

UCLA PTSD INDEX FOR DSM IV (Revision 1)
INSTRUMENT INFORMATION:
Child Version, Parent Version, Adolescent Version
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Basic Features:

Researchers and clinicians at the UCLA Trauma Psychiatry Service have developed this series of self-report instruments to be used to screen both for exposure to traumatic events and for all DSM-IV PTSD symptoms in school-age children and adolescents who report traumatic experiences. These instruments are meant to serve as brief self-report screening tools to provide information regarding trauma exposure and PTSD symptoms. The items of the UCLA PTSD indices are keyed to DSM-IV criteria and can provide preliminary PTSD diagnostic information. However, these instruments are not intended to be used in place of a structured clinical interview to definitively establish a PTSD diagnosis. Instead, the instruments are meant to be used to quickly and efficiently screen for PTSD symptoms in children and adolescents who have experienced a traumatic event, and to provide information regarding the frequency of those symptoms.

Intended Populations:

The instruments are designed to assess for exposure to a wide variety of traumatic events and are suitable to be used to evaluate PTSD symptoms in children and adolescents who have experienced any type of traumatic stress. The Child Version is worded for school-age children between the ages of 7 and 12. The Parent Version closely mirrors the Child Version and is intended to be used as the parent report of trauma exposure and PTSD symptoms for children between the ages of 7 and 12. The Parent Version was developed to complement the child's report of PTSD symptoms. Parent report of PTSD symptoms is often necessary and helpful in providing PTSD diagnostic information, particularly for the following symptoms: repetitive traumatic play, diminished interest and participation, sleep problems, irritability and angry outbursts, concentration problems, hypervigilance, and exaggerated startle. The Adolescent Version closely resembles the Child Version with minor changes in wording intended for youth age 13 or older.

Instrument Design and Item Content:

The content of the questions draws upon clinical and research experience regarding how to evaluate for exposure to traumatic experiences in children and youth, how they describe their subjective reactions during these experiences, and how traumatized children and youth describe their experiences of PTSD symptoms. All three versions of the UCLA PTSD Index are organized in the same format. Questions 1-13 comprise a trauma screen, as they assess for exposure to a variety of traumatic events. If participants report exposure to multiple events, Question 14 asks them to identify the event that currently distresses them the most. The remainder of Question 14 inquires when the event occurred and requests participants to provide a brief description of the event. Questions 15-21 assess for DSM-IV PTSD Criterion "A1" which concerns aspects of the traumatic event itself. Questions 21-26 evaluate DSM-IV PTSD Criterion "A2" which relates to the child or youth's subjective experience during or just after the traumatic event including intense fear (Question 22), helplessness (Question 23), horror (Question 24), and agitated or disorganized behavior (Questions 25-26). Question 27 assesses for a dissociative reaction at the time of the traumatic event. In questions 15-27, only parents are given the option to respond "don't know" for questions pertaining to the child's subjective reactions at the time of traumatic events. Children and youth are required to answer "yes" or "no" for each of these items. The remaining questions on pages 3 and 4 assess for the frequency of self-reported DSM-IV PTSD symptoms (Criterion "B", "C", and "D,") or associated features on a 4-point scale ranging from "none" (of the time) to "most" (of the time). Subjects refer to the Frequency Rating Sheet on Page 5 to

explain their rating choices. The Frequency Rating Sheet is designed to assess for the occurrence of PTSD symptoms over the past month, but researchers and clinicians can adapt the Rating Sheet to assess for PTSD symptoms over the time period of their interest, such as the past week. Only parents are given the option to respond “don’t know” for each question in this section of the instrument, since parents may be unaware or unsure of many PTSD symptoms experienced by their child.

Each question on pages 3 and 4 of the instrument contains a subscript that denotes the DSM-IV PTSD symptom assessed by that particular question. For example, question 1 inquires about DSM-IV Criterion “D4” (hypervigilance). The subscript “AF” denotes a PTSD “associated feature.” Although each version of the UCLA PTSD Index contains a different total number of questions, questions 1-19 are nearly identical across each version. These 19 questions assess for the 17 DSM-IV PTSD symptoms delineated in Criteria “B, C, and D,” and the PTSD associated feature of trauma-related guilt (Question 13). Note that each version contains one question to assess for each DSM-IV PTSD symptom except for the symptom of Emotional Numbing (DSM-IV symptom C6). Each version contains 2 questions (Questions 10 and 11) that assess for emotional numbing. Question 10 assesses for numbing of positive emotions, Question 11 assesses for numbing of negative emotions. The instruments are designed such that these 19 questions comprise the core of each PTSD index in each version.

The Child Version contains a total of 20 questions. In addition to the first 19 questions, Question 20 assesses a common problem reported by traumatized children, namely a fear that the traumatic event will reoccur.

The Parent Version contains a total of 21 questions. The questions are identical in content to the child version with one exception. Question 21 has been added to the Adult Version to assess for the DSM-IV PTSD symptom of repetitive traumatic play, an alternate expression of Criterion B1 in children. A parallel item was not included in the child version since the traumatic etiology of repetitive play is thought to occur outside of the awareness of the child.

The Adolescent Version contains a total of 22 questions. In addition to the first 19 questions, an alternative question (Question 20) has been included to assess for another component of DSM-IV Criterion “D2” (anger/irritability). An alternative question (Question 21) has also been included to assess for another dimension of DSM-IV Criterion “C7” (foreshortened future). Question 22 assesses a common problem reported by traumatized youth, namely a fear that the traumatic event will reoccur

Instructions for Administration:

All three versions have been designed as self-report instruments and can be administered as paper-and-pencil measures. Researchers should note that subjects often neglect to consult the Frequency Rating Sheet on Page 5 when completing pages 3 and 4 of the instrument. Therefore, it is helpful for researchers to detach this sheet and instruct subjects to refer to it when they complete pages 3 and 4.

While the Parent Version is easily administered via self-report, the Child and Adolescent Versions can easily be adapted to 1-on-1 verbal administration or to classroom administration to larger groups of children or youth.

A. 1-on-1 Verbal Administration for Child and Adolescent Versions: Based on prior work with the earlier generation instrument of the UCLA Trauma Psychiatry Service, the Child Posttraumatic Stress Disorder Reaction Index (Frederick, Pynoos, & Nader, 1992), the Child Version can be effectively administered verbally in a 1-on-1 format, where the evaluator reads the instructions and the questions to the children. Children readily respond to this interactive format, which helps to insure that they comprehend the instructions of the instrument and the task of self report. Evaluators begin by reading the instructions for each section and emphasize that if the child hears a word he/she does not understand, he/she should ask the evaluator for clarification. Evaluators proceed through the trauma screen and criterion A assessment questions on pages 1 and 2 in a fairly straightforward manner. For pages 1 and 2, evaluators inform the child of their response options for each question (Yes or No), and proceed to read the child each question and record their response. After completing pages 1 and 2, evaluators read the instructions for pages 3 and 4 of the instrument. The evaluator should next familiarize the child with their response options on the Frequency Rating Sheet.

“For each question, I want to know how often these things have been true for you (in the past month)”

“Here are your choices (show them the Frequency Rating Sheet and point to each choice and the boxed calendar pictorial representation as you read the choice to the child)

- “None of the time means not at all (in the past month)”
- “Little of the time means about two times (in the past month)”
- “Some of the time means about once a week (in the past month)”
- “Much of the time means two or three days a week (in the past month)”
- “Most of the time means almost every day (in the past month)”

Children can be asked to point to their choice on the Frequency Rating Sheet to indicate how often they have experienced the symptom in question over the past month or designated time period. Evaluators then circle the child’s response to each question on the grid provided. To orient the child to the task of the self-report of symptoms, before beginning the first question on page 3, the child is given 2 practice questions and asked to point to the choice on the Frequency Rating Sheet to answer how often in the past month the following statements have been true for the child:

- “I have had green hair”-Child should point to 0 to denote “none of the time”
- “I have had a headache”-Child should point the choice denoting the number of times (in the past month) when they have had a headache

If children do not understand the concept of self-reporting on the frequency they experience a particular problem, this will become apparent during the practice questions, and evaluators should clarify the task as necessary to help children to understand the task.

When evaluators read the questions to the child or adolescent that assess for the DSM-IV PTSD Trauma-specific symptoms [Child Version Questions numbers (DSM-IV PTSD Symptom): 2(B4), 3(B1), 5(B2), 6(B3), 9(C1), 14(AF), 15(C3), 17 (C2), 18(B5), 20(AF)], [Adolescent Version Question numbers (DSM-IV PTSD Symptom): 2(B4), 3(B1), 5(B2), 6(B3), 9(C1), 14(AF), 15(C3), 17 (C2), 18(B5), 22(AF)], they should alter the wording of these questions to tailor them to the specific traumatic event experienced by the child or adolescent. Clinical experience with index administration indicates that a direct verbal reference in each of these questions to the specific traumatic event experienced by the child helps the child to better focus on that experience and its link to the symptom in question. Children with posttraumatic avoidance often have difficulty keeping the traumatic event in mind during instrument administration. Repeatedly bringing the specific traumatic event into the awareness of the child helps to facilitate their ability to report on explicitly trauma-linked symptoms. Thus, tailoring the above questions to the specific traumatic event experienced by the child helps to increase the reliability of the child's self report, particularly in children and adolescents suffering from posttraumatic avoidance. For example if the child or had witnessed a violent shooting, the evaluator should alter the wording of the questions as follows:

Question Number	Questions with reference to a generic traumatic event	Suggested alternative wording for questions tailored to a specific traumatic event, in this example a violent shooting
2 (B4)	When something reminds me of <i>what happened</i> , I get very upset, afraid, or sad.	When something reminds me of <i>the shooting</i> , I get very upset, afraid, or sad.
3(B1)	I have upsetting thoughts, pictures, or sounds of <i>what happened</i> come into my mind when I do not want them to.	I have upsetting thoughts, pictures, or sounds of <i>the shooting</i> come into my mind when I do not want them to.
5(B2)	I have dreams about <i>what happened</i> or other bad dreams.	I have dreams about <i>the shooting</i> or other bad dreams.
6(B3)	I feel like I am back at the time when <i>the bad thing</i> happened, living through it again.	I feel like I am back at the time when <i>the shooting</i> happened, living through it again.
9(C1)	I try not to talk about, think about, or have feelings about <i>what happened</i> .	I try not to talk about, think about, or have feelings about <i>the shooting</i> .
14(AF)	I think that some part of <i>what happened</i> is my fault.	I think that some part of <i>what happened during the shooting</i> is my fault.
15(C3)	I have trouble remembering important parts of <i>what happened</i> .	I have trouble remembering important parts of <i>what happened during the shooting</i> .
17(C2)	I try to stay away from people, places, or things that make me remember <i>what happened</i> .	I try to stay away from people, places, or things that make me remember <i>the shooting</i> .
18(B5)	When something reminds me of <i>what happened</i> , I have strong feelings in my body like my heart beats fast, my head aches, or my stomach aches.	When something reminds me of <i>the shooting</i> , I have strong feelings in my body like my heart beats fast, my head aches, or my stomach aches.
20(AF)	I am afraid that <i>the bad thing</i> will happen again.	I am afraid that <i>the shooting</i> will happen again.

B. Classroom or Group Administration for Child and Adolescent Versions: The Child and Adolescent Versions can be easily adapted for classroom or group administration. Based on previous work with the Child Posttraumatic Stress Disorder Reaction Index, UCLA researchers have employed two different strategies for classroom evaluation of student self-report of PTSD symptoms.

1. Evaluation Team: In this form of classroom administration, a team of trained evaluators goes to a classroom where the evaluators divide the students into subgroups. Each evaluator then administers the Index in a 1-on-1 format to each student in the subgroup assigned to them. While evaluators are going around the room administering the Index 1-on-1 to each student at their desk, students are asked to engage in a quiet individual task such as drawing or coloring. Instructions for 1-on-1 classroom administration in this team format are identical to the instructions just delineated for 1-on-1 verbal administration. Prior to evaluation, the team should decide on a set of uniform responses to common student questions to minimize the interevaluator variability in Index administration.

2. One Evaluator per Classroom: In this form of administration, a single evaluator administers the Index to the entire classroom of students. As in 1-on-1 administration, the evaluator reads the instructions to each section of the Index to the classroom and then proceeds by reading each question in that section. While the evaluator reads the questions, students who are seated at their desks, mark their responses on their own copies of the Index. It is important that classroom evaluators stress that students should answer all questions and leave no blanks. The evaluator can closely adapt the previous instructions for 1-on-1 verbal administration to this format, although the interactive component of the 1-on-1 format is not possible in the classroom setting. Evaluators can answer student questions to clarify the task of self-report and explain how to record answers, etc. However, if evaluators are administering the Index to various classrooms in a given school, it is suggested that evaluators not attempt to answer student questions relating to the meaning of a particular item, since different questions may arise in each classroom which if answered may alter the administration and response conditions in each classroom. In this scenario, the potentially different administration conditions in each classroom would confound Index scores and make interclassroom comparison difficult. Instead of answering student questions regarding item content, in this administration format UCLA researchers suggest that evaluators respond neutrally to student questions stating: “Answer each question according to the meaning that question has for you” OR “The question means whatever it means to you, please try and understand the question as best as you can.”

Scoring, Interpretation, and Psychometric Properties:

Questions 1-11 screen for exposure to events that may be experienced as traumatic. Questions 13-19 evaluate if the event meets DSM-IV Criterion A1, and Questions 20-23 assess if the participant’s subjective response during or just after the event meets DSM-IV Criterion A2. If participants meet both Criterion A1 and A2 for the event endorsed, that experience can be classified as constituting exposure to a traumatic event according to DSM-IV.

As stated previously, the first 18 questions of each version comprise the core of each PTSD Index for evaluating Criterion B, C, and D Symptoms (the first 19 questions in the case of the Parent Version). All 17 DSM-IV PTSD symptoms are assessed by these questions, with the exception of question 13 which evaluates the associated feature of trauma-related guilt. Question 13 is excluded from scoring on all three versions. The remaining questions (Questions 19 and higher for the Child and Adolescent Versions, and Questions 20 and higher for the Parent Version) are included for experimental purposes only and are excluded from scoring.

The developers of the indices assume that the more often a symptom occurs, the more severely that symptom impacts the child or adolescent. In addition, the developers assume that the higher the number of symptoms reported by a participant, the higher the severity of their PTSD. Based on this rationale, two types of PTSD severity scores can be calculated from each index. An Overall PTSD Severity Score can be calculated by summing the scores for each question that corresponds to a DSM-IV Symptom. In addition, a separate PTSD Severity Subscore can be calculated for Criterion B, C, and D Symptoms by summing the scores for each question that assesses the symptoms belonging to each particular category. Finally, preliminary PTSD diagnostic information can be obtained by determining if participants endorse the number of symptoms from Criterion B, C, and D required for a DSM-IV PTSD diagnosis. Please note that investigators must make a determination regarding the minimum frequency reported for each item necessary for that question to be counted as a symptom. Certainly problems reported to occur “Much of the time” or “Most of the time” would likely qualify as symptoms. Whether or not problems reported to

occur “Some of the time” or “Little of the time” would qualify as symptoms is best answered as an empirical question. Please refer to the Scoring Worksheets for step-by-step instructions for scoring each version.

These instruments have only recently been developed. At the current time, the psychometric properties of these instruments have not yet been established. However, researchers at the UCLA Trauma Psychiatry Service are currently conducting psychometric studies of the instruments. In one study involving the Child and Parent Versions in a sample of acutely traumatized children, researchers are investigating the test-retest reliability of each version. Researchers are cross-validating the trauma-screen portion of the Child and Parent Versions with other standardized self-report measures of trauma exposure. Researchers are cross-validating the Criterion B, C, and D portions of the Child Version with the Child Posttraumatic Stress Disorder Reaction Index (Frederick, Pynoos, & Nader, 1992) and cross-validating the Criterion A, B, C, and D portions of the Child version with a structured clinical PTSD diagnostic interview. In this study, UCLA researchers are also cross-validating the Criterion A, B, C, and D portions of the Parent Version with a structured clinical PTSD diagnostic interview.

Since the psychometric properties of these instruments are currently under investigation, UCLA researchers suggest that other researchers who use these instruments conduct empirical studies to determine the optimal scoring procedures for their particular research populations. To conduct these studies, researchers should consider conducting structured clinical interviews to diagnose PTSD in a randomly-selected subsample of their participants with a known standardized PTSD assessment instrument. The PTSD diagnostic status and intensity scores of this subsample could then serve as “gold standards” in empirical studies which evaluate the overall PTSD severity score on each version that would most efficiently classify subsample cases according to PTSD diagnostic status. Researchers could then utilize this empirically-determined cutoff score to classify cases in their larger sample according to likelihood of a PTSD diagnosis. Researchers could also then consider the individual item scores that are necessary to generate the empirically-determined cutoff score. For example, if statistical analysis indicated that a cutoff score of 32 most efficiently classified the cases in the subsample according to PTSD diagnostic status, a score of 2 on each of the 17 questions could be considered as the symptom cutoff score for each question. In this case, any questions answered 2 or above would likely indicate the presence of a PTSD symptom. If sample size permits, investigators may choose to conduct a series of statistical analyses that investigate the relationships between Index-derived severity scores for each DSM-IV Symptom Category (B, C, D) and DSM-IV PTSD diagnostic status for those Criteria as determined by structured clinical interview. These analyses could yield separate empirically-determined cutoff Index severity scores that would most efficiently classify cases according to PTSD diagnostic status for Criterion B, C, and D. For more information, please contact the UCLA Trauma Psychiatry Service via any of the following: writing to the letterhead address, telephone: (310) 206-8973, or email: rpynoos@mednet.ucla.edu