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Avoidance Symptoms and Assessment of Posttraumatic Stress Disorder in Arab Immigrant Women

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Abstract

This study investigates whether the avoidance symptom criterion required for a Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV; American Psychiatric Association, 1994) diagnosis of posttraumatic stress disorder (PTSD) is overly conservative. Arab immigrant women (N = 453), many of whom reported experiencing multiple traumatic events, completed the Posttraumatic Diagnostic Scale in Arabic as part of a face to face interview. Analyses indicated all but one avoidance symptom was reported less frequently than reexperiencing and arousal symptoms. However, those who fully met reexperiencing, avoidance, and arousal symptom criteria had worse symptom severity and functioning than those who fully met reexperiencing and arousal symptom criteria, but only partially met avoidance symptom criterion. Study findings support importance of the PTSD avoidance symptom criterion.

It has been argued that the posttraumatic stress disorder (PTSD) avoidance symptoms may be more influenced by culture than the reexperiencing and arousal symptoms (Frey, 2001; Marsella, Friedman, & Spain, 1996). However, the reporting of avoidance symptoms currently remains critical to meeting the diagnostic criteria for PTSD. In fact, the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (*DSM-IV*; American Psychiatric Association, 1994) requires reporting at least three of seven possible avoidance symptoms. In contrast, only one of five possible reexperiencing symptoms and only two of five possible arousal symptoms are required to meet the PTSD diagnostic criteria. Meanwhile, findings in the literature suggest that avoidance symptoms may occur at a lower frequency relative to the reexperiencing and arousal symptoms (Shalev, 2002). This raises questions as to whether requiring three as opposed to one or two avoidance symptoms can be problematic when working with different cultural groups.

The aim of this study was to investigate whether the *DSM-IV* criterion C (reporting a minimum of three out of seven avoidance symptoms) is overly conservative in a sample of Arab immigrant women. Arab immigrant women are at greater risk for PTSD due to their increased likelihood to have experienced war and political or ethnic/religious persecution (e.g., Jamil, Hakim-Larson et al., 2002, 2005), gender (e.g., Nemeroff, Bremner, Foa, Mayberg, et al., 2006), and traditional cultural values (e.g., Al-Khawaja, 1997). Stressors

associated with resettlement or immigration further increase the risk for PTSD (Kimerling, Prins, Westrup, & Lee, 2004), making this an important group to screen and target for early intervention. Hence, examining issues that may impact validity of a PTSD diagnosis is critical for this population.

Culture has been theorized to effect the expression of distress (Kleinman & Cohen, 1997) as well as the definition of a traumatic stressor (Manson, 1997), but the empirical evidence for the effects of culture on the experiencing or reporting of avoidance symptoms is limited. Elsass (2001) argues that collectivist cultures differ from those that are individualistic with respect to avoidance symptoms, but noted that individuals from both cultures in his study reported the PTSD avoidance symptoms specified in the *DSM-IV*. However, these individuals differed in the nature of the additional non-*DSM-IV* symptoms they reported, and in their views of avoidance symptoms. The collectivist culture (Peruvian) viewed avoidance as adaptive whereas the individualistic culture (Colombian) viewed avoidance symptoms as something to treat. Irrespective of their views on the meaning of avoidance symptoms, both groups were clearly distressed by the violence they had experienced. Thus, Elsass's findings appear to argue for culture being more relevant to the treatment of PTSD than to its assessment.

One argument for the effect of culture on the reporting of avoidance symptoms is the lack of a clear neurobiological basis for these symptoms, which would argue for a cross-culture equivalence in symptom reporting. To our knowledge, only one study has explored the neurobiology of avoidance symptoms. In this study, de Kloet, Vermetton, Geuze, Wiegant, and Westenberg (2008) found that increases in plasma arginine (AVP), which is a modulator of the hypothalamic axis, were correlated with avoidance symptoms in veterans with PTSD. However, it is unclear whether increases in plasma AVP cause avoidance symptoms or are caused by them.

The lack of a clear neurobiological basis for avoidance symptoms also puts these symptoms at odds with what is known about the neurobiology of reexperiencing and arousal PTSD symptoms. Recent developments in the neurobiology of PTSD identify clear mechanisms underlying the development of reexperiencing and arousal symptoms postevent exposure leading many to conclude that these symptoms are part of a non-culturally specific response to trauma (e.g., Marsella et al., 1996). For example, high levels of catecholamines that are released when a person experiences a severe traumatic event are theorized to increase the probability of intrusive recollections in the immediate aftermath of the event (Yehuda, Bryan, Marmar, & Zohar, 2005) and mediate overconsolidation of memories (Pitman, Shalev, & Orr, 2000). Over-consolidation of memories is thought to impair the extinction learning in the posttrauma period that is necessary to inhibit the fear response, thereby rendering the individual more sensitized to memories of the trauma and more likely to be aroused in response to trauma-related cues (Yehuda et al., 2005). Thus, arousal symptoms develop as the individual is exposed to trauma-related cues or as she or he experiences the intrusive memories that are part of the reexperiencing symptoms initially triggered by the release of catecholamines.

In contrast to neurobiology, emotional processing theory identifies a clear mechanism underlying the development of avoidance symptoms. This theory holds that individuals use avoidance symptoms as a way to cope with reexperiencing and arousal symptoms (O'Donnell, Elliott, Lau, & Creamer, 2007), which would both create opportunity for culture to shape expression of avoidance symptoms and argue for a later expression of these symptoms relative to the other PTSD symptoms. Consistent with emotional processing theory, O'Donnell et al. (2007) found that avoidance symptom severity increased over a 12-month period in Australian motor vehicle accident victims (predominately male sample) whereas reexperiencing symptom severity remained fairly stable. However, arousal symptom severity also increased and it is unclear how treatment of physical injuries may have shaped symptom expression in general. Thus, this study does not definitely identify avoidance symptoms as a consequential development of reexperiencing and arousal symptoms.

Studies of Hispanic hurricane victims living in the United States and/or Mexico argue for increased, rather than decreased, reporting of avoidance symptoms by members of traditional cultures (Norris, Perilla, Ibanez, & Murphy, 2001), persons experiencing acculturative stress (Perilla, Norris, & Lavizzo, 2002), and those who endorse the Hispanic value of fatalism (Perilla et al., 2002). Meanwhile, Ruchkin et al. (2005) found no cultural differences in PTSD symptom presentation when comparing U.S. and Russian youth. Studies of other cultural groups often do not report the incidence of avoidance symptoms separately from other PTSD symptoms (e.g., Terheggen, Stroebe, & Kleber, 2001) making it hard to evaluate whether the effects observed for Hispanics are unique to that cultural group or are generalizable to other collectivist cultural groups.

Despite this tendency for increased reporting, avoidance symptoms are often the least frequently reported type of PTSD symptom in studies of non-U.S. born Hispanics as well as other non-U.S. populations. For example, lower frequencies of avoidance symptoms relative to reexperiencing and arousal symptoms have been observed in Mexican Hurricane victims (Norris et al., 2003), Salvadorean women refugees living in the United States (Jenkins, 1996), women living in South African townships (Dinan, McCall, & Gibson, 2004), and Palestinian and Algerian survivors of war or mass violence (de Jong et al., 2001). Moreover, Shalev (2002) asserts that avoidance symptoms are less frequently reported than reexperiencing and arousal symptoms in general, not just in non-Western populations. This suggests that the low frequencies of avoidance symptoms may reflect something inherently different about the avoidance symptoms relative to reexperiencing and arousal symptoms, and argue against culture being the sole explanation for the low frequency of these symptoms in non-Western populations.

The low frequency of avoidance symptoms is important because it can limit the proportion of the sample that meets PTSD diagnostic criteria. For example, McCall and Resick's (2003) study of PTSD in a radically non-Western culture, the Kalahari Bushmen and women (Ju/'hoansi), found that all participants met diagnostic criteria B (reexperiencing symptoms) and C (arousal symptoms) for PTSD. However, only 35% met criterion C (avoidance symptoms). Similarly, Aroian and Norris (2007) found that 61% of Arab immigrant women with high trauma exposure reported enough reexperiencing and arousal symptoms to meet

the *DSMIV-IV* diagnostic criteria B and D, but only 43% reported a sufficient number of avoidance symptoms to meet the *DSM-IV* diagnostic criterion C.

Resolving questions regarding the validity of the avoidance criterion for a positive diagnosis of PTSD is particularly important in immigrant and refugee populations because existing PTSD measures were originally developed and validated with U.S. populations. Although the cross-cultural presence of PTSD symptoms in persons exposed to traumatic events is fairly well established (e.g., Frey, 2001), the cross-cultural validity of requiring three of seven possible avoidance symptoms to meet the avoidance symptom criterion is not.

Hence, this study investigated whether functioning and the severity of reexperiencing and arousal symptoms was comparable in groups of persons that met criteria B (reexperiencing symptoms) and D (arousal symptoms), but varied with respect to meeting criterion C (avoidance symptoms). An appropriately conservative criterion C would argue for significant differences in symptom severity and functioning across these groups.

The effect of time since traumatic event on the reporting of avoidance symptoms and group differences in time since traumatic event were also investigated. Emotional processing theory would argue that the severity of avoidance symptoms should be correlated with time because those who did not fully meet the PTSD criterion C would be more likely to have experienced a traumatic event recently than those who fully met all three symptom criteria.

METHOD

Participants

Study participants ($N = 546$) were Arab Muslim immigrant women who were part of a larger study about the effect of maternal emotional status and parenting on adjustment of adolescent children of foreign-born Arab mothers living in metropolitan Detroit. All had immigrated to the United States sometime between 1989 and 2003.

Participants were recruited by bilingual research assistants who were also immigrants from the same countries of origin as participants in the study and lived in metropolitan Detroit. The local Arab immigrant community in metropolitan Detroit is the largest Arab community in the United States, with a conservative estimate of about 200,000 to 250,000 Arab immigrants residing in ethnic enclaves in metropolitan Detroit (Schopmeyer, 2000; Zogby, 1998). Research assistants verbally advertised the study and recruited interested participants during informal day-to-day contact with Arab Muslims (Aroian, Katz, & Kulwicki, 2006). Although participants could choose to be interviewed in English or Arabic, almost all chose Arabic (97%).

Participants were dropped from the analyses discussed here if they chose to complete the interview in English ($n = 18$) or did not answer one or more Posttraumatic Diagnostic Scale (PDS; Foa, 1995) symptom items ($n = 75$). Comparisons of retained ($n = 453$) and deleted ($n = 93$) participants indicated that retained participants were more at risk for PTSD: They were more likely to have been born in Iraq, lived in a refugee camp, and immigrated as refugees ($p < .01$). They also reported living longer in a refugee camp than those participants

who were deleted from the analysis ($p < .01$). However, the two groups did not differ on demographic characteristics unrelated to trauma: age, education, language ability, marital status, or number of children.

The mean age of the sample was 40 ($SD = 6$) years. Most participants were married (85%). These characteristics reflect study selection criteria: Only women with one or more adolescent were eligible for participation in the larger study. Such women tend to be older, and in the Arab culture, married.

Over half (53%) of the sample was born in Iraq and a third (34%) was born in Lebanon. The remaining 14% were born in 1 out of 12 other Arab countries in the Middle East or Northern Africa. Median length of time living in the United States was 9 years. Almost equal numbers had entered the United States as refugees (53%) or immigrants (40%), with the remaining 7% entering on tourist, student, or work visas before seeking permanent residence. Only 17% spoke English. Almost two thirds (65%) had less than a high school education and only 9% had a college degree. The majority were homemakers who were not looking for work (82%); only 16% were employed full- or part-time. Of the 387 women who had husbands currently in the home (i.e., not widowed, divorced, or separated), 53% had husbands who were employed either full- or part-time. Almost half (43%) of the husbands had less than high school education, but 21% had a college degree.

Over a third of the participants (44%) reported living through or witnessing three or more traumatic events. Far fewer reported experiencing only one (14%) or two (15%) events. The six most commonly reported types of events were military combat or war zone (89%); serious accident, fire, or explosion (70%); imprisonment (48%); political/ethnic persecution, including interrogation and being forced to flee one's homeland (47%); life-threatening illness (39%); torture (39%); and natural disaster (32%). Less than 6% reported having experienced any type of physical or sexual assault not related to war or political/ethnic persecution. Almost half (49%) identified war or political/ethnic persecution as the most bothersome traumatic event, but 25% provided an "other traumatic event" as the most bothersome. Other traumatic events included more normative stressors, such as divorce or illness or death of a family member. Yet, 87% of the participants who identified a more normative event as the most bothersome also reported one or more of the six most commonly reported types of traumas described previously.

Data collection occurred in study participants' homes. In addition to the Arabic PDS, study participants completed a battery of questionnaires including a demographic and migration questionnaire, and other measures of psychological functioning not used in analyses presented here. Participants were given \$30 for their time.

Measures

Arabic language versions of data collection materials were developed through translation and back translation as a validity check and further evaluated by committee consensus. The goal of the translation work was loyalty of meaning and equal familiarity and colloquialness in both languages (Werner & Campbell, 1970).

The demographic and migration questionnaire assessed the following demographic characteristics: age, education, marital and employment status (self and husband), and number of children. Migration characteristics included age at immigration, country of origin, refugee camp experience, time in transit, refugee status at immigration, and time in the United States.

The Posttraumatic Diagnostic Scale (PDS; Foa, 1995) is comprised of four sections. Section I contains a checklist of traumatic events and respondents indicate whether they have experienced or witnessed each of these events. An “other” category is included so that respondents can write in events not included in the checklist. Responses to Section I were used in this study to identify the types of traumatic events study participants had experienced as well as the length of time that had passed since the event occurred.

In Section II, respondents indicate which event has disturbed them the most in the past month (their “most bothersome” event), and provide a brief description of this event. They then report how long ago this event happened (less than a month, less than 3 months, 3–6 months, 6 months to 3 years, 3–5 years, more than 5 years) and complete a series of yes/no questions regarding this event that assess Criteria A (did they or someone close to them experience personal harm, feel their life was endangered, feel helpless and terrified, etc.).

Section III contains the 17 PTSD symptom items that assess Criteria B (reexperiencing symptoms), C (avoidance symptoms), and D (arousal symptoms). The frequency of each symptom's occurrence in the past month is rated on a 4-point scale, ranging from 0 (*not at all or only one time*) to 3 (*five or more times a week or almost always*). A total symptom severity score (SSS; Foa, 1995) and symptom subscale scores (reexperiencing, avoidance, arousal) can be calculated from these 17 PDS symptom items by summing item responses. In addition, these items can be dichotomized into 0 (*not at all or only one time*) and 1 (*all other responses*) to determine how many reexperiencing, avoidance, and arousal symptoms are reported and whether the number is sufficient to meet *DSM-IV* Criteria B, C, and D.

Confirmatory factor analysis of the 17 PTSD symptom items supports use of these items as three independent, but highly inter-correlated (reexperiencing, avoidance, arousal) symptom subscales (CFI = .96; $r = .64$ to $.72$). Reliability for the 17 symptom items as a whole and the symptom subscales is excellent in both the English (Foa, 1995) and Arabic (Norris & Aroian, in press) language versions (total PDS Cronbach's alpha = .93; symptom subscales Cronbach's alpha = .77–.91). Validity is supported by correlations between PDS SSS and measures of depression and anxiety for both the English (Foa, 1995) and Arabic language versions (Norris & Aroian, in press).

The last section (Section IV) contains nine yes/no items designed to assess Criterion F, including seven “domain” items that assess difficulty functioning in specific life domains (e.g., work, home, family), one item about general satisfaction with life, and one item about overall functioning in all areas of life. According to Foa (1995), a yes to the item about overall functioning, or a yes for more than five of seven domain items is scored as severe impairment in functioning. A yes for three to five domain items is scored as moderate impairment, whereas a yes for 1 or 2 is considered mild impairment. No impairment is

defined as the absence of a yes response to any Section IV items. For purposes of the analyses conducted here, scores on Section IV were collapsed to create a dichotomous measure of functioning: none or mild (0) and moderate or severe (1).

Data Analysis

Four sample subgroups were created to address the research questions. Participants were categorized on the basis of their responses to the PDS into one of four groups: (a) fully meet all three PTSD symptom criteria (full PTSD); (b) fully meet reexperiencing and arousal criteria, but only report two avoidance symptoms (partial PTSD-2AV), (c) fully meet reexperiencing and arousal criteria, but only report one avoidance symptom (partial PTSD-1AV); and (d) do not meet any symptom criteria (no PTSD).

Subgroup comparisons of symptom severity scores were made using analysis of variance (ANOVA) with the Welch (1951) robust estimate of F for groups with heterogeneous variances because the homogeneity assumption was not met. The Tamhane's T2 post hoc test for unequal group variances (Hochberg & Tamhane, 1987) was used to compare pairs of subgroup means. Subgroup comparisons of functioning (moderate or severe impaired functioning vs. little or no impairment) were assessed with chi-square statistics.

Differences in time since traumatic event (<1 or 3 months, >5 years) for participants that fully met as compared to partially met PTSD symptom criteria were investigated with the Fisher's (1922) exact test. Only these extreme time points were used to maximize detection of any group differences in avoidance symptoms associated with time since traumatic event. In addition, correlation analysis was used to assess the effect of time since traumatic event on the reporting of avoidance symptoms.

Length of time in the United States was not correlated with symptom severity as measured by the PDS total or symptom sub-scales ($r = .07$). Hence, it was not used as a covariate in any of the study analyses previously discussed.

All subgroup differences reported here were also assessed in the subsample of participants that had experienced traumatic events, but not torture ($n = 275$), to investigate whether trauma exposure in general or torture experience in particular was responsible for study findings. Results for the subsample analyses replicated those for the total sample. Hence, only results for the full study sample are reported here.

RESULTS

Frequency of PTSD Symptoms

As can be seen in Table 1, avoidance symptoms were reported least frequently with the exception of one avoidance symptom (trying not to think, talk, or have feelings about the traumatic event). Reexperiencing symptoms were generally reported more frequently than avoidance and arousal symptoms. More than two thirds of the sample reported reexperiencing symptoms of intrusive images and emotional upset when reminded of the trauma with about two thirds reporting three or more reexperiencing symptoms.

A larger proportion of the sample met the *DSM-IV* reexperiencing (82%) and arousal (62%) symptom criteria (Criterion B and D, respectively). In contrast, less than half (43%) of the sample met Criterion C for endorsing a minimum of three avoidance symptoms. Only 40% met all three diagnostic criteria for symptoms. Smaller sample subgroups met both the reexperiencing and arousal criteria, but reported only two (10%) or one avoidance symptoms (10%). These sample subgroups are hereafter referred to as full PTSD (met all three *DSM-IV* symptom criteria; $n = 189$), partial PTSD-2 AV (met Criteria B and D, and had two avoidance symptoms; $n = 45$), and partial PTSD-1 AV (met Criteria B and D, and had one avoidance symptom; $n = 44$). The subgroup of participants that did not meet any of the diagnostic criteria is referred to as no PTSD ($n = 175$).

Subgroup Analyses

The four groups differed in reexperiencing, $F(3, 124.38) = 131.78, p < .001$, avoidance, $F(3, 152.89) = 239.58, p < .001$, arousal, $F(3, 126.81) = 113.62, p < .001$, and total symptom severity; $F(3, 125.83) = 257.92, p < .001$ (see Table 2). Post hoc comparisons for the reexperiencing, arousal, and total symptom severity mean scores were significant ($p < .001$) for all group comparisons with one exception. There was no difference between the two partial PTSD groups on these symptom measures. Significant differences were observed for all mean comparisons involving avoidance severity ($p < .001$).

Functioning also varied across the four different groups. Those who met all three symptom criteria were more likely to report moderate to severe impairment (68%) than respondents in the two partial PTSD (–2 AV, 39%; –1AV, 33%) or no full/partial PTSD groups (13%), $\chi^2(3, N 453) = 118.18, p < .001$. Chi-square analyses comparing two groups at a time found no difference between the two partial PTSD groups, but consistent differences between the full PTSD group and all other groups ($p < .001$) and the no full/partial PTSD group and all other groups ($p < .001$).

Time Since Traumatic Event

The majority of participants (79%) reported that it had been more than 5 years since the event that they rated as most problematic with the median value for time being more than 5 years in all four groups. Neither of the two partial PTSD groups (3%) were more likely than those with full PTSD (3%) to have experienced a traumatic event within the past 1–3 months (Fisher's exact test, *ns*). Neither number nor severity of avoidance symptoms was correlated with time since traumatic event ($r = -.07$).

DISCUSSION

This study used data from a sample of Arab immigrant women to investigate whether the avoidance symptom criterion for a PTSD diagnosis may be overly conservative in non-Western cultural groups. Study findings argue against this criterion being overly conservative in this sample. Consistent with previous research involving other cultural groups (e.g., Dinan et al., 2004), our participants reported avoidance symptoms less frequently than other types of PTSD symptoms. However, women in the sample who met this symptom criterion in addition to the reexperiencing and arousal criteria had the highest

levels of reexperiencing and arousal symptoms, and poorest functioning. Although these findings do not rule out the influence of culture on avoidance symptom reporting, they do support use of the *DSM-IV* PTSD diagnostic Criterion C, and North et al.'s (1999) observation that the avoidance symptoms could be used to screen for PTSD.

Contrary to O'Donnell et al. (2007), we found no differences in time since traumatic event for persons who did and did not meet the PTSD symptom criterion for avoidance. However, the majority of our sample had experienced a traumatic event 5 or more years prior to the study interview. This constrained our ability to test emotional processing theory predictions.

This study does have certain limitations. All data were self-report and, as previously discussed, most participants had experienced a traumatic event more than 5 years prior to the study. However, symptom self-reports have been found to be consistent with clinician ratings (Gudmundsdottir & Beck, 2004) and the presence of PTSD symptoms have been observed 28 or more years after a traumatic experience (Acierno et al., 2007).

Additionally, we did not have independent clinical assessment data for our participants. Hence, we were unable to assess the specificity and sensitivity of the avoidance criterion. Specificity and sensitivity analyses would have provided a more direct assessment of whether reporting a minimum of three out of seven avoidance symptoms was overly conservative.

It is also possible that our sample was higher in acculturation given that the median length of time lived in the United States was 9 years. However, at least four factors argue for our sample being low in their level of acculturation despite their length of time in the United States. First, these participants chose to complete the interview in Arabic and reported Arabic as their speaking language. Language use has been used as an indicator of acculturation in a number of studies with a reliance on one's primary language as indicative of a lower level of acculturation (Berry, 2003). Second, the size of the Arab community in Detroit is such that it is possible for individuals to carry on their day-to-day life interacting only with other Arab-speaking individuals (Schopmeyer, 2000). Third, the traditional gender role expectations for Arab women are such that they are expected to remain at home (Haj-Yahia, 1995), and consistent with this, a large majority (82%) of our sample did not work. Also, even Arab women who have adopted Western standards retain traditional values and family patterns (Al-Haj, 1987; Haj-Yahia, 1995). Fourth, Arab immigrants to the United States who immigrated since 1990 are more likely than earlier Arab immigrants to maintain social and cultural ties with their nationality or region of origin (Ammar, 2000), and all but one of our participants had immigrated since 1990. All of these factors argue against a high level of acculturation in the sample from which these study results were derived.

Finally, our sample was limited to Arab immigrant women, limiting the generalizability of our findings. Nevertheless, our findings are consistent with those obtained from Western and non-Western samples with respect to the frequency of avoidance symptoms in both men and women. This supports additional research to examine issues related to the avoidance symptoms in men as well as other cultural groups.

Despite study limitations, these findings have implications for practice. First, it is worth noting that many of our study participants were multiply traumatized and reported experiencing horrendous events. This highlights the need for screening and intervention with this population. Second, these findings suggest that the conservative nature of the avoidance criterion serves a useful gatekeeping function and argue for the importance of including avoidance symptoms in PTSD assessment even in non-Western cultural groups.

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Table 1

PTSD Symptoms as Measured by the Arabic PDS Symptom Subscales in Descending Order of Reporting Frequency

Criterion	%	<i>n</i>
Reexperiencing symptoms		
B4. Emotionally upset when reminded	75	342
B1. Intrusive images	72	328
B3. Reliving of the trauma	59	268
B2. Nightmares about traumatic event	55	247
B5. Physical reactions when reminded	54	243
Avoidance symptoms		
C6. Trying not to think, talk, or have feelings about	63	285
C7. Trying to avoid activities, places, or people	39	177
C9. Loss of interest	38	173
C10. Feeling distant or cut off	34	152
C12. Lack of future plans	21	95
C11. Feeling emotionally numb	21	95
C8. Memory loss	15	68
Arousal symptoms		
D14. Irritability	61	276
D13. Difficulty sleeping	48	218
D15. Difficulty concentrating	47	213
D17. Easily startled	42	191
D16. Overly alert	39	178

Note. PTSD = Posttraumatic stress disorder; PDS = Posttraumatic Diagnostic Scale.

Table 2

Descriptive Statistics for Reexperiencing, Avoidance, Arousal, and Total Symptom Severity Scores in the Four Groups

	Full PTSD (<i>n</i> = 189)	Partial PTSD-2AV ^a (<i>n</i> = 45)	Partial PTSD-1AV ^b (<i>n</i> = 44)	No PTSD PTSD (<i>n</i> = 175)
Reexperiencing				
<i>M</i>	9.49	6.43	5.89	2.26
<i>SD</i>	3.67	2.86	3.48	3.26
Median	10.00	6.00	5.00	1.00
Range	2–15	2–14	2–15	0–15
Avoidance				
<i>M</i>	8.36	3.32	1.80	0.75
<i>SD</i>	3.79	1.14	0.84	1.44
Median	8.00	3.00	2.00	0.00
Range	3–21	2–6	1–3	0–8
Arousal				
<i>M</i>	7.79	4.27	3.80	1.43
<i>SD</i>	3.95	2.84	2.31	2.52
Median	8.00	4.00	4.00	0.00
Range	3–21	1–12	1–9	0–13
Total symptom severity score				
<i>M</i>	25.64	14.02	11.49	4.47
<i>SD</i>	9.20	5.31	5.50	5.07
Median	25.00	13.50	9.00	3.00
Range	8–51	5–27	5–26	0–27

Note. PTSD = Posttraumatic stress disorder. All post hoc two-way comparisons were significant at $p < .001$ except those between the two partial PTSD groups (partial PTSD-2AV and partial PTSD-1AV).

^aPTSD-2AV = Fully meets PTSD criteria B and D, but only has two avoidance symptoms.

^bPTSD-1AV = Fully meets PTSD criteria B and D, but only has one avoidance symptom.