



Differential treatment response trajectories in individuals with subclinical and clinical PTSD



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ABSTRACT

Subclinical presentations of posttraumatic stress disorder (PTSD), wherein patients are one or two symptom criteria short of the full disorder, are prevalent and associated with levels of distress and impaired functioning approximating that of full PTSD. Nonetheless, research examining treatment efficacy for this group is in the nascent stage. The purpose of the present study was to examine whether the subclinical PTSD group would: (1) show a greater reduction in PTSD symptoms at pre and post treatment in response to an exposure based treatment and (2) show a greater rate of change over the course of treatment, when compared to the full criteria PTSD group. We also examined whether differences would emerge when examining PTSD symptom clusters. Consistent with predictions, the subclinical PTSD group demonstrated a greater reduction in PTSD symptoms at post-treatment (29%) than those with a PTSD diagnosis (14%). Further, the groups had different treatment trajectories, with the subclinical PTSD group showing a marginally greater rate of change during the course of treatment. Findings also varied by symptom cluster with the subclinical group showing a greater rate of change in the intrusions, hyper-vigilance, and avoidance symptom clusters. There was not a significant between group difference in the numbing symptom cluster. This study provides preliminary evidence that treating PTSD symptoms at the subclinical level may result in a larger, and more rapid symptom reduction, and thus has implications supporting treatment earlier in the developmental trajectory of the disorder.

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1. Introduction

Post-traumatic stress disorder (PTSD) is one of the most prevalent mental health conditions among veterans seeking treatment at Veterans Affairs Medical Centers (VAMCs) (Seal et al., 2009). PTSD is chronic (Smith et al., 2008; Zlotnick, Franklin, & Zimmerman, 2002), associated with significantly impaired functioning (Breslau, Lucia, & Davis, 2004), and leads to substantial cost and economic burden for patients and society (Kessler, 2000). Subclinical PTSD is also prevalent, with approximately 5% of current veterans (Grubaugh et al., 2005) and 21% of lifetime veterans (Weiss et al., 1992) classified as falling within the subclinical range.

Subclinical PTSD, also referred to as partial, subthreshold, or subsyndromal PTSD (Dickstein et al., 2014; Mylle & Maes, 2004; Zlotnick et al., 2002), can be broadly defined as the presence of PTSD related symptoms that are elevated but do not meet full

diagnostic criteria for PTSD. Although subclinical PTSD has been conceptualized using a range of approaches, it has often been measured by assessing for the presence or absence of PTSD symptoms (Blanchard, Hickling, Taylor, Loos, & Gerardi, 1994), ranging from a minimum of one symptom on each PTSD symptom cluster (Stein et al., 1997) to more comprehensive definitions wherein at least one re-experiencing symptoms (Criteria B) and at least two symptoms in avoidance (Criteria C) and hyperarousal (Criteria D) domains are required as defined in the *Diagnostic and Statistical Manual for Mental Disorders DSM-IV TR* (American Psychiatric Association 2000; Kilpatrick & Resnick, 1993). A third approach is to designate subclinical PTSD according to the following DSM-IV criteria: (1) Criteria A of experiencing or witnessing a traumatic event, (2) Criteria B of re-experiencing symptoms (e.g., intrusions, flashbacks, nightmares) and (3) **either** Criteria C of avoidance and numbing symptoms (e.g., avoiding reminders of the traumatic event, lack of strong emotions) **or** Criteria D of hyperarousal symptoms (e.g., exaggerated startle reaction; Blanchard et al., 1994; Grubaugh et al., 2005) is present. Similar definitions exist for the newer DSM-5 criteria for PTSD.

Whereas significant research to improve treatment for full criteria PTSD exist (Bradley, Greene, Russ, Dutra, & Westen, 2005; Foa,

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Keane, Friedman, & Cohen, 2009), evaluation of treatments targeting subclinical PTSD are still in nascent stages (Steenkamp et al., 2012). Given the high prevalence of subclinical PTSD, examining the effectiveness and course of treatment in these individuals is of significant importance. Specifically, subclinical PTSD is associated with elevated levels of distress, impairment in interpersonal and occupational functioning (Cukor, Wyka, Jayasinghe, & Difede, 2010), and elevated levels of comorbidity (Jakupcak et al., 2007; Zlotnick et al., 2002) compared to individuals without subclinical PTSD. Subclinical PTSD is also associated with increased levels of anger, aggression, and suicidality (Marshall et al., 2001; Jakupcak et al., 2007; Zlotnick et al., 2002). Further, having subclinical PTSD may also place individuals at increased risk for developing full clinical PTSD (Mylle and Maes, 2004). Despite evidence demonstrating impairment and distress associated with subclinical PTSD, and the potential for these symptoms to increase in severity over time eventually resulting in clinical PTSD, this group has typically been neglected, and indeed excluded from PTSD treatment evaluations and randomized controlled trials (Zlotnick et al., 2002). As such, individuals with subclinical PTSD are often excluded from many PTSD treatment settings and fail to receive treatment they need, resulting in a substantial lack of treatment resources for these individuals, and a gap in the literature pertaining to the treatment of this group.

Given the lack of research examining the treatment of subclinical PTSD, there is uncertainty about appropriate approaches for this group. Recent evidence demonstrates efficacy of treating subclinical PTSD using paroxetine (Naylor et al., 2013); however, the preliminary literature examining trauma-focused psychotherapy has been somewhat equivocal. In particular, Kornfield, Klaus, McKay, Helstrom, and Oslin (2012) cautioned against the use of evidence based psychotherapy targeting avoidance symptoms of PTSD in primary care patients with subclinical PTSD. This recommendation was based on their finding of low levels of avoidance in these individuals. More recently, preliminary evidence has emerged demonstrating efficacy of evidence based psychotherapy approaches for PTSD in individuals with subclinical PTSD. Specifically, Dickstein, Walter, Schumm, and Chard (2013) examined the use of Cognitive Processing Therapy (CPT; Resnick, Monson, & Chard, 2007) to treat subclinical PTSD, finding that individuals with subclinical PTSD had a similar reduction in PTSD symptoms at post-treatment compared to the clinical PTSD group.

Preliminary evidence demonstrating the efficacy of treating subclinical PTSD with evidence-based psychotherapy is encouraging and warrants further investigation for several reasons. First, it is important to replicate these findings to add to the emerging literature on the treatment of subclinical PTSD. Moreover, research is needed examining the treatment trajectory (i.e., rate) of improvement among these groups. Although preliminary research demonstrates the efficacy of treating subclinical PTSD, it is unknown whether individuals with subclinical PTSD show a differential response during the course of treatment than those with a clinical PTSD diagnosis. Given the lower overall level of symptom frequency, and generally shorter duration or chronicity of the symptoms in individuals with subclinical PTSD, it is feasible that this group may actually respond to treatment more quickly and show different rates of symptom reduction than those with clinical PTSD. In particular, it is possible that those with subclinical PTSD may show a greater decline in symptoms from pre to post treatment. Although it could be argued that individuals with a greater severity of symptoms may demonstrate greater reduction in symptoms due to regression to the mean (Barnett, Van der Pols, & Dobson, 2005), the notion that subclinical PTSD may reflect greater reduction in symptoms is consistent with the prevention literature demonstrating benefits of treating less severe symptom presentations with brief evidence-based interventions for sub-

clinical symptoms of anxiety (Aune & Stiles, 2009; Gardenswartz & Craske, 2001). Further, those with subclinical PTSD may also demonstrate a greater rate of symptom change over the course of treatment (session-by-session symptom reduction) than those with clinical PTSD. Finally, it is possible that the PTSD symptoms clusters (i.e., intrusions, hypervigilance, avoidance, and dysphoria) will show differential treatment response patterns in those with subclinical PTSD versus those with clinical PTSD.

The purpose of the present study is to examine differential treatment response in veterans with subclinical vs. clinical PTSD. We hypothesized that: (1) participants with subclinical PTSD will respond more quickly to evidence based psychotherapy for PTSD; and (2) response patterns across PTSD symptom clusters (i.e., intrusions, hyperarousal, avoidance, and numbing) will be different in the subclinical and clinical PTSD groups (i.e., intrusions may reduce more quickly in the subclinical group than the clinical PTSD group). Although exploratory, we expected the subclinical PTSD group to show a greater rate of change in each of the PTSD symptom clusters than the clinical PTSD group.

2. Methods

2.1. Participants

The sample was composed of 238 combat veterans. Participants were recruited through referrals to a PTSD specialty clinic at a large Southeastern VAMC. Eligible participants were required to meet diagnostic criteria for combat-related PTSD ($n = 188$) or subclinical PTSD ($n = 50$). Subclinical PTSD was defined as the presence of Criteria A (traumatic event) and Criteria B (re-experiencing), and either Criteria C (avoidance) or Criteria D (hyperarousal; Grubaugh et al., 2005), along with the impairment criterion. Participants with a military related index trauma were eligible to participate in the study. Eligibility was determined via the *Clinician Administered PTSD Scale* (CAPS; Blake et al., 1995) to assess PTSD symptoms and the *Structured Clinical Interview for the DSM-IV* (SCID; First, Spitzer, Gibbon, & Williams, 1996) to assess for comorbid Axis I and Axis II disorders. Individuals who were acutely suicidal, psychotic, or met criteria for a current substance dependence disorder were excluded from participation. Participants with comorbid anxiety or mood disorders, and participants prescribed psychotropic medication were allowed to participate in the study after a 4 week stabilization period. A majority of the participants were male (92.5%), Black (47.0%) or White (46.5%), and had a mean age of 45.0 years ($SD = 14.6$). A majority of the participants were also employed (45.0%), married (61.5%), and served in the Army (60.0%). Further, approximately 39% of the percent of participants reported being disabled.

2.2. Measures

2.2.1. Clinician administered measures

The CAPS (Blake et al., 1995) was administered to assess for symptoms of PTSD. The CAPS is a semi-structured clinician administered interview used to diagnose current and lifetime PTSD. The CAPS assesses for the frequency and intensity of the 17 PTSD symptoms from the *DSM-IV* (American Psychiatric Association, 2000). Intensity and frequency ratings of each symptom are made on a five-point Likert scale. To meet threshold criteria, current symptoms must have been present for at least one month. The CAPS has been shown to have good internal consistency, test-retest reliability, convergent and discriminant validity (α s ranging from 0.73 to 0.95; Orsillo, Batten, & Hammond, 2001).

2.2.2. Structured clinical interview for the DSM-IV

The SCID (First et al., 1996) was administered to assess for the presence of current or past Axis I diagnoses for eligibility purposes.

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