



## Validation of two screening instruments for PTSD in Dutch substance use disorder inpatients

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### HIGHLIGHTS

- We test the psychometric properties of two screening instruments for PTSD.
- The MINIplus (interview) and the SRIP (self-report) are compared to the CAPS.
- The MINIplus is inadequate in detecting PTSD in substance use disorder patients.
- The SRIP is a reliable screener for PTSD in substance use disorder patients.

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### ABSTRACT

Posttraumatic stress disorder (PTSD) is highly prevalent in substance use disorder (SUD) populations. Because resources for extensive and thorough diagnostic assessment are often limited, reliable screening instruments for PTSD are needed. The aim of the current study was to test two short PTSD measures for diagnostic efficiency in predicting PTSD compared to the Clinician-Administered PTSD Scale (CAPS). The sample consisted of 197 SUD patients receiving residential substance use treatment who completed questionnaires regarding substance use and trauma-related symptoms, all abstinent from substance for 4 weeks. The PTSD section of the Mini International Neuropsychiatric Interview plus (MINIplus) and the Self-Report Inventory for PTSD (SRIP) are compared to the CAPS. Results showed low sensitivity (.58) and high specificity (.91) for the PTSD section of the MINIplus. The SRIP showed high sensitivity (.80) and moderately high specificity (.73) at a cut-off score of 48. The prevalence of PTSD as measured with the CAPS was 25.4% current and 46.2% lifetime. Results indicate that the MINIplus, a short clinical interview, has insufficient quality as a screener for PTSD. The SRIP, however, is a reliable instrument in detecting PTSD in a SUD inpatient population in The Netherlands. Screening for PTSD is time efficient and increases detection of PTSD in SUD treatment settings.

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### 1. Introduction

Research has yielded important information on the prevalence of posttraumatic stress disorder (PTSD) among substance use disorder (SUD) samples. Lifetime prevalence of PTSD in the general population ranges from 3.4% in Europe (Darves-Bornoz et al., 2008) to 6.8% in the United States (Kessler, Chiu, Demler, Merikangas, & Walters, 2005). Among treatment-seeking samples of SUD patients, the rate of co-occurring PTSD ranges from 11% to 51% current and 33% to 75% lifetime PTSD (Brown, Recupero, & Stout, 1995; Najavits, Weiss, &

Shaw, 1997). In SUD inpatients, the prevalence rate of PTSD ranges from 25% to 51% (Driessen et al., 2008; Kimerling, Trafton, & Nguyen, 2006; Ouimette, Read, & Brown, 2005; Reynolds et al., 2005). In outpatient settings, prevalence rates between 8% and 27% have been found (Clark, Masson, Delucchi, Hall, & Sees, 2001; Driessen et al., 2008; Najavits et al., 2003, 2007). Addiction severity in patients with SUD and PTSD is higher than in patients with SUD alone (Driessen et al., 2008). Furthermore, patients with comorbid SUD and PTSD show worse treatment outcomes (Brown & Wolfe, 1994; Hien, Nunes, Levin, & Fraser, 2000). Therefore, assessment of PTSD is essential for the purpose of treatment planning and providing appropriate care (Brown et al., 1995; Read, Brown, & Kahler, 2004).

One of the most widely used measures of PTSD is the Clinician-Administered PTSD Scale (CAPS) (Blake et al., 1995), a semi-structured

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**Table 1**  
Validated screening instruments for PTSD in SUD.

Instrument	No. items	Gold standard	Sensitivity	Specificity	Sample
PTSD Symptom Scale Self-Report (Coffey, Dansky, Falsetti, Saladin, & Brady, 1998)	17	DIS <sup>a</sup> (modified)	.89	.65	118 SUD in- and outpatients
Addiction Severity Index (Najavits et al., 1998)		Combination of THQ <sup>b</sup> and PCL <sup>c</sup>	.91	.46	110 cocaine dependent outpatients
Penn Inventory (Harrington & Newman, 2007)	26	CAPS <sup>d</sup>	.82	.64	44 inpatient substance users
Primary Care PTSD screening questionnaire (Kimerling, Trafton, et al., 2006)	4	SCID-I <sup>e</sup>	.91	.80	97 SUD veteran inpatients
Primary Care PTSD screening questionnaire (van Dam et al., 2010)	4	SCID-I	.86	.57	142 Dutch SUD patients

<sup>a</sup> DIS = diagnostic interview schedule.

<sup>b</sup> THQ = trauma history questionnaire.

<sup>c</sup> PCL = PTSD Checklist.

<sup>d</sup> CAPS = Clinician-Administered PTSD Scale.

<sup>e</sup> SCID = structured clinical interview for DSM disorders.

interview that is often referred to as the “gold standard” measure for PTSD. Unfortunately, this diagnostic tool is lengthy (up to 90 min) and, moreover, requires substantial training. Many SUD programs do not have the staffing nor resources for such a measure. However, considering the high prevalence of PTSD in SUD patients and the impact on treatment, standard assessment of this disorder may be crucial. For this purpose, screening instruments may be a valuable first step in evaluating trauma-related problems in SUD populations (Kimerling, Ouimette, et al., 2006; Najavits, 2004).

A number of questionnaires have been evaluated as screening measures for PTSD in SUD samples. A summary is given in Table 1. Thus far, the PC-PTSD is the only instrument that has been validated in The Netherlands (van Dam, Ehring, Vedel, & Emmelkamp, 2010), but results are not yet convincing. Changing the original cut-off score of the PC-PTSD from 3 to 2 resulted in a high sensitivity (.86), but low specificity (.57). The rationale for validating measures in SUD samples when they are already validated in samples of the general population is that in general, the cut-off scores for screening measures are lower in SUD samples, as can be seen in the PC-PTSD study as well as with the PTSD Checklist—Civilian version (PCL-C) and the Penn Inventory. It has been suggested too that female substance users minimize PTSD symptoms, which may justify a lower cut-off score (Harrington & Newman, 2007).

There are two different types of instruments that can be used for screening and diagnosis of psychiatric disorders: interviews (structured or semi-structured) and self-report questionnaires. Each has advantages and disadvantages (Eaton, Neufeld, Chen, & Cai, 2000; Wilson & Keane, 2004). In the current study, one short structured interview, the Mini International Neuropsychiatric Interview plus (MINIplus) (Sheehan et al., 1998), and one self-report questionnaire, the Self-Report Inventory for PTSD (SRIP) (Hovens et al., 1994), were tested as PTSD screens.

The MINIplus is a structured diagnostic interview that is already used regularly within SUD programs. The MINI has been proposed as a screening instrument in previous research (Black, Arndt, Hale, & Rogerson, 2004) and the PTSD section of the MINIplus could be used as a potentially helpful PTSD screen. The MINIplus closely follows the DSM criteria and is therefore expected to show good reliability. Furthermore, assessment time is short because the measure allows for skip-outs as soon as it is clear that the patient does not meet criteria for the disorder, sometimes in just one to two questions per disorder. However, there are doubts about the quality of this measure for diagnosing psychiatric disorders (Black et al., 2004). The PTSD module of this instrument, in particular, may be too brief to be useful.

The second measure that is tested in this study is the SRIP. The SRIP is an assessment tool that has been developed to be used as a screening instrument in The Netherlands. It is a self-report questionnaire containing 22 items and takes approximately 5 min to complete. Subscores can be obtained for the DSM-IV PTSD clusters. The items do not require the patient to name a particular trauma, which may be an important advantage for patients who may be hesitant or unable to disclose their traumatic experiences. Men, for example, may

underreport some traumatic experiences, such as sexual or physical abuse, if they perceive these to violate their image of masculinity (Lisak, 1994). The scale has been validated in a Swedish sample of psychiatric outpatients, treatment seeking and non-treatment seeking traumatized veterans, and a Dutch sample of elder people (Al-Saffar, Borgå, & Hällström, 2002; Van Zelst et al., 2003). The fact that the measure has already been validated in Dutch makes this measure preferable over other international screening instruments for our work. However, the scale has not yet been validated in a SUD population. Routine screening for PTSD in SUD patients has long been recommended to ensure that SUD patients who are suffering from PTSD symptoms are recognized and treated accordingly (Najavits, 2004). Also for this reason, high sensitivity of an instrument will be preferred over specificity, so that patients suffering from PTSD will not be overlooked.

In sum, the primary aim of this study was to test the psychometric properties of the MINIplus and the SRIP in screening for PTSD in an inpatient SUD population.

## 2. Methods

### 2.1. Participants

The study participants were 197 patients admitted to one of four different inpatient addiction treatment facilities<sup>1</sup> in The Netherlands between 2008 and 2011. All participants met DSM-IV-TR criteria for SUD. Participants were selected according to the following inclusion criteria: 1) current substance use disorder (alcohol or drug abuse or dependence) per DSM-IV criteria; and 2) capable of understanding and speaking the Dutch language. Exclusion criteria were the following: 1) severe cognitive impairment; 2) severe self-destructive behavior, defined as patients who are known to self-mutilate or have suicidal tendencies as assessed during intake; and 3) patients who were considered inappropriate to participate according to his or her clinician. Of the 263 eligible patients, eight did not meet inclusion criteria, 53 refused to participate and five did not complete all the interviews and were therefore excluded from the analyses (Fig. 1).

### 2.2. Measures

#### 2.2.1. Clinician-Administered PTSD Scale

The CAPS (Blake et al., 1995) has been previously translated into Dutch and validated by Hovens, Luinge, and Van Minnen (2005). It is considered the gold standard for assessing PTSD severity. The original CAPS has good psychometric properties and the Dutch translation appears to have excellent properties as well, with inter-rater reliability between .92 and 1.00 and internal consistency of .89 (Hovens et al., 1994; Weathers, Keane, & Davidson, 2001). The interviewer determines which traumatic events the individual has experienced

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