Acute stress disorder is of limited benefit in predicting post-traumatic stress disorder in people surviving traumatic injury


Q Does acute stress disorder after traumatic injury help identify people likely to develop post-traumatic stress disorder?

CONCLUSIONS
Acute stress disorder is of limited benefit in predicting post-traumatic stress disorder in people surviving traumatic injury. This is because the low sensitivity of the core dissociative symptoms of ASD results in a high number of false PTSD diagnoses. Re-experiencing and arousal symptoms may be better predictors of PTSD in this population.

Acute stress disorder (ASD) was devised as a diagnosis to allow identification of individuals likely to develop post-traumatic stress disorder (PTSD) within one month of exposure to traumatic events. The aetiological model underlying ASD stresses initial dissociative processes in the development of PTSD. However, the diagnosis was adopted with little evidence of its validity. ASD diagnoses should allow us to predict efficiently who will develop PTSD, missing few cases and generating few false alarms. Creamer et al add weight to the accumulating evidence that the ASD construct does not perform as intended. Although individuals diagnosed with ASD are likely to develop PTSD, many of those who develop PTSD would not have been diagnosed with ASD.

The raising of the dissociative process to the status of “core symptom” has proven problematic. Indeed, there has been evidence for a long time that these processes are neither the sole nor primary vulnerability factors for the development of PTSD. The solution does not appear to be a matter of lowering the bar, as Creamer et al provide data suggesting that adjustments in the diagnostic criteria of ASD—particularly lowering the threshold for dissociative symptoms—do little to improve its predictive utility.

Creamer et al’s findings regarding the predictive utility of re-experiencing and arousal symptoms are intriguing, but studies have failed to uncover consistency in the symptom clusters predicting PTSD, and Creamer et al’s data do not clarify this situation. Looking to symptom clusters for prediction of PTSD may not be the most pragmatic approach and data are starting to accumulate that suggest cognitive processing factors may prove more valuable predictors. From the clinical standpoint, however, removing ASD as a diagnostic category and allowing PTSD to be diagnosed at any point after exposure to a traumatic stressor may make the most sense, allowing early identification of individuals with difficulties and moving diagnostic criteria away from shaky aetiological assumptions concerning the role of dissociation. Creamer et al add to the evidence that ASD does little to improve our understanding of adjustment following trauma or allow for adequate prediction of psychiatric morbidity.

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