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A Confirmatory Factor Analysis of the PCL-5 in Veteran and College Student Samples

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A CONFIRMATORY FACTOR ANALYSIS OF THE PCL-5 IN VETERAN AND COLLEGE STUDENT SAMPLES

by

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Abstract

An important change in the conceptualization of posttraumatic stress disorder (PTSD) has been the shift from a three-factor model used in the DSM-IV-TR to the current four-factor model used in DSM-5. Early research initially supported the three-factor model, but most recent data suggest a four-factor model provides the best fit. Still other research has examined evidence for a five-factor model that would include depression sequelae. By way of a confirmatory factor analysis, we demonstrate the reliability of DSM-5 PTSD criteria clustering in a sample of 124 OEF/OIF/OND Veterans treated at a VAMC (49% white, 89% men) and a sample of 737 college students (48% white, 78% women). All participants were trauma-exposed, and completed the PTSD Checklist for DSM-5. The current study shows both samples best support a five-factor model over two four factor models considered for the DSM-5, though none provided better than moderate fit. Findings will be used to judge the reliability of the new DSM-5 criteria of PTSD and to accurately and consistently categorize PTSD symptomatology.

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Introduction

Posttraumatic stress disorder (PTSD) is a significant public health concern, particularly as veterans return home from overseas tours seeking treatment for trauma-induced injuries (Ivanova et al., 2011). In the general population, research suggests that 25% (Norris & Sloan, 2007) to as much as 67% (Elhai, 2012) of Americans will experience a traumatic event (as defined by the DSM-IV-TR). The lifetime prevalence of PTSD in the United States is estimated to be between 3.5-7.8% (Kessler et al., 2005, 1995) in the general population, and possibly as high as 13.8% among veterans (Tanielian, & Jaycox, 2008). Despite its prevalence, there is still some question about how to define PTSD.

PTSD criteria are arranged into symptom "clusters" in DSM. Empirical methodology determining how the symptoms relate to each other are not always employed in the DSM structure development. However, researchers still examine how the DSM symptom clusters might be improved through the use of factor analysis. Factor analysis is a method of condensing numerous variables into smaller, correlated variables, or "factors." In different samples, researchers may not find the same variables being as strongly correlated to each other. These different factors can then be tested using a confirmatory factor analysis across different samples for the strength of the correlations (Brown, 2006). These methods were used to refine the model of PTSD for the DSM-5.

PTSD Diagnosis

The current conceptualization of the PTSD model in the DSM-5 is divided into four symptom-related criteria. Criterion B designates intrusive symptoms such as recurrent involuntary memories, nightmares, and intense or prolonged stress in relation to reminders of the

trauma. Criterion C includes avoidance of thoughts, feelings, and external reminders of the trauma. Criterion D includes negative alterations in cognitions and mood such as diminished interest in activities and feeling alienated from others. Criterion E includes alterations in arousal and reactivity. It also includes sleep disturbances and exaggerated startle response. (American Psychiatric Association, 2013).

The DSM-5 criteria for PTSD reflect several structural changes relative to the DSM-IV-TR. Originally categorized as an anxiety disorder, PTSD is now in a new category called the trauma- and stressor-related disorders. Criterion A has also been changed, no longer requiring that an individual experience "fear, helplessness, or horror" to receive a PTSD diagnosis (American Psychiatric Association, 2000, 2013). The DSM-5 includes three new symptoms addressing distorted sense of blame for self and others, persistent negative mood states, and engaging in reckless or destructive behaviors. Some existing symptoms have minor clarifying revisions as well. Additionally, the symptoms are assigned to four symptom clusters, as opposed to three.

Models of PTSD criteria

At least 42 studies have been published examining the factor structure of PTSD in adults, and four models have developed strong support. Here we briefly review the representative literature on these models: the Simms model (Simms,Watson, & Doebbelling 2002), the modified King and colleagues (DSM-5) model (1998), and the Elhai model. The review examines research using confirmatory factor analyses with the two four-factor models and the Elhai 5-factor model. Table 1 presents the previous DSM-IV-TR model and DSM-IV-based symptoms for reference. It also contains the DSM-5 model and the alternative models with the new DSM-5 symptoms.

In the DSM-IV-TR, PTSD symptoms were clustered into three categories: Re-experiencing, Avoidance/Emotional Numbing, Hyperarousal (American Psychiatric Association, 2000). However, factor analytic studies suggested that there were a number of alternatives to the DSM-IV-TR model (Elhai, Contractor, Palmieri, Forbes, & Richardson, 2011; Gentes, Denis, Kimbrel, Rissling, Beckham, & Calhoun, 2014; King, King, Fairbank, Keane, & Adams, 1998; Simms et al. 2002). Models consisting of at least four factors seem to show superior fit to the three-factor model (King et al., 1998; Simms et al. 2002; Elhai et al., 2011).

Though there is evidence suggesting the Simms model provides a better fit in several studies, overall, results have been mixed (Yufik & Simms, 2010). In the Simms model, the factor analysis showed that the symptoms were found to cluster into a new category labeled as dysphoria, merging most of the symptoms now making up the Numbing and Hyperarousal clusters (Simms et al., 2002). McWilliams, Cox, & Asmundson (2005) conducted research using data from the National Comorbidity study (Kessler et al., 1995). The data showed that the King model had the best fit based on the goodness of fit index (GFI), the comparative fit index (CFI), and the root mean square error of approximation (RMSEA). However, the model did not meet criteria for good fit until elements (such as concentration difficulties and irritability) of the King model were adapted to fit more closely to the Simms model's dysphoria factor. Baschnagel, O'Conner, Colder, and Hawk (2005) looked at PTSD symptoms one and three months after trauma exposure. Ultimately the Simms model fit was better than the King model, but the fit strength of the Simms model was inconsistent at the one and 3-month time points.

Despite some mixed findings, the Simms model has a lot of support across multiple samples, including combat veterans (e.g., Williams, Monahan, & McDevitt-Murphy, 2011). A meta-analysis looking at different measures and sample sizes across 40 PTSD studies using

DSM-IV criteria found that the Simms model provided superior fit to several proposed PTSD models including the King model (Yufik & Simms, 2010). Another study also using DSM-IV-TR criteria compared the symptom structure between the Simms model and King model in deployed and non-deployed veterans. Though no significant difference in model fit was found in the non-deployed group, the Simms model provided a better model fit in the deployed veteran sample (Engdahl, Elhai, Richardson, & Frueh, 2011).

The King model also has strong support. The model split the avoidance and numbing cluster into two categories, otherwise leaving the previous symptoms intact within their symptom clusters (King et al., 1998). Results from a study of 15,593 active duty military personnel showed that the King model provided the best fit for the data (Mansfield et al., 2011), lending strong support to the model. A modified version of the King model with the three new PTSD symptoms was ultimately selected for the DSM-5 despite the fact that model fit was superior for the Simms across a variety of samples (American Psychiatric Association 2013; Gentes et al. 2014; Yufik & Simms, 2010).

With the new symptoms proposed by the APA for the DSM-5, Elhai et al. (2011) hypothesized that a 5-factor model that emphasizes the symptoms that are strongly correlated with depression and anxiety symptoms may provide the best model fit for the conceptualization of PTSD. The Re-experiencing, Avoidance, and Numbing clusters are intact, but the Hyperarousal cluster is divided into Dysphoric Arousal and Anxious Arousal. Results showed that the high comorbidity between depression and anxiety were represented structurally in a factor analysis. The results of the analysis showed the Elhai model had similar fit scores to that of the Simms and King model. A subsequent study by Amour et al. (2012) found the Elhai model had a significantly superior fit than both the King and Simms model based on a confirmatory

factor analysis of Gulf war veterans and primary care patients. A recent study by McSweeny and colleagues (2016) conducted an exploratory factor analysis using the PCL-5 also supported a five-factor model.

Though these models are similar, it is important to examine the fit across diverse samples of PTSD symptomology to ensure that the model used by the DSM-5 accurately represents these symptoms, particularly because new symptoms have been added to the PTSD diagnosis in DSM-5. Because the current PTSD diagnosis is based on committee consensus, empirical data should be used to then validate that the model fits the symptoms across samples.

Present Study

Based on existing research, there is still some question as to whether the PTSD symptom clusters, as reflected in the DSM-5 provide the best fit for the data. In the proposed work, we investigated the current model reflected in DSM-5 and alternative models for the PTSD symptom clusters. The DSM-5, Simms, and Elhai models were examined. The proposed work investigated the best-fitting models in two samples, one sample of individuals with mixed civilian trauma, and one sample of veterans to assess the universality of the different models across different groups. No previous research has examined both a civilian and veteran sample across the three different models to confirm best model fit.

Hypotheses

Based on the current literature including the extensive meta-analysis conducted by Yufik and Simms (2010), we predict that the Simms model should provide the best fit for the data in both civilian and veteran samples. This means that the model that combines most of the symptoms now comprising the Numbing and Hyperarousal into one cluster called “dysphoria” will provide a better fit for the data over the modified King/DSM-5 model, which splits the

numbing and avoidance cluster. This assessment was based on RMSEA, TFI, GFI, and CFI values. Due to the emerging support for the five-factor Elhai model, it was examined to determine its strength among the four-factor models.

Method

Participants

Sample 1. As represented in Table 2, the first sample included 124 OIF/OEF/OND veterans recruited from the Veteran Affairs Medical Center in Memphis, TN as part of a larger study. The sample included 110 (89%) men and 14 (11%) women. Sixty-one (49%) of the participants identified as white, 60 (48%) identified as African American, or at least one participant identified as Hispanic, Native American, or Asian, or multi-racial. Participant age ranged from 21 to 66 with a mean age of 35 years old (*SD* = 9.9). The mean score for the PCL-5 was 49.24 (*SD* = 19.5) out of a possible score of 80. All participants had been deployed as part of OEF/OIF for an average of 11.6 (*SD* = 7.98) months. The veterans had been returned for an average of 3.68 (*SD* = 2.75) years.

Sample 2. Also represented in Table 2, the second sample included 737 college students at the University of Memphis who reported trauma exposure. The sample contained 165 (22%) men, and 570 (78%) women and 2 individuals who did not report their gender. Nearly half of the sample, 354 (48%) identified as white, 292 (40%) as African American or at least one participant identified as Hispanic, Native American, Asian, or multi-racial. Participants' ages ranged from 18 to 54 with a mean age of 20.7 *(SD* = 4.7). The mean score on the PCL-5 was 31.2 (*SD* = 14.01) out of a possible score of 80. Participants were asked to indicate which traumatic event they considered to be the "worst" event. The most frequently identified "worst" traumatic event category was motor vehicle accident (MVA, 17.8%), followed by sexual assault (11.8%), and a

sudden violent death of someone close to them (8.4%).

Procedure

Sample 1. This study is based on data collected from Veterans were recruited from the Veterans Affairs Medical Center in Memphis. Participants were approached by research project staff at VAMC clinics and invited to participate. Interested veterans completed a brief packet of questionnaires that included the PCL-5. These participants were invited to participate in a larger study that entailed attending two assessment sessions as well, but data used in the present analyses were derived from the initial packet. The Institutional Review Boards at both the Memphis VA Medical Center and The University of Memphis approved this study.

Sample 2. The civilian sample data were collected using the Psychology Research Participation System (Sona system) at the University of Memphis as part of a larger initial study. Participants completed a set of self-report measures online and were awarded one credit hour toward any psychology course requiring research credit.

Measures

Sociodemographic questionnaire. A sociodemographic questionnaire assessed general demographic information about both veterans and college students, modified to ask sample-specific information (e.g., questions about military experience for the veteran sample and about academic progress for college students).

PTSD Checklist for DSM-5 (PCL-5). The PCL-5 is a 21-item self-reported measure assessing PTSD symptoms based on DSM-5 criteria (Weathers et al., 2013). It is a revision of the previous PCL scale that corresponded to DSM-IV-TR symptoms. The PCL-5 describes symptoms such as "Repeated, disturbing dreams of the stressful experience" and "Feeling very upset when something reminded you of a stressful experience," with anchors ranging from 0 (not

at all) to 4 (extremely). The PCL-M, PCL-C, and PCL-S based on the DSM-IV-TR has been shown to have a high convergent validity with the CAPS, considered to be the "gold standard" for PTSD diagnosis and assessment (Wilkins, 2011). The scores range from 0 to 80, with a score of 38 or greater indicating likely PTSD (Blevins et al., 2015) in college students and a score between 31-33 in veterans (Bovin, 2015). Blevins and colleagues also demonstrated that the PCL-5 exhibited strong internal consistency ($\alpha = .94$), test-retest reliability ($r = .82$), and convergent ($rs = .74$ to $.85$) and discriminant ($rs = .31$ to $.60$) validity in college students. In veterans, Bovin and colleagues (2015) found PCL-5 test scores demonstrated strong internal consistency ($\alpha = .96$), test-retest reliability ($r = .84$), and convergent and discriminant validity. In the present study, the PCL-5 demonstrated high internal consistency ($\alpha = .96$ for the veteran sample and .97 for the civilian sample).

Data Analysis Plan

Prior to conducting our analyses, data were examined for missing values. If less than twenty percent of data were missing, mean substitution was used for these missing values (Tabachnick and Fidell, 2007). The next step was to conduct confirmatory factory analysis based on modified King model/DSM-5, Simms, and Elhai models for goodness of fit with the two samples. First the sample model fit was assessed separately and then the data were combined and we examined the model fit in the combined sample. A confirmatory factor analysis has been shown to be an effective method of testing model fit (Marsh, Balla, & McDonald, 1988). For the current study, RMSEA, TFI, GFI and CFI were used as fit indices. The RMSEA is measured on a scale from 0 to 1 with a score closer to 0 being ideal. A good fit falls below .08, with .08-.10 being considered mediocre, and above .10 considered poor fit (MacCullum, Browne & Sugawara, 1996). The TFI, GFI, and CFI are measured on a scale from 0 to 1 with scores closer

to 1 being ideal. For TFI, .90 and greater are generally considered to be a good fit, however researchers have argued for a more restrictive value of .95 (Hu & Bentler, 1999). For GFI, .90 is generally considered an acceptable cutoff for good fit, however due to its sensitivity to sample size, it is recommended to use a .95 cutoff for smaller sample sizes (Miles & Shevlin, 1998). CFI has a recommended cutoff of .90, though some researchers have argued for .95 to ensure that poor models are not accepted (Hu & Bentler, 1999). We also examined whether we were measuring the same construct of PTSD across both samples using measurement invariance.

Results

Results from the confirmatory factor analysis suggested that the Elhai model had marginally superior fit statistics over both the Simms and DSM5 models in both the college student sample and the veteran sample. As represented in Table 3, we used the following cut-off scores to identify good fit: A non-significant Chi-Square test, GFI, CFI, and TFI scores equal to or greater than .9, and RMSEA scores of .08 or less. Across the three models, none provided better than moderate fit in either sample.

We investigated measurement invariance across the two samples, and found that the factor loadings did not meet criteria for measurement invariance using both configural and metric tests across all three models (Vandenberg & Lance, 2000). Table 4 displays the factor loadings across each item.

Between the two samples evaluated in the current study, the college student sample showed better overall fit, even across the IFI and CFI fit indices that are more resistant to smaller sample size type I or type II errors. The veteran sample also had poor fit across all models, particularly for RMSEA values despite low Chi-Square values. Though both the RMSEA and

Chi-Square values are affected by sample size, the acceptable range Chi-square versus degrees of freedom ratios falls between two (Tabachnick & Fidell, 2007) to five (Wheaton et al, 1977).

Discussion

The current research adds to the body of evidence supporting the similar overall fit the Simms and DSM-5 models across both samples as represented in Table 3. However, our research shows only poor to moderate support across the fit indices. The Elhai model, with five factors rather than the four of the DSM-5 and Simms model, provided better fit, though it still only provides moderate fit across both samples. Despite the DSM-5 modifications changing the diagnosis of PTSD from a three-factor model found in the DSM-IV to a four-factor model based on both empirical data and committee consensus, it still may not address the complexity of PTSD.

Also, contrary to findings by Engdahl et al. 2011), the current research was not able to establish measurement invariance between college students and veterans. In Table 4, the factor loadings disputing the measurement invariance of the samples are presented. The initial configural invariance test did not yield similar fit (fit was poorer) indices compared to those in the individual samples across all models. A follow up metric test examining Chi-square test results between the unconstrained and constrained models was used to determine whether the latent variables were similar across the samples. Measurement invariance was also not found with the metric test approach. This may be something to consider when combining datasets to satisfy the relatively large sample size requirements for CFA.

One of the limitations of this study is the relative lack of gender diversity within the samples. In the college student sample, the majority of participants were women while the veteran sample was almost exclusively men. There was also a substantial age difference between

the two samples with the veteran sample having a mean age of 35 years old (*SD* = 9.9) and the college students having a mean age of 20.7 *(SD* = 4.7). Additionally, the veterans were asked to relate their PCL-5 scores to wartime experiences, whereas the college students picked their worst lifetime event where they endorsed motor vehicle accidents, sexual assaults, and witnessing a homicide most frequently. Also, the lower overall PCL-5 scores (indicating level of severity of PTSD symptoms) in college students may have led to restriction of range when comparing model fit with the veteran sample. We may have also encountered ceiling effects based on higher veterans PCL-5 scores. Thus, there are several important differences between these samples, in addition to their roles as college student or veterans.

Another limitation is the size of the samples. The college student sample was larger than the veteran sample, which may have had some effect on the RMSEA and Chi-square tests, which are sensitive to sample size. Whenever possible, we used fit indices that were less sensitive to sample size to mitigate this concern. The size of the veteran sample is within the margin of acceptability (MacCallum et al., 1999).

This research adds to the strength of the current model of PTSD as conceptualized in DSM-5 over the Simms model. However, the fit statistics for the DSM-5 model suggest that it still leaves room for improvement. It is important that researchers continue examining models and symptom reduction methodologies to find a balance between addressing the complexity of PTSD while maintaining a practical, parsimonious diagnosis. A number of studies have been published improving the fit of various PTSD models, but these have six or seven factors, often with only two variables representing factors (Armour et al., 2015, Liu et al., 2014, and Tsai et al., 2015). Bovin and colleagues (2015) performed the PCL-5 psychometric tests across several models for PTSD, including the more complex six and seven models, also suggesting that the

current DSM-5 may still need to be reconfigured. However, with each additional factor, diagnosis becomes more complicated, with unknown consequences.

It is also important that the diagnostic PTSD model captures different traumas across multiple groups, ensuring access to treatment. Our research shows that contrary to other findings (Engdahl, et al, 2011), there is still some question about whether all sample's symptoms are represented effectively. This is especially critical as veterans return from conflicts seeking mental health services.

The implications for finding only marginally fitting models for PTSD and the acceptance of increasingly complex structures suggest examining different approaches to understanding and diagnosing PTSD. Network analysis is one such approach where researchers examine PTSD through individual symptom influences and central symptom relationships (McNally et al., 2015). Understanding PTSD from a position of holism in addition to reductionism may yield future directions for research.

As diagnostic measures improve, clinicians and researchers will be able to address the growing need of trauma survivors. Refining the methodologies in place and incorporating innovative approaches will hopefully bring researchers closer to implementing policies and enhancing mental health services.

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Appendix A

Table 1
PTSD Symptoms by Model

DSM Symptoms	DSM-IV	DSM-5	Simms	Elhai
1. Repeated, disturbing, and unwanted memories?	R	R	R	R
2. Repeated, disturbing dreams?	R	R	R	R
3. Suddenly feeling or acting as if the stressful experience were happening?	R	R	R	R
4. Feeling very upset when something reminds you of the stressful experience?	R	R	R	R
5. Having strong physical reactions to experience?	R	R	R	R
6. Avoiding memories, thoughts or feelings	A/N	A	A	A
7. Avoiding external reminder of the stressful experience?	A/N	A	A	A
8. Trouble remembering important parts of the stressful experience?	A/N	NACM	D	NACM
9. Having strong negative beliefs about yourself, others, or the world?	A/N	NACM	D	NACM
10. Blaming yourself or someone else for the stressful experience or what happened after it?	-	NACM	D	NACM
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	-	NACM	D	NACM
12. Loss of interest in activities that you used to enjoy?	A/N	NACM	D	NACM
13. Feeling distant or cut off from other people?	A/N	NACM	D	NACM
14. Trouble experiencing positive feelings?	A/N	NACM	D	NACM
15. Irritable behavior, angry outburst, or acting aggressively?	H	AR	D	DA
16. Taking too many risks or doing things that could cause you harm?	-	AR	AR	DA
17. Being "superalert" or watchful or on guard?	H	AR	AR	AA
18. Feeling jumpy or easily startled?	H	AR	AR	AA
19. Having difficulty concentrating?	H	AR	D	DA
20. Trouble falling or staying asleep?	H	AR	D	DA

Note. R = re-experiencing, A/N = avoidance and numbing, NACM = negative alterations in cognitions and mood, H = arousal and reactivity, D = dysphoria, DA = dysphoric arousal, AA = anxious arousal.

Table 2

Veteran and College Student Sample Demographics

	Veterans	College students
Age (years)	35.0	20.7
SD	9.9	4.7
Gender		
Men	110 (89%)	165 (22%)
Women	14 (11%)	570 (78%)
Race		
White	61 (49%)	354 (48%)
Black	60 (48%)	292 (40%)
Other	10 (8%)	60 (8%)

Note. Some percentage do not equal 100% due to identifying in multiple categories.

Table 3
Model Fit Indices

	Veteran						College					
	X^2	df	GFI	CFI	TFI	RMSEA (90% CI)	X^2	df	GFI	CFI	TFI	RMSEA (90% CI)
DSM5	471.652	164	0.724	0.885	0.867	0.123 (0.111-0.137	1140.22	164	0.851	0.911*	0.896	0.09 (0.085-0.095
Simms	460.877	164	0.733	0.889	0.872	0.121 (0.108-0.134	1673.85	170	0.807	0.862	0.846	0.11 (0.105-0.114
Elhai	434.06	160	0.744	0.898	0.879	0.118 (0.105-0.131)	1020.357	160	0.863	0.921*	0.906	0.085 (0.081-0.091)

Note. X^2 = chi square test; df = degrees of freedom; CFI = Comparative Fit Index; TLI = Tucker Lewis Index; RMSEA = Root Mean Square Error of Approximation. * = >.90 for GFI, CFI, and TFI.

Table 4

Veteran and College Student Sample Factor Loadings Across Models

	DSM 5 College	DSM-5 Veterans	Simms College	Simms Veterans	Elhai College	Elhai Veterans
Item 1	0.857[a]	0.910[a]	0.857[a]	0.910[a]	0.857[a]	0.909[a]
Item 2	0.752[a]	0.846[a]	0.752 [a]	0.845[a]	0.752[a]	0.841[a]
Item 3	0.751[a]	0.874[a]	0.752 [a]	0.874[a]	0.751[a]	0.874[a]
Item 4	0.819[a]	0.918[a]	0.818 [a]	0.918[a]	0.818[a]	0.920[a]
Item 5	0.777[a]	0.847[a]	0.777 [a]	0.847[a]	0.777[a]	0.849[a]
Item 6	0.909[b]	0.920[b]	0.910[b]	0.923[b]	0.909[b]	0.922[b]
Item 7	0.899[b]	0.946 [b]	0.898[b]	0.944[b]	0.898[b]	0.944[b]
Item 8	0.482[c]	0.677[c]	0.479[e]	0.677[e]	0.482[c]	0.681[c]
Item 9	0.802[c]	0.815[c]	0.786[e]	0.811[e]	0.801[c]	0.819[c]
Item 10	0.766[c]	0.766[c]	0.748[e]	0.755[e]	0.763[c]	0.763[c]
Item 11	0.817[c]	0.877[c]	0.807[e]	0.873[e]	0.814[c]	0.874[c]
Item 12	0.766[c]	0.853[c]	0.761[e]	0.854[e]	0.767[c]	0.851[c]
Item 13	0.832[c]	0.899[c]	0.831[e]	0.897[e]	0.834[c]	0.896[c]
Item 14	0.846[c]	0.876[c]	0.839[e]	0.881[e]	0.849[c]	0.881[c]
Item 15	0.838[d]	0.825[d]	0.817[e]	0.828[e]	0.844[f]	0.830[f]
Item 16	0.616[d]	0.683[d]	0.615[d]	0.651[d]	0.617[f]	0.682 [f]
Item 17	0.626[d]	0.869[d]	0.720[d]	0.902[d]	0.734[g]	0.908[g]
Item 18	0.749[d]	0.892[d]	0.834[d]	0.928[d]	0.889[g]	0.935[g]
Item 19	0.831[d]	0.803[d]	0.799[e]	0.803[e]	0.834[f]	0.803[f]
Item 20	0.699[d]	0.727[d]	0.658[e]	0.702[e]	0.700 [f]	0.704[f]

Note. Reference Table1 for item number descriptions. a = re-experiencing, b = avoidance and numbing, c = negative alterations in cognitions and mood, d = arousal and reactivity, e = dysphoria, f = dysphoric arousal, g = anxious arousal.