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The Cultural Adaptation of the Clinician-Administered PTSD Scale for Spanish-Speaking Latinos with Limited English Proficiency in the United States

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THE CULTURAL ADAPTATION OF THE CLINICIAN-ADMINISTERED PTSD SCALE FOR SPANISH-SPEAKING LATINOS WITH LIMITED ENGLISH PROFICIENCY IN THE UNITED STATES

By

María José Rendón

A DISSERTATION

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THE CULTURAL ADAPTATION OF THE CLINICIAN-ADMINISTERED PTSD SCALE FOR SPANISH-SPEAKING LATINOS WITH LIMITED ENGLISH PROFICIENCY IN THE UNITED STATES

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In this study, I conducted an empirically-based adaptation of the Clinician-Administered PTSD Scale for DSM-5 (CAPS-5; Weathers, Blake, Schnurr, Marx, & Keane, 2013b) for Spanish-speaking Latinos with limited English proficiency (LEP). The sample utilized cross-cultural equivalence guidelines posited by the Cultural Equivalence Model (Canino & Bravo, 1994; Flaherty et al., 1988) to achieve content, semantic, and technical equivalence between the Spanish adaptation of the CAPS-5 and its original English version. This process entailed seven steps: (a) the forward translation by a native Spanish speaker, (b) revision by a panel of bilingual Latino mental health professionals (n = 3), (c) revision by a community sample of Latinos with LEP via focus groups (n = 19), (d) a panel revision of the changes suggested by the community sample, (e) pre-testing with a clinical sample of Latinos with PTSD (n = 4), (f) a panel revision of the changes suggested by the clinical sample, and (g) backtranslation by a native English speaker. Altogether, results pointed to the need to reduce the literacy level of the measure. Modifications included using colloquial wording when possible, reducing the level of abstractness of the items, utilizing visual aids to explain concepts such as timeframes and percentages, reducing the length of prompts to reduce the cognitive burden on interviewees’ working memory, using the simple past tense instead of the present perfect tense, and adding cultural considerations to the CAPS-5 instruction guidelines.
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CHAPTER 1: INTRODUCTION

Test validity is “the degree to which evidence and theory support the interpretation of test scores entailed by proposed uses of tests” (p. 6; APA, AERA, NCME, 1999). The field of Posttraumatic Stress Disorder (PTSD) counts with numerous assessment instruments (see Everly & Lating, 2004; Mueser, Rosenberg, & Rosenberg, 2009; National Center for PTSD, 2009; Orsillo, 2001). The validity of these measures intrinsically depends on how well the measure represents the population’s understanding and experience of trauma and traumatization. As such, a critical task in the field of PTSD is to develop measurement tools that are sensitive to the phenomenology of the disorder among diverse ethnolinguistic populations. However, as most of these measures have been developed for use with North American or West European English-speaking populations (Başoğlu et al., 2001; Renner, Salem, & Ottomeyer, 2006), many of the existing PTSD measures are not immediately suitable for use with non-Western, non-English speaking individuals. Scores generated with such measures would likely be biased, that is, they would systematically capture variance due to confounding variables above and beyond the target construct of interest (van de Vijver & Leung, 2011). Specifically, when measures do not have a linguistically and culturally sensitive translation, test takers may miss the intended meaning of the measure’s items, and the measure ultimately overestimates or underestimates PTSD levels. The cultural adaptation of measures, while challenging, is a necessary task to ensure appropriate clinical assessment and treatment of ethnolinguistic minorities.

People who speak Spanish at home constitute the second largest linguistic group in the United States (U.S.). It is estimated that 37.5 million people speak Spanish at
home, a number that is expected to increase to 40-43 million by the year 2020 (Ortman & Shin, 2011). The vast majority of these individuals (about 34.7 million, or 92%) are Latinos (U.S. Census Bureau, 2011a). Further, 15.5 million of these Spanish speaking Latinos (44.6%) have limited English proficiency (hereupon called “Latinos with LEP”). These are individuals who would rate their English speaking ability as “less than very well” (Shin & Kominski, 2010). Latinos with LEP constitute a growing, underserved ethnocultural group that requires the availability of linguistically and culturally congruent PTSD measures that take into account cultural, educational, and regional variations in the expression of the disorder (e.g., the way people talk about trauma and related symptoms).

PTSD is defined as a mental syndrome triggered due to exposure to a trauma (American Psychiatric Association, 2013). A trauma is defined as actual or threatened death, serious injury or sexual violation that personally affected the self, either through direct exposure or learning that it happened to a loved one. The syndrome is characterized by (a) re-experiencing symptoms such as intrusive thoughts, nightmares and flashbacks about the event, (b) intentional avoidance of thoughts, feelings, and reminders of the event, (c) negative cognitions and feelings related to the event, such as estrangement, self-blame and diminished enjoyment of activities, and (d) increased arousal such as difficulty sleeping, concentrating, proneness to aggressive or irritable behavior, and hypervigilance (American Psychiatric Association, 2013). PTSD is associated with chronic mental and physical problems, including co-morbidity with other mental disorders (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Pérez Benítez, Sibrava, Zlotnick, Weisberg, & Keller, 2014; Pietrzak, Goldstein, Southwick, & Grant, 2011), worse physical health (Del Gaizo, Elhai, & Weaver, 2011; Sledjeski, Speisman, &
Dierker, 2008; Zayfert, Dums, Ferguson, & Hegel, 2002), and risk of functional role impairment, such as unemployment and marital instability (Kessler, 2000; Kessler et al., 1995).

Latinos have equivalent or higher lifetime prevalence of PTSD when compared to non-Latino Whites (Alcántara, Casement, & Lewis-Fernández, 2013; Asnaani, Richey, Dimaite, Hinton, & Hofmann, 2010; Roberts, Gilman, Breslau, Breslau, & Koenen, 2011), but regrettably, they are less likely to access mental health care services when compared to non-Latino Whites (Barrio et al., 2008; Cook, McGuire, & Miranda, 2007; López, Barrio, Kopelowicz, & Vega, 2012; Mulvaney-Day, DeAngelo, Chen, Cook, & Alegría, 2012). In particular, Latinos with LEP experience specific disparities in mental health care and research. They have been shown to experience longer periods of time with untreated disorders, and to use fewer mental health services when compared to their English speaking Latino counterparts, even after controlling for other factors such as age, insurance status, number of psychiatric disorders, and length of time in the U.S. (e.g., Bauer, Chen, & Alegría, 2010; Kim et al., 2011). Additionally, Latinos with LEP are disproportionately underrepresented in PTSD research. Indeed, a recent review of 28 studies examining the risk of PTSD among Latinos found that only half of them included Spanish speaking Latinos in their sample, and that the percentage of people who completed PTSD assessments in Spanish was very small (0.01 - 0.04 %; Alcántara et al., 2013).

When Latinos with LEP do participate in mental health services or research, it is concerning that the measures utilized to evaluate PTSD do not represent local idioms of distress (Canino & Bravo, 1994). Many examples abound in the literature on how bias
creeps into well-meaning efforts to translate measures for Spanish speaking Latinos. For instance, American idioms of distress such as “feeling blue,” “down in the dumps,” and “bent out of shape” do not have a direct, intuitive translation to Spanish, and require careful adaptation efforts to convey the intended construct clearly to Latino test takers (Canino & Bravo, 1994). Further, translators may not necessarily be aware of Latinos’ own idioms of distress in Spanish (Hinton & Lewis-Fernández, 2010, 2011; Hough, Canino, Abueg, & Gusman, 1996; Lewis-Fernández et al., 2010; Marsella, 2010), and may omit these culturally-congruent expressions in their translations. Additionally, immigrants from different Latin American regions may have different idioms of distress unique to their background (Puente, Zink, Hernández, Jackman-Venanzi, & Ardila, 2013). As such, terms and phrases that may be well-known for English speakers across the U.S. may require alternative translations to cater to within-group differences among Latinos (Puente et al., 2013).

Although the process of translating and adapting measures for use with Latinos with LEP is challenging, Marsella and Leong (1995) cautioned that using instruments that have not been culturally adapted for the ethnocultural group under study is not only insensitive to the group in question, but can potentially result in inaccurate, biased conclusions about the group. Lack of cultural adaptation can promote a view of ethnocultural minorities as deviant while glorifying the comparison group (non-Latino White Americans) as normal (Marsella & Leong, 1995). To enhance the translation of a measure, and consequently the validity of such a measure’s scores, researchers are advised to follow empirical procedures (e.g., conduct focus groups with the intended population, consult with expert colleagues; Knight, Roosa, & Umaña-Taylor, 2010b; van
de Vijver & Leung, 2011). Yet, most existing PTSD instruments that have been translated to Spanish do not have published documentation on the steps that the authors took to translate and adapt the measure. Only a few PTSD instruments, such as the WHO CIDI (which has a PTSD module), have such existing documentation (Alegría et al., 2004).

Over the past 40 years, many comprehensive guidelines have been developed to create cross-culturally equivalent measures. For instance, Flaherty et al. (1988) proposed a five-dimension framework comprised of construct, semantic, technical, content, and criterion equivalence. Marsella and Leong (1995) posited a four-dimension model inclusive of linguistic, conceptual, scalar, and normative equivalence, and van de Vijver and Leung (2011) referred to a four-dimension framework comprised of construct, structure, metric, and scalar equivalence. Although the concepts and methods posited in these models vary, all models have some commonalities. First, all frameworks support the value of using both qualitative and quantitative methods in the process of evaluating the cultural validity of measures. Second, all frameworks are multidimensional and the dimensions tend to overlap across models. For instance, conceptual equivalence in the model posited by Marsella and Leong corresponds to the concept of construct equivalence in the model by Flaherty and colleagues. Third, all models advocate for a sequenced multistep approach, where qualitative steps (e.g., ensuring that item wording matches the construct’s expression within the group of interest) precede quantitative ones (e.g., the evaluation of the measure’s factor structure).

To address previous shortcomings in the literature, and to fill the need for culturally valid PTSD measures for the Spanish speaking Latino population, I conducted an empirically-derived, culturally appropriate translation of a PTSD measure for Latinos
with LEP. In this translation and validation process, I utilized qualitative methods (consultation with experts, focus groups with Spanish speakers) to generate a Spanish translation that meets the principles of cultural adaptation proposed by cross-cultural researchers. This study sought to set the groundwork for further research on the subsequent quantitative steps of psychometric validation.

**Suitability of the CAPS-5 for Cultural Adaptation**

PTSD measures have evolved in the past 34 years reflecting the episodic changes to PTSD diagnostic criteria. With the recent publication of the fifth edition of the Diagnostic and Statistical Manual of Mental Health Disorders (DSM-5; American Psychiatric Association, 2013) and the upcoming publication of the International Classification of Diseases-11 (ICD-11; World Health Organization, 2013) in 2017, existing measures will be revised and new measures will be created to cater to a growing multicultural society.

An excellent candidate for cultural adaptation is the Clinician-Administered PTSD Scale (CAPS; Blake et al., 1995). It was first developed in the early 1990s at the National Center for PTSD using the DSM-III PTSD criteria, and has been updated accordingly with the new editions of the DSM (Blake et al., 1995; Weathers, Keane, & Davidson, 2001). This measure is widely used in clinical and research practice (Elhai, Gray, Kashdan, & Franklin, 2005) and it is considered the gold standard of PTSD assessment (Weathers et al., 2001; Weathers, Marx, Friedman, & Schnurr, 2014). As of October, 2015, a search on PsycInfo for the “Clinician Administered PTSD Scale” indicates that the CAPS has been used as a diagnostic measure for PTSD in 514 peer-reviewed articles.
The CAPS was recently revised to reflect the DSM-5 criteria (Weathers, Blake, Schnurr, Marx, & Keane, 2013b). This version has maintained many of the structural strengths featured in previous versions of the CAPS, such as (a) the use of behavioral anchors to reduce bias, (b) the consideration of frequency and severity of symptom presentation in scoring, (c) the ability to score overall symptom severity (as a continuous score), and (d) the ability to mark symptoms as absent or present (as a dichotomous score; Blake et al., 1995). See Appendix A for a copy of the CAPS-5.

Although the CAPS-5 is in the process of being evaluated for psychometric validity (Weathers et al., 2014) it is expected to reflect similar characteristics to its antecedors. There is extensive evidence for the psychometric strengths of its precursor, the CAPS for DSM-IV-TR criteria. For this previous version, the CAPS’s scores were found to have excellent reliability and validity in psychometric studies with various trauma populations (e.g., war veterans, sexual assault survivors, victims of motor vehicle accidents, victims of natural disasters; Weathers et al., 2001). Psychometric work on the CAPS encompasses numerous studies with predominantly non-Latino White populations within the U.S., as well as with international samples (cf. Weathers et al., 2001). Studies evaluating the psychometric properties of the CAPS in other countries have conducted such analyses with translated versions of the CAPS (e.g., Asukai, Hirohata, Kato, & Konishi, 2003; Benuto, Olmo-Terrasa, & Reyes-Rabanillo, 2011; Charney & Keane, 2007). This body of research across the world suggests that researchers prefer to utilize the CAPS when there is a need to evaluate PTSD among linguistically diverse groups.

The CAPS-5 was recently translated to Spanish in Puerto Rico (Vera, Obén, Merced, Juarbe, & Salas, 2014). In addition, two Spanish language versions of the CAPS
for DSM-IV were previously developed, one in the U.S. (Bustamante, Page, Zayas-Bazan, & Mellman, 1997), and another in Spain (Orengo García & Hormaechea Beldarrain, 1997). Although the Bustamante, Page, Zayas-Bazan and Mellman translation of the CAPS has been evaluated for psychometric validity with a sample of Puerto Rican veterans (Benuto et al., 2011), and the Orengo García and Hormaechea Beldarrain version has been evaluated with a civilian sample from Spain (Bobes et al., 2000), no published studies to date document the process of translation and adaptation of the CAPS-5 or the CAPS for DSM-IV to Spanish. Additionally, no studies documenting the psychometric properties of any of these measures have been conducted with Latinos living in the U.S.

In my role as a research assistant in a clinical trial for Latinos with PTSD between 2009 and 2013 (Pérez Benítez, Zlotnick, Gomez, Rendón, & Swanson, 2013), I found that Spanish speaking clients from diverse nationalities had significant difficulty understanding the meaning of some symptoms assessed by the Orengo García and Hormaechea Beldarrain CAPS for DSM-IV. Part of this difficulty emerged from item wording being irrelevant or obscure (e.g., in this version of the CAPS, emotional numbing was translated as “ser emocionalmente paralizado” or “being emotionally paralyzed,” a term that did not make sense to most of our Latino clients). In other cases, difficulty arose when the translated terms resulted in longer words or sentences that appeared to tax clients’ auditory working memory. Such difficulties led me to provide additional clarification after administering the standard prompts to enhance the validity of the items’ responses, but also made for a lengthier assessment and put into question the utility of the CAPS for evaluating PTSD in this population.
Rationale and Purpose of the Present Study

There is a large number of Spanish speaking Latinos who have limited English proficiency living in the U.S.; this segment of the Latino population is underserved in clinical practice and severely underrepresented in PTSD research. Knowing that the lack of linguistic and culturally appropriate PTSD measures contributes to these disparities, it is imperative to adapt a PTSD measure for Latinos with LEP. Therefore, the purpose of this study is to develop an empirically-driven translation and adaptation of the CAPS-5 for Latinos with LEP. In this study I followed guidelines in the cross-cultural equivalence literature to translate the CAPS-5 to Spanish, ensuring that the item content, instrument format, and administration procedures are understandable and welcoming to Latinos with LEP. The measure was first translated by a professional bilingual translator. The measure was then modified according to the feedback of (a) a panel of bilingual scholars with expertise in Latino mental health, (b) a community sample of Latinos with LEP, and (c) a clinical sample of Latinos with LEP diagnosed with PTSD. Finally, the measure was backtranslated and compared to its original version. Through each step, I systematically documented the acceptability of the measure’s modifications by each group of participants.

In the following chapter, I provide a review of the literature supporting the need for the development of this measure for Latinos with LEP. In this review, I present research regarding the cultural expression of mental health disorders among Latinos, the history and conceptualization of PTSD and the CAPS-5, and theoretical frameworks and procedures to develop culturally adapted measures.
A cross-culturally equivalent measure is one that generates reliable and valid scores for two or more cultural groups of interest. Scores produced with such measures reflect an assessment of the underlying measure’s construct for both groups. Depending on the differences between those two populations studied, a cross-culturally equivalent measure may actually comprise two versions of the measure that are quite different in wording and format (Canino & Bravo, 1994).

Cross-culturally equivalent measures play a crucial role in psychological research and practice with ethnocultural minorities. Professional organizations around the world recognize the ethical imperative of developing and using instruments that are understood by the population of interest (International Test Comission, 2010). In the U.S., The American Psychological Association’s (APA) Ethical Principles of Psychologists and Code of Conduct urges psychologists to use instruments “whose validity and reliability have been established for use with members of the population tested” (APA, 2010, p. 12). The APA’s Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists (APA, 2002) further underscore the need to use “culturally sensitive assessment techniques, data-generating procedures, and standardized instruments whose validity, reliability, and measurement equivalence have been tested across culturally diverse sample groups, particularly the target research group(s)” (APA, 2002, p. 42).

To the extent that the number of ethnocultural minorities is increasing in the U.S., and to the extent that globalization expands the study of diverse cultural groups across the world, mental health professionals will increasingly find themselves in the position of
ensuring that their assessment procedures are appropriate for the individuals with whom
they work. Cross-cultural research on PTSD, specifically, necessitates measures that
generate valid, interpretable scores for the groups of interest. When studying cultural
groups that use different language systems (e.g., English, Spanish), a cross-culturally
equivalent measure is one that is appropriately translated, demonstrates reliability and
validity for both language groups, and ensures that scores in measurement instruments
reflect an assessment of the underlying construct for both groups. Thus, given the limited
availability of PTSD measures for Spanish speaking populations, the purpose of this
study is to develop a cross-culturally-equivalent Spanish version of a widely used PTSD
measure, the CAPS for Spanish speaking Latinos with LEP.

In the current chapter I present research related to this study and discuss how the
extant literature guides my research questions and chosen methodology. In the first
section of the chapter, I discuss the universalist and relativist approaches to
understanding mental health problems, presenting a paradigm for the need to develop
measures that acknowledge cultural variations of disorders. In the next section, I describe
the population characteristics of Latinos with LEP and the available epidemiological data
on their risk of trauma exposure and PTSD. In the third section, I review the construction
of Post-Traumatic Stress Disorder as a clinical diagnosis and its applicability to
ethnocultural populations, particularly Latinos. I provide a cultural analysis on the history
of PTSD and examine extant literature on the phenomenology of post-traumatic
responses among Latinos. In the fourth section, I review the state of the field regarding
PTSD assessment. In particular, I compare the availability of existing PTSD assessment
tools in English and in Spanish, and the limited documentation of translation and
adaptation procedures available for measures in Spanish. Within this section, I review best practices in conducting PTSD assessments as well as best assessment practices with Latinos. In the fifth section of the chapter, I present an overview of cross-cultural equivalence terms and conceptual frameworks that guide my research methods. In the sixth and final section of the chapter, I present the history and attributes of the Clinician-Administered PTSD Scale (CAPS-5), and discuss my rationale for culturally adapting this measure.

**Population Characteristics of Latinos with LEP**

The meaning and usage of the terms “Latino” and “Hispanic” are unique to the U.S. (Taylor, Lopez, Martínez, & Velasco, 2012). The term “Latino” refers to individuals who can trace their heritage, nationality group, lineage, or country of birth to Latin American countries, whereas the term “Hispanic” refers to individuals coming from, or having ancestry related to, a Spanish speaking country, including Spain (Ennis, Ríos-Vargas, & Albert, 2011; Taylor et al., 2012). The present study focused on the experiences of individuals who speak predominantly Spanish and who can trace their heritage to Spanish speaking Latin American countries (Argentina, Bolivia, Chile, Colombia, Costa Rica, Cuba, Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Puerto Rico, Uruguay and Venezuela). I chose to utilize the term “Latino” throughout this document because it implies my focus on people with ties to Latin America and the exclusion of individuals with origins in Spain. Whenever necessary, I clearly differentiated the information on Spanish speaking Latinos when compared to the greater Latino population in the U.S.
Individuals who self-identify as Latino comprise 50.5 million (or 16%) of the total U.S. population (Ennis et al., 2011). Even without accounting for the number of undocumented Latinos in the U.S. (estimated at 11.2 million as of 2010; Passel & Cohn, 2011), Latinos stood out as the largest ethnocultural minority group in the 2010 U.S. Census, growing by 43% since the year 2000 (Ennis et al., 2011). Among Latinos, those who predominantly rely on Spanish to communicate make up a vibrant, growing segment of the population. On par with the increase of Latinos is the rise of Spanish as the most common language other than English spoken at home within the U.S. (U.S. Census Bureau, 2011a). Indeed, it is estimated that 37.5 million individuals over the age of five speak Spanish at home (U.S. Census Bureau, 2011a), making the U.S. the world’s second largest Spanish speaking population after Mexico (Ruiz Mantilla, 2008). Although 92% of individuals who speak Spanish at home in the U.S. are Latinos (U.S. Census Bureau, 2011a), it would be a misconception to assume that most Latinos do not speak English. In fact, U.S. Census data estimates that among Latinos age five and over, 25% speak only English at home and that 41% of Latinos are fully fluent in English and Spanish, demonstrating that more than half of U.S. Latinos do, in fact, speak English very well. However, the remaining 34% reports that they speak English “less than very well” (U.S. Census Bureau, 2011a; see Table 1 for further information on statistics of Spanish usage in the U.S.), and it is this last group, comprising about 16 million individuals, that I sought to serve through the present study, given that they cannot be provided with mental health services in English (Castaño, Biever, González, & Anderson, 2007).

Latinos with LEP share some common characteristics. The vast majority of these individuals (12.6 million, or 79.4%) are foreign born (U.S. Census Bureau, 2011a).
Further, about two thirds of all Latinos with LEP are adults aged 18 and over (U.S. Census Bureau, 2000), with middle-aged Latinos (57% of people aged 41-64) and older adults (65% of people aged 65 and over; Shin & Kominski, 2010) being more likely to rely on Spanish to conduct every day transactions.

Demographic characteristics such as country of origin, age of arrival, length of stay in the U.S., level of formal education, and naturalization status have also been shown to correlate with English proficiency among Latino immigrants (Hakimzadeh & Cohn, 2007; Motel & Patten, 2013; Shin & Kominski, 2010). Limited English proficiency is more common among Mexican (73.4%) and Central American immigrants (68.8%) than among Caribbean (42%) and South American (47.7%) immigrants (Motel & Patten, 2013). As expected, adult immigrants are also less likely to speak English proficiently if they arrived to the U.S. after the age of 10, or if they have lived in the U.S. only for a few years. Finally, individuals with more years of formal education, especially the college educated, know English better and are more likely to use it at home and work than those with fewer years of education (Hakimzadeh & Cohn, 2007). Almost a third (32%) of foreign-born Latinos age 25 and above report less than nine years of formal education (Pew Research Center, 2013). In contrast, only 4.7% of the general U.S. population age 25 and above has comparable educational levels (U.S. Census Bureau, 2014).

An analysis of the U.S. Census American Community Survey responses by individuals with LEP reveals additional information regarding their typical income and occupation (Whatley & Batalova, 2013). The estimates in this analysis refer to all individuals with LEP; however, as Latinos comprise 63% of the total LEP population in the U.S., these estimates can be helpful to elucidate the state of Latinos with LEP.
Regarding income, this report found that individuals with LEP are more likely to live in poverty (26%) than individuals who are English proficient (14%; Whatley & Batalova, 2013). Additionally, individuals with LEP who were employed were more likely to work in manual labor and service occupations than people who were English proficient. Specifically, men with LEP were more likely to work in the construction, extraction, or transportation fields than English-proficient men (30% vs. 18%) whereas women with LEP were more likely to work in the service and personal care fields than English proficient women (39% vs. 15%; Whatley & Batalova, 2013).

The geographical distribution of Spanish speakers parallels the distribution of Latinos across the continental U.S. In three states (Texas, New Mexico, and California) about three in ten residents speak Spanish at home (29.46%, 28.95%, and 28.8% respectively) and in three other states (Nevada, Arizona, and Florida) about one in five residents (20-21%) speak Spanish at home (U.S. Census Bureau, 2011a). However, when examining the states with the highest concentration of Spanish speakers with LEP, California, Texas, Florida, and Nevada rank highest (12.87%, 12.62%, 9.08% and 9.08% respectively; U.S. Census Bureau, 2011a). Although most Latino immigrants are of Mexican origin at the national level (55%; Motel & Patten, 2013) the diversity of Latino immigrants is evident when considering different enclaves across the U.S. Specifically, individuals of Mexican, Salvadoran and Guatemalan descent dominate the landscape in Southwestern states such as California, Texas and New Mexico, and Latinos from the Caribbean (Puerto Rico, Dominican Republic, Cuba) and South America (predominantly Colombia, Venezuela, Peru, Ecuador, and Argentina) diversify the cultural landscape in the Northeast and the South (Ennis, Ríos-Vargas, & Albert, 2011).
Altogether, it is clear that Latinos with LEP can be found across the U.S. and that they comprise a significant portion of the total Latino community. A review of their population characteristics suggests that they share some common factors that may increase their psychological stress, such as greater likelihood of living in poverty than their English counterparts, and that they also share factors that limit their access to services, such as less years of formal education and lack of English language skills. In the following section, I review epidemiological data on Latino mental health and service utilization to understand how trauma affects the lives of Latinos with LEP, and also review how well Latino individuals utilize available mental health services to manage their symptoms.

**Trauma, PTSD, and Service Utilization Among Latinos with LEP**

To date, research on the experience of trauma and PTSD among Latinos has not focused specifically on the experience of Spanish speakers vs. English speakers. Rather, most epidemiological research has explored mental health issues among Latinos as an overall ethnic group or examined differences in mental health based on individuals’ nativity status (e.g., Alegría et al., 2008; Alegría, Canino, Stinson, & Grant, 2006). Given that Latinos with LEP comprise about a third of the total Latino population, and given that Latinos with LEP are also predominantly foreign-born, I summarize the epidemiology of trauma and PTSD as it relates both to the overall Latino population, and more specifically as it relates to foreign-born Latinos. In the following paragraphs, I refer regularly to studies drawn from the National Epidemiological Survey on Alcohol and Related Conditions (NESARC) and the National Latino and Asian American Study (NLAAS), a sub-division of the Collaborative Psychiatric Epidemiology Studies (CPES),
the two largest sources of epidemiological data on Latinos at the national level. I also incorporate findings from smaller community studies with Latinos.

Trauma Exposure and PTSD Rates Among Latinos. A NESARC study indicated that after adjusting for age and gender, Latinos had lower risk of exposure to trauma than non-Latino Whites in five trauma categories (i.e., war related traumas, assaultive violence, unexpected death, and other injury or shocking event), but had higher risk of exposure to child maltreatment than non-Latino Whites (Roberts et al., 2011). However, other studies have shown that Latinos have higher risk of exposure to intimate partner violence (Bonomi, Anderson, Cannon, Slesnick, & Rodríguez, 2009; Caetano, Ramisetty-Mikler, & Field, 2005; Sumner, Wong, Schetter, Myers, & Rodríguez, 2012), political violence (Cervantes, Salgado de Snyder, & Padilla, 1989; Eisenman, Gelberg, Liu, & Shapiro, 2003), and natural disasters (Holman, Silver, & Waitzkin, 2000) when compared to non-Latino Whites.

Studies using the CPES and the NESARC data indicate that Latinos have a lifetime prevalence of PTSD between 5.6% - 7.0% (Asnaani et al., 2010; Roberts et al., 2011). After controlling for age, gender and socioeconomic status, the lifetime rate of PTSD for Latinos in these studies was not significantly different from the lifetime rate of PTSD for non-Latino Whites, but it was higher than that of Asian Americans and lower than that of Black Americans. This trend is not consistent among community or clinical sample studies, where Latinos have consistently been found to have higher PTSD prevalence when compared to non-Latino Whites. This trend was found in a recent meta-analysis on the risk of PTSD among Latinos (Alcántara et al., 2013), when comparing Latino vs. non-Latino male Vietnam veterans (Fontana & Rosenheck, 1994; Lewis-
Fernández et al., 2008; Ortega & Rosenheck, 2000; Schlenger et al., 1992) and when comparing Latino vs. non-Latino male police first responders to the World Trade Center attack (Bowler et al., 2010). Similarly, in longitudinal studies examining the development of PTSD as a result of a trauma event that influenced the entire sample (e.g., a terrorist attack or a natural disaster), Latinos have been found to have a higher risk of developing PTSD when compared to non-Latino Whites. For instance, this trend was found in a Manhattan cohort exposed to the World Trade Center attacks, such that Latinos were more likely to meet criteria for PTSD at five to six weeks after the attack (Galea et al., 2002), six months after the attack (Galea et al., 2004), and two to three years after the attack (DiGrande et al., 2008) than non-Latino Whites. Finally, when compared to non-Latina women, Latinas have also been found to have higher PTSD rates associated with intimate partner sexual violence (McFarlane et al., 2005).

**Trauma Exposure and PTSD Rates Among Foreign-Born Latinos.** Multiple factors have been linked to the occurrence of trauma among Latino immigrants to the U.S., including immigrants’ political and socioeconomic context in their country of origin, the circumstances of their exit (e.g., embarking on a perilous journey through the sea on a small boat vs. a safer medium, such as a plane), and the context of their new environment the U.S. (e.g., quality and safety of host neighborhoods; Alegría et al., 2007).

Many Latin American immigrants to the U.S. have experienced significant trauma events. In the past 50 years, Latin America has endured long-term periods of low intensity warfare as a result of civil war, insurgency and counter-insurgency movements. As such, exposure to armed conflict, political persecution, and the loss of economic
security resulting from warfare are common themes among certain Latino immigrant
groups living in the U.S., particularly Cuban exiles (Pumariega, Rothe, & Pumariega,
2005), as well as immigrants and refugees from Nicaragua, Guatemala, El Salvador, and
most recently, Colombia (Suárez-Orozco & Páez, 2009). Many of these immigrants have
experienced community violence in rural areas (e.g., the systematic rape and massacre of
villagers), high crime rates in urban areas, and politically-driven threats to personal safety
or the safety of family members through kidnapping and disappearances (Fortuna,
Porche, & Alegría, 2008; Michultka, Blanchard, & Kalous, 1998; Norris, 2009). Within
the context of economic and political instability, many immigrants have also been subject
to other forms of trauma at the community level (e.g., crime-related assault and
kidnapping) and at the domestic level (e.g., sexual and physical abuse in the family;
Jenkins, 1991; Jenkins, 1996; Kaltman, Hurtado de Mendoza, Gonzales, Serrano, &
Guarnaccia, 2011). Latin America has also experienced a number of devastating natural
disasters (earthquakes, hurricanes, floods, volcanic eruptions) that have caused mass
displacement, death and damage to the physical and economic infrastructure of areas
within the region.

High rates of exposure to trauma events have been documented among Central
American immigrants to the U.S. southwestern regions. One of the earliest trauma-
focused studies with Central American refugees settling in Arizona found that about 68%
of individuals who had been exposed to war-related events and were seeking asylum in
the U.S. met criteria for PTSD (Michultka et al., 1998). More recently, in another study
that included 125 Central American primary care patients, 20.8% of participants reported
exposure to interpersonal violence outside the family, 16% reported exposure to death or
violence, 17.6% reported experiencing war-related violence, and 17.6% reported exposure to “other” types of trauma, including natural disasters (Holman et al., 2000). Among 593 Mexican primary care patients who also participated in that study, 14.3% reported experiencing interpersonal violence outside of the family context, and 11% reported witnessing death or violence. A third study with immigrants in primary care settings (n = 638) in Los Angeles, CA also found that more than 54% of the sample had experienced at least one type of political violence event (Eisenman et al., 2003). These immigrants, most of whom were from Mexico, Nicaragua and Guatemala, reported exposure to attacks with bombs or heavy weapons (32%), disappearance of family members (27%), being exposed to mass violence (26%), witnessing violence to family (15%), being tortured (8%), witnessing torture or executions (5%), or being raped (3%). Finally, in a national sample of Latinos drawn from the NLAAS (n = 1630), estimates of exposure to any kind of trauma were as high as 26% (Fortuna et al., 2008).

Alegría et al. (2007) estimated that immigrant Latinos have a lifetime prevalence rate of PTSD of 4.6% and a past-year prevalence rate of 2.5% as per data from NLAAS. These rates are lower than rates for U.S.-born Latinos (6.5% and 3.7%, respectively), reflecting the trend typically found for immigrants to have better mental health rates than native-born individuals (the immigrant paradox; Alegría et al., 2007). This may suggest that most Spanish speaking Latinos are at lower risk for PTSD than their English-speaking counterparts, but no study to date has specifically compared the rates for Spanish speakers vs. English speakers.

**Mental Health Service Utilization Among Latinos.** Latinos are less likely to access mental health care services when compared to non-Latino Whites (Barrio et al.,
Latinos with LEP, in particular, are less likely to identify themselves as needing treatment, more likely to experience longer periods of time with untreated disorders, more likely to report barriers to accessing care, and less likely to receive mental health services than English speaking Latinos, even after controlling for other factors such as age, insurance status, number of psychiatric disorders, and length of time in the U.S. (e.g., Bauer et al., 2010; Kim et al., 2011). Thus, even though Latinos with LEP enjoy some protective factors such as decreased risk of meeting diagnostic criteria for PTSD, they are also less likely to receive appropriate care when they need it.

There are many factors influencing access to mental health care, including both patient factors (e.g., beliefs about mental health and illness, help-seeking patterns, and attitudes toward mental health personnel) and institutional factors (e.g., mental health policies, distance and affordability of services, availability of bilingual providers; Piedra, Andrade, & Larrison, 2011; Snowden & Yamada, 2005). Ensuring that mental health services, including assessment services, are provided in Spanish, will not solve the full range of factors contributing to the underservice of Latinos. However, it is a step in the right direction toward providing higher quality care to Latinos and ensuring equal services to all.

**The Cultural Equivalence of the PTSD Construct for Latinos with LEP**

PTSD refers to a psychiatric disorder inclusive of physiological, emotional, and behavioral symptoms that are activated following exposure to a traumatic event (American Psychiatric Association, 2013; World Health Organization, 1993). Although the conceptualization of PTSD has varied across the years, its core symptoms include (a)
the re-experiencing of the traumatic event (e.g., through nightmares, intrusive thoughts, or flashbacks), (b) the purposeful avoidance of internal or external reminders of the trauma, (c) negative conceptions about the self and affect dysregulation, and (d) increased physiological arousal (including hyperarousal, irritation or anger, insomnia; American Psychiatric Association, 2013; World Health Organization, 1993). The disorder is diagnosed when such symptoms are significantly impairing and persistent beyond the acute, transient symptoms most people experience following a traumatic stressor.

The phenomenology of PTSD symptoms has been refined through years of theoretical and empirical investigations, as well as through historical and sociopolitical events that gave momentum to the study of trauma among soldiers, women, ethnocultural minorities, and international populations. A look at the evolution of PTSD’s diagnostic criteria, as well as an examination of universalist and relativist approaches to conceptualizing trauma disorders, is necessary to understand the cultural relevance of this disorder for Spanish speaking Latinos. In the following section, I describe the evolving nosology of PTSD across the 20th and 21st centuries with special attention to the extent that cultural considerations have been taken into account in defining this disorder. I also review the universalist and relativist positions regarding the cross-cultural applicability of PTSD and discuss extant research regarding the phenomenology of PTSD among Spanish speaking Latinos.

**History of PTSD as a Clinical Diagnosis.** Although there is evidence that extreme reactions to traumatic events have existed since ancient times (e.g., as described in Hellenic literature detailing heroes’ reactions to warfare) the identification and medicalization of traumatic stress reactions only began in the 19th century (Turnbull,
Western physicians and psychiatrists began describing trauma syndromes such as “railway spine,” “traumatic neurosis,” “soldier’s heart,” “shell shock,” and “combat exhaustion,” among combat and civilian populations exposed to traumatic stressors (Birmes, Hatton, Brunet, & Schmitt, 2003; Friedman, Resick, Bryant, & Brewin, 2011; Turnbull, 1998). In the 20th century, the nosology for disorders associated with traumatic events first emerged in two independent diagnostic classification systems for mental health disorders, the Diagnostic and Statistical Manual of Mental Health Disorders (commonly referred to as the DSM), currently in its fifth edition (American Psychiatric Association, 2013), and the International Classification of Mental and Behavioural Disorders (referred to as the ICD), currently in its tenth edition (World Health Organization, 1993). Currently, the ICD is the official mental health diagnostic manual in most countries, including the U.S., but the manual most commonly used by mental health professionals in the U.S. is the DSM. The different diagnostic criteria posited by the two manuals and the different weight scholars place on using one manual over the other poses some complexity in determining whether a given patient meets criteria for PTSD. Below, I describe how trauma stress disorders have been conceptualized in both manuals since their inception, and the extent to which cultural considerations have been highlighted or omitted.

The ICD’s 6th edition included for the first time a section on mental health disorders in the year 1949 (World Health Organization, 2004). However, neither the ICD-6, ICD-7, nor ICD-8 included disorders related to psychological trauma. The first appearance of a trauma-related disorder in a diagnostic manual occurred in 1952 with the emergence of the first DSM (American Psychiatric Association, 1952). In this manual,
“gross stress reaction” emerged as a response to calls to conceptualize psychological
disturbances observed among veterans of World Wars I and II (Turnbull, 1998). Unlike
the current conceptualization of PTSD, gross stress reaction was described as a transient
condition that could be reversible. Gross stress reaction was phased out in the DSM-II
(American Psychiatric Association, 1968), where “situational reaction,” a disorder not
specifically associated with trauma events, became the only other diagnostic option.

The ICD-9 (World Health Organization, 1978) incorporated for the first time
disorders associated with traumatic events through the sub-categories of “acute reaction
to stress” and “adjustment reaction.” Similar to the first and second editions of the DSM,
these categories represented transient reactions to highly stressful situations, such as
natural catastrophes, combat bereavement, or migration (Turnbull, 1998). Until this point,
none of the iterations of the ICD or the DSM featured cultural considerations in the
descriptions of these disorders.

The third version of the DSM re-inaugurated the idea of a trauma stress disorder,
labeling it PTSD (American Psychiatric Association, 1980). To be diagnosed with this
disorder, a patient had to experience “a recognizable stressor that would evoke significant
symptoms of distress in almost anyone” (Criterion A), exhibit at least one out of three re-
experiencing symptoms (Criterion B; intrusive thoughts, nightmares, and flashbacks), one
out of three possible psychological numbing symptoms (Criterion C; diminished interest
in activities, detachment from others, constricted affect), and two out of six hyperarousal
symptoms (Criterion D; hypervigilance, sleep disturbances, survivor’s guilt, memory
impairment or problems concentrating, avoidance of activities reminiscent of the event,
physiological or psychological reactions to cues reminiscent of the trauma). These criteria
were modified in the 1987 revision of the DSM-III (the DSM-III-R), such that (a) Criterion A restricted trauma events to be “outside the range of usual human experience” and “markedly distressing to almost anyone,” and (b) the avoidance and memory symptoms that were originally located in Criterion D were moved to Criterion C (American Psychiatric Association, 1987).

The construct of PTSD was highly contested at the time it was published in the DSM-III (van der Kolk & Najavits, 2013). This diagnostic category was the result of efforts by researchers and by advocates outside of academia who wanted to find a diagnostic label for people dealing with trauma, particularly war Veterans who had been left without a diagnostic label in the DSM-II (Andreasen, 2010; Friedman et al., 2011; Gone & Kirmayer, 2010; Turnbull, 1998; van der Kolk & Najavits, 2013). During the 1970s, PTSD research focused primarily on the psychological effects of the Vietnam War on soldiers, mostly reflecting the experiences of White male combat veterans (Friedman et al., 2011; Turnbull, 1998), with no attention to cultural issues related to ethnic minorities. Research on civilian trauma and the experiences of sexual trauma among women also emerged following increased attention to the impact of child abuse, rape, and domestic battery on women and children in the 1970s (Friedman, Resick, & Keane, 2007). These sociopolitical changes, however, did not reach the DSM-III. Cultural considerations in the diagnosis of racial or ethnic minorities were not mentioned in the DSM-III nor the DSM-III-R, even though a committee on cross-cultural issues is cited in the manual’s Acknowledgement’s page (American Psychiatric Association, 1980).

The ICD first published its own rendition of PTSD criteria in its 10th edition (World Health Organization, 1993). To be diagnosed with PTSD, a patient had to
experience “an exceptionally threatening or catastrophic” event or situation that was “likely to cause pervasive distress in almost anyone” (Criterion A), exhibit at least one out of four re-experiencing symptoms (Criterion B; intrusive thoughts, nightmares, flashbacks, distress in reaction to reminders of the trauma), engage in the avoidance of trauma reminders (Criterion C), and experience either (a) psychogenic amnesia or (b) one out of five hyperarousal symptoms (sleep disturbances, irritability or outbursts of anger, problems concentrating, hypervigilance, exaggerated startle response; Criterion D). In addition, Criteria B, C, and D could only occur within six months of the occurrence of the stressor event. The 10th edition of the ICD did not include cultural considerations in the text descriptions of PTSD. At least one scholar (Haghighat, 1994) commended the ICD on being more culturally sensitive than the DSM, for instance, by not requiring changes in occupational role performance or evidence of independent living as a criterion for disorder caseness, but other scholars have been more critical of the ICD for its “benign neglect” of cultural perspectives (Alarcón, 2010).

The American Psychiatric Association published a significantly revised PTSD diagnostic criteria in the DSM-IV (American Psychiatric Association, 1994). In this edition, PTSD criteria restricted the gateway trauma stressor (Criterion A) to (a) “actual or threatened death, serious injury, or harm to the physical integrity of self or others” and specified that patients (b) must have shown a peritraumatic response of intense fear, helplessness or horror. In addition, the list of symptoms was modified, with one new symptom, sense of foreshortened future, being added to the avoidance and numbness cluster in Criterion C, and a DSM-III hyperarousal symptom, reaction to trauma reminders, being moved to the DSM-IV re-experiencing cluster. Last, further
specifications were added to establish the minimum duration of the disorder as one month (Criterion E), to require evidence of significant distress or impairment (Criterion F), and to specify the severity and onset of the symptoms. These changes remained in the DSM-IV-TR (American Psychiatric Association, 2000).

The DSM-IV was the first manual to address cultural variations in the phenomenology and epidemiology of disorders. Such a change followed calls to attend to cross-cultural issues in psychiatric nosology in the 80s and 90s (Fabrega, 1987; Kroll, 1988; Lock, 1987; Stein, 1993). In response to such complaints, the DSM-IV Task Force approached several experts in cultural psychiatry to devise a culture and diagnosis study group in 1991 (Mezzich, Berganza, & Ruiperez, 2001). However, many of the statements that the study group eventually submitted to the DSM-IV Task Force were drastically shortened or omitted (Mezzich et al., 2001). Some of the new culture-specific elements that the DSM-IV ultimately included are (a) in-text discussion of cultural variation in the clinical presentation of disorders, (b) the Cultural Formulation Model and (c) the Glossary of Culture-Bound Syndromes, these last two located in the second-to-last Appendix of the manual (American Psychiatric Association, 2000; Mezzich et al., 2001). The PTSD cultural considerations subsection in particular was limited to a paragraph discussing the possibility that PTSD is more prominent among migrants from regions vulnerable to civil conflict, and that it may be difficult for these individuals to talk about their trauma because of their vulnerable political status. This description neither confirmed nor denied cultural variation in the phenomenology, epidemiology, onset or severity of PTSD.
Current Conceptualizations of PTSD in the DSM-5 and the ICD-11. The fifth revision of the DSM, published in 2013, again presented significant revisions to the PTSD criteria. Some of the most important changes in this manual include (a) further defining the nature of the trauma event criterion and removing the peritraumatic response condition previously established in DSM-IV, (b) dividing the avoidance and numbness cluster into two separate clusters, one focused on avoidance symptoms, and another focused on negative alterations in cognition and mood, (c) creating two PTSD subtypes, one for PTSD patients with dissociative symptoms and a preschool type for children ages six and younger, and (d) housing PTSD under a new disorder section called Trauma- and Stressor-Related Disorders instead of its original location under the manual’s Anxiety Disorders.

Under the DSM-5, individuals aged seven and older are diagnosed with PTSD when they meet the gateway traumatic stressor (Criterion A), at least one of five possible re-experiencing symptoms (Criterion B; intrusive thoughts, nightmares, dissociative reactions, psychological reactions to reminders, physiological reactions to reminders), at least one of two possible avoidance symptoms (Criterion C; avoidance of thoughts or feelings, avoidance of people, places or activities), at least two of seven possible symptoms of negative alterations in cognition and mood (Criterion D; psychogenic amnesia, negative beliefs about the self, others or the world, distorted blame of self or others, persistent negative emotional state, diminished interest in activities, detachment from others, restricted positive affect), and at least two of six possible hyperarousal symptoms (Criterion E; irritability or anger, reckless behavior, hypervigilance, heightened startle response, difficulties concentrating, sleep disturbance). Symptoms
must also persist more than a month (Criterion F), cause significant distress or impairment (Criterion G), and not be accounted for by medical conditions or substances (Criterion H). In this new version, specifier options allow clinicians to note whether symptoms have “delayed expression” rather than “delayed onset” as previously noted in DSM-IV (American Psychiatric Association, 2013).

The ICD-11 is scheduled for release in 2018 (World Health Organization, 2015), but various empirical and position papers have already been published regarding its proposed PTSD criteria. The ICD-11 Working Group on the Classification of Stress-Related Disorders is proposing two conceptualizations of PTSD, one simply labeled PTSD and another labeled complex PTSD (Cloitre, Garvert, Brewin, Bryant, & Maercker, 2013; Maercker et al., 2013). Both types of PTSD require the experiencing of a traumatic stressor as a gateway criterion. However, whether patients are diagnosed with simple or complex PTSD depends on the pattern of symptoms they exhibit. Simple PTSD aims to capture the experience of individuals who present with the three classical PTSD symptom clusters of re-experiencing, avoidance, and hypervigilance. Specifically, such individuals must present with at least one re-experiencing symptom (nightmares, or flashbacks about the trauma), one avoidance symptom (avoidance of thoughts or feelings about the trauma, or avoidance of activities, people or places that remind them of the trauma), and one hyperarousal symptom (hypervigilance or heightened startle response). Complex PTSD, on the other hand, will only be assigned to individuals who, in addition to presenting with symptoms in the three core symptom clusters, also feature significant impairments in “systems of self-organization” (Cloitre et al., 2013, p. 2). Specifically, the individual must also show affect dysregulation (heightened emotional reactivity, violent outbursts,
reckless or self-destructive behavior, dissociative states under stress, emotional numbing), negative self-concept (feelings of worthlessness, feelings of guilt and shame for not overcoming the trauma or not protecting others), and difficulty in interpersonal relationships (detachment from others, avoidance or diminished interest in relationships, difficulty maintaining emotional engagement in existing relationships), although the Working Group has not yet published how many symptoms must be exhibited in each of these clusters to fulfill the Complex PTSD Criteria (Cloitre et al., 2013; Maercker et al., 2013). The Complex PTSD conceptualization is aimed to capture the experience of individuals who have experienced chronic traumas like childhood sexual abuse, torture, and genocide, although the Working Group acknowledges that these types of trauma are risk factors, not requirements of Complex PTSD (Maercker et al., 2013). Like the DSM-5, the proposed ICD-11 criteria require the disorder to be present beyond the one-month mark and to cause significant functional impairment.

The DSM-5 and the ICD-11 working groups have each documented their rationale for their chosen conceptualization of PTSD while being critical of the other group’s work. Their lively debate was published as a symposium in the October 2013 issue of the *Journal of Traumatic Stress Studies*. DSM-5 Working group members proposed that they did not wish to deviate from the existing DSM-IV criteria unless they were presented with strong evidence for modifying it (Friedman, 2013a). The ICD-11 group, in contrast, reported that they sought to establish a parsimonious version of PTSD, displaying only its “core” symptoms (re-experiencing, avoidance, hyperarousal), and that they were not obliged to privilege the existing DSM-IV or ICD-10 criteria when developing the new PTSD for ICD-11 (Maercker & Perkonigg, 2013). This group argued
that a parsimonious set of symptoms would reduce comorbidity with Major Depression Disorder and Generalized Anxiety Disorder and/or exclusion of individuals who until now have been categorized as having subthreshold PTSD (Brewin, 2013). In response, the DSM-5 working group has reported that they advocate for a broad definition of PTSD because they wish to provide clinicians with the full menu of symptoms “that would adequately cover the most typical clinical presentations” of PTSD (Friedman, 2013a, p. 550). Further, they stated that even though it is more difficult to diagnose PTSD with their diagnostic rules, this disorder had more reliability than any other disorder in the DSM field trials (Kilpatrick, 2013).

The ICD-11 working group also argued that the “complex PTSD” type is a result of existing research on individuals who have different treatment needs than those who meet criteria for simple PTSD, given their interpersonal affect regulation difficulties (Maercker & Perkonigg, 2013); on the other hand, the DSM-5 group argued that there is not enough evidence for such a subtype (Friedman, 2013b). Both groups, however, concur that many of the symptoms in the ICD-11 “complex PTSD” can be found as part of the negative mood and cognitions cluster and the dissociative symptoms cluster of the DSM-5 PTSD criteria (Friedman, 2013b; Maercker & Perkonigg, 2013).

**Cultural considerations of PTSD in the DSM-5.** The DSM-5 implemented three major changes to address cultural considerations (American Psychiatric Association, 2013). First, the manual expanded the in-text discussion of culture-related diagnostic issues for many disorders, including PTSD. Second, it presented an updated version of the Cultural Formulation Outline and provided a Cultural Formulation Interview field tested for diagnostic and patient acceptability. Third, it replaced the DSM-IV section on
culture-bound syndromes with a more comprehensive description of cultural syndromes, idioms of distress, and cultural explanations of disorders. This formulation formally acknowledged for the first time that DSM disorders can be conceptualized as cultural syndromes rather than universal constructs. Finally, the manual relabeled the DSM-IV’s Glossary of Culture-Bound Syndromes into a Glossary of Cultural Concepts of Distress, where the terms listed are clarified as either cultural syndromes or idioms of distress (American Psychiatric Association, 2013). The in-text discussion of cultural considerations for PTSD offers for the first time some information on regional differences in PTSD prevalence around the world, as well as racial and ethnic differences in PTSD prevalence within the U.S. Further, this subsection now discusses how risk of onset and severity of PTSD may vary depending on type of trauma event exposure and sociocultural factors. Finally, it also acknowledges that symptom expression and symptom organization may vary culturally (American Psychiatric Association, 2013, p. 278).

*Cultural considerations of PTSD in the ICD-11.* The ICD-11 PTSD Working Group has stated that the World Health Organization aims to facilitate discourse of mental health disorders across nations (Maercker & Perkonigg, 2013). However, it is unknown at this time whether there will be a discussion of cultural considerations for any disorder in the manual.

The history of PTSD shows that, although central features of PTSD have been identified and kept over the course of time, multiple aspects of the disorder have changed with each iteration of the DSM and the ICD. Further, the history of PTSD illustrates how
the sociopolitical and cultural climate preceding the launch of each diagnostic manual influenced the type of information was subsequently included.

Universalist and Relativist Approaches to the Study of Mental Health Disorders. Psychologists have questioned whether mental health disorders are universal (equally experienced across different cultural groups) or culturally-specific (Kirmayer, 2001; Nell, 1999). With regards to PTSD and other mental disorders, an universalist framework would posit that the disorder’s symptom structure, behavioral expression, etiology, and prevalence rates, are equal across cultures. In this position, PTSD is seen as a “natural kind,” such that it “exists independent of its sociocultural context” (Herbert & Forman, 2010). In contrast, a relativist perspective would argue that, although physiology and neuroanatomy may be equivalent across cultures, behavioral expressions are influenced by individual and environmental factors. Herbert & Forman (2010) argued that the presentation of symptoms not only varies across cultures, but also evolves across time, because it is “socially-construed and therefore culture-bound” (p. 238). On the more extreme positions of relativism, the construct of PTSD can be considered a culture-bound syndrome unique to industrialized, Western societies (Marsella, 2010), that does not represent the experience of people from other cultures.

PTSD researchers aware of this debate have endeavored to determine what aspects of PTSD might be universal and what aspects might be culture-specific (Herbert & Forman, 2010; Hinton & Lewis-Fernández, 2011; Marsella, Friedman, Gerrity, & Scurfield, 1996). One line of inquiry focuses on how people from different cultures define traumatic events. Events that threaten a person’s safety or integrity, for instance, may be potentially traumatic for people around the world, but people’s appraisal of what
infringes upon one’s safety or integrity is dependent on the ethnocultural context. For instance, Tibetans ranked destruction of religious symbols as more traumatic than the death of a friend, or personally experiencing torture (Terheggen, Stroebe, & Kleber, 2001). These events may be experienced differently by persons who hold other religious and cultural beliefs.

Another area of inquiry is whether some of the PTSD symptoms are universal and whether some may be culture-specific. Symptoms related to the autonomic nervous system (re-experiencing and hyperarousal symptoms), for instance, have been identified as universal because they have been reported in ethnographic studies among members of non-Western cultures, such as Cambodian refugees (Hinton et al., 2010; Kinzie et al., 1998), and Kalahari Bushmen (McCall & Resick, 2003). This is consistent with the notion that some of the PTSD symptoms are biologically based and largely involuntary, whereas others are learned behaviors (e.g., avoidance) and consequently largely influenced by sociocultural factors. However, there is evidence that even seemingly neurobiological reactions can be culturally influenced. For instance, it has been found that people of certain cultural groups promote attention to interoceptive cues (the extent to which one is aware of body sensations) to a greater extent than others (Chentsova-Dutton & Dzokoto, 2014; Ma-Kellams, 2014), which may explain why somatic symptoms may be more salient in trauma syndromes among such cultures. For instance, body heat is a trauma-related symptom identified by Mandinka practitioners in West Africa (Rasmussen, Smith, & Keller, 2007) and calor (also body heat) has been identified as a prominent trauma-related symptom by Salvadoran women refugees (Jenkins & Valiente, 1994).
Marsella et al. (1996) concluded that the diagnosis of PTSD can be identified in any cultural group, but that prevalence rates across countries will vary as a result of cultural differences in symptom presentation (e.g., some of the required symptoms may not be endorsed by survey respondents because they are not as common in that culture). McCall and Resick (2003) have argued that the PTSD diagnostic criteria can be found across different countries largely because PTSD studies tend to be conducted with urban samples. The assumption is that individuals living in urban centers are subject to globalization and, as such, idioms of distress imported from Western cultures (e.g., through media and economic exchanges) may influence or replace local ones. In turn, they posited that people in hunter-gatherer societies and/or who live in rural spaces in non-Western countries would be more likely to show idioms of distress that are different from those of individuals who have a Western conception of PTSD.

**PTSD Phenomenology Among Spanish Speaking Latinos.** A few studies have utilized ethnographic methods to explore the way Latinos describe their behavioral and physiological reactions to trauma. For instance, early ethnographic research with Salvadoran refugees (Jenkins, 1996; Jenkins & Valiente, 1994) found that nightmares, sleep disturbance, irritability, and concentration problems were common among Salvadoran female survivors of political and domestic violence. Norris et al. (Norris et al., 2001) also found that Spanish speaking Mexican disaster survivors reported symptoms that matched DSM-IV PTSD criteria, such as intrusive thoughts, emotional and physiological reactions to reminders of the trauma, avoidance of thoughts and reminders, hypervigilance, distressing dreams, flashbacks, diminished interest in activities, irritability, inability to recall aspects of the event, detachment from others,
restricted affect, and sleep disturbance. This sample, however, reported additional expressions that did not match with DSM-IV criteria, such as *ataques de nervios*, depression, reports of being deeply traumatized, somatic symptoms, and physical weakness.

More recently, qualitative interviews conducted by Eisenman et al. (2008) found specific idioms of distress to describe post-trauma reactions among immigrant Latinos in New York and New Jersey who screened positively for DSM-IV PTSD criteria. Participants in this study used the words *triste* (sad), *enojado/a* (angry), *nervioso/a* (nervous), and *miedo* (fear; Eisenman et al., 2008). Across the interview, which inquired about the way in which the trauma event impacted their lives, participants reported experiences that reflected the official PTSD criteria, including intrusive thoughts, concentration problems, nightmares, sleep problems, irritability, avoidance of thoughts and activities reminiscent of the event, isolation, and distrust of others. When asked about the perceived effect of the trauma on their physical health, participants also described a series of physical symptoms, particularly headaches. Other symptoms included poor appetite, dizziness, changes in blood pressure, high blood sugar, asthma, stomach ulcer, gastritis, body pains, constipation, high cholesterol, arthritis, and liver and heart problems.

Altogether, qualitative data on the expression of PTSD symptoms among Latinos suggest that many of the symptoms identified match the description of PTSD specified in the DSM-IV; however, these studies have also shown that Spanish speaking Latinos may experience additional symptoms (e.g., somatic symptoms, depression) and express specific idioms of distress following the experience of a trauma.
Universalism and Relativism and the Cross-Cultural Adaptation of Measures. The professional debate on whether mental health disorders are universal or culture-specific experiences also seeps into the discussion of whether assessment measures should be culturally adapted or not. An universalist perspective not only would posit that the construct does not vary as a result of culture, but also that the assessment methods utilized to evaluate the construct within one culture would still produce valid scores for members of another culture as long as the assessment is translated to the language of the second group. As such, a measure of PTSD developed in the U.S. for English speakers would be expected to function equally well with Spanish speaking Latinos, provided that the content of the measure is translated to convey the intended meaning of the original items. In contrast, a relativistic perspective would hold that the cultural adaptation of measures is critical because assessment methods are also subject to the influence of culture.

As a researcher who seeks to adapt a PTSD measure, I advocate for this perspective. Based on my review of the literature regarding the cross-cultural equivalence of PTSD as a construct, my stance is that PTSD symptoms can be recognized among many different cultural groups, but that the words and colloquialisms used to express these symptoms will vary according to regionally constructed narratives about these phenomena. As a result, I argue that there are likely language and cultural factors that need to be taken into account to minimize measurement error of psychological constructs.

Considering the CAPS-5 for Translation and Adaptation. If we were to choose an instrument to be adapted for Spanish speaking Latinos, it would be ideal to find an instrument that allows for the diagnosis of PTSD using both the DSM and the
ICD criteria. Doing so would allow researchers to have the widest reach possible. Items in the CAPS, however, were developed to reflect the DSM-5 PTSD criteria alone. Fortunately, it may be possible to utilize prompts from the CAPS to evaluate PTSD utilizing ICD-11 criteria.

Despite the differences in conceptualization of PTSD by the DSM-5 and the ICD-11 working groups, a comparison of these conceptualizations reveals that most symptoms listed by the ICD-11 proposed criteria are subsumed under the list of symptoms in the DSM-5 (see Table 2 for an analysis of item correspondence). Specifically, 10 symptoms are equivalent across both classification systems: intrusive memories of the trauma, nightmares, effortful avoidance of thoughts and feelings, effortful avoidance of trauma reminders, detachment or estrangement, emotional numbing, hypervigilance, irritable behavior and angry outbursts, reckless or self-destructive behavior, and heightened startle response.

Additionally, three other symptoms are similar across the manuals, but with some differences in meaning or implications. Symptoms of dissociation, for instance, are included in the DSM-5 as dissociative reactions and in the ICD-11 as tendency towards experiencing prolonged dissociative states when under stress. It appears that the ICD-11 would only assign this symptom when the patient experiences dissociation under stress, whereas the DSM-5 would assign it regardless of stress as a trigger for dissociation. Similarly, the DSM-5 counts negative cognitions about the self, others and the world, whereas the ICD-11 counts only persistent beliefs about oneself as diminished, defeated or worthless. Finally, the DSM-5 includes persistent negative emotional states (inclusive
of fear, horror, anger, shame, and guilt) whereas the ICD-11 refers to deep and pervasive feelings of shame or guilt toward the self only.

Finally, some symptoms are listed in one manual but not the other. Specifically, the ICD-11 symptom of heightened emotional reactivity is not listed in the DSM-5, whereas seven symptoms in the DSM-5, psychological reactivity to trauma reminders, physiological reactivity to trauma reminders, dissociative amnesia, distorted blame of self or others, diminished interest in activities, problems with concentration, and sleeping disturbance, are not included in the ICD-11.

In my analysis of PTSD criteria across the DSM and the ICD (Table 2), 13 of the 15 possible PTSD symptoms in the DSM-5 correspond to 13 of 14 possible PTSD symptoms in the ICD-11’s Complex PTSD diagnosis, the more extensive version of PTSD criteria in this manual. Given the strong correspondence between both classification systems regarding criteria for PTSD, it can be argued that translating and adapting the CAPS-5 for Spanish speakers also can be of utility for ICD-11 users.

The Cultural Equivalence of PTSD Assessments for Latinos with LEP

How do clinicians assess for PTSD? In particular, how do clinicians assess Spanish speaking Latinos for PTSD? In this section, I provide an overview of existing assessment tools for the evaluation of PTSD, comparing the availability of tools developed to serve English speakers and Spanish speakers. In this analysis, I demonstrate that PTSD measures in Spanish are scarce when compared to the breadth of tools available for English speakers.

Beyond the fact that PTSD tools in Spanish are scarce, however, there is the additional problem of whether the users of such tools are utilizing them appropriately.
Clinicians and researchers utilizing these tools need to understand how to use them sensitively with an increasingly diverse population. Therefore, in this section I also review existing recommendations on how to work with patients who have experienced trauma, as well as considerations on how to conduct culturally sensitive assessments with Latinos. Such recommendations were taken into account when adapting my chosen PTSD measure, to ensure that best assessment practices for this population are reflected in the training of CAPS users working with Latinos.

**Existing PTSD Instruments in English.** To know the state of the field on PTSD assessments in Spanish, it is important to first conduct a brief review of PTSD assessments available in English. The PTSD tools surveyed in this review have predominantly utilized DSM-IV criteria, but some measures do not use the full DSM-IV criteria, or utilize the ICD-10 criteria. As of August 2015, only three tools had been updated to reflect DSM-5 criteria, the CAPS-5 (Weathers et al., 2013b), the PTSD Checklist for DSM-5 (PCL; Weathers et al., 2013c), and the Life Events Checklist for DSM-5 (LEC; Weathers et al., 2013a).

PTSD assessment encompasses two steps, (a) evaluation of trauma exposure, and (b) evaluation of the symptom clusters (re-experiencing, avoidance, negative cognitions, and hyperarousal). Measures exist for both the evaluation of trauma exposure and the evaluation of PTSD symptoms. Some examples of trauma-exposure measures, such as the LEC (Weathers et al., 2013a) are listed in Table 3. However, the focus of this review is to list assessment tools that evaluate for PTSD symptoms. Such measures can be categorized as (a) biopsychological measures, (b) self-report measures, and (c) semi-
structured interviews (The National Academies Press, 2006). Different instrument types present with their own advantages and disadvantages, as reviewed next.

**Biopsychological measures.** These measures refer to the evaluation of physiological responses (e.g., heart rate, sleep disturbances), behaviors (e.g., length of eye contact with stimuli) or brain structures (e.g., hyperactivation of the amygdala, hypoactivation of prefrontal cortex, volume of the hippocampus) associated with PTSD. As an example, experimenters may measure physiological and/or behavioral responses at baseline, during, and after exposure to a trauma-related stimulus, compared to a control stimulus. Researchers may also evaluate biological markers associated with PTSD in cross-sectional studies (e.g., comparing patients with PTSD against trauma-exposed patients without PTSD or against people without exposure to trauma), as well as in longitudinal studies among special interest populations (e.g., soldiers before and after exposure to war). Biomarkers may be examined via use of imaging technology, such as fMRIs (The National Academies Press, 2006). Biopsychosocial measures present the advantage of documenting the physiological symptoms of PTSD in ways that do not rely on patient self-report and cultural adaptation. These measures, however, may rely on equipment not available in all clinical settings, may require special training to manipulate the equipment, and although they provide objective data on physiological information, it is not the most appropriate source of data to measure PTSD symptoms that rely on self-report or observation over time (e.g., amnesia, re-experiencing).

**Self-Report Measures.** These instruments are widely used in clinical and research practice. They may be presented in paper-and-pencil or computer format. Most of them assess for PTSD using the full DSM diagnostic criteria and are brief, with
administration lasting between five and 20 minutes. Self-report measures can be further categorized as (a) PTSD-only measures, which exclusively evaluate for PTSD symptoms (e.g., the PTSD Checklist; Weathers et al., 2013c), and (b) PTSD subscales within a larger measure, as is the case for the Keane PTSD Scale (Keane, Malloy, & Fairbank, 1984; Lyons & Keane, 1992) within the Minnesota Multiphasic Personality Inventory 2 (MMPI-2; Butcher, 1989). Table 3 presents a list of well-known self-report PTSD measures.

*Semi-Structured Interviews.* These tools provide a comprehensive evaluation of symptoms as well as the nature of the trauma via face-to-face interviews. In these assessments, the clinician asks questions and scores the patient on a rating scale based on the subjective information the patient communicates and the observations made during the interview. These instruments feature standardized prompts that can be followed up with clarification questions posed by the clinician. They also require a higher level of training, compared to self-reports, to ensure standardized administration and scoring. These instruments utilize the full DSM or ICD diagnostic criteria and are lengthier to administer (between 40-120 minutes) than self-report measures. Like self-report measures, semi-structured PTSD assessments may be classified as (a) PTSD-only interviews, which evaluate PTSD exclusively, such as the CAPS (Blake et al., 1995), or as (b) PTSD modules that are part of a larger diagnostic instrument, such as the PTSD Module within the Structured Clinical Interview (SCID; First, Spitzer, Gibbon, & Williams, 1996). See Table 3 for a list of these instruments.

The majority of self-report measures and semi-structured interviews available to evaluate PTSD among English speakers have existing documentation of the measure’s
creation and psychometric evaluation. However, as I note in the next section, documentation of the measure’s creation and psychometric evaluation is not usually available for measures in Spanish.

**Existing PTSD Instruments in Spanish.** There are fewer PTSD assessment tools in Spanish when compared to PTSD instruments available in English. Of the 12 PTSD instruments in Spanish found in the literature (see Table 4), five of them are structured interviews and seven are self-report measures. Whereas four of the five PTSD interview instruments are PTSD modules within larger clinical instruments (the Structured Clinical Interview for DSM Disorders I [SCID-I], the Psychiatric Research Interview for Substance and Mental Disorders [PRISM], the World Health Organization World Mental Health Composite International Diagnostic Interview [WHO WMH-CIDI], and the Diagnostic Interview Schedule, Version Three [DIS-III]), only one is a PTSD-focused clinical interview (the CAPS). In contrast, six of the seven self-report measures found assess only for PTSD symptoms (PCL-C, RCMS, SPRINT-E, TSI, DTS, PTSD-C), whereas only one of these measures is a test subscale in a larger instrument (The Keane PTSD subscale within the MMPI-2). All of the instruments discussed in this paragraph reflect DSM-IV criteria for PTSD. Among the PTSD instruments that were recently released to reflect DSM-5 criteria, only the CAPS-5 has been translated to Spanish by a team of researchers in Puerto Rico (Vera Ríos, personal communication, November 2013).

It is important to note that measures sometimes have more than one Spanish version to cater to the language of different countries. For instance, the CIDI and the CAPS for DSM-IV each have a Spain version and a U.S. Spanish version. In other cases,
the measures were translated in the context of certain Spanish speaking countries only. For instance, the DIS-III and the TSI were translated for samples in Puerto Rico, and one version of the PCL-C was translated for a sample in Chile.

Among these measures, only five instruments have existing documentation of how they were translated and adapted (DIS-III, PRISM, PCL-C, RCMS, and TSI; see Table 5). Neither the Spanish language CAPS using DSM-IV or DSM-5 criteria has documentation of the translation and adaptation procedures utilized as of yet. In contrast, all Spanish language PTSD instruments using DSM-IV criteria have at least one study that examined their psychometric properties. This trend suggests that studies conducting psychometric evaluation are easier to conduct or are more valued than studies that document the steps taken to conduct the translation.

The lack of studies documenting the steps taken to adapt these measures for Spanish speaking populations constitutes an important research gap. In practice, clinicians and researchers may realize that the translations are not fully applicable to certain subgroups of Spanish speakers, but there is little empirical evidence examining the measures’ suitability for different samples. If the measures were to be confusing for the sample of interest, instrument scores may overestimate or underestimate the true value of the symptoms assessed because of instrument bias. This points to the need for future translations to produce the necessary documentation of translation and adaptation.

**General Considerations in the Assessment of PTSD.** Mueser, Rosenberg, and Rosenberg (2009) provided useful considerations for the assessment of PTSD. First, given that the clinician’s assessment of symptoms is based on a patient’s report, clinicians are encouraged to consider the client’s reliability in remembering, verbalizing,
and assessing the trauma event and post-traumatic symptoms. Verifying the accuracy of a patient’s report may be especially challenging if the trauma event happened years ago. Second, clinicians should be sensitive to patients’ experiences of apprehension, fear, and shame when discussing traumatic events in their lives. It would be crucial for clinicians to build strong rapport with the patient and react nonjudgmentally to patient disclosure. Third, clinicians are urged to delineate the extent to which symptoms are attributable to the identified trauma or to other causes, pre- or post-trauma, such as the loss of a job or becoming homeless. Indeed, a symptom may be associated with other trauma events beyond the event chosen for the interview, and as such, it would be important to consider the patient’s perception and clinical judgment to determine which event is more strongly related to the symptom. Fourth, the purpose and context of the assessment should be considered when choosing what tools to use. Shorter, self-report measures may be more appropriate as screening tools in primary care settings, or as part of a clinical intake to evaluate if PTSD is part of a patient’s presenting problem in a clinical setting. Longer, more comprehensive assessments are typically used as outcome measures in a research study, to establish baseline scores and track changes over time. The time available to administer the measure, the data collection method (e.g., computerized, over the phone, in person), the type of setting (e.g., public vs. private) and the clinician’s level of expertise in administering and scoring the assessment, are also relevant considerations in determining which type of measure to use. Finally, clinicians have a responsibility to consider if the measure is appropriate for the client population in terms of language, cultural relevance, and availability of test norms (Mueser et al., 2009).
General Considerations in the Assessment of Latinos

Regionalisms and Phrases Without a Direct Translation. Although Spanish speakers “speak the same language,” people in different regions have also developed unique phrases or words to refer to certain objects or concepts (Puente et al., 2013). A common example is the different words for the fruit orange. Whereas in standard Spanish the translation would be naranja, in Puerto Rico it is known as china. China would, in turn, be confusing to people outside of Puerto Rico, given that this word is also used to refer to a Chinese female. These regional differences are akin to differences between British and U.S. American English, or even regional differences within the U.S. (“soda” vs. “pop” to refer to carbonated beverages). Specific slang words or phrases may also be common according to the client’s generation (e.g., a person who grew up in the 1970s vs. one who grew up in the 1990s). Regarding the assessment of PTSD, some words do not have a translation to the Spanish lexicon of everyday life. For instance, flashbacks, a psychological term that has become part of popular English language, does not have a translation to Spanish and necessitates additional details to convey the meaning intended (e.g., sudden memories where you might feel as if you are re-living the experience). In cases like this, additional attention is necessary to ensure that the translation and backtranslation truly reflect equivalent meanings.

Pronunciation, Regionalisms, and Rapport. Spoken Spanish varies in speed, intonation and pronunciation across the Americas and these differences depend on the region of origin, social class, and level of formal education (Cofresí & Gorman, 2004; Puente et al., 2013). For instance, Spanish speakers from South American countries, and in particular those who come from cities in the Andean region, tend to carefully
pronounce letters and syllables in words, whereas Spanish speakers from coastal cities and from the Caribbean soften or drop the final \( s \) in words. In Latin America, the use of standard Spanish and pronunciation that carefully pronounces letters and syllables is associated with higher levels of formal education and social status (Cofresí & Gorman, 2004; Puente & Ardila, 2000). As a result, the differences in pronunciation and regionalisms between clinician and patient may make the differences in social status and level of formal education jarring. For instance, a clinician using standard Spanish may be perceived as unapproachable, or at worst, self-important and distant, to a working-class Latino (Puente et al., 2013). The impact of pronunciation style and standard Spanish can, however, be balanced with verbal and nonverbal efforts to help the client become comfortable.

**Simpatía, Expectations of the Research Interview, and Rapport.** Clinicians should also be aware that Spanish speaking Latinos are less likely to know what to expect of a research interview or test-taking setting when compared to English speaking individuals in the U.S., given that test-taking in Latin American countries is not as common as it is in this country (Rodríguez, 1992). As such, the experience of participating in a semi-structured interview may not be what they expected when they first signed up to participate.

**Simpatia**, as originally defined by Triandis et al. (Triandis, Marín, Lisansky, & Betancourt, 1984), refers to a cultural script among Latinos that promotes conformity, respect toward others, and a general avoidance of conflict in order to maintain harmonious relationships (Ramírez-Esparza, Gosling, & Pennebaker, 2008; Triandis et al., 1984). **Simpatia** may influence the assessment task in at least two ways. First, if the
clinician does not show warmth as expected by the cultural script of simpatía (e.g., by interrupting the client from finishing a long story; by looking at notes while writing instead of looking at the patient while he or she speaks), the interviewee may perceive the clinician as impersonal and cold. Second, in the spirit of avoiding conflict, the interviewee may engage in “passive noncooperation” (Triandis et al., 1984) rather than express disagreement or communicate discomfort. A possible recommendation to navigate the expectation of warmth through the interview is for clinicians to explain that they are listening to every word even while jotting notes down, and that there may be a need to interrupt at times, not because of lack of interest, but because there are many questions pending to ask within the interview’s timeframe. These reminders can show the clinician’s understanding of the patient’s expectations and provide a rationale for not adhering to the cultural script.

The Association Between Language and Emotion. Emotional expression has been linked to language, such that “each language might have access to a specific set of memories, attitudes, beliefs, and values” (Cofresí & Gorman, 2004, p. 101). Bilingual individuals who speak English or Spanish in different contexts have been noted to express greater emotion when responding in Spanish (Guttfreund, 1990; Schwanberg, 2010). Specifically, research on memory retrieval among bilinguals suggests that people who speak more than one language encode the information in the language they used when they were experiencing the events (Schwanberg, 2010). When it is time to retrieve episodic memories stored in Spanish, it is easier to do so in Spanish to access richer descriptions and the affective information attached to them (Schwanberg, 2010). Schwanberg’s subsequent research, which evaluated the intensity of PTSD symptoms
among bilingual survivors of childhood sexual trauma, found that when bilingual individuals were assessed in Spanish, they were more likely to report symptoms more intensely than when they were interviewed in English.

Altogether, some of the findings reviewed can be incorporated into the cultural adaptation of PTSD measures for Spanish speaking Latinos. For instance, having assessment tools in Spanish would allow patients to access richer affective data than if asked to conduct them in English. In addition, the modification of words and phrases to match the cultural context of Latino patients is likely to facilitate rapport and foster trust and cooperation, which would result in more reliable and valid data. However, some recommended adaptations to the assessment process can only be achieved if the interviewer is familiar with, and is willing to enact, cultural scripts (such as simpatía) that communicate respect, interest in the patient’s story, and amenability.

**Cross-Cultural Equivalence of Measures: Terms and Conceptual Models**

In the following section, I present an overview of cross-cultural equivalence terms and conceptual frameworks that guide my research methods. Specifically, I review the concepts of validity, bias, and cross-cultural equivalence and describe well-known models of validity and cross-cultural equivalence. I conclude by explaining how these frameworks guide the adaptation of my chosen PTSD measure.

**Key Concepts in the Development of Cross-Culturally Valid Measures**

**Validity.** The Standards of Psychological and Educational Measurement (AERA, APA, NCME, 1999), define *validity* as “the degree to which evidence and theory support the interpretation of test scores entailed by the proposed used of tests” (p. 6). This definition of validity establishes two critical points. First, the purpose of a given
instrument should be clear, so that researchers can verify whether the measure’s items and format fulfill its purpose. Second, both theory and empirical evidence should be considered when determining the validity of a measure. Specifically, the Standards demand a “scientifically-sound validity argument to support the intended interpretation of test scores and their relevance to the proposed use” (p. 9). Thus, the Standards emphasize an integration between empirical research and theory as the source of evidence that can support the validity of scores in measurement instruments.

**Bias.** The total variance in scores can be accounted for by (a) the variance of the construct that an instrument aims to measure, and (b) by either random or systematic measurement error. **Bias** refers to systematic measurement error due to other constructs that the instrument is unintentionally measuring, above and beyond the target construct. Cultural bias, in particular, refers to the variance accounted for by tendencies or characteristics of the group of interest, rather than by the construct being examined (Knight, Roosa, & Umaña-Taylor, 2010a; Poortinga, 1989; van de Vijver & Leung, 2011).

Researchers have identified different ways in which bias may creep into in measures administered to different cultural groups. Measures may exhibit **construct bias** when they reflect cultural discrepancies in the conceptualization of the target construct for at least one of the cultural groups evaluated. A measure has construct bias when the construct does not exist, or exists only partially in one of the two cultural groups. A measure may present with **method bias** when the study design procedures are not congruent with the population of interest. There are three subtypes of method bias, **sampling bias, administration bias, and instrumentation bias.** Sampling bias exists when
the characteristics of the two cultural groups examined are not comparable. Administration bias occurs when the way in which the assessment is administered influences the scores. Instrumentation bias exists when test takers have different familiarity with response procedures. Finally, a measure may show item bias when the wording or format of items is unclear or confusing for one of the cultural groups evaluated (Poortinga, 1989; van de Vijver & Leung, 2011).

A well-known example of method bias in the measurement of Latino populations is the concept of extreme response bias (Marín, Gamba, & Marín, 1992; Weech-Maldonado, Elliott, Oluwole, Schiller, & Hays, 2008), which refers to Latino individuals’ tendency to choose the extreme anchors on a Likert-type scale more often than non-Latino White populations. In this type of bias, a measure’s response format (use of Likert-type scales) inadvertently affects the participants’ responses. This, in turn, can lead to validity coefficients that are either upwardly or downwardly biased (Knight et al., 2010a). Instrumentation bias can, therefore, result in severe over- or under-estimation errors in research interpretations of mean differences between groups, or in the comparison of associations between constructs across groups.

Cross-cultural studies are always threatened by bias because participants in such studies cannot be randomly assigned to cultures, and groups rarely can be matched on other background variables (van de Vijver & Leung, 2011). To overcome this limitation, cross-cultural researchers should aim to reduce bias as much as possible via careful design of study methods, including the selection of measures that are equivalent for both groups under study.
**Equivalence.** This concept refers to the extent to which a measure is understood in the same manner across two or more differing groups (e.g., two different pan-ethnic groups, such as Latinos vs. White Americans, or two groups within a pan-ethnic group, such as Colombian-Americans vs. Cuban Americans; Knight et al., 2010a; Marsella, Dubanoski, Hamada, & Morse, 2000; van de Vijver & Leung, 2011). Equivalence and bias are complementary: the less bias there is, the more equivalence there is and vice versa. Equivalence has been conceptualized as a multi-pronged concept by different cross-cultural frameworks, which is discussed in the following section.

**Validity and Cross-Cultural Equivalence Frameworks.** A measure’s validity is contingent on the proposed use of the measure as well as on the characteristics of the population. A measure’s scores may be valid for one group but not for another, if the groups are sufficiently different from each other. A cross-culturally equivalent measure is one that generates valid scores for both cultural groups of interest. Depending on the differences between those two populations studied, a cross-culturally equivalent measure may actually comprise two versions of the measure that are quite different in wording and format (Canino & Bravo, 1994).

Researchers have developed various frameworks that describe the characteristics of valid measures, and what it takes for a measure to be considered cross-culturally equivalent for two or more groups. In this section, I describe a theoretical framework of measurement validity and three frameworks of cross-cultural equivalence. Further, I discuss how the principles proposed by these cross-cultural equivalence models guide my research questions.
The Standards of Psychological and Educational Measurement (AERA, APA, NCME, 1999) are the official guidelines in education and psychological research for examining the validity of measures. The Standards adhere to Messick’s validity framework (1989). According to this framework, evidence for validity can be gathered from five sources: (a) test content, (b) response process, (c) internal structure, (d) relations to other variables, and (e) consequences of testing. Test content, as a dimension of validity, refers to how well item wording, item format, and the guidelines for administration and scoring, match the intended meaning of the construct. Response process refers to the way in which the test taker conceptualizes the measure’s prompts and elaborates a response. This dimension of validity is concerned with determining whether the nature of the test taker mental process is congruent with what would be expected. Validity evidence drawn from the measure’s internal structure is concerned with the extent to which the assessment’s factor structure reflects the theoretical structure of its construct. In a measure evaluating a unidimensional construct, for instance, items would be expected to highly correlate with each other, whereas in a measure evaluating a multidimensional construct, items would be expected to cluster into hypothesized dimensions. The measure’s relation to other variables refers to the association of the measure to other external variables. Evidence toward the validity of a measure, in this respect, would imply that the measure has high correlations with other measures of the same construct (also known as “convergent validity”; Campbell & Fiske, 1959), low correlations to dissimilar measures (also called “discriminant validity”; Campbell & Fiske, 1959), and association to theoretically related constructs in a way that is consistent with theory (also called “predictive validity”; Cronbach & Meehl, 1955). Finally,
evidence for the validity of a measure can also be acquired by examining the consequences of testing. For instance, if a measure is aimed at distinguishing true cases vs. noncases, there should be evidence that the patients do differ in the specified diagnosis.

To evaluate the validity of scores, both qualitative and quantitative methods are necessary (International Test Commission, 2010). For instance, evidence for the appropriateness of test content can be collected qualitatively (e.g., by interviewing research participants about the clarity and relevance of the test content), whereas evidence for the fit of the factor structure of the measure can best be evaluated via quantitative methods.

The Standards can be a useful guiding framework to determine if a measure’s scores are valid for a given group. For instance, the authors of the CAPS referred to the Standards when organizing the evidence for the validity of the CAPS (Weathers et al., 2001). Research on the validity of measures for ethnocultural minorities, however, tends to refer to cross-cultural equivalence models rather than the official Standards. This is because measures for ethnocultural minorities tend to be adaptations of measures originally created for White populations rather than original assessment tools (e.g., Alegria et al., 2004; Beck, Bernal, & Froman, 2003; Weiss & Berger, 2006).

There are three cross-cultural equivalence models that are frequently cited in the adaptation of measures for ethnocultural minorities and international samples: the Measurement Equivalence model by van de Vijver and colleagues (van de Vijver & Leung, 2011; van de Vijver & Tanzer, 2004), the Cultural Equivalence Model by Marsella and colleagues (Marsella et al., 2000; Marsella & Kameoka, 1989; Marsella &
Leong, 1995) and another Cultural Equivalence Model by Flaherty and colleagues (Canino & Bravo, 1994, 1999; Flaherty et al., 1988). I summarize the general ideas posited by these models in the following paragraphs.

Measurement Equivalence Model. This measurement equivalence model (van de Vijver & Leung, 2011; van de Vijver & Tanzer, 2004) presents four levels of equivalence: (a) construct equivalence, (b) structural or functional equivalence, (c) metric or measurement unit equivalence, and (d) scalar or full score equivalence. Construct equivalence exists when the construct is equally understood or experienced by the two cultural groups studied. A construct may be partially or fully equivalent according to theory and empirical evidence available to support these claims. Researchers who take an emic, relativistic viewpoint to studying culture would argue that a given construct is tied to the cultural experience of the group studied and that its presentation could not be found in exactly the same way in other cultures (van de Vijver & Leung, 2011). Other researchers, however, may argue that some constructs are universal or at least partially equivalent across cultural groups. For instance, culture-bound syndromes such as ataque de nervios share many features with Panic Disorder, but they are theoretically linked to specific events (e.g., receiving bad news), whereas panic attacks in Panic Disorder are unexpected.

Structural equivalence is found when the factor structure of a measure is similar across both cultural groups of interest. Functional equivalence, which is a type of structural equivalence, exists when the nomological network of the measure’s construct can be replicated across both cultural groups of interest. For instance, a high negative
correlation between a depression measure and a happiness measure in both cultural groups of interest would be evidence of functional equivalence.

*Metric or measurement unit equivalence* implies that the measurement units or intervals of the scale are equal across cultural groups; however, the scale origin is not identical. Celsius and Kelvin scales share the same measurement units, but not the same scale origin. The 5-point distance between one score and another in the Celsius scale would equal to the 5-point distance between one score and another in the Kelvin scale. However, the value of scores (e.g., the mean score) is not equivalent across Celsius and Kelvin scales; therefore, one of the scales needs to be transposed (i.e., the mean needs to be shifted) so that a comparison can be made (van de Vijver & Leung, 2011).

*Scalar or full score equivalence* indicates that the measurement unit and the scale origin are identical across both cultural groups of interest. A PTSD scale that has scalar equivalence would allow for the direct comparison of mean scores between two cultural groups.

These four levels of equivalence are hierarchically nested. Scalar equivalence can only be achieved if the measure has metric equivalence; metric equivalence may only be present if there is structural equivalence, and structural equivalence may only exist in the presence of construct equivalence (van de Vijver & Leung, 2011).

**Cultural Equivalence Model.** This model (Marsella et al., 2000; Marsella & Kameoka, 1989; Marsella & Leong, 1995) presents four dimensions of equivalence: (a) linguistic equivalence, (b) conceptual equivalence, (c) normative equivalence, and (d) scale equivalence. *Linguistic equivalence* is relevant when examining the cross-cultural equivalence of a measure for groups that differ in language. Measures show linguistic
equivalence when the translation of the items reflects an accurate interpretation of the original items’ meaning. However, linguistic equivalence of a measure does not guarantee that the construct this measure intends to capture exists in the same way across both groups. Conceptual equivalence, in contrast to linguistic equivalence, indicates that the nature, meaning, and implication of the construct measured are similar across groups. As an example, the construct of “dependence” is not fully equivalent across U.S. and Japanese cultures. The concept of being dependent on others is valued among Japanese as important to societal harmony. However, being dependent on someone is perceived negatively in the individualistic U.S. mindset. Therefore, a dependence measure created in Japan, even if accurately translated to English (linguistic equivalence), may not capture the concept of dependence as experienced in the U.S. (conceptual equivalence).

Normative equivalence refers to the importance of using norms that are based on the cultural group of interest to interpret findings about that group. When studying PTSD among immigrant Latino farmers in Florida, for instance, results should be compared against norms that are based on this population or a population that is similar in terms of cultural background, age, or occupation rather than on norms developed with middle class college students. Finally, scalar equivalence exists when the scale format is similarly understood and used by members from the two cultural groups of interest. Differences in the test takers’ familiarity with the scale, response style, and social desirability can lead to scale inequivalence.

The Cultural Equivalence Model. This third model was originally proposed by Flaherty et al. (1988) but expanded upon by Canino and her colleagues at the University of Puerto Rico (Canino & Bravo, 1994). The Cultural Equivalence Model proposes five
dimensions of equivalence: (a) content equivalence, (b) semantic equivalence, (c) technical equivalence, (d) conceptual equivalence, and (e) criterion equivalence. 

*Content equivalence* exists when the items’ content reflects the construct as it is experienced in both cultural groups of interest. To achieve content equivalence, items can be established deductively by defining a universe and sampling items systematically within this universe (Canino & Bravo, 1994). *Semantic equivalence* is relevant when examining instruments that need to be translated. This type of equivalence implies that the meaning of each item is the same across both groups of study. In adapting an English language instrument for Spanish speaking populations in Puerto Rico, for instance, semantic equivalence would involve adjusting the wording of both measures such that the meaning of items is intelligible and meaningful for both groups (Canino & Bravo, 1994, 1999). Content and semantic equivalence are different in that the first refers to the existence and understandability of the measure’s construct to both cultural groups, and the second refers to the capacity of the measure’s wording to reflect the specified construct for both groups.

*Technical equivalence* exists when the method of assessment for each group yields comparable data across both groups of interest. Methods of assessment may refer to the contextual environment in which the assessment is conducted (e.g., at home, in a university setting, at a coffeehouse). It also refers to the method used to gather information (e.g., through questionnaires, structured interviews, or systematic observation). Because some ethnocultural minority groups are uncomfortable or unfamiliar with paper-and-pencil surveys, gathering data through an interview format may enhance the validity of the scores. Response bias in Likert-type scales, social
desirability, and acquiescence have all been cited as sources of measurement bias that contribute to technical inequivalence (Canino & Bravo, 1994, 1999).

Conceptual equivalence occurs when the relation between the measure’s construct to other theoretically related constructs is similar for both cultural groups of interest. Evidence for conceptual equivalence can be obtained by conducting convergent and discriminant validity analyses. Finally, criterion equivalence refers to the extent to which the measure maintains strong psychometric properties across both cultural groups of interests. These psychometric properties include concurrent validity (when the measure’s scores highly correlate with the scores of other measures of the same construct), interrater reliability (the measure’s stability across instrument users) and test-retest reliability (the measure’s stability across administrations), as well as sensitivity (the instrument’s ability to detect cases) and specificity (the instrument’s ability to discriminate cases from non-cases). A measure would have criterion equivalence when the indicators described are fairly similar across groups.

These three frameworks present common elements that are useful in generating questions for the qualitative examination of a measure’s cross-cultural equivalence. First, at least one dimension in each model seeks to minimize construct bias by highlighting that the construct measured should be understood similarly by both cultural groups of interest. In the van de Vijver and Leung model (2011), this dimension is labeled construct equivalence; in the Marsella and Leong model (1995), it is called conceptual equivalence; and in the Flaherty et al. model (1988), it is labeled content equivalence.

Second, one dimension in Marsella and Leong model (1995) and another one in Flaherty et al. model (1988) seek to minimize item bias by highlighting the importance of
analyzing item wording. Specifically, these dimensions seek to ensure that the item reflects the measure’s intended meaning in the same way for both cultural groups. In the Marsella and Leong model, this dimension is called linguistic equivalence, and in the Flaherty et al. model, it is called semantic equivalence.

Finally, one dimension in the Marsella et al. model (1995) and another one in the Flaherty et al. model (1988) seek to minimize method bias by highlighting that the measure’s format (e.g., choice of rating scale) and administration procedures can influence equivalence. In the Marsella et al. model, this dimension is called scalar equivalence, and in the Flaherty et al. model, it is called technical equivalence.

The three models also propose concepts that are relevant for the quantitative study of a measure’s cross-cultural equivalence. Van de Vijver and Leung (2011) and the Flaherty et al. (1988) noted the importance of verifying that the measure’s factor structure and relation to other theoretically related constructs are similar across cultural groups. In the van de Vijver and Leung model, the dimension called structural equivalence addresses both factor structure and nomological network considerations, whereas in the Flaherty et al. model, the dimension labeled conceptual equivalence addresses only nomological network considerations. Van de Vijver and Leung also highlighted the importance of establishing metric equivalence and scalar equivalence to ensure the cross-cultural equivalence of the instrument’s measurement unit. In contrast, Marsella and Leong (1995) highlighted the normative equivalence dimension, which states that an instrument’s scores should be compared against norms developed locally for the group of interest, and not compared against norms developed for other cultural groups. These three dimensions of equivalence aim to minimize method bias by examining carefully whether
the instrument’s measurement unit and testing norms are conducive to making appropriate interpretations about the cultural groups of interest.

Finally, Flaherty et al. model (1988) includes the criterion equivalence dimension, which is concerned with determining whether an instrument’s ability to detect caseness (whether a person meets criteria for a psychological disorder) is similar across cultural groups.

In the present study, I sought to create a translation of the CAPS-5 to Spanish that is culturally appropriate for Latinos with LEP. I sought to ensure that this measure is equivalent to its original English counterpart, which was not developed specifically for the Latino population. Based on the aforementioned review, it is clear that the translation and adaptation of this measure requires a multistep approach involving both a qualitative evaluation of its wording and format, as well as the quantitative evaluation of its psychometric properties. In the current study, I followed qualitative methods to achieve content, semantic, and technical equivalence. I refer to these three dimensions of equivalence as defined in Flaherty’s model (1988), while acknowledging that these concepts are also addressed in models by Marsella and Leong (1995), and van de Vijver and Leung (2011). The resulting version of the Spanish CAPS-5 can ultimately be submitted for psychometric evaluation in future studies, in order to examine its cross-cultural equivalence utilizing quantitative methods.

The CAPS-5: A Candidate Tool for Adaptation

Since its conception in 1990, the CAPS has been widely used in clinical and research practice. Before the debut of the CAPS-5 in 2014, its predecessor, the CAPS for DSM-IV, enjoyed widespread use, had been translated to 15 languages, and had been
shown to have good validity and reliability in multiple studies. It is expected that the CAPS-5 will continue to be used widely as the gold standard of PTSD assessment. Therefore, the CAPS is a relevant candidate for cross-cultural use, and a tool that would greatly enhance research with Spanish speaking Latinos in the U.S. In the following section, I review the CAPS-5’s strengths and limitations as a potential measure for cultural adaptation. I first provide a brief review of the measure’s structure and administration procedures. Second, I discuss the history of the measure and its prevalence of use. Finally, I review psychometric evidence of validity for the CAPS for DSM-IV for English and Spanish speaking populations.

The CAPS-5: Features, Structure, and Administration Procedures. The CAPS-5 presents with various features that make it a comprehensive tool for PTSD assessment. First, it reflects the DSM-5 symptom criteria, allowing for a direct comparison of the measure’s items against the symptoms presented in the Manual. Second, it has “carefully phrased prompt questions and explicit rating scale anchors with clear behavioral referents” (Weathers et al., 2001, p. 133) that are meant to standardize the CAPS administration across settings, raters, and trauma populations. Third, the rating is based on the symptom frequency/amount and severity, allowing for a multidimensional assessment of the symptoms. Fourth, the measure provides both severity (continuous) and presence/absence (dichotomous) scores which can be quantified at the symptom, cluster, and overall syndrome level. Finally, the CAPS-5 allows for flexible evaluation of past-month, past-week, and lifetime PTSD depending on the goals of the assessment.

The CAPS-5 features 30 items of which 27 reflect one of the DSM-5 PTSD criteria. Administration of the CAPS-5 is usually preceded by administering the Life
Events Checklist (Weathers et al., 2013a) or another trauma assessment scale, to identify the trauma event to be assessed. The first CAPS-5 item evaluates trauma exposure (Criterion A). Items 2-20 assess for the 19 PTSD symptoms proposed by the DSM-5 (Criteria B-E). Item 21 inquires about symptom onset, whereas item 22 evaluates symptom duration (Criterion F). Items 23-25 evaluate subjective distress, impairment in social functioning, and impairment in occupational or other important areas of functioning (Criterion G). Items 26-28 evaluate global validity, global severity, and global improvement, which are useful markers for longitudinal evaluation of symptoms. Finally, items 29 and 30 assess dissociative symptoms and are used in the specification of dissociative subtype. All symptoms must be deemed related to the trauma rather than to other type of life events. Items 2-30 are rated on a zero to four severity scale (absent, mild/subthreshold, moderate/subthreshold, severe/markedly elevated, and extreme/incapacitating). The score on each of these items is drawn from combined ratings of symptom frequency and intensity. Frequency is rated as either the number of occurrences or the percent of time in which the symptom occurred, whereas intensity refers to self-reported symptom intensity or distress caused by the symptom. Scores on these items can also be dichotomized as present (items rated as a clearly present or higher) or not present (items rated as absent or minimal).

CAPS interviewers are trained to read the standardized prompts verbatim (as much as possible) to ensure interrater and test-retest reliability. CAPS interviewers should have formal training in structured clinical interviewing, be competent in conducting differential diagnoses, understand thoroughly the phenomenology of PTSD
symptoms, and be very familiar with the measure’s items to facilitate the administration of the measure.

**The CAPS: History and Evolution.** The CAPS was created at the National Center for PTSD in 1990 as a response to a call for the field to have a comprehensive structured interview for the assessment of PTSD (Blake, 1994). Several standards of assessment were considered in making the CAPS a flexible, yet reliable, measure that would allow for the evaluation of symptoms in the past week and past month using both dichotomous (yes/no) or continuous scores. Following field-testing and revisions, the final version of the CAPS-1 (for the assessment of PTSD over the course of a month) and the CAPS-2 (for the assessment of PTSD over the course of a week), were published in October of 1990. The 1990 versions of the CAPS included the 17 DSM-III-R PTSD symptoms, eight additional items evaluating for associated features (e.g., guilt, dissociation) and five items assessing response validity, global severity, global improvement, and social and occupational impairment.

Since 1990, the CAPS has undergone two revisions, the first one published in July of 1998, and the second, which was updated between 2013 and 2014 (Weathers et al., 2014). In the 1998 revision, various changes were made to reflect the revised PTSD criteria in the DSM-IV (published in 1994) and to incorporate user feedback while retaining backward compatibility with the original 1990 CAPS. Weathers et al. (2001) described four major changes and seven minor changes. The four major changes included (a) adding a protocol to evaluate for Criteria A (exposure to trauma event); (b) rewording of intensity rating scale anchors to standardize them across items based on symptom duration, subjective distress, and functional impairment; (c) adding a scale for clinicians
to note the extent to which emotional numbing and hyperarousal symptoms were attributable to the trauma assessed or to other causes; and (d) replacing six of the eight associated symptoms so that the CAPS could also evaluate for acute stress disorder symptoms. Some of the minor changes included the reordering or rewording of some items to reflect more closely the DSM-IV diagnostic criteria, adding a validity rating scale for each item, and merging the CAPS-1 and CAPS-2 into a single instrument. A more comprehensive explanation of these changes is available in Weathers et al. (2001).

The CAPS-5, which was updated between 2013 and 2014 to reflect the revised PTSD criteria in the DSM-5, is currently undergoing psychometric evaluation (Weathers et al., 2014). The CAPS-5 presents with the following revisions: (a) the protocol for assessing criteria A follows the new rules for assessing trauma exposure as per DSM-5, which eliminates the expectation that patients should have experienced horror or helplessness at the time of the trauma; (b) CAPS items assessing for PTSD increased to 20 to reflect the DSM-5 change of “foreshortened future” to “strong negative beliefs about oneself, others and the future,” and the addition of the three new cluster E symptoms, distorted blame, persistent negative emotional state, and reckless or self-destructive behavior; (c) the original eight associated features were reduced to two items, derealization and depersonalization; (d) the rating system now assigns a single score per item; clinicians are provided with rules for qualitatively evaluating the frequency/amount and intensity of the symptom in order to assign a score on a zero to four ordinal scale (absent, minimal, clearly present, pronounced, and extreme); (e) The scoring rules for assigning a PTSD diagnosis only take into account symptoms rated as a two (clearly present) or higher.
Prevalence of CAPS Use. For the last 20 years, the CAPS has steadily risen in prevalence among researchers and practitioners alike. A 2005 survey of members of the International Society for Traumatic Stress Studies (Elhai et al., 2005) indicated that the CAPS was the most common assessment used both in clinical and research practice among respondents. The survey indicated that the CAPS was more frequently used than many of the self-report measures (such as the PCL) in spite of the additional time and effort it takes to administer.

Within the research realm, the CAPS is widely used in pharmacological and psychosocial PTSD research. Weathers et al. (2001) indicated that the CAPS has served as the as the primary diagnostic or outcome measure in more than 200 studies as of the year 2000. As of October, 2015, a search on PsycInfo for the “Clinician Administered PTSD Scale” indicates that the CAPS has been used as a diagnostic measure for PTSD in 514 peer-reviewed articles published since 1993. An examination of these studies further shows the diversity of purposes for which the CAPS has been used, be it to evaluate the efficacy of pharmacological and psychosocial treatment trials, the prevalence and comorbidity of PTSD in moderate size samples, or to establish the relations between PTSD and other psychiatric or medical disorders (Weathers et al. 2001). The CAPS has also been used extensively as the standard measure against which new PTSD measures are evaluated (the “gold standard” of PTSD assessment). Specifically, researchers conduct independent administrations of the PTSD measure and of the CAPS, and later compare the scores on the measures to evaluate for convergent validity and verify that the new measures function similarly to the CAPS.
Psychometric Evidence of CAPS Validity for English Speakers. The Standards of Measurement” (American Educational Research Association et al., 1999) propose that the validation of a measure can be approached by developing a “scientifically sound validity argument to support the intended interpretation of test scores and their relevance to the proposed use” (pg. 9). At a minimum, validity studies should present evidence of the measure’s reliability (do assessment scores replicate across administrations?) and convergent and discriminant validity (do scores correlate strongly with scores derived from measures that evaluate the same construct? Do they correlate weakly to scores derived from measures evaluating unrelated constructs?). When assessments produce dichotomous scores, utility statistics (sensitivity, specificity) should also be obtained to determine the extent to which the measure can identify caseness when compared to other established measures. Finally, assessments may also be evaluated to determine if their factor structure reflects the expected structure of symptoms posited by theory (American Educational Research Association et al., 1999). The CAPS presents with more than 20 studies that have conducted these psychometric analyses with English speaking samples in the U.S. The accumulated evidence suggests that the CAPS has (a) high internal consistency (> .85) both in total severity scores and in cluster scores, (b) modest test-retest (>.65) and interrater reliability (>.65), (c) modest to strong convergent validity (CAPS total severity score has shown correlations of .6 or above to other PTSD measures’ total severity scores), (d) similar ability to distinguish between PTSD and non-PTSD cases when compared to the SCID-PTSD module, and (e) a factor structure that reflects the four-cluster model proposed in the DSM-5 (King, Leskin, King, & Weathers, 1998; Palmieri, Weathers, Difede, & King, 2007).
A relevant question in this review is whether the CAPS psychometric properties are applicable to different types of trauma populations and cultural minority samples. Regarding trauma type, the original team of researchers who created the CAPS has consistently evaluated the measure’s psychometrics in samples of veterans (e.g., Blake et al., 1990; Weathers, Litz, Herman, Huska, & Keane, 1993), but other investigators have also evaluated or used the measure with motor vehicle accident victims (e.g., Blanchard, Jones-Alexander, Buckley, & Forneris, 1996), survivors of sexual assault (e.g., Blanchard et al., 1996; Davidson, Malik, & Travers, 1997b; Zlotnick & Pearlstein, 1997), survivors of domestic violence (e.g., Griffin, Uhlmansiek, Resick, & Mechanic, 2004), and severe mental health patients (e.g., Mueser et al., 2001). Regarding the cultural diversity of samples, some of these studies have a subsample of African Americans or Latinos living in the U.S., but these subsamples were very small when compared to the overall sample within their study and the overall number of people that have participated in CAPS psychometric studies. Cultural diversity can rather be evidenced when considering that the CAPS has been translated and adapted for international use, and that for many translations, psychometric validity studies have been conducted in their respective settings.

**Translations of the CAPS to Other Languages.** As of 2013, the CAPS has been translated to 15 languages, including Bosnian (Charney & Keane, 2007; Priebe et al., 2010); Cambodian (Hinton et al., 2006); Croatian (Priebe et al., 2010); Dutch (Hovens et al., 1994); Farsi (Malekzai et al., 1996; Renner et al., 2006); German (Schnyder & Moergeli, 2002); Japanese (Asukai et al., 2003); Korean (Lee et al., 1999); Luo (Ertl et al., 2010); Portuguese (Pupo et al., 2011); Pushto (Malekzai et al., 1996); Serbian (Priebe,
et al., 2010); Spanish (Bustamante et al., 1997; Orengo García & Hormaechea Beldarraín, 1997); Swedish (Pauvonic & Öst, 2005), and Turkish (Aker et al., 1999). With the exception of the Dutch version, which was a translation of the CAPS published in 1990, all other translations reflect the format of the 1998 CAPS revision. In the next section, I examine the available evidence for psychometric validity for the existing translations in Spanish.

**The Spanish Versions of the CAPS: Translation, Adaptation, and Evidence of Validity.** The CAPS-5 was recently translated to Spanish in Puerto Rico (Vera et al., 2014). In addition, two Spanish versions of the CAPS for DSM-IV were independently developed, one in Spain (Orengo García & Hormaechea Beldarraín, 1997) and another one in Miami, FL (Bustamante et al., 1997). Although neither of the measures listed has documentation of how it was translated or adapted, this author communicated with the translators to learn more about the methods used. The Spanish translation of the CAPS-5 was conducted by a team of bilingual mental health professionals at the University of Puerto Rico Medical Campus. Psychometric validation of this measure has not yet been conducted (Vera, personal communication, 2014). The Spanish version from Spain was translated from English to Spanish by two Spanish psychiatrists. This translation was tailored to the context of the psychiatrists’ patients in Spain, and they did not use the backtranslation method (Orengo-García, personal communication, 2012). This version was later evaluated for psychometric properties with a sample of 63 patients diagnosed with PTSD and 23 healthy individuals recruited from 13 mental health clinics in Spain (Bobes et al., 2000). The study evaluated the measure’s internal consistency at the total and cluster level, test-retest reliability, and the measure’s convergent validity in
comparison to five other measures of PTSD. In the study, Chronbach’s alpha was high for total CAPS score (.91) and moderate to high each of the three PTSD clusters within the CAPS (83, .79, .77 for Intrusion, Avoidance/Numbness, and Hyperarousal respectively). Test-retest reliability was also high for total CAPS scores (.87) and for the three CAPS cluster scores (.93, .92, and .87). Finally, regarding convergent validity, CAPS total severity scores correlated moderately to strongly to the other measures of PTSD (between .46 and .88).

The Spanish translation of the CAPS for DSM-IV conducted in Miami was translated and reviewed by a team of bilingual psychologists, and was later backtranslated (Bustamante, personal communication, 2013). The committee members were representative of different nationalities, including Cuba, Puerto Rico, Spain, and Venezuela, and focused on enhancing cultural appropriateness for people of different nationalities by minimizing regionalisms. This version was evaluated for psychometric properties with a sample of 174 Puerto Rican veterans (Benuto et al., 2011). The study evaluated the CAPS internal consistency, item-total correlations, and convergence validity between this Spanish version of the CAPS and a Spanish version of the PCL. The study also compared the CAPS cluster scores between cases and noncases and conducted a factor analysis to evaluate the measure’s fit to four competing models (a two-factor, three-factor, and two 4-factor models). In the study, Cronbach’s alpha was high (.84), and item-total correlations ranged from .19-.57, with the two items with the lowest item-total correlations being amnesia and sleeping difficulties. Regarding convergent validity, the CAPS scores moderately correlated to PCL-C scores (.38), and regarding criterion validity, the CAPS total and cluster scores were statistically significantly higher for
PTSD positive cases. The factor analysis indicated good fit of the CAPS for the four-factor model now adopted by the CAPS-5: Intrusion, Avoidance, Numbing, and Hyperarousal (Benuto et al., 2011).

**Literature Summary**

Through this literature review, I have argued for the need of a strong measure of PTSD for Latinos with LEP, given this disorder’s crippling impact on occupational and interpersonal functioning. In my review, I found that even though Latinos with LEP make up a third of the total Latino population, they are currently underserved in clinical practice and underrepresented in research. Developing measures that are culturally appropriate to evaluate Latinos with LEP for mental health disorders is one of the most important steps in narrowing these disparities. Having appropriate assessment tools will allow clinicians and researchers to determine appropriate diagnosis and treatment, and to produce accurate statistical estimates of mental health disease in research.

To develop a cross-culturally equivalent PTSD measure, I have examined various conceptual frameworks that have guided my chosen research methodology in chapter three. I have also argued that the construct of PTSD is appropriate to capture the experience of Latinos with LEP, following an analysis of this construct’s history and more recent research regarding its phenomenology among Latinos. Finally, I have also discussed the versatility of the CAPS for DSM-IV when compared to other PTSD measures (i.e., a measure that allows for the evaluation of symptoms over different timeframes using both dichotomous and continuous scores), and also presented evidence of the reliability and validity of the CAPS for DSM-IV for U.S. and international populations. I believe that the advent of the CAPS-5 presents an opportunity to apply
state of the art procedures to create a Spanish translation of high standards. Through the present study, I expect that my adaptation of the CAPS-5 will illustrate the procedures that other researchers can follow in adapting measures for Spanish speaking Latinos.
CHAPTER 3: METHODS

The goal of this dissertation was to develop an empirically-based, culturally adapted Spanish version of the CAPS-5 (Weathers et al., 2013b) that maintains the items’ intended meaning from the original English version. I have sought to adapt the measure’s wording and format to achieve content, semantic and technical equivalence, based on the considerations posited by the Cultural Equivalence Model (Canino & Bravo, 1994; Flaherty et al., 1988; Matías-Carrelo et al., 2003). Specifically, the CAPS-5 was adapted to ensure (a) that the measure’s items are easily understood by both linguistic groups (semantic equivalence), (b) that the concepts addressed by the measure are relevant to both cultural groups (content equivalence), and (c) that the measure’s format and administration guidelines elicit equivalent information among interviewees of both cultures (technical equivalence). Changes to the CAPS-5 item wording and format were implemented when it was reasonable to do so while maintaining the intended meaning of the measure’s items and administration procedures.

To develop the Spanish version of the CAPS, I implemented a multi-step approach that followed the methods of other measurement translation and adaptation studies (e.g., Alegría et al., 2004; Bravo, Canino, Rubio-Stipec, & Woodbury-Fariña, 1991; Matías-Carrelo et al., 2003; Solomon et al., 2005). This process entailed the following steps: (a) forward translation by an independent translator; (b) review and modification of the Spanish draft by a panel of bilingual mental health professionals with expertise in Latino mental health and trauma; (c) review of the Spanish draft by a community sample of Latinos with LEP; (d) review and modification of the Spanish draft by the panel of experts, based on feedback gathered from the community sample; (e) pre-
testing of the Spanish draft with a clinical sample of Spanish speaking Latinos with PTSD; (f) review and modification of the Spanish draft by the panel of experts, based on feedback gathered from the clinical sample; (g) backtranslation by a second independent translator; and (h) documentation of discrepancies between the backtranslation and the original English CAPS-5. These steps are summarized in Table 6.

Based on the aforementioned review, it is clear that the translation and adaptation of this measure requires a multistep approach involving both a qualitative evaluation of its wording and format, as well as the quantitative evaluation of its psychometric properties. Therefore, they are deemed to act as community experts that can identify confusing wording and make suggestions on how to present some of these constructs more clearly and effectively (Erkut, Alarcón, Coll, Tropp, & García, 1999; Knight et al., 2010b). The feedback of community-dwelling individuals with LEP also presents advantages over the feedback of people who are bilingual. Panel members, as bilingual individuals, are expected to have access to cultural and linguistic information in both Spanish and English languages which may lead them to ignore grammatical, wording, or stylistic errors that might be confusing to monolingual Spanish speakers (I Fortuny et al., 2005; Knight et al., 2010b). Community participants, because they do not have access to the English language, may identify problematic wording in Spanish more effectively than bilingual reviewers.

Cognitive pre-testing with the population for whom the measure is designed is crucial to capture additional problems that may not be otherwise detected by academic reviewers or by a community sample. When considering PTSD patients in particular, it is important to evaluate whether the final translation of the measure is parsimonious, clear,
and amenable to individuals who may have difficulties with concentration or memory. As the cognitive interviews are best conducted in a one-on-one private setting, they can also emulate the actual context in which a CAPS-5 interview would typically be conducted.

I propose that incorporating these procedures, in addition to the traditional translation and backtranslation approaches, allows for a more comprehensive review of the translation. In the remainder of this chapter, I describe the study’s sample, informed consent process, measures, and procedures. Also, consistent with qualitative research standards of trustworthiness (Lincoln & Guba, 1985; Morrow, 2005), it is important that researchers explain how their personal and professional values and experiences influence their work. Therefore, I will first describe the researchers’ positionality in the next section.

**Researcher Positionality**

**Principal Investigator.** In qualitative research, researchers are urged to reflect on, and communicate to readers, their personal characteristics, values, experiences, and beliefs so as to understand how these attributes influence the research product (Lincoln & Guba, 1985; Morrow, 2005). It is therefore important that I describe my positionality regarding cultural adaptation of psychological tools. I will proceed to explain the personal and professional experiences that have shaped my motivations to conduct this study, as well as the ways in which these attributes may have influenced the development of this project.

I am a fully bilingual and bicultural Ecuadorian American who migrated to the U.S. with her family in the early 2000s. At the time of our move, my parents were in their early 40’s, my younger sister was nine, and I was 16. Prior to moving to the U.S., we all
had studied some English as part of the educational curriculum. Although we could understand spoken and written English, we all had limited oral and writing fluency. In Miami, about 65% of the population speaks Spanish (U.S. Census Bureau, 2011b). For my parents, this meant that they were able to find occupations and adjust while relying on Spanish as their main language, but it also delayed their development of oral and written English fluency. Both my sister and I, who enrolled in school, attained oral and written fluency within two years, with my sister becoming the most acculturated and fluent of us all. Although my parents now speak English fairly well, for many years they relied on my sister and I to translate and act as cultural ambassadors when the family engaged with English-speaking providers and institutions. Despite their English fluency, Spanish continues to be the language with which my parents express themselves best, and the language in which they would prefer to discuss their ideas and emotions. From these personal experiences, I understood that many Latinos may not have equal opportunity to develop English proficiency, and that even among those who become bilingual, Spanish is the default language to address what is important to them. In addition, living in Miami also presented the opportunity to interact with people from different Latin American cultures and, as such, to sample the cultural variations in the Spanish language across the continent.

As I began my clinical training, I found my family’s experiences with acculturation and language acquisition were echoed in the experiences of many immigrant Latinos with whom I worked. Specifically, I learned that for many Latinos the opportunities to become fluent in English and acculturate are limited. Many first generation Latinos recognize the importance of attaining English fluency to avoid
discrimination and attain better opportunities for financial advancement (Hakimzadeh & Cohn, 2007). However, age, social class, documentation status, and geographical location may limit opportunities available to learn the language. For instance, within my family and social network, as well as among the Spanish speaking clients with whom I have worked, many adults use their available time to work and provide for their families, and thus have less time available to learn English. Further, although many immigrant youth assimilate and acquire the language through their schooling, many others may never attend school or may drop out after experiencing academic challenges related to language acquisition (APA Presidential Task Force on Immigration, 2012). Finally, many immigrants join existing enclaves that replicate similar social and cultural structures to those from their country of origin. In these contexts there is less of a necessity to begin speaking English immediately, and the exposure to the host culture is limited.

In addition, the social justice orientation of my counseling program exposed me to a discourse that explicitly acknowledges that language proficiency is a tool to acquire and retain economic and social power. In the words of Puente et al. (2013), “Spanish is not socially, academically, economically, and politically equivalent to English, and it is often viewed as a marginal language” (p. 18). I learned that as a result of ethnocentric, colonial, and imperialistic perspectives imbued in U.S. identity, many people learn to marginalize ethnolinguistic minorities and perceive that it is the responsibility of minorities to acculturate (Cofresí & Gorman, 2004). This, in turn, contributes to health disparities for linguistic minorities because the funding needed to provide linguistically and culturally sensitive services is not prioritized (Castaño et al., 2007; Piedra et al., 2011). Access to higher levels of education has allowed me to equip myself to identify and counter
discourses where my Latin American heritage is any less precious than the values and language I learned in the U.S.

Finally, I began to recognize that as a psychologist, I can use my research and clinical practice to advocate for ethnolinguistic minorities. Research on the utility and implementation of culturally adapted interventions and assessment tools is a topic I have become passionate about. In developing this dissertation study, I did not question whether the CAPS need to be culturally adapted for Spanish speaking Latinos; I assumed that was the case. Developing and integrating culturally adapted measures into practice is but one of several steps that providers must take to alleviate disparities, along with allocating institutional resources toward the provision of interpreters, well-translated materials, and cultural sensitivity training among health and mental health providers (Piedra et al., 2011).

It is important to note that my personal and professional characteristics as a researcher may also pose limitations. Although being a Spanish speaker Latina likely facilitated the extent to which I could build rapport with the participants, as an “insider,” I may have failed to recognize unique aspects of the culture that would be more salient to someone with culturally dystonic views.

**Research Assistant.** The research assistant is a bilingual Puerto Rican woman whose first language is Spanish. She completed 11 years of formal education in Spanish while living in Puerto Rico and completed her high school, undergraduate, and doctorate studies in counseling psychology in English while living in the United States. Her graduate training and research has centered on Latina/o psychology and health; thus, she has worked with Spanish speaking Latinos in clinical and research positions. She believes
that culturally adapted measures are an important step toward ensuring that measurements operate equally across different cultural groups, given that measurement scholarship has been historically understood from the perspective of European-Americans. She expects psychologists to question whether instrument items convey the same meaning across languages and cultures different from the ones in which they were originally conceptualized. Her previous scholarly work (Capielo, Mann, Nevels, & Delgado-Romero, 2014) highlights that it is critical to evaluate the linguistic and cultural equivalence of the content in psychological measures so that they are relevant to racial and ethnic minority groups, above and beyond the process of translation and backtranslation.

**Translators**

**Forward Translator.** A certified bilingual translator was recruited to conduct a professional forward translation. The translator who conducted the forward translation of the original English CAPS to Spanish (Step 1) is a bilingual Venezuelan-American woman who is a native Spanish speaker. The translator attained 17 years of formal education in Spanish while living in Venezuela and completed four years of graduate studies in English the U.S. She also attained a certification by the American Translation Association. She reported 25 years of translation experience in health and other fields since she migrated to the U.S.

**Backtranslator.** English as a first language was a recommended criterion for the backtranslator, in accordance to recommendations by Knight and colleagues (2010b). The translator who conducted the translation of the final draft of the Spanish CAPS to English (Step 7) is a bilingual European-American man who is a native English speaker. The
translator’s education, inclusive of doctoral studies in counseling psychology, was completed in the U.S. He learned Spanish through a two-year immersive program with Latino communities in the Northeast. He reported two years of Spanish teaching experience, two years of clinical work, and one year of research with Latino Spanish speakers.

Sample

Mental Health Professionals’ Demographics. A purposive sample of three mental health professionals was recruited. Criteria to participate included (a) ability to speak Spanish and English fluently, and (b) at least three years of clinical or research experience working with Spanish speaking trauma populations. To ensure that the panel would be representative of different Latin American regions, I recruited professionals who were from, or worked with people from, three major Latin American regions: the Caribbean, Mexico and Central America, and South America. Recruitment was conducted via word of mouth through a network of professionals.

Three professional experts agreed to be part of this study. The first panelist is a female, Nicaraguan, clinical psychologist with more than 10 years of clinical and research experience with Spanish speaking Latinos, primarily in pediatric settings. In particular, her research experiences include participating in the development and psychometric evaluation of an acute stress measure for Spanish speaking children.

The second panelist is a female, Argentinean psychiatrist who completed her medical studies in Argentina and pursued her residency in psychiatry in the U.S. She reported more than 30 years of clinical experience with Spanish speaking Latinos, both in Argentina and in the U.S. She has served as the director of a hospital psychiatric
emergency room and currently holds a private practice with Spanish and English speaking adults.

The third panelist is a male, Colombian psychologist who obtained his doctorate in clinical psychology in Colombia as well as a master’s in mental health and a master’s in public health in the U.S. He directs a community mental health and advocacy agency serving victims of domestic violence, sexual abuse, human trafficking, and other trauma events.

**Community Sample Demographics.** The recruitment criteria for the community sample included: (a) being 18 years of age or older, (b) identification as Latina/o or Hispanic, (c) and being a Spanish speaking person with LEP. Following approval by the Human Subjects Research Office (HSRO) at the University of Miami, a purposive sample of nineteen community-dwelling participants was recruited via word of mouth and by introducing the study to gatekeepers in local social services agencies in Miami, FL between October 2014 and February 2015. See Appendices B and C for English and Spanish language flyers distributed to recruit community participants. In addition, see Appendices D and E for the script the researcher used to advertise the study in social service agencies. Interested participants were provided with the study phone contact and were screened over the phone. During the screening, this author explained the purpose of the study, the format of the focus groups, confidentiality issues, as well as length and location of the groups. Participants were offered $30 in cash as compensation for their participation. See Appendices F and G for the English and Spanish script utilized to screen participants over the phone.
Three focus groups were conducted, where each group was composed of six to seven participants, consistent with recommendations by Morgan (1998b) regarding group size. The sample was representative of different ages (range: 23-82 years of age), but most participants were middle-aged ($M = 52.89$, $SD = 16.37$) consistent with statistics on the average age of Spanish speaking Latinos living in the U.S. (Shin & Kominski, 2010). Altogether, there were eight male and 11 female participants. Participants were from Colombia ($n = 6$), Cuba ($n = 6$), Ecuador ($n = 2$), Mexico ($n = 4$), and Venezuela ($n = 1$). About 60% of participants reported seven to 12 years of formal education ($n = 12$), 20% ($n = 4$) reported up to six years of formal education, and 15% ($n = 3$) reported more than 12 years of formal education. Table 7 presents participants’ self-rated Spanish and English proficiency on the AMAS-ZAAB (see measure’s description below). On average, participants reported that they understood and spoke Spanish “Pretty well” or “Extremely well, like a native” and that they understood and spoke English “A Little” or “Not at all.” Recruitment was ended after the third focus group given that response saturation was reached (McLafferty, 2004).

**Clinical Sample Demographics.** Although some guidelines have been discussed regarding adequate sample size for cognitive pre-testing interviews (see Blair & Conrad, 2011), I did not find a model that would account for the fact that the present study integrated two additional review methodologies (panel of experts and focus groups) in addition to cognitive-pretesting interviews. In designing the current study, I expected that the initial reviews of the measure by the panel of experts and the community sample would help identify the measure’s most severe problems (i.e., problems with clarity and understandability), and that the cognitive pre-testing interviews would provide feedback.
specifically related to the administration of the measure to individuals with PTSD symptomatology. As such, after reviewing the extant literature and consulting with researchers with qualitative research expertise, I estimated that interviewing 10 participants would allow me to include people from different regional backgrounds and educational levels while providing sufficient opportunities to detect any additional problems with the measure that may have been missed in the previous phases.

Originally, the recruitment criteria for the clinical sample included: (a) being 18 years of age or older, (b) identification as Latina/o or Hispanic, (c) being a Spanish speaking person with LEP, and (d) being diagnosed with PTSD by an independent clinician. However, as a result of recruitment challenges, two of these criteria were modified, such that bilingual individuals were also invited to participate. In addition, instead of requiring participants to be diagnosed with PTSD by a clinician, I admitted participants who were under the care of a licensed mental health provider and who endorsed three or more symptoms in the Primary Care PTSD Screen (PC-PTSD Screen; Prins et al., 2003).

Recruitment was conducted at local social services agencies in Miami, FL serving trauma populations. I met or corresponded with community gatekeepers at these agencies to introduce the study. Following approval by these agencies, the study was introduced to agency clinicians as well as to agency clients during center events (e.g., support groups; see Appendices H and I for English and Spanish language flyers distributed to recruit community participants, and Appendices J and K for the script the researcher used to advertise the study in social service agencies). Interested participants were screened via phone. The screening process included an explanation of the purpose of the study, the
format of the pre-testing interview, confidentiality issues, and length and location of the interview. Participants were offered $25 in cash for their participation (see Appendices L and M for the English and Spanish script utilized to screen participants over the phone).

Four participants qualified to participate in this part of the study. Participants were recruited at community mental health agencies serving primarily survivors of trauma in Miami Dade County between February and July 2015. Among the four participants, one or more participants identified as transgender. To prevent these participants from being identified, I have decided to omit the gender specification of the overall clinical sample. This group of participants was homogeneous in terms of age, culture, and educational level. All participants were born in Cuba. Their average age was 52.5 years (SD = 5.97, range of 44 to 58 years of age). Two of the participants had six or less years of formal education, and the other two participants had between seven and 12 years of formal education. Three of the participants discussed childhood sexual abuse as the trauma event for the interview, whereas one participant discussed the death of a loved one. Table 7 presents participants’ self-rated Spanish and English proficiency on the AMAS-ZAAB (see measure’s description below). On average, participants reported that they understood and spoke Spanish “Extremely well, like a native” and that they understood and spoke English “A Little.”

Protection of Human Subjects. This study was approved by the University of Miami Human Subjects Research Office (see Appendix N for letter of approval). Following screening, all participants who agreed to participate in either the focus groups or the individual interviews met with the clinician independently prior to the procedures and underwent the informed consent process in Spanish (see Appendices O, P, for the
English and Spanish Informed Consent forms for the community sample and see Appendices Q and R for the English and Spanish consent forms for the clinical sample). During the informed consent process, I reiterated the purpose of the study as well as the efforts made to protect the confidentiality of participants. Participants were also informed of risk for distress while reviewing CAPS-5 items, and that they could (a) stop participating at any time, or (b) refuse to answer any questions they did not wish to answer, without penalty. Two participants who appeared especially distressed when discussing their experiences during the pre-testing interviews were invited to stop the interview if needed, but they indicated their desire to continue the interview. I suggested to these participants that they contact their mental health provider if they felt they would benefit from further assistance. I also informed participants that I could provide a list of community referrals if they required it; however, none of the participants requested a copy of this list (see Appendices S and T for the referral list in English and Spanish).

Focus groups and pre-testing interviews were audio recorded. Audio-recorded data collected through the interviews was stored electronically on a secure server and was erased following data analysis. Data collected about the participants’ demographics and language proficiency were assigned an identification number, and these files were not linked to the participants’ names or contact information. Participants’ names and contact information were kept in a locked cabinet at an office at the University of Miami. All files were only accessed by the principal investigator and key research personnel associated to this study. In addition, the pre-testing sessions were conducted in private, on a one-on-one basis.
Measures

Demographics. Participants in the community and clinical samples completed a demographics questionnaire that collected information about their age, gender, country of birth, age at arrival to U.S., and highest level of formal education completed (see Appendices U and V for English and Spanish versions of the demographics form, respectively). In addition, I informally collected demographic, educational, and occupational data from translators and members of the professional expert panel.

Language Proficiency. Participants in the community and clinical samples completed four items of the Abbreviated Multidimensional Acculturation Scale (AMAS-ZABB; Zea, Asner-Self, Birman, & Buki, 2003) to rate their comprehension and oral proficiency in Spanish and English on a scale of one (not proficient) to four (perfect proficiency, like a native speaker). Only people who reported low English comprehension and oral proficiency were included in the present study (see Appendices U and V for English and Spanish versions of the AMAS-ZABB items within the aforementioned demographics forms).

PTSD Symptoms. PTSD symptoms were screened using the PC-PTSD Screen (Prins et al., 2003). The PC-PTSD Screen features four yes/no questions that inquire whether the respondent has experienced intrusive thoughts, avoidance of reminders, hyperarousal, and emotional detachment. Participants who answered “yes” to three out of the four questions were eligible to participate (see Appendices W and X for English and Spanish versions of the PC-PTSD Screen).
Procedures

Translation of the CAPS-5 from English to Spanish (Step One). The forward translator was provided with an electronic copy of the English CAPS item prompts. The general guidelines of the measure and the item headings were not included in this copy. The translator was asked to complete a direct translation of the text. She was not asked to incorporate principles of cultural adaptation and guidelines for the translation were not provided to her.

Review of the Translation by Mental Health Professionals (Steps Two, Four, and Six). The experts were invited to participate in three meetings to discuss changes to the measure after the first translation (step two), after the community sample review (step four) and after the clinical sample review (step six). The first meeting was conducted in person. The second and third meetings were conducted over the phone. During the third meeting, one of the panelists was unable to attend. She subsequently reviewed and accepted the changes discussed during the meeting via e-mail.

During the first meeting, I asked the experts to review the Spanish draft produced by the translator, compare it to the original CAPS-5 in English, and make recommendations for cultural adaptation. With the permission of Dr. Vera, I also provided panelists with a copy of the Spanish translation of the CAPS-5 developed by Dr. Vera’s research team in Puerto Rico (Vera et al., 2014) as a resource that they could utilize to identify examples of alternative wording and phrasing for the items.

Panelists began their revisions on the translation conducted by the local translator in Miami while referring to the Spanish translation of the CAPS-5 conducted in Puerto Rico for alternative wording suggestions. However, starting with item D3, panelists...
indicated that they felt it would be more efficient to review the items in the Puerto Rican version instead of the Miami translation, because they consistently found that the Puerto Rican version already had a very good translation of the items’ meaning. As a result, items A through D2 are largely based on the original translation conducted by the Miami translator, whereas items D3 – I2 are largely based on the Spanish CAPS-5 translation provided by Dr. Vera. All changes suggested by panelists after their revision were incorporated into the measure to create a second draft of the Spanish CAPS-5.

During the first panelist meeting, my research assistant acted as moderator, while I acted as note-taker. This ensured that I would prioritize the input of panelists and community sample participants while minimizing my own suggestions or comments as the primary researcher. In preparation for the second meeting with the panel of experts, I prepared a summary document with the changes recommended by the community sample. At the meeting, I acted as a moderator while my research assistant acted as note-taker. In the second meeting, panelists dialogued about the proposed changes and voted on whether to accept them or not. As a moderator, I summarized the points raised by the panelists, and then asked them to choose among the wording options proposed. Panelists typically reached consensus on these issues. However, when panelists did not agree, I collected further data on the issue by subsequently asking the clinical sample for feedback on the proposed wording choices; this feedback from participants was discussed with the panel of experts in our third meeting.

During the third meeting with the panel of experts, I again prepared a summary document with the changes suggested by the clinical sample. In cases where there was no clear decision, I suggested changes based on my clinical impressions and experience
administering the measure. In reviewing the recommendations, panelists accepted the changes proposed and also added additional feedback on how to improve upon these changes when necessary. All meetings with the panel of experts were audio recorded and reviewed to ensure that no information was lost.

**Review of the Translation by a Community Sample (Step Three).** Focus groups were conducted at a private space, such as a living room, a gathering area, or a conference room in a community agency. During the first focus group, the research assistant facilitated the discussion while the principal investigator served as the note-taker. During the second focus group, the research assistant was not available, and the principal investigator facilitated the discussion alone. During the third focus group, the principal investigator facilitated the discussion while the research assistant served as the note-taker. Following introductions and a discussion of ground rules, each item of the CAPS-5 draft, as agreed upon in step two by the panel of experts, was presented verbally and visually to elicit participants’ feedback on item clarity and understandability.

Participants were provided with a booklet in which each of the CAPS-5 items were displayed in Century Gothic font, size 16 (see Appendix Y for a sample excerpt of the focus group stimulus packet). Participants were provided with pencils and adhesive notes, and were encouraged to write suggestions as they read the items. Participants were then invited to dialogue on the applicability of these items for Latinos with LEP using a semi-structured focus group guide (see Appendices Z and AA for English and Spanish versions of the focus group guide respectively).

I sought to conduct at least two focus groups, but a third focus group was added to ensure more representation of participants from the Caribbean region. The first focus
group lasted two hours, whereas the second and third groups lasted approximately one hour. Changes suggested in the first focus group were incorporated and tested with the second focus group. Similarly, changes suggested in the second focus group were incorporated and tested in the third focus group. As the problems identified became redundant or decreased over time (reaching response saturation), a decision was made to stop recruiting participants after the third focus group.

**Cognitive Pre-Testing of the Translation by a Clinical Sample (Step Five).** Participants met individually with the principal investigator in a private office at the participant’s referring agency. The entire Spanish CAPS-5 was administered to each of the participants. While conducting the cognitive interview, I took field notes regarding patient comprehension of the items. Participants were also asked to point out whether there were questions that were confusing, and if so, to provide suggestions for change. In addition, the researcher asked specific questions regarding the utility of some words or assessment strategies (e.g., the use of visual aids) previously recommended by the community sample or the expert panelists. See Appendices BB and CC for English and Spanish versions of the Pretesting Interview guide. Given that the researcher did not seek to evaluate the CAPS-5 scoring system or its psychometric properties, she did not score participants’ responses. The interviews lasted between 50 and 90 minutes.

**Backtranslation from Spanish to English (Step Seven).** To conduct the backtranslation, the translator had no contact with the original English version of the CAPS-5 as recommended by Wang, Lee and Fetzer (2006). The translator was asked to provide a direct translation of the Spanish text to English without culturally adapting, such that the translated wording could closely reflect the changes applied in the Spanish
adaptation. The purpose of the backtranslation is not to produce an exact copy of the English original, but rather to ensure that the intended meaning of the items remains across the original English version and the final backtranslated version.

**Documentation of Discrepancies Between Backtranslation and Original CAPS-5 (Step Eight).** In this step, I documented differences in literal content and meaning between the versions in order to determine the extent to which the Spanish version of the CAPS-5 produced in this study reflected the intended meaning of the original English CAPS-5. This process was conducted with the “Compare Documents” feature in Microsoft Word, which highlights differences between two documents. Altogether, the backtranslation revealed planned changes resulting from the implementation of the recommendations. It also showed minor changes in the wording or sentence structure that are similar in content to the original English translation. There were no unexpected or unintended changes, and as such no additional steps were taken to review the measure.

**Data Analysis and Summary.** Following each meeting with the panel of mental health professionals, the community sample, and the clinical sample, I created tables to keep track of how the items changed as a result of the revisions. These tables listed the original item in the first row of a table, a list of the changes suggested in the second row of the table, and the revised item wording in the third row of the table (see Appendix DD for an example of how one of the CAPS-5 items evolved through this process). To create the summary documents, I reviewed the audio recordings and field notes at the end of each meeting with panelists, community, or clinical participants. I also compared field notes with the research assistant to document issues identified.
In addition to the tables, I compiled a list of all suggestions provided on a separate document. Specifically, I clustered together the suggestions that appeared to address the same idea (e.g., sentence length issues, use of colloquial language). Whenever there were new recommendations that did not fit the existing categories, I created a new category. I report this data-driven organization of the recommendations on the Results chapter. Finally, I also organized the recommendations in the context of the Cultural Adaptation Framework by Flaherty et al. (1988). I report this theory-driven organization of the recommendations in the Discussion chapter.
CHAPTER 4: RESULTS

In this chapter, I describe the recommendations that participants suggested to adapt the Spanish version of the CAPS-5, and provide a data-driven categorization of the recommended changes. Consistently, participants recommended reducing the measure’s literacy level. The recommendations included (a) increasing the use of colloquial words and phrases, (b) reducing sentence length, (c) clarifying abstract concepts such as dissociative experiences, timeframes, and frequency (d) reducing the use of superlative descriptors, and (e) correcting grammatical errors. In addition to the adaptation of items’ wording and format, (f) a recommendation was added to the CAPS-5 instruction guidelines regarding the assessment of emotions and physical reactions in items B4 and B5. The final version of the adapted CAPS-5 for Spanish Speaking Latinos in the U.S. developed in this study is presented in Appendix EE.

Use of Colloquial Words and Phrases

Focus group participants and panelists suggested rewording a number of terms and phrases with the purpose of facilitating clarity, reducing complexity, and increasing language familiarity for individuals with fewer years of formal education. For example, participants suggested the use of the word “recuerdos” instead of “memorias,” to refer to the concept of memories, indicating that “memorias” refers to the idea of memory capacity rather than the concept of remembrances. In another example, participants recommended using the word “comportamiento” rather than the word “conducta” to explain the term behavior, with the rationale that “conducta” is often used in the context of children’s “good behavior” or “bad behavior” in school settings, whereas “comportamiento” is used more widely to mean behavior. The recommendation of using
simpler words and phrases was pervasive throughout the review of the whole measure. Please refer to Table 8, which illustrates the changes implemented to simplify the measure’s vocabulary. Of note, after applying changes suggested by the focus group and panelist sample, no further changes in the vocabulary of the measure were suggested by the clinical sample, except for the words and phrases used to assess flashbacks (item B3, see discussion below).

Reduction of Sentence and/or Word Length

In the initial translation of the CAPS-5 from English to Spanish, I noted that the questions were lengthier in Spanish, providing greater opportunity to tax the auditory working memory and attention span of participants. For instance, the first prompt in item D3 contains 26 syllables in English and 40 in Spanish. Participants, therefore, made three types of recommendations to reduce the length of sentences and facilitate participants’ ability to attend to the questions. The first recommendation was to rephrase questions using shorter words. For instance, the question stem in item D7, “How much difficulty do you have…?” can be translated to “¿Cuánta dificultad tiene…?” (“How much difficulty do you have…?”) or “¿Qué tan difícil se le hace…?” (“How difficult is it for you to…?”). Congruent with an expectation that shorter words are easier to attend to, and are more common in the vocabulary of people with low levels of formal education, focus group participants suggested the use of words that have less syllables, even if the number of words in the sentence increases. For instance, it is easier to listen to “¿Qué tan difícil se le hace…?” where the longest word is three syllables, than “¿Cuánta dificultad tiene…?” in which the longest word has four syllables.
The second recommendation was to split long questions into two or more parts, to give interviewees the opportunity to process the prompts separately. For instance, the initial prompt in item I1, which inquires about dissociative symptoms, was split into three questions to allow interviewees opportunities to address the symptoms separately. More notably, a decision was made to split the symptom onset question at the end of items D2-D6 (“Did [this symptom] start or get worse after [EVENT]?”), into two separate questions (“Did [this symptom] start after the [EVENT]?” and “Did [this symptom] get worse after the [EVENT]?”), and to subsume the latter question as an optional follow-up prompt to be administered if the interviewee answers negatively to the first question. Altogether, the splitting of questions was applied to items B1, D2, D3, and I1.

The third recommendation was to eliminate repetitive information when possible. Participants noted that some items described the phenomenology of the experience using two or more synonyms. For instance, on item E3, interviewees are asked to identify incidents in which they are “in danger or threatened in some way.” Participants indicated that the sentence would still be understood without a secondary clause. Participants, therefore, suggested that the interviewees be asked to identify incidents in which they are “in danger in any way.” In addition, during interviews with the clinical sample, I noted that the first prompt for items B3, D7, E1, E2, and I2 “In the past month, have there been times when you had [the symptom]?” could be simplified to “In the past month, did you have [the symptom]?” to shorten the questions without altering the meaning of the item. For instance, item D7 (“In the past month, have there been times when you had difficulty experiencing positive feelings like love or happiness?”) would still be understood if rephrased as “In the past month, was it difficult to feel positive feelings like love or
happiness?” Therefore, in consultation with expert panelists, I rephrased this prompt in the aforementioned items to shorten the length of the questions.

Finally, the fourth recommendation was to utilize the preterit tense instead of the present perfect tense to ask the CAPS-5 questions. The English version of the CAPS-5 frequently uses the present perfect tense (e.g., “Have you ever had [the symptom]?”; “How many times have you had [the symptom]?”) to evaluate for the occurrence of symptoms in the past month. Both in English and Spanish, the present perfect tense is a type of composite verb tense that inquires about events that began in the past and continue into the present (Whitley, 2002). An alternative way of inquiring about past month symptom occurrence is to utilize the simple past tense, or preterit (e.g., “Did you ever have [the symptom]?”; “How many times did you have [the symptom]?”) which inquires about events that began and ended in the past (Whitley, 2002). Consequently, in consultation with the panel of experts, I decided to utilize the preterit tense instead of the present perfect tense to ask questions. The benefit would be that the questions would be shorter and still gather the information the CAPS-5 intends to measure. Focus group participants also reported preference for the preterit tense compared to the present perfect. Among the clinical sample, it was observed that the use of the simple tense improved the flow of the questions.

Clarification of Abstract Concepts

I found that a number of concepts needed additional clarification when first explained to participants, particularly (a) the description of dissociative phenomenology (e.g., flashbacks), (b) the quantification of symptom frequency (“How often” and “How much of the time” questions), and (c) the clarification of what “The past month”
timeframe refers to (the last 30 days). Panelists also commented that these items were likely problematic because the concepts conveyed are abstract (e.g., the concepts of time and frequency) or, alternatively, because such concepts are not part of people’s everyday experiences (e.g., dissociative symptoms). Changes made are described next.

**Concretization of Dissociative Symptom Items.** Participants were asked for feedback on how to define dissociative symptoms (i.e., flashbacks, amnesia, depersonalization, derealization) in simpler terms, acknowledging that these symptoms are not part of people’s everyday experiences. Item B3 (flashbacks), in particular, changed significantly through the different iterations of the revision process. Panelists noted that there is no direct translation for the term “flashbacks” to Spanish. Focus group participants proposed the term “revivir” (to re-live) as a term to express the experience of flashbacks, and through the interviews with the clinical sample, it became apparent that even the term “revivir” does not convey the dissociative component of the flashback experience (e.g., that one may forget where one actually is while experiencing the memory). Therefore, I asked clinical participants who endorsed having flashbacks to explain the symptom in their own words to provide some suggestions for the item wording. One participant described flashbacks as follows: “To have memories that are stronger than others” (“Tener memorias más fuertes que otras”). She added: “It feels so real that one thinks that the same [event] is happening. You are not here, but rather, what you already lived is happening [again]” (“Se siente tan real que uno piensa que está pasando lo mismo. No estás acá sino que está pasando lo que tú ya viviste”). Another participant also described flashbacks by stating: “It is as if you forget everything that is happening around you and you are thinking only in that [event], as if you are living it in
that moment” (“Es como que te olvidas de todo lo que está alrededor y estás pensando solamente en eso, como si lo estás viviendo en ese momento”), and added: “I don’t understand anything that is happening in that moment around me. I am concentrated in that [event], as if they were doing it to me again in that moment” (“Yo no entiendo nada de lo que está pasando en ese momento alrededor. Estoy concentrada en eso, como si me lo estuvieran haciendo en ese momento”).

Using participants’ wording, the question of flashbacks was worded to separate the ideas of intrusive memories and dissociation into two parts. Specifically, the item was worded as follows:

“In the past month, did you have stronger memories in which you felt that you were re-living the [EVENT]? This is as if you forget everything that is happening around you and you think the [EVENT] is happening again” (“En el último mes, tuvo recuerdos más fuertes, en que sintió que revivía el [EVENTO]? Esto es como que uno olvida todo lo que sucede a su alrededor y piensa que el [EVENTO] está pasando otra vez.”).

This adaptation reduced the amount of words used in the original wording (“In the past month, have there been times when you suddenly acted or felt as if the [EVENT] were actually happening again?”) and made the essential meaning of the optional follow-up prompt (“This is different than thinking about it or dreaming about it – now I’m asking about flashbacks, when you feel like you’re actually back at the time of [EVENT], actually reliving it.”) part of the original prompt, using simpler words.

In addition, I observed during the clinical interviews that using an open-ended question to ask participants about the intensity of the symptom (“How much does it seem as if the [EVENT] were happening again?”) was difficult to understand by participants. Participants did not have difficulties understanding the optional follow-up prompt (“Are you confused about where you actually are?”). As a result, I recommended to use this
prompt only to allow the interviewer to use clinical judgment in determining the intensity of the flashback.

In contrast, items D1 (amnesia), I1 (depersonalization) and I2 (derealization) were virtually unchanged as they were deemed to be the best explanations for these experiences. For item I1, however, participants suggested that the interview clarify that the phenomena assessed should occur while being awake. As a result, a slight clause stating “While you were awake,” was added to the original prompt (“In the last month, while you were awake, have there been occasions in which…?”).

**Concretization of Frequency Questions.** All questions in the CAPS first prompt participants to describe the phenomenology of the symptom, the frequency of the symptom, and the intensity of the symptom. Among some items, the frequency question inquired “How often” the symptom happened in the past month, whereas among other items, the frequency question inquired “How much of the time” the symptom occurred in the past month. Instructions for the CAPS-5 interviewer indicate that items asking “How much of the time” are to be coded as percentages, such that the symptom is considered to be threshold when it occurs 20-30% of the time, and the symptom is considered to cause severe impairment when it occurs 50-60% of the time.

For items inquiring “How often,” focus group participants preferred the translation “Cuántas veces” (“How many times”) rather than the direct translation of “How often” (“Con qué frecuencia”). This change was approved by panelists and did not present problems among the clinical sample. For items inquiring “How much of the time” (D2, D3, D4, D6, D7, E3, E5), participants in the clinical sample tended to respond using adverbs of frequency (e.g., “a lot”) which does not provide specific information needed to
determine percentage of the time. Therefore, panelists suggested the creation of a hand-out card with a visual aid to help interviewees understand the concept of percentages and generate more specific information. It is important to note that the visual aid is not intended to function as a Likert scale from where participants must choose and answer, but rather a teaching tool to explain the meaning of percentages and provide some examples. The visual aid created features pie charts with different gradations providing five examples: “0%,” “25%,” “50%,” “75%,” and “100%” (see Figure 1). In addition, the following text (in italics) was added to the instructions of the CAPS-5:

*In general,* DO NOT read rating scale anchors to the respondent. They are intended only for you, the interviewer, because appropriate use requires clinical judgment and a thorough understanding of CAPS-5 scoring conventions. *However, participants with lower levels of literacy might not understand the concept of percentages expected in items asking “how much of the time [did your symptom occur] in the past month” (present in items D2, D3, D4, D6, D7, E3, E5). When this is the case, we recommend providing participants with “Visual aid 2” as a hand-out card to facilitate interviewees’ understanding of the type of responses that are expected. Note that this visual aid is not intended to function as a Likert scale from where participants must choose and answer, but rather a teaching tool to explain the meaning of percentages and provide some examples.*

**Clarification of Past Month Timeframe.** The CAPS-5 can be utilized to evaluate for symptoms in the past month, the past week, or to assess for lifetime occurrence of PTSD symptoms. This study focused on modifying the past-month version of the CAPS. Participants issued two recommendations for the assessment of symptoms in the past month. The first recommendation was to clarify the meaning of “past month” in Spanish at the beginning of the protocol, given that patients may misinterpret the question to ask about the occurrence of symptoms in the present month (e.g., just within the span of the last 20 days if it is the 20th of the month) rather than the last 30 days. Of note, “In the past month” can be translated as “en el mes pasado” or “en el ultimo mes.”
Neither focus group participants nor panelists had a preference as to whether to use “mes pasado” or “ultimo mes”; therefore, I made the decision to utilize “ultimo mes.”

The second recommendation was to utilize a visual aid during the administration of CAPS-5 items to help interviewees ground themselves in the 30-day period. During interviews with the clinical sample, I observed that despite the addition of the timeframe explanation at the beginning of the measure, some participants described lifetime occurrence of symptoms rather than the past month occurrence. This research, in consultation with panelists, therefore recommended that the CAPS-5 include another visual aid that can be handed out to interviewees to help them ground themselves in the 30-day period prior to the date of the interview. This hand-out should include the picture of a timeline and three blank spaces where the interviewee or interviewer can write the approximate date of the trauma event, the date of the interview, and 30 days prior to the day of the interview (see Figure 2). In addition, the following text was added to the CAPS-5 instructions:

Although the introductory text in the cultural adaptation of the CAPS-5 explicitly indicates that “the past month” refers to the last thirty days as of the interview’s date, some participants may forget to discuss symptoms within the specified timeframe begin to describe the lifetime occurrence of symptoms over the course of the measure administration. If participants continue to discuss lifetime symptoms instead of past month symptoms in subsequent items, utilize Visual Aid 1 to ground them in the 30 day period prior to the date of the interview.

Minimizing the Use of Extreme Examples

Focus group participants indicated that it was unnecessary to utilize exaggerated examples for certain items, because Latino patients would be unlikely to endorse them, even if they really experienced the symptom described by the item. For instance, participants suggested that the notion of the world being a completely dangerous place on
item D2 would be very unlikely to be endorsed. Participants, therefore, suggested to change the wording of this phrase to “the world is a very dangerous place.” Likewise, on item E2, participants recommended to ask if the interviewee has been taking risks, rather than more risks in the past month.

**Correction of Grammatical Issues**

Participants identified a number of grammatical issues in the document. One such issue was the need to add “o/a” to adjectives and nouns to make them gender-neutral. Another issue was the lack of articles such as “el,” “la,” “los,” “las,” “del,” or “al” (“the,” “of,” or “to”) before nouns when the text was translated from English to Spanish. Although these articles are not always required in English grammar, they are important in Spanish. For instance, participants identified that it would be important to add the articles “el” and “la” to the words “love” (“el amor”) and “happiness” (“la felicidad”) in the translation of item 14 (“Have there been times when you had difficulty experiencing positive feelings like love or happiness?”).

**The Assessment of Emotions and Physical Reactions**

In the clinical sample, some participants discussed physical reactions (e.g., “my blood pressure shot up”) when answering item B4 (which refers to emotional reactions), and subsequently discussed emotional reactions (e.g., “I became angry”) when answering item B5 (which refers to physical reactions). In addition, one participant in the focus group and one participant in the clinical sample indicated that it was not clear what “physical reactions” meant in item B5, and suggested for the interviewer to provide optional examples as part of the initial prompt. Following consultation with the panel of experts, it was ultimately decided not to provide examples of physical reactions as part of
the initial prompt in B5. This decision was made to avoid biasing participants to endorse the examples presented. Instead, instructions regarding cultural considerations in the assessment of physical and emotional reactions was added to the CAPS-5 guidelines. Specifically, the following text was added to page of the instructions:

In addition, note that some Latino patients may not immediately differentiate emotional from physical reactions in items B4 and B5. It is recommended that the interviewer utilize the follow-up prompts in these items accordingly to help interviewees provide the relevant information. The interviewer should code information regarding physical symptoms and regarding emotional symptoms to rate B4 and B5 accordingly.

**Recommendations that Were Not Accepted**

Three recommendations ultimately were not accepted because there was not sufficient support from participants to make these changes. One participant recommended for the measure to provide, up front, individualized examples of the symptom assessed in D7, (inability to experience positive emotions). Yet, to avoid biasing responses, panelists suggested leaving the initial prompts in this item unchanged, and to make use of the standardized follow-up questions, as well as clarifying comments, on an as-needed basis. Another participant indicated that the wording in item C1 (“Have you tried to avoid thoughts or feelings about the (EVENT)?”) confused her because she perceived that “thoughts” and “feelings” cannot be separated from each other, but she perceived the question asked her to do so. She added that she perceived Latinos do not tend to separate thoughts from emotions, and suggested revision of the question. However, because no other participants expressed confusion or suggested changes for this item, I did not apply this recommendation. One other participant noted that item E6 (sleep disturbance) was very similar to item B2 (nightmares) and suggested both items appear to ask the same question. However, another member in the same group contended that each item is
assessing different symptoms and recommended against merging both questions. Following discussion with panelists it was decided not to make changes given that the items assess different symptoms.

Comments Regarding the Researcher’s Influence on Results

In those cases where participants had difficulty providing alternative ways of rephrasing an item, I provided suggestions; these were based on my experience assisting participants in understanding item content when using the CAPS for DSM-IV in a previous research study (Pérez-Benítez et al. 2013), as well as on my reading of articles listing potential problems with the adaptation of measures. I then used participants’ preference regarding the suggested options to make revisions to the measure.

Finally, I brought up certain issues for discussion with participants in those cases where the issues had been challenging for participants in the past, even if the current participants did not raise them. Specifically, I asked for feedback from panelists and participants on three issues: (a) how to best explain items measuring percentage of the time (“how much of the time”), (b) whether to use the simple past tense instead of the present perfect tense, and (c) whether to eliminate some wording used to explain symptoms. In these instances, participants’ feedback shaped the final recommendations.
CHAPTER 5: DISCUSSION

A critical task in psychology is to develop measurement tools that are sensitive to the phenomenology of the disorder among diverse ethnolinguistic populations. In the present study, I sought to develop an empirically-based adaptation of the Clinician-Administered PTSD Scale (CAPS-5; Weathers et al., 2013b) for Latino Spanish speakers in the U.S. In this chapter, I organize the changes applied to the measure within the context of the dimensions of Flaherty et al. (1988)’s Cultural Adaptation Framework: content equivalence, semantic equivalence, and technical equivalence (Canino & Bravo, 1999; Flaherty et al., 1988). This is a theory-driven organization of the recommendations implemented, which contrast with the data-driven organization of the recommendations reported in the previous chapter. In this discussion, I contextualize each change in light of research across different disciplines, including neuropsychology, survey construction, and linguistics research. Next, I will discuss the implications of this study for PTSD research and treatment of Latinos, and will address the generalizability and limitations of this study. Finally, I will discuss recommendations for future research.

Changes to Achieve Content Equivalence

As previously discussed, content equivalence is achieved when items reflect the intended construct as it is experienced in the cultural group of interest. Altogether, only two changes were implemented to achieve content equivalence, reflecting that the CAPS-5 symptoms were generally well-understood by reviewers: (a) an addendum was added to the CAPS-5 instructions regarding the assessment of emotions and physical reactions in items B4 and B5, and (b) the use of extreme symptom examples on certain items was reduced.
Cultural Considerations in the Assessment of Emotional and Physical Reactions. When asked about their emotional reactions to trauma reminders (Item B4), participants at times discussed physical reactions to trauma reminders (which would correspond to Item B5). I observed this when administering the CAPS-5 to both the non-clinical and clinical participants. Upon inquiry, participants did not indicate a need to simplify or clarify the wording. Rather, some participants indicated that both items appeared to evaluate the same concept. The participants’ tendency to discuss physical reactions when asked about emotions may be linked to existing evidence that emotional distress is more likely to be communicated in psychosomatic sensations rather than through emotional states among Latinos (Angel & Guarnaccia, 1989; Escobar, 1987; Koss, 1990; Tófoli, Andrade, & Fortes, 2011). Hinton & Lewis-Fernandez (Hinton & Lewis-Fernández, 2010, 2011) suggested that among Latinos, trauma-related symptoms may be codified into existing cultural syndromes featuring somatic and dissociative presentations. For instance, Latinos with PTSD may conceptualize and report their symptoms as part of susto, nervios, or ataque de nervios, which have physical features in the form of startle reactions as well as other physical reactions (e.g., palpitations, fainting) in response to trauma reminders. Patients may have ataque de nervios anchored on a trauma event or triggered by a trauma reminder. Although further research is needed to understand cultural differences in the expression of emotions via somatic symptoms, researchers have proposed a few explanatory mechanisms, including the notion that (a) some cultural models portray emotions as entwined and inseparable from the body, (b) that somatic symptoms are learned responses to distressing events, or (c) that the culture’s language (idioms of distress) minimize the differences between the emotions
Reducing the Use of Extreme Symptom Examples. This change was applied to items D2 (negative beliefs about the self, others, or the world), and E2 (risk-taking behaviors). This recommendation might appear to contradict existing literature indicating that Latinos, particularly individuals with lower levels of acculturation and education, tend to favor an extreme response style in surveys (Davis, Resnicow, & Couper, 2010; Marín et al., 1992). However, such studies refer to Latinos’ response style in self-report measures using Likert scales, whereas the CAPS-5 poses yes/no questions asking the interviewees whether they have experienced a particular symptom. In this scenario, the question is administered verbally, and there are no Likert scale options from which to select a choice; instead, the interviewees must determine whether they have experienced the symptom presented and provide examples to substantiate their claim. As such, people with threshold symptoms may fail to endorse these symptoms if the questions present with examples that are too extreme (e.g., believing that “the world is completely dangerous?” or whether they were “taking more risks” as opposed to “taking risks”). In other words, extreme examples may discriminate against false positives (preventing Type I errors), but may result in false negatives (Type II errors). Participants in this study indicated that providing less extreme examples of the symptom would still capture their experience. Although the only participants that made this recommendation were part of the non-clinical sample, interviewees in the clinical sample that completed the modified items were able to respond to the items as would be expected. Hence, it is recommended
to keep these changes in items D2 and E2, and for the interviewer to utilize follow-up questions to determine if there is enough evidence for caseness.

**Changes to Achieve Semantic Equivalence**

Semantic equivalence is achieved when the phrasing of the item is intelligible and meaningful for both groups. Most of the changes applied throughout the measure were made in an effort to lower its literacy level, thereby enhancing semantic equivalence. The literacy level was lowered both by (a) reducing the burden of sentence length on interviewee’s working memory resources, and by (b) reducing the abstraction level of items.

**Reducing the Length of Question Prompts.** As discussed previously, the translation of the CAPS-5 prompts to Spanish at times resulted in question prompts that are longer than the original English prompts. Reviewers recommended reducing the length of item questions by (a) rephrasing questions using shorter words, (b) splitting questions with multiple clauses into two or more independent questions, (c) eliminating repetitive information when possible, and (d) utilizing the simple past tense instead of the present perfect tense to ask the CAPS-5 questions. These recommendations are contextualized in neuropsychological literature regarding working memory. First, research has shown that longer words (e.g., multisyllabic words) and sentences are related to limits in working memory capacity (Chen & Cowan, 2005). Second, people with PTSD are more likely to present with working memory deficits when compared to trauma-exposed controls or to people without trauma exposure (Buodo et al., 2011; El-Hage, Gaillard, Isingrini, & Belzung, 2006; Hayes, VanElzakker, & Shin, 2012; Morey et al., 2009). Third, emotionally-laden content has been shown to be more taxing of
cognitive resources than neutral content among people with PTSD when compared to trauma-exposed controls (Schweizer & Dalgleish, 2011). The CAPS-5 requires interviewees to recall traumatic memories and trauma-related symptoms which may trigger visual, auditory, olfactory, sensory, and emotional information that interviewees must regulate while expressing their thoughts to the interviewer. In essence, responding to the CAPS-5 items can be a very taxing task for PTSD patients that may result in participants becoming distracted, overwhelmed, or fatigued as the interview progresses. During the cognitive interviews with the clinical sample, I observed this occurrence among some of the participants. One participant commented:

*Yo te entiendo todo lo que tú me estás hablando... Ay, I'm sorry, ahora sí caí... Pero soy yo, no eres tú la del problema... soy yo. Porque como me hiciste la pregunta, todavía mi mente está en otra parte. Ahorita mi mente está en otra... y no me puedo concentrar en lo que tú me estás diciendo.*

I understand everything you are talking about.... Ay, I’m sorry, I realize [what you mean] now… But it’s me, not you, who has the problem. It’s me. Because when you asked me the question, my mind was still elsewhere. Right now my mind is somewhere else… and I can’t concentrate on what you are saying. [This author’s translation].

Given the many factors taxing the cognitive resources of CAPS-5 interviewees, reducing sentence length is a recommended step toward reducing the burden on cognitive resources.

**Concretization of Frequency Questions.** In my prior experience administering the CAPS to Spanish speakers, it became apparent that the question “how often” is more difficult to answer than the question “how many times.” It could be argued that “how often” and “how many times” seemingly inquire about different types of information, given that these questions ask about relative and absolute frequencies, respectively (Schaeffer & Presser, 2003). Specifically, “how often” questions ask about relative
frequencies that require the use of what the survey research field calls “vague quantifiers” (e.g., “always,” “often,” “sometimes,” “seldom,” and “never”; Nelson Laird, Korkmaz, & Chen, 2008; Schaeffer & Presser, 2003), whereas “how many times” questions ask about absolute frequencies and can be answered by specifying the approximate number of times the symptom has happened (e.g., three times, five times). To my knowledge, no prior study has identified differences in response difficulty between relative vs. absolute frequency questions among Spanish speaking adults, but extant research with English speakers suggests that vague quantifiers used to answer relative frequency questions such as “how often” are interpreted differently depending on interviewee characteristics such as age (Borgers, Hox, & Sikkel, 2003) and education (Schaeffer, 1991). For example, exercising three times per week might be considered “often” to one person but “rarely” to another. In addition, when considering frequency adverbs used in Spanish to answer “how often” questions, it also is possible that they also require a higher level of abstraction than if interviewees were asked about absolute frequencies. Therefore, asking participants about the absolute frequency of their symptoms might not only provide interviewers with more specific information regarding symptom occurrence, but also simplify the participants’ process of quantifying symptom frequency.

**Use of Colloquial Words and Phrases.** Various terms and phrases were modified in order to use language that is familiar and simple to individuals with fewer years of formal education. These changes were necessary in light of the fact that a third of foreign-born Latinos report less than nine years of formal education (Pew Research Center, 2013). An effort was also made to make the words general enough to be understood by people from different Latin American regions. Using words and phrases
that do not vary in meaning across different Latin American regions is consistent with recommendations regarding the assessment of Spanish speaking Latinos (Acevedo-Polakovich et al., 2007; Cofresí & Gorman, 2004; Puente et al., 2013).

The modification of the flashbacks question (Item B3) is an example of how people from different Latin American countries can have different ways of communicating about the same concept (Canino & Bravo, 1999; Moscoso & Spielberger, 2011). As mentioned previously, there is no direct Spanish translation for the word “flashbacks.” However, panelists noted that in the CAPS-5 translation conducted in Puerto Rico, the item retained the English word “flashbacks” as an optional description of the symptom. Panelists indicated this is likely due to the fact that many Puerto Rican individuals are bilingual and have been exposed to the concept of flashbacks through English language media. Spanish speakers from other countries might not immediately recognize the term, and as such, the intrusive and dissociative experience of having a flashback needs to be detailed in the prompt to communicate this idea. Hence, participant feedback was used to revise the item.

Changes to Achieve Technical Equivalence

Technical equivalence exists when the assessment format and method yields the intended information, minimizing measurement bias. The changes in this dimension are perhaps the most noticeable given that it is recommended to add visual aids to the measure (a) to clarify the concept of percentage in “how much of the time” frequency questions, and (b) to clarify the referent period of “past month.”

Visualization of Percentage for “How Much of the Time” Questions. As discussed previously, questions regarding the frequency of events in the past month
period were confusing for some participants. A visual aid that would help explain the concept of percentages (Figure 1) was therefore created to help participants answer “how much of the time” frequency questions. Survey researchers have at times recommended the use of visual aids to facilitate the measurement of symptom intensity, for instance via the use of a visual analog scale or pictures of faces signaling degrees symptom intensity (McDowell, 2006; Reynolds-Keefer & Johnson, 2011). In addition, health literacy researchers have recommended alternative representation of numerical information, such as proportions, for people with low literacy and numeracy levels (Sheridan et al., 2011), particularly in the adaptation of health educational materials for Latino populations (Buki, Salazar, & Pitton, 2008; Elder, Ayala, Parra-Medina, & Talavera, 2009). To my knowledge, however, no other study has proposed the use of a pie chart aid to visualize percentages. When deciding on the number of indicators for this scale, I took into consideration the parameters that the CAPS-5 authors suggested to determine if a symptom was subthreshold, moderate, or severe. As per CAPS-5 authors, symptom occurrence 20-30% of the time would be considered “clearly present,” and 50-60% of the time would be considered “severe.” I decided to include five pie charts pictures with different percentage gradations (0%, 25%, 50%, 75%, and 100%; see Figure 1). I decided to provide five examples to provide examples of half of the time (50%), extremes (none of the time if 0% or all the time if 100%) and examples for in-between percentages. This is consistent with recommendations in the development of rating scales for Latino respondents in Buki, Yee, Weiterschan and Lehardy (2015) where Latino respondents indicated preference for having middle indicator instead of no middle indicator.
Although the authors of the English CAPS-5 have advised against providing interviewees with examples of the criteria interviewers must use to determine their severity ratings, in my past experiences administering the CAPS to Spanish speaking Latinos I found that the difficulty of this question was pervasive among interviewees and hindered the interview process. In general, CAPS-5 interviewers are urged to read the standardized prompts verbatim (as much as possible) to reduce administration bias (i.e., inserting systematic bias due to differences in the way the measure was administered) and promote interrater and test-retest reliability. However, the utilization of visual aids might be a necessary step in helping individuals with lower literacy levels provide the appropriate information, and as such it would reduce administration bias. In addition, I argue that including the visual aid will also prevent administration bias by providing standardized examples that the interviewers can use to explain the concept of percentages, instead of relying on the interviewers to come up with non-standardized ways of illustrating this concept. Given the proposed scale appears to be a new way of assessing for “percentage of the time,” it will be helpful to continue testing this tool in future studies to determine its value in enhancing the validity of the measure.

**Visualization of Past Month Period.** In addition, some participants had difficulty identifying that they must discuss the frequency of their symptoms within the past month, instead discussing the frequency of their symptoms within their lifetime. The use of a visual aid (Figure 2) was again helpful to facilitate participants in the clinical sample anchor themselves in the desired 30-day period. This method was included in the clinical interviews of the last two participants in the clinical sample, and both of these individuals were receptive to this way of explaining the past month period. Given that
this strategy is also a novel way of illustrating the past month timeframe, it will be helpful to continue testing it in future studies to determine its utility.

**Implications for PTSD Research**

Researchers have questioned whether prevalence rates of PTSD are accurate or the result of measurement artifacts that may lead to overreporting or underreporting of symptoms (Lewis-Fernández et al., 2008; Ortega & Rosenheck, 2000). The results of this study point to a number of factors that make communication of PTSD symptoms more difficult, such as mistranslations, language-specific problems (e.g., the lengthening of sentences in Spanish, which are likely to take a toll on working memory), and clients’ unfamiliarity with abstract or complex concepts unique to the psychology field (e.g., flashbacks). The aim of culturally adapting measures is to identify and minimize these factors to reduce assessment bias and, consequently, increase the validity and reliability of the results. As an outcome of this study, the CAPS-5 now has a second empirically-based Spanish version, specifically adapted for Spanish speaking Latinos in the U.S.

This study is part of a growing body of research advocating for the cultural adaptation of measures (Leong, Leung, & Cheung, 2010; van de Vijver & Leung, 2011; van de Vijver & Tanzer, 2004). Psychometric analyses of the adapted CAPS-5 still need to be conducted to determine whether the measure has achieved equivalent properties as its original counterpart, or whether there is a need to modify the measure further. However, through the qualitative process conducted in this study, the resulting measure is clear and easy to understand, which has potential to facilitate more accurate assessment of PTSD with the Spanish-speaking population. Consequently, the availability of this Spanish version of the CAPS-5 is intended to facilitate research with Latinos who would
otherwise not be represented in research. As the DSM-5 was only launched in 2013, the availability of Spanish versions of the CAPS-5 by 2015 represents relatively early strides toward promoting this research.

**Clinical Implications**

Kirmayer (2001) noted that “in most parts of the world, people with symptoms related to depression and anxiety do not view their problems as psychiatric and may reject psychological or psychiatric treatments couched in culturally unfamiliar or dissonant terms” (p. 25). He added that any interaction between clinicians and clients is an intercultural exchange by virtue of the cultural induction that the clinician has had into the role through training. Further differences between the client and the clinician across other important layers of identity (age, race, ethnicity, language, disability, sexual orientation, religious or spiritual beliefs) may further influence the client and clinician’s understanding of one another. Therefore, acquiring knowledge, awareness, and skills (Sue, Arredondo, & McDavis, 1992) regarding the assessment and treatment of diverse populations, is key in bridging the distance between clinician and client.

Consider the fact that assessment instruments are routinely used as part of the initial clinical interview, where both client and clinician are forming first impressions of each other. Just as the clinician collects clinical observations to understand the client’s presenting problem and etiological factors, the client also gathers data to determine whether the clinician is competent, approachable, and trustworthy in the role. Therefore, providing an assessment and treatment experience that is congruent with the client’s cultural background is critical in building trust. The absence of culturally adapted assessment instruments for Spanish speaking Latinos may in fact contribute to the
Spanish-speaking client’s mistrust of clinician competency, and subsequently influence the client’s willingness to accept treatment or continue with treatment (Kouyoumdjian, Zamboanga, & Hansen, 2003).

The development of culturally adapted measures may greatly benefit the relationship between clinicians and clients as well as the treatment prognosis of clients. First, providing clients with inadequate materials is one of the factors that may lead clients to lose confidence in the clinician’s competence. Many clients may form negative first impressions of clinicians when they encounter the unfortunately common “unmistakable errors that even poorly educated native Spanish-speakers would recognize as the language mistakes made by nonnative, non-fluent individuals… errors in phonology, morphology, syntax, and semantics” (I Fortuny et al., 2005, p. 557). Further, Kouyoumdjian, Zamboanga and Hansen (2003) argued that among Spanish speaking Latinos who are not familiar with psychological testing practices, “an awkward assessment experience may further contribute to their skepticism of mental health services” (p. 406). Providing clients with culturally congruent assessment materials and guidelines may instead contribute to confidence in the clinician’s credibility.

Second, culturally adapted assessment tools and practices not only provide more accurate interpretation of symptoms to the clinician, but also make the discussion of identified symptoms more familiar and attuned to clients’ experiences. The information discussed during an assessment interview may, in fact, facilitate clients’ process of psychoeducation about their symptoms in subsequent sessions, given that the questions in an assessment may clue clients into the clinician’s diagnostic thinking.
Finally, we should also consider that among Latinos/as, health and mental health professionals are likely to be regarded as sources of authoritarian knowledge who are not to be challenged. Latinos, particularly those with lower levels of formal education, may be inclined to acquiesce to the clinicians’ recommendations even if they do not understand the instructions or the rationale behind the instructions. Clients may even feel too intimidated to note that they are misunderstanding the information presented. Ultimately, this may result in lack of compliance, worsening or maintenance of symptoms, and decreased trust in providers. Therefore, speaking in clear and simple terms, using culturally adapted informational materials, and utilizing culturally adapted assessment tools increases the likelihood that clients will understand the messages clinicians intend to convey. However, I believe that along with presenting information clearly, clinicians also need to have an understanding of cultural norms surrounding the attribution of authoritarian knowledge to doctors, the benefits of incorporating personalismo and simpatía in building rapport, and the importance of inviting clients to express their concerns or discomfort with recommendations.

Study Generalizability and Limitations

Limitations Regarding Participant Sample. This qualitative study developed a product that is tailored to serve Latinos with LEP in the U.S. A limitation in the generalizability of this study is that, although I aimed to recruit Latinos who are diverse in terms of region of origin, the sample is local to Miami, FL and not nationally representative. As such, I caution researchers and clinicians to consider carefully whether differences in their population of interest may warrant additional adaptation to achieve cultural equivalence for their priority population.
The clinical sample size was also limited in this study. I initially aimed to recruit a sample size of 10 clinical participants, a number that I considered appropriate to detect prevalent and severe problems in the measure (Blair & Conrad, 2011), in combination with the other review phases of this study. However, despite recruitment efforts, I only identified four participants who met criteria and who were available to participate within the projected timeframe of this research. In addition, the clinical sample was homogeneous in terms of age, culture, country of origin, formal educational level, and trauma type. In addition, three out of four discussed their experiences with childhood sexual abuse. Although a more diverse clinical sample would be desirable, it is important to remember that the 19 other participants who reviewed the measure in the community sample were diverse in terms of age, education, and regional background. As such, issues regarding higher-level vocabulary and regionalisms in the measure were likely reviewed adequately. The main caveat regarding having a small clinical sample would be that more participants with PTSD would likely be needed to detect problems unique to a clinical sample, such as concentration problems related to their PTSD presentation.

Lack of Evidence For or Against the Use of Visual Aids. The proposal to implement a visual rating scale to measure percentage of time was suggested only after the last pre-testing interview with the fourth participant in the clinical sample. Although the expert panelists and I judged that this method would likely be suitable to assess the percentage of time a symptom occurs, feedback from community and clinical participants could not be collected, precluding a balanced discussion regarding the suitability of this scale. Extant research does not provide information regarding the utility of similar pictorial aids for explaining time percentage in particular. I will therefore evaluate this
tool in subsequent cognitive interviews with the clinical sample to determine its suitability.

**Generalizability of Recommendations and Adaptation Methods.** Although the final product developed in this study cannot be used with non-Spanish speakers, the recommendations suggested in this study, and the methodology used to adapt the measure are generalizable. In particular, many of the recommendations suggested in this study could benefit the development or adaptation of measures evaluating for mental health disorders among different cultural groups. Indeed, reducing a measure’s literacy level by simplifying the psychological constructs, utilizing visual aids to explain concepts, and reducing sentence length is likely to help interviewees of any language better grasp the content of mental health measures. For instance, it is possible that these recommendations may be applicable to the English version of the CAPS-5 when working with English speakers with lower levels of literacy.

**Recommendations for Future Research**

Given the limitations indicated previously, researchers examining the adequacy of the Spanish version of the CAPS-5 for Latinos should make efforts to recruit a larger and more diverse clinical sample. Also, the translation and adaptation of a measure would remain incomplete without a psychometric evaluation. In the current study, I followed qualitative methods to achieve content, semantic, and technical equivalence in the Spanish CAPS-5, which represents the first phase of cultural and linguistic adaptation. However, the measure should undergo psychometric evaluation in a future study. Candidate analyses would include a factor analysis, test-retest and intrarater reliability tests, concurrent validity tests, convergent and discriminant validity tests, as well as
sensitivity and specificity analyses. These analyses would generate information regarding the criterion and conceptual validity of the measure. These values could then be compared to the criterion and validity scores of the original CAPS-5 measure to determine whether there is criterion and conceptual equivalence between both measures, as posited in the Flaherty et al. (1988)’s model of cross-cultural equivalence. In addition, differential item functioning analyses (Faulkner-Bond & Sireci, 2015; He & van de Vijver, 2012) should be performed to reveal whether there are items that do not perform equally for Spanish speaking Latinos and the general English speaking population in the U.S. The psychometric analysis of the Spanish CAPS-5 may point to items that should be further modified. The process of culturally adapting measures is ultimately an iterative process. If the psychometric analysis identifies items that need to be further modified, it would be important to obtain qualitative feedback from the panel of experts and/or a clinical sample to adjust the items, and such items should be subsequently retested. However, given that the qualitative procedures applied in this first part of the CAPS-5 adaptation were aimed to minimize problems with the measure, and as such I expect that few modifications would be proposed following a psychometric analysis of the items.

**Recommended Guidelines for the Adaptation of Measures**

Many guidelines already exist regarding the cultural adaptation of measures. In the final section of this study, I provide some recommendations that researchers can follow in the development or adaptation of measures based on my experiences with the current study. I will first discuss some recommendations regarding the sample composition and the review methodologies. Subsequently, I propose some professional
development recommendations for researchers who aim to conduct the cultural
adaptation of measures.

**Translators, Panelists, and Sample Considerations.** One of the most important
tasks is to consider the demographic characteristics of the translators, the panelists, and
the sample involved in culturally adapting the measure. In the present study, for example,
I sought to include people with and without English proficiency (English-proficient
participants were included as translators and expert panelists, whereas Spanish speakers
with limited English proficiency were included in the community and clinical samples),
with diverse years of education (people with limited and with many years of education
were included in the community and clinical samples), from diverse countries, and with
our without the clinical disorder measured by the assessment instrument, so as to have a
diverse array of people who could capture different types of problems.

There are specific recommendations I share based on the study. First, researchers
will find very helpful to task a mental health professional with the initial translation of
the measure. Although the original translator in this study was a professional certified
translator, she was not a mental health professional; thus, some of her suggested
translations of psychological concepts (e.g., for “flashbacks”) were not accurate. As a
result, the panel of experts ultimately identified translation problems and recommended
more appropriate wording when reviewing the measure. Second, it was very helpful to
include individuals with many years of formal education as well as individuals with few
years of education. Those with higher levels of formal education quickly recognized
grammatical errors and provided suggestions to emulate appropriate use of the Spanish
language, whereas those with fewer years of formal education identified words, phrases,
and sentences that were too complex or taxing for people with lower levels of literacy. Finally, including a clinical sample was particularly helpful because participants who presented with symptomatology (particularly concentration and attention problems) had noticeable difficulties understanding certain items, which helped me identify items that needed to be simplified further. In summary, I recommend that researchers carefully consider the demographic characteristics of the individuals involved in the review of the measure, because having a diverse sample will facilitate the detection of different types of problems in the measure.

**Focus Groups vs. Cognitive Pre-Testing Interviews.** In the present study, I utilized two different types of qualitative methods, focus groups (for the community sample) and cognitive pretesting interviews (for the clinical sample). Both methodologies presented with particular strengths and limitations. The focus group strategy was very helpful in capturing ideas from many people in a short period of time (Morgan, 1998a). The group setting allowed for a dynamic exchange of ideas among participants with different backgrounds and opinions. As such, the suggestions were rich and benefited from diverse points of view. However, because of the time limit and the input of many people at once, some individuals may have chosen to not disclose their opinions, and likely breadth of content was prioritized over depth of content.

In contrast, cognitive pre-testing interviews provided an opportunity to examine in more detail the response process of fewer participants. Specifically, cognitive interviews focused on examining the way in which participants with PTSD symptoms captured, processed, and responded to the measure’s items (APA, AERA, & NCPE, 1999) by asking them to “think out loud” about their reasoning process as they choose
their answers to the question (Cook & Beckman, 2006; Miller, 2003). This methodology prioritized depth over breadth of content and also replicated the one-on-one setting that the CAPS-5 interview would require in real-life settings, unlike the focus group setting. The main limitation with this approach is the fact that interviews are lengthy and many cognitive pre-testing interviews would be needed to reach saturation of results. Given my experiences with both focus groups and cognitive pre-testing methods, I would recommend that researchers utilize both methodologies so as to strike a balance between breadth of content captured from multiple informants as well as depth in the exploration of the response process.

**Suggestions for the Professional Development of the Researcher.** There are several unique competencies that would be extremely helpful to anyone working in this area, above and beyond experience working with the Latino population and knowledge of scale development. These unique competencies, which researchers in this area should strive to attain, include: (a) being familiar with multicultural competency guidelines regarding the assessment of cultural minorities, (b) understanding cross-cultural equivalence models and the relevant qualitative and quantitative methods associated with cross-cultural equivalence research, and (c) learning to develop relationships with community based organizations. These are discussed in more detail next.

**Become Familiar with Multicultural Competency Guidelines Pertinent to the Assessment of Cultural Minorities.** It will be important for some assessment tools to include guidelines for clinicians on how to administer the measure. These instructions should contain specific cultural considerations on the use of the assessment with ethnolinguistic minorities. Some resources on cultural considerations include the APA’s
Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists (American Psychological Association, 2002) and the International Test Commission Guidelines for Translating and Adapting Tests (International Test Comission, 2010). In addition, it is important for assessors to be aware of ethnocentric biases (Cofresí & Gorman, 2004) in defining behavior as normal or abnormal. For researchers focused on the adaptation of assessments for Spanish speaking Latinos, the following articles provide an excellent overview of considerations in the assessment of Spanish-speaking Latino clients: Acevedo-Polakovich et al. (2007), Cofresí & Gorman (2004) I. Fortuny et al. (2005), Puente et al. (2013), and Puente and Ardila (Puente & Ardila, 2000).

**Understand Cross-Cultural Equivalence Models and Methods.** There is an extensive literature on cross-cultural equivalence models and procedures. In my literature review, I discussed cross-cultural equivalence models posited by Flaherty et al., (1988), van de Vijver and Leung (2011), and Marsella and Leong (1995). The International Test Commission Guidelines (International Test Comission, 2010), which are based on the van de Vijver and Leung model, provide a comprehensive list of considerations. I also recommend acquiring a copy of the Translation and Adaptation Review Form (Hambleton & Zeniski, 2011), which includes 25 items addressing problems covering five domains, namely General Translation, Item Format and Appearance, Grammar and Phrasing, Passages and Other Item-Relevant Stimulus Materials, and Cultural Relevance or Specificity. Researchers should check their measure to identify whether it features the types of problems indicated on the Translation and Adaptation Review Form. Finally, I recommend that researchers who are interested in adapting measures for Spanish
speaking Latinos become acquainted with the work of Canino and colleagues, who expanded on the cross-cultural framework of Flaherty et al. (1988) for the Puerto Rican population. Conceptual issues are discussed in Canino and Bravo (1994, 1999), whereas examples of qualitative and quantitative research methods for the evaluation of cross-cultural methods are presented in Canino et al. (1999), Chavez, Matías-Carrelo, Barrio, and Canino (2006), Cortés et al. (2007), and Matías Carrelo (2003). To review psychometric analyses for evaluating the cross-cultural equivalence of measures, researchers will find useful the works of Knight, Roosa and Umaña-Taylor (2010a), Ægisdóttir, Gerstein, and Çinarbas (2008), van de Vijver & Leung (2011), Kankaraš and Moors (2010), and Sireci, Patsula, and Hambleton (2005).

**Learn to Develop Relationships with Community or Institutional Partners.** In my position as a doctoral student, my relationships with faculty who were already affiliated with, and engaged in, research projects with local community centers facilitated recruitment of hard-to-reach populations. Learning about community-based participatory research, however, was critical to my own understanding of how to engage with community gatekeepers and establish relationships of my own. I recommend that researchers working with vulnerable populations understand the relationship between their institutions and the community they seek to serve, and seek training and/or mentorship on how to develop and maintain these relationships in the long-term.

**Conclusion**

In this study, I conducted a cultural adaptation of the CAPS-5 for Spanish-speaking Latinos with LEP. As a result of this multi-step process, the Spanish CAPS-5 produced in this study is expected to capture the experience of PTSD for Spanish
speaking Latinos with low literacy levels. My hope is that the availability of this measure will facilitate more accurate assessment of PTSD and subsequently enhance clinical work and research with this population.
REFERENCES


He, J., & van de Vijver, F. (2012). Bias and equivalence in cross-cultural research. *Online readings in psychology and culture, 2*(2). doi: http://dx.doi.org/10.9707/2307-0919.1111


Hooper, L., Stockton, P., Krupnick, J., & Green, B. L. (2011). Development, use, and psychometric properties of the Trauma History Questionnaire. *Journal of Loss and Trauma, 16*, 258-283


Figure 1. Visual Aid to Explain Percentage of the Time in the Past Month

Figura 1. ¿Por cuánto tiempo tuvo [el síntoma] en el último mes? Ejemplos de respuestas como porcentajes.
Figure 2. Visual Aid for Explaining Timeframe of Symptoms in the Past Month

Figura 2. El último mes se refiere a los últimos 30 días. Por favor anote las fechas de los siguientes eventos.
# TABLES

**Table 1**  
*Population estimates for Spanish speaking Latinos in the U.S.*

<table>
<thead>
<tr>
<th>Demographic</th>
<th>Estimate</th>
<th>% total Latino population age 5 and over</th>
<th>% Spanish speaking Latinos age 5 and over with LEP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total U.S. population</td>
<td>311,591,917a</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total U.S. population age 5 and over</td>
<td>291,524,091b</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total Latino population</td>
<td>52,035,850a</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total Latino population age 5 and over</td>
<td>46,782,479b</td>
<td>100</td>
<td>-</td>
</tr>
<tr>
<td>Spanish speaking Latinos</td>
<td>34,745,940b</td>
<td>66.7</td>
<td>-</td>
</tr>
<tr>
<td>Spanish speaking Latinos with LEP</td>
<td>15,866,700b</td>
<td>33.9</td>
<td>100</td>
</tr>
<tr>
<td>Native-born Latinos with LEP</td>
<td>3,327,493b</td>
<td>6.3</td>
<td>20.6</td>
</tr>
<tr>
<td>Foreign-born Latinos with LEP</td>
<td>12,602,939b</td>
<td>24.2</td>
<td>79.4</td>
</tr>
</tbody>
</table>

*Note.* Language estimates for population age 5 and older only.
Table 2

*Diagnostic Criteria for PTSD: Comparison of DSM-5 and Proposed ICD-11*

<table>
<thead>
<tr>
<th>List of PTSD symptoms</th>
<th>In DSM-5 Criteria</th>
<th>In Proposed ICD-11 Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exposure to trauma stressor</td>
<td>Criterion A</td>
<td>Criterion A/ “gate criterion”</td>
</tr>
<tr>
<td>Intrusive memories</td>
<td>Criterion B1</td>
<td>Criterion B2</td>
</tr>
<tr>
<td>Recurrent distressing dreams</td>
<td>Criterion B2</td>
<td>Criterion B1</td>
</tr>
<tr>
<td>Dissociative reactions (e.g., flashbacks)</td>
<td>Criterion B3, states “Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.”</td>
<td>There is no separate item for “dissociative reactions” or specifically, flashbacks. Criterion E4 states “Dissociative states when under stress.” Although the wording is similar, it is unclear if “reactions” is equivalent to the idea that states would occur when under stress. Flashbacks may be subsumed under ICD-11 Criterion B2, which states: “Repeated daytime images related to event… experienced as recurring in the present and accompanied by marked fear or horror.”</td>
</tr>
<tr>
<td>Psychological distress in response to internal or external reminders</td>
<td>Criterion B4</td>
<td>N/A</td>
</tr>
<tr>
<td>Physiological reactions to internal or external reminders</td>
<td>Criterion B5</td>
<td>N/A</td>
</tr>
<tr>
<td>Effortful avoidance of memories, thoughts or feelings</td>
<td>Criterion C1</td>
<td>Criterion C1. However, symptom is inclusive of “conversations” about trauma.</td>
</tr>
<tr>
<td>Effortful avoidance of external reminders (e.g., people, places, conversations, activities, objects, situations)</td>
<td>Criterion C2</td>
<td>Criterion C2. However, symptom excludes “conversations” about trauma.</td>
</tr>
<tr>
<td>Dissociative amnesia</td>
<td>Criterion D1</td>
<td>N/A. Unlikely part of Criterion E4, which states “dissociative states while under stress.”</td>
</tr>
<tr>
<td>Negative expectations about self, others or the world</td>
<td>Criterion D2</td>
<td>Criterion F1 only states “persistent beliefs about oneself as diminished, defeated or worthless,” no cognitions noted about others or the world</td>
</tr>
<tr>
<td>Blame of self or others</td>
<td>Criterion D3</td>
<td>N/A</td>
</tr>
<tr>
<td>-------------------------</td>
<td>-------------</td>
<td>-----</td>
</tr>
<tr>
<td>Persistent negative emotional state (fear, horror, anger, guilt, shame)</td>
<td>Criterion D4</td>
<td>Criterion F2 states “deep and pervasive feelings of shame or guilt,” does not include fear, horror, anger.</td>
</tr>
<tr>
<td>Lack of interest in, or reduced participation in significant activities</td>
<td>Criterion D5</td>
<td>N/A</td>
</tr>
<tr>
<td>Detachment or estrangement</td>
<td>Criterion D6</td>
<td>Possibly Criterion G, Interpersonal disturbances, which states: “difficulties may present in a variety of ways but are exemplified by difficulties in feeling close to others or maintaining emotional engagement.”</td>
</tr>
<tr>
<td>Emotional numbing</td>
<td>Criterion D7</td>
<td>Criterion E5</td>
</tr>
<tr>
<td>Irritability or anger</td>
<td>Criterion E1</td>
<td>Criterion E2, states “violent outbursts” only</td>
</tr>
<tr>
<td>Heightened emotional reactivity</td>
<td>N/A</td>
<td>Criterion E1</td>
</tr>
<tr>
<td>Reckless or self-destructive behavior</td>
<td>Criterion E2</td>
<td>Criterion E3</td>
</tr>
<tr>
<td>Hypervigilance</td>
<td>Criterion E3</td>
<td>Criterion D1</td>
</tr>
<tr>
<td>Exaggerated startle response</td>
<td>Criterion E4</td>
<td>Criterion D2</td>
</tr>
<tr>
<td>Problems with concentration</td>
<td>Criterion E5</td>
<td>N/A</td>
</tr>
<tr>
<td>Sleep disturbance</td>
<td>Criterion E6</td>
<td>N/A</td>
</tr>
<tr>
<td>Symptoms present for at least one month</td>
<td>Criterion F</td>
<td>Criterion H in Complex PTSD, Criterion E in regular PTSD</td>
</tr>
<tr>
<td>Significant distress or impairment</td>
<td>Criterion G</td>
<td>Criterion I in Complex PTSD, Criterion F in regular PTSD</td>
</tr>
<tr>
<td>Depersonalization</td>
<td>Criterion I1</td>
<td>Possibly Criterion E4: “Dissociative states when under stress”; however it could be argued this is a separate item not included in DSM-5.</td>
</tr>
<tr>
<td>Derealization</td>
<td>Criterion I2</td>
<td>Possibly Criterion E4: “Dissociative states when under stress,” however it could be argued this is a separate item not included in DSM-5.</td>
</tr>
</tbody>
</table>
### Table 3

**PTSD assessment instruments for English Speakers**

<table>
<thead>
<tr>
<th><strong>TRAUMA EXPOSURE SCALES</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>The Life Events Checklist (LEC; Weathers et al., 2013a)</td>
</tr>
<tr>
<td>Life Stressor Checklist – Revised (LSC-R; Wolfe &amp; Kimmerling, 1997)</td>
</tr>
<tr>
<td>The Trauma History Screen (Carlson et al.)</td>
</tr>
<tr>
<td>The Trauma History Questionnaire (THQ; Hooper, Stockton, Krupnick, &amp; Green, 2011)</td>
</tr>
<tr>
<td>Trauma Assessment for Adults (TAA; Resnick, 1993)</td>
</tr>
<tr>
<td>The Brief Trauma Questionnaire (BTQ; Schnurr, Vielhauer, Weathers, &amp; Findler, 1999)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>PTSD-SYMPTOM SEMI-STRUCTURED INTERVIEWS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD-only interviews</td>
</tr>
<tr>
<td>Clinician-Administered PTSD Scale (CAPS) (Blake et al., 1990)</td>
</tr>
<tr>
<td>Structured Interview for PTSD (SI-PTSD or SIP; (Davidson, Kudler, &amp; Smith, 1990)</td>
</tr>
<tr>
<td>PTSD Symptom Scale Interview (PSS-I; Foa, Riggs, Dancu, &amp; Rothbaum, 1993)</td>
</tr>
<tr>
<td>PTSD Interview (Watson, Juba, Manifold, Kucala, &amp; Anderson, 1991)</td>
</tr>
<tr>
<td>PTSD Modules in Diagnostic Tests</td>
</tr>
<tr>
<td>Structured Clinical Interview (SCID) PTSD Module (Spitzer et al., 1990)</td>
</tr>
<tr>
<td>Composite International Diagnostic Interview (WHO CIDI; World Health Organization, 1990)</td>
</tr>
<tr>
<td>The Psychiatric Research Interview for Substance and Mental Disorders (PRISM; Hasin et al., 1996)</td>
</tr>
<tr>
<td>Diagnostic Interview Schedule (DIS; Helzer, Robins &amp; McEnvoy, 1987)</td>
</tr>
<tr>
<td>Anxiety Disorders Interview Schedule-Revised (ADIS-R; DiNardo &amp; Barlow, 1988)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>PTSD-SYMPTOM SELF-REPORT MEASURES</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD-only scales</td>
</tr>
<tr>
<td>PTSD Symptom Scale – Self-Report (PSS-S; Foa et al., 1993)</td>
</tr>
<tr>
<td>PTSD Checklist (PCL) (Weathers et al., 1993)</td>
</tr>
<tr>
<td>Posttraumatic Diagnostic Scale (PTDS; Foa et al., 1997)</td>
</tr>
<tr>
<td>Davidson Trauma Scale (DTS; Davidson et al., 1997)</td>
</tr>
<tr>
<td>Mississippi Scale for Combat-related PTSD (M-PTSD; Keane et al., 1988)</td>
</tr>
<tr>
<td>Impact of Event Scale-Revised (IES-R) (Horowitz et al., 1979; Weiss &amp; Marmar, 1997)</td>
</tr>
<tr>
<td>Short PTSD Rating Interview (SPRING; Norris, Hamblen, Brown, &amp; Schinka, 2008)</td>
</tr>
<tr>
<td>PTSD subscales in psychometric tests</td>
</tr>
<tr>
<td>Minnesota Multiphasic Personality Inventory 2, Keane PTSD Scale (PK; Lyons &amp; Keane, 1992)</td>
</tr>
<tr>
<td>Personality Assessment Inventory, Traumatic Stress subscale in the Anxiety-Related Disorders scale (ARD-T; McDevitt-Murphy, Weathers, Adkins &amp; Daniels, 2005)</td>
</tr>
</tbody>
</table>
### Table 4

*PTSD assessment instruments for Spanish Speakers*

#### TRAUMA EXPOSURE SCALES

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
</table>
| | The Life Events Checklist (LEC; Orengo García & Hormaechea Beldarrain, 1997)  
Cuestionario de Eventos Traumáticos (TEQ; Bobes et al., 2000) |

#### PTSD-SYMPTOM SEMI-STRUCTURED INTERVIEWS

<table>
<thead>
<tr>
<th>PTSD-only interviews</th>
<th>Clinician-Administered PTSD Scale (CAPS) (Blake et al., 1990)</th>
</tr>
</thead>
</table>
| PTSD Modules in Diagnostic Tests | Structured Clinical Interview (SCID) PTSD Module (Spitzer et al., 1990)  
Composite International Diagnostic Interview (WHO CIDI; World Health Organization, 1990)  
The Psychiatric Research Interview for Substance and Mental Disorders (PRISM; Hasin et al. 1996)  
Diagnostic Interview Schedule (DIS; (Robins, Helzer, Croughan, & Ratcliff, 1981) |

#### PTSD-SYMPTOM SELF-REPORT MEASURES

| PTSD-only scales | The PTSD Checklist-Civilian version (Vera-Villarroel, Celis-Atenas, Córdova-Rubio, Zych, & Buela-Casal, 2011)  
The Revised Civilian Mississippi Scale for PTSD (Norris & Perilla, 1996)  
Short Posttraumatic Stress Disorder Rating Interview (Leiva-Bianchi & Cuadra, 2013)  
Trauma Symptom Inventory (Gutiérrez Wang, Cosden, & Bernal, 2011)  
Davidson Trauma Scale (Leiva-Bianchi & Araneda, 2013)  
Lista de síntomas para el diagnóstico de TEPT (Pineda, Guerrero, Pinilla, & Estupiñán, 2002) |
<p>| PTSD subscales in psychometric tests | Minnesota Multiphasic Personality Inventory 2, Keane PTSD Scale (PK; Keane et al., 1984; Lyons &amp; Keane, 1992) |</p>
<table>
<thead>
<tr>
<th>Measure name</th>
<th>Original Citation</th>
<th>Source of translation/adaptation</th>
<th>Source of psychometric properties</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>STRUCTURED INTERVIEWS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Translation and cultural adaptation for Puerto Rico (Bravo, Canino, &amp; Biro, 1987; Bravo et al., 1991)</td>
<td>Reliability and concordance for adaptation for Puerto Rico (Canino et al., 1987)</td>
</tr>
<tr>
<td>Composite International Diagnostic Interview (CIDI version 2.1; WHO CIDI) (ICD-9, ICD-10 criteria)</td>
<td>(WHO, 1990)</td>
<td>Adaptation for Latin America (Rubio-Stipec, Bravo, &amp; Canino, 1991)</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Adaptation of the Latin America Spanish version for Spain (Navarro-Mateu et al., 2012)</td>
<td></td>
</tr>
<tr>
<td>Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I - PTSD Module)</td>
<td>(First, Spitzer, Gibbon, &amp; Williams, 2002)</td>
<td>Translation of 1996 SCID questions conducted by the Behavioral Sciences Research Institute at the University of Puerto Rico, the New York State Psychiatric Institute Spanish translation Committee at Columbia University, the Latino Mental Health Clinic at Harvard University and the Hispanic Research Center at Fordham University. Translation updated to conform to the April 2005 version by Gladyris Concepcion and Ana Alicia De La Cruz at the New York State Psychiatric Institute (SCID4.org/trans.html).</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Another version for Spain available (First, Spitzer, Gibbon & Williams, 1999)

<table>
<thead>
<tr>
<th>Instrument</th>
<th>Translation Method</th>
<th>Sample Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Psychiatric Research Interview for Substance and Mental Disorders (PRISM)</td>
<td>Translation and backtranslation for patients in Spain (Torrens et al., 2004)</td>
<td>Psychometrics completed with a Spain sample (Torrens et al., 2004)</td>
</tr>
<tr>
<td>The CAPS</td>
<td>CAPS translation in Spain (Orengo García &amp; Hormaechea Beldarrain, 1997) CAPS translation for Latinos in the U.S. (Bustamante et al., 1997)</td>
<td>Psychometrics with sample from Spain (Bobes et al., 2000) Psychometrics with sample from Puerto Rico (Benuto et al., 2011)</td>
</tr>
</tbody>
</table>

**SELF-REPORT MEASURES**

<table>
<thead>
<tr>
<th>Instrument</th>
<th>Translation Method</th>
<th>Sample Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>The MMPI-II</td>
<td>PENDING, THERE ARE MULTIPLE VERSIONS</td>
<td>Velázquez et al. 2000</td>
</tr>
<tr>
<td></td>
<td>Translation and backtranslation for Chilean sample (Vera-Villarroel et al., 2011)</td>
<td></td>
</tr>
<tr>
<td>Instrument</td>
<td>Method/Translation/Reliability</td>
<td>Source(s)</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>------------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Short Posttraumatic Stress Disorder Rating Interview (SPRINT-E)</td>
<td>N/A</td>
<td>Psychometrics for Chilean sample (Leiva-Bianchi &amp; Cuadra, 2013)</td>
</tr>
<tr>
<td>Trauma Symptom Inventory (TSI)</td>
<td>Translation and backtranslation for Puerto Rican sample (Gutiérrez Wang et al., 2011)</td>
<td>Internal consistency, construct validity for Puerto Rican sample (Gutiérrez Wang et al., 2011)</td>
</tr>
<tr>
<td>Davidson Trauma Scale (DTS)</td>
<td>N/A</td>
<td>Psychometric properties in a sample from Spain (Bobes et al., 2000) Psychometric properties for Chilean sample (Leiva-Bianchi &amp; Cuadra, 2013) Psychometric properties for Argentinean sample (Villafañe, Milanesio, Marcellino, &amp; Amodei, 2003)</td>
</tr>
<tr>
<td>Lista de síntomas para el diagnóstico de TEPT</td>
<td>N/A</td>
<td>(Pineda et al., 2002)</td>
</tr>
<tr>
<td>Step</td>
<td>Procedures</td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>------------</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Certified translator to conduct CAPS-5 translation from English to Spanish</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Panel of 3 bilingual mental health professionals to review and modify the translation based on cultural adaptation considerations</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Community sample of Latinos with LEP to generate suggestions for change via 3-4 focus groups</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Panel of 3 bilingual mental health professionals to review changes suggested in step 3 and modify the translation</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Measure to be pre-tested with clinical sample of Spanish speaking Latinos with PTSD</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Panel of 3 bilingual mental health professionals to review changes suggested in step 5 and modify the translation</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Second certified translator to conduct backtranslation of final Spanish draft of the CAPS-5</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Documentation of discrepancies between backtranslation and the original English CAPS-5</td>
<td></td>
</tr>
</tbody>
</table>
Table 7
Spanish and English proficiency on AMAS-ZABB for community and clinical samples

<table>
<thead>
<tr>
<th>Language Proficiency</th>
<th>Community sample</th>
<th>Clinical sample</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Spanish Comprehension</td>
<td>3.68</td>
<td>0.48</td>
</tr>
<tr>
<td>Spanish Oral Proficiency</td>
<td>3.58</td>
<td>0.51</td>
</tr>
<tr>
<td>English Comprehension</td>
<td>1.74</td>
<td>0.65</td>
</tr>
<tr>
<td>English Oral Proficiency</td>
<td>1.47</td>
<td>0.51</td>
</tr>
<tr>
<td>CAPS-5 Item(s)</td>
<td>Original English Version</td>
<td>Original Translation to Spanish</td>
</tr>
<tr>
<td>----------------</td>
<td>--------------------------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>Throughou...</td>
<td>How well…</td>
<td>Cuán bien…</td>
</tr>
<tr>
<td>B1 Memories</td>
<td>Recuerdos</td>
<td>Recuerdos</td>
</tr>
<tr>
<td>B1</td>
<td>How does it happen that you start…</td>
<td>Cómo ocurre que usted empieza…</td>
</tr>
<tr>
<td>B3, E1, E2, I1, I2</td>
<td>Behavior(s)</td>
<td>Conducta(s)</td>
</tr>
<tr>
<td>B4 Become upset</td>
<td>Disgustarse</td>
<td>Alterarse</td>
</tr>
<tr>
<td>B5</td>
<td>Ritmo respiratorio</td>
<td>respiración</td>
</tr>
<tr>
<td>C2</td>
<td>How much effort do you make</td>
<td>Siente que hay lagunas en su memoria</td>
</tr>
<tr>
<td>D1</td>
<td>How often has this happened…?</td>
<td>La forma en que responderían otras personas</td>
</tr>
<tr>
<td>D1</td>
<td>Siente que hay lagunas en su memoria</td>
<td>Hay partes que se le olvidaron</td>
</tr>
<tr>
<td>D3 In what sense…</td>
<td>Can you see other ways of…?</td>
<td>Puede visualizar otras formas de…?</td>
</tr>
<tr>
<td>D3, D7</td>
<td>Tell me more…</td>
<td>Digame más…</td>
</tr>
<tr>
<td>D4 Such as</td>
<td>Enjoy</td>
<td>Disfrutar</td>
</tr>
<tr>
<td>D5 Enjoy</td>
<td>Disfrutar</td>
<td>Gustar</td>
</tr>
<tr>
<td>E1, E2, E4, E6, I1, I2</td>
<td>How often...</td>
<td>¿Qué tan frecuentemente ha sucedido?</td>
</tr>
</tbody>
</table>

Note: a: Backtranslation also reflects change in verb tense that was applied to all items.
APPENDIX A

The Clinician-Administered PTSD Scale for DSM-5 (CAPS-5; Weathers et al., 2013b)

National Center for PTSD

CLINICIAN-ADMINISTERED PTSD SCALE FOR DSM-5
PAST MONTH VERSION

Name: ___________________________

Interviewer: _______________________

Study: ___________________________

ID#: ______________________

Date: ________________________

Frank W. Weathers, Dudley D. Blake, Paula P. Schnurr, Danny G. Kaloupek, Brian P. Marx, & Terence M. Keane

National Center for Posttraumatic Stress Disorder
October 28, 2013
Instructions

Standard administration and scoring of the CAPS-5 are essential for producing reliable and valid scores and diagnostic decisions. The CAPS-5 should be administered only by qualified interviewers who have formal training in structured clinical interviewing and differential diagnosis, a thorough understanding of the conceptual basis of PTSD and its various symptoms, and detailed knowledge of the features and conventions of the CAPS-5 itself.

Administration

1. Identify an index traumatic event to serve as the basis for symptom inquiry. Administer the Life Events Checklist and Criterion A inquiry provided on p. 5, or use some other structured, evidence-based method. The index event may involve either a single incident (e.g., “the accident”) or multiple, closely related incidents (e.g., “the worst parts of your combat experiences”).

2. Read prompts verbatim, one at a time, and in the order presented, EXCEPT:
   a. Use the respondent’s own words for labeling the index event or describing specific symptoms.
   b. Rephrase standard prompts to acknowledge previously reported information, but return to verbatim phrasing as soon as possible. For example, inquiry for item 20 might begin: “You already mentioned having problems sleeping. What kinds of problems?”
   c. If you don’t have sufficient information after exhausting all standard prompts, follow up ad lib. In this situation, repeating the initial prompt often helps refocus the respondent.
   d. As needed, ask for specific examples or direct the respondent to elaborate even when such prompts are not provided explicitly.

3. In general, DO NOT suggest responses. If a respondent has pronounced difficulty understanding a prompt it may be necessary to offer a brief example to clarify and illustrate. However, this should be done rarely and only after the respondent has been given ample opportunity to answer spontaneously.

4. DO NOT read rating scale anchors to the respondent. They are intended only for you, the interviewer, because appropriate use requires clinical judgment and a thorough understanding of CAPS-5 scoring conventions.

5. Move through the interview as efficiently as possible to minimize respondent burden. Some useful strategies:
   a. Be thoroughly familiar with the CAPS-5 so that prompts flow smoothly.
   b. Ask the fewest number of prompts needed to obtain sufficient information to support a valid rating.
   c. Minimize note-taking and write while the respondent is talking to avoid long pauses.
   d. Take charge of the interview. Be respectful but firm in keeping the respondent on task, transitioning between questions, pressing for examples, or pointing out contradictions.

Scoring

1. As with previous versions of the CAPS, CAPS-5 symptom severity ratings are based on symptom frequency and intensity, except for items 8 (amnesia) and 12 (diminished interest), which are based on
amount and intensity. However, CAPS-5 items are rated with a single severity score, in contrast to previous versions of the CAPS which required separate frequency and intensity scores for each item that were either summed to create a symptom severity score or combined in various scoring rules to create a dichotomous (present/absent) symptom score. Thus, on the CAPS-5 the clinician combines information about frequency and intensity before making a single severity rating. Depending on the item, frequency is rated as either the number of occurrences (how often in the past month) or percent of time (how much of the time in the past month). Intensity is rated on a four-point ordinal scale with ratings of Minimal, Clearly Present, Pronounced, and Extreme. Intensity and severity are related but distinct. Intensity refers to the strength of a typical occurrence of a symptom. Severity refers to the total symptom load over a given time period, and is a combination of intensity and frequency. This is similar to the quantity/frequency assessment approach to alcohol consumption. In general, intensity rating anchors correspond to severity scale anchors described below and should be interpreted and used in the same way, except that severity ratings require joint consideration of intensity and frequency. Thus, before taking frequency into account, an intensity rating of Minimal corresponds to a severity rating of Mild / subthreshold, Clearly Present corresponds with Moderate / threshold, Pronounced corresponds with Severe / markedly elevated, and Extreme corresponds with Extreme / incapacitating.

2. The five-point CAPS-5 symptom severity rating scale is used for all symptoms. Rating scale anchors should be interpreted and used as follows:

0 Absent The respondent denied the problem or the respondent’s report doesn’t fit the DSM-5 symptom criterion.

1 Mild / subthreshold The respondent described a problem that is consistent with the symptom criterion but isn’t severe enough to be considered clinically significant. The problem doesn’t satisfy the DSM-5 symptom criterion and thus doesn’t count toward a PTSD diagnosis.

2 Moderate / threshold The respondent described a clinically significant problem. The problem satisfies the DSM-5 symptom criterion and thus counts toward a PTSD diagnosis. The problem would be a target for intervention. This rating requires a minimum frequency of 2 X month or some of the time (20-30%) PLUS a minimum intensity of Clearly Present.

3 Severe / markedly elevated The respondent described a problem that is well above threshold. The problem is difficult to manage and at times overwhelming, and would be a prominent target for intervention. This rating requires a minimum frequency of 2 X week or much of the time (50-60%) PLUS a minimum intensity of Pronounced.

4 Extreme / incapacitating The respondent described a dramatic symptom, far above threshold. The problem is pervasive, unmanageable, and overwhelming, and would be a high-priority target for intervention.

3. In general, make a given severity rating only if the minimum frequency and intensity for that rating are both met. However, you may exercise clinical judgment in making a given severity rating if the reported frequency is somewhat lower than required, but the intensity is higher. For example, you may make a severity rating of Moderate / threshold if a symptom occurs 1 X month (instead of the required 2 X month) as long as intensity is rated Pronounced or Extreme (instead of the required Clearly Present). Similarly, you may make a severity rating of Severe / markedly elevated if a symptom occurs 1 X week (instead of the required 2 X week) as long as the intensity is rated Extreme (instead of the required Pronounced). If you are unable to decide between two severity ratings, make the lower rating.

4. You need to establish that a symptom not only meets the DSM-5 criterion phenomenologically, but is also functionally related to the index traumatic event, i.e., started or got worse as a result of the event. CAPS-5 items 1-8 and 10 (reexperiencing, effortful avoidance, amnesia, and blame) are inherently
linked to the event. Evaluate the remaining items for trauma-relatedness (TR) using the TR inquiry and rating scale. The three TR ratings are:

a. **Definite** = the symptom can clearly be attributed to the index trauma, because (1) there is an obvious change from the pre-trauma level of functioning and/or (2) the respondent makes the attribution to the index trauma with confidence.

b. **Probable** = the symptom is likely related to the index trauma, but an unequivocal connection can’t be made. Situations in which this rating would be given include the following: (1) there seems to be a change from the pre-trauma level of functioning, but it isn’t as clear and explicit as it would be for a “definite”; (2) the respondent attributes a causal link between the symptom and the index trauma, but with less confidence than for a rating of Definite; (3) there appears to be a functional relationship between the symptom and inherently trauma-linked symptoms such as reexperiencing symptoms (e.g., numbing or withdrawal increases when reexperiencing increases).

c. **Unlikely** = the symptom can be attributed to a cause other than the index trauma because (1) there is an obvious functional link with this other cause and/or (2) the respondent makes a confident attribution to this other cause and denies a link to the index trauma. Because it can be difficult to rule out a functional link between a symptom and the index trauma, a rating of Unlikely should be used only when the available evidence strongly points to a cause other than the index trauma. **NOTE:** Symptoms with a TR rating of Unlikely should not be counted toward a PTSD diagnosis or included in the total CAPS-5 symptom severity score.

5. **CAPS-5 total symptom severity score** is calculated by summing severity scores for items 1-20. **NOTE:** Severity scores for the two dissociation items (29 and 30) should NOT be included in the calculation of the total CAPS-5 severity score.

6. **CAPS-5 symptom cluster severity scores** are calculated by summing the individual item severity scores for symptoms contained in a given DSM-5 cluster. Thus, the Criterion B (reexperiencing) severity score is the sum of the individual severity scores for items 1-5; the Criterion C (avoidance) severity score is the sum of items 6 and 7; the Criterion D (negative alterations in cognitions and mood) severity score is the sum of items 8-14; and the Criterion E (hyperarousal) severity score is the sum of items 15-20. A symptom cluster score may also be calculated for dissociation by summing items 29 and 30.

7. **PTSD diagnostic status** is determined by first dichotomizing individual symptoms as “present” or “absent,” then following the DSM-5 diagnostic rule. A symptom is considered present only if the corresponding item severity score is rated 2=Moderate/threshold or higher. Items 9 and 11-20 have the additional requirement of a trauma-relatedness rating of Definite or Probable. Otherwise a symptom is considered absent. The DSM-5 diagnostic rule requires the presence of least one Criterion B symptom, one Criterion C symptom, two Criterion D symptoms, and two Criterion E symptoms. In addition, Criteria F and G must be met. Criterion F requires that the disturbance has lasted at least one month. Criterion G requires that the disturbance cause either clinically significant distress or functional impairment, as indicated by a rating of 2=moderate or higher on items 23-25.
Criterion A: Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the event(s) as it occurred to others.
3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse). Note: Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

I'm going to ask you about the stressful experiences questionnaire you filled out. First I'll ask you to tell me a little bit about the event you said was the worst for you. Then I'll ask how that event may have affected you over the past month. In general I don't need a lot of information – just enough so I can understand any problems you may have had. Please let me know if you find yourself becoming upset as we go through the questions so we can slow down and talk about it. Also, let me know if you have any questions or don't understand something. Do you have any questions before we start?

The event you said was the worst was (EVENT). What I'd like for you to do is briefly describe what happened.

Index event (specify):

<table>
<thead>
<tr>
<th>What happened? (How old were you? How were you involved? Who else was involved? Was anyone seriously injured or killed? Was anyone's life in danger? How many times did this happen?)</th>
<th>Exposure type:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Experienced ___</td>
</tr>
<tr>
<td></td>
<td>Witnessed ___</td>
</tr>
<tr>
<td></td>
<td>Learned about ___</td>
</tr>
<tr>
<td></td>
<td>Exposed to aversive details___</td>
</tr>
<tr>
<td>Life threat?</td>
<td>NO  YES  [self ___ other ___]</td>
</tr>
<tr>
<td>Serious injury?</td>
<td>NO  YES  [self ___ other ___]</td>
</tr>
<tr>
<td>Sexual violence?</td>
<td>NO  YES  [self ___ other ___]</td>
</tr>
<tr>
<td>Criterion A met?</td>
<td>NO  PROBABLE  YES</td>
</tr>
</tbody>
</table>

For the rest of the interview, I want you to keep (EVENT) in mind as I ask you about different problems it may have caused you. You may have had some of these problems before, but for this interview we're going to focus just on the past month. For each problem I'll ask if you've had it in the past month, and if so, how often and how much it bothered you.
Criterion B: Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:

1. (B1) Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). Note: In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.

   In the past month, have you had any unwanted memories of (EVENT) while you were awake, so not counting dreams? [Rate 0=Absent if only during dreams]

   How does it happen that you start remembering (EVENT)?
   
   [If not clear:] (Are these unwanted memories, or are you thinking about [EVENT] on purpose?) [Rate 0=Absent 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?

   Circle: Distress = Minimal Clearly Present Pronounced Extreme

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

   Key rating dimensions = frequency / intensity of distress
   Moderate = at least 2 X month / distress clearly present, some difficulty dismissing memories
   Severe = at least 2 X week / pronounced distress, considerable difficulty dismissing memories

2. (B2) Recurrent distressing dreams in which the content and/or affect of the dream are related to the event(s). Note: In children, there may be frightening dreams without recognizable content.

   In the past month, have you had any unpleasant dreams about (EVENT)?

   Describe a typical dream. (What happens?)

   [If not clear:] (Do they wake you up?)

   [If yes:] (What do you experience when you wake up? How long does it take you to get back to sleep?)

   [If reports not returning to sleep:] (How much sleep do you lose?)

   How much do these dreams bother you?

   Circle: Distress = Minimal Clearly Present Pronounced Extreme

   How often have you had these dreams in the past month? # of times

   Key rating dimensions = frequency / intensity of distress
   Moderate = at least 2 X month / distress clearly present, less than 1 hour sleep loss
   Severe = at least 2 X week / pronounced distress, more than 1 hour sleep loss
3. (B3) Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.) Note: In children, trauma-specific reenactment may occur in play.

In the past month, have there been times when you suddenly acted or felt as if (EVENT) were actually happening again?

[If not clear:] (This is different than thinking about it or dreaming about it – now I’m asking about flashbacks, when you feel like you’re actually back at the time of [EVENT], actually reliving it.)

How much does it seem as if (EVENT) were happening again? (Are you confused about where you actually are?)

What do you do while this is happening? (Do other people notice your behavior? What do they say?)

How long does it last?

Circle: Dissociation = Minimal Clearly Present Pronounced Extreme

How often has this happened in the past month? # of times __________

Key rating dimensions = frequency / intensity of dissociation
Moderate = at least 2 X month / dissociative quality clearly present, may retain some awareness of surroundings but relives event in a manner clearly distinct from thoughts and memories
Severe = at least 2 X week / pronounced dissociative quality, reports vivid reliving, e.g., with images, sounds, smells

4. (B4) Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

In the past month, have you gotten emotionally upset when something reminded you of (EVENT)?

What kinds of reminders make you upset?

How much do these reminders bother you?

Are you able to calm yourself down when this happens? (How long does it take?)

Circle: Distress = Minimal Clearly Present Pronounced Extreme

How often has this happened in the past month? # of times __________

Key rating dimensions = frequency / intensity of distress
Moderate = at least 2 X month / distress clearly present, some difficulty recovering
Severe = at least 2 X week / pronounced distress, considerable difficulty recovering
5. (B5) Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

In the past month, have you had any physical reactions when something reminded you of (EVENT)?

Can you give me some examples? (Does your heart race or your breathing change? What about sweating or feeling really tense or shaky?)

What kinds of reminders trigger these reactions?

How long does it take you to recover?

Circle: Physiological reactivity = Minimal | Clearly Present | Pronounced | Extreme

How often has this happened in the past month? # of times _________

Key rating dimensions = frequency / intensity of physiological arousal
Moderate = at least 2 / month / reactivity clearly present, some difficulty recovering
Severe = at least 2 / week / pronounced reactivity, sustained arousal, considerable difficulty recovering

Criterion C: Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:

6. (C1) Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

In the past month, have you tried to avoid thoughts or feelings about (EVENT)?

What kinds of thoughts or feelings do you avoid?

How hard do you try to avoid these thoughts or feelings? (What kinds of things do you do?)

Circle: Avoidance = Minimal | Clearly Present | Pronounced | Extreme

How often in the past month? # of times _________

Key rating dimensions = frequency / intensity of avoidance
Moderate = at least 2 / month / avoidance clearly present
Severe = at least 2 / week / pronounced avoidance
7. (C2) Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

In the past month, have you tried to avoid things that remind you of (EVENT), like certain people, places, or situations?

What kinds of things do you avoid?

How much effort do you make to avoid these reminders? (Do you have to make a plan or change your activities to avoid them?)

[If not clear:] (Overall, how much of a problem is this for you? How would things be different if you didn’t have to avoid these reminders?)

Circle: Avoidance = Minimal Clearly Present Pronounced Extreme

How often in the past month? # of times ________

Key rating dimensions = frequency / intensity of avoidance
Moderate = at least 2 X month / avoidance clearly present
Severe = at least 2 X week / pronounced avoidance

---

Criterion D: Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

8. (D1) Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).

In the past month, have you had difficulty remembering some important parts of (EVENT)? (Do you feel there are gaps in your memory of (EVENT)?)

What parts have you had difficulty remembering?

Do you feel you should be able to remember these things?

[If not clear:] (Why do you think you can’t? Did you have a head injury during (EVENT)? Were you knocked unconscious? Were you intoxicated from alcohol or drugs?) [Rate 0=Absent if due to head injury or loss of consciousness or intoxication during event]

[If still not clear:] (Is this just normal forgetting? Or do you think you may have blocked it out because it would be too painful to remember?) [Rate 0=Absent if due only to normal forgetting]

Circle: Difficulty remembering = Minimal Clearly Present Pronounced Extreme

In the past month, how many of the important parts of (EVENT) have you had difficulty remembering? (What parts do you still remember?) # of important aspects ______

Would you be able to recall these things if you tried?

Key rating dimensions = amount of event not recalled / intensity of inability to recall
Moderate = at least one important aspect / difficulty remembering clearly present, some recall possible with effort;
Severe = several important aspects / pronounced difficulty remembering, little recall even with effort
9. (D2) Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., “I am bad,” “No one can be trusted,” “The world is completely dangerous,” “My whole nervous system is permanently ruined”).

| In the past month, have you had strong negative beliefs about yourself, other people, or the world? |
| Can you give me some examples? (What about believing things like “I am bad,” “there is something seriously wrong with me,” “no one can be trusted,” “the world is completely dangerous”?) |
| How strong are these beliefs? (How convinced are you that these beliefs are actually true? Can you see other ways of thinking about it?) |
| Circle: Conviction = Minimal Clearly Present Pronounced Extreme |
| How much of the time in the past month have you felt that way? % of time |
| Did these beliefs start or get worse after (EVENT)? (Do you think they’re related to [EVENT]? How so?) Circle: Trauma-relatedness = Definite Probable Unlikely |

**Key rating dimensions = frequency / intensity of beliefs**

Moderate = some of the time (20-30%) / exaggerated negative expectations clearly present, some difficulty considering more realistic beliefs

Severe = much of the time (50-60%) / pronounced exaggerated negative expectations, considerable difficulty considering more realistic beliefs

10. (D3) Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.

| In the past month, have you blamed yourself for (EVENT) or what happened as a result of it? Tell me more about that. (In what sense do you see yourself as having caused [EVENT]? Is it because of something you did? Or something you think you should have done but didn’t? Is it because of something about you in general?) |
| What about blaming someone else for (EVENT) or what happened as a result of it? Tell me more about that. (In what sense do you see [OTHERS] as having caused [EVENT]? Is it because of something they did? Or something you think they should have done but didn’t?) |
| How much do you blame (YOURSELF OR OTHERS)? |
| How convinced are you that [YOU OR OTHERS] are truly responsible for what happened? (Do other people agree with you? Can you see other ways of thinking about it?) |
| [Rate 0=Absent if only blames perpetrator, i.e., someone who deliberately caused the event and intended harm] Circle: Conviction = Minimal Clearly Present Pronounced Extreme |
| How much of the time in the past month have you felt that way? % of time |

**Key rating dimensions = frequency / intensity of blame**

Moderate = some of the time (20-30%) / distorted blame clearly present, some difficulty considering more realistic beliefs

Severe = much of the time (50-60%) / pronounced distorted blame, considerable difficulty considering more realistic beliefs
11. (D4) Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).

In the past month, have you had any strong negative feelings such as fear, horror, anger, guilt, or shame?

Can you give me some examples? *(What negative feelings do you experience?)*

How strong are these negative feelings?

How well are you able to manage them?

_Circle:_ Negative emotions = Minimal Clearly Present Pronounced Extreme

How much of the time in the past month have you felt that way?  %

_Did these negative feelings start or get worse after (EVENT)?* *(Do you think they’re related to [EVENT]? How so?)* _Circle:_ Trauma-relatedness = Definite Probable Unlikely

Key rating dimensions = frequency / intensity of negative emotions  
Moderate = some of the time (20-30%) / negative emotions clearly present, some difficulty managing  
Severe = much of the time (50-60%) / pronounced negative emotions, considerable difficulty managing

12. (D5) Markedly diminished interest or participation in significant activities.

In the past month, have you been less interested in activities that you used to enjoy?

What kinds of things have you lost interest in or don’t do as much as you used to? *(Anything else?)*

Why is that? *(Rate 0=Absent if diminished participation is due to lack of opportunity, physical inability, or developmentally appropriate change in preferred activities)*

How strong is your loss of interest? *(Would you still enjoy [ACTIVITIES] once you got started?)*

_Circle:_ Loss of interest = Minimal Clearly Present Pronounced Extreme

Overall, in the past month, how many of your usual activities have you been less interested in?  % of activities

What kinds of things do you still enjoy doing?

_Did this loss of interest start or get worse after (EVENT)?* *(Do you think it’s related to [EVENT]? How so?)* _Circle:_ Trauma-relatedness = Definite Probable Unlikely

Key rating dimensions = percent of activities affected / intensity of loss of interest  
Moderate = some activities (20-30%) / loss of interest clearly present but still has some enjoyment of activities  
Severe = many activities (50-60%) / pronounced loss of interest, little interest or participation in activities
13. (D6) Feelings of detachment or estrangement from others.

In the past month, have you felt distant or cut off from other people?

Tell me more about that.

How strong are 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?)

Circle: Detachment or estrangement = Minimal Clearly Present Pronounced Extreme

How much of the time in the past month have you felt that way? % of time __________

Did this feeling of being distant or cut off start or get worse after (EVENT)? (Do you think it's related to [EVENT]? How so?) Circle: Trauma-relatedness = Definite Probable Unlikely

Key rating dimensions = frequency / intensity of detachment or estrangement
Moderate = some of the time (20-30%) / feelings of detachment clearly present but still feels some interpersonal connection
Severe = much of the time (50-60%) / pronounced feelings of detachment or estrangement from most people, may feel close to only one or two people

14. (D7) Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

In the past month, have there been times when you had difficulty experiencing positive feelings like love or happiness?

Tell me more about that. (What feelings are difficult to experience?)

How much difficulty do you have experiencing positive feelings? (Are you still able to experience any positive feelings?)

Circle: Reduction of positive emotions = Minimal Clearly Present Pronounced Extreme

How much of the time in the past month have you felt that way? % of time __________

Did this trouble experiencing positive feelings start or get worse after (EVENT)? (Do you think it’s related to [EVENT]? How so?) Circle: Trauma-relatedness = Definite Probable Unlikely

Key rating dimensions = frequency / intensity of reduction in positive emotions
Moderate = some of the time (20-30%) / reduction of positive emotional experience clearly present but still able to experience some positive emotions
Severe = much of the time (50-60%) / pronounced reduction of experience across range of positive emotions
Criterion E: Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

15. (E1) Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.

<table>
<thead>
<tr>
<th>In the past month, have there been times when you felt especially irritable or angry and showed it in your behavior?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can you give me some examples? (How do you show it? Do you raise your voice or yell? Throw or hit things? Push or hit other people?)</td>
</tr>
<tr>
<td>Circle: Aggression = Minimal Clearly Present Pronounced Extreme</td>
</tr>
<tr>
<td>How often in the past month? # of times ________</td>
</tr>
<tr>
<td>Did this behavior start or get worse after (EVENT)? (Do you think it’s related to [EVENT]? How so?) Circle: Trauma-relatedness = Definite Probable Unlikely</td>
</tr>
</tbody>
</table>

**Key rating dimensions = frequency / intensity of aggressive behavior**

- Moderate = at least 2 X month / aggression clearly present, primarily verbal
- Severe = at least 2 X week / pronounced aggression, at least some physical aggression

| 0 Absent |
| 1 Mild / subthreshold |
| 2 Moderate / threshold |
| 3 Severe / markedly elevated |
| 4 Extreme / incapacitating |

16. (E2) Reckless or self-destructive behavior.

<table>
<thead>
<tr>
<th>In the past month, have there been times when you were taking more risks or doing things that might have caused you harm?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can you give me some examples?</td>
</tr>
<tr>
<td>How much of a risk do you take? (How dangerous are these behaviors? Were you injured or harmed in some way?)</td>
</tr>
<tr>
<td>Circle: Risk = Minimal Clearly Present Pronounced Extreme</td>
</tr>
<tr>
<td>How often have you taken these kinds of risks in the past month? # of times ________</td>
</tr>
<tr>
<td>Did this behavior start or get worse after (EVENT)? (Do you think it’s related to [EVENT]? How so?) Circle: Trauma-relatedness = Definite Probable Unlikely</td>
</tr>
</tbody>
</table>

**Key rating dimensions = frequency / degree of risk**

- Moderate = at least 2 X month / risk clearly present, may have been harmed
- Severe = at least 2 X week / pronounced risk, actual harm or high probability of harm

| 0 Absent |
| 1 Mild / subthreshold |
| 2 Moderate / threshold |
| 3 Severe / markedly elevated |
| 4 Extreme / incapacitating |
17. (E3) Hypervigilance.

<table>
<thead>
<tr>
<th>In the past month, have you been especially alert or watchful, even when there was no specific threat or danger? (Have you felt as if you had to be on guard?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can you give me some examples? (What kinds of things do you do when you’re alert or watchful?)</td>
</tr>
<tr>
<td>(If not clear: What causes you to react this way? Do you feel like you’re in danger or threatened in some way? Do you feel that way more than most people would in the same situation?)</td>
</tr>
<tr>
<td>Circle: Hypervigilance = Minimal Clearly Present Pronounced Extreme</td>
</tr>
<tr>
<td>How much of the time in the past month have you felt that way? % of time</td>
</tr>
<tr>
<td>Did being especially alert or watchful start or get worse after (EVENT)? (Do you think it’s related to [EVENT]? How so?) Circle: Trauma-relatedness = Definite Probable Unlikely</td>
</tr>
<tr>
<td>Key rating dimensions = frequency / intensity of hypervigilance</td>
</tr>
<tr>
<td>Moderate = some of the time (20-30%) / hypervigilance clearly present, e.g., watchful in public, heightened awareness of threat</td>
</tr>
<tr>
<td>Severe = much of the time (50-60%) / pronounced hypervigilance, e.g., scans environment for danger, may have safety rituals, exaggerated concern for safety of self/family/home</td>
</tr>
</tbody>
</table>

18. (E4) Exaggerated startle response.

<table>
<thead>
<tr>
<th>In the past month, have you had any strong startle reactions?</th>
</tr>
</thead>
<tbody>
<tr>
<td>What kinds of things made you startle?</td>
</tr>
<tr>
<td>How strong are these startle reactions? (How strong are they compared to how most people would respond? Do you do anything other people would notice?)</td>
</tr>
<tr>
<td>How long does it take you to recover?</td>
</tr>
<tr>
<td>Circle: Startle = Minimal Clearly Present Pronounced Extreme</td>
</tr>
<tr>
<td>How often has this happened in the past month? # of times</td>
</tr>
<tr>
<td>Did these startle reactions start or get worse after (EVENT)? (Do you think they’re related to [EVENT]? How so?) Circle: Trauma-relatedness = Definite Probable Unlikely</td>
</tr>
<tr>
<td>Key rating dimensions = frequency / intensity of startle</td>
</tr>
<tr>
<td>Moderate = at least 2 X month / startle clearly present, some difficulty recovering</td>
</tr>
<tr>
<td>Severe = at least 2 X week / pronounced startle, sustained arousal, considerable difficulty recovering</td>
</tr>
</tbody>
</table>
19. (E5) Problems with concentration.

In the past month, have you had any problems with concentration?  

Can you give me some examples?  

Are you able to concentrate if you really try?  

Circle: Problem concentrating = Minimal  Clearly Present  Pronounced  Extreme

How much of the time in the past month have you had problems with concentration?  

% of time ______  

Did these problems with concentration start or get worse after (EVENT)?  
(Do you think they’re related to [EVENT]? How so?)  

Circle: Trauma-relatedness = Definite  Probable  Unlikely

Key rating dimensions = frequency / intensity of concentration problems  
Moderate = some of the time (20-30%) / problem concentrating clearly present, some difficulty but can concentrate with effort  
Severe = much of the time (50-60%) / pronounced problem concentrating, considerable difficulty even with effort

20. (E6) Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

In the past month, have you had any problems falling or staying asleep?  

What kinds of problems?  
(How long does it take you to fall asleep?  
How often do you wake up in the night?  Do you wake up earlier than you want to?)  

How many total hours do you sleep each night?  

How many hours do you think you should be sleeping?  

Circle: Problem sleeping = Minimal  Clearly Present  Pronounced  Extreme

How often in the past month have you had these sleep problems?  

# of times ______

Did these sleep problems start or get worse after (EVENT)?  
(Do you think they’re related to [EVENT]? How so?)  

Circle: Trauma-relatedness = Definite  Probable  Unlikely

Key rating dimensions = frequency / intensity of sleep problems  
Moderate = at least 2 X month / sleep disturbance clearly present, clearly longer latency or clear difficulty staying asleep, 30-90 minutes loss of sleep  
Severe = at least 2 X week / pronounced sleep disturbance, considerably longer latency or marked difficulty staying asleep, 90 min to 3 hrs loss of sleep

<table>
<thead>
<tr>
<th>Absent</th>
<th>Mild / subthreshold</th>
<th>Moderate / threshold</th>
<th>Severe / markedly elevated</th>
<th>Extreme / incapacitating</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
Criterion F: Duration of the disturbance (Criteria B, C, D, and E) is more than 1 month.

21. Onset of symptoms

[If not 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?)

<table>
<thead>
<tr>
<th>Total # months delay in onset</th>
<th>With delayed onset (≥ 6 months)?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NO  YES</td>
</tr>
</tbody>
</table>

22. Duration of symptoms

[If not clear:] How long have these (PTSD SYMPTOMS) lasted altogether?

<table>
<thead>
<tr>
<th>Total # months duration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Duration more than 1 month?</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO  YES</td>
</tr>
</tbody>
</table>

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

23. Subjective distress

Overall, in the past month, how much have you been bothered by these (PTSD SYMPTOMS) you’ve told me about? [Consider distress reported on earlier items]

<table>
<thead>
<tr>
<th>0</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Mild, minimal distress</td>
</tr>
<tr>
<td>2</td>
<td>Moderate, distress clearly present but still manageable</td>
</tr>
<tr>
<td>3</td>
<td>Severe, considerable distress</td>
</tr>
<tr>
<td>4</td>
<td>Extreme, incapacitating distress</td>
</tr>
</tbody>
</table>

24. Impairment in social functioning

In the past month, have these (PTSD SYMPTOMS) affected your relationships with other people? How so? [Consider impairment in social functioning reported on earlier items]

<table>
<thead>
<tr>
<th>0</th>
<th>No adverse impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Mild impact, minimal impairment in social functioning</td>
</tr>
<tr>
<td>2</td>
<td>Moderate impact, definite impairment but many aspects of social functioning still intact</td>
</tr>
<tr>
<td>3</td>
<td>Severe impact, marked impairment, few aspects of social functioning still intact</td>
</tr>
<tr>
<td>4</td>
<td>Extreme impact, little or no social functioning</td>
</tr>
</tbody>
</table>

25. Impairment in occupational or other important area of functioning

[If not clear:] Are you working now?

[If yes:] In the past month, 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 trauma, assess pre-trauma school performance and possible presence of behavior problems]

<table>
<thead>
<tr>
<th>0</th>
<th>No adverse impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Mild impact, minimal impairment in occupational/other important functioning</td>
</tr>
<tr>
<td>2</td>
<td>Moderate impact, definite impairment but many aspects of occupational/other important functioning still intact</td>
</tr>
</tbody>
</table>
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?

Global Ratings

26. 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”

27. 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
1 Mild, minimal distress or functional impairment
2 Moderate, definite distress or functional impairment but functions satisfactorily with effort
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

28. Global improvement

Rate total overall improvement since the previous rating. 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
Specify whether with dissociative symptoms: The individual’s symptoms meet the criteria for posttraumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:

29. (1) Depersonalization: Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one’s mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).

In the past month, have there been times when you felt as if you were separated from yourself, like you were watching yourself from the outside or observing your thoughts and feelings as if you were another person?

[If no:] (What about feeling as if you were in a dream, even though you were awake? Feeling as if something about you wasn’t real? Feeling as if time was moving more slowly?)

Tell me more about that.

How strong is this feeling? (Do you lose track of where you actually are or what’s actually going on?)

What do you do while this is happening? (Do other people notice your behavior? What do they say?)

How long does it last?

Circle: Dissociation = Minimal Clearly Present Pronounced Extreme

[If not clear:] (Was this due to the effects of alcohol or drugs? What about a medical condition like seizures?) [Rate 0=Absent if due to the effects of a substance or another medical condition]

How often has this happened in the past month? # of times

Key rating dimensions = frequency / intensity of dissociation
Moderate = at least 2 X month / dissociative quality clearly present but transient, retains some realistic sense of self and awareness of environment
Severe = at least 2 X week / pronounced dissociative quality, marked sense of detachment and unreality
30. (2) Derealization: Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted).

<table>
<thead>
<tr>
<th>In the past month, have there been times when things going on around you seemed unreal or very strange and unfamiliar?</th>
</tr>
</thead>
<tbody>
<tr>
<td>[If no:] (Do things going on around you seem like a dream or like a scene from a movie? Do they seem distant or distorted?)</td>
</tr>
<tr>
<td>Tell me more about that.</td>
</tr>
<tr>
<td>How strong is this feeling? (Do you lose track of where you actually are or what’s actually going on?)</td>
</tr>
<tr>
<td>What do you do while this is happening? (Do other people notice your behavior? What do they say?)</td>
</tr>
<tr>
<td>How long does it last?</td>
</tr>
<tr>
<td>Circle: Dissociation = Minimal Clearly Present Pronounced Extreme</td>
</tr>
<tr>
<td>[If not clear:] (Was this due to the effects of alcohol or drugs? What about a medical condition like seizures?) [Rate 0=Absent if due to the effects of a substance or another medical condition]</td>
</tr>
<tr>
<td>How often has this happened in the past month? # of times</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Key rating dimensions = frequency / intensity of dissociation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderate = at least 2 X month / dissociative quality clearly present but transient, retains some realistic sense of environment</td>
</tr>
<tr>
<td>Severe = at least 2 X week / pronounced dissociative quality, marked sense of unreality</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>0</th>
<th>Absent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Mild / subthreshold</td>
</tr>
<tr>
<td>2</td>
<td>Moderate / threshold</td>
</tr>
<tr>
<td>3</td>
<td>Severe / markedly elevated</td>
</tr>
<tr>
<td>4</td>
<td>Extreme / incapacitating</td>
</tr>
</tbody>
</table>
### CAPS-5 SUMMARY SHEET

Name: ___________ ID#: _______ Interviewer: _______________ Study: _______
Date: __________

**A. Exposure to actual or threatened death, serious injury, or sexual violence**

<table>
<thead>
<tr>
<th>Criterion A met?</th>
<th>0 = NO</th>
<th>1 = YES</th>
</tr>
</thead>
</table>

**B. Intrusion symptoms (need 1 for diagnosis)**

<table>
<thead>
<tr>
<th>Sev</th>
<th>Past Month</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- (1) B1 – Intrusive memories
- (2) B2 – Distressing dreams
- (3) B3 – Dissociative reactions
- (4) B4 – Cued psychological distress
- (5) B5 – Cued physiological reactions

**B subtotals**

- B Sev = 
- # B Sx = 

**C. Avoidance symptoms (need 1 for diagnosis)**

<table>
<thead>
<tr>
<th>Sev</th>
<th>Past Month</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- (6) C1 – Avoidance of memories, thoughts, feelings
- (7) C2 – Avoidance of external reminders

**C subtotals**

- C Sev = 
- # C Sx = 

**D. Cognitions and mood symptoms (need 2 for diagnosis)**

<table>
<thead>
<tr>
<th>Sev</th>
<th>Past Month</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- (8) D1 – Inability to recall important aspect of event
- (9) D2 – Exaggerated negative beliefs or expectations
- (10) D3 – Distorted cognitions leading to blame
- (11) D4 – Persistent negative emotional state
- (12) D5 – Diminished interest or participation in activities
- (13) D6 – Detachment or estrangement from others
- (14) D7 – Persistent inability to experience positive emotions

**D subtotals**

- D Sev = 
- # D Sx = 

**E. Arousal and reactivity symptoms (need 2 for diagnosis)**

<table>
<thead>
<tr>
<th>Sev</th>
<th>Past Month</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- (15) E1 – Irritable behavior and angry outbursts
- (16) E2 – Reckless or self-destructive behavior
- (17) E3 – Hypervigilance
- (18) E4 – Exaggerated startle response
- (19) E5 – Problems with concentration
- (20) E6 – Sleep disturbance
<table>
<thead>
<tr>
<th><strong>E subtotals</strong></th>
<th><strong>E Sev</strong></th>
<th><strong># E Sx</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>PTSD totals</strong></th>
<th><strong>Past Month</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Total Sev</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Sum of subtotals (B+C+D+E)</strong></th>
<th><strong>Past Month</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>F. Duration of disturbance</strong></th>
<th><strong>Current</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>(22) Duration of disturbance ≥ 1 month?</td>
<td>0 = NO 1 = YES</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>G. Distress or impairment (need 1 for diagnosis)</strong></th>
<th><strong>Past Month</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Sev</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Cx (Sev ≥ 2 )?</strong></td>
</tr>
<tr>
<td>(23) Subjective distress</td>
<td>0 = NO 1 = YES</td>
</tr>
<tr>
<td>(24) Impairment in social functioning</td>
<td>0 = NO 1 = YES</td>
</tr>
<tr>
<td>(25) Impairment in occupational functioning</td>
<td>0 = NO 1 = YES</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>G subtotals</strong></th>
<th><strong>Past Month</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>G Sev</strong></td>
<td><strong># G Cx</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Global ratings</strong></th>
<th><strong>Past Month</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>(26) Global validity</td>
<td></td>
</tr>
<tr>
<td>(27) Global severity</td>
<td></td>
</tr>
<tr>
<td>(28) Global improvement</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Dissociative symptoms (need 1 for subtype)</strong></th>
<th><strong>Past Month</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Sev</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Sx (Sev ≥ 2 )?</strong></td>
</tr>
<tr>
<td>(29) 1 -- Depersonalization</td>
<td>0 = NO 1 = YES</td>
</tr>
<tr>
<td>(30) 2 -- Derealization</td>
<td>0 = NO 1 = YES</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Dissociative subtotals</strong></th>
<th><strong>Past Month</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Diss Sev</strong></td>
</tr>
<tr>
<td></td>
<td><strong># Diss Sx</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>PTSD diagnosis</strong></th>
<th><strong>Past Month</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD PRESENT – ALL CRITERIA (A-G) MET?</td>
<td>0 = NO 1 = YES</td>
</tr>
<tr>
<td>With dissociative symptoms</td>
<td>0 = NO 1 = YES</td>
</tr>
<tr>
<td>(21) With delayed onset (&gt; 6 months)</td>
<td>0 = NO 1 = YES</td>
</tr>
</tbody>
</table>
APPENDIX B
Flyer – Community Sample – English

We are recruiting Spanish-speaking Latina/os to help us review the Spanish translation of a questionnaire. This questionnaire will be used to interview Latinos about their life after going through a difficult life event. If you qualify, we will invite you to a discussion group where you will be asked to review the questionnaire and provide feedback. Please note that you do not need to have lived through a difficult life event to qualify. The group will last approximately 2 and a half hours. You will be compensated with a gift card valued at $30.

If you:

- Are 18 years of age or older
- Identify as Latina/o or Hispanic
- Speak Spanish most of the time

You may qualify to participate in this project.
Please call María José Rendón at 305.482.6613 for further information.
APPENDIX C

Flyer – Community Sample – Spanish

¿HABLAS ESPAÑOL?

Estamos reclutando Latinas/os que hablan español para que nos ayuden a revisar la traducción de las preguntas de una entrevista. Estas preguntas serán usadas para entrevistar a Latinas/os acerca de sus experiencias después de vivir un evento difícil. Si usted califica, le invitaremos a participar en un grupo de discusión donde revisaremos las preguntas de esta entrevista. Cabe recalcar que no necesita haber vivido un evento difícil en su vida para calificar. El grupo durará aproximadamente 2 horas y media. Usted será compensada/o con una tarjeta de regalo valorada en $30. Si usted es:

- Mayor de 18 años
- Se identifica como Latina/o o Hispana/o
- Habla español la mayor parte del tiempo

Puede que usted califique para participar en este proyecto.

Por favor, comuníquese con María José Rendón al 305.482.6613 para más información.
APPENDIX D

Recruitment Script – Community Sample – English

CAPS-5 ADAPTATION STUDY
RECRUITMENT SCRIPT

In-person recruitment script – community sample (English)

Hi, my name is María José Rendón, and I am a doctoral candidate in Counseling Psychology at the University of Miami. I am recruiting Latinos who speak Spanish to help review the translation of a questionnaire. This questionnaire will be used to interview Latinos about their life after going through a difficult life event. I want to make sure that the translation is accurate and easy to understand. If you qualify and are interested, I would like to invite you to be part of a focus group comprising between four to six people. In this group, you will help us review this questionnaire to make it easier to understand.

If you are 18 or older, identify as Latino/a or Hispanic, and speak Spanish most of the time, you may qualify to participate in this project. Please note that you do not need to have lived through a difficult life event to qualify. There are other requirements that I will explain to you in detail if you are interested in participating.

I appreciate your help in conducting this study. People who participate will be awarded a $30 gift card as compensation for their participation.

If you want to learn more about this study, please speak to me or one of the research assistants present today. Thank you for your time.
APPENDIX E

Recruitment Script – Community Sample – Spanish

CAPS-5 ADAPTATION STUDY
RECRUITMENT SCRIPT

In-person recruitment script – community sample (Spanish)

Hola mi nombre es María José Rendón, y soy una candidata al doctorado en Counseling Psychology en la Universidad de Miami. Estoy reclutando Latina/os que hablan español para que nos ayuden a revisar la traducción de las preguntas en una entrevista. Esta entrevista se usa para entrevistar Latinas/os acerca de sus experiencias después de pasar por un evento difícil. Quiero asegurarme que la traducción sea correcta y fácil de entender. Si usted califica y le interesa participar, me gustaría invitarle a ser parte de un grupo de discusión de cuatro a seis personas. En este grupo, usted nos ayudará a revisar esta entrevista para hacerla más fácil de entender.

Si usted es mayor de 18 años, se identifica como Latina/o o Hispana/o, y habla español la mayor parte del tiempo, puede ser que califique para este proyecto. Por favor note que no tiene que haber pasado por una experiencia difícil en su vida para calificar. Hay otros requerimientos que le explicaremos en más detalle si usted está interesada/o en participar.

Aprecio mucho su ayuda en realizar este proyecto. Como compensación por su participación en el estudio le entregaremos una tarjeta de regalo valorada en $30.

Si está interesada/o en saber más acerca del estudio, por favor acérquese a hablar conmigo o con alguna/o de las asistentes de investigación presentes hoy. Muchas gracias por su atención.
APPENDIX F

Screening Script – Community Sample - English

CAPS-5 ADAPTATION STUDY
FOCUS GROUP PHONE SCREENING SCRIPT

1. GREETING
Hi, my name is María José Rendón, and I’m a doctoral candidate in Counseling Psychology at the University of Miami.

If referred by an agency: “I am calling you by recommendation of (referrer) at (referral site), who thought you might be interested in being part of a project I am conducting at the University of Miami. This project is designed to ensure that a questionnaire is well translated from English into Spanish. Would you like to hear more about it?

If self-referral: “You left us a message to learn more about a project.”

2. DESCRIPTION
We are recruiting Latinos who speak Spanish to help review the translation of a questionnaire. This questionnaire will be used to interview Latinos about their life after going through a difficult life event. Please note that you do not need to have lived through a difficult life event to qualify. In this study, we want to make sure that the translation is accurate and easy to understand. Would you like to learn more about how you can participate?

Allow me to describe the study. If you decide to participate, we will ask you to be part of a focus group that will last about two and a half hours. The group will review a questionnaire that is used to understand the emotions that people tend to experience after a difficult life event. The group will include between four and six people who also identify as Hispanic/Latino and who speak Spanish most of the time. Do you think you would be interested in participating?

3. MEASURES
There are some questions I must ask you to see if you meet the study requirements. Are you available for approximately 10 minutes for a small interview? [complete screener form].

4. IF RECRUIT DOES NOT QUALIFY
Unfortunately you do not qualify for this study because we need to include participants who speak Spanish most of the time. Again, thank you for your time today.

5. IF RECRUIT QUALIFIES
You qualify to participate in this study. Allow me to provide you with further information about the groups.

Compensation: If you participate, you will be awarded a $30 gift card. We will also cover your parking or public transportation costs.

Dates: We have some tentative dates for this month’s focus groups [discuss options]. Which days and times would be best for you? [if not available for current dates, ask for days and times they might be available in the next month for possible future groups, so we can invite them back].
Confidentiality: The groups will be audio recorded. To protect your privacy, all information about you collected during the project will not be identified by name. Instead, it will be linked to a number. However, because you will participate in a discussion group with other participants, we cannot guarantee confidentiality.

During the groups, it may be that the questionnaire will remind you of difficult life experiences you have had in the past. This group is not a therapy group or a support group, and therefore it will not be the best place to speak about these topics. If you desire to speak with a mental health professional about your experiences in the past or as part of this group, please let us know before or after the group, so that we can share with you referral resources. You can also choose not to answer a question or stop participation at any time without penalty. A member of our research team will also be available at the groups for consultation if you need help. If you bring other people to the group (e.g., a person who is driving you to the center), they will have to wait in the waiting room area. Do you have any questions?"

6. REMINDER
[Restate date, time, location.] We will call you the day before the group to remind you of your appointment. [Restate your name, affiliation, phone number]. Thank you again for your participation, see you soon!
APPENDIX G
Screening Script – Community Sample – Spanish

CAPS-5 ADAPTATION STUDY
FOCUS GROUP PHONE SCREENING SCRIPT (SPANISH)

7. SALUDO
Buenos días/Buenas tardes, (or any appropriate greeting), mi nombre es María José Rendón y soy una candidata al doctorado en Counseling Psychology en la Universidad de Miami.

Si fue referido por una agencia: “Le estoy llamando por recomendación de (referrer) en (referral site), el/la cual pensó que a Ud. le interesaría participar en un proyecto que estoy realizando en la Universidad de Miami. En este proyecto vamos a revisar la traducción de las preguntas en una entrevista, del inglés al español, para asegurarnos que la traducción esté bien hecha. ¿Le interesaría conocer más acerca de este proyecto?

Si se refirió personalmente: “Ud. nos dejó un mensaje para saber más acerca de este estudio.”

8. DESCRIPCIÓN
Estamos reclutando Latinas/os que hablan español para que nos ayuden a revisar la traducción de las preguntas en una entrevista. Esta entrevista se usa para evaluar los síntomas emocionales que ocurren después de pasar por un evento difícil en su vida. Cabe recalcar que no necesita haber vivido un evento difícil en su vida para calificar. En este proyecto, queremos asegurarnos que la traducción sea correcta y fácil de entender. ¿Le interesaría saber cómo Ud. puede participar?

Permítame describirle el estudio. Si usted decide participar, se le pedirá que asista a grupo de discusión que durará dos horas y media. La entrevista que revisaremos se usa para entender las emociones que las personas a veces desarrollan después de vivir un evento difícil en su vida. El grupo revisará esta entrevista. El grupo consistirá de cuatro a seis adultos que también se identifican como Latinas/os o Hijpans/os y que hablan español la mayor parte del tiempo. ¿Piensa que le interesaría participar?

9. CUESTIONARIOS
Hay algunas preguntas que debo hacerle para ver si Ud. califica para participar en el estudio. ¿Está disponible por unos 10 minutos para hacerle unas preguntas? [complete screener/demographics form].

10. SI NO CALIFICA
Desafortunadamente Ud. no califica para este estudio, ya que estamos buscando personas que hablan español la mayor parte del tiempo. Una vez más, gracias por su tiempo.

11. SI CALIFICA
Usted califica para participar en este estudio. Permítame darle más información acerca de los grupos.

Compensación: Si usted participa, le compensaremos con una tarjeta de regalo valorada en $30. También cubriremos su parqueo o costos de transporte público.
**Fechas:** Tenemos algunas fechas previstas para realizar los grupos este mes [discuss options]. ¿Me puede indicar qué días y horas serían más convenientes para usted? [if not available, ask for days and times they might be available for following rounds, so we can invite them back].

**Confidencialidad:** Los grupos serán grabados en una cinta de audio digital. Para proteger su privacidad, toda información colectada acerca de usted durante el proyecto no será identificada con su nombre, si no, con un número. Sin embargo, ya que usted va a ser parte de un grupo de discusión con otros participantes, no podemos garantizar la confidencialidad.

Durante los grupos, puede ser que leer el cuestionario le haga recordar eventos difíciles en su vida. Este grupo no es un grupo de terapia o de apoyo, y por lo tanto no es el mejor momento para que hablemos de estos temas. Si Ud. desea adquirir servicios de salud mental profesional para hablar de sus experiencias, por favor, póngase en contacto con nosotros antes o después del grupo para darle una lista de servicios a bajo costo. Usted también puede elegir contestar preguntas que sean incómodas, y puede dejar de participar en cualquier momento sin ninguna penalidad. Un miembro de nuestro equipo también estará a su disposición si Ud. necesita ayuda en ese momento. Si Ud. trae otras personas al grupo, ellas tendrán que esperar en la sala de espera. ¿Tiene alguna pregunta hasta ahora?"

12. **RECORDATORIO**
[Restate date, time, location.] Le llamaremos el día anterior para recordarle de su cita. [Restate your name, affiliation, phone number]. Muchas gracias por su participación, ¡lo/a esperamos!
We are recruiting Spanish-speaking Latinas/os to help us review the Spanish translation of a questionnaire. This questionnaire will be used to interview Latinas/os about their life after going through a difficult life event. If you qualify, we will invite you to complete this questionnaire and provide feedback. You will be compensated with a gift card valued at $25.

If you:

- Are 18 years of age or older
- Identify as Latina/o o Hispanic
- Speak Spanish most of the time

You may qualify to participate in this project.

Please call María José Rendón at 305.482.6613 for further information.
APPENDIX I

Flyer – Clinical Sample – Spanish

Estamos reclutando Latinas/os que hablan español para que nos ayuden a revisar la traducción de las preguntas de una entrevista. Estas preguntas serán usadas para entrevistar a Latinas/os acerca de sus experiencias después de vivir un evento difícil. Si usted califica, le invitaremos a completar esta entrevista y a dar su opinión acerca de la traducción. Usted será compensada/o con una tarjeta de regalo valorada en $25. Si usted es:

- Mayor de 18 años
- Se identifica como Latina/o o Hispana/o
- Habla español la mayor parte del tiempo

Puede que usted califique para participar en este proyecto. Por favor, comuníquese con María José Rendón al 305.482.6613 para más información.
Hi, my name is María José Rendón and I am a doctoral candidate in Counseling Psychology at the University of Miami. I am recruiting Latinos who speak Spanish to help review the translation of a questionnaire. This questionnaire will be used to interview Latinos about their life after going through a difficult life event. I want to make sure that the translation is accurate and easy to understand. If you qualify and are interested, I would like to invite you to participate in an interview using this questionnaire. By completing this interview, you will help us review this questionnaire to make it easier to understand.

If you are 18 or older, identify as Latino/a or Hispanic, and speak Spanish most of the time, you may qualify to participate in this project. There are other requirements that I will explain to you in detail if you are interested in participating.

I appreciate your help in conducting this study. People who participate will be awarded $25 as compensation for their participation.

If you want to learn more about this study, please speak to me or one of the research assistants present today. Thank you for your time.
In-person recruitment script – clinical sample (Spanish)

Hola mi nombre es María José Rendón y soy una candidata al doctorado en Counseling Psychology en la Universidad de Miami. Estoy reclutando Latina/os que hablan español para que nos ayuden a revisar la traducción de las preguntas en una entrevista. Esta entrevista se usa para entrevistar Latinas/os acerca de sus experiencias después de pasar por un evento difícil. Quiero asegurarme que la traducción sea correcta y fácil de entender. Si usted califica y le interesa participar, me gustaría invitarle a realizar esta entrevista. Al realizar la entrevista, usted nos ayudará a revisarla para hacerla más fácil de entender.

Si usted es mayor de 18 años, se identifica como Latina/o o Hispana/o, y habla español la mayor parte del tiempo, puede ser que califique para este proyecto. Hay otros requerimientos que le explicaremos en más detalle si usted está interesada/o en participar.

Aprecio mucho su ayuda en realizar este proyecto. Como compensación por su participación en el estudio le compensaremos con $25.

Si está interesada/o en saber más acerca del estudio, por favor acérquese a hablar conmigo o con alguna/o de las asistentes de investigación presentes hoy. Muchas gracias por su atención.
APPENDIX L

Screening Script – Clinical Sample – English

CAPS-5 ADAPTATION STUDY
CLINICAL SAMPLE SCREENING SCRIPT

1. GREETING
Hi, my name is María José Rendón and I’m a doctorate candidate in Counseling Psychology at the University of Miami.

If referred by an agency: “I am calling you by recommendation of (referrer) at (referral site), who thought you might be interested in being part of a project I am conducting at the University of Miami. This project is designed to ensure that a questionnaire is well translated from English into Spanish. Would you like to hear more about it?

If self-referred: “You left us a message to learn more about a project.”

2. DESCRIPTION
We are recruiting Latinos who speak Spanish to help review the translation of a questionnaire. This questionnaire is used to understand the emotions that people tend to experience after a difficult life event. In this study, we want to make sure that the translation is accurate and easy to understand for Latinos who speak Spanish. Would you like to learn more about how you can participate?

Allow me to describe the study. As I mentioned earlier, the purpose of this study is to make sure that the Spanish translation is easy to understand. We are currently testing the interview with individuals who are willing to answer questions about a difficult life event in their life and about the symptoms they may have developed after it.

Do you think you would be interested in participating? [Provide some time for questions and building rapport with participant].

3. MEASURES
There are some questions I must ask you to see if you meet the study requirements. Are you available for approximately 10 minutes for a small interview? [complete screener form].

4. IF RECRUIT DOES NOT QUALIFY
Unfortunately you do not qualify for this study because we need to include participants who [describe reason for exclusion]. Again, thank you for your time today.

5. IF RECRUIT QUALIFIES
You qualify to participate in this study. Allow me to provide you with further information.

Procedures. If you decide to participate, you will complete the CAPS-5 interview in a one-on-one setting. The questions in the CAPS-5 will ask you to talk about sensitive topics. In the first part of the interview, you will be asked to briefly describe a trauma event that you have experienced in your life. In the next sections, you will be asked about thoughts, emotions and behaviors that you may have started having after this traumatic event. The interview will last approximately one hour. Because the nature of the questions is sensitive, the interviewer will
work with you in managing any uncomfortable reactions you may have during the interview. There are no right or wrong answers to these questions. You can also choose not to answer a question or stop participation at any time without penalty. At the end of the interview, you will be asked to share your opinion about the interview wording and format.

**Confidentiality:** The interview will be audio recorded because we do not want to miss anything you say during the interview. To protect your privacy, all information about you collected during the project will not be identified by name. Instead, it will be linked to a number. Do you have any questions?"

**Compensation:** If you participate, you will be awarded a $25 gift card. We will also cover your parking or public transportation costs.

**Dates and Location:** [schedule individual interview date, time and location according to interviewer and participant’s availability].

6. **REMINDE**
[Restate date, time, location.] We will call you the day before the group to remind you of your appointment. [Restate your name, affiliation, phone number]. Thank you again for your participation, see you soon!
APPENDIX M

Screening Script – Clinical Sample – Spanish

CAPS-5 ADAPTATION STUDY
CLINICAL SAMPLE SCREENING SCRIPT (SPANISH)

1. **SALUDO**
Buenos días/Buenas tardes, (or any appropriate greeting), mi nombre es María José Rendón y soy una candidata al doctorado en Counseling Psychology en la Universidad de Miami.

**Si fue referido por una agencia:** “Le estoy llamando por recomendación de (referrer) en (referral site), el/la cual pensó que a Ud. le interesaría participar en un proyecto que estoy realizando en la Universidad de Miami. En este proyecto vamos a revisar la traducción de las preguntas en una entrevista, del inglés al español, para asegurarnos que la traducción esté bien hecha. ¿Le interesaría conocer más acerca de este proyecto?

**Si se refirió personalmente:** “Ud. nos dejó un mensaje para saber más acerca de este estudio.”

2. **DESCRIPCIÓN**
Estamos reclutando Latinas/os que hablan español para que nos ayuden a revisar la traducción de las preguntas en una entrevista. Esta entrevista se usa para evaluar los síntomas emocionales que ocurren después de un evento difícil en su vida. En este proyecto, queremos asegurarnos que la traducción sea correcta y fácil de entender. ¿Le interesaría saber cómo Ud. puede participar?

Permítame describirle el estudio. Como mencioné anteriormente, el propósito de este proyecto es asegurarnos que la traducción al español de esta entrevista sea fácil de entender. Estamos buscando personas que estén dispuestas a responder preguntas acerca de un evento difícil en su vida, y de los síntomas que tal vez hayan desarrollado después de aquel evento.

¿Piensa que le interesaría participar? [Provide some time for questions and building rapport with participant].

3. **CUESTIONARIOS**
Hay algunas preguntas que debo hacerle para ver si Ud. califica para participar en el estudio. ¿Está disponible por unos 10 minutos para hacerle unas preguntas? [complete screener/demographics form].

4. **SI NO CALIFICA**
Desafortunadamente Ud. no califica para este estudio, ya que estamos buscando personas que [describe reason for exclusion]. Una vez más, gracias por su tiempo.

5. **SI CALIFICA**
Usted califica para participar en este estudio. Permítame darle más información.

**Procedimientos:** Si decide participar, usted completará la entrevista del CAPS-5 en un lugar privado. Las preguntas en el CAPS-5 le llevarán a hablar de temas delicados. En la primera parte de la entrevista, se le pedirá que describa brevemente un evento traumático que usted haya pasado en su vida. En las siguientes secciones, se le harán preguntas acerca de pensamientos, emociones, y comportamientos que usted pueda haber desarrollado después de pasar por este evento.
traumático. La entrevista durará aproximadamente una hora. Dado que la naturaleza de las
preguntas es delicada, la entrevistadora le ayudará a sentirse menos incómodo/a durante la
entrevista.

No hay respuestas correctas o incorrectas a estas preguntas. Usted también puede elegir no
contestar preguntas o puede dejar de participar en cualquier momento sin ninguna penalidad. Al
final de la entrevista, se le pedirá que comparta su opinión acerca del formato del cuestionario.

Confidencialidad: La entrevista será grabada en una cinta de audio digital porque no queremos
perder nada que usted diga durante la entrevista. Para proteger su privacidad, toda información
colectada acerca de usted durante el proyecto no será identificada con su nombre, si no, con un
número. ¿Tiene alguna pregunta hasta ahora?

Compensación: Si usted participa, le compensaremos con una tarjeta de regalo valorada en $25.
También cubriremos su parqueo o costos de transporte público.

Fechas y ubicación: [schedule individual interview date, time and location according to
interviewer and participant’s availability].

6. RECORDATORIO
[Restate date, time, location.] Le llamaremos el día anterior para recordarle de su cita. [Restate
your name, affiliation, phone number]. Muchas gracias por su participación, ¡lo/a esperamos!
APPENDIX N

Letter of IRB Approval

- Submission #: 20140469   Issue Date: 6/23/2014

UNIVERSITY
OF MIAMI

University of Miami
Human Subjects Research Office (HSRO)
P.O. Box 016660, Miami, Florida 33101
4000 N.W. 8th Avenue, Suite 1002, Miami, Florida
Ph.: 305-243-3195
Fax: 305-243-3328
www.hsro.miami.edu

APPROVAL

June 23, 2014

Lydia Buki
312-E Merrick Building
5202 University Drive
Dept. of Educational Psychology
Coral Gables, FL 33146
305-284-2230
lbuki@miami.edu

Dear Dr. Lydia Buki:

On 6/23/2014, the IRB reviewed the following submission:

<table>
<thead>
<tr>
<th>Type of Review:</th>
<th>Initial Study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investigator:</td>
<td>Lydia Buki</td>
</tr>
<tr>
<td>IRB ID:</td>
<td>20140469</td>
</tr>
<tr>
<td>Funding:</td>
<td>None</td>
</tr>
<tr>
<td>Documents Reviewed:</td>
<td>• Acculturation and language scale - AMAS-ZABB - English and Spanish, Category: Questionnaire/Survey; • Clinician Administered PTSD Scale (CAPS-5) - English original, Category: Questionnaire/Survey; • Clinical sample - recruitment script - English, Category: Recruitment Materials; • Community sample - Informed Consent Form - English, Category: Consent Form; • Clinical sample - Informed Consent Form - English, Category: Consent Form; • Community sample - flyer - English, Category: Recruitment Materials; • Clinical sample - Pretesting questions - English, Category: Other; • Bilingual sample - Item Translation and Adaptation</td>
</tr>
</tbody>
</table>

Page 1 of 2

206
The IRB approved the study from 6/23/2014 to 6/22/2017 inclusive with a waiver of documentation of consent for screening. Before 6/22/2017 or within 45 days of the approval end date, whichever is earlier, you are to submit a completed Continuing Review to request continuing approval or closure.

If continuing review approval is not granted before the expiration date of 6/22/2017 approval of this study expires on that date.

To document consent, use the consent documents that were approved and stamped by the IRB. Go to the Documents tab to download them.

*NOTE: Translations of IRB approved study documents, including informed consent documents, into languages other than English must be submitted to HSRO for approval prior to use.*

In conducting this study, you are required to follow the requirements listed in the Investigator Manual (HRP-103), which can be found by navigating to the IRB Library within the IRB system.

Should you have any questions, please contact: Vivienne Carrasco, Sr. IRB Regulatory Analyst, (phone: 305-243-6713; email: vcarrasco@med.miami.edu)

Sincerely,

*This is a representation of an electronic record that was signed electronically and this page is the manifestation of the electronic signature*

Amanda Coltes-Rojas, MPH, CIP
Director
Regulatory Affairs & Educational Initiatives
APPENDIX O

Informed Consent Form – Community Sample - English

UNIVERSITY OF MIAMI
INFORMED CONSENT TO PARTICIPATE IN A RESEARCH PROJECT

TITLE OF STUDY: The Cultural Validity of the Clinician-Administered PTSD Scale for Spanish-Speaking Latinos with Limited English Proficiency in the United States

NAME OF PRINCIPAL RESPONSIBLE INVESTIGATOR: Lydia P. Buki, Ph.D.

NAME OF PRINCIPAL INVESTIGATOR: María José Rendón, B.A.

DEPARTMENT: Department of Educational and Psychological Studies

FOR QUESTIONS/PROBLEMS, CONTACT: María José Rendón at (305) 482-6613 or Lydia P. Buki, at (305) 284 2230.

ABOUT INFORMED CONSENT: You are being asked to participate in a University of Miami research project. This document will describe in detail the purpose of the project, the procedures to be used, and the possible risks and benefits of your participation. You may also ask the research project staff members any questions that may help you to understand the project. If you decide to participate in the research project, please sign this form. You will be given a copy of this form to keep.

PURPOSE OF THE PROJECT: The purpose of the study is to develop a Spanish translation of a questionnaire called “The Clinician-Administered PTSD Scale” (CAPS-5), which is used to evaluate symptoms of trauma and stress following a difficult life experience. Our goal is to make the CAPS-5 clear and understandable for Spanish-speaking Latinos of various countries and educational backgrounds.

PROCEDURES: Focus group interviews will be conducted with Spanish-speaking Latinos to obtain feedback about the translation of the CAPS-5. If you decide to participate, you will be asked to join a group discussion of 4-6 people to review the measure. In the group, you will hear and read the CAPS-5 questions in Spanish. You will be asked to suggest other ways of saying the question so that it is easier to understand. You will NOT be asked about individual issues, diagnosis, or your personal history. Before the group, you will be asked to provide sociodemographic information on a questionnaire. The meeting will last approximately 2 hours and a half. The focus group will be audio taped.

RISKS: Risks in this study are considered minimal. During the groups, the questionnaire may remind you of difficult life experiences you have had in the past. This group is not a therapy group or a support group, and therefore it will not be the best place to speak
about these topics. If you desire to speak with someone about your symptoms, however, your facilitator may refer you for low cost support services. You can also refuse to answer a question or stop your participation in the project at any time without penalty. A member of our research team will also be available at the groups for consultation if you need help.

**BENEFITS:** The study is expected to benefit Spanish speaking Latinos with limited English proficiency. It is expected that creating a well-translated questionnaire will improve researchers and clinicians’ ability to identify trauma symptoms among Spanish speaking Latinos. No direct benefit can be promised to you from your participation in this study. Your help in gathering this information is greatly appreciated.

**COMPENSATION:** To compensate you for your time and participation, you will receive a $30.00 gift certificate upon completion of the study. We will also cover your parking or public transportation costs.

**CONFIDENTIALITY:** Only your first name will be used in the focus group. All information about you collected during the project will not be identified by name. Instead, it will be linked to a number. Any information collected about you will be stored in a locked filing cabinet at the responsible principal investigator’s research office. Audio files will be kept in a password-protected account at a secure server on a University of Miami computer. All files will be destroyed after the project is completed. Any information obtained in connection with this study that can be identified with you will remain confidential, to the extent of the law, and will be disclosed only with your permission.

**CONTACT INFORMATION:** If you have any questions about this project, please contact María José Rendón (doctoral candidate) at (305) 482-6613, or Lydia P. Buki, Ph.D. (dissertation chair), at (305) 284-2230. If you have any questions regarding your rights as a study participant, you may contact the Human Subjects Research Office at the University of Miami at (305) 243-3195.

**VOLUNTARY PARTICIPATION:** Your decision whether or not to participate in this project will not affect your future relations with the University of Miami or any cooperating institution. Your participation is voluntary and you have the right to stop at any time without penalty or loss of benefits. Your signature acknowledges that you have read the information stated and that you voluntarily agree to take part in this project and to have the focus group audiotaped. Your signature also acknowledges that you have been offered, on the date signed, a copy of this document containing two pages.

Signature of Participant: _____________________________ Date: __________

Signature of Person obtaining consent: _______________________Date: __________
APPENDIX P

Informed Consent Form – Community Sample - Spanish

UNIVERSIDAD DE MIAMI
CONSENTIMIENTO PARA PARTICIPAR EN UN PROYECTO DE INVESTIGACIÓN
(Grupo de Discusión)

TÍTULO DEL ESTUDIO: La Validez Cultural de la Escala CAPS-5 (Clinician Administered PTSD Scale 5 [Escala de Trastorno de Estrés Posttraumático Administrada por el Clínico 5]) para Latinos Hispanohablantes con Dominio Limitado del Idioma Inglés en los Estados Unidos

NOMBRE DE LA INVESTIGADORA PRINCIPAL RESPONSABLE: Lydia P. Buki, Ph.D.

NOMBRE DE LA INVESTIGADORA PRINCIPAL: María José Rendón, B.A.

DEPARTAMENTO: Departamento de Estudios Educacionales y Psicológicos

PARA PREGUNTAS/PROBLEMAS, FAVOR CONTACTARSE CON: María José Rendón al (305) 482-6613 o con Lydia P. Buki, al (305) 284 2230

ACERCA DEL CONSENTIMIENTO: A usted se le ha pedido que participe en un proyecto de investigación en la Universidad de Miami. Este documento describirá en detalle el propósito del proyecto, los procedimientos que se usarán, y los posibles riesgos y beneficios que su participación implica. Ud. también puede pedirles a los miembros de personal de investigación que contesten cualquier pregunta que le ayude a comprender el proyecto. Si usted decide participar, por favor firme este formulario. Ud. recibirá una copia adicional de este formulario para su propia información.

PROPÓSITO DEL PROYECTO: Este estudio tiene como propósito desarrollar una traducción al español de una entrevista llamada Clinician Administered PTSD Scale (CAPS-5; Escala de Trastorno de Estrés Posttraumático Administrada por el Clínico), la cual es usada para evaluar síntomas de trauma y estrés después de haber pasado por una experiencia difícil. Nuestra meta es que el CAPS-5 sea claro y fácil de entender para Latinos Hispanohablantes de varios países y niveles educacionales.

PROCEDIMIENTOS: Realizaremos grupos de discusión con Latinos Hispanohablantes para revisar la traducción del CAPS-5. Si usted decide participar, se le invitará a un grupo de discusión de 4 a 6 personas para revisar el cuestionario. En el grupo, usted escuchará y leerá las preguntas del CAPS-5 en español. Se le pedirá que sugiera otras maneras de decir las preguntas para que sean más fáciles de entender. NO le preguntaremos acerca de problemas personales, diagnósticos, o de su historia personal. Antes del grupo, se le pedirá que complete un cuestionario acerca de su información sociodemográfica. El grupo durará aproximadamente 2 horas y media. La discusión de grupo será grabada para asegurarnos que no se pierda ninguna información.

RIESGOS: Se considera que los riesgos en este estudio son mínimos. Durante los grupos, puede ser que las preguntas del CAPS-5 le recuerde eventos difíciles que usted haya vivido en el pasado. Este grupo no es un grupo de terapia o de apoyo, y como resultado, no es el mejor momento para hablar de estos temas. Sin embargo, si usted desea hablar con alguien acerca de sus
síntomas, la moderadora del grupo puede darle una lista de servicios de apoyo a bajo costo en la comunidad. Usted también puede negarse a contestar preguntas o cesar su participación en el proyecto en cualquier momento sin ninguna penalidad. Un miembro de nuestro equipo de investigación también estará disponible en la sala de discusión si usted necesita ayuda.

**BENEFICIOS:** Se espera que este estudio beneficiará a Latinos hispanohablantes que tienen dominio limitado del idioma inglés. Se espera que una entrevista bien traducida ayudará a que investigadores y profesionales de salud mental puedan identificar con más facilidad síntomas de trauma entre Latinos que hablan español. No podemos prometerle ningún beneficio directo a usted por su participación en este estudio. Apreciamos inmensamente su ayuda en colectar esta información.

**COMPENSACIÓN:** Como compensación por su tiempo y esfuerzo, usted recibirá una tarjeta de regalo valorada en $30.00 al completar este estudio. También pagaremos por el costo del parqueo o el costo de transporte público que usted use para llegar a su cita.

**CONFIDENCIALIDAD:** Sólo usaremos su primer nombre en los grupos de discusión. Además, toda la información colectada acerca suyo durante el proyecto no será identificada por nombre, si no por un número. Cualquier información colectada acerca suyo será guardada en un gabinete con llave en la oficina de la investigadora principal responsable. Los archivos de audio serán guardados en una cuenta protegida con clave, dentro de un servidor con contraseña, en una computadora de la Universidad de Miami. Todos los archivos serán destruidos cuando el proyecto haya finalizado. Cualquier información obtenida en relación a este estudio que puede identificiarla/o Ud. como participante seguirá siendo confidencial, en la medida que la ley lo permita, y será revelada sólo con su permiso explícito.

**INFORMACIÓN DE CONTACTO:** Si usted tiene alguna pregunta acerca de este proyecto, por favor contacte a María José Rendón (candidata al doctorado) al (305) 482-6613, o Lydia P. Buki, Ph.D. (directora de la disertación) al (305) 284-2230. Si usted tiene alguna pregunta sobre sus derechos como participante en el estudio, puede comunicarse con la Oficina de Investigación de Participantes Humanos (the Human Subjects Research Office, HSRO) en la Universidad de Miami al (305) 243-3195.

**PARTICIPACIÓN VOLUNTARIA:** Su decisión de participar o no en este proyecto no afectará sus relaciones futuras con la Universidad de Miami o con cualquier institución cooperante. Su participación es voluntaria y usted puede retirar su consentimiento y negar su participación en el estudio en cualquier momento sin riesgo de ser penalizada/o o de perder los beneficios que le corresponden por su participación. Su firma en este documento indicará que Ud. ha leído la información proporcionada, y que ha aceptado de forma voluntaria participar en este proyecto y que la entrevista sea grabada. Su firma también indica que en el día de la fecha se le ha ofrecido una copia de esta forma que contiene dos páginas.

Firma del Participante: _____________________________ Fecha: __________

Testigo: ________________________________       Fecha: _____________
APPENDIX Q
Informed Consent Form – Clinical Sample – English

UNIVERSITY OF MIAMI
INFORMED CONSENT TO PARTICIPATE IN A RESEARCH PROJECT

TITLE OF STUDY: The Cultural Validity of the Clinician-Administered PTSD Scale for Spanish-Speaking Latinos with Limited English Proficiency in the United States

NAME OF PRINCIPAL RESPONSIBLE INVESTIGATOR: Lydia P. Buki, Ph.D.

NAME OF PRINCIPAL INVESTIGATOR: María José Rendón, B.A.

DEPARTMENT: Department of Educational and Psychological Studies

FOR QUESTIONS/PROBLEMS, CONTACT: María José Rendón at (305) 482-6613 or Lydia P. Buki, at (305) 284 2230.

ABOUT INFORMED CONSENT: You are being asked to participate in a University of Miami research project. This document will describe in detail the purpose of the project, the procedures to be used, and the possible risks and benefits of your participation. You may ask the project staff members any questions that may help you to understand the project. If you decide to participate, please sign this form. You will be given a copy of this form to keep.

PURPOSE OF THE PROJECT: The purpose of the study is to develop a Spanish translation of a questionnaire called “The Clinician-Administered PTSD Scale” (CAPS-5), which is used to evaluate symptoms of trauma and stress following a difficult life experience. Our goal is to make the CAPS-5 clear and understandable for Spanish-speaking Latinos of various countries and educational backgrounds.

PROCEDURES: Spanish-speaking Latinos who have been diagnosed with PTSD by their provider will be invited to complete the CAPS-5 interview. During the interview, you will be asked to discuss one or more difficult life events that you have experienced in your life, as well as to discuss the symptoms you may have as a result of this event. Before the interview, you will be asked to provide sociodemographic information on a questionnaire. After the interview, you will be asked to provide feedback about the interview process. The interview will last approximately 1 hour.

The interview will be audiotaped to ensure that none of the information given by you is lost. However, only your first name will be used for these records, and your name will not be included on any written materials.

RISKS: Risks in this study are considered minimal. Because the information discussed in the interview is related to a difficult experience, you may feel some distress during the discussion. However, it is expected that this distress will be temporary. You can also refuse to answer a question, or stop your participation in the project at any time without penalty.
**BENEFITS:** The study is expected to benefit Spanish speaking Latinos with limited English proficiency. It is expected that creating a well-translated questionnaire will improve researchers’ and clinicians’ ability to identify trauma symptoms among Spanish speaking Latinos. No direct benefit can be promised to you from your participation in this study. Your help in gathering this information is greatly appreciated.

**COSTS:** There are no costs associated with your participation in this study.

**COMPENSATION:** To compensate you for your time and participation, you will receive a $25.00 gift certificate upon completion of the study. We will also cover your parking or public transportation costs.

**CONFIDENTIALITY:** Only your first name will be used in the interview recording. In addition, all information about you collected during the project will not be identified by name. Instead, it will be linked to a number. Any information collected about you will be stored in a locked filing cabinet at the responsible principal investigator’s research office. Audio files will be kept in a password-protected account at a secure server on a University of Miami computer. All files will be destroyed after the project is completed. Any information obtained in connection with this study that can be identified with you will remain confidential, to the extent of the law, and will be disclosed only with your permission.

**CONTACT INFORMATION:** If you have any questions about this project, please contact María José Rendón (doctoral candidate) at (305) 482-6613, or Lydia P. Buki, Ph.D. (dissertation chair), at (305) 284-2230. If you have any questions regarding your rights as a study participant, you may contact the Human Subjects Research Office at the University of Miami at (305) 243-3195.

**VOLUNTARY PARTICIPATION:** Your decision whether or not to participate in this project will not affect your future relations with the University of Miami or any cooperating institution. Your participation is voluntary and you have the right to stop at any time without penalty or loss of benefits to which you are otherwise entitled. Your signature acknowledges that you have read the information stated and that you voluntarily agree to take part in this project and to have the interview audiotaped. Your signature also acknowledges that you have been offered, on the date signed, a copy of this document containing two pages.

Signature of Participant: _____________________________ Date: __________

Witness: _____________________________ Date: __________
APPENDIX R

Informed Consent Form – Clinical Sample – Spanish

UNIVERSIDAD DE MIAMI
CONSENTIMIENTO PARA PARTICIPAR EN UN PROYECTO DE INVESTIGACIÓN
(ENTREVISTAS INDIVIDUALES)

TÍTULO DEL ESTUDIO: La Validez Cultural de la Escala CAPS-5 (Clinician Administered PTSD Scale 5 [Escala de Trastorno de Estrés Posttraumático Administrada por el Clínico 5]) para Latinos Hispanohablantes con Dominio Limitado del Idioma Inglés en los Estados Unidos

NOMBRE DE LA INVESTIGADORA PRINCIPAL RESPONSABLE: Lydia P. Buki, Ph.D.

NOMBRE DE LA INVESTIGADORA PRINCIPAL: María José Rendón, B.A.

DEPARTAMENTO: Departamento de Estudios Educacionales y Psicológicos

PARA PREGUNTAS/PROBLEMAS, FAVOR CONTACTARSE CON: María José Rendón al (305) 482-6613 o con Lydia P. Buki, al (305) 284 2230.

ACERCA DEL CONSENTIMIENTO: A usted se le ha pedido que participe en un proyecto de investigación en la Universidad de Miami. Este documento describirá en detalle el propósito del proyecto, los procedimientos que se usarán, y los posibles riesgos y beneficios que su participación implica. Ud. también puede pedirles a los miembros de personal de investigación que contesten cualquier pregunta que le ayude a comprender el proyecto. Si usted decide participar, por favor firme este formulario. Ud. recibirá una copia adicional de este formulario para su propia información.

PROPÓSITO DEL PROYECTO: Este estudio tiene como propósito desarrollar una traducción al español de una entrevista llamada Clinician Administered PTSD Scale (CAPS-5; Escala de Trastorno de Estrés Posttraumático Administrada por el Clínico), la cual es usada para evaluar síntomas de trauma y estrés después de haber pasado por una experiencia difícil. Nuestra meta es que el CAPS-5 sea claro y fácil de entender para Latinos Hispanohablantes de varios países y niveles educacionales.

PROCEDIMIENTOS: En este proyecto, invitamos a Latinos Hispanohablantes que han sido diagnosticados con TEPT por su proveedor de servicios de salud a que completen la entrevista CAPS-5. Durante la entrevista, se le pedirá a usted que reporte uno o más eventos difíciles por los que haya pasado en su vida, y que describa los síntomas que usted puede haber desarrollado como resultado de este evento. Antes de la entrevista, se le pedirá que complete un cuestionario con su información sociodemográfica. Después de la entrevista, se le pedirá que comparta su opinión acerca de la entrevista. La entrevista durará aproximadamente 1 hora.

La entrevista será grabada para asegurarnos que no se pierda ninguna información. Sin embargo, sólo usaremos su primer nombre en esta grabación, y su nombre no será incluido en ningún material escrito.
RIESGOS: Se considera que los riesgos en este estudio son mínimos. Es posible que usted se sienta incómoda/o durante la entrevista ya que los temas a tratar son referentes a una experiencia difícil en su vida. Sin embargo, se espera que estos efectos sean temporarios. Usted también puede negarse a contestar preguntas o dejar de participar en el proyecto en cualquier momento sin ninguna penalidad.

BENEFICIOS: Se espera que este estudio beneficiará a Latinos hispanohablantes que tienen dominio limitado del idioma inglés. Se espera que una entrevista bien traducida ayudará a que investigadores y profesionales de salud mental puedan identificar con más facilidad síntomas de trauma entre Latinos que hablan español. No podemos prometerle ningún beneficio directo a usted por su participación en este estudio. Apreciamos inmensamente su ayuda en colectar esta información.

COMPENSACIÓN: Como compensación por su tiempo y esfuerzo, usted recibirá una tarjeta de regalo valorada en $25.00 al completar este estudio. También pagaremos por el costo del parqueo o el costo de transporte público que usted use para llegar a su cita.

CONFIDENCIALIDAD: Sólo usaremos su primer nombre en la grabación de la entrevista. Además, toda la información colectada acerca suyo durante el proyecto no será identificada por nombre, si no por un número. Cualquier información colectada acerca suyo será guardada en un gabinete con llave en la oficina de la investigadora principal responsable. Los archivos de audio serán guardados en una cuenta protegida con clave, dentro de un servidor con contraseña, en una computadora en la Universidad de Miami. Todos los archivos serán destruidos cuando el proyecto haya finalizado. Cualquier información obtenida en relación a este estudio que puede identificara/o Ud. como participante seguirá siendo confidencial, en la medida que la ley lo permita, y será revelada sólo con su permiso explícito.

INFORMACIÓN DE CONTACTO: Si usted tiene alguna pregunta acerca de este proyecto, por favor contacte a María José Rendón (candidata al doctorado) al (305) 482-6613, o Lydia P. Buki, Ph.D. (directora de la disertación) al (305) 284-2230. Si usted tiene alguna pregunta sobre sus derechos como participante en el estudio, puede comunicarse con la Oficina de Investigación de Participantes Humanos (the Human Subjects Research Office, HSRO) en la Universidad de Miami al (305) 243-3195.

PARTICIPACIÓN VOLUNTARIA: Su decisión de participar o no en este proyecto no afectará sus relaciones futuras con la Universidad de Miami o con cualquier institución cooperante. Su participación es voluntaria y usted puede retirar su consentimiento y negar su participación en el estudio en cualquier momento sin riesgo de ser penalizada/o o de perder los beneficios que le corresponden por su participación. Su firma en este documento indicará que Ud. ha leído la información proporcionada, y que ha aceptado de forma voluntaria participar en este proyecto y que la entrevista sea grabada. Su firma también indica que en el día de la fecha se le ha ofrecido una copia de esta forma que contiene dos páginas.

Firma del Participante: _____________________________ Fecha:  __________

Testigo: ________________________________       Fecha:  _____________
## Referral List

<table>
<thead>
<tr>
<th>Agency</th>
<th>Number</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mental Health Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carlos Albizu Goodman Psychological Services Center</td>
<td>(305) 592-7860</td>
<td>Doral</td>
</tr>
<tr>
<td>Low-cost counseling (sliding scale fee).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coordinated Victim Assistance Center</td>
<td>(305) 285-5900</td>
<td>Coconut Grove</td>
</tr>
<tr>
<td>Counseling, legal, housing, education services for victims of domestic abuse.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Citrus Health Network</td>
<td>(305) 825-0300</td>
<td>Multiple locations</td>
</tr>
<tr>
<td>Low cost health and mental health services, comprehensive psychiatric services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Counseling Services</td>
<td>(305) 740-8998</td>
<td>South Miami</td>
</tr>
<tr>
<td>Low cost services, focus on families, children, and trauma survivors.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Here's Help</td>
<td>(305) 685-8201</td>
<td>Palmetto Bay</td>
</tr>
<tr>
<td>Residential and outpatient substance abuse treatment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Institute for Child and Family Health</td>
<td>(305) 558-2480</td>
<td>N. Dade, Hialeah, S. Miami</td>
</tr>
<tr>
<td>Low cost child and family counseling.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Institute for Individual and Family Counseling, University of Miami</td>
<td>(305) 284-6949</td>
<td>Coral Gables</td>
</tr>
<tr>
<td>Low-cost counseling (sliding scale fee).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Miami Behavioral Health</td>
<td>(305) 774-3633/32</td>
<td>Miami</td>
</tr>
<tr>
<td>Fees start at $30 for sessions; Medicaid covers 100%.</td>
<td>(305) 774-3300</td>
<td></td>
</tr>
<tr>
<td>(Crisis line)</td>
<td>(regular)</td>
<td></td>
</tr>
<tr>
<td>Miami Switchboard</td>
<td>211</td>
<td>NA</td>
</tr>
<tr>
<td>Free Helpline and crisis counseling.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nova Southeastern University</td>
<td>(954) 262-5730</td>
<td>N. Miami/S. Broward</td>
</tr>
<tr>
<td>Low cost child and family counseling.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### APPENDIX T

List of Community Referrals – Spanish

<table>
<thead>
<tr>
<th>Agencia</th>
<th>Teléfono</th>
<th>Ubicación</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carlos Albizu Goodman Psychological Services Center</td>
<td>(305) 592-7860</td>
<td>Doral</td>
</tr>
<tr>
<td>Consejería a bajo costo (cuota proporcional según los ingresos del cliente).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coordinated Victim Assistance Center</td>
<td>(305) 285-5900</td>
<td>Coconut Grove</td>
</tr>
<tr>
<td>Servicios de consejería, servicios legales, educacionales, y para conseguir alojamiento, para víctimas de abuso doméstico.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Citrus Health Network</td>
<td>(305) 825-0300</td>
<td>Multiples ubicaciones en la ciudad de Miami</td>
</tr>
<tr>
<td>Servicios de salud física y mental a bajo costo, servicios psiquiátricos comprensivos.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Counseling Services</td>
<td>(305) 740-8998</td>
<td>South Miami</td>
</tr>
<tr>
<td>Servicios a bajo costo, con enfoque en familias, niños y supervivientes de trauma.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Here’s Help</td>
<td>(305) 685-8201</td>
<td>Palmetto Bay</td>
</tr>
<tr>
<td>Servicios residenciales y ambulatorios para personas con problemas de abuso de alcohol y sustancias.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Institute for Child and Family Health</td>
<td>(305) 558-2480</td>
<td>North Miami Dade, Hialeah, South Miami</td>
</tr>
<tr>
<td>Consejería a bajo costo para niños y familias.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Institute for Individual and Family Counseling, University of Miami</td>
<td>(305) 284-6949</td>
<td>Coral Gables</td>
</tr>
<tr>
<td>Consejería a bajo costo (cuota proporcional según los ingresos del cliente).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Miami Behavioral Health</td>
<td>(305) 774-3633/32</td>
<td>Miami</td>
</tr>
<tr>
<td>El costo de sesiones es de $30 o más; Medicaid cubre costos al 100%.</td>
<td>(305) 774-3300 (regular)</td>
<td></td>
</tr>
<tr>
<td>Miami Switchboard</td>
<td>211</td>
<td>NA</td>
</tr>
<tr>
<td>Línea de crisis (por teléfono) gratis y consejería de crisis.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nova Southeastern University</td>
<td>(954) 262-5730</td>
<td>North Miami/South Broward</td>
</tr>
<tr>
<td>Consejería a bajo costo para niños y familias.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# APPENDIX U

## Study Screener – English

### SCREENING PROTOCOL

(Community and Clinical sample)

1. **PRE-SCREENING**

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you identify as Latino/a or Hispanic?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What is your age? _____ <em>(Must be 18 or older)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender: Male</td>
<td>Female</td>
<td>Transgender</td>
</tr>
<tr>
<td>In what country were you born?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>At what age did you migrate permanently to the U.S. (if applicable)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What is your highest level of formal education?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Clinical sample only.** Are you currently under the care of a licensed mental health provider? *(must answer yes)*  

### Language Proficiency

**AMAS-ZABB items:** Must answer “1” or “2” to items 16 and 21, and “3” or “4” to items 25 and 30 to participate.

<table>
<thead>
<tr>
<th>Item</th>
<th>Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACC 25. How well do you SPEAK Spanish in general?</td>
<td>1: Not at all</td>
</tr>
<tr>
<td>ACC 30. How well do you UNDERSTAND Spanish in general?</td>
<td>2: A little</td>
</tr>
<tr>
<td>ACC 21. How well do you UNDERSTAND English in general?</td>
<td>4: Extremely well, or like a native</td>
</tr>
</tbody>
</table>

**For Community Sample Only:** Please note ability to read and write to determine accommodations during focus groups.

- How well do you read in Spanish?
- How well do you write in Spanish?

2. **COMMUNITY SAMPLE:** availability for focus groups, select first and second choice

<table>
<thead>
<tr>
<th>FG 1</th>
<th>FG2</th>
<th>FG3</th>
<th>FG4</th>
<th>OTHER</th>
</tr>
</thead>
</table>

3. **CLINICAL SAMPLE:** availability for pretesting interview, determine date, time and location

### 3. End of screening/Contact Information

**Contact Information**

Name: __________________________ Phone #s: __________________________

Best time to reach you? __________________________

Best days for future groups (if not available for groups scheduled above)? __________________________

**Interviewer Initials:**

218
APPENDIX V

Study Screener – Spanish

SCREENING PROTOCOL
(Community and Clinical sample)
SPANISH

1. PRE-SCREENING

<table>
<thead>
<tr>
<th>Ud. se identifica como Latino/a o Hispano/a?</th>
<th>SÍ   NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>¿Cuál es su edad? _____ <em>(Must be 18 or older)</em></td>
<td>SÍ   NO</td>
</tr>
<tr>
<td>Género: Masculino</td>
<td>Femenino</td>
</tr>
<tr>
<td>¿En qué país nació? _______________</td>
<td></td>
</tr>
<tr>
<td>¿A qué edad empezó a vivir permanentemente en los Estados Unidos? _________________</td>
<td></td>
</tr>
<tr>
<td>¿Cuál es año escolar más alto que completó? __________________________</td>
<td></td>
</tr>
</tbody>
</table>

Clinical sample only. Está usted en este momento recibiendo consejería o tratamiento psicológico con un/a psicólogo/a, psiquiatra, consejero/a, etc.? *(Determine whether patient is being seen by a licensed mental health provider. Participant must answer yes.)*

<table>
<thead>
<tr>
<th>SÍ   NO</th>
</tr>
</thead>
</table>

Language Proficiency

AMAS-ZABB items: Must answer “1” or “2” to items 16 and 21, and “3” or “4” to items 25 and 30 to participate.

| ACC 25. ¿Cuán bien HABLA(S) Español en general? |       |
| ACC 30. ¿Cuán bien ENTENDE(S) Español en general? |       |
| ACC 16. ¿Cuán bien HABLA(S) Inglés en general? |       |
| ACC 21. ¿Cuán bien ENTENDE(S) Inglés en general? |       |

For Community Sample Only: Please note ability to read and write to determine accommodations during focus groups.

| ¿Cuán bien lee(s) en Español? |       |
| ¿Cuán bien escribe(s) en Español? |       |

2. COMMUNITY SAMPLE: availability for focus groups, select first and second choice

<table>
<thead>
<tr>
<th>FG 1</th>
<th>FG2</th>
<th>FG3</th>
<th>FG4</th>
<th>OTHER</th>
</tr>
</thead>
</table>

3. CLINICAL SAMPLE: availability for pretesting interview, determine date, time and location

3. End of screening/Contact Information

Nombre: _________________________________ Teléfono(s):__________________________________________

Mejor hora para contactarle? __________________

Mejores días de la semana para participar en grupos futuros *(if not available for groups scheduled above)?

Interviewer Initials:

ID NUMBER
APPENDIX W

Primary Care PTSD Screen – English

Primary Care PTSD Screen

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you*

1. Have had nightmares about it or thought about it when you did not want to?

YES NO

2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?

YES NO

3. Were constantly on guard, watchful, or easily startled?

YES NO

4. Felt numb or detached from others, activities, or your surroundings?

YES NO

The primary care PTSD screen (PC-PTSD); Development and operating characteristics. Prins, Annabel; Ouimette, Paige; Kimerling, Rachel; Primary Care Psychiatry, Vol 9(1), Mar 2003. pp. 9-14. [Original Journal Article] __

APPENDIX X

Primary Care PTSD Screen - Spanish

Primary Care PTSD Screen – Spanish

Ha pasado por una experiencia tan espantosa, horrible, o trastornadora en su vida que en el último mes Ud.:

1. ¿Ha tenido pesadillas perturbadoras o piensa sobre esa experiencia sin quererlo?
   
   SI      NO

2. ¿Ha tratado, sin logro, de no pensar en la experiencia, o ha tratado a toda costa (o a todo costo) de evitar situaciones que le recuerden esa experiencia?

   SI      NO

3. ¿Ha estado Ud. a la defensiva, vigilante de su entorno, o se sobresalta fácilmente desde que tuvo esa experiencia?

   SI      NO

4. ¿Ha Ud. tenido sensaciones de entumecimiento en los brazos o en las piernas; se ha sentido aislado o desprendido de otros (amigos, seres queridos), de su entorno, o de actividades que disfrutaba antes?

   SI      NO
PARTE C
SECCIÓN 2

En el mes pasado, ¿ha tratado de evitar cosas que le recuerdan el [EVENTO], como ciertas personas, lugares, o situaciones?

¿Qué clase de cosas evitó?

¿Cuánto esfuerzo le tomó para evitar estas cosas que le recuerdan el [EVENTO]?

(¿Tiene que hacer un plan o cambiar sus actividades para evitarlas?)

(En general, ¿en qué medida representa esto un problema para usted? ¿Cómo sería su vida diferente si no tuviese que evitar lo que le recuerda el [EVENTO]?)

¿Cuántas veces tuvo que hacer esto durante el último mes?
APPENDIX Z
Focus Group Guide – Community Sample – English

CAPS-5 ADAPTATION STUDY
FOCUS GROUP GUIDE FOR COMMUNITY SAMPLE

Before the Focus Group

Allow 15-25 minutes for phone contact regarding directions, parking, getting to building, filling out consent form, and completing background questionnaire. Estimate 15-20 minutes of small talk with participants.

Focus Group Interview Guide

Introduction (5-10 minutes)

Good evening everyone. I would like to begin our session and explain the steps we will follow tonight. My name is María José Rendón and I’m a Counseling Psychology student at the University of Miami. We are here tonight to review the translation of a questionnaire and ensure that it is easy to understand for Spanish-speaking Latinos. I’d like to introduce you to the other members of our team […].

I began this project because in my training, there were many times where I interviewed patients in Spanish. In many occasions, the questionnaire that we were using was not easy to understand for them. Thus, I became interested in ensuring the best possible quality of materials translated into Spanish. Tonight we will review a questionnaire that asks readers to report on their experiences related to a traumatic event. We want to use this questionnaire with Latinos from different regions. For this reason, we have invited you to tonight’s group because as Latinos of various ancestries, we believe that you are the experts, and you can tell us what is easy to understand and what is not. We believe that you can give us very valuable advice to help us improve this questionnaire.

I’d like us to introduce ourselves. We are also going to test the audio recorders. Please say your first name and favorite dish. [test equipment; ask people with low voices speak louder and/or sit closer to the recorders].

Confidentiality
I would like to ask every person present to respect the confidentiality of today’s discussions. It is possible that you may say something personal that is pertinent to the task we will undertake today, but it is not something you would disclose in another setting to others. Therefore, although I cannot guarantee confidentiality, I would like to ask all of you to not share the identity of other group members or the content of today’s conversations with anyone outside of this group. Likewise, keep in mind that you control how much personal information you give others in our conversation today.

Ground Rules
- My role as a moderator is to guide the discussion
- Please speak one at a time to ensure we do not miss any important information
- We can address each other by first name
Instructions

Allow me to tell you a little about the questionnaire we are going to review tonight. It is called the CAPS-5, which stands for the Clinician Administered PTSD-Scale. The CAPS-5 is used to interview people about very difficult life events they have had, what we typically would call a trauma. The questions ask individuals to describe what happened to them, and to describe emotional symptoms they might have developed after the trauma. Remember, today you will not be answering the CAPS-5 questions—you will be helping us make sure that they are easy to understand in Spanish.

The CAPS-5 has 30 items. To help us review the questions, we are going to review them in sections. I will give you the questions on paper in large print, along with post-its, pencils, and highlighters. You can use these tools to make notes about questions that you find difficult to understand or confusing. However, it is important to know that the questions in the CAPS-5 are always asked verbally through an interview. In fact, the people interviewed never actually see the questions written on paper. Because of this, I’d like you to consider whether these questions make sense when spoken out loud. We will give you the questions in written format so that you can write your comments on the paper, but I’ll also read them out loud so you can hear them.

Section 1 (10-15 mins)

[Distribute page 1. Read the introduction, in a conversational manner, providing pauses for people to make annotations on their copies; the idea is that participants point out areas that are difficult to understand and give you some alternative wording. Once they give you enough for you to make the changes later, move on.]

1. What impressions do you have about the passages I just read?
2. Were any sentences hard to understand?
3. If so, PROBES:
   a) What made this sentence hard to understand?
   b) How can we improve this sentence? [Probe for clarity and meaning].
   c) What word would be easier to understand? Are there other ways to pose this idea?
   d) Are there other opinions in the group? Is this new version of the sentence easier?

Sections 2 – 7 (10-15 mins each)

[Distribute pages for each section one at a time. Read the questions on a particular section, in a conversational manner, providing pauses for people to make annotations on their copies].

Questions for each section

1. What impressions do you have about the questions I just read?
2. Were any questions hard to understand?
3. If so, PROBES:
   a) What made this question hard to understand?
   b) How can we improve this question? [Probe for clarity and meaning]
c. What word would be easier to understand? Are there other ways to pose this question?
d. Are there other opinions in the group? Is this new version of the question easier?

[Repeat steps for each section, estimate around 15 mins for each of the following sections].

**Closing (10 mins)**

You have worked very hard tonight. You have shared very valuable advice that will help us improve the questionnaire. We have completed this process, but I want to check once more, is there anything we didn’t talk about that we should have addressed? Anything we can do to improve the next focus groups?

Thank you for your participation. [Explain process of getting compensation before leaving.]
Before the focus group

Allow 15-25 minutes for phone contact regarding directions, parking, getting to building, filling out consent form, and completing background questionnaire. Estimate 15-20 minutes of small talk with participants.

Focus Group Interview Guide

Introduction (5-10 minutes)

Buenas noches a todos, me gustaría empezar nuestra sesión y explicar los pasos a seguir esta noche. Mi nombre es María José Rendón y soy una estudiante en psicología de consejería en la Universidad de Miami. Estamos aquí porque vamos a revisar la traducción de un cuestionario para asegurarnos que sea fácil de entender para Latinos que hablan español. Me gustaría presentarles los otros miembros de nuestro equipo […].

Yo empecé este proyecto porque en mis prácticas, muchas veces me tocó hacer entrevistas en español con mis pacientes. Y en muchas de estas ocasiones, el cuestionario que utilizamos no era fácil de entender en español. Esta noche vamos a revisar un cuestionario que se usa para entrevistar personas acerca de eventos traumáticos que han tenido en su vida. Queremos que este cuestionario se pueda usar con Latinos de diferentes regiones. Por lo tanto, los hemos invitado a este grupo porque, al ser Latinos provenientes de diferentes regiones, consideramos que ustedes son expertos en esto, y pueden decírnos fácilmente qué se entiende y qué no se entiende. Creemos que ustedes nos pueden dar sugerencias muy valiosas para ayudarnos a mejorar este cuestionario.

Me gustaría que nos presentemos. Vamos también a hacer un test del equipo. Por favor diga su nombre y plato favorito. [test equipment; ask people with low voices speak louder and/or sit closer to the recorders].

Confidentiality

Me gustaría pedirles a cada uno de ustedes que por favor respeten la confidencialidad de las discusiones que vamos a realizar hoy. Es posible que ustedes compartan información personal que está relacionada con el trabajo que vamos a realizar hoy, pero que tal vez ustedes no hubieran compartido normalmente en otras circunstancias. Por lo tanto, aunque no puedo garantizar la confidencialidad de lo que ustedes compartan, me gustaría pedirles a todos que no hagan saber la identidad de otros participantes, o que compartan lo que vamos a conversar aquí con nadie fuera del grupo. También recuerden que ustedes controlan cuánta información personal ustedes comparten con nosotros el día de hoy.
Ground Rules

- Mi papel como moderadora es el de guiar la discusión
- Por favor, hablemos una persona a la vez para que no perdamos ninguna información importante
- Podemos dirigirnos los unos a los otros usando el primer nombre
- No hay respuestas correctas o incorrectas, sólo desacuerdo en opiniones
- Escuchemos respetuosamente cuando otros comparten sus opiniones
- Puede ser que yo interrumpa de vez en cuando para invitar a otros que no han hablado todavía a que compartan sus opiniones
- Por favor apaguen los teléfonos celulares para evitar distracciones durante nuestra discusión.
- Terminaremos a las [time scheduled]

Instructions

Permíteme explicar un poco acerca del cuestionario que vamos a revisar esta noche. Se llama el CAPS-5, el cual significa Escala de Trastorno de Estrés Posttraumático Administrada por un Clínico. El CAPS-5 se usa para entrevistar a personas acerca de eventos muy difíciles que hayan pasado en su vida, lo que típicamente llamamos un trauma. Las preguntas le piden a la persona que describa lo que le pasó, y que describa síntomas emocionales que puede haber desarrollado después de un trauma. Recuerde, el día de hoy, que usted no va a contestar las preguntas del CAPS-5. Usted nos ayudará a asegurarnos que sean fáciles de entender en español.

El CAPS-5 tiene 30 preguntas. Para que sea más fácil revisar las preguntas, vamos a separarlas en secciones. Yo les daré las preguntas en papel, con letras grandes, y también les daré notas adhesivas (post-it notes), lápices, y señaladores. Usted puede usar estos para hacer notas acerca de preguntas que le parecen confusas o difíciles de entender. Sin embargo, es importante que sepa que las preguntas del CAPS-5 siempre se hacen en forma oral a través de una entrevista. Por eso, quisiera que consideren si las preguntas tienen sentido cuando alguien las hace verbalmente. Les vamos a dar las preguntas por escrito para que puedan anotar sus comentarios en papel, pero también se las voy a leer para que las puedan escuchar.

Section 1 (10-15 mins)

[Distribute page 1. Read the introduction, in a conversational manner, providing pauses for people to make annotations on their copies; the idea is that participants point out areas that are difficult to understand and give you some alternative wording. Once they give you enough for you to make the changes later, move on.]

1. ¿Qué le pareció el texto que acabo de leer?
2. ¿Hubieron oraciones que fueron difíciles de entender?
3. If so, PROBES:
Section 2 – 7 (10-15 mins each)
[Distribute pages for each section one at a time. Read the questions on a particular section, in a conversational manner, providing pauses for people to make annotations on their copies].

Questions for each section

1. ¿Qué les parecieron las preguntas que acabo de leer?
2. ¿Hubieron preguntas que fueron difíciles de entender?
3. If so, PROBES:
   a. ¿Qué hizo que esta pregunta fuera difícil de entender?
   b. ¿Cómo podemos mejorar esta pregunta? [Probe for clarity and meaning].
   c. ¿Qué palabra sería más fácil de entender? ¿Hay otras maneras de comunicar esta idea?
   d. ¿Hay otras opiniones en el grupo? ¿Les parece fácil de entender esta nueva versión de la pregunta?

[Repeat steps for each section, estimate around 15 mins for each of the following sections].

Closing (10 mins)

Hemos trabajado muy duro el día de hoy. Ustedes han compartido varias sugerencias muy valiosas para mejorar el cuestionario. Hemos terminado con este proceso, pero quiero preguntarles una vez más, ¿hay algo que hizo falta conversar? ¿Hay algún cambio que pudiera mejorar nuestros próximos grupos?

Gracias por su participación. [Explain process of getting compensation before leaving.]
APPENDIX BB

Cognitive Interview Guide – Clinical Sample - English

CAPS-5 ADAPTATION STUDY
INDIVIDUAL INTERVIEW GUIDE

Administer questions at the end of the CAPS-5 interview.

1. Were any questions hard to understand? (backtrack to questions that were difficult as suggested by the participant) If so, PROBES:
   a. What made this question hard to understand?
   b. How can we improve this question? [Probe for clarity and meaning]
   c. What word would be easier to understand? Are there other ways to pose this question?
APPENDIX CC

Cognitive Interview Guide – Clinical Sample – Spanish

CAPS-5 ADAPTATION STUDY
INDIVIDUAL INTERVIEW GUIDE

Administer questions at the end of the CAPS-5 interview.

1. ¿Hubieron preguntas que fueron difíciles de entender? *(backtrack to questions that were difficult as suggested by the participant)*. If so, PROBES:
   a. ¿Qué hizo que esta pregunta fuera difícil de contestar?
   b. ¿Cómo podemos mejorar esta pregunta? [Probe for clarity and meaning].
   c. ¿Qué palabra sería más fácil de entender? ¿Hay otras maneras de preguntar esto?
APPENDIX DD

EXAMPLE ADAPTATION OF ITEM B1

In the following example, I show the evolution of the wording of item B1 (intrusive thoughts) from its original form in English through the translation, revisions, backtranslation, and comparison of the backtranslation to the original. Wording changes are highlighted in yellow.

<table>
<thead>
<tr>
<th>ENGLISH ORIGINAL</th>
<th>Item</th>
<th>Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item Text</td>
<td>In the past month, have you had any unwanted memories of (EVENT) while you were awake, so not counting dreams?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>How does it happen that you start remembering (EVENT)?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>[If not clear:] (Are these unwanted memories, or are you thinking about [EVENT] on purpose?)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>How much do these memories bother you?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Are you able to put them out of your mind and think about something else?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>How often have you had these memories in the past month? # of times _____</td>
<td></td>
</tr>
<tr>
<td>Revisions Made</td>
<td>Not applicable.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FORWARD TRANSLATION</th>
<th>Item Text</th>
<th>En el mes pasado, ¿ha tenido alguna vez recuerdos no deseados del (EVENTO) mientras estaba despierto/a, o sea, sin contar en sueños?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>¿Cómo empieza a recordar el (EVENTO)?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>¿Estos recuerdos son recuerdos no deseados, o está pensando en el [EVENTO] a propósito?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>¿Cuánto malestar le han causado estos recuerdos?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>¿Es capaz de quitárselos de la mente y de pensar en otra cosa?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>¿Cuántas veces ocurrieron durante el último mes?</td>
<td></td>
</tr>
<tr>
<td>Revisions Made</td>
<td>Text translated to Spanish</td>
<td></td>
</tr>
</tbody>
</table>

<p>| EXPERT PANEL REVIEW 1 | Item Text | En el mes pasado, ¿ha tenido alguna vez memorias no deseadas del (EVENTO) mientras estaba despierto/a, o sea, cuando no estaba soñando? |</p>
<table>
<thead>
<tr>
<th>Item</th>
<th>Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>En el mes pasado, ¿ha tenido alguna vez recuerdos no deseados del (EVENTO) mientras estaba despierto/a, o sea, cuando no estaba soñando?</td>
<td></td>
</tr>
<tr>
<td>¿Cómo ocurre que usted empieza a recordar el (EVENTO)?</td>
<td></td>
</tr>
<tr>
<td>¿Estos recuerdos son recuerdos no deseados, o está pensando en el [EVENTO] a propósito?</td>
<td></td>
</tr>
<tr>
<td>¿Cuánto malestar le han causado estos recuerdos?</td>
<td></td>
</tr>
<tr>
<td>¿Es capaz de quitárselos de la mente y de pensar en otra cosa?</td>
<td></td>
</tr>
<tr>
<td>¿Cuántas veces ocurrieron durante el mes pasado?</td>
<td></td>
</tr>
</tbody>
</table>

**Revisions Made**

**Summary:** (a) “memorias” reverted to “recuerdos,” and “el último mes” changed to “el mes pasado.”

**Details:** Focus group 1 suggested to use “recuerdos” instead of “memorias.” They argued that memorias refers to having memory rather than the concept of remembrances. “Recuerdos” was used and the subsequent groups did not comment further on this word. In addition, Focus group 1 preferred “mes pasado” instead of “último mes” albeit they agreed that either term would carry the same meaning.
¿Estos recuerdos son recuerdos no deseados, o está pensando en el [EVENTO] a propósito?

¿Cuánto malestar le han causado estos recuerdos?

¿Es capaz de quitárselos de la mente y de pensar en otra cosa?

¿Cuántas veces ocurrieron durante los últimos 30 días?

---

**Revisions Made**

**Summary:** (a) “¿Cómo ocurre que usted empieza a recordar...?” was changed to “¿Cómo es que usted empieza a recordar...?” and “el mes pasado” was changed to “los últimos 30 días.”

**Details:** Focus group 2 suggested to replace “¿Cómo ocurre que usted empieza...” with “¿Cómo es que usted empieza...?” (Item B1). In addition, participants indicated that it would be more straightforward to ask about symptom occurrence “in the last 30 days” instead of “the last month” because it leaves no room for ambiguity.

---

**FOCUS GROUP 3**

**Item Text**

Text remained unchanged.

**Revisions Made**

**Summary:** No changes, but concerns would be consulted with panelists at next step.

**Details:** Two participants indicated that it would be best to revert back to “the last month” because “in the last 30 days” may make people nervous about needing to be too specific. Given discrepancies between participants’ opinions in focus groups 2 and 3, the item was not changed, and a note was made to subsequently ask the panel of experts about the preferred wording.

---

**EXPERT PANEL REVIEW 2**

**Item Text**

En el último mes, ¿Tuvo alguna vez recuerdos no deseados del (EVENTO) mientras estaba despierto/a, o sea, cuando no estaba soñando?

¿Cómo es que usted empezó a recordar el (EVENTO)?

¿Estos recuerdos fueron recuerdos no deseados, o estaba pensando en el [EVENTO] a propósito?

¿Cuánto malestar le causaron estos recuerdos?

¿Fue capaz de quitárselos de la mente y de pensar en otra cosa?

¿Cuántas veces ocurrieron durante el último mes?

**Revisions Made**

**Summary:** (a) “los últimos 30 días” reverted to “el último mes,” and (b) the simple past tense was incorporated throughout the measure.

**Details:** Panelists were provided with summary document for all changes since their last review. In item B1 for instance, I noted the participants’ preference for “recuerdos” instead of “memorias” and for the wording “¿Cómo es que usted empieza...?” I presented the list of changes to the panelists and invited them to make suggestions for any needed changes. However, the panelists did not suggest any revisions.
I also brought forth more complicated issues where the way to proceed (a) was not clearly addressed in the literature, or (b) would affect all items globally. For example, I asked panelists’ opinions regarding the use of “past month” or “the last 30 days,” given that this change would affect all items and concerned specificity of symptom occurrence. Panelists ultimately suggested to continue utilizing “the past month” and to clarify at the beginning of the interview the meaning of the past month. They added that the interviewer would be charged with explaining the concept repeatedly if the participant was confused about its meaning.

Finally, I raised an issue that no focus group participant had raised, which prompted me to consult with the panelists to obtain feedback. I noted during the third focus group that some of the questions were long and hard to follow as I orally presented them to participants, and I perceived that the verb tense (present perfect) could be simplified if turned into the simple past tense while maintaining the intended meaning of the questions. The panelists agreed that the past tense would still fulfill the intentions of the question.

<table>
<thead>
<tr>
<th>CLINICAL INTERVIEW 1</th>
<th>Item</th>
<th>Text</th>
<th>Revisions Made</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Item</td>
<td>Text</td>
<td>Summary: There were no changes, but I took note of concerns regarding the “past month” timeframe.</td>
</tr>
<tr>
<td></td>
<td>Details:</td>
<td>I noted that the participant misunderstood item B1, expanding further on the details of the traumatic event instead of explaining whether she experienced intrusive memories or not. When redirected to answer the question, she understood the question and provided evidence of her symptom. When asked about the frequency of her symptoms in the past month, she discussed lifetime symptoms instead of her symptoms in the past month but was responsive to redirection.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CLINICAL INTERVIEW 2</th>
<th>Item</th>
<th>Text</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Item</td>
<td>En el último mes, ¿Tuvo alguna vez recuerdos no deseados del (EVENTO)?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>¿Tuvo estos recuerdos mientras estaba despierto/a, o sea, cuando no estaba soñando?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>¿Cómo es que usted empezó a recordar el (EVENTO)?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>¿Estos recuerdos fueron recuerdos no deseados, o estaba pensando en el [EVENTO] a propósito?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>¿Cuánto malestar le causaron estos recuerdos?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>¿Fue capaz de quitárselos de la mente y de pensar en otra cosa?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>¿Cuántas veces ocurrieron durante el último mes?</td>
</tr>
<tr>
<td>Revisions Made</td>
<td>Summary: (a) first question was split into two, and (b) instructions were added for the interviewer to provide a visual aid as an optional tool to explain symptom occurrence in the past month.</td>
<td></td>
</tr>
<tr>
<td>----------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Details: The participant discussed lifetime symptoms instead of symptoms in the past month. She was responsive to redirection. This problem was consistent throughout the interview, even when interviewed and redirected to discuss past month symptoms. As a result, I implemented two changes to facilitate question understanding: (a) reduced length of first sentence by splitting it into two questions, and created a visual aid to illustrate the meaning of the “past month.”</td>
<td></td>
</tr>
</tbody>
</table>

**CLINICAL INTERVIEW 3**

<table>
<thead>
<tr>
<th>Item Text</th>
<th>Text remained unchanged.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revisions Made</td>
<td>Summary: No revisions were made.</td>
</tr>
<tr>
<td></td>
<td>Details: Participant answered the item appropriately. She did not need a visual aid to understand the question or quantify symptom frequency.</td>
</tr>
</tbody>
</table>

**CLINICAL INTERVIEW 4**

<table>
<thead>
<tr>
<th>Item Text</th>
<th>Text remained unchanged.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revisions Made</td>
<td>Summary: No changes were applied.</td>
</tr>
<tr>
<td></td>
<td>Details: The participant did not have problems understanding the item or quantifying symptom frequency. She did not need visual aid to understand the question or quantify symptom frequency.</td>
</tr>
</tbody>
</table>

**EXPERT PANEL REVIEW 3**

<table>
<thead>
<tr>
<th>Item Text</th>
<th>Text remained unchanged. Visual aid was updated as follows:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revisions Made</td>
<td>Summary: Visual aid was updated to include participants’ trauma date, the assessment date, and the past month period.</td>
</tr>
</tbody>
</table>
Details: Panelists were provided with a summary document for all changes since their last review.

Regarding item B1, I informed panelists that items that were double- or triple-barreled were split into smaller questions to reduce the amount of information processed by the interviewee. In addition, I proposed the use of the visual aid to evaluate for past month symptoms and consulted on whether a visual aid should be provided to all participants or only used on a case-by-case basis, based on the clinical judgment of the interviewer. One panelist suggested adding blank spaces to the visual aid to tailor it to the participants’ trauma date, the assessment date, and the past month period. Other panelists agreed to this change. In addition, this panelist proposed that the visual aid can be printed on a card and that it could be used during the initial explanation of the past month timeframe. It could then be left on the table, so participants have it available. Panelists agreed with this process.

### FINAL ADAPTATION (formatting added to reflect original version)

<table>
<thead>
<tr>
<th>Item</th>
<th>Text</th>
</tr>
</thead>
</table>
| Text | En el último mes, ¿Tuvo alguna vez recuerdos no deseados del (EVENTO)?  
¿Tuvo estos recuerdos mientras estaba despierto/a, o sea, cuando no estaba soñando?)  
¿Cómo es que usted empezó a recordar el (EVENTO)?  
[If not clear:] (¿Estos recuerdos fueron recuerdos no deseados, o estaba pensando en el [EVENTO] a propósito?)  
¿Cuánto malestar le causaron estos recuerdos?  
¿Fue capaz de quitárselos de la mente y de pensar en otra cosa?  
¿Cuántas veces ocurrieron durante el último mes?__________ |

<table>
<thead>
<tr>
<th>Evento traumático</th>
<th>Hace 30 días</th>
<th>Hoy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fecha aproximada</td>
<td>Fecha</td>
<td>Fecha</td>
</tr>
</tbody>
</table>

Revisions Made

Not applicable.
## Backtranslation

<table>
<thead>
<tr>
<th>Item</th>
<th>Text</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In the last month, have you had unwanted flashbacks of the (EVENT)?</strong> (Did you have these flashbacks while you were awake, in other words, when you were not sleeping?)</td>
<td></td>
</tr>
<tr>
<td>How do you begin to remember the (EVENT)?</td>
<td></td>
</tr>
<tr>
<td>Were these flashbacks unwanted or were you thinking about the event intentionally?</td>
<td></td>
</tr>
<tr>
<td>How much discomfort did these flashbacks cause you?</td>
<td></td>
</tr>
<tr>
<td>Were you able to get them out of your mind and think about something else?</td>
<td></td>
</tr>
<tr>
<td>How many times did this happen in the last month?</td>
<td></td>
</tr>
</tbody>
</table>

**Notes**

The backtranslator’s version of “recuerdos no deseados” was “unwanted flashbacks.” It is likely that he interpreted unwanted memories as flashbacks because he was familiar with PTSD symptoms and desired his translation to be congruent with his knowledge of PTSD symptoms. However, the correct translation of “recuerdos” is “memories” or “remembrances,” and “no deseados” translates to “unwanted,” “undesired,” or “not wanted” as a few examples. In other words, the backtranslation properly translated “no deseados” but incorrectly interpreted “recuerdos” as flashbacks instead of memories. The rest of the wording is congruent with the Spanish meaning of the final adaptation.

## Comparison of Original English Version and Backtranslation

<table>
<thead>
<tr>
<th>Item</th>
<th>Text</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In the past last month, have you had any unwanted memories flashbacks of the (EVENT)?</strong></td>
<td></td>
</tr>
<tr>
<td>(Did you have these flashbacks while you were awake, so in other words, when you were not counting dreams sleeping?)</td>
<td></td>
</tr>
<tr>
<td>How does it happen that you start remembering do you begin to remember the (EVENT)?</td>
<td></td>
</tr>
<tr>
<td>Are Were these flashbacks unwanted memories, or are were you thinking about (EVENT) intentionally?)</td>
<td></td>
</tr>
<tr>
<td>How much do discomfort did these memories bother flashbacks cause you?</td>
<td></td>
</tr>
<tr>
<td>Are Were you able to put get them out of your mind and think about something else?</td>
<td></td>
</tr>
<tr>
<td>How often have you had these memories many times did this happen in the past last month?</td>
<td></td>
</tr>
</tbody>
</table>

**Notes**

**Expected changes:** The comparison shows the following changes: (a) change from “past month” to “last month” reflecting use of “último mes,” (b) splitting of the first question into two, making the second clause optional, (c) use of the simple past tense instead of present perfect, (d) use of “how many times” instead
of “how often” when inquiring about the last month. Not reflected here is the optional use of the visual aid.

**Unexpected changes:** In addition, the comparison between the original and the backtranslation reveal the use of colloquial wording in Spanish is slightly variant from the original English version. For instance, instead of “how much do these memories bother you?” the words and sentence format became “how much discomfort did these memories cause you?” This translation was provided by the original translator in the first step, and was not changed by subsequent reviewers because it still maintains the intended meaning of the question.
APPENDIX EE

Cultural Adaptation of the CAPS-5 for Spanish Speaking Latinos in the U.S.

National Center for PTSD

CLINICIAN-ADMINISTERED PTSD SCALE FOR DSM-5

PAST MONTH VERSION

FOR SPANISH SPEAKING LATINOS IN THE U.S.

Name: ___________________________ ID#: ______________
Interviewer: _______________________ Date: ______________
Study: ____________________________

Frank W. Weathers, Dudley D. Blake, Paula P. Schnurr, Danny G. Kaloupek, Brian P. Marx, & Terence M. Keane

National Center for Posttraumatic Stress Disorder
October 28, 2013

Cultural Adaptation by María José Rendón
University of Miami
October 3, 2015

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About the Cultural Adaptation of the CAPS-5 for Spanish Speaking Latinos in the U.S.

The cultural adaptation was developed by utilizing principles of the Cultural Adaptation Framework (Flaherty et al.). The measure was translated by a professional translator, reviewed by a panel of 3 bilingual mental health professionals, reviewed in focus groups by a community sample of 19 culturally diverse Latinos with limited English proficiency, and pre-tested with a clinical sample of 4 Cuban persons who met criteria for PTSD. The cultural adaptation made the following modifications: Altogether, participants made recommendations that contributed to the reduction of the questions’ literacy level in Spanish. These recommendations included (a) the use of simpler words and phrases, (b) the reduction of sentence length, (c) clarification of abstract concepts, particularly the description of dissociative phenomenology (e.g., flashbacks), the quantification and intensity of symptoms (“how often” and “how much” questions) and the clarification of the “past month” timeframe, (d) the utilization of the simple past tense to facilitate the evaluation of symptoms in the past month, (e) the reduction of superlative descriptors, and (f) the correction of grammatical errors. In addition to the adaptation of items’ wording and format, (g) a recommendations was added to the CAPS-5 guidelines regarding the assessment emotions and physical reactions in items B4 and B5. The CAPS-5 guidelines below are provided by the original authors. Note discussion of cultural considerations throughout the instructions.

Instructions

Standard administration and scoring of the CAPS-5 are essential for producing reliable and valid scores and diagnostic decisions. The CAPS-5 should be administered only by qualified interviewers who have formal training in structured clinical interviewing and differential diagnosis, a thorough understanding of the conceptual basis of PTSD and its various symptoms, and detailed knowledge of the features and conventions of the CAPS-5 itself.

Administration

1. Identify an index traumatic event to serve as the basis for symptom inquiry. Administer the Life Events Checklist and Criterion A inquiry provided on p. 5, or use some other structured, evidence-based method. The index event may involve either a single incident (e.g., “the accident”) or multiple, closely related incidents (e.g., “the worst parts of your combat experiences”).

2. Read prompts verbatim, one at a time, and in the order presented, EXCEPT:

   a. Use the respondent’s own words for labeling the index event or describing specific symptoms.

   b. Rephrase standard prompts to acknowledge previously reported information, but return to verbatim phrasing as soon as possible. For example, inquiry for item 20 might begin: “You already mentioned having problems sleeping. What kinds of problems?” In addition, note that some Latino patients may not immediately differentiate emotional from physical reactions in items B4 and B5. It is recommended that the interviewer utilize the follow-up prompts in these items accordingly to help interviewees provide the relevant information. The interviewer should code information regarding physical symptoms and regarding emotional symptoms to rate B4 and B5 accordingly.

   c. If you don’t have sufficient information after exhausting all standard prompts, follow up ad lib. In this situation, repeating the initial prompt often helps refocus the respondent.

   d. Although the introductory text in the cultural adaptation of the CAPS-5 explicitly indicates that “the past month” refers to the last thirty days as of the interview’s date, some participants may forget to discuss symptoms within the specified timeframe begin to describe the lifetime occurrence of symptoms over the course of the measure administration. If participants continue to discuss lifetime symptoms instead of past month symptoms in subsequent items, utilize Visual Aid 1 to ground them in the 30 day period prior to the date of the interview.

   e. As needed, ask for specific examples or direct the respondent to elaborate even when such prompts are not provided explicitly.

3. In general, DO NOT suggest responses. If a respondent has pronounced difficulty understanding a prompt it may be necessary to offer a brief example to clarify and illustrate. However, this should be done rarely and only after the respondent has been given ample opportunity to answer spontaneously.
4. In general, DO NOT read rating scale anchors to the respondent. They are intended only for you, the interviewer, because appropriate use requires clinical judgment and a thorough understanding of CAPS-5 scoring conventions. However, participants with lower levels of literacy might not understand the concept of percentages expected in items asking “how much of the time [did your symptom occur] in the past month” (present in items D2, D3, D4, D6, D7, E3, E5). When this is the case, we recommend providing participants with “Visual aid 2” as a hand-out card to facilitate interviewees’ understanding of the type of responses that are expected. Note that this visual aid is not intended to function as a Likert scale from where participants must choose and answer, but rather a teaching tool to explain the meaning of percentages and provide some examples.

5. Move through the interview as efficiently as possible to minimize respondent burden. Some useful strategies:
   a. Be thoroughly familiar with the CAPS-5 so that prompts flow smoothly.
   b. Ask the fewest number of prompts needed to obtain sufficient information to support a valid rating.
   c. Minimize note-taking and write while the respondent is talking to avoid long pauses.
   d. Take charge of the interview. Be respectful but firm in keeping the respondent on task, transitioning between questions, pressing for examples, or pointing out contradictions.

Scoring

1. As with previous versions of the CAPS, CAPS-5 symptom severity ratings are based on symptom frequency and intensity, except for items 8 (amnesia) and 12 (diminished interest), which are based on amount and intensity. However, CAPS-5 items are rated with a single severity score, in contrast to previous versions of the CAPS which required separate frequency and intensity scores for each item that were either summed to create a symptom severity score or combined in various scoring rules to create a dichotomous (present/absent) symptom score. Thus, on the CAPS-5 the clinician combines information about frequency and intensity before making a single severity rating. Depending on the item, frequency is rated as either the number of occurrences (how often in the past month) or percent of time (how much of the time in the past month). Intensity is rated on a four-point ordinal scale with ratings of Minimal, Clearly Present, Pronounced, and Extreme. Intensity and severity are related but distinct. Intensity refers to the strength of a typical occurrence of a symptom. Severity refers to the total symptom load over a given time period, and is a combination of intensity and frequency. This is similar to the quantity/frequency approach to alcohol consumption. In general, intensity rating anchors correspond to severity scale anchors described below and should be interpreted and used in the same way, except that severity ratings require joint consideration of intensity and frequency. Thus, before taking frequency into account, an intensity rating of Minimal corresponds to a severity rating of Mild / subthreshold. Clearly Present corresponds with Moderate / threshold, Pronounced corresponds with Severe / markedly elevated, and Extreme corresponds with Extreme / incapacitating.

2. The five-point CAPS-5 symptom severity rating scale is used for all symptoms. Rating scale anchors should be interpreted and used as follows:

   0 Absent The respondent denied the problem or the respondent’s report doesn’t fit the DSM-5 symptom criterion.

   1 Mild / subthreshold The respondent described a problem that is consistent with the symptom criterion but isn’t severe enough to be considered clinically significant. The problem doesn’t satisfy the DSM-5 symptom criterion and thus doesn’t count toward a PTSD diagnosis.

   2 Moderate / threshold The respondent described a clinically significant problem. The problem satisfies the DSM-5 symptom criterion and thus counts toward a PTSD diagnosis. The problem would be a target for intervention. This rating requires a minimum frequency of 2 X month or some of the time (20-30%) PLUS a minimum intensity of Clearly Present.

   3 Severe / markedly elevated The respondent described a problem that is well above threshold. The problem is difficult to manage and at times overwhelming, and would be a prominent target for intervention. This rating requires a minimum frequency of 2 X week or much of the time (50-60%) PLUS a minimum intensity of Pronounced.
4 Extreme / incapacitating The respondent described a dramatic symptom, far above threshold. The problem is pervasive, unmanageable, and overwhelming, and would be a high-priority target for intervention.

3. In general, make a given severity rating only if the minimum frequency and intensity for that rating are both met. However, you may exercise clinical judgment in making a given severity rating if the reported frequency is somewhat lower than required, but the intensity is higher. For example, you may make a severity rating of Moderate / threshold if a symptom occurs 1 X month (instead of the required 2 X month) as long as intensity is rated Pronounced or Extreme (instead of the required Clearly Present). Similarly, you may make a severity rating of Severe / markedly elevated if a symptom occurs 1 X week (instead of the required 2 X week) as long as the intensity is rated Extreme (instead of the required Pronounced). If you are unable to decide between two severity ratings, make the lower rating.

4. You need to establish that a symptom not only meets the DSM-5 criterion phenomenologically, but is also functionally related to the index traumatic event, i.e., started or got worse as a result of the event. CAPS-5 items 1-8 and 10 (reexperiencing, effortful avoidance, amnesia, and blame) are inherently linked to the event. Evaluate the remaining items for trauma-relatedness (TR) using the TR inquiry and rating scale. The three TR ratings are:

a. **Definite** = the symptom can clearly be attributed to the index trauma, because (1) there is an obvious change from the pre-trauma level of functioning and/or (2) the respondent makes the attribution to the index trauma with confidence.

b. **Probable** = the symptom is likely related to the index trauma, but an unequivocal connection can’t be made. Situations in which this rating would be given include the following: (1) there seems to be a change from the pre-trauma level of functioning, but it isn’t as clear and explicit as it would be for a “definite”; (2) the respondent attributes a causal link between the symptom and the index trauma, but with less confidence than for a rating of **Definite**; (3) there appears to be a functional relationship between the symptom and inherently trauma-linked symptoms such as reexperiencing symptoms (e.g., numbing or withdrawal increases when reexperiencing increases).

c. **Unlikely** = the symptom can be attributed to a cause other than the index trauma because (1) there is an obvious functional link with this other cause and/or (2) the respondent makes a confident attribution to this other cause and denies a link to the index trauma. Because it can be difficult to rule out a functional link between a symptom and the index trauma, a rating of **Unlikely** should be used only when the available evidence strongly points to a cause other than the index trauma. NOTE: Symptoms with a TR rating of **Unlikely** should not be counted toward a PTSD diagnosis or included in the total CAPS-5 symptom severity score.

5. **CAPS-5 total symptom severity score** is calculated by summing severity scores for items 1-20. NOTE: Severity scores for the two dissociation items (29 and 30) should NOT be included in the calculation of the total CAPS-5 severity score.

6. **CAPS-5 symptom cluster severity scores** are calculated by summing the individual item severity scores for symptoms contained in a given DSM-5 cluster. Thus, the Criterion B (reexperiencing) severity score is the sum of the individual severity scores for items 1-5; the Criterion C (avoidance) severity score is the sum of items 6 and 7; the Criterion D (negative alterations in cognitions and mood) severity score is the sum of items 8-14; and the Criterion E (hyperarousal) severity score is the sum of items 15-20. A symptom cluster score may also be calculated for dissociation by summing items 29 and 30.

7. **PTSD diagnostic status** is determined by first dichotomizing individual symptoms as “present” or “absent,” then following the DSM-5 diagnostic rule. A symptom is considered present only if the corresponding item severity score is rated 2=Moderate/threshold or higher. Items 9 and 11-20 have the additional requirement of a trauma-relatedness rating of **Definite** or **Probable**. Otherwise a symptom is considered absent. The DSM-5 diagnostic rule requires the presence of least one Criterion B symptom, one Criterion C symptom, two Criterion D symptoms, and two Criterion E symptoms. In addition, Criteria F and G must be met. Criterion F requires that the disturbance has lasted at least one month. Criterion G requires that the disturbance cause either clinically significant distress or functional impairment, as indicated by a rating of 2=moderate or higher on items 23-25.
Criterion A: Exposure to actual or threatened death, serious injury, or sexual violence, in one or more of the following ways:

1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the event(s) as it occurred to others.
3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse).

Note: Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work-related.

[Administer Life Events Checklist or other structured trauma screen]

Le voy a preguntar sobre el cuestionario de experiencias estresantes que llenó. Primero le pediré que describa brevemente la situación traumática que dijo que fue peor para usted. Luego le preguntaré cómo esa situación le pudo afectar en el último mes. En general no necesito mucha información – sólo lo suficiente para comprender cualquier problema que pudo tener. A medida que avancemos, si se siente incómodo/a, digame y podremos ir más despacio y hablar sobre ello. También, si tiene alguna pregunta o no entiende algo, por favor, digamelo. ¿Tiene alguna pregunta antes de que comencemos?

El evento que indicó como el peor fue el (EVENTO). Quisiera que describa brevemente lo que sucedió.

Index event (specify):

<table>
<thead>
<tr>
<th>¿Qué sucedió? (¿Qué edad tenía? ¿Cómo estuvo envuelto/a? ¿Quién más estuvo allá? ¿Alguien resultó lesionado gravemente o muerto? ¿Peligró la vida de alguien? ¿Cuántas veces ocurrió esto?)</th>
<th>Exposure type:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experienced ___</td>
<td>Witnessed ___</td>
</tr>
<tr>
<td>Learned about ___</td>
<td>Exposed to aversive details___</td>
</tr>
<tr>
<td>Life threat? NO YES [self ___ other ___]</td>
<td>Serious injury? NO YES [self ___ other ___]</td>
</tr>
<tr>
<td>Sexual violence? NO YES [self ___ other ___]</td>
<td>Criterion A met? NO PROBABLE YES</td>
</tr>
</tbody>
</table>

Durante el resto de la entrevista, quiero que mantenga en la mente el (EVENTO) cuando le pregunte sobre los diferentes problemas que puede haberle causado. Usted puede haber tenido algunos de estos problemas antes, pero en esta entrevista nos concentraremos solamente en el último mes. (UTILIZE VISUAL AID 1 TO CLARIFY TIME PERIOD IF NECESSARY). Para cada problema le preguntaré si lo ha tenido en el último mes, y en ese caso, cuántas veces y cuanto malestar le ha causado ese problema. Algunos de los síntomas que vamos a revisar pueden parecer fuera de lo normal, pero son comunes en personas que han pasado situaciones traumáticas.
Criterion B: Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:

1. (B1) Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). Note: In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.

En el último mes, ¿Tuvo alguna vez recuerdos no deseados del (EVENTO)? (If not clear:) ¿Tuvo estos recuerdos mientras estaba despierto/a, o sea, cuando no estaba soñando? [Rate 0=Absent if only during dreams]

¿Cómo es que usted empezó a recordar el (EVENTO)?

[If not clear:] ¿Estos recuerdos fueron recuerdos no deseados, o estaba pensando en el [EVENTO] a propósito? [Rate 0=Absent unless perceived as involuntary and intrusive]

¿Cuánto malestar le causaron estos recuerdos?

¿Fue capaz de quitárselos de la mente y de pensar en otra cosa?

Circle: Distress = Minimal Clearly Present Pronounced Extreme

¿Cuántas veces ocurrieron durante el último mes? # of times

Key rating dimensions = frequency / intensity of distress
Moderate = at least 2 X month / distress clearly present, some difficulty dismissing memories
Severe = at least 2 X week / pronounced distress, considerable difficulty dismissing memories

2. (B2) Recurrent distressing dreams in which the content and/or affect of the dream are related to the event(s). Note: In children, there may be frightening dreams without recognizable content.

En el último mes, ¿Tuvo alguna vez sueños desagradables acerca del (EVENTO)?

Describa un sueño típico. (¿Qué sucedió?)

[If not clear:] ¿Le despertó este sueño?

[If yes:] ¿Qué pasó cuando se despertó? ¿Cuánto tardó en volverse a dormir? (¿Cuánto sueño perdió?)

¿Cuánto malestar le causaron estos sueños?

Circle: Distress = Minimal Clearly Present Pronounced Extreme

¿Cuántas veces tuvo estos sueños en el último mes? # of times

Key rating dimensions = frequency / intensity of distress
Moderate = at least 2 X month / distress clearly present, less than 1 hour sleep loss
Severe = at least 2 X week / pronounced distress, more than 1 hour sleep loss
3. (B3) Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.) Note: In children, trauma-specific reenactment may occur in play.

En el último mes, ¿tuvo recuerdos más fuertes, en que sintió que revivía el (EVENTO)? Esto es como que uno olvida todo lo que sucede a su alrededor y piensa que el (EVENTO) está pasando otra vez.

¿Se confundió acerca de dónde estaba?
¿Qué hizo mientras esto estaba ocurriendo? (¿Otras personas notaron su comportamiento? ¿Qué le dijeron?)
¿Cuánto duró?
Círculo: Dissociation = Minimal  Clearly Present  Pronounced  Extreme

¿Cuántas veces le pasó esto en el último mes?  # of times ________

Key rating dimensions = frequency / intensity of dissociation
Moderate = at least 2 X month / dissociative quality clearly present, may retain some awareness of surroundings but relives event in a manner clearly distinct from thoughts and memories
Severe = at least 2 X week / pronounced dissociative quality, reports vivid reliving, e.g., with images, sounds, smells

4. (B4) Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

En el último mes, ¿alguna vez se alteró emocionalmente cuando algo le recordó el (EVENTO)?
¿Qué clase de recuerdos le disgustaron?
¿Cuánto malestar le causaron estos recuerdos?
¿Pudo tranquilizarse cuando esto ocurrió? (¿Cuánto tiempo duró?)
Círculo: Distress = Minimal  Clearly Present  Pronounced  Extreme

¿Cuántas veces ocurrió esto durante el último mes?  # of times ________

Key rating dimensions = frequency / intensity of distress
Moderate = at least 2 X month / distress clearly present, some difficulty recovering
Severe = at least 2 X week / pronounced distress, considerable difficulty recovering
5. (B5) Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

<table>
<thead>
<tr>
<th>En el último mes, ¿tuvo alguna vez alguna reacción física cuando algo le recordó el (EVENTO)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>¿Puede darme algunos ejemplos? (¿Se aceleró su corazón o cambió su respiración? ¿Sudó, o se sintió tenso o tembloroso?)</td>
</tr>
<tr>
<td>¿Qué clase de recuerdos le provocaron estas reacciones físicas?</td>
</tr>
<tr>
<td>¿Cuánto tiempo le tomó recuperarse de estas reacciones físicas?</td>
</tr>
<tr>
<td>Circle: Physiological reactivity = Minimal Clearly Present Pronounced Extreme</td>
</tr>
<tr>
<td>¿Cuántas veces tuvo estas reacciones físicas durante el último mes? # of times ________</td>
</tr>
</tbody>
</table>

**Key rating dimensions = frequency / intensity of physiological arousal**
- Moderate = at least 2 X month / reactivity clearly present, some difficulty recovering
- Severe = at least 2 X week / pronounced reactivity, sustained arousal, considerable difficulty recovering

6. (C1) Avoidance of, or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

<table>
<thead>
<tr>
<th>En el último mes, ¿trató usted de evitar pensamientos o sentimientos acerca del (EVENTO)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>¿Qué clase de pensamientos o sentimientos trató de evitar?</td>
</tr>
<tr>
<td>¿Cuánto esfuerzo hizo para evitar estos pensamientos o sentimientos? (¿Qué clase de cosas hizo?)</td>
</tr>
<tr>
<td>Circle: Avoidance = Minimal Clearly Present Pronounced Extreme</td>
</tr>
<tr>
<td>¿Cuántas veces durante el último mes? # of times ________</td>
</tr>
</tbody>
</table>

**Key rating dimensions = frequency / intensity of avoidance**
- Moderate = at least 2 X month / avoidance clearly present
- Severe = at least 2 X week / pronounced avoidance
7. (C2) Avoidance of, or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

<table>
<thead>
<tr>
<th>Avoidance =</th>
<th>Minimal</th>
<th>Clearly Present</th>
<th>Pronounced</th>
<th>Extreme</th>
</tr>
</thead>
</table>

- ¿En el último mes, trató de evitar cosas que le recuerdan el (EVENTO), como ciertas personas, lugares, o situaciones?
- ¿Qué clase de cosas evitó?
- ¿Cuánto esfuerzo le tomó para evitar estas cosas que le recuerdan el (EVENTO)? (¿Tiene que hacer un plan o cambiar sus actividades para evitarlas?)

(If not clear:) (En general, ¿en qué medida representa esto un problema para usted? ¿Cómo sería su vida diferente si no tuviese que evitar lo que le recuerda el [EVENTO]?)

<table>
<thead>
<tr>
<th>Key rating dimensions = frequency / intensity of avoidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderate = at least 2 X month / avoidance clearly present</td>
</tr>
<tr>
<td>Severe = at least 2 X week / pronounced avoidance</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>¿Cuántas veces tuvo que hacer esto durante el último mes?</th>
<th># of times</th>
</tr>
</thead>
</table>

8. (D1) Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).

<table>
<thead>
<tr>
<th>Difficulty remembering =</th>
<th>Minimal</th>
<th>Clearly Present</th>
<th>Pronounced</th>
<th>Extreme</th>
</tr>
</thead>
</table>

- ¿En el último mes, tuvo dificultad para recordar algunas partes importantes del (EVENTO)? (¿Hay partes que se le olvidaron sobre el [EVENTO]?)
- ¿Qué partes se le hizo más difícil recordar?
- ¿Cree que debería de recordar estas cosas?

(If not clear:) ¿Por qué piensa que no puede? ¿Sufrió una lesión en la cabeza durante el [EVENTO]? ¿Quedó inconsciente? ¿Estaba bajo los efectos del alcohol u otras drogas? [Rate 0=Absent if due to head injury or loss of consciousness or intoxication during event]

(If still not clear:) ¿Es esto un olvido normal? ¿O considera que las bloqueó porque resultaría muy doloroso recordarlas? [Rate 0=Absent if due only to normal forgetting]

<table>
<thead>
<tr>
<th>Key rating dimensions = amount of event not recalled / intensity of inability to recall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderate = at least one important aspect / difficulty remembering clearly present, some recall possible with effort</td>
</tr>
<tr>
<td>Severe = several important aspects / pronounced difficulty remembering, little recall even with effort</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>¿Podría recordar estas cosas si lo intentara?</th>
<th># of important aspects</th>
</tr>
</thead>
</table>
9. (D2) Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., “I am bad,” “No one can be trusted,” “The world is completely dangerous,” “My whole nervous system is permanently ruined”).

En el último mes, ¿tuvo opiniones negativas sobre usted mismo? ¿Tuvo opiniones negativas sobre otras personas? ¿Tuvo opiniones negativas sobre el mundo?

¿Puede darme algunos ejemplos? (¿Piensa cosas como: “soy malo/a,” “pasa algo realmente malo conmigo,” “no puedo confiar en nadie,” “el mundo es un lugar muy peligroso”)

¿Qué tan fuertes fueron estas opiniones? (¿Estaba muy convencido/a de que lo que creía era realmente verdad? ¿Puede ver otras maneras de pensar al respecto?)

Durante el último mes, ¿cuánto tiempo se sintió así? % of time

¿Estas opiniones comenzaron después del (EVENTO)? [if not] ¿Estas opiniones empeoraron después del (EVENTO)? [if not] ¿Cree que son debido a otras razones?

Key rating dimensions = frequency / intensity of beliefs
Moderate = some of the time (20-30%) / exaggerated negative expectations clearly present, some difficulty considering more realistic beliefs; Severe = much of the time (50-60%) / pronounced exaggerated negative expectations, considerable difficulty considering more realistic beliefs

10. (D3) Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.

En el último mes, ¿se sintió culpable por el (EVENTO)? ¿O se sintió culpable por lo que sucedió como resultado de este?

¿Cuánto más acerca de eso. (¿De qué manera se ve a sí mismo como causante de [EVENTO]? ¿Es debido a algo que usted hizo? ¿O a algo que piensa que debió haber hecho pero que no hizo? ¿Es debido a algo acerca de usted en general?)

¿Y qué hay de culpar a alguien más por el (EVENTO) o por lo que sucedió como resultado de este? ¿Cuánto más acerca de eso. (¿De qué manera ve a [OTROS] como causantes de [EVENTO]? ¿Es debido a algo que hicieron? ¿O algo que usted piensa que debían de haber hecho pero que no hicieron?)

¿Cuánto usted (SE CULPA O CULPA A OTROS) por el (EVENTO) o por el resultado de este?

¿Qué tan convencido/a está de que [USTED U OTROS] son verdaderamente responsables de lo que sucedió? (¿Otras personas están de acuerdo con usted? ¿Puede imaginar otras formas de pensar acerca de esto?)

[Rate 0=Absent if only blames perpetrator, i.e., someone who deliberately caused the event and intended harm]

¿Por cuánto tiempo se sintió de esa manera en el último mes? % of time

Key rating dimensions = frequency / intensity of blame
Moderate = some of the time (20-30%) / distorted blame clearly present, some difficulty considering more realistic beliefs; Severe = much of the time (50-60%) / pronounced distorted blame, considerable difficulty considering more realistic beliefs
11. (D4) Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).

<table>
<thead>
<tr>
<th>Question</th>
<th>Rating Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>¿Tuvo algún sentimiento negativo fuerte, como por ejemplo, miedo, terror, ira, culpa o vergüenza?</td>
<td>0 Absent 1 Mild / subthreshold 2 Moderate / threshold 3 Severe / markedly elevated 4 Extreme / incapacitating</td>
</tr>
<tr>
<td>¿Puede darme algunos ejemplos? (¿Qué sentimientos negativos experimenta usted?)</td>
<td></td>
</tr>
<tr>
<td>¿Qué tan fuertes fueron estos sentimientos negativos?</td>
<td></td>
</tr>
<tr>
<td>¿Qué tan bien pudo manejarlos?</td>
<td></td>
</tr>
<tr>
<td>Circle: Negative emotions = Minimal  Clearly Present  Pronounced  Extreme</td>
<td></td>
</tr>
<tr>
<td>¿Por cuánto tiempo se sintió de esa manera en el último mes? % of time</td>
<td></td>
</tr>
<tr>
<td>¿Estos sentimientos negativos comenzaron después del (EVENTO)? [if not:]</td>
<td></td>
</tr>
<tr>
<td>(¿Estos sentimientos empeoraron después del (EVENTO)?) [if not:] (¿Son debido a otras razones?)</td>
<td>0 Absent 1 Mild / subthreshold 2 Moderate / threshold 3 Severe / markedly elevated 4 Extreme / incapacitating</td>
</tr>
</tbody>
</table>

Key rating dimensions = frequency / intensity of negative emotions
Moderate = some of the time (20-30%) / negative emotions clearly present, some difficulty managing
Severe = much of the time (50-60%) / pronounced negative emotions, considerable difficulty managing

12. (D5) Markedly diminished interest or participation in significant activities.

<table>
<thead>
<tr>
<th>Question</th>
<th>Rating Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>¿Estuvo menos interesado/a en actividades que antes le gustaba hacer?</td>
<td>0 Absent 1 Mild / subthreshold 2 Moderate / threshold 3 Severe / markedly elevated 4 Extreme / incapacitating</td>
</tr>
<tr>
<td>¿En qué tipo de cosas perdió el interés? ¿Qué tipo de cosas ya no hace tanto como antes? (¿Algo más?)</td>
<td></td>
</tr>
<tr>
<td>¿Por qué le pasó esto? [Rate 0=Absent if diminished participation is due to lack of opportunity, physical inability, or developmentally appropriate change in preferred activities]</td>
<td></td>
</tr>
<tr>
<td>¿Qué tan fuerte fue su pérdida de interés? (¿Todavía disfrutaría [ACTIVIDADES] una vez que las comience?)</td>
<td></td>
</tr>
<tr>
<td>Circle: Loss of interest = Minimal  Clearly Present  Pronounced  Extreme</td>
<td></td>
</tr>
<tr>
<td>En general, en el último mes, ¿cuántas de sus actividades regulares dejó de hacer?</td>
<td></td>
</tr>
<tr>
<td>¿Qué tipo de cosas le gusta hacer todavía? % of activities</td>
<td></td>
</tr>
<tr>
<td>¿Esta pérdida de interés comenzó después del (EVENTO)? [if not:] (¿Esta pérdida de interés empeoró después del evento?; [if not] (¿Es debido a otras razones?)</td>
<td>0 Absent 1 Mild / subthreshold 2 Moderate / threshold 3 Severe / markedly elevated 4 Extreme / incapacitating</td>
</tr>
</tbody>
</table>

Key rating dimensions = percent of activities affected / intensity of loss of interest
Moderate = some activities (20-30%) / loss of interest clearly present but still has some enjoyment of activities
Severe = many activities (50-60%) / pronounced loss of interest, little interest or participation in activities
13. (D6) Feelings of detachment or estrangement from others.

En el último mes, ¿se sintió distante o apartado de otras personas? Cuénteme más acerca de eso.

¿Qué tan intensa es su sensación de estar distante o apartado/a de otros? (¿Quién es la persona más cercana a usted? ¿Con cuántas personas se siente cómoda/a de hablar acerca de sus cosas personales?)

Circle: Detachment or estrangement = Minimal Clearly Present Pronounced Extreme

¿Por cuánto tiempo se sintió de esa manera en el último mes? % of time

¿Esta sensación de estar distante o apartado/a comenzó después del (EVENTO)? [if not] (¿Esta sensación de estar distante empeoró después del evento?) [if not] (¿Es debido a otras razones?)

Circle: Trauma-relatedness = Definite Probable Unlikely

Key rating dimensions = frequency / intensity of detachment or estrangement
Moderate = some of the time (20-30%) / feelings of detachment clearly present but still feels some interpersonal connection
Severe = much of the time (50-60%) / pronounced feelings of detachment or estrangement from most people, may feel close to only one or two people

14. (D7) Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

En el último mes, ¿se le hizo difícil sentir emociones positivas como el amor o la alegría? Cuénteme más acerca de eso. (¿Qué emociones se le hace difícil sentir?)

¿Qué tan difícil se le hace sentir emociones positivas? (¿Todavía es capaz de sentir alguna emoción positiva?)

Circle: Reduction of positive emotions = Minimal Clearly Present Pronounced Extreme

¿Por cuánto tiempo se sintió de esa manera en el último mes? % of time

¿Esta dificultad para sentir emociones positivas comenzó después del (EVENTO)? [if not] (¿Esta dificultad para sentir emociones positivas empeoró después del evento?) [if not] (¿Es debido a otras razones?)

Circle: Trauma-relatedness = Definite Probable Unlikely

Key rating dimensions = frequency / intensity of reduction in positive emotions
Moderate = some of the time (20-30%) / reduction of positive emotional experience clearly present but still able to experience some positive emotions
Severe = much of the time (50-60%) / pronounced reduction of experience across range of positive emotions
15. (E1) Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.

| En el último mes, ¿se sintió particularmente **irritado/a** o **enojado/a** y lo demostró con su comportamiento? |
| | ¿Puede darle algunos ejemplos? (¿Cómo lo demostró? ¿Levantó la voz o gritó? ¿Tiró o golpeó cosas? ¿Empujó o golpeó a otras personas?) |
| Circle: Aggression = Minimal | Clearly Present | Pronounced | Extreme |
| ¿Cuántas veces le pasó esto en el último mes? # of times __________ |
| ¿Este comportamiento comenzó después del (EVENTO)? [if not:] (¿Este comportamiento empeoró después del evento?) [if not:] (¿Es debido a otras razones?) |
| Circle: Trauma-relatedness = Definite | Probable | Unlikely |

**Key rating dimensions = frequency / intensity of aggressive behavior**
- Moderate = at least 2 X month / aggression clearly present, primarily verbal
- Severe = at least 2 X week / pronounced aggression, at least some physical aggression

16. (E2) Reckless or self-destructive behavior.

| En el último mes, ¿tomó **riesgos** o hizo cosas que pudieron causarle daño? |
| | ¿Puede darle algunos ejemplos? |
| | ¿Cuántos riesgos tomó? (¿Qué tan peligrosos fueron estos comportamientos? ¿Resultó herido o lastimado alguna vez?) |
| Circle: Risk = Minimal | Clearly Present | Pronounced | Extreme |
| ¿Cuántas veces tomó este tipo de riesgos en el último mes? # of times __________ |
| ¿Este comportamiento comenzó después del (EVENTO)? [if not:] (¿Este comportamiento empeoró después del evento?) [if not:] (¿Es debido a otras razones?) |
| Circle: Trauma-relatedness = Definite | Probable | Unlikely |

**Key rating dimensions = frequency / degree of risk**
- Moderate = at least 2 X month / risk clearly present, may have been harmed
- Severe = at least 2 X week / pronounced risk, actual harm or high probability of harm
17. (E3) Hypervigilance.

En el último mes, ¿Estuvo particularmente alerta, aún cuando no había una amenaza específica? (¿Sintió como si tuviera que estar en alerta?)

¿Puede darme algunos ejemplos? (¿Qué cosas hizo cuando estaba alerta?)

[If not clear:] (¿Qué le hizo reaccionar de esta manera? ¿Sintió que estaba en peligro de alguna manera? ¿Sintió que estaba más alerta que otras personas estarian en la misma situación?)

¿Por cuánto tiempo se sintió de esa manera en el último mes? % of time

¿Este comportamiento comenzó después del (EVENTO)? [if not:] (¿Este comportamiento empeoró después del evento?) [if not:] (¿Es debido a otras razones?)

Circle: Trauma-relatedness = Definite Probable Unlikely

Key rating dimensions = frequency / intensity of hypervigilance
Moderate = some of the time (20-30%) / hypervigilance clearly present, e.g., watchful in public, heightened awareness of threat
Severe = much of the time (50-60%) / pronounced hypervigilance, e.g., scans environment for danger, may have safety rituals, exaggerated concern for safety of self/family/home

0 Absent
1 Mild / subthreshold
2 Moderate / threshold
3 Severe / markedly elevated
4 Extreme / incapacitating

18. (E4) Exaggerated startle response.

En el último mes, ¿se sintió sobresaltado/a?

¿Qué cosas le sobresaltaron?

¿Qué tan fuertes fueron estas reacciones de sobresalto? (¿Qué tan fuertes fueron en comparación con la reacción de otras personas? ¿Hizo algo que otras personas notarían?)

¿Cuánto tiempo le tomó recuperarse?

¿Cuántas veces le pasó esto en el último mes? # of times

¿Este comportamiento comenzó después del (EVENTO)? [if not:] (¿Este comportamiento empeoró después del evento?) [if not:] (¿Es debido a otras razones?)

Circle: Trauma-relatedness = Definite Probable Unlikely

Key rating dimensions = frequency / intensity of startle
Moderate = at least 2 X month / startle clearly present, some difficulty recovering
Severe = at least 2 X week / pronounced startle, sustained arousal, considerable difficulty recovering

0 Absent
1 Mild / subthreshold
2 Moderate / threshold
3 Severe / markedly elevated
4 Extreme / incapacitating
19. (E5) Problemas con la concentración.

En el último mes, ¿tuvo algún problema para prestar atención?
¿Puede darme algunos ejemplos?

¿Pudo prestar atención si realmente intentaba?
Circle: Problem concentrating = Minimal Clearly Present Pronounced Extreme

¿Por cuánto tiempo tuvo problemas para prestar atención en el último mes?
% of time __________

¿Estos problemas de atención comenzaron después del (EVENTO)? [if not:]
(¿Estos problemas de atención empeoraron después del evento?) [if not:] (¿Son debido a otras razones?)
Circle: Trauma-relatedness = Definite Probable Unlikely

Key rating dimensions = frequency / intensity of concentration problems
Moderate = some of the time (20-30%) / problem concentrating clearly present, some difficulty but can concentrate with effort
Severe = much of the time (50-60%) / pronounced problem concentrating, considerable difficulty even with effort

20. (E6) Disturbios del sueño (e.g., dificultad para dormir o estar dormido).

En el último mes, ¿tuvo algún problema para dormir?

¿Qué tipo de problema? (¿Cuánto tiempo le tomó quedarse dormido?)
¿Cuántas veces se despertó en la noche? ¿Se despertó más temprano de lo que desearía?)

¿Cuántas horas en total durmió cada noche?

¿Cuántas horas cree que debería dormir?
Circle: Problem sleeping = Minimal Clearly Present Pronounced Extreme

¿Cuántas veces tuvo estos problemas para dormir en el último mes? # of times _______

¿Estos problemas para dormir comenzaron después del (EVENTO)? [if not:]
(¿Estos problemas para dormir empeoraron después del evento?) [if not:] (¿Son debido a otras razones?)
Circle: Trauma-relatedness = Definite Probable Unlikely

Key rating dimensions = frequency / intensity of sleep problems
Moderate = at least 2 X month / sleep disturbance clearly present, clearly longer latency or clear difficulty staying asleep, 30-90 minutes loss of sleep
Severe = at least 2 X week / pronounced sleep disturbance, considerably longer latency or marked difficulty staying asleep, 90 min to 3 hrs loss of sleep
### Criterion F: Duration of the disturbance (Criteria B, C, D, and E) is more than 1 month.

#### 21. Onset of symptoms

<table>
<thead>
<tr>
<th>[If not clear:] ¿Cuándo comenzó a tener por primera vez (SÍNTOMAS DEL TEPT) de los que me habló? (¿Cuánto tiempo después del trauma comenzaron? ¿Más de seis meses?)</th>
<th>Total # months delay in onset __________</th>
</tr>
</thead>
<tbody>
<tr>
<td>With delayed onset (≥ 6 months)? NO YES</td>
<td></td>
</tr>
</tbody>
</table>

#### 22. Duration of symptoms

<table>
<thead>
<tr>
<th>[If not clear:] ¿Cuánto duraron en total estos (SÍNTOMAS DEL TEPT)?</th>
<th>Total # months duration __________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duration more than 1 month? NO YES</td>
<td></td>
</tr>
</tbody>
</table>

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

#### 23. Subjective distress

<table>
<thead>
<tr>
<th>En general, en el último mes, ¿cuánto le molestaron estos (SÍNTOMAS DEL TEPT) de los que me habló? [Consider distress reported on earlier items]</th>
<th>0 None</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 Mild, minimal distress</td>
</tr>
<tr>
<td></td>
<td>2 Moderate, distress clearly present but still manageable</td>
</tr>
<tr>
<td></td>
<td>3 Severe, considerable distress</td>
</tr>
<tr>
<td></td>
<td>4 Extreme, incapacitating distress</td>
</tr>
</tbody>
</table>

#### 24. Impairment in social functioning

<table>
<thead>
<tr>
<th>En el último mes, ¿estos (SÍNTOMAS DEL TEPT) afectaron su relación con otras personas? ¿Cómo? [Consider impairment in social functioning reported on earlier items]</th>
<th>0 No adverse impact</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 Mild impact, minimal impairment in social functioning</td>
</tr>
<tr>
<td></td>
<td>2 Moderate impact, definite impairment but many aspects of social functioning still intact</td>
</tr>
<tr>
<td></td>
<td>3 Severe impact, marked impairment, few aspects of social functioning still intact</td>
</tr>
<tr>
<td></td>
<td>4 Extreme impact, little or no social functioning</td>
</tr>
</tbody>
</table>

#### 25. Impairment in occupational or other important area of functioning

<table>
<thead>
<tr>
<th>[If not clear:] ¿Está trabajando ahora? [If yes:] En el último mes, ¿estos (SÍNTOMAS DEL TEPT) afectaron su trabajo o su capacidad para trabajar? ¿Cómo? [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 trauma, assess pre-trauma school performance and possible presence of behavior problems]</th>
<th>0 No adverse impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>[If no:] ¿Estos (SÍNTOMAS DEL TEPT) afectaron cualquier otra área importante de su vida? [As appropriate, suggest examples such as parenting, housework, schoolwork, volunteer work, etc.] ¿Cómo?</td>
<td>1 Mild impact, minimal impairment in occupational/other important functioning</td>
</tr>
<tr>
<td></td>
<td>2 Moderate impact, definite impairment but many aspects of occupational/other important functioning still intact</td>
</tr>
<tr>
<td></td>
<td>3 Severe impact, marked impairment, few aspects of occupational/other important functioning still intact</td>
</tr>
<tr>
<td></td>
<td>4 Extreme impact, little or no occupational/other important functioning</td>
</tr>
</tbody>
</table>
### Global Ratings

| 26. Global validity | 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” |

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.

| 27. Global severity | 0 | No clinically significant symptoms, no distress and no functional impairment |
| | 1 | Mild, minimal distress or functional impairment |
| | 2 | Moderate, definite distress or functional impairment but functions satisfactorily with effort |
| | 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 |

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.

| 28. Global improvement | 0 | Asymptomatic |
| | 1 | Considerable improvement |
| | 2 | Moderate improvement |
| | 3 | Slight improvement |
| | 4 | No improvement |
| | 5 | Insufficient information |

Rate total overall improvement since the previous rating. Rate the degree of change, whether or not, in your judgment, it is due to treatment.
Specify whether with dissociative symptoms: The individual’s symptoms meet the criteria for posttraumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:

29. (1) Depersonalization: Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one’s mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).

<table>
<thead>
<tr>
<th>Circle</th>
<th>Dissociation</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Absent</td>
</tr>
<tr>
<td>1</td>
<td>Mild / subthreshold</td>
</tr>
<tr>
<td>2</td>
<td>Moderate / threshold</td>
</tr>
<tr>
<td>3</td>
<td>Severe / markedly elevated</td>
</tr>
<tr>
<td>4</td>
<td>Extreme / incapacitating</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th># of times</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>of times</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

En el último mes, mientras que estaba despierto, ¿Hubieron ocasiones en que se sintió como si estuviera separado de sí mismo? ¿Qué tal como si estuviera mirándose a sí mismo desde afuera? ¿O como que está observando sus pensamientos y sentimientos como si fuera otra persona?

(También, ¿sintió como si estuviera en un sueño, aún estando despertado/a? ¿Sintió como si algo acerca de usted no fuera real? ¿Sintió como si el tiempo pasara más lentamente?)

Cuénteme más acerca de eso.

¿Qué tan fuerte fue esa sensación? (¿Perdió la noción de dónde se encontraba o de lo que estaba ocurriendo?)

¿Qué hizo mientras esto ocurrió? (¿Otras personas notaron su comportamiento? ¿Qué le dijeron?)

¿Cuánto tiempo le duró?

[If no] (¿Se debió a los efectos de alcohol o drogas? ¿O se debió a una condición médica como por ejemplo, convulsiones?)

[Rate 0=Absent if due to the effects of a substance or another medical condition]

¿Cuántas veces le pasó esto en el último mes? # of times
30. (2) Derealization: Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted).

En el último mes, ¿hubieron ocasiones cuando las cosas que estaban pasando a su alrededor parecían muy extrañas y desconocidas?

[If no:] ¿Las cosas a su alrededor parecían como un sueño o como una escena de una película? ¿Parecían distantes o distorsionadas?

Cuénteme más acerca de eso.

¿Qué tan fuerte fue esa sensación? ¿Perdió la noción de dónde se encontraba o de lo que estaba ocurriendo? ¿Otras personas notaron su comportamiento? ¿Qué le dijeron?

¿Cuánto tiempo le duró?

Circle: Dissociation = Minimal  Clearly Present  Pronounced  Extreme

[If not clear:] ¿Se debió a los efectos de alcohol o drogas? ¿O se debió a una condición médica como por ejemplo, convulsiones? [Rate 0=Absent if due to the effects of a substance or another medical condition]

¿Cuántas veces le pasó esto en el último mes? # of times_________

Key rating dimensions = frequency / intensity of dissociation
Moderate = at least 2 X month / dissociative quality clearly present but transient, retains some realistic sense of environment
Severe = at least 2 X week / pronounced dissociative quality, marked sense of unreality
**CAPS-5 SUMMARY SHEET**

Name:________________ ID#:________ Interviewer:________________ Study:___________
Date:________

### A. Exposure to actual or threatened death, serious injury, or sexual violence

<table>
<thead>
<tr>
<th>Criterion A met?</th>
<th>0 = NO</th>
<th>1 = YES</th>
</tr>
</thead>
</table>

### B. Intrusion symptoms (need 1 for diagnosis)

#### Past Month

<table>
<thead>
<tr>
<th>Sev</th>
<th>Sx (Sev ≥ 2)?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>(1) B1 – Intrusive memories</td>
<td>0 = NO</td>
</tr>
<tr>
<td>(2) B2 – Distressing dreams</td>
<td>0 = NO</td>
</tr>
<tr>
<td>(3) B3 – Dissociative reactions</td>
<td>0 = NO</td>
</tr>
<tr>
<td>(4) B4 – Cued psychological distress</td>
<td>0 = NO</td>
</tr>
<tr>
<td>(5) B5 – Cued physiological reactions</td>
<td>0 = NO</td>
</tr>
</tbody>
</table>

#### B subtotals

<table>
<thead>
<tr>
<th>B Sev =</th>
<th># B Sx =</th>
</tr>
</thead>
</table>

### C. Avoidance symptoms (need 1 for diagnosis)

#### Past Month

<table>
<thead>
<tr>
<th>Sev</th>
<th>Sx (Sev ≥ 2)?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>(6) C1 – Avoidance of memories, thoughts, feelings</td>
<td>0 = NO</td>
</tr>
<tr>
<td>(7) C2 – Avoidance of external reminders</td>
<td>0 = NO</td>
</tr>
</tbody>
</table>

#### C subtotals

<table>
<thead>
<tr>
<th>C Sev =</th>
<th># C Sx =</th>
</tr>
</thead>
</table>

### D. Cognitions and mood symptoms (need 2 for diagnosis)

#### Past Month

<table>
<thead>
<tr>
<th>Sev</th>
<th>Sx (Sev ≥ 2)?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>(8) D1 – Inability to recall important aspect of event</td>
<td>0 = NO</td>
</tr>
<tr>
<td>(9) D2 – Exaggerated negative beliefs or expectations</td>
<td>0 = NO</td>
</tr>
<tr>
<td>(10) D3 – Distorted cognitions leading to blame</td>
<td>0 = NO</td>
</tr>
<tr>
<td>(11) D4 – Persistent negative emotional state</td>
<td>0 = NO</td>
</tr>
<tr>
<td>(12) D5 – Diminished interest or participation in activities</td>
<td>0 = NO</td>
</tr>
<tr>
<td>(13) D6 – Detachment or estrangement from others</td>
<td>0 = NO</td>
</tr>
<tr>
<td>(14) D7 – Persistent inability to experience positive emotions</td>
<td>0 = NO</td>
</tr>
</tbody>
</table>

#### D subtotals

<table>
<thead>
<tr>
<th>D Sev =</th>
<th># D Sx =</th>
</tr>
</thead>
</table>

### E. Arousal and reactivity symptoms (need 2 for diagnosis)

#### Past Month

<table>
<thead>
<tr>
<th>Sev</th>
<th>Sx (Sev ≥ 2)?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>(15) E1 – Irritable behavior and angry outbursts</td>
<td>0 = NO</td>
</tr>
<tr>
<td>(16) E2 – Reckless or self-destructive behavior</td>
<td>0 = NO</td>
</tr>
<tr>
<td>(17) E3 – Hypervigilance</td>
<td>0 = NO</td>
</tr>
<tr>
<td>(18) E4 – Exaggerated startle response</td>
<td>0 = NO</td>
</tr>
<tr>
<td>(19) E5 – Problems with concentration</td>
<td>0 = NO</td>
</tr>
<tr>
<td>(20) E6 – Sleep disturbance</td>
<td>0 = NO</td>
</tr>
</tbody>
</table>

#### E subtotals

<table>
<thead>
<tr>
<th>E Sev =</th>
<th># E Sx =</th>
</tr>
</thead>
</table>
### PTSD totals

<table>
<thead>
<tr>
<th></th>
<th>Past Month</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total Sev</td>
</tr>
</tbody>
</table>

Sum of subtotals (B+C+D+E)

### F. Duration of disturbance

<table>
<thead>
<tr>
<th>Current</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(22) Duration of disturbance ≥ 1 month?</td>
<td>0 = NO 1 = YES</td>
</tr>
</tbody>
</table>

### G. Distress or impairment (need 1 for diagnosis)

<table>
<thead>
<tr>
<th>Sev</th>
<th>Cx (Sev ≥ 2)?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0 = NO 1 = YES</td>
</tr>
</tbody>
</table>

| (23) Subjective distress | 0 = NO 1 = YES |
| (24) Impairment in social functioning | 0 = NO 1 = YES |
| (25) Impairment in occupational functioning | 0 = NO 1 = YES |

G subtotals: G Sev = # G Cx =

### Global ratings

<table>
<thead>
<tr>
<th>Past Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>(26) Global validity</td>
</tr>
<tr>
<td>(27) Global severity</td>
</tr>
<tr>
<td>(28) Global improvement</td>
</tr>
</tbody>
</table>

### Dissociative symptoms (need 1 for subtype)

<table>
<thead>
<tr>
<th>Sev</th>
<th>Sx (Sev ≥ 2)?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0 = NO 1 = YES</td>
</tr>
</tbody>
</table>

| (29) 1 – Depersonalization | 0 = NO 1 = YES |
| (30) 2 – Derealization | 0 = NO 1 = YES |

Dissociative subtotals: Diss Sev = # Diss Sx =

### PTSD diagnosis

<table>
<thead>
<tr>
<th>Past Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD PRESENT – ALL CRITERIA (A-G) MET?</td>
</tr>
<tr>
<td>With dissociative symptoms</td>
</tr>
<tr>
<td>(21) With delayed onset (&gt; 6 months)</td>
</tr>
</tbody>
</table>
CAPS-5 for Spanish Speaking Latinos in the U.S.

Visual Aids

Figura 1. ¿Por cuánto tiempo tuvo [el síntoma] en el último mes? Ejemplos de respuestas como porcentajes.
Figura 2. El último mes se refiere a los últimos 30 días. Por favor anote las fechas de los siguientes eventos.

Evento traumático

Hace 30 días

Hoy

Fecha aproximada

Fecha

Fecha