Psicothema
ISSN: 0214-9915
psicothema@cop.es
Universidad de Oviedo
España

Crespo, María; Mar Gómez, M.
Diagnostic concordance of DSM-IV and DSM-5 Posttraumatic Stress Disorder (PTSD) in a clinical sample
Psicothema, vol. 28, núm. 2, 2016, pp. 161-166
Universidad de Oviedo
Oviedo, España

Available in: http://www.redalyc.org/articulo.oa?id=72745361009

Psicothema

Psicothema 2016, Vol. 28, No. 2, 161-166
doi: 10.7334/psicothema2015.213

ISSN 0214 - 9915 CODEN PSOTEG

www.psicothema.com

Diagnostic concordance of DSM-IV and DSM-5 Posttraumatic Stress Disorder (PTSD) in a clinical sample

María Crespo and M. Mar Gómez
Universidad Complutense de Madrid

Abstract

Background: The present study aims to analyze diagnostic concordance between the DSM-IV and the DSM-5 for posttraumatic stress disorder (PTSD) diagnostic criteria and their different groups of symptoms. Furthermore, analyses are conducted to establish the features of participants with no concordant diagnoses. **Method:** The study assessed 166 people over 18 who had experienced at least one traumatic event. PTSD diagnosis was established using the Global Scale for Posttraumatic Stress (EGEP), a self-report measure to assess PTSD. **Results:** The presence of cognitive avoidance was a determinant in the PTSD DSM-5 diagnosis (86% positive predictive value). The analysis of the non-concordant individuals revealed that individuals who were diagnosed according to the DSM-IV criteria but not the DSM-5 criteria were primarily indirect victims. Conversely, individuals who were diagnosed with the DSM-5 criteria and not with the DSM-IV criteria presented cognitive avoidance and alterations in cognition not included in the DSM-IV criteria. **Conclusions:** A within-subjects concordance analysis showed high agreement for PTSD diagnosis between the two classifications. Differences between the diagnoses are due to the new definition of C (avoidance) and D (negative alterations in cognitions and mood) in the DSM-5.

Keywords: PTSD, posttraumatic stress, DSM-IV, DSM-5, diagnostic concordance.

Resumen

Concordancia diagnóstica entre DSM-IV y DSM-5 para el Trastorno de Estrés Postraumático (TEPT) en una muestra clínica. **Antecedentes:** el presente estudio tiene como objetivo analizar la concordancia diagnóstica entre la clasificación DSM-IV y DSM-5 para el Trastorno de Estrés Postraumático (TEPT), en relación al diagnóstico y a la presencia de los diferentes grupos de síntomas. Además, se analizan las características de los participantes que no obtienen concordancia diagnóstica entre las dos clasificaciones. **Método:** 166 participantes, mayores de 18 años, fueron evaluados utilizando la Escala Global de Estrés Postraumático (EGEP), instrumento autoaplicado para evaluar la presencia de sintomatología postraumática y diagnóstico de TEPT. **Resultados:** el análisis de la no concordancia entre los diagnósticos reveló que los participantes diagnosticados de TEPT, según DSM-IV pero no diagnosticados según DSM-5, eran principalmente víctimas indirectas, mientras que los participantes diagnosticados de TEPT según DSM-5 pero no según DSM-IV presentaban síntomas de evitación cognitiva y alteraciones en cognición y ánimo, ambos síntomas no recogidos en la clasificación DSM-IV. **Conclusiones:** existe una alta concordancia entre las clasificaciones para el diagnóstico de TEPT. Las diferencias en el diagnóstico son debidas fundamentalmente a la nueva conceptualización de criterio C (evitación) y del criterio D (alteraciones negativas cognitivas y del estado del ánimo) en el DSM-5.

Palabras clave: TEPT, estrés postraumático, DSM-IV, DSM-5, concordancia diagnóstica.

The psychological reactions resulting from traumatic exposure were included in the *Diagnostic and Statistical Manual of Mental Disorders* ([DSM] American Psychiatric Association [APA], 1952) for the first time under the name of "Stress Response Syndrome". However, the inclusion of Post-Traumatic Stress Disorder (PTSD) as such, was only included for the first time in the third edition of DMS (APA, 1980), within the "Anxiety Disorders" section. It was defined as a condition caused by exposure to recognizable stress, which could cause significant symptoms of distress in almost everyone. Since its first inclusion in diagnostic classifications, criteria for PTSD have been controversial for the scientific community. This has led to a proliferation of studies that attempt to improve both the concept of traumatic event, as well as a clinical structure of its symptoms (Breslau & Kessler, 2001; Kessler, Chiu, Demler, Merikangas, & Walters, 2005; Owashi & Perkonigg, 2008). Based on these data, different editions of the DSM have introduced changes both in the diagnostic criteria and in the consideration of the traumatic event that causes this disorder.

Nonetheless, these 30 years of research have not ended the controversy about the syndrome manifestations. In relation to the publication of the DSM-5 (APA, 2013), several studies have focused on analyzing: (a) the suitability of the PTSD classification within anxiety disorder (Friedman et al., 2011a, 2011b; Resick &

Received: August 4, 2015 • Accepted: February 5, 2016
Corresponding author: María Crespo
Facultad de Psicología
Universidad Complutense de Madrid
28223 Madrid (Spain)
e-mail: mcrespo@psi.ucm.es

Miller, 2009); (b) PTSD's current structure (Asmundson et al., 2000; Yufik & Simms, 2010); (c) the A1 (event) and A2 (response) criteria (Brewin, Andrews, & Rose, 2000; Brewin, Lanius, Novac, Schnyder, & Galea, 2009; Kilpatrick, Resnick, & Acierno, 2009; McNally, 2009; Wittchen, Gloster, Beesdo, Schönfeld, & Perkonigg, 2009); (d) symptom clusters (Forbes et al., 2011; Wilson, Droždek, & Turkovic, 2006); and (e) duration and subtypes (Andrews, Brewin, Stewart, Philpott, & Hejdenberg, 2009).

Friedman et al. (2011a) exhaustively reviewed such studies. Their proposals were considered in the DSM-5 (American Psychiatric Association, 2013) and specifically included the following modifications of the DSM-IV: (1) reformulation of the A1 Criterion and the elimination of the A2 Criterion (*response to the event*); (2) four distinct symptom clusters rather than the three-cluster structure found in the DSM-IV; and (3) the inclusion of other symptoms often associated with exposure to a traumatic event, such as negative alterations in cognition or reckless and self-destructive behavior. Consequently, the PTSD diagnosis is based on 20 symptoms (previously 17) structured in four clusters: re-experiencing, avoidance, negative alterations in cognition and mood, and arousal. Thus, DSM-IV Criterion C (avoidance and numbing) is divided into two clusters referred to as *avoidance behavior* (Criterion C) and *negative alterations in cognitions and mood* (Criterion D). Additionally, some of the symptoms were reformulated, or their wording was changed (e.g., B1).

To date, a few studies have analyzed how these changes will affect PTSD diagnosis. Elhai et al. (2012) assessed a convenience sample of college students who completed a web survey that included a modified form of the PTSD Symptom Scale (PSS-SR; Foa, Riggs, Dancu, & Rothbaum, 1993). These authors found that PTSD prevalence was higher, but not significantly, when they applied the DSM-5 than when they applied the DSM-IV criteria. Conversely, Calhoun et al. (2012), using a nonprobability sample of 185 volunteers recruited from an academic medical center and a Veterans Affairs medical center and applying the Clinical Administered PTSD Scale (CAPS; Blake et al., 1995), predicted that DSM-5 prevalence would be substantially higher than DSM-IV prevalence. However, these studies do not permit generalization to adults in the general population. Moreover, they do not consider the reasons for change in the PTSD diagnosis between the two classifications. Consequently, Kilpatrick et al. (2013) compared the prevalence of PTSD according to the DSM-IV and the DSM-5 in a national sample of U.S. adults (n = 2,953) recruited from an online panel. PTSD was measured through a self-administered, highly structured survey completed online. Contrary to Calhoun et al.'s (2012) prediction, they found that the changes made in the DSM-5 did not result in increased PTSD prevalence.

In this vein, the present study aims to analyze the diagnostic concordance between the DSM-IV and the DSM-5 in PTSD diagnosis in a clinical sample of victims of traumatic events entering treatment. Unlike Kilpatrick et al.'s (2013) study, the present study focuses on a directly recruited and assessed clinical sample. Notably, this study analyzes the reasons for the differences in meeting the PTSD criteria as defined in the two classifications. Additionally, analyses will be conducted to establish the features of participants who meet the DSM-IV criteria but not DSM-5 criteria and, conversely, the features of no-PTSD DSM-IV individuals who meet the DSM-5 criteria. Based on data from previous studies and on the changes made between the classifications, we propose the following hypothesis: (1) the changes between classifications are minor, diagnostic concordance will be high; and (2) the greatest changes are in the former avoidance and numbing criteria, diagnostic discrepancies will be driven by avoidance symptoms and negative alterations in cognition; specifically, individuals who meet the DSM-IV but not DSM-5 criteria will fail to have at least one active-avoidance symptom, whereas individuals who meet the DSM5 but not the DSM-IV criteria will show more cognition and mood alterations. All in all, the results will show the future tendency of PTSD diagnosis and will help in the understanding of its clinical implications.

Method

Participants

Participants were recruited from several trauma services; they were trauma victims who were entering treatment and volunteered to take part in the study. The inclusion criteria for the study were as follows: (a) the participant was exposed to a traumatic event (the participant directly experienced the event, witnessed it, or learned that it had occurred to someone he/she loved); (b) the event occurred at least 1 month before the assessment; (c) the participant was aged 18 years or older; and (d) the participant had mastery of Spanish (both oral and written). The exclusion criteria were that the participant had (a) current psychosis, (b) cognitive impairment, or (c) substance intoxication at the time of assessment. Participants had to provide written consent to participate in the study.

Initially, 175 trauma victims were recruited. Because 9 did not complete the assessment, the final sample consisted of 166 participants (response rate 94.86%).

Instruments

Posttraumatic symptoms were assessed by the Global Scale for Posttraumatic Stress ([Escala Global de Estrés Postraumático – EGEP]; Crespo & Gómez, 2012a). The EGEP was designed as a self-report measure in Spanish that aimed to assess posttraumatic symptoms following DSM-IV criteria and to provide both a PTSD diagnosis and symptom severity scores. In addition, it targets other posttraumatic symptoms that are not included in the criteria—self-blame, mistrust, feelings of danger, detachment, depersonalization, and decreased self-value. These other symptoms would allow for the classification of the subjects according to the DSM-5 criteria. According to PTSD features, the EGEP consisted of three sections:

(1) *Events:* It includes a checklist of 11 traumatic events plus an additional open category. Individuals are asked to indicate how many of these events they have directly experienced, witnessed, or learned had occurred to a close relative or friend in their lives. This section provides information about Criterion A for PTSD DSM-IV diagnosis.
(2) *Symptoms* (28 items) include the 17 DSM-IV PTSD symptoms (i.e., 5 for re-experiencing—Criterion B, 7 for avoidance and numbing—Criterion C, and 5 for arousal—Criterion D) and 9 additional items (called subjective clinical symptoms—SCS) that were constructed to address new or substantially modified DSM-5 PTDS symptoms (i.e., D2, D3, D4 and E2) and dissociative specification. The participant must indicate whether he/she had experienced each symptom in the last month and, if so, the degree of

discomfort that it caused on a 0-4 scale (0 = *no discomfort*; 4 = *extreme discomfort*). These ratings are used to compute severity scores, and higher scores indicate severe symptoms. Two final items rate the duration of the symptoms and their onset moment.

(3) *Functioning* assesses the resulting impairment in different life areas with 7 items (Yes/No) that address the DSM-IV Criterion F.

The internal consistency of the EGEP, computed by Cronbach's alpha, was .92 for the total severity score, .86 for re-experience symptoms, .77 for avoidance and numbing symptoms, .73 for hyperarousal, and .80 for SCS. Diagnostic performance according to DSM-IV was established using the PTSD Section of the Composite International Diagnostic Interview—CIDI (World Health Organization, 1990) as the "golden standard", and it showed 91% sensitivity, 75% specificity, a .89 positive predictive value, a .78 negative predictive value, and 86.11% accuracy (Crespo & Gómez, 2012a, 2012b).

Procedure

After giving informed consent, participants were individually assessed in a single session through a structured protocol that included sociodemographic information collection and EGEP administration. Assessment sessions were always carried out under trained psychologists' supervision. Approval for the study was obtained from the center's Research Ethics Board.

Data analysis

The within-subject concordance analyses of the proportion of subjects meeting both the DSM-IV and the DSM-5 PTSD criteria for PTSD diagnosis was examined using Cohen's (1960) kappa statistic, which corrects for chance agreement. Kappa values range from 1.0 to -1.0, with values of 0 indicating agreement at only chance levels. Values above.75 are often considered good, values between .40 and.75 are fair, and values below .40 indicate poor agreement (Fleiss, 1981).

Next, we examined concordance for more specific contrasts, represented by 2×2 contingency tables, to better understand patterns of disagreement. Participants were assigned to one of four groups, depending on diagnostic concordance: Individuals who met the diagnostic criteria according to the DSM-IV but not the DSM-5 (*Yes/No group*) were compared with individuals who met the diagnostic criteria according to both classifications (*Yes/Yes group*); individuals who did not meet the DSM-IV criteria but met the DSM-5 criteria (*No/Yes group*) were compared with individuals who did not meet the diagnostic criteria in either classification (*No/No group*). Group differences in sociodemographic and traumatic event features and in the presence of posttraumatic symptoms were computed using a chi-squared test. When the expected values in any of the cells of the contingency table were below 5, Fisher's exact test was applied.

Results

Characteristics of participants

The mean age of the participants was 39.21 (*SD* = 12.63), ranging from 18 to 76 years. Seventy percent were female, 52% were married or cohabiting with their partners, 30% were single, 11.5% were divorced or separated, and 6.5% were widowed. They were mostly Spanish (92%), and the rest come from several Latin-American countries. Approximately 37% had completed high school, and approximately 33% were employed full time.

Participants experienced a mean of 6.2 traumatic events in their lives (*SD* = 4.56), including events that were directly experienced (*M* = 3.2, *SD* = 1.88), were witnessed (*M* = 1.00, *SD* = 1.76), or had happened to someone with whom they were close (*M* = 2.06, *SD* = 2.14). The lists of traumatic events experienced by the participants and their frequencies are presented in Table 1, along with the trauma that the participants chose as the most present and bothersome and to which their posttraumatic symptoms referred. The event considered "most traumatic" was primarily directly experienced (79.4%); 19.4% had witnessed the event, and in only 1.2% of the cases, the event had occurred to a beloved person. Additionally, 91% of participants assessed the event as severe or extreme (none of them assessed it as light.) For 85% of the victims, the event involved gruesome scenes; for 57.2%, it involved threats to their physical integrity; and for 51.7%, it included life-threatening situations. Most of the events had occurred during adulthood (only 11% had occurred in childhood or adolescence).

Table 1
Traumatic events experienced by the participants (n = 166)

	Directly experienced (%)	Witnessed (%)	Learned had occurred (%)	Considered most traumatic (%)
Natural disaster	12	7.4	10.3	0.6
Transport accident	45.1	22.3	38.3	20
Other accident	22.3	10.9	20.6	3.4
Combat or war exposure	5.7	3.4	6.9	0
Rape, sexual abuse or assault	17.1	2.3	10.9	9.1
Harassment or psychological maltreatment	42.3	8.6	14.9	22.9
Physical violence	37.7	10.9	18.3	9.1
Terrorism or torture	10.3	10.3	15.4	13.1
Imprisonment	8	3.4	9.7	1.1
Life-threating illness	31.4	9.7	33.1	12.6
Death of a beloved person	69.7	9.7	25.1	6.9
Other traumatic events	20.6	1.7	3.4	1.2

Table 2
Within-subject concordance analyses of proportion of subjects meeting DSM-IV and DSM-5 PTSD Criteria (n = 166)

DSM-IV / EGEP		DSM-5		Kappa	p
A1 Event	100%	A Event	100%	–	
A2 Response to event	99.4%				
B: Re-experiencing	96.6%	B: Re-experiencing	96.6%	–	
C: Avoidance and numbing	73.1%	C: Avoidance	76.9%	.444	<.001
Subjective Clinical Symptoms (EGEP)	76.6%	D: Negative alterations in cognitions	87.6%	.479+ .563*	<.001 <.001
D: Arousal	92.6%	E: Arousal	92.6%	–	
E: Duration	95.5%	F: Duration	95.5%	–	
F: Impairment	94.9%	G: Impairment	94.9%	–	
PTSD	68%	PTSD	66.3%	.686	<.001

+ Concordance DSM-5 (criterion D) - DSM-IV (criterion C)
* Concordance DSM-5 (criterion D) - EGEP Subjective Clinical Symptoms

Diagnostic concordance

The rate of PTSD diagnosis was similar in the two diagnostic systems: 68% for the DSM-IV and the 66.3% for DSM-5. Table 2 shows the within-subject concordance analysis of the proportion of subjects who met the DSM-IV and the DSM-5 PTSD criteria and the kappa coefficients. The kappa coefficients were not calculated for criteria without changes between the two versions. The agreement was fair for PTSD diagnosis and was also fair, though lower, for criteria C and D (DSM-5). The lowest agreement was found between the new DSM-5 criterion C (avoidance) and DSM-IV criterion C (including avoidance and numbing), where the Kappa coefficient was just below the fair-threshold level. The new DSM-5 criterion D (negative alterations in cognition and mood) also presented a moderate agreement with DSM-IV criterion C (avoidance and numbing).

All in all, 86.2% of participants remained in their category (60.3% diagnostic and 25.9% not diagnostic) in both classification systems, whereas 13.8% changed; 6% of the participants did not meet the DSM-IV criteria but met the DSM-5 criteria; and 7.8% of the participants who met the DSM-IV criteria did not meet the criteria for the DSM-5.

Characteristics of the participants with no concordant diagnoses

To know the features of *those who met the DSM-IV PTSD criteria but not the DSM-5*, individuals in the *Yes/No group* were compared with individuals in the *Yes/Yes group*, considering sociodemographic data, traumatic event characteristics and symptoms. Significant differences (see Table 3) show that individuals in the *Yes/No group* were more frequently victims of accidents in transportation and were indirect victims (i.e., there were fewer individuals who had directly experienced the event and more individuals who had learned about an event that had happened to a beloved one; the percentage of individuals who had witnessed the event was almost null). Moreover, they also show a higher frequency of events that involved others' serious injuries and life-threatening situations, and the individuals presented fewer fear responses in reaction to these events. The symptoms analysis showed that fewer individuals in the *Yes/No group* had avoidance symptoms. The frequency of avoidance symptoms (cognitive and behavioral) was, in fact, significantly lower in this group when compared with individuals who met the PTSD diagnosis in both classifications.

To know the features of *those who did not meet the DSM-IV PTSD criteria but did meet the DSM-5*, individuals in the *No/Yes group* were compared with individuals who did not meet the criteria in any classifications (i.e., *No/No group*). There were no significant differences between these groups in any feature related to the traumatic event. However, there were significant differences in different posttraumatic symptoms. Individuals who were diagnosed with the DSM-5 criteria showed cognitive avoidance, startled responses, feelings that the world is dangerous, and detachment from the world around them more frequently, and they felt decreased interest or pleasure in activities less frequently.

Table 3
Significant Differences between Yes/No (PTSD in DSM-IV / no PTSD in DSM-5) vs. Yes/Yes (PTSD in DSM-IV / PTSD in DSM-5) Groups and between No/No (no PTSD in DSM-IV / no PTSD in DSM-5) vs. No/Yes (no PTSD in DSM-IV / PTSD in DSM-5) Groups

	Yes / No (n = 13)	Yes / Yes (n = 100)	χ2 df = 1	p
Transport accident	46.2%	14%	8.165	.011
Event…				
Directly experienced	53.8%	82%	6.092	.048
Witnessed	0%	1%		
Learned	46.2%	17%		
Fear	38.5%	82.8%	13.045	<.001
Others' serious injury	76.9%	44.3%	4.878	.027
Others' life threatened	75%	43.8%	4.180	.041
Cognitive avoidance	15.4%	83%	28.219	<.001
Behavioral avoidance	15.4%	83%	28.219	<.001
	No / No (N = 43)	**No / Yes (N = 10)**	**χ2 df = 1**	**p**
Male	32.6%	0%	4.425	.047
Cognitive avoidance	30.2%	70%	5.461	.019
Dismissed interest or pleasure	37.2%	0%	5.330	.021
Easily startled	41.9%	90%	7.523	.006
Feelings that the world is dangerous	41.9%	80%	4.722	.030
Detached from world around them	41.9%	90%	7.523	.006

The examination of the 10 subjects in this group revealed that they showed cognitive avoidance (7 subjects) or behavioral avoidance (3) but not both. Finally, it is worth mentioning that all the subjects in the *No/Yes group* were women.

Because the presence of avoidance, particularly *cognitive avoidance*, seems to be crucial in the diagnosis of PTSD in the DSM-5, further analyses of the cognitive avoidance symptom were run. The data revealed that among individuals with cognitive avoidance, the percentages of PTSD diagnoses were very high in both classifications: 82% in the DSM-IV and 85.7% in the DSM-5. The analysis of affirmative responses to the cognitive avoidance item for the different groups showed the following data: 30.2% in the *No/No group*, 83% in the *Yes/Yes group*, 15.4% in the *Yes/No group*, and 70% in the *No/Yes group*. Consequently, the percentage is high when the DSM-5 criteria are met, independently of the DSM-IV results. Only 9.04% of the subjects who reported cognitive avoidance did not meet the DSM-5 criteria. This symptom reached a positive predictive value for PTSD DSM-5 diagnosis of 86% (with a negative predictive value of 67% and an efficiency coefficient of approximately 79%).

Discussion

The present study provides data on the diagnostic concordance for PTSD between the DSM-IV and the DSM-5 from a nonprobability sample of trauma victims entering treatment. All in all, the results show a high concordance between the two classifications. Moreover, the study is the first to analyze the reasons for non-concordance between the two classifications in a clinical sample as well as the features of persons with non-concordant diagnoses, which could have further implications in clinical decisions.

The application of DSM-5 criteria involves a small decrease (1.7%) in the percentage of individuals who meet the criteria to be diagnosed with PTSD. As expected, the results show a good and significant concordance between the DSM-IV and the DSM-5: Over 86% of the subjects would remain in the same category (diagnosis or non-diagnosis) in both classifications. These finding are consistent with the results of Elhai et al. (2012) and Kilpatrick et al. (2013), who observed no difference in the prevalence of PTSD. Their findings contrast with Calhoun et al.'s (2012) findings on medical center users, who displayed a higher PTSD prevalence according to the DSM-5 criteria (52% vs. 50%). Consequently, further research would be needed to highlight this issue, particularly in different trauma victims.

The differences between the diagnoses are due to the new definition of C (avoidance) and D (negative alterations in cognitions and mood) in the DSM-5, as noted by Kilpatrick et al. (2013). Furthermore, in line with the pre-eminence given to avoidance responses, the data show that the presence of this symptom, particularly of cognitive avoidance, is a determinant in PTSD diagnosis according to the DSM-5 criteria. Avoidance symptoms will consequently be a defining feature of PTSD in the DSM-5, which follows North, Suris, Davis, & Smith (2009), who say that the defining features of PTSD are avoidance and numbing, partly on the grounds that these symptoms are less commonly endorsed than re-experiencing. Brewin et al. (2009) add that it is important to know whether it is numbing, avoidance or both that account for the predictive power of this symptom cluster. According to the present results, avoidance, primarily cognitive avoidance, shows the highest predictive value.

For practical purposes, it is particularly interesting to know the features of the approximately 14% of participants who changed categories. A group-difference analysis shows that *individuals who met the DSM-IV PTSD criteria but not the DSM-5 criteria* were primarily indirect victims who learned about a traumatic event that happened to a beloved one that involved serious injuries or were life threatening. They showed fewer fear responses to the event, likely because they did not experience the event themselves. Concerning symptoms, they were less avoidant both cognitively and behaviorally. This finding is in line with Kilpatrick et al. (2013), who found that these individuals failed to have at least one active-avoidance symptom. To sum up, the data indicate that indirect victims with no avoidant responses would not meet the DSM-5 criteria. This could have important practical consequences because psychological symptoms, particularly the presence of PTSD, are a determinant for close relatives of a direct victim (who are not usually physically affected) to be legally considered as a victim. Moreover, further decisions about their disability recognition and compensation and benefits could be conditioned to the presence of a PTSD diagnosis.

Individuals who did not meet the DSM-IV criteria but met the DSM-5 criteria showed more frequent cognitive avoidance, startled responses, feelings of the world as dangerous and detachment from the world around them. This group would thus comprise people who, for some reason (e.g., impossibility to effectively avoid trauma-related situations), exhibit mostly cognitive-avoidance strategies. Furthermore, they showed few numbing symptoms: Their negative alterations of cognitions and mood clusters of symptoms essentially consisted of alterations in cognitions that are not included in the DSM-IV criteria. Consequently, individuals who newly met the PTSD diagnosis when applying the DSM-5 criteria would comprise people who showed pre-eminent secondary emotions in the context of the dual representation theory suggested by Brewin (Brewin, 2001; Brewin, Dalgleish, & Joseph, 1996) or emotional reactions other than fear (e.g., anger or shame; Brewin et al., 2000; Dalgleish & Power, 2004). In this sense, non-fear-based victims, who were usually excluded from a PTSD diagnosis with the DSM-IV criteria, would meet the DSM-5 criteria.

Several limitations should be taken into account when interpreting the results of this study. First, there is no perfect adjustment between EGEP items and the DSM-5 criteria. Furthermore, the wording of some of the EGEP items and some minor changes in the DSM-5's description of the symptoms involve small differences within the criteria. Second, because ours was a convenience sample, and it showed a high PTSD prevalence, the extent to which our findings are generalizable to other trauma victims might be limited. Furthermore, the use of a self-report measure for PTSD and the sample size are worth mentioning. Even more, though the recently proposed DSM-5 PTSD model seems to be an advance over DSM-IV model, recent studies analyzing other factor models (e.g. six and seven factors) suggest that DSM-5 factor structure could require further revision and refinement (Armour, Müllerová, & Elhai, 2016).

Nevertheless, all in all, this study is the first to offer empirical clinical data about the concordance of the DSM-IV and the DSM-5 for PTSD diagnosis and information about the features of non-concordant individuals. Moreover, it highlights practical implications that could have further consequences in the clinical and forensic consideration of traumatic event victims.

Acknowledgements

Participants were recruited from the following institutions: Nuestra Señora de América Hospital, Militar Hospital Gómez Ulla, Beccaria Associations for Victims Support, Stop-Accidents, National Association of Victims of Violence, ICAS-Attention in Disasters, Political Refugees Refectory of Madrid Region, Women Centre Rosa Luxemburgo in Leganés (Madrid), IPSE-Psychological Specialized Intervention, and the Association Against Work Harassment.

References

American Psychiatric Association (1952). *Diagnostic and statistical manual of mental disorders (1st ed.)*. Washington, DC: Author.

American Psychiatric Association (1980). *Diagnostic and statistical manual of mental disorders (3rd ed.)*. Washington, DC: Author.

American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

Andrews, B., Brewin, C. R., Stewart, L., Philpott, R., & Hejdenberg, J. (2009). Comparison of immediate-onset and delayed-onset posttraumatic stress disorder in military veterans. *Journal of Abnormal Psychology, 118,* 767-777.

Armour, C., Müllerová, J., & Elhai, J. (2016). A systematic literature review of PTSD's latent structure in the Diagnostic and Statistical Manual of Mental Disorders: DSM-IV to DSM-5. *Clinical Psychology Review, 44*, 60-74.

Asmundson, G. J., Frombach, I., McQuaid, J., Pedrelli, P., Lenox, R., & Stein, M. B. (2000). Dimensionality of posttraumatic stress symptoms: A confirmatory factor analysis of DSM-IV symptom clusters and other symptom models. *Behavior Research and Therapy, 38,* 203-214.

Blake, D. D., Weathers, F. W., Nagy, L. M., Kaloupek, D. G., Gusman, F. D., Charney, D. S., & Keane, T. M. (1995). The development of a clinician-administered PTSD scale. *Journal of Traumatic Stress, 8,* 75-80.

Breslau, N., & Kessler, R. C. (2001). The stressor criterion in DSM-IV posttraumatic stress disorder: An empirical investigation. *Biological Psychiatry, 50,* 699-704.

Brewin, C. R. (2001). A cognitive neuroscience account of posttraumatic stress disorder and its treatment. *Behaviour Research and Therapy, 39,* 373-393.

Brewin, C. R., Andrews, B., & Rose, S. (2000). Fear, helplessness, and horror in posttraumatic stress disorder: Investigating DSM-IV criterion A2 in victims of violent crime. *Journal of Traumatic Stress, 13,* 499-509.

Brewin, C. R., Dalgleish, T., & Joseph, S. (1996). A dual representation theory of post traumatic stress disorder. *Psychological Review, 103*, 670-686.

Brewin, C. R., Lanius, R. A., Novac, A., Schnyder, U., & Galea, S. (2009). Reformulating PTSD for DSM-V: Life after criterion A. *Journal of Traumatic Stress, 22,* 366-373.

Calhoun, P. S., Hertzberg, J. S., Kirby, A. C., Dennis, M. F., Hair, L. P., Dedert, E. A., & Beckham, J. C. (2012). The effect of draft DSM-V criteria on posttraumatic stress disorder prevalence. *Depression and Anxiety, 29,* 1032-1042.

Cohen, J. (1960). A coefficient of agreement for nominal scales. *Educational and Psychological Measurement*, *20,* 37-46.

Crespo, M., & Gómez, M. M. (2012a). *Evaluación global de Estrés Postraumático (EGEP)* [Global assessment of posttraumatic stress questionnaire (EGEP)]. Madrid: TEA Ed.

Crespo, M., & Gómez, M. M. (2012b). La evaluación del Estrés Postraumático: presentación de la Escala de Evaluación global del Estrés Postraumático (EGEP) [Posttraumatic stress assessment: Introducing the Global Assessment of Posttraumatic Stress Questionnaire], *Clinical and Health, 23,* 25-41.

Dalgleish, T., & Power, M. J. (2004). Emotion-specific and emotion-non-specific components of posttraumatic stress disorder (PTSD): Implications for a taxonomy of related psychopathology. *Behaviour Research and Therapy, 42*, 1069-1088.

Elhai, J. D., Miller, M. E., Ford, J. D., Biehn, T. L., Palmieri, P. A., & Frueh, B. C. (2012). Posttraumatic stress disorder in *DSM-5*: Estimates of prevalence and symptom structure in a nonclinical sample of college students. *Journal of Anxiety Disorders, 26*, 58-64.

Fleiss, J. L. (1981). *Statistical methods for rates and proportions*. New York: Wiley.

Foa, E. B., Riggs, D. S., Dancu, C. V., & Rothbaum, B. O. (1993). Reliability and validity of a brief instrument for assessing post-traumatic stress disorder. *Journal of Traumatic Stress, 6,* 459-473.

Forbes, D., Fletcher, S., Lockwood, E., O'Donnell, M., Creamer, M., Bryant, R. A., & McFarlane, A., Silove, D. (2011). Requiring both avoidance and emotional numbing in DSM-V PTSD: Will it help? *Journal of Affective Disorders, 130*, 483-486.

Friedman, M. J., Resick, P. A., Bryant, R. A., & Brewin, C. R. (2011a). Considering PTSD for DSM-5. *Depression and Anxiety, 28,* 750-769.

Friedman, M. J., Resick, P. A., Bryant, R. A., Strain, J., Horowitz, M., & Spiegel, D. (2011b). Classification of trauma and stressor-related disorders in DSM-5. *Depression and Anxiety*, 28, 737-749.

Kessler, R. C., Chiu, W. T., Demler, O., Merikangas, K. R., & Walters, E. E. (2005). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*, 617-627.

Kilpatrick, D. G., Resnick, H. S., & Acierno, R. (2009). Should PTSD criterion A be retained? *Journal of Traumatic Stress, 22,* 374-383.

Kilpatrick, D. G., Resnick, H. S., Milanak, M. E., Miller, M. W., Keyes, K. M., & Friedman, M. J. (2013). National estimates of exposure to traumatic events and PTSD prevalence using DSM-IV and DSM-5 criteria. *Journal of Traumatic Stress, 26*, 537-547.

McNally, R. J. (2009). Can we fix PTSD in DSM-V? *Depression and Anxiety,* 26(7), 597-600.

North, C. S., Suris, A. M., Davis, M., & Smith, R. P. (2009). Toward validation of the diagnosis of posttraumatic stress disorder. *American Journal of Psychiatry, 166,* 34-34.

Owashi, T., & Perkonigg, A. (2008). The natural course of PTSD and PTSD symptoms: Findings from longitudinal epidemiological studies. *Directions in Psychiatry, 27,* 207-220.

Resick, P. A., & Miller, M. W. (2009). Posttraumatic stress disorder: Anxiety or traumatic stress disorder? *Journal of Traumatic Stress, 22,* 384-390.

Wilson, J. P., Droždek, B., & Turkovic, S. (2006). Posttraumatic shame and guilt. *Trauma, Violence, & Abuse, 7,* 122-141.

Wittchen, H. U., Gloster, A., Beesdo, K., Schönfeld, S., & Perkonigg, A. (2009). Posttraumatic stress disorder: Diagnostic and epidemiological perspectives. *CNS Spectrums, 14*(1), 5-12.

World Health Organization (1990). *Composite International Diagnostic Interview (CIDI)*. Geneva: Author.

Yufik, T., & Simms, L. J. (2010). A meta-analytic investigation of the structure of posttraumatic stress disorder symptoms. *Journal of Abnormal Psychology*, *119,* 764-776.