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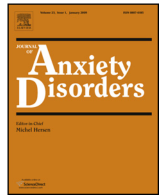

Review

Comparing the effect of *DSM*-congruent traumas vs. *DSM*-incongruent stressors on PTSD symptoms: A meta-analytic review

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ABSTRACT

Experts have long debated how to define the PTSD traumatic stressor criterion. Prior research demonstrates that PTSD symptoms (PTSS) sometimes stem from events that do not meet the *DSM* requirements for Criterion A (e.g., divorce, bereavement, illness). This meta-analysis of 22 studies examined whether PTSS differ for *DSM*-congruent criterion A1 traumatic events vs. *DSM*-incongruent events. The overall effect was significant, albeit small, suggesting that PTSS were greater for individuals who experienced a *DSM*-congruent event; heterogeneity analyses also indicated further exploration. Two significant moderators emerged: assessment of both A1 and A2 (vs. A1 alone) yielded a significant effect for higher PTSS following traumas vs. stressors. Likewise, self-report assessment of life threat (Criterion A1)—vs. rater or a priori assessment of A1—yielded a significant effect for higher PTSS following traumas. Our results indicate that higher levels of PTSS develop following traumas, and highlight important methodological moderators that may affect this relationship.

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Contents

1. Introduction 38
   1.1. Classification of PTSD 38
   1.2. Theoretical basis of PTSD 38
   1.3. Current study 39
      1.3.1. Sample type 39
      1.3.2. Self-report vs. interview assessments for PTSS and events 39
      1.3.3. Criterion A1 and A2 assessment 39
      1.3.4. Method of identifying the index event 39
      1.3.5. Event timeframe 41
2. Method 41
   2.1. Procedure 41
      2.1.1. Coding of studies 42
   2.2. Data analysis 42
      2.2.1. Heterogeneity 42
      2.2.2. Moderation analyses[1] 42

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[1] Since we could not use DSM version as a moderator (given that only one study used DSM-III criteria), we examined whether the results changed excluding the one DSM-III-based study. This study had a Hedge's *g* effect size of .91; results of the overall analyses did not change when excluding it.

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2.2.3. Publication bias 42
3. Results 42
3.1. Moderators 43
3.2. Publication bias 43
4. Discussion 43
4.1. Limitations and future directions 44
Acknowledgements 45

1. Introduction

Within the trauma literature, experts have long debated how to define the traumatic stressor criterion of Posttraumatic Stress Disorder (PTSD). This debate has been reflected in the modified definitions of PTSD throughout various editions of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) and World Health Organization's *International Classification of Diseases* (*ICD*), the two main classification systems used worldwide for mental health diagnoses. These definitions have significant implications for theory, research, practice, and forensics: in practical and clinical applications, defining a trauma and subsequent PTSD diagnosis may affect who is able to be reimbursed through the legal system for PTSD-related damages, who is treated for the disorder, and how treatment is understood to address the disorder. As such, defining trauma is critical for defining PTSD, and thus has implications for conceptualizing the etiology and phenomenology of the disorder.

The debate regarding the definition of trauma has been fueled by empirical research reporting the full symptom picture of PTSD following events that are stressful but not traditionally "traumatic" (Rosen and Lilienfeld, 2008). Based on this research, definitions of PTSD (reviewed below) have evolved over time: many have advocated for a more inclusive definition of trauma (e.g., Avina and O'Donohue, 2002; Butts, 2002) that encompasses both extreme events that are traditionally viewed as traumatic (e.g., combat, interpersonal violence) and events that are traditionally viewed as stressful life events (e.g., sexual harassment, divorce, chronic illness, racial discrimination; see Rosen & Lillienfeld, 2008 for a review). Others have advocated for a more restrictive definition (McNally, 2003; Rosen, 2004), and/or for completely eliminating the need to objectively define a traumatic event (Brewin, Lanius, Novac, Schnyder, & Galea, 2009). To some extent, this is a question of deciding on the purpose of the criterion: whether to capture all events that may precipitate PTSD, thus capturing more individuals who may be eligible for PTSD-related treatment or services, or whether to be more restrictive so as to capture only those with the most severe cases (Kilpatrick, Resnick, & Acierno, 2009). However, it is also an empirical question, and although studies have increasingly begun to specifically examine the strength of the relationship between DSM-congruent traumas vs. DSM-incongruent stressors and PTSD symptoms (PTSS), no quantitative synthesis of such studies has been conducted to date.

1.1. Classification of PTSD

The diagnosis of PTSD was first officially codified in the *DSM-III* in 1980 within the anxiety disorders chapter. In this initial version, trauma was defined fairly narrowly (an event that "is generally outside the range of usual human experience") and circularly ("a recognizable stressor that would evoke significant symptoms of distress in almost everyone"; American Psychiatric Association, 1980, p. 236). Specificity was added to the *DSM-III-R*, which provided examples of the types of events that might qualify as traumatic (i.e. "serious threat to one's life or physical integrity; serious threat or harm to one's children, spouse, or other close relatives or friends; sudden destruction of one's home or community; or seeing another person who has recently been, or is being, seriously injured or killed as the result of an accident or physical violence"[American Psychiatric Association, 1987, p. 250]). This definition of trauma was then expanded in the *DSM-IV* to include two parts: (1) individuals must have experienced, witnessed, or confronted an event that "involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others" (*Criterion A1*) and (2) their response much have involved "intense fear, helplessness, or horror" (*Criterion A2*; p. 467; American Psychiatric Association, 1994). This *DSM-IV* definition of Criterion A1 remains Criterion A in the DSM-5 version of the PTSD diagnostic criteria (American Psychiatric Association, 2013).

However, due to conflicting evidence that this subjective criterion A2 did not necessarily improve diagnostic accuracy of PTSD (see Bedard-Gilligan and Zoellner, 2008; Brewin et al., 2009), this definition has again significantly shifted in the *DSM-5*, maintaining criterion A1, but eliminating the emotional component of A2. Moreover, the types of events that may lead to the disorder have been restricted in the *DSM-5* Criterion A. For example, the following *DSM IV* events have been eliminated from *DSM-5* criterion A precipitating events: death of a loved one (unless violent or accidental), witnessing an event (unless in person, violent or accidental death of loved one, or repeated exposure to details of traumas), and various life-threatening medical illnesses (unless a sudden catastrophic event occurs, e.g., waking during surgery). Recent research suggests that changes to the *DSM-5* definition of PTSD have led to decreased prevalence rates of events classified as *traumas*, but minimal changes in actual prevalence rates of *PTSD* (see Elhai, Miller, Ford, Biehn, Palmieri, Frueh, 2012; Kilpatrick et al., 2013).

Alternatively, in the *ICD* system (used in World Health Organization Member States, typically to report mortality statistics, but also for diagnostic purposes), PTSD was not introduced until 1992. In *ICD-10* (adopted in 1994), PTSD required exposure to "a stressful event or situation (either short or long lasting) of exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone" (World Health Organization, 1992). For the upcoming ICD-11, the draft version does not include a stressor criterion per se; instead specifying that PTSD may develop "following exposure to an extremely threatening or horrific event or series of events" (ICD-11 Beta Draft, 2015 Maercker et al., 2013). Brewin et al. (2009) argue that any event that precipitates this particular cluster of symptoms should qualify as a trauma (and that doing so will not change the prevalence or meaning of the disorder in an appreciable way, as low-magnitude stressors are not likely to lead to full PTSD).

1.2. Theoretical basis of PTSD

The changes in both the *DSM* and *ICD* have highlighted tensions surrounding the conceptualization and theoretical underpinnings of trauma and its consequences. In the DSM-5, PTSD was moved from the anxiety disorder chapter into the new Trauma- and Stressor-Related Disorders chapter (and Criterion A2 was eliminated). This change contrasts the traditional conceptualization of PTSD as a disorder of fear extinction (see Foa and Kozak, 1986; Mowrer, 1960), and reflects arguments that fear and anxiety are not

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