CAPS criteria. The other participant did not meet the SCID or the CAPS criteria. Descriptive statistics for the sample may be found in Table 4.1.

Of the seven participants, three did not meet the CAPS threshold, but met the subthreshold in Criteria B and D (Tables 4. 9 and 4.10).

Table 4.11 details results from each of the three assessment tools. All of the participants discussed a traumatic event that occurred several years ago, specifically ranging from three to more than 20 years ago. It is interesting that for all participants, the CAPS Lifetime figure – meaning the symptoms occurred more than 1 week/ 1 month ago – was much higher than the current week/ current month score. Participants 5 and 7 the lifetime number is nearly double the current scores.

Table 4.1Demographics of Participants

Participant Number	Gender	Age	Racial/ Ethnic Background	Marital Status	Education Level Attained	Employment Status	Veteran
1	Female	49	Caucasian	Single/ Never Married	High School Diploma	Unemployed / Looking	Yes, Navy
2	Female	24	Caucasian	Single / Never Married	Some College	Full time Student	Yes, Army
3	Male	30	Caucasian	Married	Associate's Degree	Full time student	Yes, Marines
4	Female	23	Hispanic/ Latino	Single / Never Married	Bachelor's Degree	Full time student	No
5	Female	29	African American	Married	Some College	Employed and Full time student	No
6	Male	35	Caucasian	Divorced	Bachelor's Degree	Self-Employed	Yes, Marines
7	Male	26	African American	Single / Never Married	High School Diploma	Military	Yes, Army

Table 4.2Gender of Participants

	Frequency	Valid Percent	Cumulative Percent
Male	3	42.9	42.9
Female	4	57.1	100.0
Total	7	100.0	

Table 4.3 Racial / Ethnic Background

	Frequency	Valid Percent	Cumulative Percent
Caucasian	4	57.1	57.1
Black/ African American	1	14.3	71.4
Latino	2	28.6	100.0
Total	7	100.0	

Table 4.4 Marital Status

	Frequency	Valid Percent	Cumulative Percent
Single / Never Married	4	57.1	57.1
Married	2	28.6	85.7
Divorced	1	14.3	100.0
Total	7	100.0	

Table 4.5 Education Level Completed

	Frequency	Valid Percent	Cumulative Percent
GED / HS Diploma	2	28.6	28.6
Some College	3	42.9	71.4
Bachelor's Degree	2	28.6	100.0
Total	7	100.0	

Table 4.6 Employment Status

	Frequency	Valid Percent	Cumulative Percent
Employed	1	14.3	14.3
Self-Employed	1	14.3	28.6
Full Time Student	3	42.9	71.4
Military	1	14.3	85.7
Out of Work	1	14.3	100.0
Total	7		

Table 4.7 Veteran Status

	Frequency	Valid Percent	Cumulative Percent
No	2	28.6	28.6
Yes	5	71.4	100.0
Total	7	100.0	

Table 4.8 Military Branch

	Frequency	Valid Percent	Cumulative Percent
Army	2	40.0	40.0
Navy	1	20.0	60.0
Air Force	1	20.0	80.0
Marine	1	20.0	100.0
Total	5	100.0	

Table 4.9 Frequency of CAPS Scores

	CAPS		Total
	Subthreshold	Full	
Frequency	3	4	7

Table 4.10 Frequencies of SCID and PCL-M Scores

	SCID		PCL-M		Total
	Subthreshold	Full	Subthreshold	Full	
Frequency	1	1	2	3	7

Table 4.11 Participant Scores on the CAPS, SCID, and PCL-M

Participant	CAPS Current Week Score	CAPS Current Month Score	CAPS Lifetime Score	SCID All Criterion Met*	PCL-M Score*
1	25	25	46	Yes	
2	38	38	66		31
3	102	118	117		71
4	73	86	90		57
5	22	28	52	No	
6	37	39	48		26
7	47	60	88		66

Note. Participants received either the SCID or the PCL-M, not both.

The most common question that received a “Never” response was question 8 (C-3) “Have you had difficulty remembering some parts of the (EVENT)?” Participant responses ranged from, “I’ll never forget that (event)”; “If you want, I can draw you a very graphic picture (spoken defensively)”; “No one will ever erase what happened to me.”

As I conducted the CAPS, I gave each participant the Life Events Checklist (LEC). This checklist is part of the CAPS and gives the participant a guideline of typical traumatic events on which he/ she can mark their level of experience with each. The LEC benefits the researcher and the participant because it gives them a starting point when determining the validity of the experience in Criterion A.

Table 4.12 Frequency of Life Events Checklist Items

Event	Happened to me / Witnessed It	Learned about it	Doesn't apply / Not Sure
Natural Disaster, Fire or Explosion	5	3	6
Transportation Accident, Serious Accident at work, home or during recreational activity	5	2	7
Physical Assault, Assault with a Weapon	8	1	5
Sexual Assault, Other unwanted or uncomfortable sexual experience	3	3	8
Combat or exposure to a war-zone, Exposure to toxic substance	3	2	9
Captivity	1	1	5
Life threatening illness or injury or sudden violent death	8	2	4
Serious unexpected death of someone close to you, Severe human suffering	5	1	8
Serious injury, harm or death you caused to someone else	2		5
Any other very stressful event or experience	4		3

Note. On the final event that could be rated above, participants described events that were not listed within the other items on the Life Events Checklist, hence "Any other very stressful event or experience." Participants noted events including emotional or mental abuse by parents (2), being held captive at parent home and only being allowed out of bedroom to attend school, excessive worry about the health of parents. While emotional / mental abuse could have been considered under 'Severe human suffering,' the participants chose to identify the abuse separately from the items listed. When asked, the participant who was held captive by her parent did not want to mark 'Captivity' as her choice because she stated she was allowed to go to school and leave her room to use the restroom or eat dinner. She chose 'other' as her option to explain her experience.

I reviewed the CAPS assessment's 30 questions reviewed and interesting patterns emerged. The most frequently endorsed symptoms: sleep disturbance, irritability/anger, hypervigilance, and impairment of social functioning remained similar to other research projects. Table 4.13 displays the specific CAPS

question number. Interestingly, none of the participants had delayed onset with their PTSD, they describe their symptoms, especially sleep disturbance and irritability, as occurring almost immediately.

The least endorsed symptoms were recurrent dreams, a sense of a foreshortened future, difficulty concentrating, derealization, and depersonalization. Additionally, only one participant endorsed the question regarding the inability to recall an important aspect of the trauma. Two others endorsed it, but their answers were not related to the trauma, i.e. one participant said she had trouble keeping track of things because she was withdrawing from cannabis abuse and alcohol abuse; another participant stated she had trouble concentrating because mid-term exams were approaching. Only one participant noted an occupational or school impairment. He was unable to continue working shortly after returning from combat. Other participants denied any type of impairment with work or school.

Table 4.13 Participant Endorsed Symptoms

	5 or more participants, all sx at all levels	5 or more participants, some sx at some levels	1 -2 participants, any sx at any level
Question Numbers	13, 14, 16	1,2,3,4,5,6,7,10	3,12,15,29,30

Note: Sx = Symptoms.

4.2 Qualitative Results

To prepare for this project, I practiced giving the CAPS to a variety of people including my best friend, my spouse, my mother, my sisters, and even my nephews. I was anxious to begin my research, and I was nervous about my abilities in giving a formal assessment to a stranger. I benefitted of practicing with some students who are both veterans and members of the Student Veteran Project. They were patient and kind as I stumbled through my practice attempts with the CAPS and provided useful tips multiple times.

Initially I felt ill prepared regarding the practice CAPS and to give a formalized measurement since I did not learn about them or practice them in any of my graduate level courses. I learned about the CAPS on my own research time prior to beginning my thesis. I reached out to the National Center for PTSD to find information on tools used with veterans and civilians. I believe a great deal of my anxiety and nervousness could have been allayed had I received any introduction or practice with validated assessment tools, as the NASW and CSWE encourage (2012, 2010)

4.2.1 Reflective journaling

After practicing with all my family members, I had my first 'real practice' experience with a student I work with in the Student Veteran Project. It was the first time I was alone in a clinical room with someone I did not know very well. Being in the formal atmosphere of the special room changed my demeanor; I felt

the need to be more ‘professional’ or somehow less personable. Before we reached the mid-point of the assessment, however, the student stopped me and gave me feedback on my techniques.

He stated that I seemed too rigid and “stand-offish;” he did not feel as if he could connect even at a professional level. We took a five minute break during which I re-grouped; I acted more like myself in the rest of the interview. Being more comfortable means I cannot stare at the CAPS, and I engage the participant in more questions/ discussion about his answers rather than nodding and making marks on the forms without giving feedback. Changing my method and opening my demeanor – by smiling when the participant made jokes or showing concern when the participant shared something serious or painful to him – led to a deeper understanding of the participant, and I was able to gain more insight into the qualitative nature of the CAPS. The feedback I received at the end of the practice was much more favorable and he said that I was a different person after the break. I was relieved that I could be more ‘myself’ with a participant while still remaining professional and cordial.

I noted in past experiences that I tend to swing from too rigid to too loose. This ‘real practice’ allowed me to try a ‘middle way’ where I could be relaxed and professional at the same time. I was highly encouraged and felt ready to complete more practice attempts.

After my first real practice, I practiced with two other students working with the Student Veteran Project. The first student was not a veteran; during her assessment, she made up a traumatic incident and imagined what symptoms she might have had. It was an interesting event for the both of us, with a few giggles in between about her supposed symptoms. I appreciated her willingness to participate, but we focused on my ability to use the CAPS successfully, not on her actual answers. I became more familiar with the questions and their many parts before conducting a real assessment which was incredibly helpful.

The second student with whom I attempted to practice the CAPS was a student veteran. She had completed the CAPS with a licensed practitioner some time before our practice. At the beginning of my practice with her, she was open and willing to participate. Unfortunately, very early in the experience, before we reached the Criteria B questions, she became upset and was unable to complete the practice CAPS with me. I was a little unnerved about my experience with her because I had not expected such a strong reaction. This experience taught me to tread delicately with the participants. It also taught me to be more reassuring toward the participant and make sure they are comfortable. It underscored the reasons why they are provided with a detailed list of resources as part of the research protocol.

I completed one practice evaluation with a child of 12, which was requested by the clinical staff to augment the prior clinical interview. The child's

licensed practitioner was in the room throughout the event. I gave the child the TESI–C (Traumatic Events Screening Inventory for Children). The 16 questions in the TESI-C ask about the various domains of traumatic experiences. If a child endorses a "Yes" response to any traumatic event, further questions are asked to determine if the child's life was threatened or if they were at risk for serious injury (2011). The TESI-C is a guide and screen to determine exposure to possibly traumatic experiences, but it is not a definitive identification or rule-out instrument (2011). Only Criterion A is discerned; symptomology/ Criteria B-F are not discussed.

In hindsight, I would have given the child the CAPS-CA (Clinician Administered PTSD Scale for Children and Adolescents) as it is a more thorough measurement that can be used to clinically diagnose a child with PTSD and includes all the diagnosis criteria. Overall the episode was strained. I noticed a several instances of negative body language from the child including crossing her arms and legs, not making good eye contact and readjusting her sitting position continually (restlessness). I feel that the licensed practitioner who observed the in the evaluation room with me also influenced the results, by interrupting the standardized questions with her own questions, and bringing up topics that the child's grandmother had told the practitioner (of which I had no knowledge). As soon as the other practitioner brought up the grandmother's statements from a previous interview, the child stopped answering my questions. After a few

minutes of talking about her school classes and asking about her friendships, she relaxed so I continued the TESI-C. Her results from an earlier assessment indicated she had experienced a traumatic event, but she denied any events in which she felt scared or helpless. She has continued with further therapy at the Center for Clinical Social Work with her therapist. I felt very awkward with the situation and would not want to repeat it without meeting first with the other clinician to determine the best method of evaluation / what my expectations would be – that the other clinician not interrupt or introduce information from an outside source.

My first true experience was of a 49 year old female veteran who was intermittently homeless. She had been previously diagnosed with Chronic PTSD based on her SCID results after several traumatic life events including sexual abuse by her father, physical abuse from a boyfriend when she was in her 20s, experiencing gunfire in her home when she was 9 years old, and her nephew had been murdered the previous year. She was dealing with extreme bereavement. She met all the SCID criteria and I was asked to complete a more detailed assessment of her PTSD since the participant was tangential in her thinking and her clinician was unsure of the duration of her symptoms.

My experience with the participant was unique. Again, her clinician sat in the clinical room with me while I conducted the CAPS. In addition to her PTSD, she had a provisional diagnosis of Borderline Personality Disorder. During the

majority of the CAPS evaluation, the participant only made eye contact with her clinician, and during some parts of the visit, she would look at her clinician and make a funny face – sort of like a face that a person might make if they were trying to include someone in a joke. I was not sure what was going on with those behaviors. The participant was determined to have subthreshold PTSD. She did not meet the minimum requirement of having three Criterion C symptoms. Her final CAPS Lifetime score was 46; the cut-off for full PTSD is 65.

One of the benefits of using the CAPS is the qualitative portion of the measurement in which the participant can give further details, descriptions and examples for each question. When she responded to question 4 (B-4) (See Appendix C), where I asked about the frequency at which the participant became emotionally upset, she was able to talk about what feelings she experienced, "I feel really angry when I am blamed by my son's friend's mom for what happened." This specific insight would not have been recorded on another tool, such as the SCID or PLC-M. Later, in question 7 (C-2), she described what types of activities, places, and people she avoided after her traumatic event; "I stayed away from my dad and never slept in my own room again. I always slept with my sister."

I enjoy learning from others, especially in a supervisory capacity. Since she was my first official assessment, I was glad that the clinician stayed in the room during the CAPS.

My second participant was a bright, 24 year old female. She was an Army veteran and a student at a local school. She endorsed several experiences on the Life Events Checklist, but decided to only focus on an experience of sexual assault. I would later call my encounter with her, "faking good." While the participant stated that she had experienced several traumatic events, she declared, "None of that bothers me at all. I'm fine." She also joked about many of the questions I asked her and would briefly say 'No' and then laugh a little to most of the questions without elaboration – even if I asked for more details/ information, such as when I would say, "That question seemed to be amusing, can you tell me more about that?".

Again, I was observed while conducting a formal evaluation. The student assisting the participant through the Student Veteran Project was very curious about the CAPS and wanted to be present to help debrief the participant afterwards in case she had any upsetting feelings or was distraught because of the experience. If anything, I felt that the participant was 'faking good;' I cannot say with certainty that her answers stayed valid. She did state that she had been" completely fine," for years until the birth of her son. She said, "The thoughts faded and went away for a long time until [my son] was born. Now I have a lot of bad dreams and I don't like to go to sleep." When I asked her about how much distress she is currently having, she refused to answer but looked away and said she did not want to talk about it. The participant's main concern

was that she had recently been lashing out at her son, having frequent irritability, and showing strong feelings of anger (question D-2, Appendix C). She said, “I was really showing my anger to my son and he really saw it and started to cry.” She stated that she recovered quickly and made an effort to point out that she never hit her son, “Ever.”

She qualified as subthreshold PTSD by not endorsing any symptoms under Criterion C. Her scores were: Lifetime: 66, Current: 38. The cutoff for clinically diagnostic PTSD is 65. I learned a great deal from my experience with this participant. I learned about meeting a client where they are and being flexible in order to accomplish my goals and to make the participant more comfortable.

My third participant was a young male veteran. He endorsed multiple events on the Life Events Checklist including a serious transportation accident that left him physically injured, sexual assault, and witnessing a sudden violent death. We met in a quiet room along with a different student who was assisting this participant through the Student Veteran Project who wanted to observe the formalized process and be available to the participant if he needed it. The young man met Criterion A for all three events that we discussed. He endorsed experiences of dissociation, such as not remembering where he was or how he got to a place. He recalled multiple instances in which someone had to shake him to ‘wake him up.’

As my first assessment of a person with full PTSD, I was sometimes overwhelmed by the amount of information the participant shared and sometimes shaken by what he experienced. He continues to have frequent flashbacks especially when someone raises their voice or yells, even if the person is not yelling at him. He stated that it sent him into a panic,

> Anytime I get in trouble, like one time during a music rehearsal in my class. The director was yelling and I was completely out of it. The director had to wake me up, and I felt they were all watching me. I felt 'the finger' was on me.

In this instance, he was unresponsive to outside stimuli until the music director physically touched him on the shoulder. In another instance, he stated that going to the gym and working out scared him. "I'm afraid I'll reinjure myself. Every time I go to the gym, I am reminded of my accident." These experiences created extreme, incapacitating distress; he was unable to keep his physical therapy appointments since they take place at a gym. This participant is unable to work due to his fear of driving because of his collision, which resulted in serious injuries. He tries to avoid all driving and he was also scared to go to work because when people yell, it brings up flashbacks of his childhood abuse.

A benefit of the CAPS is that a clinician can determine PTSD criteria from multiple events, keeping track of individual totals of different events and different experiences in the large spaces provided on the assessment tool. Case in point,

during question 7 (C-2), I was able to write notes for Criteria 1A – the abuse and Criteria 2A – the serious vehicle collision (Appendix C).

The most worrying of this participant's symptoms were his dissociative ones. He frequently did not know how he arrived home; he had trouble in school and work. Clearly his PTSD is severe and I was glad to provide him with a comprehensive list of mental health providers, hospitals, and clinics available to him, in addition to the current mental health services he is receiving (i.e., medication and supportive therapy). His overall scores were: Current: 102, Past Month: 118, and Lifetime: 117. His results nearly doubled the cutoff rate with a maximum available total of 129.

He person was a severe case, yet I learned so much from my meeting with him. In some ways, I felt it was my best assessment. We were not bothered or distracted, we were not time limited, and he was open and honest with me about terrible experiences in his life, including his struggle to deal with them. His honesty about his struggles was moving. I was apprehensive about how the evaluation would go since he was my first male veteran and he appeared very tough and 'macho' when I first met him. I was not sure how open he would be to my questions or to the fact that I was a female. I was wrong. It was an honest measurement and he went above and beyond to give answers to all the questions.

I met my fourth participant at a university health fair. She had endorsed all four of the short symptom list on a measurement provided by the campus counseling center. I asked if she would be interested in participating in my research and she agreed. Approximately half way through the evaluation process, I began to worry about the validity of the assessment. As she became more comfortable with me, she was more honest that many of her anxiety symptoms might be caused by her self-acknowledged marijuana withdrawal. She stated that she became a heavy, daily marijuana smoker to deal with domestic violence from her boyfriend, who was also a drug dealer. I later determined that the majority of her Criterion D symptoms were to be the result of her marijuana withdrawal including reduced sleep, irritability/ anger, and difficulty concentrating. She also stated that she had begun carrying a knife, “every day, just in case I see my ex-boyfriend.”

The participant stated that she had previously been diagnosed with Major Depressive Disorder in middle school but did never felt like taking the medication and had stopped taking it as soon as she was out of high school. While we finished the CAPS, the participant met subthreshold PTSD criteria; she did not meet Criteria C or D. While she had been exposed to trauma, her overlapping issues of Major Depressive Disorder and Cannabis Withdrawal may have interfered with the PTSD determination, alternatively the impact of these other conditions on her cognitive status during trauma exposure may have affected the

actual processing and therefore impact of the trauma. It is also possible the CAPS accurately measured her PTSD symptom level. I referred this participant to the campus counseling and psychiatric services department and gave her a comprehensive list of mental health resources in the nearby community.

I completed an assessment of a 29-year-old African American woman who was not a veteran. My fifth participant had experienced severe trauma as a teenager by being locked in her room for over a year until she was rescued by an uncle and taken to her father's house. A few months later, her mother kidnapped her from her father's house. She reported severe physical abuse and showed me scars on her arms from one of the beatings. Curiously, she did not meet the PTSD criteria on the SCID (Appendix E); I gave her the CAPS to definitively determine whether she had PTSD. After a thorough completion of the CAPS, I determined she did not meet the full or subthreshold PTSD criteria. She had a few subthreshold symptoms such as a high startle reflex and nightmares from which she awakens screaming, but overall, she denied most of the symptoms entirely. She stated that she did not remember any of her dreams, but that her husband would wake her up to stop her screaming.

She talked honestly about how frequently thoughts will come to her that remind her of the two years with her mother, but she refuses to think about them. She stated she would not "let them get in the way!" I was openly impressed by her resiliency and recovery from a situation that could have been detrimental to

her entire well-being. I was surprised by her fresh outlook on her experiences and her forgiveness of her mother.

I met my sixth participant at a neighborhood hangout. He is applying to attend a local school and we started talking about the veterans' assistance programs at various local schools and my personal research. He volunteered on the spot to participate in my research. A couple of weeks later, I brought him a PCL-M and my CAPS materials. Prior to the meeting, I called him to ask him not to have any alcohol before the assessment. He was open when I first met him about his drinking habits and the amount of alcohol he consumes. He stated he was, "just trying to forget about my guys. They're already gone, so thinking about them won't bring them back." He stated he drank at least one large bottle of vodka per day. He agreed not to drink until after our "little talk" was over; I was glad to see he kept his word. When I arrived he was sober and ready to talk.

At first we sat in a slightly quiet area of the hangout to complete the informed consent and demographic paperwork, but moved to the outside patio because indoors proved too loud. I was able to maintain a confidential atmosphere by having him only complete paperwork silently so no one was nearby listening or looking over our shoulders. The patio was a better location to conduct the CAPS as we were the only two people outside. The participant noticeably relaxed once we left the noisy hangout. He sat facing the door and leaned back in his chair seemingly nonchalant. The participant stopped talking

whenever the door opened. He is a 26 year old Hispanic male who was recently discharged from the Army after serving two tours in Afghanistan. He was glad to be home and answered my questions thoughtfully and carefully. He appreciated the list of mental health resources and said he would use those as a backup plan for the VA since it was really hard to get appointments at his location.

This assessment took much longer than my other experiences, possibly because of his thoroughness. He met the PTSD lifetime threshold with an 88. In the past few months and weeks, he met the subthreshold criteria with a 60. Regarding the change between his lifetime and more recent results, he said, "Look, I've been working on a lot of this stuff because I don't want to be who the Army made me. I want to be my old self." He is currently receiving services from the local VA office. I enjoyed spending time and appreciated that the participant took the time to consider his answers rather than either rushing through the questions.

Chapter 5

Discussion

5.1 Meeting the Purpose of the Thesis Study

The purpose of this study was to enhance my clinical skills as a Social Work student, by gaining additional skills in standardized, psychometrics and in the utility of different instruments in a clinical community population outpatient setting. This purpose was met. I learned, through multiple practices and actual assessments with clients of varying demographic characteristics and presenting problems, how to give the CAPS. I learned that a formal diagnostic tool is different from a subjective interview and one must follow the instructions, and use the specified guidelines exactly in order to maintain a valid measurement.

At first, using the specific wording felt stiff and awkward, and my practice clients noticed that I came across as uncomfortable. In later practices, I used the designated statements but also paused and asked if the participant had any questions, and added a few of my own words to help the flow. My new method worked much better. I feel fully confident in my ability to administer the CAPS and look forward to learning other psychometrics.

5.2 Support of the Hypothesis

The research question sought to address whether the CAPS diagnostic results vary from other “gold standard” PTSD instruments. This question has

implications for its validity and utility as a diagnostic tool in a community clinic population; although a full psychometric co-validation investigation was beyond the scope of this study. I was therefore unable to support a co-validity hypothesis, largely due to the small sample size of my project, but I did find that diagnostic results varied across instruments. In my personal experience during my training, I felt the CAPS tool to be a more in-depth evaluation to determine PTSD than the SCID or the PCL-M. The SCID focuses on "Yes/No" responses and does not ask questions about frequency or intensity of the symptoms. It does not ask about what the specific traumatic event was and it does not provide questions that are more qualitative in nature. The PCL-M asks questions about specific symptoms, but it is a self-report questionnaire rather than an administered interview (like the SCID and the CAPS). It also does not ask about what the traumatic event was. In comparison, the CAPS evaluation asks about all these items, but it is only to be used to examine PTSD.

I found that the SCID, PCL-M, and CAPS work best together. The SCID or the PCL-M can be used as rule-out assessments and if the participant endorses PTSD symptoms on either of these, then the CAPS can be used as an additional tool to determine frequency and intensity of client symptoms, and the length of time they have experienced them. In my personal experience with these three assessment tools, the CAPS also works well in obtaining additional

information from clients about their symptoms and the length of time they have experienced them, which is not covered in the PCL-M.

5.3 Knowledge of Subthreshold PTSD in Participants

Near the end of my data collection, I noted that a few of the participants did not meet the full PTSD criteria. The concept of subthreshold PTSD was new to me. I completed an additional review of the literature on the topic and learned that the participants who did not meet the full criteria did meet the criteria for subthreshold PTSD.

Criterion B in the diagnosis for PTSD refers to symptoms of reexperiencing, such as nightmares, or feeling as if the event is happening again (flashbacks). The majority of the participants had some form of reexperiencing, but only one participant had flashbacks.

Symptoms of avoidance are determined in Criterion C. As noted in Table 5.1, the majority of the participants only experienced two of the symptoms. . These results are in keeping with recent research about subthreshold PTSD. When people are given a PTSD evaluation, it is most common that the person to not meet Criterion C (Kessler, Sonnega, Bromet, Hughes, and Nelson, 1995; Milanak and Berenbaum, 2009; Kulka, Schlenger, and Fairbank, et al, 1988; Weiss, Marmar, Schlenger, Fairbank, Jordan, Hough, and Kulka, 1992; Kilpatrick, Resnick, and Milanak, et.al, 2013; Breslau, Lucia, and Davis, 2004). A person must have at least 3 symptoms endorsed under Criterion C to meet the

minimum PTSD threshold (DSM-IV-TR, 2000). Hyper arousal symptoms are noted in Criterion D. In my study, the majority of the participants endorsed this cluster of symptoms, including loss of sleep and being watchful or on guard.

Table 5.1 Frequency of Positive Symptoms by Criterion

	Question #	Frequency
Criterion B	1	4
	2	4
	3	1
	4	4
	5	3
Criterion C	6	5
	7	3
	8	3
	9	3
	10	5
	11	4
	12	2
Criterion D	13	6
	14	6
	15	2
	16	5
	17	3

5.4 Comparison of DSM-V Criteria with DSM-IV-TR

The DSM-V and DSM-IV-TR differ in their diagnostic criteria for PTSD. The DSM-IV-TR has seven criteria and the DSM-V has eight. While several of the categories have the same labels, the symptoms under each criterion may have changed and/ or moved to other categories. Criterion D was added to include alterations in mood or cognition because of the traumatic event; Criterion H was also added to state that "the disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition" (DSM-V, 2013, p. 272).

As the DSM has changed over the years, the PTSD definition has also changed and the goal of the DSM-V was to further tighten the definition. The DSM-IV definition was prone to false positives (Spitzer, First, and Wakefield, 2007). Before this change occurred, lifetime prevalence rose to 89.6% of the U.S. population (Breslau and Kessler, 2001). This event may have been created by the changes in the DSM-IV to add "learned about" a traumatic event after the fact, such as learning about an event while watching the news, reading a newspaper, or viewing a website.

DSM-IV research field trials increased the likelihood that a person might be diagnosed with PTSD if they had ever experienced a traumatic event or learned about an event after the fact. The DSM-V attempted to tighten Criterion

A to decrease the number of people who were given a 'false positive' diagnosis of PTSD. The CAPS, SCID, and PCL-M are efforts to ensure that a person genuinely qualifies for a diagnosis of PTSD. The CAPS is a newer tool; the one I used was validated with the DSM-IV. It goes into deeper detail in order to rule out those 'false positives.' As these assessments tools are updated to align with the DSM-V, I will be pleased to already have experience using them and they will continue to be useful.

In a meta-analysis of changes for the DSM-V, it was noted that only one study supported the DSM-IV structure of having three criteria (Friedman, Resick, Bryant, and Brewin, 2011). On the other hand, multiple studies support using four criteria by adding negative alterations of mood and cognition (previously called dysphoria) to the other three categories listed earlier (Asmundson, Frombach, McQuaid, Pedrilli, Lenox, and Stein, 2000; Duhamel, Ostroff, Ashman, Winkel, Mundy, Keane, Morasco, et al, 2004; D. King, Leskin, L. King, and Weathers, 1998; McWilliams, Cox and Asmundson, 2005; Andrews, Joseph, Shevlin, and Troop, 2006; Simms, Watson, and Doebbeling, 2002; Elkit and Shevlin, 2007).

5.5 Remembering the Traumatic Event

Table 5.1 notes that three participants endorsed question 8, but I identified problems with the validity. One participant stated she could not remember things because she was constantly using cannabis and was drinking heavily. Another

participant endorsed the question, but towards the end of the assessment, openly recalled the entire traumatic event. When I asked her if she could indeed remember the traumatic event she said, “Oh, yes, I think about it all the time.” Therefore, only one participant endorsed question 8.

Participants were adamant about question 8, “Have you had difficulty remembering some important parts of (EVENT)? Some even smacked their leg or a table lightly while saying “Never!” Participants’ emphatic responses ranged from, “I’ll never forget that (event)!”; “If you want, I can draw you a very graphic picture! (Spoken defensively)”; “No one will ever erase what happened to me!” The exclamation marks are the participants’ own. These occurrences are different from the current knowledge about PTSD (Paunovic, Lundh, and Öst, 2002; Hayes, VanElzakker, and Shin, 2012; Steinmetz, Scott, Smith, and Kensinger, 2012; Klein, Caspi, and Gil, 2003; Golier, Yehuda, Lupien, and Harvey, 2003; Shalev, Yehuda, and McFarlane, 2000). Research in 2009 found multiple deficits in memory related to PTSD (Samuelson, Neylan, Lenoci, Metzler, Cardenas, Weiner, and Marmar, 2009). In two different translational research studies, hormones were able to replicate this memory loss (Reist, Duffy, Fujimoto, and Cahill, 2001; Kaouane, Porte, Vallée, Brayda-Bruno, and Mons, et.al, 2012). A neuroimaging study in 2012 found functional changes to the brain in the areas of memory and cognition (Hayes, VanElzakker, and Shin, 2012).

Further research will need to be completed to determine why six of my seven participants did not have any memory loss of their traumatic event. Elizabeth Loftus, a noted psychologist in the study of memory, states repeatedly in her many studies that no memory is 100% accurate, especially over time, or in relation to trauma (G. Loftus, and E. Loftus, 1974; Loftus, 1991; Loftus, 1996; Bernstein, Godfrey, Davison, and Loftus, 2004; Loftus, 2005). She also notes that when a person is strongly expected to remember something, they will make up details to fit what they think they remember (1974, 1991, and 2005).

A future question would be to ask the participants to actually describe the traumatic event to determine what specifically they remember.

5.6 Bias and Threats to Validity

A bias potential bias exists in the CAPS assessment tool. Questions about whether the symptom is clearly related to the traumatic event can be subjective. It may seem as though the participant is experiencing symptoms related to trauma, but the symptoms may be related to other life experiences, as was the case for my participant who was struggling with concentration and memory only to determine that her symptoms ensued because she was leading a very hectic life by being a full-time student, full-time employed, raising three young children, and taking care of her household.

The CAPS has been validated through multiple tests; however psychometric co-validation with the SCID and PCL-M was beyond the scope of this study.

5.7 Limitations of the Study

My study was limited by using only adults while not including adolescents or children. It was also limited by focusing solely on the CAPS, SCID, and PCL-M. Other psychometric tools that could have been used include the MMPI and the PCL-C (PTSD Checklist-Civilian). A further limitation to my study was that I did not include a wider range of traumatic events associated with PTSD including natural disasters, or man-made disasters (such as the events of September 11, 2001 or the bombing in Oklahoma City in 1995).

5.8 Importance of Findings

While my findings are statistically insignificant, they create interesting questions. Why did my participants deny forgetting any part of their traumatic event? Why did so few have problems in Cluster C? I wonder if some of them, more than I would like to admit, were 'faking good' on their answers in order to impress me, or if another reason was present. Even though I carefully noted multiple times in the informed consent, the participants may have been fearful that their answers would affect their Veteran's benefits.

5.9 Recommendations based on Study

Regardless of the individual findings of this study, the purpose, to provide experience to me as a graduate social work student in the use of professional psychometrics, was met. My study was significant for me. It has been a valuable experience to learn about the CAPS, SCID, and PCL-M and to learn to use them correctly. I recommend strongly that schools of social work begin offering more detailed information about psychometrics in their current courses and it would be practical and valuable to offer entire courses in formal clinical measurement and evaluation tools. As social workers, we frequently assess individuals and couples as part of providing services to them. It would be constructive for students to have knowledge and experience with these tools prior to graduation and entering the field.

Appendix A

Letter of Approval from Institutional Review Board

Office of Research Administration
Regulatory Services
817-272-3723
regulatoryservices@uta.edu
http://www.uta.edu/research/administration

February 5, 2014

Emily Clark-Nimz
Dr. Alexa Smith-Osborne
The University of Texas at Arlington
School of Social Work
Box 19129

EXPEDITED APPROVAL OF HUMAN SUBJECT RESEARCH

IRB No.: 2014-0247
TITLE: *Comparing Standardized Assessment Tools*
Effective Date: February 4, 2014
Expiration Date: February 4, 2015

Approved Number of Participants: 20 (Do not exceed without prior IRB approval).

The University of Texas Arlington Institutional Review Board (UTA IRB) has made the determination that this research protocol involving human subjects is eligible for expedited review in accordance with Title 45 CFR 46.110(a)-(b)(1), 63 FR 60364 and 63 FR 60353, category (7). The IRB Chairperson (or designee) approved this protocol effective February 4, 2014. IRB approval for the research shall continue until February 4, 2015.

APPROVED NUMBER OF PARTICIPANTS:
This protocol has been approved for enrollment of a maximum of 20 participants and is not to exceed this number. If additional data are needed, the researcher must submit a modification request to increase the number of approved participants **before** the additional data are collected. Exceeding the number of approved participants is considered an issue of non-compliance and will result in the destruction of the data collected beyond the approval number and will be subject to deliberation set forth by the IRB.

INFORMED CONSENT DOCUMENT:
The IRB approved and stamped informed consent document (ICD) showing the approval and expiration date must be used when prospectively enrolling volunteer participants into the study. The use of a copy of any consent form on which the IRB-stamped approval and expiration dates are not visible, or are replaced by typescript or handwriting, is prohibited. The signed consent forms must be securely maintained on the UT Arlington campus for the duration of the study plus a minimum of three years after the completion of all study procedures (including data analysis). The complete study record is subject to inspection and/or audit during this time period by entities including but not limited to the UT Arlington IRB, Regulatory Services staff, OHRP, and by study sponsors (if the study is funded).

Office of Research Administration
Regulatory Services
817-272-3723
regulatoryservices@uta.edu
http://www.uta.edu/research/administration

MODIFICATION TO AN APPROVED PROTOCOL:
Pursuant to Title 45 CFR 46.103(b)(4)(iii), investigators are required to, "promptly report to the IRB ***any*** proposed changes in the research activity, and to ensure that such changes in approved research, during the period for which IRB approval has already been given, are **not initiated without prior IRB review and approval** except when necessary to eliminate apparent immediate hazards to the subject." Modifications include but are not limited to: Changes in protocol personnel, number of approved participants, and/or updates to the protocol procedures or instruments and must be submitted via the electronic submission system. Failure to obtain approval for modifications is considered an issue of non-compliance and will be subject to review and deliberation by the IRB which could result in the suspension/termination of the protocol.

ANNUAL CONTINUING REVIEW:
In order for the research to continue beyond the first year, a Continuing Review must be completed via the online submission system within 30 days preceding the date of expiration indicated above. A reminder notice will be forwarded to the attention of the Principal Investigator (PI) 30 days prior to the expiration date. Continuing review of the protocol serves as a progress report and provides the researcher with an opportunity to make updates to the originally approved protocol. Failure to obtain approval for a continuing review will result in automatic ***expiration of the protocol*** all activities involving human subjects must cease immediately. The research will not be allowed to commence by any protocol personnel until a new protocol has been submitted, reviewed, and approved by the IRB. Per federal regulations and UTA's Federalwide Assurance (FWA), there are no exceptions and no extensions of approval granted by the IRB. The continuation of study procedures after the expiration of a protocol is considered to be an issue of non-compliance and a violation of federal regulations. Such violations could result in termination of external and University funding and/or disciplinary action.

ADVERSE EVENTS:
Please be advised that as the principal investigator, you are required to report local adverse (unanticipated) events to The UT Arlington Office of Research Administration; Regulatory Services within 24 hours of the occurrence or upon acknowledgement of the occurrence.

HUMAN SUBJECTS TRAINING AND CONFLICTS OF INTEREST DISCLOSURE:
All investigators and key personnel identified in the protocol must have documented Human Subjects Protection (HSP) training on file AND must have filed an annual Conflict of Interest Disclosure (COI) with The UT Arlington Office of Research Administration; Regulatory Services. HSP completion certificates are valid for 2 years from completion date.

COLLABORATION:
If applicable, approval by the appropriate authority at a collaborating facility is required prior to subject enrollment. If the collaborating facility is *engaged in the research*, an OHRP approved Federalwide Assurance (FWA) may be required for the facility (prior to their participation in research-related activities). To determine whether the collaborating facility is engaged in research, go to: http://www.hhs.gov/ohrp/humansubjects/assurance/engage.htm

Office of Research Administration
Regulatory Services
817-272-3723
regulatoryservices@uta.edu
http://www.uta.edu/research/administration

CONTACT FOR QUESTIONS:
The UT Arlington Office of Research Administration; Regulatory Services appreciates your continuing commitment to the protection of human research subjects. Should you have questions or require further assistance, please contact Robin Dickey by calling 817-272-9329.

Sincerely,

Maria Martinez-Cosio, Ph.D.
Associate Professor
UT Arlington IRB Chair

Appendix B

Informed Consent

UT Arlington
Informed Consent Document

PRINCIPAL INVESTIGATOR
Emily J. Clark-Nimz, BA, BS, School of Social Work, Contact Information:
Located in SOCW A,
Emily.Clark@mavs.uta.edu

FACULTY ADVISOR
Alexa Smith-Osborne, Ph.D., School of Social Work
Contact information: 817-272-3181
alexaso@uta.edu

TITLE OF PROJECT
Comparing Standardized Assessment Tools

INTRODUCTION
You are being asked to participate in a research study comparing assessment questionnaires that are commonly used in Social Work practice. Your participation is voluntary. Refusal to participate or discontinuing your participation at any time will involve no penalty or loss of benefits to which you are otherwise entitled. Please ask questions if there is anything you do not understand.

PURPOSE
The specific purpose of this research study is to compare, after your consent to release this prior information, scores on assessments you have completed before with your score on the Clinician Administered PTSD Scale (CAPS) you are being asked to complete now. The CAPS is a clinician interview that asks specific questions about your symptoms following a traumatic event or multiple traumatic events in your life.

DURATION
You will be asked to participate in 1 study visit which will last approximately 1 hour.

NUMBER OF PARTICIPANTS
The number of anticipated participants in this research study is 20.

PROCEDURES
The procedures which will involve you as a research participant include: Answering a set of questions regarding your symptoms following a traumatic event(s) in your life and how they have affected you.

This interview will not be audio or video recorded.

POSSIBLE BENEFITS

IRB Approval Date: FEB 0 4 2014

IRB Expiration Date: FEB 0 4 2015

You will gain further insight into life events. You will gain further insight into the assessment process which is part of the helping process which will potentially improve the services you are seeking. Your help in this study is valuable in determining which assessment tools are the most accurate for different situations and in advancing helpers' practice skills in using them.

POSSIBLE RISKS/DISCOMFORTS
Some people experience mild distress while completing an assessment. You will not be urged or encouraged to share more information about your life events than what you are comfortable with. You will be interviewed in a clinical setting, and if you do experience these discomforts, counselors will be nearby and available to you at no charge should you experience any concerns. **Also available at any time is a 24-hour PTSD Crisis Line at 1-800-273-8255,press 1. If you have concerns Dr. Smith-Osborne is also available by phone at 817-272-2165 from 3-9 p.m., Monday through Thursday. You may also consult the attached list of available resources.**
You have the right to stop the interview at any time at no consequence to yourself and may do so by informing the researcher that you wish to stop.

COMPENSATION
No compensation will be offered for your participation in this research study.

ALTERNATIVE PROCEDURES
There are no alternative procedures offered for this study. You have the right to not participate in this study or quit the interview at any time at no consequence to yourself and may do so by informing the researcher that you wish to stop. Non-participation in this research study will not affect any other services you are receiving from the University of Texas at Arlington.

VOLUNTARY PARTICIPATION
Participation in this study is voluntary. You have the right to not participate in any or all study procedures, including how much information you want to share about your specific traumatic event, or quit at any time with no consequences.

CONFIDENTIALITY
Every attempt will be made to see that your study results are kept confidential. A copy of this signed consent form and all data collected from this study will be stored in locked filing cabinets in the faculty advisor's office room 208 A, in the School of Social Work for at least three (3) years after the end of this research. After signing the consent form, all identifying information will be removed and you will be assigned an anonymous case number used for data collection and analysis. The results of this study may be published and/or presented at meetings without naming you as a participant. Additional research

IRB Approval Date: FEB 0 4 2014

IRB Expiration Date: FEB 0 4 2015

studies could evolve from the information you have provided, but your information will not be linked to you in anyway; it will be anonymous. Although your rights and privacy will be maintained, the Secretary of the Department of Health and Human Services, the UTA Institutional Review Board (IRB), and personnel particular to this research have access to the study records. Your records will be kept completely confidential according to current legal requirements. They will not be revealed unless required by law, or as noted above. The IRB at UTA has reviewed and approved this study and the information within this consent form. If in the unlikely event it becomes necessary for the Institutional Review Board to review your research records, the University of Texas at Arlington will protect the confidentiality of those records to the extent permitted by law.

CONTACT FOR QUESTIONS
Questions about this research study may be directed to Emily Clark-Nimz Emily.Clark@mavs.uta.edu or Dr. Alexa Smith-Osborne at alexaso@uta.edu. Any questions you may have about your rights as a research participant or a research-related injury may be directed to the Office of Research Administration; Regulatory Services at 817-272-2105 or regulatoryservices@uta.edu.

As a representative of this study, I have explained the purpose, the procedures, the benefits, and the risks that are involved in this research study:

Signature and printed name of principal investigator or person obtaining consent **Date**

CONSENT
By signing below, you confirm that you are 18 years of age or older and have read or had this document read to you. You have been informed about this study's purpose, procedures, possible benefits and risks, and you have received a copy of this form. You have been given the opportunity to ask questions before you sign, and you have been told that you can ask other questions at any time.

You voluntarily agree to participate in this study by permitting release of prior assessment score information from other university studies in which you are participating and by taking CAPS interview schedule for score comparison. By signing this form, you are not waiving any of your legal rights. Refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled. You may discontinue participation at any time without penalty or loss of benefits, to which you are otherwise entitled.

SIGNATURE OF VOLUNTEER **DATE**

IRB Approval Date: FEB 0 4 2014

IRB Expiration Date: FEB 0 4 2015

Appendix C

CAPS

National Center for PTSD

CLINICIAN-ADMINISTERED PTSD SCALE FOR DSM-IV

Name: _____ ID # :_____

Date: _____

Interviewer: _____

Study: _____

Dudley D. Blake, Frank W. Weathers, Linda M. Nagy,
Danny G. Kaloupek, Dennis S. Charney, & Terence M. Keane

National Center for Posttraumatic Stress Disorder

Behavioral Science Division -- Boston VA Medical Center
Neurosciences Division -- West Haven VA Medical Center

Revised July 1998

Criterion A. The person has been exposed to a traumatic event in which both of the following were present:
(1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
(2) the person's response involved intense fear, helplessness, or horror. Note: In children, this may be expressed instead by disorganized or agitated behavior

I'm going to be asking you about some difficult or stressful things that sometimes happen to people. Some examples of this are being in some type of serious accident; being in a fire, a hurricane, or an earthquake; being mugged or beaten up or attacked with a weapon; or being forced to have sex when you didn't want to. I'll start by asking you to look over a list of experiences like this and check any that apply to you. Then, if any of them do apply to you, I'll ask you to briefly describe what happened and how you felt at the time.

Some of these experiences may be hard to remember or may bring back uncomfortable memories or feelings. People often find that talking about them can be helpful, but it's up to you to decide how much you want to tell me. As we go along, if you find yourself becoming upset, let me know and we can slow down and talk about it. Also, if you have any questions or you don't understand something, please let me know. Do you have any questions before we start?

ADMINISTER CHECKLIST, THEN REVIEW AND INQUIRE UP TO THREE EVENTS. IF MORE THAN THREE EVENTS ENDORSED, DETERMINE WHICH THREE EVENTS TO INQUIRE (E.G., FIRST, WORST, AND MOST RECENT EVENTS; THREE WORST EVENTS; TRAUMA OF INTEREST PLUS TWO OTHER WORST EVENTS, ETC.)

IF NO EVENTS ENDORSED ON CHECKLIST: *(Has there ever been a time when your life was in danger or you were seriously injured or harmed?)*

IF NO: *(What about a time when you were threatened with death or serious injury, even if you weren't actually injured or harmed?)*

IF NO: *(What about witnessing something like this happen to someone else or finding out that it happened to someone close to you?)*

IF NO: *(What would you say are some of the most stressful experiences you have had over your life?)*

EVENT #1

What happened? *(How old were you? Who else was involved? How many times did this happen? Life threat? Serious injury?)*	*Describe (e.g., event type, victim, perpetrator, age, frequency):*
How did you respond emotionally? *(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?)*	*A. (1)* *Life threat? NO YES [self ___ other ___]* *Serious injury? NO YES [self ___ other ___]* *Threat to physical integrity? NO YES [self ___ other ___]* *A. (2)* *Intense fear/help/horror? NO YES [during ___ after ___]* *Criterion A met? NO PROBABLE YES*

EVENT #2

What happened? *(How old were you? Who else was involved? How many times did this happen? Life threat? Serious injury?)*	*Describe (e.g., event type, victim, perpetrator, age, frequency):*
How did you respond emotionally? *(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?)*	*A. (1)* *Life threat? NO YES [self ___ other ___]* *Serious injury? NO YES [self ___ other ___]* *Threat to physical integrity? NO YES [self ___ other ___]* *A. (2)* *Intense fear/help/horror? NO YES [during ___ after ___]* *Criterion A met? NO PROBABLE YES*

EVENT #3

What happened? *(How old were you? Who else was involved? How many times did this happen? Life threat? Serious injury?)*	*Describe (e.g., event type, victim, perpetrator, age, frequency):*
How did you respond emotionally? *(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?)*	*A. (1)* *Life threat? NO YES [self ___ other ___]* *Serious injury? NO YES [self ___ other ___]* *Threat to physical integrity? NO YES [self ___ other ___]* *A. (2)* *Intense fear/help/horror? NO YES [during ___ after ___]* *Criterion A met? NO PROBABLE YES*

For the rest of the interview, I want you to keep (EVENTS) in mind as I ask you some questions about how they may have affected you.

I'm going to ask you about twenty-five questions altogether. Most of them have two parts. First, I'll ask if you've ever had a particular problem, and if so, about how often in the past month *(week)*. Then I'll ask you how much distress or discomfort that problem may have caused you.

Criterion B. The traumatic event is persistently reexperienced in one (or more) of the following ways:

1. (B-1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions.
Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.

Frequency	***Intensity***	***Past week***
Have you ever had unwanted memories of (EVENT)? What were they like? *(What did you remember?)* [IF NOT CLEAR:] *(Did they ever occur while you were awake, or only in dreams?)* [EXCLUDE IF MEMORIES OCCURRED ONLY DURING DREAMS] **How often have you had these memories in the past month *(week)*?** 0 Never 1 Once or twice 2 Once or twice a week 3 Several times a week 4 Daily or almost every day ***Description/Examples***	**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?** *(How hard did you have to try?)* **How much did they interfere with your life?** 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 ***QV (specify)*** _____	*F* ____ *I* ____ ***Past month*** *F* ____ *I* ____ ***Sx: Y N*** ***Lifetime*** *F* ____ *I* ____ ***Sx: Y N***

2. (B-2) recurrent distressing dreams of the event. **Note:** In children, there may be frightening dreams without recognizable content.

Frequency	***Intensity***	***Past week***
Have you ever had unpleasant dreams about (EVENT)? Describe a typical dream. *(What happens in them?)* **How often have you had these dreams in the past month *(week)*?** 0 Never 1 Once or twice 2 Once or twice a week 3 Several times a week 4 Daily or almost every day ***Description/Examples***	**How much distress or discomfort did these dreams cause you? Did they ever wake you up?** [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?)* 0 None 1 Mild, minimal distress, may not have awoken 2 Moderate, awoke in distress but readily returned to sleep 3 Severe, considerable distress, difficulty returning to sleep 4 Extreme, incapacitating distress, did not return to sleep ***QV (specify)*** _____	*F* ____ *I* ____ ***Past month*** *F* ____ *I* ____ ***Sx: Y N*** ***Lifetime*** *F* ____ *I* ____ ***Sx: Y N***

3. (B-3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). **Note:** In young children, trauma-specific reenactment may occur.

Frequency	***Intensity***	***Past week***
Have you ever suddenly acted or felt as if (EVENT) were happening again? *(Have you ever had flashbacks about [EVENT]?)* [IF NOT CLEAR:] *(Did this ever occur while you were awake, or only in dreams?)* [EXCLUDE IF OCCURRED ONLY DURING DREAMS] **Tell me more about that. How often has that happened in the past month *(week)*?** 0 Never 1 Once or twice 2 Once or twice a week 3 Several times a week 4 Daily or almost every day ***Description/Examples***	**How much did it seem as if (EVENT) were happening again?** *(Were you confused about where you actually were or what you were doing at the time?)* **How long did it last? What did you do while this was happening?** *(Did other people notice your behavior? What did they say?)* 0 No reliving 1 Mild, somewhat more realistic than just thinking about event 2 Moderate, definite but transient dissociative quality, still very aware of surroundings, daydreaming quality 3 Severe, strongly dissociative (reports images, sounds, or smells) but retained some awareness of surroundings 4 Extreme, complete dissociation (flashback), no awareness of surroundings, may be unresponsive, possible amnesia for the episode (blackout) ***QV (specify)*** _____	*F* ____ *I* ____ ***Past month*** *F* ____ *I* ____ ***Sx: Y N*** ***Lifetime*** *F* ____ *I* ____ ***Sx: Y N***

4. (B-4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

Frequency	***Intensity***	***Past week***
Have you ever gotten emotionally upset when something reminded you of (EVENT)? *(Has anything ever triggered bad feelings related to [EVENT]?)* **What kinds of reminders made you upset? How often in the past month *(week)*?** 0 Never 1 Once or twice 2 Once or twice a week 3 Several times a week 4 Daily or almost every day ***Description/Examples***	**How much distress or discomfort did (REMINDERS) cause you? How long did it last? How much did it interfere with your life?** 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, marked disruption of activities 4 Extreme, incapacitating distress, unable to continue activities ***QV (specify)*** _____	*F* ____ *I* ____ ***Past month*** *F* ____ *I* ____ ***Sx: Y N*** ***Lifetime*** *F* ____ *I* ____ ***Sx: Y N***

5. (B-5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

Frequency	***Intensity***	***Past week***
Have you ever had any physical reactions when something reminded you of (EVENT)? *(Did your body ever react in some way when something reminded you of [EVENT]?)* **Can you give me some examples?** *(Did your heart race or did your breathing change? What about sweating or feeling really tense or shaky?)* **What kinds of reminders triggered these reactions? How often in the past month *(week)*?** 0 Never 1 Once or twice 2 Once or twice a week 3 Several times a week 4 Daily or almost every day ***Description/Examples***	**How strong were (PHYSICAL REACTIONS)? How long did they last?** *(Did they last even after you were out of the situation?)* 0 No physical reactivity 1 Mild, minimal reactivity 2 Moderate, physical reactivity clearly present, may be sustained if exposure continues 3 Severe, marked physical reactivity, sustained throughout exposure 4 Extreme, dramatic physical reactivity, sustained arousal even after exposure has ended ***QV (specify)*** _____	*F* ____ *I* ____ ***Past month*** *F* ____ *I* ____ ***Sx: Y N*** ***Lifetime*** *F* ____ *I* ____ ***Sx: Y N***

Criterion C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

6. (C-1) efforts to avoid thoughts, feelings, or conversations associated with the trauma

Frequency	***Intensity***	***Past week***
Have you ever tried to avoid thoughts or feelings about (EVENT)? *(What kinds of thoughts or feelings did you try to avoid?)* **What about trying to avoid talking with other people about it?** *(Why is that?)* **How often in the past month *(week)*?** 0 Never 1 Once or twice 2 Once or twice a week 3 Several times a week 4 Daily or almost every day ***Description/Examples***	**How much effort did you make to avoid (THOUGHTS/FEELINGS/CONVERSATIONS)?** *(What kinds of things did you do? What about drinking or using medication or street drugs?)* [CONSIDER ALL ATTEMPTS AT AVOIDANCE, INCLUDING DISTRACTION, SUPPRESSION, AND USE OF ALCOHOL/DRUGS] **How much did that interfere with your life?** 0 None 1 Mild, minimal effort, little or no disruption of activities 2 Moderate, some effort, avoidance definitely present, some disruption of activities 3 Severe, considerable effort, marked avoidance, marked disruption of activities, or involvement in certain activities as avoidant strategy 4 Extreme, drastic attempts at avoidance, unable to continue activities, or excessive involvement in certain activities as avoidant strategy ***QV (specify)*** _____	*F* ____ *I* ____ ***Past month*** *F* ____ *I* ____ ***Sx: Y N*** ***Lifetime*** *F* ____ *I* ____ ***Sx: Y N***

7. (C-2) efforts to avoid activities, places, or people that arouse recollections of the trauma

Frequency	***Intensity***	***Past week***
Have you ever tried to avoid certain activities, places, or people that reminded you of (EVENT)? *(What kinds of things did you avoid? Why is that?)* **How often in the past month *(week)*?** 0 Never 1 Once or twice 2 Once or twice a week 3 Several times a week 4 Daily or almost every day ***Description/Examples***	**How much effort did you make to avoid (ACTIVITIES/PLACES/PEOPLE)?** *(What did you do instead?)* **How much did that interfere with your life?** 0 None 1 Mild, minimal effort, little or no disruption of activities 2 Moderate, some effort, avoidance definitely present, some disruption of activities 3 Severe, considerable effort, marked avoidance, marked disruption of activities or involvement in certain activities as avoidant strategy 4 Extreme, drastic attempts at avoidance, unable to continue activities, or excessive involvement in certain activities as avoidant strategy ***QV (specify)*** _____	*F* ____ *I* ____ ***Past month*** *F* ____ *I* ____ *Sx: Y N* ***Lifetime*** *F* ____ *I* ____ *Sx: Y N*

8. (C-3) inability to recall an important aspect of the trauma

Frequency	***Intensity***	***Past week***
Have you had difficulty remembering some important parts of (EVENT)? Tell me more about that. *(Do you feel you should be able to remember these things? Why do you think you can't?)* **In the past month *(week)*, how much of the important parts of (EVENT) have you had difficulty remembering?** *(What parts do you still remember?)* 0 None, clear memory 1 Few aspects not remembered (less than 10%) 2 Some aspects not remembered (approx 20-30%) 3 Many aspects not remembered (approx 50-60%) 4 Most or all aspects not remembered (more than 80%) ***Description/Examples***	**How much difficulty did you have recalling important parts of (EVENT)?** *(Were you able to recall more if you tried?)* 0 None 1 Mild, minimal difficulty 2 Moderate, some difficulty, could recall with effort 3 Severe, considerable difficulty, even with effort 4 Extreme, completely unable to recall important aspects of event ***QV (specify)*** _____	*F* ____ *I* ____ ***Past month*** *F* ____ *I* ____ *Sx: Y N* ***Lifetime*** *F* ____ *I* ____ *Sx: Y N*

9. (C-4) markedly diminished interest or participation in significant activities

Frequency	***Intensity***	***Past week***
Have you been less interested in activities that you used to enjoy? *(What kinds of things have you lost interest in? Are there some things you don't do at all anymore? Why is that?)* [EXCLUDE IF NO OPPORTUNITY, IF PHYSICALLY UNABLE, OR IF DEVELOPMENTALLY APPROPRIATE CHANGE IN PREFERRED ACTIVITIES] **In the past month *(week)*, how many activities have you been less interested in?** *(What kinds of things do you still enjoy doing?)* **When did you first start to feel that way?** *(After the [EVENT]?)* 0 None 1 Few activities (less than 10%) 2 Some activities (approx 20-30%) 3 Many activities (approx 50-60%) 4 Most or all activities (more than 80%) ***Description/Examples***	**How strong was your loss of interest?** *(Would you enjoy [ACTIVITIES] once you got started?)* 0 No loss of interest 1 Mild, slight loss of interest, probably would enjoy after starting activities 2 Moderate, definite loss of interest, but still has some enjoyment of activities 3 Severe, marked loss of interest in activities 4 Extreme, complete loss of interest, no longer participates in any activities ***QV (specify)*** _____ ***Trauma-related?*** *1 definite 2 probable 3 unlikely* *Current* _____ *Lifetime* _____	*F* ____ *I* ____ ***Past month*** *F* ____ *I* ____ ***Sx: Y N*** ***Lifetime*** *F* ____ *I* ____ ***Sx: Y N***

10. (C-5) feeling of detachment or estrangement from others

Frequency	***Intensity***	***Past week***
Have you felt distant or cut off from other people? What was that like? How much of the time in the past month *(week)* have you felt that way? When did you first start to feel that way? *(After the [EVENT]?)* 0 None of the time 1 Very little of the time (less than 10%) 2 Some of the time (approx 20-30%) 3 Much of the time (approx 50-60%) 4 Most or all of the time (more than 80%) ***Description/Examples***	**How strong were your feelings of being distant or cut off from others?** *(Who do you feel closest to? How many people do you feel comfortable talking with about personal things?)* 0 No feelings of detachment or estrangement 1 Mild, may feel "out of synch" with others 2 Moderate, feelings of detachment clearly present, but still feels some interpersonal connection 3 Severe, marked feelings of detachment or estrangement from most people, may feel close to only one or two people 4 Extreme, feels completely detached or estranged from others, not close with anyone ***QV (specify)*** _____ ***Trauma-related?*** *1 definite 2 probable 3 unlikely* *Current* _____ *Lifetime* _____	*F* ____ *I* ____ ***Past month*** *F* ____ *I* ____ ***Sx: Y N*** ***Lifetime*** *F* ____ *I* ____ ***Sx: Y N***

11. (C-6) restricted range of affect (e.g., unable to have loving feelings)

Frequency	***Intensity***	***Past week***
Have there been times when you felt emotionally numb or had trouble experiencing feelings like love or happiness? What was that like? *(What feelings did you have trouble experiencing?)* **How much of the time in the past month *(week)* have you felt that way? When did you first start having trouble experiencing (EMOTIONS)?** *(After the [EVENT]?)* 0 None of the time 1 Very little of the time (less than 10%) 2 Some of the time (approx 20-30%) 3 Much of the time (approx 50-60%) 4 Most or all of the time (more than 80%) ***Description/Examples***	**How much trouble did you have experiencing (EMOTIONS)?** *(What kinds of feelings were you still able to experience?)* [INCLUDE OBSERVATIONS OF RANGE OF AFFECT DURING INTERVIEW] 0 No reduction of emotional experience 1 Mild, slight reduction of emotional experience 2 Moderate, definite reduction of emotional experience, but still able to experience most emotions 3 Severe, marked reduction of experience of at least two primary emotions (e.g., love, happiness) 4 Extreme, completely lacking emotional experience ***QV (specify)*** _____ ***Trauma-related?*** *1 definite 2 probable 3 unlikely* *Current* _____ *Lifetime* _____	*F* ____ *I* ____ ***Past month*** *F* ____ *I* ____ ***Sx: Y N*** ***Lifetime*** *F* ____ *I* ____ ***Sx: Y N***

12. (C-7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

Frequency	***Intensity***	***Past week***
Have there been times when you felt there is no need to plan for the future, that somehow your future will be cut short? Why is that? [RULE OUT REALISTIC RISKS SUCH AS LIFE-THREATENING MEDICAL CONDITIONS] **How much of the time in the past month *(week)* have you felt that way? When did you first start to feel that way?** *(After the [EVENT]?)* 0 None of the time 1 Very little of the time (less than 10%) 2 Some of the time (approx 20-30%) 3 Much of the time (approx 50-60%) 4 Most or all of the time (more than 80%) ***Description/Examples***	**How strong was this feeling that your future will be cut short?** *(How long do you think you will live? How convinced are you that you will die prematurely?)* 0 No sense of a foreshortened future 1 Mild, slight sense of a foreshortened future 2 Moderate, sense of a foreshortened future definitely present, but no specific prediction about longevity 3 Severe, marked sense of a foreshortened future, may make specific prediction about longevity 4 Extreme, overwhelming sense of a foreshortened future, completely convinced of premature death ***QV (specify)*** _____ ***Trauma-related?*** *1 definite 2 probable 3 unlikely* *Current* _____ *Lifetime* _____	*F* ____ *I* ____ ***Past month*** *F* ____ *I* ____ ***Sx: Y N*** ***Lifetime*** *F* ____ *I* ____ ***Sx: Y N***

Criterion D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

13. (D-1) difficulty falling or staying asleep

Frequency	***Intensity***	***Past week***
Have you had any problems falling or staying asleep? How often in the past month *(week)*? When did you first start having problems sleeping? *(After the [EVENT]?)* 0 Never 1 Once or twice 2 Once or twice a week 3 Several times a week 4 Daily or almost every day Sleep onset problems? Y N Mid-sleep awakening? Y N Early a.m. awakening? Y N Total # hrs sleep/night _____ Desired # hrs sleep/night _____	**How much of a problem did you have with your sleep?** *(How long did it take you to fall asleep? How often did you wake up in the night? Did you often wake up earlier than you wanted to? How many total hours did you sleep each night?)* 0 No sleep problems 1 Mild, slightly longer latency, or minimal difficulty staying asleep (up to 30 minutes loss of sleep) 2 Moderate, definite sleep disturbance, clearly longer latency, or clear difficulty staying asleep (30-90 minutes loss of sleep) 3 Severe, much longer latency, or marked difficulty staying asleep (90 min to 3 hrs loss of sleep) 4 Extreme, very long latency, or profound difficulty staying asleep (> 3 hrs loss of sleep) ***QV (specify)*** _____ ***Trauma-related?*** *1 definite 2 probable 3 unlikely* *Current* _____ *Lifetime* _____	F ____ I ____ ***Past month*** F ____ I ____ Sx: Y N ***Lifetime*** F ____ I ____ Sx: Y N

14. (D-2) irritability or outbursts of anger

Frequency	***Intensity***	***Past week***
Have there been times when you felt especially irritable or showed strong feelings of anger? Can you give me some examples? How often in the past month *(week)*? When did you first start feeling that way? *(After the [EVENT]?)* 0 Never 1 Once or twice 2 Once or twice a week 3 Several times a week 4 Daily or almost every day ***Description/Examples***	**How strong was your anger?** *(How did you show it?)* [IF REPORTS SUPPRESSION:] *(How hard was it for you to keep from showing your anger?)* **How long did it take you to calm down? Did your anger cause you any problems?** 0 No irritability or anger 1 Mild, minimal irritability, may raise voice when angry 2 Moderate, definite irritability or attempts to suppress anger, but can recover quickly 3 Severe, marked irritability or marked attempts to suppress anger, may become verbally or physically aggressive when angry 4 Extreme, pervasive anger or drastic attempts to suppress anger, may have episodes of physical violence ***QV (specify)*** _____ ***Trauma-related?*** *1 definite 2 probable 3 unlikely* *Current* _____ *Lifetime* _____	F ____ I ____ ***Past month*** F ____ I ____ Sx: Y N ***Lifetime*** F ____ I ____ Sx: Y N

15. (D-3) difficulty concentrating

Frequency	***Intensity***	***Past week***
Have you found it difficult to concentrate on what you were doing or on things going on around you? What was that like? How much of the time in the past month *(week)*? When did you first start having trouble concentrating? *(After the [EVENT]?)* 0 None of the time 1 Very little of the time (less than 10%) 2 Some of the time (approx 20-30%) 3 Much of the time (approx 50-60%) 4 Most or all of the time (more than 80%) ***Description/Examples***	**How difficult was it for you to concentrate?** [INCLUDE OBSERVATIONS OF CONCENTRATION AND ATTENTION IN INTERVIEW] **How much did that interfere with your life?** 0 No difficulty with concentration 1 Mild, only slight effort needed to concentrate, little or no disruption of activities 2 Moderate, definite loss of concentration but could concentrate with effort, some disruption of activities 3 Severe, marked loss of concentration even with effort, marked disruption of activities 4 Extreme, complete inability to concentrate, unable to engage in activities ***QV (specify)*** _____ ***Trauma-related?*** *1 definite 2 probable 3 unlikely* *Current* _____ *Lifetime* _____	*F* ____ *I* ____ ***Past month*** *F* ____ *I* ____ ***Sx: Y N*** ***Lifetime*** *F* ____ *I* ____ ***Sx: Y N***

16. (D-4) hypervigilance

Frequency	***Intensity***	***Past week***
Have you been especially alert or watchful, even when there was no real need to be? *(Have you felt as if you were constantly on guard?)* **Why is that? How much of the time in the past month *(week)*? When did you first start acting that way?** *(After the [EVENT]?)* 0 None of the time 1 Very little of the time (less than 10%) 2 Some of the time (approx 20-30%) 3 Much of the time (approx 50-60%) 4 Most or all of the time (more than 80%) ***Description/Examples***	**How hard did you try to be watchful of things going on around you?** [INCLUDE OBSERVATIONS OF HYPERVIGILANCE IN INTERVIEW] **Did your (HYPERVIGILANCE) cause you any problems?** 0 No hypervigilance 1 Mild, minimal hypervigilance, slight heightening of awareness 2 Moderate, hypervigilance clearly present, watchful in public (e.g., chooses safe place to sit in a restaurant or movie theater) 3 Severe, marked hypervigilance, very alert, scans environment for danger, exaggerated concern for safety of self/family/home 4 Extreme, excessive hypervigilance, efforts to ensure safety consume significant time and energy and may involve extensive safety/checking behaviors, marked watchfulness during interview ***QV (specify)*** _____ ***Trauma-related?*** *1 definite 2 probable 3 unlikely* *Current* _____ *Lifetime* _____	*F* ____ *I* ____ ***Past month*** *F* ____ *I* ____ ***Sx: Y N*** ***Lifetime*** *F* ____ *I* ____ ***Sx: Y N***

17. (D-5) exaggerated startle response

Frequency	***Intensity***	***Past week***
Have you had any strong startle reactions? When did that happen? *(What kinds of things made you startle?)* **How often in the past month *(week)*? When did you first have these reactions?** *(After the [EVENT]?)* 0 Never 1 Once or twice 2 Once or twice a week 3 Several times a week 4 Daily or almost every day ***Description/Examples***	**How strong were these startle reactions?** *(How strong were they compared to how most people would respond?)* **How long did they last?** 0 No startle reaction 1 Mild, minimal reaction 2 Moderate, definite startle reaction, feels "jumpy" 3 Severe, marked startle reaction, sustained arousal following initial reaction 4 Extreme, excessive startle reaction, overt coping behavior (e.g., combat veteran who "hits the dirt") ***QV (specify)*** _____ ***Trauma-related?*** *1 definite 2 probable 3 unlikely* *Current* _____ *Lifetime* _____	*F* ____ *I* ____ ***Past month*** *F* ____ *I* ____ ***Sx: Y N*** ***Lifetime*** *F* ____ *I* ____ ***Sx: Y N***

Criterion E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

18. onset of symptoms

[IF NOT ALREADY CLEAR:] **When did you first start having (PTSD SYMPTOMS) you've told me about?** *(How long after the trauma did they start? More than six months?)*	_____ ***total # months delay in onset*** ***With delayed onset (≥ 6 months)? NO YES***

19. duration of symptoms

		Current	***Lifetime***
[CURRENT] **How long have these (PTSD SYMPTOMS) lasted altogether?** [LIFETIME] **How long did these (PTSD SYMPTOMS) last altogether?**	*Duration more than 1 month?*	***NO YES***	***NO YES***
	Total # months duration	_____	_____
	Acute (< 3 months) or chronic (≥ 3 months)?	***acute chronic***	***acute chronic***

Criterion F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

20. subjective distress

		Past week
[CURRENT] **Overall, how much have you been bothered by these (PTSD SYMPTOMS) you've told me about?** [CONSIDER DISTRESS REPORTED ON EARLIER ITEMS] [LIFETIME] **Overall, how much were you bothered by these (PTSD SYMPTOMS) you've told me about?** [CONSIDER DISTRESS REPORTED ON EARLIER ITEMS]	0 None 1 Mild, minimal distress 2 Moderate, distress clearly present but still manageable 3 Severe, considerable distress 4 Extreme, incapacitating distress	____ ***Past month*** ____ ***Lifetime***

21. impairment in social functioning

[CURRENT] **Have these (PTSD SYMPTOMS) affected your relationships with other people? How so?** [CONSIDER IMPAIRMENT IN SOCIAL FUNCTIONING REPORTED ON EARLIER ITEMS] [LIFETIME] **Did these (PTSD SYMPTOMS) affect your social life? How so?** [CONSIDER IMPAIRMENT IN SOCIAL FUNCTIONING REPORTED ON EARLIER ITEMS]	0 No adverse impact 1 Mild impact, minimal impairment in social functioning 2 Moderate impact, definite impairment, but many aspects of social functioning still intact 3 Severe impact, marked impairment, few aspects of social functioning still intact 4 Extreme impact, little or no social functioning	***Past week*** ____ ***Past month*** ____ ***Lifetime*** ____

22. impairment in occupational or other important area of functioning

[CURRENT -- IF NOT ALREADY CLEAR] **Are you working now?** IF YES: **Have these (PTSD SYMPTOMS) affected your work or your ability to work? How so?** [CONSIDER REPORTED WORK HISTORY, INCLUDING NUMBER AND DURATION OF JOBS, AS WELL AS THE QUALITY OF WORK RELATIONSHIPS. IF PREMORBID FUNCTIONING IS UNCLEAR, INQUIRE ABOUT WORK EXPERIENCES BEFORE THE TRAUMA. FOR CHILD/ADOLESCENT TRAUMAS, ASSESS PRE-TRAUMA SCHOOL PERFORMANCE AND POSSIBLE PRESENCE OF BEHAVIOR PROBLEMS] IF NO: **Have these (PTSD SYMPTOMS) affected any other important part of your life?** [AS APPROPRIATE, SUGGEST EXAMPLES SUCH AS PARENTING, HOUSEWORK, SCHOOLWORK, VOLUNTEER WORK, ETC.] **How so?** [LIFETIME -- IF NOT ALREADY CLEAR] **Were you working then?** IF YES: **Did these (PTSD SYMPTOMS) affect your work or your ability to work? How so?** [CONSIDER REPORTED WORK HISTORY, INCLUDING NUMBER AND DURATION OF JOBS, AS WELL AS THE QUALITY OF WORK RELATIONSHIPS. IF PREMORBID FUNCTIONING IS UNCLEAR, INQUIRE ABOUT WORK EXPERIENCES BEFORE THE TRAUMA. FOR CHILD/ADOLESCENT TRAUMAS, ASSESS PRE-TRAUMA SCHOOL PERFORMANCE AND POSSIBLE PRESENCE OF BEHAVIOR PROBLEMS] IF NO: **Did these (PTSD SYMPTOMS) affect any other important part of your life?** [AS APPROPRIATE, SUGGEST EXAMPLES SUCH AS PARENTING, HOUSEWORK, SCHOOLWORK, VOLUNTEER WORK, ETC.] **How so?**	0 No adverse impact 1 Mild impact, minimal impairment in occupational/other important functioning 2 Moderate impact, definite impairment, but many aspects of occupational/other important functioning still intact 3 Severe impact, marked impairment, few aspects of occupational/other important functioning still intact 4 Extreme impact, little or no occupational/other important functioning	***Past week*** ____ ***Past month*** ____ ***Lifetime*** ____

Global Ratings

23. global validity

ESTIMATE THE OVERALL VALIDITY OF RESPONSES. CONSIDER FACTORS SUCH AS COMPLIANCE WITH THE INTERVIEW, MENTAL STATUS (E.G., PROBLEMS WITH CONCENTRATION, COMPREHENSION OF ITEMS, DISSOCIATION), AND EVIDENCE OF EFFORTS TO EXAGGERATE OR MINIMIZE SYMPTOMS.	0	Excellent, no reason to suspect invalid responses
	1	Good, factors present that may adversely affect validity
	2	Fair, factors present that definitely reduce validity
	3	Poor, substantially reduced validity
	4	Invalid responses, severely impaired mental status or possible deliberate "faking bad" or "faking good"

24. global severity

ESTIMATE THE OVERALL SEVERITY OF PTSD SYMPTOMS. CONSIDER DEGREE OF SUBJECTIVE DISTRESS, DEGREE OF FUNCTIONAL IMPAIRMENT, OBSERVATIONS OF BEHAVIORS IN INTERVIEW, AND JUDGMENT REGARDING REPORTING STYLE.	0	No clinically significant symptoms, no distress and no functional impairment	***Past week***
	1	Mild, minimal distress or functional impairment	____
	2	Moderate, definite distress or functional impairment but functions satisfactorily with effort	***Past month***
	3	Severe, considerable distress or functional impairment, limited functioning even with effort	____
	4	Extreme, marked distress or marked impairment in two or more major areas of functioning	***Lifetime*** ____

25. global improvement

RATE TOTAL OVERALL IMPROVEMENT PRESENT SINCE THE INITIAL RATING. IF NO EARLIER RATING, ASK HOW THE SYMPTOMS ENDORSED HAVE CHANGED OVER THE PAST 6 MONTHS. RATE THE DEGREE OF CHANGE, WHETHER OR NOT, IN YOUR JUDGMENT, IT IS DUE TO TREATMENT.	0	Asymptomatic
	1	Considerable improvement
	2	Moderate improvement
	3	Slight improvement
	4	No improvement
	5	Insufficient information

Current PTSD Symptoms

Criterion A met (traumatic event)? NO YES

_____ *# Criterion B sx (≥ 1)?* NO YES

_____ *# Criterion C sx (≥ 3)?* NO YES

_____ *# Criterion D sx (≥ 2)?* NO YES

Criterion E met (duration ≥ 1 month)? NO YES

Criterion F met (distress/impairment)? NO YES

_____

CURRENT PTSD (Criteria A-F met)? NO YES

IF CURRENT PTSD CRITERIA ARE MET, SKIP TO ASSOCIATED FEATURES.

IF CURRENT CRITERIA ARE NOT MET, ASSESS FOR LIFETIME PTSD. IDENTIFY A PERIOD OF AT LEAST A MONTH SINCE THE TRAUMATIC EVENT IN WHICH SYMPTOMS WERE WORSE.

Since the (EVENT), has there been a time when these (PTSD SYMPTOMS) were a lot worse than they have been in the past month? When was that? How long did it last? *(At least a month?)*

IF MULTIPLE PERIODS IN THE PAST: **When were you bothered the most by these (PTSD SYMPTOMS)?**

IF AT LEAST ONE PERIOD, INQUIRE ITEMS 1-17, CHANGING FREQUENCY PROMPTS TO REFER TO WORST PERIOD: **During that time, did you (EXPERIENCE SYMPTOM)? How often?**

Lifetime PTSD Symptoms

Criterion A met (traumatic event)? NO YES

_____ *# Criterion B sx (≥ 1)?* NO YES

_____ *# Criterion C sx (≥ 3)?* NO YES

_____ *# Criterion D sx (≥ 2)?* NO YES

Criterion E met (duration ≥ 1 month)? NO YES

Criterion F met (distress/impairment)? NO YES

_____

LIFETIME PTSD (Criteria A-F met)? NO YES

Associated Features

26. guilt over acts of commission or omission

Frequency	***Intensity***	***Past week***
Have you felt guilty about anything you did or didn't do during (EVENT)? Tell me more about that. *(What do you feel guilty about?)* **How much of the time have you felt that way in the past month *(week)*?** 0 None of the time 1 Very little of the time (less than 10%) 2 Some of the time (approx 20-30%) 3 Much of the time (approx 50-60%) 4 Most or all of the time (more than 80%) ***Description/Examples***	**How strong were these feelings of guilt? How much distress or discomfort did they cause?** 0 No feelings of guilt 1 Mild, slight feelings of guilt 2 Moderate, guilt feelings definitely present, some distress but still manageable 3 Severe, marked feelings of guilt, considerable distress 4 Extreme, pervasive feelings of guilt, self-condemnation regarding behavior, incapacitating distress ***QV (specify)*** _____	*F* ____ *I* ____ ***Past month*** *F* ____ *I* ____ ***Sx: Y N*** ***Lifetime*** *F* ____ *I* ____ ***Sx: Y N***

27. survivor guilt [APPLICABLE ONLY IF MULTIPLE VICTIMS]

Frequency	***Intensity***	***Past week***
Have you felt guilty about surviving (EVENT) when others did not? Tell me more about that. *(What do you feel guilty about?)* **How much of the time have you felt that way in the past month *(week)*?** 0 None of the time 1 Very little of the time (less than 10%) 2 Some of the time (approx 20-30%) 3 Much of the time (approx 50-60%) 4 Most or all of the time (more than 80%) 8 N/A ***Description/Examples***	**How strong were these feelings of guilt? How much distress or discomfort did they cause?** 0 No feelings of guilt 1 Mild, slight feelings of guilt 2 Moderate, guilt feelings definitely present, some distress but still manageable 3 Severe, marked feelings of guilt, considerable distress 4 Extreme, pervasive feelings of guilt, self-condemnation regarding survival, incapacitating distress ***QV (specify)*** _____	*F* ____ *I* ____ ***Past month*** *F* ____ *I* ____ ***Sx: Y N*** ***Lifetime*** *F* ____ *I* ____ ***Sx: Y N***

28. a reduction in awareness of his or her surroundings (e.g., "being in a daze")

Frequency	***Intensity***	***Past week***
Have there been times when you felt out of touch with things going on around you, like you were in a daze? What was that like? [DISTINGUISH FROM FLASHBACK EPISODES] **How often has that happened in the past month *(week)*?** [IF NOT CLEAR:] *(Was it due to an illness or the effects of drugs or alcohol?)* **When did you first start feeling that way?** *(After the [EVENT]?)* 0 Never 1 Once or twice 2 Once or twice a week 3 Several times a week 4 Daily or almost every day ***Description/Examples***	**How strong was this feeling of being out of touch or in a daze?** *(Were you confused about where you actually were or what you were doing at the time?)* **How long did it last? What did you do while this was happening?** *(Did other people notice your behavior? What did they say?)* 0 No reduction in awareness 1 Mild, slight reduction in awareness 2 Moderate, definite but transient reduction in awareness, may report feeling "spacy" 3 Severe, marked reduction in awareness, may persist for several hours 4 Extreme, complete loss of awareness of surroundings, may be unresponsive, possible amnesia for the episode (blackout) ***QV (specify)*** _____ ***Trauma-related?*** *1 definite 2 probable 3 unlikely* *Current* _____ *Lifetime* _____	*F* ____ *I* ____ ***Past month*** *F* ____ *I* ____ ***Sx: Y N*** ***Lifetime*** *F* ____ *I* ____ ***Sx: Y N***

29. derealization

Frequency	***Intensity***	***Past week***
Have there been times when things going on around you seemed unreal or very strange and unfamiliar? [IF NO:] *(What about times when people you knew suddenly seemed unfamiliar?)* **What was that like? How often has that happened in the past month *(week)*?** [IF NOT CLEAR:] *(Was it due to an illness or the effects of drugs or alcohol?)* **When did you first start feeling that way?** *(After the [EVENT]?)* 0 Never 1 Once or twice 2 Once or twice a week 3 Several times a week 4 Daily or almost every day ***Description/Examples***	**How strong was (DEREALIZATION)? How long did it last? What did you do while this was happening?** *(Did other people notice your behavior? What did they say?)* 0 No derealization 1 Mild, slight derealization 2 Moderate, definite but transient derealization 3 Severe, considerable derealization, marked confusion about what is real, may persist for several hours 4 Extreme, profound derealization, dramatic loss of sense of reality or familiarity ***QV (specify)*** _____ ***Trauma-related?*** *1 definite 2 probable 3 unlikely* *Current* _____ *Lifetime* _____	*F* ____ *I* ____ ***Past month*** *F* ____ *I* ____ ***Sx: Y N*** ***Lifetime*** *F* ____ *I* ____ ***Sx: Y N***

30. depersonalization

Frequency	***Intensity***	***Past week***
Have there been times when you felt as if you were outside of your body, watching yourself as if you were another person? [IF NO:] *(What about times when your body felt strange or unfamiliar to you, as if it had changed in some way?)* **What was that like? How often has that happened in the past month *(week)*?** [IF NOT CLEAR:] *(Was it due to an illness or the effects of drugs or alcohol?)* **When did you first start feeling that way?** *(After the [EVENT]?)* 0 Never 1 Once or twice 2 Once or twice a week 3 Several times a week 4 Daily or almost every day ***Description/Examples***	**How strong was (DEPERSONALIZATION)? How long did it last? What did you do while this was happening?** *(Did other people notice your behavior? What did they say?)* 0 No depersonalization 1 Mild, slight depersonalization 2 Moderate, definite but transient depersonalization 3 Severe, considerable depersonalization, marked sense of detachment from self, may persist for several hours 4 Extreme, profound depersonalization, dramatic sense of detachment from self ***QV (specify)*** _____ ***Trauma-related?*** *1 definite 2 probable 3 unlikely* *Current* _____ *Lifetime* _____	*F* ____ *I* ____ ***Past month*** *F* ____ *I* ____ ***Sx: Y N*** ***Lifetime*** *F* ____ *I* ____ ***Sx: Y N***

CAPS SUMMARY SHEET

Name:_____ ID#:_____ Interviewer:_____ Study:_____ Date:_____

A. Traumatic event:

B. Reexperiencing symptoms	*PAST WEEK*			*PAST MONTH*			*LIFETIME*		
	Freq	*Int*	*F+I*	*Freq*	*Int*	*F+I*	*Freq*	*Int*	*F+I*
(1) intrusive recollections									
(2) distressing dreams									
(3) acting or feeling as if event were recurring									
(4) psychological distress at exposure to cues									
(5) physiological reactivity on exposure to cues									
B subtotals									
Number of Criterion B symptoms (need 1)									

C. Avoidance and numbing symptoms	*PAST WEEK*			*PAST MONTH*			*LIFETIME*		
	Freq	*Int*	*F+I*	*Freq*	*Int*	*F+I*	*Freq*	*Int*	*F+I*
(6) avoidance of thoughts or feelings									
(7) avoidance of activities, places, or people									
(8) inability to recall important aspect of trauma									
(9) diminished interest in activities									
(10) detachment or estrangement									
(11) restricted range of affect									
(12) sense of a foreshortened future									
C subtotals									
Number of Criterion C symptoms (need 3)									

D. Hyperarousal symptoms	*PAST WEEK*			*PAST MONTH*			*LIFETIME*		
	Freq	*Int*	*F+I*	*Freq*	*Int*	*F+I*	*Freq*	*Int*	*F+I*
(13) difficulty falling or staying asleep									
(14) irritability or outbursts of anger									
(15) difficulty concentrating									
(16) hypervigilance									
(17) exaggerated startle response									
D subtotals									
Number of Criterion D symptoms (need 2)									

Total Freq, Int, and Severity (F+I)	*PAST WEEK*			*PAST MONTH*			*LIFETIME*		
	Freq	*Int*	*F+I*	*Freq*	*Int*	*F+I*	*Freq*	*Int*	*F+I*
Sum of subtotals (B+C+D)									

E. Duration of disturbance	*CURRENT*	*LIFETIME*
(19) duration of disturbance at least one month	*NO YES*	*NO YES*

F. Significant distress or impairment in functioning	*PAST WEEK*	*PAST MONTH*	*LIFETIME*
(20) subjective distress			
(21) impairment in social functioning			
(22) impairment in occupational functioning			
AT LEAST ONE ≥ 2?	*NO YES*	*NO YES*	*NO YES*

PTSD diagnosis	*CURRENT*	*LIFETIME*
PTSD PRESENT -- ALL CRITERIA (A-F) MET?	*NO YES*	*NO YES*
Specify: (18) with delayed onset (≥ 6 months delay)	*NO YES*	*NO YES*
(19) acute (< 3 months) or chronic (≥ 3 months)	*acute chronic*	*acute chronic*

Global ratings	*PAST WEEK*	*PAST MONTH*	*LIFETIME*
(23) global validity			
(24) global severity			
(25) global improvement			

Associated features	*PAST WEEK*			*PAST MONTH*			*LIFETIME*		
	Freq	*Int*	*F+I*	*Freq*	*Int*	*F+I*	*Freq*	*Int*	*F+I*
(26) guilt over acts of commission or omission									
(27) survivor guilt									
(28) reduction in awareness of surroundings									
(29) derealization									
(30) depersonalization									

Appendix D

PCL-M

PCL-M

INSTRUCTIONS: Below is a list of problems and complaints that veterans sometimes have in response to stressful military 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 *memories, thoughts,* or *images* of a stressful military experience?	1	2	3	4	5
2.	Repeated, disturbing *dreams* of a stressful military experience?	1	2	3	4	5
3.	Suddenly *acting* or *feeling* as if a stressful military experience *were happening again* (as if you were reliving it)?	1	2	3	4	5
4.	Feeling *very upset* when *something reminded you* of a stressful military experience?	1	2	3	4	5
5.	Having *physical reactions* (e.g., heart pounding, trouble breathing, sweating) when *something reminded you* of a stressful military experience?	1	2	3	4	5
6.	Avoiding *thinking about* or *talking about* a stressful military experience or avoiding *having feelings* related to it?	1	2	3	4	5
7.	Avoiding *activities* or *situations* because *they reminded you* of a stressful military experience?	1	2	3	4	5
8.	Trouble *remembering important parts* of a stressful military experience?	1	2	3	4	5
9.	*Loss of interest* in activities that you used to enjoy?	1	2	3	4	5
10.	Feeling *distant* or *cut off* from other people?	1	2	3	4	5
11.	Feeling *emotionally numb* or being unable to have loving feelings for those close to you?	1	2	3	4	5
12.	Feeling as if your *future* will somehow be *cut short*?	1	2	3	4	5
13.	Trouble *falling* or *staying asleep*?	1	2	3	4	5
14.	Feeling *irritable* or having *angry outbursts*?	1	2	3	4	5
15.	Having *difficulty concentrating*?	1	2	3	4	5
16.	Being "*super-alert*" or watchful or on guard?	1	2	3	4	5
17.	Feeling *jumpy* or easily startled?	1	2	3	4	5

PCL-M for DSM-IV (11/1/94) Weathers, Litz, Huska, & Keane National Center for PTSD - Behavioral Science Division

Appendix E

SCID Evaluation of PTSD

POSTTRAUMATIC STRESS DISORDER

Sometimes things happen to people that are extremely upsetting--things like being in a life threatening situation like a major disaster, very serious accident or fire; being physically assaulted or raped; seeing another person killed or dead, or badly hurt, or hearing about something horrible that has happened to someone you are close to. At any time during your life, have any of these kinds of things happened to you?

IF UNKNOWN: Have you ever been in an automobile accident?

IF UNKNOWN: Have you ever been the victim of a crime?

IF NO SUCH EVENTS, CHECK HERE ___ AND GO TO ***GENERALIZED ANXIETY DISORDER,*** F. 31 F103

LIST ONLY TRAUMATIC EXPERIENCES CORRESPONDING IN SEVERITY TO CRITERION A(1), i.e., the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others

Traumatic Events List

Brief Description	Date (Month/Yr)	Age
F103a	F103b	F103c
F103d	F103e	F103f
F103g	F103h	F103i
F103j	F103k	F103l
F103m	F103n	F103o
F103p	F103q	F103r
F103s	F103t	F103u

IF ANY EVENTS LISTED: Sometimes traumatic experiences like (TRAUMAS LISTED ABOVE) keep coming back in nightmares, flashbacks, or thoughts that you can't get rid of. Has that ever happened to you?

IF NO: What about being very upset when you were in a situation that reminded you of one of these terrible things?

IF NO TO BOTH OF ABOVE, CHECK HERE ___ AND SKIP TO ***GENERALIZED ANXIETY DISORDER,*** F. 31. F104

?=inadequate information 1=absent or false 2=subthreshold 3=threshold or true

POSTTRAUMATIC STRESS DISORDER CRITERIA

FOR FOLLOWING QUESTIONS, FOCUS ON TRAUMATIC EVENT(S) MENTIONED IN SCREENING QUESTION ABOVE.

A. The person has been exposed to a traumatic event in which both of the following were present:

IF MORE THAN ONE TRAUMA IS REPORTED: Which of these do you think affected you the most?

(1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others — ? 1 2 3 — F105

→ GO TO *GAD* F. 31

IF UNCLEAR: How did you react when (TRAUMA) happened? (Were you very afraid or did you feel helpless or horrified?)

(2) the person's response involved intense fear, helplessness or horror — ? 1 2 3 — F106

→ GO TO *GAD* F. 31

Now I'd like to ask a few questions about specific ways that it may have affected you.

B. The traumatic event is persistently reexperienced in one (or more) of the following ways:

For example...

...did you think about (TRAUMA) when you didn't want to or did thoughts about (TRAUMA) come to you suddenly when you didn't want them to?

(1) recurrent and intrusive distressing recollections of the event, including images, thoughts or perceptions — ? 1 2 3 — F107

...what about having dreams about (TRAUMA)?

(2) recurrent distressing dreams of the event — ? 1 2 3 — F108

...what about finding yourself acting or feeling as if you were back in the situation?

(3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations and dissociative flashback episodes, including those that occur on awakening or when intoxicated) — ? 1 2 3 — F109

...what about getting very upset when something reminded you of (TRAUMA)?

(4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event — ? 1 2 3 — F110

?=inadequate information 1=absent or false 2=subthreshold 3=threshold or true

...what about having physical symptoms--like breaking out in a sweat, breathing heavily or irregularly, or your heart pounding or racing, when something reminded you of (TRAUMA)?	(5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event	?	1	2	3	F111
	AT LEAST ONE "B" SX IS CODED "3."		1		3	F112
	C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:		GO TO *GAD* F. 31			
Since (THE TRAUMA)...						
...have you made a special effort to avoid thinking or talking about what happened?	(1) efforts to avoid thoughts, feelings, or conversations associated with the trauma	?	1	2	3	F113
...have you stayed away from things or people that reminded you of (TRAUMA)?	(2) efforts to avoid activities, places, or people that arouse recollections of the trauma	?	1	2	3	F114
...have you been unable to remember some important part of what happened?	(3) inability to recall an important aspect of the trauma	?	1	2	3	F115
...have you been less interested in doing things that used to be important to you, like seeing friends, reading books or watching TV?	(4) markedly diminished interest or participation in significant activities	?	1	2	3	F116
...have you felt distant or cut off from others?	(5) feeling of detachment or estrangement from others	?	1	2	3	F117
...have you felt "numb" or like you no longer had strong feelings about anything or loving feelings for anyone?	(6) restricted range of affect, (e.g., unable to have loving feelings)	?	1	2	3	F118

...did you notice a change in the way you think about or plan for the future? (Like you didn't think you would ever have a career, get married, or have children?)	(7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)	?	1	2	3	F119
	AT LEAST THREE "C" SXS ARE CODED "3."		1 → GO TO *GAD* F. 31		3	F120
Since (THE TRAUMA)...	D. Persistent symptoms of increased arousal (not present before the trauma) as indicated by two (or more) of the following:					
...have you had trouble sleeping? (What kind of trouble?)	(1) difficulty falling or staying asleep	?	1	2	3	F121
...have you been unusually irritable? What about outbursts of anger?	(2) irritability or outbursts of anger	?	1	2	3	F122
...have you had trouble concentrating?	(3) difficulty concentrating	?	1	2	3	F123
...have you been watchful or on guard even when there was no reason to be?	(4) hypervigilance	?	1	2	3	F124
...have you been jumpy or easily startled, like by sudden noises?	(5) exaggerated startle response	?	1	2	3	F125
	AT LEAST TWO "D" SXS ARE CODED "3."		1 → GO TO *GAD* F. 31		3	F126

?=inadequate information 1=absent or false 2=subthreshold 3=threshold or true

About how long did these problems--(CITE POSITIVE PTSD SYMPTOMS)--last?

E. Duration of the disturbance (symptoms in criteria B, C, and D) is more than 1 month.

? 1 2 3 F127

1 → GO TO ***GAD*** F. 31

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

? 1 2 3 F128

1 → GO TO ***GAD*** F. 31

POSTTRAUMATIC STRESS DISORDER CRITERIA A, B, C, D, E, AND F ARE CODED "3."

1 3 F129

1 → GO TO ***GAD*** F. 31

3 → POST-TRAUMATIC STRESS DISORDER

?=inadequate information 1=absent or false 2=subthreshold 3=threshold or true

About how long did these problems--(CITE POSITIVE PTSD SYMPTOMS)--last?

E. Duration of the disturbance (symptoms in criteria B, C, and D) is more than 1 month.

? 1 2 3 F127

1 → GO TO ***GAD*** F. 31

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

? 1 2 3 F128

1 → GO TO ***GAD*** F. 31

POSTTRAUMATIC STRESS DISORDER CRITERIA A, B, C, D, E, AND F ARE CODED "3."

1 3 F129

1 → GO TO ***GAD*** F. 31

3 → POST-TRAUMATIC STRESS DISORDER

?=inadequate information 1=absent or false 2=subthreshold 3=threshold or true

CHRONOLOGY OF PTSD ? 1 3 F130

IF UNCLEAR: During the past month, have you had (SYMPTOMS OF PTSD)?

Has met criteria for Posttraumatic Stress Disorder during past month

INDICATE CURRENT SEVERITY: F131
1 - **Mild:** Few, if any, symptoms in excess of those required to make the diagnosis are present, and symptoms result in no more than minor impairments in social or occupational functioning.
2 - **Moderate:** Symptoms or functional impairment between "mild" and "severe"
3 - **Severe:** Many symptoms in excess of those required to make the diagnosis, or several symptoms that are particularly severe, are present, or the symptoms result in marked impairment in social or occupational functioning.

CONTINUE WITH ***AGE AT ONSET,*** BELOW.

IF CURRENT CRITERIA NOT FULLY MET (OR NOT AT ALL): F132
4 - **In Partial Remission:** The full criteria for the disorder were previously met, but currently only some of the symptoms or signs of the disorder remain.
5 - **In Full Remission:** There are no longer any symptoms or signs of the disorder, but it is still clinically relevant to note the disorder.
6 - **Prior History:** There is a history of the criteria having been met for the disorder, but the individual is considered to have recovered from it.

When did you last have (SXS OF POST TRAUMATIC STRESS DISORDER)?

Number of months prior to interview when last had a symptom of Posttraumatic Stress Disorder ___ ___ ___ F133

AGE AT ONSET

IF UNKNOWN: How old were you when you first started having (SXS OF PTSD)?

Age at onset of Posttraumatic Stress Disorder (CODE 99 IF UNKNOWN). ___ ___ F134

GO TO ***GAD*** F. 31

?=inadequate information 1=absent or false 2=subthreshold 3=threshold or true

References

American Psychiatric Association. (1980). Posttraumatic Stress Disorder. In *Diagnostic and Statistical Manual of Mental Disorders 3rd Edition*. (pp. 247-251). Washington, DC: American Psychiatric Publishing.

American Psychiatric Association. (1994). Posttraumatic Stress Disorder. In *Diagnostic and Statistical Manual of Mental Disorders 4th Edition*. (pp. 424-429). Washington, DC: American Psychiatric Publishing.

American Psychiatric Association. (2000). Posttraumatic Stress Disorder. In *Diagnostic and Statistical Manual of Mental Disorders 4th Edition, Text Revision*. (pp. 463-468). Washington, DC: American Psychiatric Publishing.

American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders 5th Edition*. (pp. 271-280). Washington, DC: American Psychiatric Publishing.

Adams, R. E., & Boscarino, J. A. (2006). Predictors of PTSD and delayed PTSD after disaster: The impact of exposure and psychosocial resources. *Journal of Nervous and Mental Disease*, *194*(7), 485–493.

Andrews, L., Joseph, S., Shevlin, M., & Troop, N. (2006). Confirmatory factor analysis of posttraumatic stress symptoms in emergency personnel: An examination of seven alternative models. *Personality and Individual Differences, 41*(2), 213-224.

Asmundson, G. J. G., Frombach, I., McQuaid, J. R., Pedrilli, P., Lenox, R. J., & Stein, M. B. (2000). Dimensionality of posttraumatic stress symptoms: A confirmatory factor analysis of DSM-IV symptom clusters and other symptom models. *Behaviour Research and Therapy, 38*(2), 203-214.

Bernstein, D. M., Godfrey, R. D., Davison, A., & Loftus E. F. (2004). Conditions affecting the revelation effect for autobiographical memory. *Memory and Cognition, 32*(3), 455-462. Retrieved from http://ezproxy.uta.edu/docview/85617986?accountid=7117.

Blake, D. D., Weathers, F. W., Nagy, L. M. & Kaloupek, D. G. (1995). The development of a clinician-administered PTSD scale. *Journal of Traumatic Stress, 8*(1), 75-90.

Blake, D., Weathers, F., Nagy, L., Kaloupek, D., Klauminzer, G., Charney, D., Keane, T., & Buckley, T. C. (2000). *Instruction manual for the National Center for PTSD Clinician-Administered PTSD Scale (CAPS).* The National Center for Posttraumatic Stress Disorder: West Haven CT.

Blanchard, E. B., Hickling, E. J., Taylor, A. E., Loos, W. R., & Gerardi, R. J. (1994). Psychological morbidity associated with motor vehicle accidents, *Behavior Research and Therapy, 32,* 283-290. doi: http://dx.doi.org/10.1016/0005-7967(94)90123-6.

Blanchard, E. B., Jones-Alexander, J., Buckley, T. C., & Forneris, C. A. (1996). Psychometric properties of the PTSD checklist (PCL). *Behavioral Research and Therapy, 34*(8), 669-673.

Breslau, N. & Kessler, R. C. (2001). The stressor criterion in DSM-IV posttraumatic stress disorder: An empirical investigation. *Biological Psychiatry, 50*(9), 699-704.

Breslau, N., Lucia, V. C., & Davis, G. C. (2004). Partial PTSD versus full PTSD: An empirical examination of associated impairment. *Psychological Medicine, 34*(7), 1205-1214. doi: http://dx.doi.org/10.1017/S0033291704002594.

Caliso, J. A. & Milner, J. S. (1992). Childhood history of abuse and child abuse screening. *Child Abuse and Neglect, 16*(5), 647-659. doi: http://dx.doi.org/10.1016/0145-2134(92)90103-X

Cicchetti, D., Fontana, A. & Showalter, D. (2008). Evaluating the reliability of multiple assessments of PTSD symptomatology: Multiple examiners, one patient. *Psychiatry Research, 166*(2-3), 269-280.

Council on Social Work Education. (2010). *Advanced Social Work Practice in Military Social Work.* Center for Innovation and Research on Veterans and Military Families, University of Southern California School of Social Work.

Cukor, J., Jayasinghe, N. & Difede, J. (2010). The nature and course of subthreshold PTSD. *Journal of Anxiety Disorders, 24*(8)*,* 918-923. doi: http://dx.doi.org/10.1016/j.janxdis.2010.06.017

Dartmouth Child Trauma Research Group. (2011). *An Interview for Children: Traumatic Events Screening Inventory (TESI-C).* The National Center for Posttraumatic Stress Disorder: West Haven CT.

Dattilio, F. M. (2004). Extramarital affairs: The much overlooked PTSD. *Behavior Therapist, 27*(4), 76-78. Retrieved from http://ezproxy.uta.edu/docview/42427976?accountid=7117.

Duhamel, K. N., Ostroff, J., Ashman, T., Winkel, G., Mundy, E. A., Keane, T. M., Morasco, B. J.,... Redd, W. (2004). Construct validity of the Posttraumatic Stress Disorder Checklist in cancer survivors: Analysis based on two samples. *Psychological Assessment, 16*(3)*,* 255-266.

Elkit, A. & Shevlin, M. (2007). The structure of PTSD symptoms: A test of alternative models using confirmatory factor analysis, *British Journal of Clinical Psychology, 46*(3)*,* 299-313.

First, M. B., Spitzer, R. L., Gibbon, M. & Williams, J. B. W. (2002) *Structured Clinical Interview for DSM-IV-TR Axis I Disorders, Research Version, Patient Edition. (SCID-I/NP)*. New York: Biometrics Research, New York State Psychiatric Institute.

First, M. B., Spitzer, R. L., Gibbon, M. & Williams, J. B. W. (1995). *Structured Clinical Interview for DSM-IV Axis I Disorders – Patient Edition (SCID – I/P, version 2.0)*. New York: Biometrics Research Department, New York State Psychiatric Institute.

Fleming, R. H. (1985). Post Vietnam Syndrome: Neurosis or sociosis? *Psychiatry, 48*(2), 122. Retrieved from http://ezproxy.uta.edu/docview/1301429209?accountid=7117

Foa, E. B. & Tolin, D. F. (2000). Comparison of the PTSD Symptom Scale-Interview Version and the Clinician Administered PTSD Scale. *Journal of Traumatic Stress, 13*(2), 181 – 191. doi: http://dx.doi.org/0894-9867/00/0400-0181$18.00/1

Franklin, C. L., Sheeran, T. & Zimmerman, M. (2002). Screening for trauma histories, posttraumatic stress disorder (PTSD) and subthreshold PTSD in psychiatric outpatients. *Psychological Assessment, 14*(4)*,* 467-471. doi: http://dx.doi.org/10.1037/1040-3590.14.4.467.

Friedman, M. J., Resick, P. A., Bryant, R. A. & Brewin, C. R. (2011). Considering PTSD for DSM-5. *Depression and Anxiety, 28*(9)*,* 750-769.

Friedman, M. J., Schnurr, P. P., Sengupta, A., Holmes, T., & Ashcraft, M. (2004). The Hawaiian Vietnam Veterans Project: Is minority status a risk factor for posttraumatic stress disorder? *Journal of Nervous and Mental Disease,*

192(1), 42-50, doi: http://dx.doi.org/10.1097/01.nmd.0000105999.57129.ee

Fullerton, C. S., Ursan, R. J., Epstein, R. S., Crowley, B., Vance, K., Kao, T., Dougall, A. & Baum, A. (2001). Gender differences in Posttraumatic Stress Disorder after motor vehicle accidents. *American Journal of Psychiatry, 158*(9), 1486-1491.

Galea, S., Vlahov, D., Tracy, M., Hoover, D. R., Resnick, H. & Kilpatrick, D. (2004). Hispanic ethnicity and post-traumatic stress disorder after a disaster: Evidence from a general population survey after September 11, 2001. *Annals of Epidemiology*, *14*(8), 520–531.

Golier, J. A., Yehuda, R., Lupien, S. J. & Harvey, P. D. (2003). Memory for trauma-related information in holocaust survivors with PTSD. *Psychiatry Research, 121*(2), 133-143. doi: http://dx.doi.org/10.1016-S0925-4927(03)00120-3.

Hoge, C. W., Castro, C. A., Messer, S. C., McGurk, D., Cotting, D. I. & Koffman, R. L. (2004). Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. *The New England Journal of Medicine, 351(*1), 13-22. doi: http://dx.doi.org/10.1056/NEJMoa040603

Johansen, V. A., Wahl, A. K., Eilertsen, D. E. & Weisaeth, L. (2007). Prevalence and predictors of Posttraumatic Stress Disorder (PTSD) in physically injured victims of non-domestic violence: A longitudinal study. *Social*

Psychiatry and Psychiatric Epidemiology, 2007(40), 583-593. doi: http://dx.doi.org/10.1007-s00127-007-0205-0.

Kaouane, N., Porte, Y., Vallée, M., Brayda-Bruno, L., Mons, N. Calandreau, L., … Desmedt, A. (2012). Glucocorticoids can induce PTSD-like memory impairments in mice. *Science, 335,* 1510-1513. doi: http://dx.doi.org/10.1126/science.1207615.

Keane, T. M., Wolfe, J. & Taylor, K. C. (1987). Post-traumatic stress disorder: Evidence for diagnostic validity and methods of psychological assessment. *Journal of Clinical Psychology, 43*(1), 32-43.

Keane, T. M., Brief, D. J., Pratt, E. M. & Miller, M. W. (2007). Assessment of PTSD and its comorbidities in adults. In M. J. Friedman, T. M. Keane & P. A. Resnick (Eds.) *The Handbook of PTSD: Science and Practice* (pp. 279-305). New York: The Guilford Press.

Kessler, R. C., Berglund, P., Delmer, O., Jin, R., Merikangas, K. R. & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*(6): 593-602.

Kessler, R. C., Barker, P. R., Colpe, L. J., Epstein, J. F., Gfroerer, J. C., Hiripi, E., Howes, M. J, Normand, S-L. T., Manderscheid, R. W., Walters, E. E., & Zaslavsky, A. M. (2003). Screening for serious mental illness in the general population. *Archives of General Psychiatry, 60*(2), 184-189.

Kessler, R. C., Berglund, P. A., Bruce, M. L., Koch, J. R., Laska, E. M., Leaf, P. J., Manderscheid, R. W., Rosenheck, R. A., Walters, E. E., & Wang, P. S. (2001). The prevalence and correlates of untreated serious mental illness. *Health Services Research, 36,* 987-1007.

Kessler, R. C., Sonnega, A., Bromet, E. J., Hughes, M. & Nelson, C. B. (1995). Posttraumatic stress disorder in the national comorbidity survey. *Archives of General Psychiatry, 52*(12), 1048-1060. Retrieved from http://ezproxy.uta.edu/docview/42395998?accountid=7117

Kilpatrick, D. G., Resnick, H. S., Milanak, M. E., Miller, M. W., Keyes, K. M. & Friedman, M. J. (2013). National estimates of exposure to traumatic events and PTSD prevalence using DSM-IV and DSM-5 criteria. *Journal of Traumatic Stress, 26*(5)*,* 537-547. doi: http://dx.doi.org/10.1002/jts.21848.

Kimerling, R. (2009). *Examining the diagnostic and clinical utility of the PTSD Checklist.* (HSR&D Study: SHP-169). United States Department of Veteran Affairs. Washington, DC: Government Printing Office.

King, D. W., Leskin, G. A., King, L. A. & Weathers, F. W. (1998). Confirmatory factor analysis of the Clinician Administered PTSD Scale: Evidence for the dimensionality of posttraumatic stress disorder. *Psychological Assessment, 10*(2), 90-96.

Klein, E. M., Caspi, Y. & Gil, S. (2003). The relation between memory of the traumatic event and PTSD: Evidence from studies of traumatic brain injury. *Canadian Journal of Psychiatry, 48*(1), 28-33. Retrieved from http://ezproxy.uta.edu/docview/42429695?accountid=7117.

Kulka, R. A., Schlenger, W. E., Fairbank, J. A., Hough, R. L., Jordan, B. K. & Marmar, C. R., …Weiss, D. S. (1988). *Contractual report of findings from the National Vietnam Veterans Readjustment Study (NVVRS). Volume 1: Executive summary, description of findings, and technical appendices.* Research Triangle Park, North Carolina: Research Triangle Institute. Retrieved from http://ezproxy.uta.edu/docview/42397696?accountid=7117

-- (1990). *Trauma and the Vietnam War generation: Report findings from the National Vietnam Veterans readjustment study.* New York: Brunner/ Mazel.

Loftus, G. R. & Loftus, E. F. (1974). The influence of one memory retrieval on a subsequent memory retrieval. *Memory & Cognition, 2*(3), 467-471. Retrieved from http://ezproxy.uta.edu/docview/57893790?accountid=7117.

Loftus, E. F. (1991). Memory distortions. *Canadian Psychology, 32*(4), 645. Retrieved from http://ezproxy.uta.edu/docviews/1297766534?account id=7117.

-- (1996). Memory distortion and false memory creation. *Bulletin of the American Academy of Psychiatry and the Law, 24*(3), 281-295. Retrieved from http://ezproxy.uta.edu/docview/42398978?accountid=7117.

-- (2005). Planting misinformation in the human mind: A 30-year investigation of the malleability of memory. *Learning and Memory, 12*(4), 361-366. Retrieved from http://ezproxy.uta.edu/docview/62004646?accountid=7117.

Luft, B. J., Schechter, C., Kotov, R., Broihier, J., Reissman, D., Guerrera, K., … Bromet, E.J. (2012). Exposure, probable PTSD and lower respiratory illness among World Trade Center rescue, recovery and clean-up workers. *Psychological Medicine, 42*(5), 1069-1079. doi: http://dx.doi.org/10.1017/S003329171100256X.

Macleod, A. D. (2004). Shell shock, Gordon Holmes and the Great War. *Journal of the Royal Society of Medicine, 97*(2), 86-89.

McFall, M. E., Smith, D. E., Mackay, P. W., & Tarver, D., J. (1990). Reliability and validity of the Mississippi Scale for combat-related posttraumatic stress disorder. *Psychological Assessment, 2*, (2), 114-121. Doi: http://dx.doi.org/10.1037/1040-3590.2.2.114.

McWilliams, L. A., Cox, B. J. & Asmundson, G. J. G. (2005). Symptom structure of posttraumatic stress disorder in a nationally representative sample. *Journal of Anxiety Disorders, 19*(6)*,* 626-641.

Michalopoulos, L. & Aparicio, E. (2012).Vicarious trauma in social workers: The role of trauma history, social support, and years of experience. *Journal of Aggression, Maltreatment and Trauma, 21*(6)*,* 1-19. doi: http://dx.doi.org/10.1080/10926771.2012.689422

Milanak, M. E. & Berenbaum, H. (2009). The relationship between PTSD symptom factors and emotion. *Journal of Traumatic Stress, 22*(2), 139-145. doi: http://dx.doi.org/10.1002/jts.

Mitchell, K. S., Mazzeo, S. E., Schlesinger, M. R., Brewerton, T. D. & Smith, B. N. (2012). Comorbidity of partial and subthreshold PTSD among men and women with eating disorders in the National Comorbidity Survey-Replication study. *International Journal of Eating Disorders, 45*(3)*,* 307-315. doi: http://dx.doi.org/10.1002/eat.20965.

National Association of Social Workers (2012). *NASW Standards for Social Work Practice with Service Members, Veterans and Their Families.* Washington, DC: National Association of Social Workers.

National Association of Social Workers. (2011b). Social workers in government agencies: Occupational profile. Washington, DC: NASW Center for Workforce Studies.

Newell, J. M. & MacNeil, G. A. (2010). Professional burnout, vicarious trauma, secondary traumatic stress, and compassion fatigue: A review of

theoretical terms, risk factors, and preventive methods for clinicians and researchers. *Best Practice in Mental Health, 6*(2), 57-68.

North, C. (2002). Psychiatric disorders in rescue workers after the Oklahoma City bombing. *American Journal of Psychiatry. 159*(5), 857-859.

North, C. S., Oliver, J. & Pandya, A. (2012). Examining a comprehensive model of disaster-related Posttraumatic Stress Disorder in systemically studied survivors of 10 disasters. *American Journal of Public Health, 102*(10), e40-e48. doi: http://dx.doi.org/10.2105/AJPH.2012.300689/

Ortega, A. N. & Rosenheck, R. (2000). Posttraumatic stress disorder among Hispanic Vietnam veterans. *American Journal of Psychiatry*, *157*(4), 615–619.

Paunovic, N., Lundh, L. & Öst, L. (2002). Attentional and memory bias for emotional information in crime victims with acute posttraumatic stress disorder (PTSD). *Journal of Anxiety Disorders, 16*(6), 675-692. doi: http://dx.doi.org/10.1016/S0887-6185(02)00136-6.

Pearlman, L. & MacIan, P. (1995). Vicarious traumatization: An empirical study of the effects of trauma therapists. *Professional Psychology: Research and Practice, 26*(6), 558-565.

Pietrzak, R. H., Goldstein, R. B., Southwick, S. M. & Grant, B. F. (2011a). Prevalence and Axis I comorbidity of full and partial posttraumatic stress disorder in the United States: Results from Wave 2 of the National

Epidemiologic Survey on Alcohol and Related Conditions. *Journal of Anxiety Disorders, 25*(3)*,* 456-465. doi: http://dx.doi.org/10.1016/j.janxdis.2010.11.010.

Pietrzak, R. H., Schechter, C. B., Bromet, E. J., Katz, C. L., Reissman, D. B., Osbay, F.,... Southwick, S. M. (2012). The burden of full and subsyndromal posttraumatic stress disorder among police involved in the World Trade Center rescue and recovery effort. *Journal of Psychiatric Research, 46*(7)*,* 835-842. doi: http://dx.doi.org/10.1016/j.jpsychires.2012.03.011.

Pole, N., Gone, J. P. & Kulkarni, M. (2008). Posttraumatic Stress Disorder among ethnoracial minorities in the United States. *Clinical Psychology: Science & Practice, 15*(1), 35-61. doi: http://dx.doi.org/10.1111/j.1468-2850.2008.00109.x

Regier, D. A., Narrow, W. E., Clarke, D. E., Kraemer, H. C., Kuramoto, S. J., Kuhl, E. A. & Kupfer, D. J. (2013). DSM-5 field trials in the United States and Canada, Part II: Test-Retest reliability of selected categorical diagnoses. *American Journal of Psychiatry, 170*(1), 59-70.

Reist, C., Duffy, J. G., Fujimoto, K. & Cahill, L. (2001). Beta –adrenergic blockade and emotional memory in PTSD. *International Journal of Neuropsychopharmacology, 4*(4), 377-383. doi: http://dx.doi.org/10.1017/S1461145701002607.

Robins, L., Helzer, H., Croughan, J. & Ratcliff, K. (1981). National Institute of Mental Health Diagnostic Interview Schedule: Its history, characteristics, and validity. *Archives of General Psychiatry, 38*(4), 381-389.

Samuelson, K. W., Neylan, T. C., Lenoci, M. A., Metzler, T. J., Cardenas, V. A., Weiner, M. W. & Marmar, C. R. (2009). Longitudinal effects of PTSD on memory functioning. *Journal of the International Neuropsychological Society, 15*(6), 853-861. doi: http://dx.doi.org/10.1017/S1355617709990282.

Schauben, L. J. & Frazier, P. A. (1995). Vicarious trauma: The effects on female counselors of working with sexual violence survivors. *Psychology of Women Quarterly, 19*(1)*,* 49-64.

Schnurr, P. P., Ford, J. D., Friedman, M. J., Green, B. L., Dain, B. J. & Sengupta, A. (2000). Predictors and outcomes of posttraumatic stress disorder in World War II Veterans exposed to mustard gas. *Journal of Consulting and Clinical Psychology, 68*(2)*,* 258-268.

Shalev, A. Y.; Yehuda, R. & McFarlane, A. C. (2000). *International Handbook of Human Response to Trauma*. New York: Kluwer Academic/Plenum Press.

Simms, L. J., Watson, D. & Doebbeling, B. N. (2002). Confirmatory factor analysis of posttraumatic stress symptoms in deployed and nondeployed veterans of the Gulf war. *Journal of Abnormal Psychology, 111*(4)*,* 637-647.

Smid, G. (2009). Delayed posttraumatic stress disorder: systematic review, meta-analysis, and meta-regression analysis of prospective studies. *The Journal of Clinical Psychiatry, 70*(11), 1572-1575.

Spitzer, R. L., Williams, J. B., Gibbon, M. & First, M. B. (1992). The Structured Clinical Interview for DSM-III-R (SCID). I: History, rationale, and description. *Archives of General Psychiatry, 49*(8), 624-9.

Spitzer, R. L., First, M. B. & Wakefield, J. C. (2007). Saving PTSD from itself in the DSM-V. *Journal of Anxiety Disorders, 21*(2), 233-241.

Steinmetz, K. R. M., Scott, L. A., Smith, D. & Kensinger, E. A. (2012). The effects of trauma exposure and posttraumatic stress disorder (PTSD) on the emotion-inducing memory trade-off. *Frontiers in Integrative Neuroscience, 6*. doi: http://dx.doi.org/10.3389/fnint.2012.00034.

Thompson, W. W., Gottesman, I. I. & Zalewski, C. (2006). Reconciling disparate prevalence rates of PTSD in large samples of US Male Vietnam veterans and their controls. *BMC Psychiatry, 6,* 1-10. doi: http://dx.doi.org/10.1196/1471-244X-6-19.

U.S. Centers for Disease Control. (1988). Health status of Vietnam veterans. I. Psychosocial characteristics. The Vietnam Experience Study (VES). *Journal of the American Medical Association, 259*(18), 2701-2707. doi: http://dx.doi.org/10.1001/jama.1988.03720180027028

U.S. Department of Veterans Affairs. (2012). *History of VA social work: Social work in the Department of Veterans Affairs*. Retrieved from: www.socialwork.va.gov/about.asp.

University of Texas at Arlington Research Centers. (2013). *Center for Clinical Social Work*. Retrieved from http://www.uta.edu/ssw /research/research-centers.php.

Van Deusen, K. M. & Way, I. (2006). Vicarious trauma: An exploratory study of the impact of providing sexual abuse treatment on clinicians' trust and intimacy. *Journal of Child Sexual Abuse, 15*(1), 69-85.

Von Känel, R., Begré, S., Abbas, C. C., Saner, H., Gander, M., & Schmid, J. (2010). Inflammatory biomarkers in patients with posttraumatic stress disorder caused by myocardial infarction and the role of depressive symptoms. *Neuroimmunomodulation, 17*(1), 39-46. doi:http://dx.doi.org/10.1159/000243084

Watson, C. G., Juba, M., Anderson, P. E. D. & Manifold, V. (1990). What does the PTSD scale for the MMPI Measure? *Journal of Clinical Psychology, 46*(5)*,* 600-606.

Watson, C. G., Plemel, D., DeMotts, J., Howard, M. T., Tuorila, J., Moog, R.,… Anderson, D. (1994). A comparison of four PTSD measures' convergent validities in Vietnam veterans. *Journal of Traumatic Stress, 7*(1)*,* 75-82. doi: http://dx.doi.org/10.1007/BF02111913

Weiss, D. S., Marmar, C. R., Schlenger, W. E., Fairbank, J. A., Jordan, B. K., Hough, R. L., & Kulka, R. A. (1992). The prevalence of lifetime and partial post-traumatic stress disorder in Vietnam theater veterans. *Journal of Traumatic Stress, 5*(3), 365-376, doi: http://dx.doi.org/10.1007/BF00977234.

Yaeger, D., Himmelfarb, N., Cammack, A. & Mintz, J. (2006). DSM-IV Diagnosed Posttraumatic Stress Disorder in women veterans with and without military sexual trauma. *Journal of General Internal Medicine, 21*(s.3), S65-S69. doi: http://dx.doi.org/10.1111/j.1525-1497.2006.00377.x

Zimering, R., Munroe, J. & Gulliver, S. B. (2003). Secondary traumatization in mental health care providers. *Psychiatric Times, 20*(4), 20–28.

Zimmerman, M. (1999). Is posttraumatic stress disorder under diagnosed in routine clinical settings? *The Journal of Nervous and Mental Disease, 187*(7), 420-425.

Biographical Information

Emily Joy Clark-Nimz earned a Bachelor of Science in Education, English from Baylor University, a Bachelor of Arts in Psychology from the University of North Texas, and is a candidate for a Master in Social Work from the University of Texas at Arlington. Ms. Clark-Nimz has completed internships at a residential substance abuse treatment center and a psychiatric hospital. She was an English teacher for six years prior to beginning her Master's Degree. Ms. Clark-Nimz will apply for licensure as a Licensed Master Social Worker and a Licensed Chemical Dependency Counselor in the summer of 2014 prior to graduation.

Future plans for Ms. Clark-Nimz including pursuing further research with PTSD and Substance Abuse. She plans to pursue her Ph.D. in Clinical Psychology. Currently, Ms. Clark-Nimz is a full-time student, clinical intern, and enjoys several volunteer activities and spending time in her garden.