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## The Relevance of Trauma and Re-experiencing in PTSD, Mood, and Anxiety Disorders

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### ABSTRACT

How traumatic events (TEs) should be defined, and how specific TEs are for Post-traumatic Stress Disorder (PTSD) were examined in a general mental health care population. Three definitions of TEs were defined, according to the PTSD criteria of DSM-IV. Half of the sample reported any TE, with a high prevalence of TEs among non-PTSD disorders. Previous mental health care, female gender, and the likelihood of assigning PTSD were associated with more severe trauma definitions. Reexperiencing symptoms were especially common among mood disorders. The implications for treatment are discussed and an alternative, dimensional definition of trauma has been proposed.

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Traumatic event; traumatic stress; post-traumatic stress disorder; mood disorder; intrusion

## Introduction

The original assumption underlying the formulation of the Post-Traumatic Stress Disorder (PTSD) in DSM-III (APA, 1980) was the central role of exposure to a traumatic event (TE; Criterion A) as the presumptive primary etiological factor. Since TEs are still mandatory for diagnosing PTSD in DSM-5 (APA, 2013), a clear definition of this criterion is crucial to reliably diagnose this disorder, but it is also one of the most challenging and controversial aspects of PTSD (Brewin et al., 2009; Stein et al., 2016). Two major points of dispute about Criterion A are pointed out here.

The first key point of debate is how TEs should be defined. Stressor severity can be placed on a continuum, ranging from daily hassles to severe and/or catastrophic events (Breslau & Kessler, 2001; Liu et al., 2017; Weathers & Keane, 2007). There is general agreement that high-impact events like combat, torture, and sexual violence fall under Criterion A. Controversy rises about the relatively less severe adverse life events, such as

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unexpected death of a family member, marital disruption, employment-related stressors, and about the impact of indirectly experiencing a TE (Frueh et al., 2010).

The DSM-III definition of Criterion A (“The existence of a recognizable stressor that would evoke significant symptoms of distress in almost everyone;” APA, 1980, p. 238) was criticized as being too vague, broad, and subjective (Weathers & Keane, 2007). Therefore, in DSM-IV the criterion was tightened and divided into two sub-criteria (APA, 1994). Criterion A1 (A1) specified the type and nature of the events: the person must have experienced, or was confronted with an event that involved actual or threatened death, serious injury, or physical integrity of self or others; or the person was learning about these events experienced by a family member or other close associate. To stress the impact of the event, Criterion A2 (A2) was added: “the person’s response involved intense fear, helplessness, or horror” (APA, 1994, p. 427).

Regarding A2, several advantages have been described: A2 would strengthen the validity of the definition of a traumatic event and would also play a gatekeeper role in defining traumatic events by distinguishing the so-called real traumatic events from a variety of other less distressing events (Armour et al., 2011). In addition, A2 would be of added value because, as some authors have argued, not only the type of event but also the response to the event is a significant risk factor for psychological distress (Cameron et al., 2010). However, several important points of criticism were made. A conceptual criticism was that A2 is an emotional response and not a defining feature of the event itself. Second, the reliability of A2 was questioned because patients have to tell in retrospect about their feelings during the traumatic event (O’Donnell et al., 2010). Third, the lack of predictive utility of A2 in diagnosing PTSD was depicted (Friedman et al., 2011). Last, findings indicated that some populations, such as military or police officers trained not to feel emotions or victims of sexual abuse who dissociated during the TE, reported no emotional response (Adler et al., 2008; Friedman, 2013), or reported symptoms not belonging to A2, such as worrying or physical symptoms (O’Donnell et al., 2010). In DSM-5, A2 was abolished while the definition of the events in Criterion A was newly defined, namely “exposure to actual or threatened death, serious injury, or sexual violence” in ways like for instance, “directly experiencing the traumatic event(s)” or “witnessing, in person, the event(s) as it occurred to others” (APA, 2013, p. 271).

A second key point in the debate about criterion A concerned the unclear relationship between TEs and PTSD. In short, only a minority of people who experienced TEs have been found to develop PTSD (Knipscheer et al., 2020; Liu et al., 2017) while people may even develop

PTSD symptoms without experiencing an event that meets the definition of Criterion A (Bodkin et al., 2007; Gold et al., 2005; Long et al., 2008; Robinson & Larson, 2010). Furthermore, there is evidence that not only PTSD but also a range of other mental disorders are associated with TEs (Kuzminskaite et al., 2022; Laugharne et al., 2010).

Defining Criterion A is of importance because it has serious implications for diagnosing PTSD (as defined in the DSM) as well as the identification of (alleged) trauma victims, allocation of resources for them, indication of specific treatment approaches, and trauma-related research (Long et al., 2008).

The current study was designed to address the described issues about the trauma criterion. Since the definition of the stressor criterion according to DSM-IV consists of two steps, namely Criteria A1 and A2, the use of this definition, in particular, had an important advantage in studying the influence of the trauma definition on prevalence and possible mental consequences. Whereas most studies investigating the trauma criterion were performed in general community samples or in samples of traumatized patients, this study was conducted in a heterogeneous sample of treatment-seeking general outpatients with mental health complaints. This has the advantage of investigating TEs in a broader spectrum of psychopathology and in a population of patients most mental health clinicians encounter in daily practice.

The first objective was to investigate the impact of how the traumatic stressor criterion is defined by establishing the prevalence of TEs in our sample according to three definitions. For this purpose, the diagnostic process described by Weathers and Keane (2007, p. 116) was followed: “The diagnostic criteria for PTSD consist of a series of accumulating requirements that create an increasingly specific diagnostic rule for the diagnosis.” They stated that PTSD according to DSM-IV is defined by a broad Criterion A1, a constraining Criterion A2, and then the other PTSD Criteria B-F. The definitions of the TEs used in this study are largely consistent with this reasoning, but in the third of our three definitions, only Criterion B (reexperiencing symptoms) was included, because reexperiencing is often seen as a very recognizable and disabling trauma-related PTSD symptom. Accordingly, in this study, a traumatic stressor was defined in the following ways: TEs as described in Criterion A1 (named here: *TE-A1*), events having a mental impact during or shortly after the event as described in Criterion A2 (full Criterion A, named: *TE-A*), and finally events that continued to have an impact long after the event, operationalized by the presence of re-experiences as described in Criterion B (full Criteria A plus B, named: *TE-AB*).

Due to the assumed gatekeeper role of A2, *TE-A1* would be expected to have a higher prevalence than *TE-A* and because not everyone develops

post-traumatic symptoms after TEs, TE-AB would have the lowest prevalence. In addition, we explored if people who experienced TE-A1, TE-A, or TE-AB differed in terms of sociodemographic variables (i.e., gender, marital status, and previous mental health care usage). Since experiencing a traumatic event is associated with impaired socioeconomic functioning (e.g., Mock & Arai, 2010), we hypothesized that, first, patients with higher use of previous mental health services and second, with life without a partner reported more high impact TEs. Furthermore, we hypothesized that female patients reported more high-impact TEs than male patients (Olf, 2017).

The next objective was to investigate the relationship between the TE definitions and mental disorders to examine the specificity of the TEs for the disorders in question. As TEs and reexperiencing symptoms are common in mood and to a lesser extent in anxiety disorders (Bryant et al., 2011; Payne et al., 2019), it was hypothesized that TE-ABs (TEs and reexperiencing symptoms) were most common in PTSD and next, more common in mood disorders than in anxiety disorders.

## Method

### *Participants and procedure*

Participants were all newly referred patients ( $N=422$ ) during a 10 months period who were admitted to a mental health outpatient clinic, part of a large general hospital in the Netherlands.<sup>1</sup> This general outpatient clinic was only accessible to patients between 18 and 65 years of age, mainly with a wide range of anxiety and mood disorders. Patients with chronic severe mental illness (SMI) like psychosis were referred elsewhere.

The study has a naturalistic design and, as such, cohered closely with clinical practice. A short, standardized structured interview, the Three Step Trauma Interview (TSTI), designed by the first two authors, was administered to specify the trauma criterion according to the three categories TE-A1, TE-A, and TE-AB (Figure 1). Additional assessments were based on the clinical judgment of two experienced clinicians: all patients were assessed and interviewed by a clinical psychologist and a psychiatrist and, then, diagnostic conclusions were discussed. Together, they came to a diagnostic classification according to DSM-IV.

Data were archived anonymously. Patients were informed about the storage of the anonymized assessment data. Because assessments did not put a burden on patients, were part of the regular intake assessment, and were archived anonymously, no review of the ethical merits of this study was needed.

**Question 1.**

Have you ever, at any time in your life, experienced, witnessed, or were you confronted with such a traumatic event that involved actual or threatened death or serious injury, or a threat to the physical integrity of yourself or others?

Ⓢ YES:      *go to Q2*

Ⓢ NO       $\longrightarrow$       stop. *Fulfilling no TE Category*

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**Question 2.**

Did the response to these experiences during or directly after the traumatic event involved one or more of these reactions:

# intense fear or # feelings of helplessness or # feelings of horror

Ⓢ YES:      *go to Q3*

Ⓢ NO       $\longrightarrow$       stop. *Fulfilling TE-A1*

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**Question 3.**

Did you re-experience the event(s) in the last month in a disturbing manner? For instance in dreams / nightmares, flashbacks, intense remembering, or physical reactions

Ⓢ YES       $\longrightarrow$       *Fulfilling TE-AB*

Ⓢ NO       $\longrightarrow$       *Fulfilling TE-A*

**Figure 1.** The Three Step Trauma Interview (TSTI).

## Measures

Besides the routine intake assessment, the prevalence of TEs according to three different definitions was registered by means of the TSTI (Figure 1). As mentioned, the TSTI is based on the diagnostic process described by Weathers and Keane (2007). Defining the TEs in these three steps was a way of assessing the impact of the traumatic event.

Before starting the TSTI, the interviewer explained the definition of a TE according to the description in the SCID Axis I diagnostic assessment in the following way: “Sometimes things happen to people that are extremely upsetting; things like being in a life-threatening situation, a major disaster, very serious accident of fire, being physically assaulted or raped, seeing another person killed or dead, or badly hurt, or hearing about something horrible that has happened to someone you are close to. We call this traumatic events” (Peirce et al., 2009, p. 4). Then, the interviewer followed the TSTI. In the first step, patients were asked about A1 (*lifetime*) according to the DSM-IV. Then, as a second step, patients were asked for the distress reactions according to Criterion A2 of DSM-IV, namely intense fear, feelings of helplessness, or feelings of horror during or shortly after the event.

In the third step, patients were asked about reexperiencing symptoms according to Criterion B of DSM-IV (*within the last month*).

Other information was obtained through careful clinical examination by the same two assessors (see Participants and procedure). All axis I DSM-IV diagnoses were recorded (*last month*). The interviewers also registered age, gender, marital status, and the use of previous mental health care services.

### Statistical analysis

The results of the TSI, sociodemographics, and all DSM-IV axis I diagnoses were recorded. Patients were categorized based on their principal disorders. Because many disorders were too rare, only the participants with anxiety and mood disorders were included and grouped according to the following clusters: all unipolar depressive disorders including dysthymia were called Unipolar Mood Disorders (UMD); patients with comorbid PTSD were excluded. Those with any anxiety disorder excluding PTSD were called Anxiety Disorders (AnxD). PTSD was defined as a separate group.

To test all hypotheses, Pearson Chi-Square tests were used ( $\alpha$  level  $<0.05$ ). IBM SPSS for Windows 27 was used to perform the statistical analyses.

## Results

### Prevalence of traumatic event types

Four hundred and twenty-two patients referred to the clinic were included. 60% were female and 40% male. The mean age was 36.7 years ( $SD = 12.3$ ). Half of the patients reported one or more TEs (Table 1).

The first hypothesis was that TE-A1 had a higher prevalence than TE-A, and TE-AB had the lowest prevalence. Indeed, as shown in Table 1 (middle column), half of all patients in the sample reported any TE, 28.9% reported only a TE according to Criterion A1, 21.2% reported a TE with A1 plus A2 during their lifetime, and 11.3% reported A1, A2, plus B. Of the 21.1% of patients reporting an A1 plus A2, 9.9% reported *only* A1 plus A2, and 11.3% reported also reexperiencing symptoms (Criterion B). In the

**Table 1.** Prevalence of reported trauma definitions according to the TSTI.

	In total sample (%/N) (N = 415)	In sample with any TE (N/%) (N = 208)
No traumatic event	49.9% (207)	—
Any traumatic event	50.1% (208)	100% (208)
Patients with only A1	28.9% (120)	57.7% (120)
Patients with A1 plus A2	21.2% (88)	42.3% (88)
Of these: with <i>only</i> A1 + A2	9.9% (41)	19.7% (41)
Of these: with A1, A2, <i>plus</i> B	11.3% (47)	22.6% (47)

TSTI: Three Step Trauma Interview; TE: Traumatic Event; A1: TE according to PTSD Criterion A1; A2: according to Criterion A2; B: according to Criterion B. All according to DSM-IV.

**Table 2.** Sociodemographic variables and impact of TE definition.

	No TE	TE-A1	TE-A	TE-AB
Gender ( <i>N</i> = 414)				
Male: 166 (40%)	102 (61.4%)	39 (23.5%)	11 (6.6%)	14 (8.4%)
Female: 248 (60%)	104 (41.9%)	81 (32.7%)	30 (12.1%)	33 (13.3%)
Marital status ( <i>N</i> = 404)				
Married: 133 (32.9%)	74 (55.6%)	32 (24.1%)	11 (8.3%)	16 (12%)
Never married: 204 (50.5%)	105 (51.4%)	61 (29.9%)	20 (9.8%)	18 (8.8%)
Divorced: 59 (14.6%)	22 (37.3%)	20 (33.9%)	8 (13.68%)	9 (15.2%)
Widowed: 8 (2%)	2 (25%)	4 (50%)	2 (25%)	0
Previous mental health care ( <i>N</i> = 404)				
No: 275 (68%)	147 (53.5%)	82 (29.8%)	24 (8.7%)	22 (8%)
Yes: 129 (31.9%)	56 (43.4%)	35 (27.1%)	16 (12.4%)	22 (17%)

TE: traumatic event; TE-A1: TE according to PTSD Criterion A1; TE-A: Criteria A1 + A2; TE-AB: Criteria A1 + A2 + B. All according to DSM-IV.

subsample of patients who reported any traumatic event (third column, Table 1), 43.3% reported the full Criterion A (A1 plus A2), and 22.6% reported re-experiencing symptoms in the past month.

### **Sociodemographics and TEs**

When looking at the association with sociodemographic factors, a chi-square analysis revealed significant differences regarding previous health care consumption: patients reporting more severe defined TE categories were more likely to have had previous mental health care,  $\chi^2$  (3, *n* = 404) = 9.79, *p* < .05. No significant difference was found between the TE definitions concerning marital status. Consistent with our third socio-demographic hypothesis, female patients reported more TEs and significantly more severe TEs compared to male patients,  $\chi^2$  (3, *n* = 414) = 15.58, *p* < .001 (Table 2).

### **PTSD, mood and anxiety disorders, and TEs**

In the total sample, 25 patients (6%) were assessed by the clinicians as having PTSD. The frequency of PTSD was 12% (*N* = 25) in the sample of patients who reported any traumatic event (*N* = 208), regardless of the TE definition. In patients who reported a TE-AB, the PTSD rate was 31.9% (15 out of 47). The likelihood of assigning PTSD increased from TE-A1 to TE-A. As expected, a diagnosis of PTSD was highly associated with TE-AB,  $\chi^2$  (3, *n* = 414) = 67.76, *p* < .001 (Table 3).

Of all patients with a principal diagnosis of unipolar mood disorder (UMD) (without PTSD), 47.4% reported any TE, regardless of the TE definition. Moreover, 13.1% (18 out of 137) of UMD patients reported a TE with reexperiencing symptoms (TE-AB) without being diagnosed with PTSD. When looking at UMD patients (without PTSD) who reported any



**Table 3.** Impact of TE definition and PTSD.

		No PTSD	PTSD	Total
TE definition	No TE	206	1	207
	TE-A1	111	8	119
	TE-A	40	1	41
	TE-AB	32	15	47
Total		389	25	414

TE: traumatic event; A1: according to PTSD Criterion A1; A: Criteria A1 and A2; AB: Criteria A1, A2, and B; PTSD: post-traumatic stress disorder. All according to DSM-IV.

**Table 4.** Patients with unipolar mood disorders, anxiety disorders, and PTSD and impact of TE definition.

	No TE	TE-A1	TE-A	TE-AB
UMD ( <i>N</i> = 137)	72 (52.6%)	36 (26.3%)	11 (8%)	18 (13.1%)
AnxD ( <i>N</i> = 68)	36 (52.9%)	16 (23.5%)	12 (17.6%)	4 (5.9%)
PTSD ( <i>N</i> = 25)	1 (4%)	8 (32%)	1 (4%)	15 (60%)
Total ( <i>N</i> = 230)	109	60	24	37

TE: traumatic event; TE-A1: fulfilling PTSD Criterion A1; TE-A: Criteria A1 + A2; TE-AB: Criteria A1 + A2 + B; UMD: unipolar mood disorders without PTSD; AnxD: anxiety disorders without PTSD; PTSD: post-traumatic stress disorder. All according to DSM-IV.

**Table 5.** UMD and AnxD subsamples and impact of TE definition.

	No TE	TE-A1	TE-A	TE-AB	Total
No UMD	135 (48.7%)	83 (30%)	30 (10.8%)	29 (10.5%)	277
Yes UMD	72 (52.5%)	36 (26.3%)	11 (8%)	18 (13.1%)	137
Total	207	119	41	47	414
No AnxD	171 (49.3%)	104 (30%)	29 (8.4%)	43 (12.4%)	347
Yes AnxD	36 (52.9%)	16 (23.5%)	12 (17.6%)	4 (5.9%)	68
Total	207	120	41	47	415

TE: traumatic event; TE-A1: fulfilling PTSD Criterion A1; TE-A: Criteria A1 + A2; TE-AB: Criteria A1 + A2 + B; UMD: unipolar mood disorders without PTSD; AnxD: anxiety disorders without PTSD. All according to DSM-IV.

TE, 27.7% (18 out of 65) reported reexperiencing symptoms. In patients with a primary diagnosis of any anxiety disorder without PTSD (AnxD; *N* = 68), the prevalence of any TE, regardless of the TE definition, was comparable to that of UMD (47.1%), but the rate for reporting reexperiencing symptoms was relatively low compared to UMD patients: 5.9% (Table 4).

Chi-square tests revealed that there were no significant differences within groups in TEs for UMD,  $\chi^2 (3, n = 414) = 2.002, p = .572$  and AnxD,  $\chi^2 (3, n = 415) = 2.414, p = .415$  (Table 5). This means that there were no differences between UMD and non-UMD patients regarding the prevalence of the differently defined TEs. The same was found for AnxD patients. However, between the groups UMD, AnxD, and PTSD there was a significant association between the severity of TEs and diagnosis. Patients with PTSD reported the most TE-AB, followed by UMD and lastly AnxD,  $\chi^2 (9, n = 226) = 56.944, p < .001$  (Table 4).

## Discussion

### *Type and impact of trauma, reexperiencing, and PTSD*

To determine the relevance of the definition of a traumatic event (TE), we examined in a sample of 422 patients referred to a general mental health care outpatient clinic, the prevalence of traumatic events (TEs) according to three definitions (characterized by Criterion A1 (TE-A1), A1 plus A2 (TE-A), and A1, A2, and B (TE-AB) according to the PTSD definition in DSM-IV), and the relationship between these TEs and the classifications PTSD, unipolar mood disorders, and anxiety disorders.

The prevalence of a lifetime Criterion A1 traumatic event in the sample was 50.1%. In community samples, lifetime prevalence rates of TEs in European countries vary with percentages of 41–44% (Knipscheer et al., 2020; Lukaschek et al., 2013), up to even 80% (De Vries & Olff, 2009). Since our sample is a patient sample, 50.1% seems relatively low. In general, differences in sampling methods, measures, definitions of TE, and sociodemographic variables may lead to different outcomes. In our study, we applied a single-question assessment for traumatic events. Whereas this way of assessing TEs is believed to be a useful way of screening in clinical practice (Elhai et al., 2008), it generally yields lower prevalence rates compared to multiple-item assessments (Peirce et al., 2009). Moreover, the study population was generally not very severely mentally ill, with only 31% of the population having received psychiatric treatment before admission, while patients with SMI were excluded.

Of all patients who reported an A1 TE during their lifetime ( $N=208$ ), 42.3% ( $N=88$ ) also reported events that met the definition of the whole trauma criterion according to DSM-IV (A1 plus A2). This means that A2 indeed played a gatekeeping role in that it narrowed the definition of what constitutes a TE. This finding is in line with previous studies (e.g., Armour et al., 2011) and provides further evidence that the way the stressor criterion is defined has implications for diagnosing PTSD.

In addition, patients who received prior mental health care reported significantly more severely defined TE categories compared to patients that did not have had mental health care before. This supports the assertion that A1 together with A2 has a greater impact on mental health compared to patients who reported only an A1 traumatic event.

The clinician-rated PTSD prevalence in the total sample was 6%. PTSD prevalence rates in community samples vary, with average rates in large samples of 3.5–4% (Knipscheer et al., 2020; Liu et al., 2017). However, despite the fact that the PTSD rate in this study is higher than the figures from community samples, 6% for a patient sample is relatively low. An

explanation could be that most studies examined patients with severe, chronic mental illness (Cusack et al., 2004; Mauritz et al., 2013), whereas in our study the population suffered from less chronic forms of mental disorders.

The likelihood of assigning PTSD increased from TE-A1 to TE-A. This is in line with a previous study (O'Donnell et al., 2010). These findings again suggest that, more broadly, defining what exactly constitutes a traumatic event affects the prevalence of PTSD.

An interesting finding is that of the clinician-diagnosed patients with PTSD, 32% ( $N=8$ ) did not meet Criterion A2 according to the TSTI (Table 3). It is possible that the clinicians considered Criterion A1 and PTSD symptoms to be of greater value here than A2.

Nowadays, the way of defining the stressor criterion of PTSD is still in a debate: the definitions of the stressor criterion by DSM-5 and ICD-11 are very different. In the DSM-5, the trauma criterion has been redefined strictly (APA, 2013), while in the ICD-11 it is more loosely defined and represented as “exposure to a threatening or horrific event or series of events” (WHO, 2018).

Another way of defining TEs will probably help in the search for a more meaningful definition of trauma. This calls for a different, more substantive view of the trauma criterion. First, a look from a quantitative point of view will be necessary, as there is a continuum in the severity of traumatic stressors (Liu et al., 2017). Second, TEs as such do not always have the same impact on each individual. For this reason, A2 was defined in the DSM-IV. However, A2 is not the best way to define the impact of an event on the individual, as described before. Different qualitative properties of both the event and the individual's response to the event play a role in the experience of the event, such as degree of negativity, suddenness, perceived life threat, and lack of control (Cameron et al., 2010; Carlson & Dalenberg, 2000).

### ***Trauma and reexperiencing symptoms in mood and anxiety disorders***

In this study, we had the advantage of examining a broader spectrum of psychopathology compared to community samples or samples of traumatized patients and found that TEs were common in patients with mental disorders other than PTSD.

There was a high prevalence of A1 TEs in patients diagnosed with unipolar mood disorders (UMD) (47.4%) and anxiety disorders (AnxD) (47.1%) without PTSD while 26.3 and 23.5%, respectively, reported the full Criterion A (A1 plus A2). A notable finding in this study was that 13.1% of UMD patients without PTSD reported re-experiencing symptoms in the

past month, while this was the case in 5.9% of patients with AnxD. This is an important finding which is consistent with other studies: reexperiencing symptoms, essential to PTSD, can also be a hallmark of other mental disorders, in particular, UMD without PTSD (Birrer et al., 2007; Bryant et al., 2011; Payne et al., 2019). Diagnostic confusion may easily arise because the perceived characteristics of the intrusions along with the distress they cause are broadly similar between PTSD and UMD although they show some phenomenological differences: PTSD intrusions typically have a more sensory and here-and-now quality compared to UMD intrusions (Birrer et al., 2007; Bryant et al., 2011).

### ***Clinical implications***

In this study, it was found that the way the stressor criterion is defined is important in relation to its psychological consequences. Furthermore, the prevalence of reexperiencing symptoms among patients with traumatic experiences without a PTSD classification was relatively high. This gives debate on the way the traumatic stress criterion should be defined and on the specificity of the reexperiencing symptoms that are generally considered to belong to PTSD.

First, the present study adds meaningful information to the extensive literature discussing the role of defining the stressor criterion of PTSD. One way to deal with this definition problem would be to let go of the strict definition of Criterion A like is the case in the ICD-11 (WHO, 2018). This could make sense because even mild stressors can lead to PTSD symptoms or even PTSD. Also, the diagnosis of PTSD is thus straightened out with most other DSM diagnoses that do not have causative criteria. Moreover, this approach would mean that clinicians will be less focused on PTSD as the sole trauma-related disorder and more aware of other psychological disorders associated with trauma as described in this study. Nevertheless, an unlimited extension of the trauma definition will also have several negative consequences. The rationale for PTSD as originally conceived in the DSM-III (APA, 1980), namely a set of symptoms after “a catastrophic stressor beyond the reach of usual human experience” would cease to exist (Rosen & Lilienfeld, 2008). This would mean that PTSD would totally fall back on the defined set of symptom criteria, likely blurring the clear line between PTSD symptoms and symptoms of other disorders. After all, many PTSD symptoms are part of the criteria for other mental disorders (Spitzer et al., 2007).

TEs during the lifetime often have a profound, disruptive impact on patients' lives. Therefore, a better understanding of defining TEs and investigating its effects on PTSD and certainly other mental disorders is

warranted. As some authors have argued, there is a need for a more flexible definition of trauma from a clinical perspective, especially since the course of PTSD and other psychological complaints can differ according to the severity and variability of the events (Cameron et al., 2010). Therefore, we propose to define TEs in a clear, but above all more substantive, flexible and personalized way. In other words: TEs should be defined both on a quantitative and a qualitative scale. A more explicitly defined quantitative scale should reflect the stressor dose with the characteristics “degree of severity,” “duration,” and “number and/or variety of events.” In addition to the stressor dose, a qualitative scale should include specific characteristics that determine the impact of TEs namely “extreme powerlessness or lack of control,” “highly negative experience,” “suddenness of the experience” (Carlson & Dalenberg, 2000; Kleber & Brom, 2003), and “perceived life threat” (Berna et al., 2012). All these features can be brought together in a dimensional model of the stressor criterion.

Second, the findings that reexperiencing symptoms are common in mood and anxiety disorders have important consequences in clinical practice: these often prominent symptoms may erroneously lead to the diagnosis of PTSD, while the diagnosis of UMD should be made. They may lead to specific PTSD treatment options in UMD patients without PTSD (Laugharne et al., 2010). This would not be a problem if PTSD and UMD with traumatic reexperiencing both represent the same underlying condition, e.g. due to an inaccuracy in our classification. Indeed, several authors have suggested that PTSD and depression stem from similar predictive variables and a shared vulnerability, and argued that these disorders should not be considered as entirely distinct conditions (O’Donnell et al., 2004; Stander et al., 2014). Others argue that trauma-related depression is a distinct subtype within the group of mood disorders (Harald & Gordon, 2012). In this case, other treatment options may be needed. Further research is important because, despite the high number of reexperiencing symptoms in non-PTSD diagnoses, there are as yet no clear treatment guidelines for these conditions (Flory & Yehuda, 2015).

### ***Strengths and limitations***

Several limitations apply to the present study. Firstly, for DSM-IV axis I classifications no use was made of validated diagnostic instruments. Instead, the clinical judgment of two experienced clinicians was used. Secondly, interrater reliability in the use of the TSTI was not evaluated. Thirdly, the TSTI only used a single-item survey for TEs. This fits well in clinical practice but a drawback may be an underreporting of the prevalence of TEs compared to multi-item checklists. Fourthly, in our sample of

psychiatric outpatients patients with severe mental illness were excluded, and thus generalizability to all psychiatric patients is not clear. The strengths of the study are the large sample which consisted of a heterogeneous group of psychiatric outpatients who were referred to a mental health clinic that was not specifically specialized in psychotrauma. The sample, therefore, showed a broad range of psychopathology that closely resembles the patients most mental health clinicians encounter in their daily practice.

### **Conclusion**

The definition of a traumatic event is of considerable importance, for example for identifying (alleged) trauma victims in specific populations, for diagnosing possible PTSD, for treatment options, and for research. Especially for clinicians, a new and flexible, personalized way to define the traumatic stressor criterion will provide a way to weigh the impact of the TE on the specific patient and give it a more meaningful character. It will allow both clinicians and patients to identify the important differences between the wide variety of traumatic experiences people have endured. A one size fits all definition of trauma will not do justice to the individual patient, and the impact it has on his or her life, both in terms of psychopathology and interpersonal and social functioning. In addition, the fact that reexperiencing symptoms are relatively common in mood disorders means that clinicians should be aware that these symptoms should not automatically lead to a PTSD diagnosis. In these cases, correct recognition, but above all adapted treatment programs are needed.

### **Note**

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### **Disclosure statement**

No potential conflict of interest was reported by the author(s).

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### Data availability statement

The data that support the findings of this study are available from the corresponding author, (RJ), upon reasonable request.

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