The Predictive Power of Peritraumatic Dissociation and Acute Stress Symptoms for Posttraumatic Stress Symptoms: A Three-Month Prospective Study

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Objective: The authors prospectively examined the power of peritraumatic dissociation and acute stress symptoms in predicting posttraumatic stress disorder (PTSD) symptoms.

Method: Thirty-five assault victims were assessed with the Peritraumatic Dissociative Experiences Questionnaire within 24 hours of the assault. Participants were reassessed 2 weeks after the trauma with the Stanford Acute Stress Reaction Questionnaire and 3 months after the trauma with the Clinician-Administered PTSD Scale and the Impact of Event Scale. Correlational analyses and a hierarchical multiple regression were conducted.

Results: Peritraumatic dissociation and acute stress symptoms were correlated with later PTSD symptoms and diagnosis. Together, peritraumatic dissociation and acute stress symptoms accounted for 33% of the variance in PTSD symptoms.

Conclusions: These results support earlier findings that peritraumatic dissociative experiences and acute stress are robust predictors of PTSD. Such symptoms may be of use for identifying at an early stage individuals at highest risk of remaining symptomatic. Future studies should investigate the predictive power of specific peritraumatic and acute stress disordersymptom clusters.

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Peritraumatic dissociation is defined as the occurrence of detached or detached perceptions and/or experiences that are traumatic in nature. After ruling out collinearity between our two predictors (variance inflation factor=1.53, tolerance=0.65), we computed a hierarchical multiple linear regression (10). Peritraumatic dissociation, which occurs first and is of short duration, was entered first and accounted for adjusted R²=25.8% of the PTSD symptoms (F=12.80, df=1, 33, p=0.001). Entered in the second step, the acute stress symptoms accounted for an additional 7% of the variance (t=2.10, p=0.044), for a total of 32.8% (F=9.25, df=1, 32, p=0.001). Reversing the order of entry of the variables led to acute stress symptoms explaining 28.1% of the PTSD symptoms and the peritraumatic dissociation explaining an additional 4.6% of the variance (t=1.80, p=0.08).

### Results

Of the 35 participants, 18 had been shot, stabbed, mugged, or threatened with a weapon and 17 had been badly beaten. Seven victims were hospitalized in surgical units. At 3 months, 12 participants had PTSD. There was no relation between PTSD status and age (mean age=44.1, SD=15.5, for PTSD subjects versus mean=37.5, SD=16.1, for subjects without PTSD) (t=1.17, df=33, p=0.25), marital status (p=0.27, Fisher’s exact test), level of employment (p=0.11, Fisher’s exact test), or type of trauma (χ²=0.35, df=4, N=35, p=0.55). As expected, the Peritraumatic Dissociative Experiences Questionnaire scores of the 12 participants with PTSD (mean=3.1, SD=0.9) were higher than the scores of the 23 participants without PTSD (mean=2.3, SD=0.6) (t=3.2, df=33, p<0.01). Also as expected, Stanford Acute Stress Reaction Questionnaire scores of the participants with PTSD (mean=88.2, SD=30) were higher than those of participants without PTSD (mean=59.5, SD=27.6) (t=2.8, df=33, p<0.01).

We examined Pearson’s intercorrelation coefficients between peritraumatic dissociation and acute stress symptoms and PTSD symptoms and diagnosis. As shown in Table 1, peritraumatic dissociation and acute stress symptoms were related to PTSD symptoms and diagnosis. The overlapping confidence intervals around the correlations, particularly the subscales of the Stanford Acute Stress Reaction Questionnaire, suggest that no early predictor is significantly stronger than any other.

We next compared the predictive power of peritraumatic dissociation and total acute stress symptoms in explaining the occurrence of PTSD symptoms 3 months after the trauma. After ruling out collinearity between our two predictors (variance inflation factor=1.53, tolerance=0.65), we computed a hierarchical multiple linear regression (10). Peritraumatic dissociation, which occurs first and is of short duration, was entered first and accounted for adjusted R²=25.8% of the PTSD symptoms (F=12.80, df=1, 33, p=0.001). Entered in the second step, the acute stress symptoms accounted for an additional 7% of the variance (t=2.10, p=0.044), for a total of 32.8% (F=9.25, df=1, 32, p=0.001). Reversing the order of entry of the variables led to acute stress symptoms explaining 28.1% of the PTSD symptoms and the peritraumatic dissociation explaining an additional 4.6% of the variance (t=1.80, p=0.08).

### Discussion

To our knowledge, our study is the first to contrast prospectively and concurrently the power of peritraumatic dissociation and acute stress symptoms in predicting PTSD symptoms using well-established measures. The results of the multiple regression indicate that both variables are good predictors of subsequent PTSD symptoms. This replicates and extends the finding of others (1, 3–6). There were methodological limitations, however, such as a greater dropout rate among unemployed and younger participants. The small number of subjects also prevented us from making more fine-grained analyses, such as looking at acute stress symptom clusters in predicting PTSD. Although replication of these results is needed to draw firm conclusions, quantification of immediate dissociative experiences and acute stress symptoms may eventually help the clinician identify at an early stage traumatized victims at highest risk for developing PTSD.

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**TABLE 1. Correlations (Pearson’s r) Between PTSD Symptoms and Diagnosis and Their Predictors in a Group of 35 Assault Victims**

<table>
<thead>
<tr>
<th>Predictor Variable</th>
<th>Total</th>
<th>Dissociation</th>
<th>Intrusion</th>
<th>Avoidance</th>
<th>Hyperarousal</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>r</td>
<td>95% CI</td>
<td>r</td>
<td>95% CI</td>
<td>r</td>
</tr>
<tr>
<td>Peritraumatic dissociation</td>
<td>0.59**</td>
<td>0.32 to 0.77</td>
<td>0.58**</td>
<td>0.31 to 0.77</td>
<td>0.41*</td>
</tr>
<tr>
<td>Acute stress symptoms</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total score</td>
<td>0.88**</td>
<td>0.78 to 0.94</td>
<td></td>
<td>0.85**</td>
<td>0.73 to 0.92</td>
</tr>
<tr>
<td>Dissociation</td>
<td>0.69**</td>
<td>0.47 to 0.83</td>
<td></td>
<td>0.55**</td>
<td>0.26 to 0.75</td>
</tr>
<tr>
<td>Intrusion</td>
<td>0.63**</td>
<td>0.37 to 0.79</td>
<td></td>
<td>0.69**</td>
<td>0.46 to 0.83</td>
</tr>
<tr>
<td>Avoidance</td>
<td>0.69**</td>
<td>0.46 to 0.83</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*a Peritraumatic Dissociative Experiences Questionnaire—Self-Report Version.
*b Stanford Acute Stress Reaction Questionnaire.
*c Impact of Event Scale.
*d Impact of Event Scale plus Clinician-Administered PTSD Scale.
*p<0.05. **p<0.01.
Traumatic Grief as a Disorder Distinct From Bereavement-Related Depression and Anxiety: A Replication Study With Bereaved Mental Health Care Patients

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Objective: Earlier studies have shown that symptoms of traumatic grief are distinct from those of bereavement-related depression and anxiety. This study was an attempt to replicate that finding.

Method: Data were derived from 103 patients. Traumatic grief was measured with the Inventory of Traumatic Grief. Depression and anxiety were measured with the Symptom Checklist. The distinctiveness of the three symptom clusters was determined with principal axis factoring.

Results: Symptoms of traumatic grief, depression, and anxiety clustered together in three distinct factors.

Conclusions: These results confirm the previous finding of a distinction between symptoms of traumatic grief and symptoms of bereavement-related depression and anxiety.


Several studies have shown that symptoms of traumatic grief constitute a distinct form of bereavement-related emotional distress apart from bereavement-related depression and anxiety (1). Using data on recently widowed elders, Prigerson et al. (2) found that symptoms of traumatic grief (e.g., searching, preoccupation) were dis-