The Clinician-Administered PTSD Scale:

Assessment Evaluation of the Clinician-Administered PTSD Scale

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This paper evaluates The Clinician-Administered PTSD Scale for use in a setting with clients over the age of 16 who are interested in a mind/body therapeutic approach to traumatic experiences such as rape, sexual abuse, complicated grief, battle field exposure and other traumatic experiences. The paper will document and review the development, administration, uses, reliability, validity, and other relevant data for this scale. Recommendations for the use of the CAPS in this population will conclude this brief review.

Development and Publishing

According to the CAPS Instruction Manual (2000) published by the National Center for PTSD, The Clinician-Administered PTSD Scale was developed in 1990 and is published by the National Center for Posttraumatic Stress Disorder (PTSD). CAPS is used for diagnosing and measuring the severity of PTSD. It was revised in 1994 with the publication of the DSM-IV to improve the diagnostic usefulness for this scale (Blake,et al.,2002 p. 13). The PTSD Life Events Checklist (Weathers, Litz, Herman, Huska, and Keane, 1993) is a 17-item scale originally based on the DSMIII-R PTSD criteria and revised in 1994 to correspond to the DSM-IV criteria is used as a preliminary screening tool and was added as a component of the scale during the 1994 revision of the CAPS.

Purpose and Scoring

The main purpose of the CAPS is to provide a clear picture of symptom severity and enough information to make a PTSD diagnosis if warranted. The CAPS can be used either as a diagnostic measure or as a continuous measure of PTSD symptom severity. The CAPS assesses both the

frequency and intensity of individual PTSD symptoms on separate 5-point (0-4) rating scales, and these ratings can be summed to create a 9-point (0-8) severity score for each symptom (Blake, et al., 2002 p. 13).

While the CAPS is designed for use with a population from age 16 to adults, there is a version of the interview for use with children and younger adolescents (ages 8 to 15), The Clinician-Administered PTSD Scale for Children and Adolescents (CAPS-CA) (Newman, & Ribbe, 1996). Manuals and relevant data are available from Western Psychological Press and also from the National Center for PTSD. The kit includes 10 Interview Booklets (each including a Life Events Checklist); 1 Interviewer's Guide; Technical Manual is $110.00. Purchased separately, the Technical Manual is $50.00, reusable Interviewer's Guide is $30.00, 10 Interview Booklets, and including Life Events Checklist is $40.00. It may be possible to obtain a complete battery of PTSD complete with manuals and inventories free of charge from the National Center for PTSD.

Content and Administration

The CAPS requires approximately one hour to administer, though it can be customized and abbreviated by eliminating less relevant components (Watson et al, 2002, p 20). The CAPS consists of 30 carefully worded structured interview questions that target DSM-IV criteria for PTSD without leading the respondent. The CAPS 17-item Life Event Checklist is administered as a preliminary means of identifying exposure to different traumatic events (Watson, McFall & McBrine, 2002 p 19). Upon review of the checklist, determine which three events to use when evaluating PTSD on the inventory (Blake, et al., 1998).

In terms of appropriate respondent characteristics, the CAPS was initially validated on combat veterans. The CAPS has now been used successfully in a wide variety of trauma populations,

including victims of rape, crime, motor vehicle accidents, incest, the Holocaust, torture, burns and cancer It was noted in several resources as the gold standard for PTSD evaluation and has been translated in 10 different languages (Charney and Keane, 2007, p162). “Of the studies reviewed in this section, 11 of 29 included at least some females and 15 of 29 included at least some participants with civilian trauma.” (cited in Blake,et al.,2002 p. 31). It has been translated into 10 of languages including Bosnian (Charney and Keane, 2007, p162). There is extensive data for many norm populations and samples.

Training is required and can be purchased from NTIS, National Technical Information Service for Fifty dollars. Western Psychological offers two continuing education credits for mastering the CAPS Interviewer’s Guide and Technical Manual which will cost 24.00 (Western Psychological Web site). VA providers can obtain training and information on PTSD from the US Department of Veterans Affairs National Center for PTSD.

Scoring and Data

There are nine different scoring rules for the CAPS (Weathers, Ruscio, Keane, 1999, p 125). These assess core PTSD symptoms and related issues: Re-experiencing Symptoms, Avoidance and Numbing Symptoms, Hyperarousal Symptoms, in addition to gathering information on Trauma-Related Guilt, Dissociation, Subjective Distress, Functional Impairment, Onset, Duration, Symptom Severity, Symptom Improvement, Response Validity (Blake, et al 1998). Different scoring rules can be applied to different assessment tasks (e.g., screening versus diagnosis).

Reliability coefficients for frequency and intensity scores for individual items were strong, ranging from .59 to 1.00 for frequency, with a mean of .92, and .52 to 1.00 for intensity, with a

mean of .86. At the symptom cluster level, reliability coefficients ranged from .92 to 1.00 for frequency and .92 to .98 for intensity. Regarding internal consistency, Hovens et al. found alphas of .63 for re-experiencing, .78 for avoidance and numbing, .79 for hyperarousal, and .89 for all 17 core PTSD symptoms. No rationale was given for the decision to report internal consistency for intensity scores but not for frequency or severity (frequency + intensity) scores (cited in Blake, et al 1999, p. 20).

In reference to convergent validity, in several studies the CAPS correlated strongly with the Mississippi Scale (.70 and .73) and the PK scale (.84, .83.,74). It also correlated (.42, .62) with the CES, a moderate correlation that is typical for correlations between measures of trauma exposure and measures of PTSD (Blake, et al 1999 p 19). Equivalent measures and higher were seen consistently across articles and the manual consulted.

There is no lack of statistical information and research relevant to the use of the CAPS in many populations. In particular is the data that suggests high sensitivity 74%, specificity 84%, and 79% efficiency when using the clinical interview as the criterion. The computerized version had 95% sensitivity and 95% specificity, with a kappa of .90. Finally, with the exception of amnesia, the prevalence of each of the 17 core PTSD symptoms on the CAPS was significantly greater in participants with PTSD than in those without PTSD, indicating robust discrimination between the two groups (Blake, et al 1999 p 20-23).

In a research subsample, there was perfect agreement as to PTSD diagnostic status, not only between the SCID-DTREE and the SCID, but between the CAPS and the SCID. In the full sample, against a PTSD diagnosis based on the SCID-DTREE, the CAPS had 90% sensitivity, 95% specificity, and 93% efficiency, and a kappa of .75. The CAPS also demonstrated high internal

consistency, with alphas of .88 for re-experiencing, .87 for avoidance and numbing, .88 for hyperarousal, and .95 for all 17 core items (Blake, et al 1999 p 20-23).

In addition to the data above, Dr. Keane of the National Center for PTSD, U.S. Department of Veterans Affairs Web, outlined in a PowerPoint presentation Assessment *of PTSD* (2002, 2011) the following problems that might be associated with the CAPS.

"Self report can yield…intentional or unintentional inaccuracies….sensitivity and specificity even at a rate of .90, when you're dealing with large populations, yields false positives and false negatives that are significant in size. And .90 sensitivity and specificity is typically seen as excellent validity indicator….There are limits of skills and background experience of evaluators and best practices in the administration and the analysis and the interpretation of the various instruments are often not adopted."

Personal Evaluation

The CAPS seems to have excellent usefulness in the realm of trauma work as both a diagnostic, screening and follow-up tool. The interview format makes it conducive to use at all reading levels, provided opportunity for interaction between the interviewer and the client. The validity and reliability are high. The CAPS is considered a 'gold standard'. There is even preliminary research results that the CAPS-S is both reliable and valid for use with women with dual diagnosis such as schizophrenia (Gearon, Bellack, and. Tenhula, 2004 p124). Criticism of the CAPS tends to focus on three concerns. The primary concern is that the CAPS is cumbersome and lengthy. This is address with advice that suggest with an articulate, motivated respondent this single question may elicit all the information necessary to rate both the frequency and intensity of a given symptom. The indepth uses of the questionnaire provide additional

questions to be used only if: (a) a response is incomplete, vague, confusing, or in some way insufficient to make a rating, and therefore needs to be clarified; or (b) the respondent doesn't understand what is being asked (Weathers, 1999 Manual p32).

The CAPS scale would provide a fairly clear clinical framework convening severity of symptoms and the subsequent use could provide an indicator of improvement as a result of the therapy used. The results of the scale can provide excellent feedback to the therapist and client to indicate that treatment is successful or if a change in the treatment plan might be necessary to improve symptoms. Correlation with the DSM IV TR was not documented and further investigation of the correlation with the DSM with the newer editions is recommended.

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