THE CHILD PTSD SYMPTOM SCALE FOR DSM-V (CPSS-V SR)

PSYCHOMETRIC PROPERTIES SUMMARY

The CPSS-SR-5 is a modified version of Child PTSD Symptom Scale self-report (CPSS-SR) for DSM-5. The 20 PTSD symptom items are rated on a 5-point scale of frequency and severity from 0 (not at all) to 4 (6 or more times a week /severe). The 7 functioning items are rated on yes/no.

Use the 20 symptom items to calculate a total symptom severity score. The CPSS-SR-5 has excellent internal consistency for total symptom severity (Cronbach's alpha = .924) and good test-retest reliability (r = .800). The CPSS-SR-5 also demonstrates convergent validity with CPSS-I-5 (r = .904), and discriminant validity with the Multidimensional Anxiety Scale (MASC) for Children and Child Depression Inventory (CDI). A cut off score of 31 can be used for identifying a probable PTSD diagnosis in children. In sum, the CPSS-SR-5 is a valid and reliable self-report instrument for assessing DSM-5 PTSD diagnosis and severity for children and adolescents.

CPSS SYMPTOM SEVERITY RANGES

Symptom Severity	Range
Minimal	0-10
Mild	11-20
Moderate	21-40
Severe	41-60
Very Severe	61-80

Note: We have included on the following page a trauma screen checklist in the event the clinician would find this helpful prior to doing the CPSS-V SR. Completing it is optional.

TRAUMA SCREEN (OPTIONAL – IF NEEDED)

Name: _____ Date: _____

INSTRUCTIONS

Many children go through frightening or stressful events. Below is a listed of frightening or stressful events that can happen. Mark YES if you have experienced any of these events. Mark NO if you have not experienced these events.

	Yes	No
1. A severe natural disaster such as a flood, tornado, hurricane, earthquake, or fire	☐	☐
2. Serious accident or injury caused by a car or bike crash, being bitten by a dog, or caused by playing sports	☐	☐
3. Being robbed by threat, force, or weapon	☐	☐
4. Being slapped, punished, or beaten by a relative	☐	☐
5. Being slapped, knifed, or beaten by a stranger	☐	☐
6. Seeing a relative get slapped, punished, or beaten	☐	☐
7. Seeing somebody in your community being slapped, punished, or beaten	☐	☐
8. Being touched in your sexual/private parts by an adult/someone older who should not be touching you there	☐	☐
9. Being forced/pressured to have sex at a time when you could not say no	☐	☐
10. A family member or somebody close dying suddenly or in a violent way	☐	☐
11. Being attacked, shot, stabbed, or seriously injured	☐	☐
12. Seeing someone be attacked, shot, stabbed, or seriously injured or killed	☐	☐
13. Having a stressful or frightening medical procedure	☐	☐
14. Being around a war	☐	☐
15. Any other stressful or frightening event Describe: _____	☐	☐

Which of these events bothers you most? _____

If you answered **NO** to all of the above questions, **STOP**. If you answered **YES** to any of the above questions, please answer the following questions.

When the event happened, did you feel:	Yes	No
Fear that you were going to die or be seriously injured?	☐	☐
Fear that someone else was seriously hurt?	☐	☐
Unable to help yourself?	☐	☐
Shame or disgust?	☐	☐

CPSS – V

Name or ID: _____ Date: _____

Sometimes scary or upsetting things happen to kids. It might be something like a car accident, getting beaten up, living through an earthquake, being robbed, being touched in a way you didn't like, having a parent get hurt or killed, or some other very upsetting event.

Please write down the scary or upsetting thing that bothers you the most when you think about it (this should be the event you listed in the Trauma Screen, if the Trauma Screen was used):

When did it happen? _____

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/a lot	6 or more times a week/almost always

These questions ask about how you feel about the upsetting thing you wrote down. Read each question carefully. Then circle the number (0-4) that best describes how often that problem has bothered you IN THE LAST MONTH.

1. Having upsetting thoughts or pictures about it that came into your head when you didn't want them to	0	1	2	3	4
2. Having bad dreams or nightmares	0	1	2	3	4
3. Acting or feeling as if it was happening again (seeing or hearing something and feeling as if you are there again)	0	1	2	3	4
4. Feeling upset when you remember what happened (for example, feeling scared, angry, sad, guilty, confused)	0	1	2	3	4
5. Having feelings in your body when you remember what happened (for example, sweating, heart beating fast, stomach or head hurting)	0	1	2	3	4
6. Trying not to think about it or have feelings about it	0	1	2	3	4
7. Trying to stay away from anything that reminds you of what happened (for example, people, places, or conversations about it)	0	1	2	3	4
8. Not being able to remember an important part of what happened	0	1	2	3	4
9. Having bad thoughts about yourself, other people, or the world (for example, "I can't do anything right", "All people are bad", "The world is a scary place")	0	1	2	3	4
10. Thinking that what happened is your fault (for example, "I should have known better", "I shouldn't have done that", "I deserved it")	0	1	2	3	4
11. Having strong bad feelings (like fear, anger, guilt, or shame)	0	1	2	3	4
12. Having much less interest in doing things you used to do	0	1	2	3	4
13. Not feeling close to your friends or family or not wanting to be around them	0	1	2	3	4
14. Trouble having good feelings (like happiness or love) or trouble having any feelings at all	0	1	2	3	4
15. Getting angry easily (for example, yelling, hitting others, throwing things)	0	1	2	3	4
16. Doing things that might hurt yourself (for example, taking drugs, drinking alcohol, running away, cutting yourself)	0	1	2	3	4
17. Being very careful or on the lookout for danger (for example, checking to see who is around you and what is around you)	0	1	2	3	4

Name or ID: _____ Date: _____

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/a lot	6 or more times a week/almost always

18. Being jumpy or easily scared (for example, when someone walks up behind you, when you hear a loud noise)	0	1	2	3	4
19. Having trouble paying attention (for example, losing track of a story on TV, forgetting what you read, unable to pay attention in class)	0	1	2	3	4
20. Having trouble falling or staying asleep	0	1	2	3	4

Have the problems above been getting in the way of these parts of your life IN THE PAST MONTH? Total Score :

YES	NO	21. Fun things you want to do
YES	NO	22. Doing your chores
YES	NO	23. Relationships with your friends
YES	NO	24. Praying
YES	NO	25. Schoolwork
YES	NO	26. Relationships with your family
YES	NO	27. Being happy with your life