Evidence-Based Assessment of Trauma and PTSD

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Overview

• Where we’ve been
  ◦ A brief, selective history
• Where we are
  ◦ Best practices
  ◦ Assessment scenarios
• Where we’re going
  ◦ DSM-5 criteria
  ◦ PCL-5 and CAPS-5
  ◦ To-do list
Where we’ve been

- The field of traumatic stress has a (very) long past and a (very) short history
- The effects of trauma have been recognized throughout history
- But systematic scientific investigation began only 30 years ago after the introduction of PTSD in DSM-III

Herman (1992)

- Though [the study of psychological trauma] has in fact an abundant and rich tradition, it has been periodically forgotten and must be periodically reclaimed.
- [It] does not languish for lack of interest. Rather, the subject provokes such intense controversy that it periodically becomes anathema.
- Without the context of a political movement it has never been possible to advance the study of psychological trauma.
- [It] seems to be firmly established as a legitimate field of inquiry. But history teaches us that this knowledge could also disappear.
Thus . . .

- Psychological trauma has been and continues to be controversial
- Those of us in the field are the advocates, are the movement
- We are in the longest sustained period of the scientific study of trauma and its effects
- But it really only took hold after 1980 and the introduction of PTSD

Citation Frequency of PTSD and Trauma Since 1980
Construct of PTSD

- Despite the criticism and controversy, PTSD is a well-explicated construct embedded in a richly articulated nomological net
  - Phenomenology (characteristic syndrome, comorbidity, course, outcome)
  - Epidemiology (prevalence, risk factors)
  - Etiology (genetics, biological aspects, two-factor learning theory, cognitive factors, recovery context)
  - Treatment (exposure, cognitive processing, pharmacotherapy)

Role of assessment

- All of these advances were made possible by of a practical, customized, psychometrically sound measurement technology
- PTSD has been a model for evidence-based assessment
  - The complexity of PTSD poses numerous measurement challenges and requires ingenuity and rigor
  - The rapidly expanding field, with the pressing need to understand and treat survivors, drove demand for assessment solutions
In the beginning

- After DSM-III, PTSD research flourished
- Lacking validated assessment tools many investigators developed their own
- Because of the lag time to collect and publish psychometric data, little consensus across labs
- Early consensus on IES, but reliance on well-established non-PTSD measures (MMPI, STAI, BDI)

Keane and colleagues

- Created the foundation of evidence-based assessment for PTSD starting in early 1980s
- Drew on behavior assessment, personality assessment, neuropsychological assessment, and medical model
- Emphasized multimodal assessment: Interviews, behavioral observations, self-report measures, psychophysiological assessment
- Explored utility of existing measures (MMPI) for PTSD assessment
- Created new measures of trauma exposure and PTSD
- All are either still in use or the direct predecessors to the most widely used measures today
For example (1983-1989)

- Structured interview for PTSD
- Standardized psychophysiological protocol
- Characteristic MMPI PTSD profile
- MMPI PTSD subscale
- Psychometric detection of fabricated PTSD
- Defining traumatic stress
- Mississippi Scale
- Combat Exposure Scale

Where we are

- Use of standardized, psychometrically sound measures is the essence of evidence-based assessment
- Many well-validated PTSD measures available, many in the public domain
- No longer any legitimate reason for not incorporating standardized measures, even in routine clinical practice
The usual suspects

- Interviews (CAPS, SCID, PSS-I)
- Self-report measures
  - DSM-correspondent (PCL, PDS, DAPS)
  - PTSD-focused (IES, Mississippi Scale)
  - Empirically derived (PK, SCL-90-R)
- Multiscale inventories (MMPI-2, PAI)
  - Comorbidity
  - Response bias
- Psychophysiological assessment

PTSD assessment scenarios

- Standard clinical assessment
  - Lifetime trauma history, structured interview, DSM-correspondent self-report measure, multiscale inventory
- Treatment outcome / program evaluation
  - Full clinical battery at baseline, post-tx, follow-up; DSM-correspondent self-report measure for repeated interim assessments
- Survey
  - Self-report trauma measure, narrative description of index event, DSM-correspondent self-report measure
Where we’re going

• DSM-5 criteria
  ◦ Revision of Criterion A -- no A2, specifies sexual violation, clarifies exposure other than experiencing/witnessing
  ◦ Four symptom clusters -- following King et al. numbing model, separates effortful avoidance and numbing
  ◦ Reconceptualizes numbing as negative alterations in cognitions and mood – three new symptoms
  ◦ One new symptom in arousal cluster
  ◦ Dissociative subtype

PCL-5

• Single version of PCL-5 – specific trauma version
• Items revised to correspond to DSM-5 criteria
• Rating scale change from 1-5 to 0-4
• First psychometric study complete in trauma-exposed undergraduate sample
PCL-5

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- Confirmatory factor analysis
  - Elhai et al. 5-factor dysphoric arousal model consistently best fit for all measures
    - DSM-IV measures (PCL, PDS, DAPS) but also PCL-5
  - Similar fit for 16 DSM-IV items on PCL-5 as for PCL, so good backward compatibility for these items
  - DSM-5 implied four-factor model yielded worse fit

- Prevalence estimate
  - PCL = 13.2%; PCL-5 = 13.6%
CAPS-5

- Main goals for CAPS revision
  - Reduce administration time
  - Facilitate dissemination by making it easier to learn standard administration and scoring
  - Adopt a single rating scale for symptom severity
  - Maintain backward compatibility
- Extensive content validation process
- Psychometric study underway
- Currently in use or planned for use in several large-scale projects

Frequency
In the past month, have you had any 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 in the past month?

- 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

Intensity
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) ____________________________
In the past month, have you had any \textit{unwanted memories} of (EVENT) while you were awake, so not counting dreams? \textbf{[Rate 0=A\textit{bsent} if only during dreams]}

How does it happen that you start remembering (EVENT)?

\textbf{[If not clear: (Are these unwanted memories, or are you thinking about [EVENT] on purpose?) [Rate 0=A\textit{bsent} unless perceived as involuntary and intrusive]}

How much do these memories bother you?

Are you able to put them out of your mind and think about something else?

\textbf{Circle:} Distress = Minimal Clearly Present Pronounced Extreme

How often have you had these memories in the past month?

\textbf{Key rating dimensions = frequency / intensity of distress}

\textbf{Abs}ent

\textbf{Mild} / subthreshold

\textbf{Moderate} / threshold

\textbf{Severe} / markedly elevated

\textbf{Extreme} / incapacitating

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**To-do list (partial!)**

- Continue to revise and validate measures for DSM-5 criteria
- Improve measurement of trauma exposure – work toward standardization and consensus
- Develop and validate measures of constructs closely related to PTSD syndrome
  - Functional impairment
  - Dissociation, especially depersonalization and derealization
  - Response bias, primarily symptom exaggeration and malingering
To-do list

- Dissemination of evidence-based measures – fostering routine use of best practices in a wide range of settings
  - Diagnostic utility / cutoff scores for screening and differential diagnosis in different populations
  - Short forms
  - Translations for international applications

Take-home messages

- We are in the longest sustained period in history of the scientific study of psychological trauma and its effects
- Although there are many unresolved issues regarding the nature of trauma and trauma-related syndromes, PTSD is a well-explicated construct embedded in a richly articulated nomological net
- The remarkable progress in PTSD research and treatment has been made possible by a robust evidence-based assessment technology
Take-home messages

• DSM-5 measures are here and ready for roll-out as soon as the criteria are finalized.

• The main goals for the assessment of PTSD in the near future are:
  ◦ Validate DSM-5 PTSD measures
  ◦ Develop and validate measures of closely related constructs
  ◦ Get the word out about best practices