National Center for PTSD
Posttraumatic Stress Disorder

U.S. Department of Veterans Affairs
National Center for PTSD
ADVANCING SCIENCE AND PROMOTING UNDERSTANDING OF TRAUMATIC STRESS
www.ptsd.va.gov

Using the PTSD Checklist (PCL)

What is the PCL?

The PCL is a 17-item self-report measure reflecting DSM-IV symptoms of PTSD. The PCL has a variety of clinical and research purposes, including:

- screening individuals for PTSD
- aiding in diagnostic assessment of PTSD
- monitoring change in PTSD symptoms

There are three versions of the PCL:

- The **PCL-M** (military) asks about symptoms in response to "stressful military experiences." It is often used with active service members and Veterans.

- The **PCL-C** (civilian) asks about symptoms in relation to generic "stressful experiences" and can be used with any population. This version simplifies assessment based on multiple traumas because symptom endorsements are not attributed to a specific event. In many circumstances it is advisable to also assess traumatic event exposure to ensure that a respondent has experienced at least one event that meets DSM-IV Criterion A.

- The **PCL-S** (specific) asks about symptoms in relation to an identified "stressful experience." The PCL-S aims to link symptom endorsements to a specified event. Similar to the PCL-C, it is optimal to assess traumatic event exposure to ensure that the index event meets PTSD Criterion A. Respondents also can be instructed to complete the PCL-S in reference to a specified event or event type (e.g., assault, disaster, or accident).

How is the PCL administered and scored?

The PCL is a self-report instrument that can be read by respondents themselves or read to them either in person or over the telephone. It can be completed in approximately 5-10 minutes.

The PCL can be scored in several ways:

- A **total symptom severity score** (range = 17-85) can be obtained by summing the scores from each of the 17 items that have response options ranging from 1 "Not at all" to 5 "Extremely".

- The gold standard for diagnosing PTSD is a structured clinical interview such as the Clinician-Administered PTSD Scale (CAPS). When necessary, the PCL can be scored to provide a presumptive diagnosis. This has been done in three ways:

    (1) determine whether an individual meets DSM-IV symptom criteria as defined by at least 1 B item (questions 1-5), 3 C items (questions 6-12), and at least 2 D items (questions 13-17).

Symptoms rated as "Moderately" or above (responses 3 through 5 on individual items) are counted as present.

(2) determine whether the total severity score exceeds a given normative threshold (see Table 1).

(3) combine methods (1) and (2) to ensure that an individual meets both the symptom pattern and severity threshold.

Choosing a cut-point score

Factors to be considered when choosing a PCL cut-point score include:

- **The goal of the assessment**: A lower cut-point is considered when screening for PTSD or when it is desirable to maximize detection of possible cases. A higher cut-point is considered when informing diagnosis or to minimize false positives.

- **The prevalence of PTSD in the target setting**: Generally, the lower the prevalence of PTSD in a given setting, the lower the optimal cut-point. In settings with expected high rates of PTSD, such as specialty mental health clinics, consider a higher cut-point. In settings with expected low rates of PTSD, such as primary care clinics or circumstances in which patients are reluctant to disclose mental health problems, consider a lower cut-point.

Below are suggested cut-point ranges based on prevalence and setting characteristics. There is no absolute method for determining the correct cut-point on the PCL. If you know the prevalence of PTSD in your target population, use column 1 to find the suggested PCL cut-point (column 3). If you do not know the prevalence in your population, you can choose a cut-point based on the type of setting (column 2) in which you are working. Consider scores on the low end of the range if the goal is to screen for PTSD. Consider scores on the high end of the range if the goal is to aid in diagnosis of PTSD.

Table 1. Suggested PCL cut-point scores

Estimated Prevalence of PTSD	Typical Setting	Suggested PCL Cut-Point Scores
15% or Below	e.g. civilian primary care, Department of Defense screening, or general population samples	30-35
16-39%	e.g. specialized medical clinics (such as TBI or pain) or VA primary care	36-44
40% or Above	e.g. VA or civilian specialty mental health clinics	45-50

Note. These recommendations are general and approximate, and are not intended to be used for legal or policy purposes. Research is needed to establish optimal cut-point scores for a specific application.

Measuring change

Good clinical practice often involves monitoring patient progress. Evidence suggests that a 5-10 point change is reliable (i.e., not due to chance) and a 10-20 point change is clinically meaningful (Monson et al., 2008). Therefore, we recommend using 5 points as a minimum threshold for determining whether an individual has responded to treatment and 10 points as a minimum threshold for determining whether the improvement is clinically meaningful.

Studies that informed our recommendations

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11. Weathers, F., Litz, B., Herman, D., Huska, J., & Keane, T. (October 1993). *The PTSD Checklist (PCL): Reliability, Validity, and Diagnostic Utility*. Paper presented at the Annual Convention of the International Society for Traumatic Stress Studies, San Antonio, TX. NOTE: Due to some confusion over versions of the PCL, some of the published papers state that the PCL-C was used in this study, but the authors have confirmed that the PCL-S was the version actually used.
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