



Examining PTSD treatment choice among individuals with subthreshold PTSD



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ABSTRACT

Subthreshold posttraumatic stress disorder (PTSD) is associated with impairment and has a prevalence rate comparable to full PTSD. Yet, little is known regarding treatment preferences among individuals with subthreshold PTSD, even though they seek trauma-related treatment at a similar rate to those with full PTSD. This study explored subthreshold diagnostic PTSD diagnostic category and treatment preference in undergraduate ($N = 439$) and trauma-exposed community ($N = 203$) samples. Participants completed the Posttraumatic Stress Diagnostic Scale (PDS), viewed standardized treatment rationales, and made a hypothetical PTSD treatment choice: prolonged exposure (PE), sertraline, combination treatment, or no treatment. The PDS was used to categorize individuals into four PTSD categories: no trauma exposure, trauma exposure only, subthreshold PTSD, and full PTSD. Within the samples, 8.9% ($n = 39$) of undergraduates and 16.7% ($n = 34$) of community members met subthreshold PTSD criteria. The majority of individuals with subthreshold PTSD in each sample reported impairment, 59.0% of undergraduates and 76.5% of community members. Within subthreshold PTSD groups, the most commonly selected treatments were PE (61.5%) for undergraduates and combination treatment (47.1%) for community members. Findings underscore the necessity of further examining subthreshold PTSD, which may hold important clinical implications for treatment processes and outcomes.

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Subthreshold posttraumatic stress disorder (PTSD) (also referred to as partial, subsyndromal, or subclinical PTSD; Blanchard, Hickling, Taylor, Loos, & Gerardi, 1994; Grubaugh et al., 2005; Stein, Walker, Hazen, & Forde, 1997) generally refers to the presence of clinically significant PTSD symptoms that fall short of the full *Diagnostic and Statistical Manual of Mental Disorders* PTSD diagnostic criteria (DSM-5; American Psychiatric Association [APA], 2013). Initially developed as a way of classifying Vietnam veterans who did not meet full PTSD criteria but were still experiencing symptoms and impairment (Weiss et al., 1992), research on subthreshold PTSD has extended to civilian samples (e.g., Breslau, Lucia, & Davis, 2004; Marshall et al., 2001; Stein et al., 1997). Although individuals with subthreshold PTSD report substantial distress (e.g., Dickstein, Walter, Schumm, & Chard, 2013; Grubaugh et al., 2005; Marshall et al., 2001), little attention has been given to the clinical significance and potential treatment needs of this population (Zlotnick, Franklin, & Zimmerman, 2002).

As individuals with subthreshold PTSD do not meet full symptomatic criteria, impairment may be the next best criterion for establishing subthreshold diagnosis (Zlotnick et al., 2002). Research has consistently shown that individuals with subthreshold PTSD experience significant distress and impairment (Mylle & Maes, 2004), which is at greater levels than trauma-exposed individuals without PTSD (Jakupcak et al., 2007), but less than individuals with full PTSD (Breslau et al., 2004). Individuals with subthreshold PTSD also report depressive symptoms (Cukor, Wyka, Jayasinghe, & Difede, 2010), suicidal ideation (Marshall et al., 2001), alcohol use (Adams, Boscarino, & Galea, 2006), anger and aggression (Jakupcak et al., 2007), impairment in social and family functioning (Stein et al., 1997; Zlotnick et al., 2002), work-loss days (Breslau et al., 2004), and medical illnesses (Zhang, Ross, & Davidson, 2004). Although some suggest that designating subthreshold PTSD as its own clinical concept pathologizes common reactions to trauma (e.g., Breslau et al., 2004), others support the concept of subthreshold PTSD as a means to potentially identify a crucial subpopulation that experiences significant psychopathology and functional impairment

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that persists (e.g., Jakupcak et al., 2007). Though we should not pathologize common reactions to trauma, we should also not ignore the potentially clinically relevant impairment experienced by individuals with subthreshold PTSD.

Further underscoring the need for clinical attention toward this population is that prevalence rates of subthreshold PTSD are similar to those of full PTSD. For example, in an epidemiological study, past month prevalence rates were comparable between full PTSD (2.7% of women; 1.2% of men) and partial PTSD (3.4% of women; .3% of men; Stein et al., 1997). Similarly, lifetime prevalence of full PTSD among Vietnam veterans was 30.9% for males and 26.0% for females, whereas prevalence rates of lifetime partial PTSD was 22.5% for males and 21.2% for females (Weiss et al., 1992). As demonstrated by these comparable prevalence rates, there may be a sizable and clinically meaningful number of individuals in the former diagnostic category that could be potentially overlooked when adhering to more stringent diagnostic criteria. Evidence that some individuals after trauma exposure fall short of full diagnostic criteria for PTSD, yet still experience psychological and functional impairment, is consistent with the notion that PTSD is dimensional in nature rather than its own distinct taxon (Broman-Fulks et al., 2006).

Though subthreshold PTSD is consistently linked with significant impairment, its trajectory and stability over time is less clear. Some evidence suggests that subthreshold PTSD remits at a higher rate than full PTSD following trauma exposure (Blanchard et al., 1997) and that individuals with subthreshold PTSD are more likely to improve at a higher and faster rate than individuals with full PTSD (Shiner et al., 2012). It is difficult to make causal statements surrounding the course of subthreshold PTSD and the extent to which it may remit on its own, however, as neither of the above studies experimentally manipulated or examined potential effects of treatment on symptom remission. Notably, when left untreated, subthreshold PTSD can be stable and chronic (Cukor et al., 2010). In a longitudinal study assessing symptoms of 9/11 World Trade Center disaster recovery workers, 29.0% meeting subthreshold PTSD at baseline met criteria for subthreshold or full PTSD at one year follow-up, and 25.0% still met criteria at two year follow-up (Cukor et al., 2010). Accordingly, psychological and functional impairment associated with subthreshold PTSD may not remit on its own for a substantial minority of individuals.

Little is known regarding treatment seeking behaviors or effective treatment options for those with subthreshold PTSD (Kornfield, Klaus, McKay, Helstrom, & Oslin, 2012). There is some evidence, however, to suggest that patterns of treatment seeking may be comparable, as indicated by a survey of a random sample of community members in which individuals with full and subthreshold PTSD were identified, then asked about whether they had sought help following their traumatic experience (Stein et al., 1997). Despite individuals with full PTSD reporting greater impairment, there was a similar rate of help seeking for trauma-related symptoms between individuals with full PTSD (60.0%) and subthreshold PTSD (52.6%). Though little is known about treatment options for individuals with subthreshold PTSD, for those with full PTSD a number of treatments have been shown to be effective. Prolonged exposure (PE) and sertraline, a selective serotonin reuptake inhibitor, are both considered efficacious PTSD interventions (e.g., Benedek, Friedman, Zatzick, & Ursano, 2009; Powers, Halpern, Ferenschak, Gillihan, & Foa, 2010). In the treatment preference literature thus far, PTSD treatment choices have been explored in clinical and non-clinical samples, asking individuals to make real or hypothetical treatment choices and generally have found a treatment preference for PE over sertraline (e.g., Angelo, Miller, Zoellner, & Feeny, 2008; Chen, Keller, Zoellner, & Feeny, 2013; Feeny, Zoellner, Mavissakalian, & Roy-Byrne, 2009;

Zoellner, Feeny, & Bittinger, 2009; Zoellner, Feeny, Cochran, & Pruitt, 2003).

Specific factors that may influence PTSD treatment choice include psychopathology and treatment beliefs. Individuals with more severe PTSD and depression prefer sertraline over PE (e.g., Feeny et al., 2009; Rytwinski, Rosoff, Feeny, & Zoellner, 2014) and individuals are more likely to select a treatment if they find it credible and have a positive reaction to it (Zoellner et al., 2009). Literature regarding the influence of prior treatment history on PTSD treatment choice is mixed, with some evidence finding that previous treatment experience may play a role in current choice of treatment among individuals with PTSD (Pruitt, Zoellner, Feeny, Caldwell, & Hanson, 2012; Rytwinski et al., 2014). It should be noted that while these factors have been linked to treatment choice regarding full PTSD, no study to our knowledge has examined these relationships in individuals with subthreshold PTSD.

Unlike previous treatment choice studies (e.g., Feeny et al., 2009; Zoellner et al., 2009), the current study included both monotherapy (i.e., PE or sertraline) and combination treatment (i.e., PE and sertraline) choices. A recent meta-analysis found that, although individuals are more likely to receive monotherapy in clinical settings, combination treatments may be a more effective treatment than monotherapy medication for certain disorders, such as depression, panic disorder, and obsessive-compulsive disorder (Cuijpers et al., 2014). In a randomized controlled multi-site trial comparing medication, psychotherapy, and combination of medication and psychotherapy among individuals with chronic depression, treatment preferences moderated treatment outcome, such that individuals who received their preferred treatment reported less depressive symptoms and higher remission rate at the end of treatment (Kocsis et al., 2009). This study highlights the importance of presenting both monotherapy and combined therapy treatment options to individuals, if consistent with the efficacy literature, as some might not do as well if they are forced to select a monotherapy, when they really wanted combination treatment or vice versa. In spite of these findings, individuals are more likely to receive a monotherapy in real-world clinical settings (e.g., Olfson & Marcus, 2010), meaning that they might not be presented with both treatment options. This is important to note as meta-analytic findings indicate that when individuals receive the treatment they prefer, they are more likely to have a better treatment outcome and less likely to drop out of treatment (Swift & Callahan, 2009).

The current study examined PTSD treatment preference in two samples, undergraduates and trauma-exposed community members, with a wide range of trauma exposure. To maximize generalizability of the current study, two large samples of undergraduates and trauma-exposed community members were utilized. An undergraduate sample was included as this demographic group has endorsed high rates of trauma exposure and is at an age where there is a high likelihood of future trauma exposure (e.g., Tjaden & Thoennes, 1998; Turchik, 2012). The primary aims of the current study were: 1) to examine impairment, psychopathology, and prior treatment history among individuals with subthreshold PTSD; and 2) to explore PTSD treatment beliefs and treatment preference among individuals with subthreshold PTSD. Based on prior research (e.g., Breslau et al., 2004; Feeny et al., 2009; Jakupcak et al., 2007), we hypothesized that individuals with subthreshold PTSD will report significant functional impairment and psychopathology and will be more likely to report a treatment history than either trauma-exposed individuals without PTSD and individuals with no trauma exposure, but less than full PTSD. Given the lack of literature of treatment beliefs and choice among those with subthreshold PTSD, we did not specify directionality of these hypotheses.

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