Author's response to reviews

Title: Violence and post-traumatic stress disorder in Sao Paulo and Rio de Janeiro, Brazil: the protocol for an epidemiological and genetic survey

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Version: 2 Date: 30 March 2009

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We are grateful to the comments raised by the referee giving us the opportunity to discuss these issues as follows:

Referee: "In the epidemiological survey, non-professionals are trained to apply structured clinical interviews. While I think that it may be possible to achieve valid results for a diagnosis of PTSD when non-experts are adequately trained to apply the CIDI, the actual outcome achieved by the interviewers would have to be validated. This could, in principal, be realized using the expert interviews (based on the CAPS), as indicated by the second ms (the research strategy would have to be adequately adjusted)".
Reply: The CIDI-2.1 PTSD diagnostic section was previously validated against the SCID applied by expert interviewers (paper submitted). The SCID can be regarded as a more accurate “gold standard” than the CAPS questionnaire. This procedure may allow us to adjust the prevalence findings in the second phase.

Referee: "More difficult to apply are the instruments that determine peri-traumatic responding. These will require partial imaginative exposure to the traumatic events - a task that requires a profound understanding of the psychophysiology of trauma and considerable clinical experience with techniques to overcome avoidance and to prevent dissociation at the same time."
"In addition, a clinically experienced expert would have to assure habituation of fear-responses in order not to potentially harm traumatized respondents”.

Reply: Since the creation of the PTSD diagnosis, trauma experts raised the preoccupation that research with a focus on psychological trauma could make participants relive auditory or visual reminders of unpleasant situations, and in so doing, they may feel painful emotions such as fear, anger and shame. For instance, below there is a paragraph from Seedat et al’ paper entitled “Ethics of Research on Survivors of Trauma”, published in Current Psychiatry Reports 2004, 6:262–267, showing how the field is dealing with this possibility:

“….Recent observations that many trauma survivors are grateful for the opportunity to share their experiences with a researcher who is unlikely to judge or condemn them suggests that this population may be less fragile than we think, even in the acute aftermath of a traumatic event [5••]. Empiric data on participant reactions to different assessment procedures in trauma samples (eg, domestic violence, rape, and physical assault) demonstrate that the majority do not find the experience distressing, but rather view it as valuable and relieving [5••]. For many survivors, sharing stories of trauma provides an opportunity to give testimony about the past and is perceived as therapeutic.” (pg. 262)

Given this broad framework, we can reply to the referee worries about eliciting peritraumatic phenomena questions. Based on our clinical experience, and a review of the literature, we found no evidence that asking about peritraumatic
reactions is worse than what is usually done when researchers ask about the traumatic memory of the event in an autobiographical perspective. We also observed that some of our peritraumatic questions that index behavioral and physical phenomena such as panic attack and tonic immobility were well-received by the patients. Usually patients are much more upset describing the traumatic event than answering if they had tremor or felt paralyzed during or in the aftermath of an event. Hence, we do agree with the reviewer that this issue is a relevant topic and think that empirical research focusing on the risk and benefits of peritraumatic reactions-related questions is amply justified.

We also prepared our research team to deal with some of the aforementioned ethical issues. In order to prepare the interviewers to deal with respondents' emotional reactions, the interviewees' training (30-hour theoretical and practical module, plus 10 supervised interviews) included rapport techniques, role plays, and case discussions. Additionally, two of the authors (one psychologist and one psychiatrist) were available 24/7 during the field work through a telephone line. Therefore, the interviewers could count on qualified support if they had doubts, or faced any difficulties when doing the interviews. Moreover, the same professionals had systematic meetings with the interviewers in order to supervise and evaluate their experiences in the field work.

Another important issue raised by the referee is concerned with the potential benefit derived from the contributions that could be achieved with the help of results of such as those in the present study. A crucial question is if peritraumatic reactions is a subject that deserves being studied (taking in consideration the risk-benefit ratio for the participants). We definitely think it is. Peritraumatic factors were the strongest predictors of PTSD, according to an influential meta-analysis (Ozer et al. Predictors of posttraumatic stress disorder and symptoms in adults: a meta-analysis. Psychol Bull 129:52-73, 2003). Peritraumatic variables had effect size largest than other important predictors including prior trauma, prior psychological adjustment, family history of psychopathology, perceived life threat during the trauma, and posttrauma social support. Since this meta-analysis, the interest in peritraumatic phenomena has increased in the trauma field as attested by the mounting number of articles focusing on this issue. However, despite the positive findings in several studies, there is some controversy about the role of peritraumatic reactions in the development of PTSD. The main advance of the present study is the opportunity to investigate peritraumatic reactions in a community sample.