

**Manual for the Administration and Scoring of the PTSD
Symptom Scale – Interview (PSS-I)**

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Introduction

The PTSD Symptom Scale – Interview (PSS-I) was designed as a flexible semi-structured interview to allow clinicians who are familiar with posttraumatic stress disorder (PTSD) to make a diagnosis of PTSD as well as obtaining an estimate of the severity of the symptoms. When completing the PSSI, interviewers should link the symptoms to a single identified “target” trauma. In most cases this will be the trauma identified by the person as the one that causes the most current distress, but the PSSI may be used to assess symptoms relative to any identifiable traumatic event.

The PSSI allows the interviewer to establish the time frame in which symptoms are to be reported. It has been found valid for assessing symptoms over the course of a month and over a two-week period (reference). In theory, the PSSI could be used to assess symptoms over longer and shorter periods of time, but the validity of the interview under these conditions has not been examined. The interviewer should select the time period prior to beginning the interview and remind the person of the time frame throughout the interview.

The PSSI has typically been used to assess current symptoms of PTSD. On occasions when the interviewer is interested in obtaining a lifetime diagnosis (i.e., assessing symptoms present in the past but not currently), the interviewer should identify a particular period of time in the person’s history and evaluate the symptoms present at that time. Again, the symptoms should be related to a particular target trauma.

When scoring each item on the PSSI, the interviewer should endeavor to integrate all of the information obtained during the interview. The final severity rating combines the interviewer’s impressions of the frequency with which the symptoms are experienced and the intensity of the symptoms when they are experienced. This manual offers some guidelines for making such ratings for each symptom.

Administration

Traumatic Event – the interviewer should first establish the presence of a DSM-IV Criterion A trauma.

DSM-IV Definition

- A. Exposure 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.

Be sure to assess both the objective (i.e., real/threatened danger) and subjective (i.e., horrified, terrified, or helpless) components of the event.

Examples of directly experienced traumatic events: combat, life threatening accident (e.g., plane crash, motor vehicle accident), violent physical/sexual assault (in childhood or adulthood), torture, incarceration as a prisoner of war or in a concentration camp, natural or manmade disaster (e.g., earthquake, fire hurricane, flood), robbery, stabbing/shooting, being diagnosed with a life threatening illness.

Examples of witnessed traumatic events: observing death or injury of another person due to assault, war, or disaster, unexpectedly seeing a dead body or body parts.

Examples of traumatic events confronted with or learned about: learning of family member's (or friend's) sudden, unexpected death, or learning that one's child had a life threatening disease.

In order to facilitate the identification of specific traumatic events, probe for the content of current intrusive thoughts or recollections, nightmares, or flashbacks. If a person reports more than one event that qualifies as a trauma, determine which event is the target trauma, or the trauma that is associated with current PTSD symptoms.

Questions that are useful in ascertaining this:

“In this interview, I will be focusing on one traumatic event. Which of the events that you mentioned to me bothers you the most at the present time?”

“Which of the traumatic experiences you mentioned currently gets in the way of your life the most?”

“Which one of these events do you find yourself having the most upsetting and unwanted thoughts about lately?”

In determining which trauma to target in assessing symptoms it is important to remember that a traumatic event that seems to be objectively the worst may not be the currently most distressing or most frequently re-experienced trauma. The person's current, subjective experience is the more important criterion for determining the target trauma than the objective or actual events experienced.

When the trauma is an event that occurred repeatedly and/or over a prolonged period of time (i.e., as is often the case in childhood sexual abuse), it is useful to ask the person if there is a particular abuse incident that they remember as the most upsetting or distressing or that they currently re-experience most frequently. The person should be instructed to think about that incident(s) in relation to the questions about symptoms.

Rating period: As noted earlier, it is necessary to establish the time period to which the ratings refer. For assessing current PTSD all interviewer ratings are based on symptoms experienced in relation to one specific traumatic event in the past two weeks. It is helpful

to be very concrete about this with the person you are interviewing, repeatedly referring to this time frame throughout the interview.

To assess lifetime PTSD the interviewer should inquire about the presence of symptoms at any time after the target traumatic experience. Example introduction: “Now I’m going to ask you about trauma related difficulties you may have experienced since the event.” Duration of these difficulties and age of onset will also need to be assessed (see page 5 of this manual for diagnostic criteria for PTSD).

Instructions:

“I want to get a really good picture of how things have been going for you in the past 2 weeks in terms of trauma related difficulties. So, today is **(insert date)**, two weeks ago takes us back to **(insert date)**, this is the period of time that I will focus on. Remember that throughout the interview I will be asking about difficulties related to the event that you identified as the most distressing, the **(repeat event)**. Do you have any questions?”

General administration /scoring conventions:

Read all questions as they are written

- Modify or rephrase questions only if necessary for the person to understand.
- Use the prompt questions as written on the interview – use additional queries as needed to accurately determine frequency/intensity of the symptom (see examples of this below in symptom section).

Be careful to not double count symptoms

- Avoid using the same statement to count as two PTSD symptoms unless it is very clear that you should. When in doubt, ask again.
- For example, if a person reports not going to the gym anymore, this should be rated as either behavioral avoidance (if fear is the motivating factor) or loss of interest (if lack of motivation or energy is the explanation) but not both.

Avoid using the PSS-I anchor points in your questions

- Translate them in to your own words. - For example, instead of asking, “did that happen 5 or more time per week” use open ended questions to carefully inquire about frequency (e.g., “How often did that happen in the past two weeks? How about the week before?”). This is true when inquiring about severity of symptoms.

It is appropriate to use information that comes up later in the interview to modify an earlier rating.

- Remember that symptoms are rated by integrating all of the information that the person has given you during the interview when making judgments about presence and severity of any given symptom. For example, sometimes people will report experiencing flashbacks of the trauma, but as they further describe their re-experiencing symptoms, it becomes clear that they are actually describing intense emotional distress upon reminders of the trauma. Ratings should be modified accordingly.

When judging the frequency and severity of symptoms that are not clearly directly related to the traumatic event (e.g., concentration problems, irritability):

- Make sure that the symptoms represent a change from functioning prior to the trauma. Impaired functioning that is not above pre-trauma levels should be scored a 0.
- Change in functioning can be particularly difficult to determine in cases of childhood trauma because the event(s) occurred so long ago. In the event of this difficulty, ask the person whether he or she perceives the symptom to be related to the trauma and how so. If the symptom does appear to be trauma related, then include it in your ratings.

Symptom ratings

The rater's task is to 1) determine whether a symptom is present and 2) evaluate the current severity of that symptom. The current severity of a symptom is rated on the basis of its frequency, intensity/severity, or both. Some symptoms are more easily rated on the basis on one dimension than the other, but generally, the severity of the symptoms should reflect both frequency and intensity of the symptoms. .

Numbers below correspond to PSS-I item numbers.

B. Re-experiencing symptoms

- 1) This question refers to trauma-related intrusive thoughts or images that are currently distressing – whether cued or uncued by trauma reminders. Frequency estimates are most useful for rating these symptoms. If the rating falls between 2 scores based on frequency, inquire about degree of distress to determine whether to go up or down.
- 2) Rate frequency/severity of trauma related nightmares/bad dreams in the past two weeks. With this question, frequency is often all you need to make a rating, however severity may influence your rating. For example, if the person reports one really bad night with several terrifying nightmares that woke her up screaming, but reports having no dreams on any other nights, you can take this into consideration in your rating (i.e., increase your rating to account for the severity of the one night).

- 3) Flashbacks can be rated with a combination of frequency and severity information. The interviewer should first gather information about frequency, then about severity (e.g., duration of flashback) of the episodes. This must include an at least momentary sense that the trauma is re-occurring (e.g., “it is happening again” or “I am back in time”). If the person’s description of the event refers to a very distressing sensory or emotional experience that is similar to the feelings experienced during the trauma, and the person does not report true dissociation, score the experience as symptom 4 or 5 below.
- 4) This question refers to emotional upset in response to trauma reminders. Emotional upset is not limited to fear - also count sadness, anger, guilt or shame, and worry. Emotional numbness in response to triggers should not be included here. With this question, it is often useful to ask the person to give examples of trauma reminders (e.g., for an assault victim: nighttime, TV shows, newspaper articles, people that look like the assailant, knives, etc), then determine how times the person encountered reminders in the past two weeks, and of those, how many times he/she was “intensely emotionally upset.”

Make sure that the trauma reminder is a situation is objectively safe – do not score emotional reactions to objectively dangerous situations. Again, use distress ratings to push up or down a rating that falls between two scores.

5) Physical reactions in response to trauma reminders are best rated with frequency information. At this point, the interviewer should know how many reminders the person encountered in the past two weeks - ask whether and how often physical reactions (e.g sweating, nausea, heart racing) occurred in these situations. Use distress ratings to push up or down a rating that falls between two scores.

C. Avoidance

- 6) Examples of cognitive avoidance (when reported as specifically utilized to avoid trauma related thoughts): “pushing the thoughts away,” talking on the phone, “keeping busy,” playing music. Frequency information is most useful when rating this item. Use distress ratings to push up or down a rating that falls between two scores.

In cases where cognitive avoidance is unclear (e.g., avoiding thoughts of the legal proceeding related to the trauma, but not the trauma itself), look for fear as the motivating factor. If the person is reporting fear of the thoughts, then count these cases as cognitive avoidance.

- 7) Behavioral avoidance- score behaviors as avoidance if the avoidance is motivated by not wanting to confront trauma reminders or be in situations that remind the person of the traumatic event. If this sort of avoidance is endorsed, get a good list of situations, people, and places that are avoided and inquire about how much this impairs functioning as the basis of your rating.

- 8) Psychogenic amnesia is scored when the person indicates that her memory of the target trauma has important or significant gaps or missing details. This symptom should not be scored if the loss of memory is associated with the passage of time (memory decay or aging) or is the result of loss of consciousness during the trauma (e.g., due to being hit on the head or under the influence of drugs). In these cases, in the absence of clear evidence of psychogenic amnesia, assume that the amnesia is organic in nature and do not score it. For instance, psychogenic amnesia may be scored if the person reports a fairly detailed memory of the trauma up to a certain point, then a gap in time or detail, followed by more details about what happened after that gap.
- 9) Loss of interest should not be confused with reduction in activity related to avoidance of trauma reminders. Thus if a person reports that they are no longer interested in doing X because they are afraid, this should be counted under behavioral avoidance. Apathy, low energy/motivation, lack of interest (e.g., “I used to love doing X, but it just isn’t fun anymore”) should be coded here. If the loss of interest appears to be due to depression, it should still be scored. If there is a lack of interest due to a physical inability (e.g., injury resulting from the trauma) to pursue the activity, then it is not counted here.
- 10) Detachment from others – often this is described as feeling cutoff, disconnected, different, or unable to feel close to or trusting of others. Severity (e.g., “How strong is the feeling of disconnection?” “Do you have any one that you feel close to?” “How much does this bother you?”) is often more useful than frequency for rating this item. You may also determine the amount of functional impairment by inquiring about whether there are “any people” that the person feels emotionally connected to upon occasion (e.g., children, spouse, best friend, etc.).
- 11) This question refers to emotional numbness. Ratings should capture emotional flatness or lack of responsivity despite good or bad things happening. If restriction of range of emotion is due to the exclusive experience of one emotion (e.g., sad all the time) or the exclusion of positive emotion (e.g., person reports feeling only negative emotions and no happiness, interest, loving feelings) it can be scored. Inquire whether this has been continuous or whether it has fluctuated over the past two weeks to determine the rating along with the amount of impairment.
- 12) Foreshortened future – this symptom is scored if the person reports the perception of permanent, negative change as a result of the trauma (e.g., “I will never have children”, “never achieve anything I wanted to do”, “my life will be short”, etc.). There must involve the perception that there is permanent damage or change to the person’s life that are directly attributable to the traumatic event(s). Frequency of such thoughts and severity of the perceived “damage” should be taken into account in making rating.

D.. Arousal

- 13) To accurately capture sleep difficulty the interviewer will typically need a combined rating of frequency and intensity. First, get a good count of how many nights sleep were disrupted either by difficulty falling or staying asleep. Then assess the duration/severity of the disturbance (e.g., “How long did it take on average to fall asleep?” “When you woke up, how long did you stay awake?” “How many hours of sleep did you get per night?”). Use distress ratings to push up or down a rating that falls between two scores. If possible, ensure that this represents a change from before the target trauma. **Note: when sleep medication is being used, make your ratings on the basis of the objective data and not on the basis of speculation about how the person would be sleeping if she were not on medication.**
- 14) When rating irritability attempt to ensure that the symptoms represent a change from functioning prior to the trauma. Impaired functioning that is not above pre-trauma levels should be scored a 0. First determine the frequency of the irritable or angry behavior. Use distress ratings to push up or down a rating that falls between two scores.
- 15) Concentration problems are best rated in terms of severity – ask for example, about ability to follow a conversation, to watch and comprehend a short TV show, to complete required tasks at work, to read and comprehend a paragraph, and to maintain a train of thought. Determine whether the person is able to concentrate in any situations (e.g., watch a TV show, read a book, etc.).
- 16) When the person uses terms like “wariness” this is likely hypervigilance. Assess hypervigilance in the home and outside of the home – ask about checking to make sure no one is behind the person, scanning faces, listening for small sounds, being on the alert in general. Determine the frequency (e.g., percentage of the day/week the person feels on edge) of the symptom.
- 17) When rating exaggerated startle response, be sure to differentiate it from a reasonable startle response (e.g., car coming toward person). Determine the frequency of these exaggerated startles in the last two weeks. Use distress ratings (e.g., how long does it take you to calm down after being startled) to push up or down a rating that falls between two scores.

PTSD severity is determined by totaling the 17 PSS-I item ratings. Scores range from **0-51**.

PTSD diagnosis is determined by counting the number of symptoms endorsed (a rating of 1 or greater) per symptom cluster – 1 Re-experiencing, 3 Avoidance, and 2 Arousal symptoms are needed to meet diagnostic criteria.

A PTSD diagnosis also requires **symptom duration of more than one month** (criterion E) and **clinically significant distress or impairment** (Criterion F).