# TECHNICAL COMMENTARY

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## Avoidance

### Introduction

Avoidance is a core symptom of PTSD, with at least one avoidance symptom being required for a diagnosis. People often try to cope with the trauma and escape painful or difficult emotions by avoiding the distressing memories, thoughts, or feelings associated with the event. Avoidance may be effective in the short-term but in the long run, it may be associated with increased severity of symptoms.

### Method

We have included only systematic reviews (systematic literature search, detailed methodology with inclusion/exclusion criteria) published in full text, in English, from the year 2010 that report results separately for people with a diagnosis of PTSD. Reviews were identified by searching the databases MEDLINE, EMBASE, and PsycINFO. Hand searching reference lists of identified reviews was also conducted. Reviews with pooled data are prioritised for inclusion.

Review reporting assessment was guided by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) checklist that describes a preferred way to present a meta-analysis[1]. Reviews with less than 50% of items checked have been excluded from the library. The PRISMA flow diagram is a suggested way of providing information about studies included and excluded with reasons for exclusion. Where no flow diagram has been presented by individual reviews, but identified studies have been described in the text, reviews have been checked for this item. Note that early reviews may have been guided by less stringent reporting checklists than the PRISMA, and that some reviews may have been limited by journal guidelines.

Evidence was graded using the Grading of Recommendations Assessment, Development and Evaluation (GRADE) Working Group approach where high quality evidence such as that gained from randomised controlled trials (RCTs) may be downgraded to moderate, low or very low if review and study quality is limited, if there is inconsistency in results, indirect comparisons, imprecise or sparse data and high probability of reporting bias. It may also be downgraded if risks associated with the intervention or other matter under review are high. Conversely, low quality evidence such as that gained from observational studies may be upgraded if effect sizes are large, there is a dose dependent response or if results are reasonably consistent, precise and direct with low associated risks (see end of table for an explanation of these terms)[2]. The resulting table represents an objective summary of the available evidence, although the conclusions are solely the opinion of staff of NeuRA (Neuroscience Research Australia).

### Results

We found one systematic review that met our inclusion criteria[3].

- Moderate to low quality evidence finds three clusters of avoidance symptoms; avoidance of thoughts and feelings, activity, and memory.
- Thoughts/feelings avoidance items include; *I tried not to talk about the trauma, I tried not to think of things that remind me of something bad that happened to me, I tried not to think about the trauma, I avoided thinking about or talking about a stressful experience from the past,* and *I avoided thinking about or talking about the trauma.*
- Activity avoidance items include; *I felt less connected to people after the trauma, I avoided situations because they reminded me of a stressful experience, I tried to avoid situations or people that reminded me of the trauma, I avoided situations that might remind me of something terrible that*



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*happened to me, I tried to avoid activities, people or places that remind me of the traumatic event,* and *I avoided activities that reminded me of the trauma.*

- Memory avoidance items include; *I stayed away from reminders of the trauma, I tried to forget about the bad things that happened to me, I had trouble remembering important parts of the stressful experience, I could not remember much about bad things that have happened to me, I had difficulty remembering,* and *I had difficulty remembering some things that happened during the event/trauma.*



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*Del Vecchio N, Elwy AR, Smith E, Bottonari KA, Eisen SV*

**Enhancing self-report assessment of PTSD: development of an item bank**

**Journal of Traumatic Stress 2011; 24: 191-9**

View review abstract online

| | |
|---|---|
| **Comparison** | **Self-report items relating to the PTSD symptom cluster of avoidance.** |
| **Summary of evidence** | **Moderate to low quality evidence (direct, unclear sample size, unable to assess consistency or precision) finds three clusters of avoidance symptoms; avoidance of thoughts and feelings, activity, and memory, related to the trauma are common in people with PTSD.** |

**Avoidance items assessed on:**

**Acute Stress Disorder Scale (ASDS), Anxiety and Depression Detector (ADD), Beck Anxiety Inventory – Primary Care (BAI-PC), Seven Symptom Scale - Short Screening Scale for PTSD, Davidson Trauma Scale (DTS) , Detailed Assessment of Posttraumatic Stress (DAPS), Harvard Trauma Questionnaire (HTQ), Impact of Event Scale-Revised (IES-R), Late Effect of Accidental Injury Questionnaire, Los Angeles Symptom Checklist (LASC), Millon Clinical Multiaxial Inventory-III (MCMI-III), MMPI-2 Keane PTSD subscale, Mississippi Scale for Combat Related PTSD, Modified PTSD Symptom Scale (MPSS), National Anxiety Disorder Day Screen, National Women's Study-PTSD module (NWS-PTSD), Penn Inventory, Peritraumatic Distress Inventory (PDI), Posttraumatic Chronic Pain Test (PCPT), Posttraumatic Cognitions Inventory (PTCI), Posttraumatic Stress Scale (PTSS-10,14), Primary Care PTSD Screen (PC-PTSD), Psychiatric Diagnostic Screening Questionnaire (PDSQ), PTSD Checklist (PCL all versions), PTSD Diagnostic Scale (PDS), PTSD Inventory, PTSD Screening and Diagnostic Scale (PSDS), PTSD Symptom Scale-Self-Report (PSS-SR), Problem Checklist, Project IMPACT PTSD Screener, Purdue Posttraumatic Scale (PPS), Responses to Script-Driven Imagery Scale (RSDI), Revised Civilian Mississippi Scale for PTSD (R-CMS), Screen for Posttraumatic Stress Disorder (SPTSS), Short Post-Traumatic Stress Disorder Rating Interview, expanded version (SPRINT-E), Trauma Screening Questionnaire (TSQ), Trauma Stress Schedule (TSS), Traumatic Stress Symptom Checklist (TSSC), Trauma Symptom Checklist-40 (TSC-40), Trauma Symptom Inventory (TSI), UK PTSS-14**

275 studies, N not reported

Thoughts/Feelings Avoidance

I tried not to talk about the trauma.

I tried not to think of things that remind me of something bad that happened to me.

I tried not to think about the trauma.



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|---|
| I avoided thinking about or talking about a stressful experience from the past.<br>I avoided thinking about or talking about the trauma.<br><u>Activity Avoidance</u><br>I felt less connected to people after the trauma.<br>I avoided situations because they reminded me of a stressful experience.<br>I tried to avoid situations or people that reminded me of the trauma.<br>I avoided situations that might remind me of something terrible that happened to me.<br>I tried to avoid activities, people or places that remind me of the traumatic event.<br>I avoided activities that reminded me of the trauma.<br><u>Memory Avoidance</u><br>I stayed away from reminders of the trauma.<br>I tried to forget about the bad things that happened to me.<br>I had trouble remembering important parts of the stressful experience.<br>I could not remember much about bad things that have happened to me.<br>I had difficulty remembering.<br>I had difficulty remembering some things that happened during the event/trauma. |

| | |
|---|---|
| **Consistency in results**‡ | Unable to assess; no measure of consistency is reported. |
| **Precision in results**§ | Unable to assess; no measure of precision is reported. |
| **Directness of results**‖ | Direct |

## Explanation of acronyms

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| N = number of participants |



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## Explanation of technical terms

* Bias has the potential to affect reviews of both RCT and observational studies. Forms of bias include; reporting bias – selective reporting of results; publication bias - trials that are not formally published tend to show less effect than published trials, further if there are statistically significant differences between groups in a trial, these trial results tend to get published before those of trials without significant differences; language bias – only including English language reports; funding bias - source of funding for the primary research with selective reporting of results within primary studies; outcome variable selection bias; database bias - including reports from some databases and not others; citation bias - preferential citation of authors. Trials can also be subject to bias when evaluators are not blind to treatment condition and selection bias of participants if trial samples are small[4].

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† Different effect measures are reported by different reviews.

Prevalence refers to how many existing cases there are at a particular point in time. Incidence refers to how many new cases there are per population in a specified time period. Incidence is usually reported as the number of new cases per 100,000 people per year. Alternatively some studies present the number of new cases that have accumulated over several years against a person-years denominator. This denominator is the sum of individual units of time that the persons in the population are at risk of becoming a case. It takes into account the size of the underlying population sample and its age structure over the duration of observation.

Reliability and validity refers to how accurate the instrument is. Sensitivity is the proportion of actual positives that are correctly identified (100% sensitivity = correct identification of all actual positives) and specificity is the proportion of negatives that are correctly identified (100% specificity = not identifying anyone as positive if they are truly not). A receiver operating characteristic (ROC) curve represents sensitivity/specificity pairs corresponding to different cut-off values. A guide for interpreting the area under the curve (AUC) statistic is; 0.90 to 1.00 = excellent, 0.80 to 0.90 = good, 0.70 to 0.80 = fair, 0.60 to 0.70 = poor, and 0.50 to 0.60 = fail.

Weighted mean difference scores refer to mean differences between treatment and comparison groups after treatment (or occasionally pre to post treatment) and in a randomized trial there is an assumption that both groups are comparable on this measure prior to treatment. Standardized mean differences are divided by the pooled standard deviation (or the standard deviation of one group when groups are homogenous) that allows results from different scales to be combined and compared. Each study's mean difference is then given a weighting depending on the size of the sample and the variability in the data. 0.2 represents a small effect, 0.5 a moderate effect, and 0.8 and over represents a large effect[4].

Odds ratio (OR) or relative risk (RR) refers to the probability of a reduction (< 1) or an increase (> 1) in a particular outcome in a treatment group, or a group exposed to a risk factor, relative to the comparison group. For example, a RR of 0.75 translates to a reduction in risk of an outcome of 25% relative to those not receiving the treatment or not exposed to the risk factor. Conversely, a RR of 1.25 translates to an increased risk of 25% relative to those not receiving treatment or not having been exposed to a risk factor. A RR or OR of 1.00 means there is no difference between groups. A medium effect is considered if RR > 2 or < 0.5 and a large



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effect if RR > 5 or < 0.2[5]. lnOR stands for logarithmic OR where a lnOR of 0 shows no difference between groups. Hazard ratios measure the effect of an explanatory variable on the hazard or risk of an event.

Correlation coefficients (eg, r) indicate the strength of association or relationship between variables. They can provide an indirect indication of prediction, but do not confirm causality due to possible and often unforseen confounding variables. An r of 0.10 represents a weak association, 0.25 a medium association and 0.40 and over represents a strong association. Unstandardized (*b*) regression coefficients indicate the average change in the dependent variable associated with a 1 unit change in the independent variable, statistically controlling for the other independent variables. Standardized regression coefficients represent the change being in units of standard deviations to allow comparison across different scales.

‡ Inconsistency refers to differing estimates of effect across studies (i.e. heterogeneity or variability in results) that is not explained by subgroup analyses and therefore reduces confidence in the effect estimate. $I^2$ is the percentage of the variability in effect estimates that is due to heterogeneity rather than sampling error (chance) - 0% to 40%: heterogeneity might not be important, 30% to 60%: may represent moderate heterogeneity, 50% to 90%: may represent considerable heterogeneity and over this is considerable heterogeneity. $I^2$ can be calculated from Q (chi-square) for the test of heterogeneity with the following formula[4];

$$I^2 = \left(\frac{Q - df}{Q}\right) \times 100\%$$

§ Imprecision refers to wide confidence intervals indicating a lack of confidence in the effect estimate. Based on GRADE recommendations, a result for continuous data (standardised mean differences, not weighted mean differences) is considered imprecise if the upper or lower confidence limit crosses an effect size of 0.5 in either direction, and for binary and correlation data, an effect size of 0.25. GRADE also recommends downgrading the evidence when sample size is smaller than 300 (for binary data) and 400 (for continuous data), although for some topics, these criteria should be relaxed[6].

‖ Indirectness of comparison occurs when a comparison of intervention A versus B is not available but A was compared with C and B was compared with C that allows indirect comparisons of the magnitude of effect of A versus B. Indirectness of population, comparator and/or outcome can also occur when the available evidence regarding a particular population, intervention, comparator, or outcome is not available and is therefore inferred from available evidence. These inferred treatment effect sizes are of lower quality than those gained from head-to-head comparisons of A and B.



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