



Predicting PTSD from the Child Behavior Checklist: Data from a field study with children and adolescents in foster care

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ABSTRACT

Previous publications have suggested that treatment providers can screen children for posttraumatic stress disorder (PTSD) by using specific subscales derived from the Child Behavior Checklist (CBCL). We tested three CBCL-PTSD scales for their utility to screen for PTSD. 36 traumatized children and adolescents in foster care were interviewed using the Clinician Administered PTSD Scale of Children and Adolescents (CAPS-CA). The children's foster parents completed the CBCL. CBCL-PTSD scales showed no or small to moderate, but nonsignificant correlations with the number of PTSD symptoms and symptom severity. Overall, predictive properties of the respective scales were not sufficient. Therefore, instead of using CBCL-PTSD subscales as screens, we recommend the application of specific instruments for screening for PTSD.

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1. Introduction

The American Academy of Child and Adolescent Psychiatry (AACAP) practice parameter highlights “the importance of early identification of posttraumatic stress disorder” (Cohen et al., 2010, p. 414) in order to prevent its chronification and associated impairment. Yet assessing children and adolescents for posttraumatic stress disorder (PTSD) is difficult for a number of reasons. First of all, almost all measures begin by asking for a traumatic event, following the DSM-IV definition of PTSD which requires the presence of trauma exposure as a necessary condition for PTSD diagnosis. If no traumatic event can be specified, in some instruments further assessment of PTSD is deemed unnecessary. This procedure might result in a substantial number of false negatives: Some children and adolescents are reluctant to disclose a traumatic event; they may be too embarrassed, distressed, or afraid to talk about what has happened; perpetrators may have forbidden them to talk about it; or they do not remember the event. Secondly, assessment is hampered by the possible distress of the interviewees while discussing the traumatic event, which makes some clinicians fear retraumatization or aggravation of symptoms. Therefore, some clinicians avoid asking explicitly about traumatic events and posttraumatic stress (PTS) symptoms, especially when they do not have a specific reason to suspect traumatization. Thirdly, PTSD is difficult to assess because it occurs as a mixture of internalizing and externalizing symptoms. Especially younger children have difficulties with reporting

internalizing symptoms such as intrusions or feelings of detachment. A certain amount of insight is needed to recognize changes in one's own mood, cognition, and behavior, especially concerning avoidance (cf. Scheeringa, Zeanah, Drell, & Larrieu, 1995), and these symptoms are not easily observed by caretakers either. With regard to externalizing symptoms, however, caretakers' observations might be a more reliable source. Yet Meiser-Stedman, Smith, Glucksman, Yule, and Dalgleish (2007) found little evidence of, for example, hyperarousal symptoms showing greater parent–child agreement than reexperiencing symptoms. Overall, parent–child agreement for PTSD was rather poor (see also Shemesh et al., 2005). Fourthly, PTS symptoms seem to manifest differently in children than in adults, and especially so in younger children (De Young, Kenardy, & Cobham, 2011; Scheeringa, Wright, Hunt, & Zeanah, 2006; Scheeringa et al., 1995), so current DSM-IV criteria might not be appropriate for this age group (Scheeringa, Peebles, Cook, & Zeanah, 2001; Scheeringa et al., 1995). Finally, even if children are old enough to be regarded as valid information source, the acknowledged clinical interviews for PTSD, such as the Clinician Administered PTSD Scale of Children and Adolescents (CAPS-CA; Nader et al., 1996), are time-consuming and therefore not a part of routine assessment.

For all these reasons, clinicians and researchers search for efficient, economic, and unobtrusive screening measures for PTS symptoms. Because many health-care institutions routinely use the Child Behavior Checklist (CBCL; Achenbach & Edelbrock, 1983) as part of their standard assessment battery, developing a CBCL subscale for PTS symptoms seems a sensible strategy. Several studies examined the CBCL as a possible screening instrument for PTSD or PTS symptoms. While some studies endeavored to discriminate between children with and without PTSD by using the established

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CBCL syndrome scales (e.g., Saigh, Yasik, Oberfield, Halamandaris, & McHugh, 2002), other authors developed specific CBCL-PTSD subscales to screen for symptomatic children (Dehon & Scheeringa, 2006; Ruggiero & McLeer, 2000; Sim et al., 2005; Wolfe, Gentile, & Wolfe, 1989). Wolfe et al. (1989) proposed a subset of 20 CBCL-PTSD items (see Table 1) by selecting items that conformed to the DSM-III criteria of PTSD. The authors studied 71 sexually abused children and compared their scores with the CBCL normative sample. Sexually abused children scored about five times higher on the CBCL-PTSD scale. Ruggiero and McLeer (2000) further evaluated Wolfe et al.'s item set. The authors compared 63 sexually abused children (between 6 and 16 years of age) with two control groups (a psychiatric outpatient sample and a non-clinical school sample) and found adequate internal consistency for the CBCL-PTSD scale (Cronbach's $\alpha = .85$), but questionable concurrent and poor discriminant validity. The scale did not discriminate between sexually abused children and not sexually abused psychiatric outpatients. However, within the sexually abused group, the CBCL-PTSD scale correlated significantly with the total number of PTS symptoms endorsed on a structured interview for PTSD ($r = .57$), and the score was significantly higher in sexually abused children with PTSD vs. sexually abused children without a PTSD diagnosis. Nevertheless, the same was true for several other CBCL subscales, and also for the Internalizing scale and the Total Problem score. The authors calculated sensitivity and specificity and reported good sensitivity and weak to moderate specificity for a cut-off score of 8. Levendosky, Huth-Bocks, Semel, and Shapiro (2002) assessed 62 preschool children who had been exposed to domestic violence. For children at the age of three, the respective CBCL version was used resulting in a 14-item adaptation of the CBCL-PTSD scale of Wolfe et al. (1989). For older preschool children, the authors used a 22-item adaptation, but without specifying which items they added. Results showed that the number of PTS symptoms directly reported by the mothers on a PTSD rating scale adhering to DSM-IV criteria did not significantly correlate with the CBCL-PTSD scale. Dehon and Scheeringa (2006) assessed 62 traumatized children between the age of 2 and 6 years. Similar to Levendosky et al. (2002), they removed all items from Wolfe et al.'s scale that did not appear in the preschool form of the CBCL and

maintained 15 CBCL items (see Table 1). Their modified CBCL-PTSD scale correlated significantly ($r = .66$) with the number of PTS symptoms reported by a caretaker in a semi-structured interview preceding the CBCL assessment. The Internalizing ($r = .57$) and Externalizing ($r = .42$) scales also correlated significantly with reported PTS symptoms. Furthermore, the authors showed in a regression analysis that the CBCL-PTSD scale had significant incremental predictive power. Sim et al. (2005) applied a new strategy to determine whether the CBCL adequately screens for PTSD. They developed an item list based on expert ratings of all CBCL items and tested it with a confirmatory factor analysis in a sample of over 1700 children. The authors derived a PTSD subscale, a dissociation subscale, and a combined PTSD/dissociation scale from the CBCL. With the PTSD scale, six items were identical to Wolfe et al.'s (1989) scale and one new item was added (see Table 1). However, the new CBCL-PTSD scale did not significantly correlate ($r = .26$) with a self-report measure for PTS symptoms that Sim et al. used for validation in a subsample of 56 children (aged 8 to 12). Furthermore, the authors found no differences in CBCL-PTSD scores between clinical groups when comparing a not sexually abused psychiatric sample with a sample of children who were sexually abused. Sim and colleagues conclude that the CBCL is not a good measure for PTSD in children and adolescents, and that parents may be poor raters for their children's posttraumatic symptomatology. Moreover, the CBCL-PTSD scale seems to reflect "generic distress, as opposed to trauma-related, distress" (p. 697). Recently, Loeb, Stettler, Gavila, Stein, and Chinitz (2011) evaluated Dehon and Scheeringa's (2006) CBCL-PTSD scale in a sample of 51 preschool-aged children with high trauma exposure and receiving outpatient child-parent psychotherapy for PTSD. In particular, they tested the scale's validity in comparison to clinicians' DSM-IV diagnoses and to diagnoses based on the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* (DC:0-3; Zero to Three, 2005) which provides a more developmentally sensitive and appropriate PTSD definition for very young children. Additionally, caregiver reports on trauma exposure and symptoms were assessed using an established PTSD-screening instrument. While children with clinician-based DSM-IV diagnosis showed significantly higher CBCL-PTSD scores, there were no significant differences in scores regarding PTSD diagnosis based on DC:0-3 criteria. Moreover, receiver operator characteristic analyses yielded no adequate results for the CBCL-PTSD scale as a screening tool. CBCL-PTSD scores correlated significantly ($r = .40$) with the number of symptoms endorsed by parents on the PTSD screening, but not with the number of criteria endorsed by treating clinicians. Like Sim et al. (2005), Loeb et al. (2011) conclude that the CBCL-PTSD subscale is not specific enough for screening for PTSD.

Table 1 displays the CBCL-PTSD subscales discussed above and their respective items.

While all studies assessed PTSD or PTS symptoms, each used a different measure: a self-report scale (Sim et al., 2005), or caretaker rating (Levendosky et al., 2002), or a semi-structured caretaker interview (Dehon & Scheeringa, 2006), or caretaker rating plus clinician's diagnosis (Loeb et al., 2011). Ruggiero and McLeer (2000) used clinical diagnosis based on an interview that combined caretaker and self-report. Only Sim et al. (2005) and Ruggiero and McLeer (2000) assessed samples with children old enough to take into account self-reported symptoms too. Therefore, one reason for the mixed results so far might be the application of different assessment methods, the use of different sources of information, as well as the study of different age groups. Furthermore, the two studies with samples of school-aged children (i.e., Ruggiero & McLeer, 2000; Sim et al., 2005) focused on PTSD according to DSM criteria, which have been developed on the basis of research on adults, and have been criticized as not appropriate for children and adolescents (Scheeringa et al., 2001). Therefore, alternative criteria are of interest. One set of criteria has been proposed by Scheeringa et al. (2001; Scheeringa,

Table 1
Comparison of the CBCL-PTSD scales.

Item number	Wolfe et al. (1989)	Dehon and Scheeringa (2006)	Sim et al. (2005)	Item wording
Item 3	X	X		Argues a lot
Item 8	X	X		Can't concentrate or can't pay attention for long
Item 9	X		X	Can't get his/her mind off certain thoughts; obsessions
Item 11	X	X		Clings to adults or too dependent
Item 29	X	X	X	Fears certain animals, situations, or places other than school
Item 34	X			Feels others are out to get him/her
Item 45	X	X	X	Nervous, high-strung, or tense
Item 47	X	X	X	Nightmares
Item 50	X	X	X	Too fearful or anxious
Item 52	X			Feels too guilty
Item 56b	X			Headaches
Item 56c	X	X		Nausea, and feels sick
Item 56f	X	X		Stomachaches
Item 56g	X	X		Vomiting, throwing up
Item 69	X			Secretive, keeps things to self
Item 76			X	Sleeps less than most kids
Item 86	X	X		Stubborn, sullen, or irritable
Item 87	X	X		Sudden changes in mood or feelings
Item 100	X	X	X	Trouble sleeping
Item 103	X	X		Unhappy, sad, or depressed
Item 111	X	X		Withdrawn, doesn't get involved with others

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