

Are Traumatic Events Necessary to Elicit Symptoms of Posttraumatic Stress?

Jordan S. Robinson and Christine Larson
University of Wisconsin—Milwaukee

A diagnosis of posttraumatic stress disorder (PTSD) has been conceptualized as being precipitated by a particularly traumatic stressor (e.g., combat exposure, rape, and violent assault). Recent research suggests that common stressful events (e.g., relational problems, divorce, and expected death of a loved one) may also be capable of eliciting posttraumatic symptomatology. The current study replicated and extended these previous findings, examining three groups of event exposure: those who reported experiencing only traumatic events in the past year, those who reported experiencing only significant stressful life events in the last year, and those who experienced both types of events. Consistent with previous findings, we found that all three groups of event exposure, including those experiencing only stressful life events, experienced similar amounts of PTSD symptomatology across symptom clusters. These data add to the growing literature that suggests that the type of events that cause symptoms of PTSD may be broader than the current diagnostic criteria indicate, and as such calls for more rigorous research in this area to better understand the diagnostic implications of these findings.

Keywords: PTSD, life events, PCL, life stress, posttraumatic stress

Since the formal inclusion of posttraumatic stress disorder (PTSD) into the *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed.; *DSM-III*; American Psychiatric Association [APA], 1980), controversy has arisen with the diagnosis, much of it centered on Criterion A1 (the “stressor criterion”). In *DSM-III*, this event criterion held that an individual had to experience an “event that is outside the range of usual human experience and that would be markedly distressing to almost anyone” (APA, 1980). One of the first critiques of PTSD came from Breslau and Davis (1987), who claimed that the connection between this stressor criterion and the symptom constellation of the PTSD diagnosis had not been adequately tested in an empirical manner. An additional criticism of this early criterion concerned the definition of a traumatic event as one that occurred rarely in the population. Epidemiological studies have shown that traumatic stressors are relatively common, with most people experiencing at least one traumatic event within their lifetime (Breslau, Davis, Andreski, & Peterson, 1991). In addition to these early criticisms of PTSD as a construct, several research studies have documented that events not necessarily considered traumatic elicit the symptom constellation thought to be associated with PTSD, raising questions concerning the disorder’s symptom specificity.

A study conducted by Joseph, Mynard, and Mayall (2000) on English adolescents found a relationship between high scores on measures of posttraumatic stress symptoms and stressful life

events that normally would not be classified as *traumatic* by the current PTSD inclusion criteria (e.g., parental separation, trouble with the police, and family member with a drug or alcohol problem). Additionally, Mol and colleagues (2005) used a general population sample to examine whether stressful events could generate symptoms of PTSD and found that those who identified a stressful life event as their worst subjective experience endorsed higher levels of PTSD symptoms than did those whose worst experience was a traumatic event. Similarly, Gold, Marx, Soler-Baillo, and Sloan (2005) divided college undergraduate participants into two groups: those who endorsed a traumatic event consistent with the A1 criterion of PTSD and those who experienced a negative life event not consistent with that criterion. Consistent with previous research, individuals who reported experiencing negative life events not consistent with the traumatic nature of the A1 criterion showed equal, if not more, posttraumatic symptomatology than did those who indicated the experience of a traumatic event in their life. A more recent study using structured clinical interviews found similar results in a sample of people seeking treatment for major depression (Bodkin, Pope, Detke, & Hudson, 2007). These recent findings underscore a perceived problem with the construct of PTSD and the stressor criterion that has received increased attention as we move closer to the release of *DSM* (5th ed.). These studies also highlight the importance of additional research in this area to further explore the A1 criterion of PTSD and the stressors that can lead to a posttraumatic stress symptom constellation.

Current Study

The current study sought to replicate and extend the findings that posttraumatic symptomatology may also be present among individuals who have experienced stressful life events (Bodkin et al., 2007; Gold et al., 2005; Mol et al., 2005). The large sample of

Jordan S. Robinson and Christine Larson, Department of Psychology, University of Wisconsin—Milwaukee.

The data for this study were collected at Michigan State University.

Correspondence concerning this article should be addressed to Christine L. Larson, Department of Psychology, University of Wisconsin—Milwaukee, 2441 East Hartford Avenue, Garland 210, Milwaukee, WI 53211. E-mail: larsoncl@uwm.edu

college undergraduates obtained in the current study allowed us to clearly delineate three groups of event exposure: those who reported experiencing a traumatic event and no significant stressful events in the past year, those who reported experiencing only significant stressful life events in the past year without the experience of a traumatic event, and those who experienced both types of events in the past year. This enables us to build on methods used in previous research, in that it allows for assessment of PTSD symptoms in groups with more specific exposure to traumatic or stressful life events as well as examination of the cumulative effects of exposure to both types of stressful life experiences. Specifically, we predict results consistent with previous literature, that traumatic events not consistent with the A1 criterion of PTSD will elicit symptoms of posttraumatic stress on self-report measures, even after controlling for differential exposure to both traumatic and stressful events in the past year. This will be addressed by predicting symptom severity on the PTSD Checklist—Civilian version (PCL—C) as a function of type of event experienced. Additionally, we compared severity of PTSD symptoms between groups exposed to different types of events (traumatic only, stressful only, and both types).

Method

Participants

The participants in this study were 1190 adults, ages 18–26 years, recruited through the Michigan State University Human Participant in Research (HPR) subject pool website. Participants were volunteers enrolled in undergraduate psychology courses who received course credit or extra credit for their participation. Participants in the study read a description of the study procedures and gave informed consent before participation. Men accounted for 52.5% of the sample. Participants were predominantly Caucasian (84.5%), along with 5.6% identifying themselves as African American, 4.1% as Hispanic, and the remaining participants as “other.” Fifty-one participants were lost because of technical problems with the HPR database. Those having experienced at least one traumatic event within the past year accounted for 22.9% of participants. Traumatic event prevalence for men was 19.5% and was 26.8% for women within the past year. After selecting those who reported events in the past year, the final sample consisted of 362 participants (178 men and 184 women). This final sample consisted of (a) those individuals experiencing only traumatic events in the last year without the experience of a negative stressful event (trauma only group, $n = 64$), (b) individuals experiencing only a negative stressful life event with no experience of a traumatic event within their life (stressful event group, $n = 149$), and (c) those having experienced both types of events in the past year (both groups, $n = 149$). The prevalence of exposure to different types of events is reported in Table 1.

Procedure and Materials

After providing written informed consent, participants completed a series of questionnaires assessing life event exposure and posttraumatic stress symptoms anonymously through the HPR website.

Table 1
Frequency of Traumatic and Stressful Event Exposure in the Past Year by Gender

Event type	Male (%) ($n = 178$)	Female (%) ($n = 184$)
Traumatic events		
Life-threatening accident	51 (28.7)	55 (29.9)
Physical assault	20 (11.2)	11 (6.0)
Sexual assault	9 (5.1)	34 (18.5)
Witness life-threatening accident	51 (28.7)	51 (27.7)
Experience domestic violence	10 (5.6)	21 (11.4)
Witness violence (nonfamily)	50 (28.1)	29 (15.8)
Unexpected death of loved one	38 (21.3)	65 (35.3)
Stressful events		
Expected death of a loved one	71 (39.9)	81 (44)
Relational stress	86 (48.3)	97 (52.7)
Problems with school/work	62 (34.8)	73 (39.7)
Serious illness in the family	36 (20.2)	40 (21.7)
Legal problems	55 (30.9)	35 (19)

Trauma and stressful life events scales. The Traumatic Events Screening Inventory (TESI; Ribbe, 1996) was used to assess the occurrence of events that would be considered traumatic by *DSM* (4th ed., text rev.; *DSM-IV-TR*; American Psychiatric Association [APA], 2000) standards. This questionnaire inquires about a variety of traumatic stressors that may be encountered throughout an individual’s life (e.g., death of a loved one, witnessing an assault, and sexual assault). In addition to measuring occurrence of events, this scale inquires as to the severity of the stressor as experienced by the individual in terms of a subjective rating on a 7-point Likert scale. Participants were also asked to indicate whether or not each event endorsed had been experienced in the past year.

The Life Events Survey (LES; Sarason, Johnson, & Siegel, 1978) was used to assess stressful life events. The LES is a 49-item self-report measure that yields an occurrence rate and individualized weightings of the impact of life events for each individual. The questions ask about common life stressors (e.g., “Major change in financial status”; “Serious injury or illness of close friend”; and “Marriage”) and asks individuals to indicate which events have occurred over the past year and rate the severity of those events on a 7-point scale from -3 (*extremely negative*) to $+3$ (*extremely positive*). A summed score for positive and negative events is obtained along with an overall event score. Positive life events were included because of previous research suggesting that positive events can be stressful and possibly lead to exacerbation of symptomatology when other vulnerability or stress factors are present (e.g., Brown & McGill, 1989).

Posttraumatic stress measures. The PCL—C (Weathers & Ford, 1996) is a 17-item inventory that assesses the 17 symptoms of PTSD as is outlined in the *DSM-IV-TR*. Subscales for each type of symptom (reexperiencing, avoidance, and hyperarousal) are calculated along with an overall score for PTSD symptomatology. Participants are asked to rate how much they have been bothered by a particular symptom (e.g., “Feeling *jumpy* or easily startled” or “Feeling as if your *future* will somehow be *cut short*”). Participants were asked to rate each symptom on the basis of what they felt their most stressful life experience was. The event that each

participant indicated for these ratings is consistent with how they were assigned for analysis. The PCL–C shows adequate reliability in the current sample ($\alpha = .92$, $M = 14.63$, $SD = 11.36$).

Results

Individuals in the *traumatic event only* group reported a mean number of 2.05 traumatic events ($SD = 1.26$, maximum = 6). Those in the *stressful life event only* group reported a mean number of 2.75 stressful events ($SD = 2.22$, maximum = 14). Last, individuals experiencing both types of events endorsed a mean number of 2.39 traumatic events ($SD = 1.30$, maximum = 7) and 3.71 stressful events ($SD = 2.42$, maximum = 12). Individuals in the *both events* group did experience significantly more stressful life events than did those individuals who had endorsed only a stressful life event in the past year ($t = 3.57$, $p < .05$). There was no difference in the incidence of traumatic events between the *traumatic event only* group and the *both events* group ($t = 1.77$, $p > .05$).

The analyses conducted attempted to replicate previous findings (Bodkin et al., 2007; Gold et al., 2005; Mol et al., 2005) suggesting that stressful life events can precipitate posttraumatic symptomatology and extended this work by using groups with more clearly defined exposure to traumatic and nontraumatic stressful events. To assess the level of posttrauma symptoms as a function of exposure to different types of life events, we used two approaches: regressions predicting posttrauma symptoms as a function of perceived severity of different types of stressful events and a comparison of mean levels of PTSD symptoms among groups' experience exposure to different types of life events.

The multiple regression analyses were calculated using PCL–C scores as the outcome variable and perceived severity of life events as the predictor. Separate regression analyses were conducted for three groups, defined on the basis of exposure to different types of life events, including individuals who had reported experiencing no traumatic events in the past year but had experienced at least one negative event and possibly one or more positive life events in the past year ($n = 149$), individuals who reported the experience of at least one traumatic event without the experience of significant stressful life events in the past year ($n = 64$), and individuals who

had experienced both traumatic and stressful life events ($n = 149$). This grouping extends previous work in two ways: first, by allowing a comparison not only between those who have and have not experienced a significant traumatic event, but also allowing a comparison group of individuals experiencing both types of life events; and second, by removing the possible confound of including individuals who experienced both types of events in the same analysis. Those who reported experiencing solely stressful life events did not have a traumatic event severity predictor variable in the regression. The regression results for each of these three groups are presented in Table 2.

Among those who endorsed traumatic event exposure with no negative stressful events in the past year, traumatic event severity accounted for 16.3% unique variance in posttraumatic stress symptomatology and positive event severity accounted for 3.9% of the remaining variance. The zero-order correlation between TESI traumatic event severity and PCL–C scores was $r = 0.37$ ($p < .001$). For those endorsing only stressful life events, negative event severity accounted for 8.6% of the unique variance in posttraumatic stress symptomatology, and positive event severity accounted for another 2.2% of variance in the equation. Last, within the group for which both types of events were endorsed, negative stressful life event severity accounted for 6.2% of unique variance, traumatic event severity accounted for 4.5%, and positive life event severity accounted for a nonsignificant 0.2% of variance for posttraumatic stress symptomatology. These results indicate that although the effect sizes are small, the experience of negative stressful life events may contribute as much, or slightly more, to the experience of symptoms of posttraumatic stress.

It is possible that different types of stressors led to different types of symptoms. To examine this possibility, the PCL–C was broken down into its constituent symptom clusters of Reexperiencing, Avoidance, and Hyperarousal. With this distinction made, mean levels of PTSD symptoms for each cluster were compared among the three groups (traumatic event only, stressful event only, and both). The means and standard deviations of these clusters across these groups are listed in Table 3. A Symptom Cluster $\times$ Group analysis of variance (ANOVA) did not reveal any interac-

Table 2
Results of Simultaneous Regression Predicting PCL–C Scores by Type of Event Experienced

Trauma type	Predictor variable	Unstandardized coefficient (b)	Standard error	Standardized coefficient (β)	Significance (p)	Effect size
Traumatic only	Constant	27.135	2.249		<.001	
	TESI	1.010	.293	.394	.001	.163
	LES pos	-.706	.310	-.260	.026	.078
Stressful events only	Constant	28.731	1.479		<.001	
	LES pos	-.288	.151	-.149	.058	.022
	LES neg	.725	.193	.293	<.001	.086
Both events	Constant	28.305	1.978		<.001	
	TESI	.428	.164	.217	.010	.045
	LES pos	-.101	.181	-.043	.577	.002
	LES neg	.674	.218	.257	.002	.062

Note. PCL–C = Posttraumatic Stress Disorder Checklist—Civilian version; TESI = subjective current severity of distress from traumatic event; LES pos = subjective rating of current positive life events; LES neg = subjective rating of current stressful life events. Traumatic events only $n = 64$; stressful events only $n = 149$; both events $n = 149$.

Table 3
Group Means and Standard Deviations in Posttraumatic Symptomatology

Group	Total PCL-C (SD)	Reexperiencing (SD)	Avoidance (SD)	Arousal (SD)
Trauma only	30.29 (12.28)	9.00 (4.19)	11.82 (4.79)	9.43 (4.04)
Stress only	30.13 (10.08) ^a	8.64 (3.64) ^a	12.06 (4.63)	9.36 (3.39) ^a
Both events	34.27 (12.16) ^a	10.39 (4.22) ^a	13.29 (5.13)	10.52 (4.18) ^a

Note. PCL-C = Posttraumatic Stress Disorder Checklist—Civilian version. *Stress only* refers to the stressful life event group. Traumatic events only $n = 64$; stressful events only $n = 149$; both events $n = 149$.

^a Significantly different at $p < .05$.

tion effects as a function of symptom type and event exposure type ($p = .71$) and thus is not reported further here.¹

For each symptom cluster (Reexperiencing, Avoidance, and Hyperarousal) as well as overall symptom count (PCL-C composite), we calculated a one-way ANOVA with group as the lone factor (traumatic event only, stressful event only, and both events). ANOVAs for all four symptom severity variables indicated a significant main effect for group as follows: PCL-C composite score, $F(2, 359) = 5.68, p = .004$; Reexperiencing symptoms, $F(2, 359) = 7.63, p < .001$; Avoidance symptoms, $F(2, 359) = 3.14, p = .044$; and Hyperarousal symptoms, $F(2, 359) = 3.85, p = .022$. When the means were compared for each group (using a Games–Howell test for multiple comparisons with unequal sample sizes), the both events group showed significantly greater symptom severity for the Reexperiencing and Hyperarousal clusters of symptoms, as well as total PCL-C scores, than did the stressful life event only group ($ps < .02$). The both events group showed higher values than did the trauma only group, but these results only trended toward significance ($ps = .073-.118$). The stressful life event only group and the traumatic event only group did not differ significantly in their mean scores.

To determine whether these effects were due to the inclusion of those with relatively low levels of PTSD symptomatology, we ran the same one-way ANOVAs for each symptom cluster on individuals who endorsed PCL-C scores greater than 45. A cut score of 45 was chosen because previous research suggests that this score displays adequate sensitivity and specificity in civilian populations exposed to traumatic events (Blanchard, Jones-Alexander, Buckley, & Forneris, 1996). These results are presented in Table 4. None of the main effects were significant in any of the four ANOVAs (PCL-C total score, Reexperiencing, Avoidance, or Hyperarousal), indicating that among those with more severe PTSD symptoms, PCL-C scores did not vary as a function of the type of event that they deemed most stressful or traumatic.

Discussion

Supporting previous findings, results from the present study indicated that traditionally stressful negative life events not included in the A1 criterion of PTSD—such as loss of job, problems with school or work, or change in financial status—may be capable of eliciting symptoms of posttraumatic stress. In addition, the current study attempted to resolve one possible methodological issue from previous studies in which PTSD symptoms were assessed as a function of participants' self-designated "worst event" experienced in their lives. As a result of this procedure, it is possible that although an individual reported that a stressful life

event was the "worst" event that they had experienced, they may have experienced a significant traumatic event in their life that would contribute to the experience of posttraumatic stress. The current study accounted for this potential problem by comparing rates of PTSD symptoms in participants who reported experiencing only a traumatic event, experiencing only a stressful negative life event, and those who reported experiencing both types of events.

Comparisons of these three groups indicated similar levels of posttrauma symptom severity for all three symptom clusters among people who had endorsed the experience of only a traumatic type event and people who had reported the experience of only stressful negative life events. However, participants who reported experiencing both traumatic and stressful life events had higher, albeit nonsignificant, symptoms for all clusters, with the Reexperiencing cluster significantly differing from the stressful events only group. This finding suggests that although both traditional traumatic events and negative life events generally not considered traumatic can cause similar levels of posttraumatic symptomatology, the additive effect of experiencing both types of events within a relatively short period of time may lead to a significantly higher level of symptom severity across most clusters. It should be noted, however, that for the individuals who endorsed both types of events, they could have anchored their posttraumatic stress symptoms to either type of event, a methodological issue that should be addressed in future studies. Additionally, there is a possibility that the increased levels of posttraumatic symptomatology are due to the fact that the individuals in the both events experienced group experienced slightly more stressful life events when compared with the stressful event only group.

While the findings that both traumatic and stressful events are capable of eliciting posttraumatic stress may call for more rigorous study regarding symptoms of posttraumatic stress following these events, it is also important to recognize that outcomes regarding clinically significant distress experienced may be different for the two types of events. Exploration of this possibility is beyond the scope of the current study; however, the finding of Mol and colleagues (2005)—that posttrauma symptoms persist longer among those experiencing traumatic events—suggests that further study of the effects of different types of events is warranted. Our data do, however, suggest that therapists should consider the posttraumatic stress symptom constellation in response to a

¹ It should be noted that we also examined the three event groups at the item level of posttraumatic stress symptoms. These results did not offer any new information beyond those obtained in the symptom cluster analysis.

Table 4
Group Means and Standard Deviations in Posttraumatic Symptomatology: PCL-C Greater Than 45

Group	Total PCL-C (SD)	Reexperiencing (SD)	Avoidance (SD)	Arousal (SD)
Trauma only	50.14 (5.01)	15.33 (2.31)	18.91 (2.61)	15.75 (2.34)
Stress only	50.79 (4.09)	14.56 (3.24)	21.56 (2.87)	14.56 (2.47)
Both events	53.40 (6.42)	16.25 (3.91)	20.71 (3.41)	16.28 (2.70)

Note. PCL-C = Posttraumatic Stress Disorder Checklist—Civilian version. *Stress only* refers to the stressful life event group. The main effect for group was not significant for the analysis of variance for any of the four scales. Traumatic events only $n = 12$; stressful events only $n = 16$; both events $n = 32$.

broader range of negative life events rather than exclusively following traditionally traumatic events. This is not to say that clinicians should necessarily consider diagnosing PTSD arising from these stressful life events, rather that they should be aware that these events may elicit a similar symptom constellation. Traditionally, these individuals would most likely be given a diagnosis of adjustment disorder. Taking into consideration the current study and previous research, it may be worthwhile to examine whether or not treatments effective in treating PTSD could not be easily modified to treat individuals suffering from similar symptoms arising from more common stressful life events that do not meet the A1 criterion for PTSD.

PTSD is one of the only disorders in the *DSM-IV-TR* for which an etiological factor (in this case a precipitating traumatic event) is included in the criteria. It is now evident that a traumatic event consistent with the A1 criterion may not be a necessary etiological factor in eliciting the cascade of symptoms associated with the diagnosis of PTSD. However, we need to be careful in the early interpretation of this research, because some authors argue that broadening the definition of what constitutes a trauma consistent with the A1 criterion of PTSD may cause the “significance of the traumatic experience to diminish” (Gold et al., 2005, p. 695). This caution echoes earlier sentiment in trauma research pertaining to the A1 criterion of PTSD. For example, in a recent critique, Spitzer, First, and Wakefield (2007) called for a tightening of the definition of what constitutes an event that qualifies for the A1 criterion. They argue that the A1 diagnostic criteria should be restricted to an event in which “the person *directly* experienced or witnessed an event or events” (Spitzer et al., 2007, p. 235) rather than merely being confronted with such an event, as is stated in earlier definitions of the criterion. The authors state that this clarification of terminology will serve to assist clinicians and researchers in the area of trauma distinction between PTSD-producing events and other stressors that may produce a similar symptom cluster. Having this distinction more clearly demarcated may assist future research in more fully understanding the etiology of PTSD and how different stressors contribute to the experience of posttraumatic stress and similar symptom constellations.

After reviewing the evolution of the A1 criterion through its various incarnations, Weathers and Keane (2007) offered an alternative perspective. In contrast to Spitzer et al. (2007), they viewed the current A1 criterion of PTSD as an adequate definition of what constitutes a traumatic event capable of eliciting posttraumatic stress. Though they are satisfied with this definition, they argued against studies that have suggested broadening the criteria to include such events as sexual harassment (Avina & O’Donohue, 2002) or extramarital affairs (Dattilio, 2004). Weathers and Keane (2007) argued that a further broadening of the definition of trauma

within current PTSD guidelines would lead to an “excessively broad definition of trauma” (p. 115) and possibly lead to problems with the A1 criterion that were present in *DSM-III* (APA, 1980).

The research and critiques surrounding the A1 criterion highlight the need for further study using more rigorous methods. To date, most of the research in this area, with the exception of the Bodkin et al. (2007) study, relied on self-report methods to assess symptoms of posttraumatic stress. Unfortunately, people may interpret the items on trauma symptom questionnaires in a way that is not consistent with the intent of the clinical criteria. For example, one reexperiencing symptom of PTSD requires that an individual have recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Someone experiencing a negative life event not consistent with the A1 criterion (e.g., failing an important exam) may be ruminating about the event and construe that as fulfilling the reexperiencing requirement when filling out a self-report measure. In addition to the lack of clinical judgment in the form of clinical interviews, research in this area has also failed to examine the extent to which symptoms arising from stressful life events may cause significant distress and functional impairment, important factors to consider when diagnosing psychopathology.

Another limitation of this study was the absence of A2 criterion measurement. The A2 criterion states that an individual must have a subjective emotional response that involves “intense fear, helplessness, or horror” (APA, 2000, p. 467) in order to meet diagnostic criteria for PTSD. Although obtaining a direct measurement of this criterion would be ideal, inferences can be made in its absence. In a recent article, Bedard-Gilligan and Zoellner (2008) found that across three samples (two undergraduate and one community), the A2 criterion lacked specificity in its ability to diagnose PTSD. In other words, the A2 criterion did not predict very well who would develop the disorder by its presence. This finding has also been observed in other studies, suggesting that the A2 criterion does not improve predictive accuracy of diagnosis above and beyond the A1 criterion alone (Kilpatrick et al., 1998; Schnurr, Spiro, Vielhauer, Findler, & Hamblen, 2002).

Additionally, recent research has examined the effect that order of measure presentation has on filling out stressful and traumatic event questionnaires and how it relates to PTSD symptom endorsement (Long, Elhai, Schweinle, Gray, & Frueh, 2008). Participants in the Long et al. (2008) study filled out a stressful life event and traumatic life event screener but were counterbalanced on what order they completed these measures in. After each of these, they completed a posttraumatic symptom measure anchored to their worst event on each measure. Long and colleagues found that those who completed the stressful life events measure and accompanying PTSD symptom measure displayed higher rates of PTSD

and symptomatology in response to non-Criterion A1 events (stressful life events) than they did to Criterion A1-consistent events, suggesting that there may be some sort of priming effect at work when individuals are asked about different types of events. Although we did not anchor PTSD symptom measures to both types of events simultaneously as did this study, its results support the notion that there is a need for more rigorous research in the area of posttraumatic stress symptom constellations in response to a variety of life events.

Thus, research considering a broader range of life events is warranted to better understand the specific aspects of stressful life events that can lead to reexperiencing, avoidance, and hyperarousal symptoms. Future research in this area needs to examine the extent to which these different types of traumatic and stressful events cause clinically significant markers of psychopathology (e.g., symptom constellation, distress, and impairment in functioning). This research would need to address the limitations found within the larger body of previous work. Namely, more methodologically rigorous studies need to replicate these findings with structured clinical interviews and better accounting of events experienced (i.e., chronicity, frequency, and severity). Such research would also more definitively establish whether these traditionally stressful events are indeed capable of causing posttraumatic psychopathology or whether their inclusion in the A1 criterion of PTSD would constitute what has been considered a "bracket creep" (McNally, 2003, p. 231) by artificially expanding this conceptualization of what constitutes trauma. In addition, if the definition of what constitutes a traumatic event is widened, PTSD may "shift from an anxiety disorder resulting from a traumatic experience to more of an adjustment disorder related to difficult life experiences" (Gold et al., 2005, p. 695).

In conclusion, the data from this and other recent studies suggest that a wide variety of life events are capable of eliciting some form of posttraumatic stress. Future research should further examine whether or not symptoms of PTSD are consistent with reactions to a variety of life stressors or whether the definition of what constitutes a "traumatic event" in the mental health field needs to be broadened. The clinical ramifications of this finding are potentially important and serve as a call to assess posttrauma symptoms following a broad range of stressful life events. It is beyond the scope of this study to determine and unclear in the literature as to the extent to which these symptoms of posttraumatic stress arising from traditionally stressful events cause impairment in functioning (interpersonal, occupational/academic, and emotional) to the individuals who experience them. Further research is warranted in this area to illustrate the clinical impact that these stressful negative life events have and how best to treat symptoms of possible differing severities and composition.

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