

Dissociative Subtype of Posttraumatic Stress Disorder in US Military Veterans: Prevalence, Correlates, and Clinical Characteristics

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The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*, introduced a dissociative subtype of posttraumatic stress disorder (DS-PTSD), which is characterized by depersonalization and derealization, greater symptom complexity and comorbidity, and poorer engagement or response to standard trauma-focused therapies.^{1–4} A recent meta-analysis found that 48.1% (95% CI = 35.0%–61.3%) of individuals with PTSD have DS-PTSD,² suggesting that dissociative symptoms may be more central to PTSD than previously understood. Although veterans with dissociative symptoms have higher prevalence of co-occurring depression, anxiety, substance use, and suicidal thoughts and behaviors,^{3,4} DS-PTSD can often go undetected, as widely used self-report tools such as the PTSD Checklist for *DSM-5* (PCL-5) do not assess dissociative symptoms.

Using data from a nationally representative sample of US veterans, we examined the prevalence and clinical characteristics of DS-PTSD. Based on prior literature,^{1–3} we hypothesized that approximately 50% of veterans with PTSD would have DS-PTSD and that veterans with DS-PTSD would report more traumas and higher levels of co-occurring depression and anxiety symptoms.

Methods

Sample. Data were analyzed from the National Health and Resilience in Veterans Study (NHRVS),⁶ which surveyed a nationally representative sample of 4,069 US veterans. Participants were drawn from Ipsos' KnowledgePanel, a probability-based panel covering 98% of US households.

Poststratification weights⁷ were applied in inferential analyses. The VA Connecticut Healthcare System Human Subjects Committee approved all procedures, and participants gave electronic informed consent.

Measures. PTSD symptoms were assessed using a modified PCL-5,^{5,8} which included an assessment of dissociative symptoms using items from the Clinician-Administered PTSD Scale for *DSM-5* (Table 1).

Data analysis. Independent-samples *t* tests and χ^2 tests were used to compare sample characteristics by DS-PTSD status. Multivariable logistic regression analyses were conducted to examine associations between DS-PTSD status and clinical correlates while adjusting for relevant covariates.

Results

Of 169 veterans who screened positive for past-month PTSD, 87 (weighted 58.7%, 95% CI = 48.4%–68.3%) screened positive for DS-PTSD. After adjusting for covariates, veterans with DS-PTSD had elevated odds of current major depressive and drug use disorders, suicidal ideation, and lifetime suicide plan and nonsuicidal self-injury (Table 1).

Discussion

In this nationally representative study, 58.7% of US veterans with current PTSD screened positive for *DSM-5* DS-PTSD, consistent with the 48.1% (95% CI = 35.0–61.3%) prevalence reported in a recent meta-analysis.² Results corroborate prior work^{3,4} emphasizing the clinical significance of DS-PTSD, as those with this subtype of PTSD had markedly greater psychiatric burden.

DS-PTSD was associated with a 3-fold greater odds of lifetime suicide plan and current suicidal ideation, and 5-fold greater odds of lifetime nonsuicidal self-injury. Given that veterans have a 41%–61% higher suicide risk than civilians⁹ and accounted for 13% of suicides in 2022 despite representing only 6% of the population,^{10,11} these findings underscore the urgent need for routine screening for dissociative symptoms in veterans with PTSD, particularly those presenting with elevated suicide risk. Incorporating brief dissociation screeners into standard PTSD assessments may help identify high-risk individuals who could benefit from tailored treatment approaches that emphasize stabilization, grounding, and emotion regulation.^{2,4,12–15}

Limitations of the study include its cross-sectional design, use of self-report measures and a nonvalidated assessment of dissociative symptoms, and potential limitations in generalizability to nonveteran populations. However, these limitations are offset by several strengths, including the use of a conservative, *DSM-5*-based assessment of PTSD and dissociative symptoms, and the recruitment of a nationally representative sample of veterans.

Overall, results of this study highlight the importance of assessing, monitoring, and treating dissociative symptoms in veterans with PTSD, as they are prevalent and linked to elevated psychiatric burden and suicide risk. Further research is warranted to refine screening tools and develop targeted interventions for DS-PTSD.

Table 1.

Background and Clinical Characteristics by Dissociative Subtype of PTSD Screening Status

	Weighted mean (SD) or N (weighted %)		Bivariate test of difference	P value
	PTSD only, N = 82 (weighted 41.3%)	DS-PTSD, N = 87 (weighted 58.7%)		
Background characteristics				
Age*	51.2 (12.8)	47.0 (13.5)	2.27	.012
Male sex	60 (74.4%)	66 (80.3%)	1.02	.31
Race and ethnicity			11.51	.009
White, non-Hispanic	60 (67.5%)	55 (71.8%)		
Black, non-Hispanic*	14 (26.7%)	10 (11.6%)		
Hispanic*	5 (3.5%)	15 (11.6%)		
Other	3 (2.3%)	7 (5.0%)		
College graduate or higher education*	43 (41.2%)	23 (16.5%)	15.50	<.001
Married/partnered	48 (68.2%)	58 (63.6%)	0.47	.49
Annual household income >\$60,000	42 (54.7%)	39 (42.6%)	2.93	.087
Combat veteran*	38 (44.2%)	47 (64.5%)	8.39	.004
Years of military service			13.07	.001
3 or fewer years*	26 (22.4%)	35 (46.3%)		
4–9 years	33 (45.8%)	35 (35.5%)		
10+ years*	23 (31.8%)	17 (18.2%)		
Adverse childhood experiences ^a	3.3 (2.3)	3.2 (3.0)	0.13	.90
Direct potentially traumatic events ^b	5.1 (2.8)	5.8 (3.1)	1.43	.15
Indirect potentially traumatic events ^b	8.6 (8.8)	9.5 (8.8)	0.67	.50
Military sexual trauma ^c	20 (24.7%)	28 (29.8%)	0.63	.42
Index traumatic event ^b			17.69	.001
Disaster/accident*	10 (11.0%)	15 (24.8%)		
Interpersonal violence*	28 (46.5%)	21 (22.0%)		
Combat/captivity*	15 (13.7%)	21 (29.4%)		
Illness/injury	16 (27.4%)	16 (22.9%)		
Injury/harm/death to other	2 (1.4%)	2 (0.9%)		
PTSD Checklist for <i>DSM-5</i> score ^d	37.5 (9.9)	53.0 (14.6)	9.12	<.001
Time since index trauma (years)	22.6 (16.7)	24.0 (17.9)	0.55	.58
				Adjusted odds ratio (95% CI)
Clinical characteristics				
Current major depressive disorder ^e	26 (35.7%)	55 (68.9%)	22.10	<.001
Current generalized anxiety disorder ^e	24 (33.3%)	49 (63.6%)	18.22	<.001
Current alcohol use disorder ^f	14 (23.5%)	20 (26.4%)	0.22	.63
Current drug use disorder ^g	13 (14.5%)	20 (33.0%)	8.58	.003
Current suicidal ideation ^h	18 (25.0%)	47 (62.0%)	27.24	<.001
Lifetime suicide plan ⁱ	17 (23.0%)	28 (40.0%)	5.49	.019
Lifetime suicide attempt ⁱ	13 (14.0%)	17 (20.8%)	1.61	.20
Lifetime nonsuicidal self injury ^j	8 (7.1%)	17 (22.3%)	8.64	.003
Future suicidal intent ⁱ	4 (2.4%)	9 (10.7%)	5.21	.023

References for measures are as follows:

^aFelitti VJ, Anda RF, Nordenberg D, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. *Am J Prev Med*. 1998;14(4):245–258.

^bWeathers FW, Blake D, Schnurr PP, Kaloupek DG, Marx BP, Keane TM. The life events checklist for DSM-5 (LEC-5). 2013. Available from <https://www.ptsd.va.gov/>

^cKimerling R, Gima K, Smith MW, Street A, Frayne S. The Veterans Health Administration and military sexual trauma. *Am J Public Health*. 2007;97(12):2160–2166.

^dWeathers, FW, Litz, BT, Keane, TM, Palmieri, PA, Marx, BP, & Schnurr, PP. The PTSD Checklist for DSM-5 (PCL-5). 2013. Available from <https://www.ptsd.va.gov/>

^eKroenke K, Spitzer RL, Williams JB, Löwe B. An ultra-brief screening scale for anxiety and depression: the PHQ-4. *Psychosomatics*. 2009;50(6):613–621.

^fSaunders JB, Aasland OG, Babor TF, de la Fuente JR, Grant M. Development of the Alcohol Use Disorders Identification Test (AUDIT): WHO Collaborative Project on Early Detection of Persons with Harmful Alcohol Consumption-II. *Addiction*. 1993;88(6):791–804.

^gTiet QQ, Leyva YE, Moos RH, Frayne SM, Osterberg L, Smith B. Screen of drug use: diagnostic accuracy of a new brief tool for primary care. *JAMA Intern Med*. 2015;175(8):1371–1377.

^hKroenke K, Spitzer RL, Williams JB. The PHQ-9: Validity of a brief depression severity measure. *J Gen Intern Med*. 2001;16(9):606–613.

ⁱOsman A, Bagge CL, Gutierrez PM, et al. The Suicidal Behaviors Questionnaire-Revised (SBQ-R): Validation with clinical samples. *Assessment*. 2001;8(4):443–454.

^jNock MK, Holmberg EB, Photos VI, Michel BD. Self-Injurious Thoughts and Behaviors Interview—Short Form: Development and validation of an abbreviated measure of suicidal and self-injurious behavior. *Psychol Assess*. 2007;19(4):309–317.

^kWeathers FW, Blake DD, Schnurr PP, Kaloupek DG, Marx BP, Keane TM. The Clinician-Administered PTSD Scale for DSM-5 (CAPS-5). 2013. Available from www.ptsd.va.gov

PTSD Assessment: Participants were asked to identify their “worst stressful experience” on the Life Events Checklist for DSM-5,^b which assesses lifetime exposure to 16 potentially traumatic events (PTEs), and to rate how much it bothered them in the past month on the PTSD Checklist for DSM-5 (PCL-5).^d A positive PTSD screen was defined as endorsing a PTE (Criterion A), meeting the DSM-5 criteria for all 4 symptom clusters (B-E; with moderate or greater symptom severity); having symptoms lasting more than 1 mo (Criterion F); and experiencing distress or functional impairment (Criterion G; endorsement of moderate or greater severity to the question: “Did these

reactions cause you distress or result in a failure to fulfill obligations at home, work, or school?"). The dissociative subtype of PTSD was operationalized as endorsement of either or both of the following symptoms at moderate or greater severity from the Clinician-Administered PTSD Scale for *DSM-5* (CAPS-5)^k: "Feeling as if you were separated from yourself, watching yourself or your thoughts and feelings as if you were another person" or "Feeling that things going on around you seemed unreal or very strange and unfamiliar." Use of a symptom severity threshold of *moderate or greater* to indicate symptom endorsement is consistent with the assessment of other PTSD symptoms on the validated PCL-5^d and aligns with CAPS-5 conventions, in which moderate severity reflects a clinically significant symptom in the assessment of *DSM-5* diagnostic criteria and represents a target for clinical intervention^k (Cronbach's $\alpha = 0.92$).

For clinical characteristics, results of multivariable logistic regression analyses are adjusted for age, race, and ethnicity, education, combat veteran status, years of military service, index trauma, and PCL-5 scores.

* $P < .05$, ** $P < .01$; statistically significant difference.

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