



Is worst-event trauma type related to PTSD symptom presentation and associated features?



Hillary L. Smith, Berta J. Summers, Kirsten H. Dillon, Jesse R. Cougle*

Department of Psychology, Florida State University, P.O. Box 3064301, Tallahassee, FL 32306, USA

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ABSTRACT

Posttraumatic stress disorder (PTSD) is generally assessed with reference to a “worst-event” (index) trauma, though little research has examined whether symptom presentation and comorbidity differ across worst-events. Data from individuals meeting lifetime PTSD criteria in the National Comorbidity Survey-Replication ($N = 398$) were used to examine relations between PTSD presentation and comorbidity with the three most commonly reported “worst-event” trauma types: sexual trauma, non-sexual physical violence, and unexpected death of a loved one. Sexual trauma and non-sexual physical violence were associated with more symptomatic presentation of PTSD and lifetime trauma types compared to other worst-events. Non-sexual physical violence was associated with comorbid substance use disorder, and unexpected death of a loved one was associated with comorbid depression. Inclusion of number of lifetime trauma types as a covariate rendered most, but not all associations non-significant. These findings suggest worst-event trauma type is related to some important differences in PTSD presentation.

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1. Introduction

Posttraumatic stress disorder (PTSD) is a highly heterogeneous disorder. Recently, researchers calculated a total of 79,794 unique symptom constellations that meet the clinical threshold for PTSD diagnosis based on DSM-IV criteria (Galatzer-Levy and Bryant, 2013). Research on the chronicity, comorbidity, and presentation of PTSD is mostly limited to specific trauma-exposed populations (e.g., combat veterans, sexual assault survivors, crime victims). Combat-related and civilian trauma have been contrasted, showing higher risk for development of PTSD and greater PTSD severity from combat than other traumas (Koenen et al., 2003). However, a dearth of research exists comparing and contrasting the experience of PTSD across different types of civilian trauma (e.g., unexpected death of a loved one, physical assault, rape). PTSD diagnosis is generally anchored to an index or the individual’s “worst-event” trauma. If worst-event trauma types were significantly associated with features and correlates of PTSD, this may inform our understanding and treatment of this diagnosis.

Research on vulnerability factors associated with PTSD may provide some insight into where differences may exist in reactions

to civilian trauma. A number of demographic characteristics have been identified as risk factors for PTSD. Many studies have found that women develop PTSD at nearly twice the rate of their male counterparts (Breslau and Davis, 1992; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; McLean, Asnaani, Litz, & Hofmann, 2011; Zlotnick et al., 2006). Relatedly, a wealth of research exists showing women to be at increased risk of exposure to sexual victimization compared to men (Breslau and Kessler, 2001; Norris, Foster, & Weisshaar, 2002; Perkonig, Kessler, Storz, & Wittchen, 2000; Smyth, Hockemeyer, Heron, Wonderlich, & Penedaker, 2008). Other research points to low socio-economic status as a risk factor for exposure to severe types of trauma (e.g., assaultive trauma) as well as PTSD (Breslau et al., 1998; Brewin, Andrews, & Valentine, 2000; Vogel and Marshall, 2001).

Notably, PTSD is associated with high rates of comorbidity, the patterns of which may differ across trauma types (Fairbanks, Ebert, & Caddel, 2001; Gros, Price, Magruder, & Frueh, 2012; Kessler et al., 1995; McFarlane et al., 2009; Perkonig et al., 2000). Research has found that different index traumatic events are uniquely associated with risk for non-PTSD disorders including depression, anxiety disorders, and substance use disorders (Cougle, Timpano, Sachs-Ericsson, Keough, & Riccardi, 2010b; Ehling and Quack, 2010). For instance, interpersonal trauma (e.g., assaultive trauma) has been linked to alcohol and substance use disorders (McFarlane et al., 2009; Read et al., 2012). These studies, however, are somewhat limited in terms of trauma types investigated. Additionally, using data

* Corresponding author at: Department of Psychology, Florida State University, 1107 W. Call Street, Tallahassee, FL 32306, USA. Fax: +1 850 644 7739.

E-mail address: cougle@psy.fsu.edu (J.R. Cougle).

from the original National Comorbidity Survey, researchers found that individuals who endorsed experiencing a life-threatening accident, witnessing violence to others, or sexual molestation showed the highest risk for the development of major depressive disorder (MDD) following PTSD onset (Breslau, Davis, Peterson, & Schultz, 2000). Further, a worst-event trauma of unexpected death of a loved one has been linked to the experience of panic attacks among those with PTSD (Cougles, Feldner, Keough, Hawkins, & Fitch, 2010a).

Extant literature has found links between PTSD diagnosis with pre- and post-trauma psychopathology. Examining data from the Early Developmental Stages of Psychopathology (EDSP) sample, researchers found elevated rates of pre-existing substance use disorders, anxiety disorders, and major depression in individuals who later developed PTSD (Perkonig et al., 2000). With regard to post-trauma psychopathology development, Perkonig et al. (2000) found that rates of substance use disorders and MDD increased, but rates of anxiety disorders were affected differently across diagnoses (i.e., increased rates of generalized anxiety disorder (GAD) and agoraphobia, but other anxiety disorders remained unaffected). If high rates of pre-existing comorbidity or differential risk for secondary development of comorbid psychopathology are associated with certain trauma types, this could have important diagnostic and treatment implications. Specific relationships of this sort have been given little attention in the literature.

PTSD symptom presentation appears to vary reliably by type of traumatic experience (Elhai, Frueh, Gold, Gold, & Hamner, 2000; Kelley, Weathers, McDevitt-Murphy, Eakin, & Flood, 2009; Rasmussen, Smith, & Keller, 2007). For instance, existing research has found that interpersonal trauma is associated with more symptomatic PTSD presentation and longer duration of symptoms when compared to non-interpersonal trauma such as exposure to natural disaster or motor vehicle accident (Chapman et al., 2012; Chung & Breslau, 2008; Cougles, Resnick, & Kilpatrick, 2013; Ehrling and Quack, 2010; Ford, Steinberg, & Zhang, 2011; Green et al., 2000; Lancaster, Melka, & Rodriguez, 2009; Resnick, Kilpatrick, Dansky, Saunders, & Best, 1993). In terms of differential severity across diagnostic symptom clusters, Amir, Kaplan, and Kotler (1996) examined symptom presentation differentially across trauma type in a sample of Israeli civilians and military personnel. They found intrusive re-experiencing and avoidance symptoms were greatest among individuals exposed to combat, lower among those exposed to civilian terrorism, and lowest among those exposed to motor vehicle accidents. The severity of symptoms was not significantly different between the latter two groups. Kelley et al. (2009) found differentiation in symptom presentation between sexual assault, motor vehicle accident, and unexpected death of a loved one in a large college sample. Their analyses revealed that sexual assault was related to the greater re-experiencing, avoidance/numbing, and hyperarousal symptoms compared to the other index events, with no differences in PTSD symptom presentation between death of a loved one and accident traumas.

Although extant research on PTSD has brought to light certain trends in pre-trauma psychopathology and vulnerabilities to post-trauma psychopathology, existing research examining differential characteristics of PTSD across trauma type is limited by a number of factors. Most studies have focused on non-representative samples or investigated specific trauma-exposed populations in isolation, rather than comparing across traumatic experiences. In addition, only a few studies have compared PTSD following unexpected death of a loved one, which is among the most commonly reported trauma types, to other forms of trauma (Kessler et al., 1995; Keyes et al., 2014; Vrana and Lauterbach, 1994; Zisook, Chentsova-Dutton, & Shuchter, 1998). In order to explore differences in PTSD presentation across trauma type, researchers would

require access to a representative population that has greater variance in reported trauma types.

The current study sought to explore differences in demographics, trauma history, comorbidity and symptom presentation across trauma types in a large epidemiological sample (National Comorbidity Survey-Replication; NCS-R) of individuals meeting diagnostic criteria for lifetime PTSD ($n=389$). Kessler and colleagues examined data from the original NCS with similar aims, but focused on risk factors for PTSD development and did not examine differential rates of comorbidity, chronicity, sociodemographic variables, and symptom presentation across worst-event trauma type (Kessler et al., 1995). To address our aims, we examined the three most endorsed types of worst-event traumas: sexual trauma, non-sexual physical violence, and unexpected death of a loved one. Given previous research showing greater symptom severity and longer duration of PTSD in survivors of sexual trauma, we hypothesized greater severity, and chronicity-related outcomes would be more strongly associated with sexual worst-event trauma compared to other worst-event traumas. Based on existing findings linking substance and alcohol use disorders to interpersonal and assaultive trauma (McFarlane et al., 2009; Ouimette, Kimerling, Shaw, & Moos, 2000; Read et al., 2012), we hypothesized that post-trauma onset of substance use disorders would be associated with worst-events of sexual and physical trauma. Bearing in mind the limited literature investigating differences in comorbidity among PTSD worst-events, we considered analyses examining pre-existing and comorbid disorders to be exploratory in nature. Further, recognizing that cumulative trauma has been evidenced to be a powerful predictor of PTSD severity, comorbidity, and associated features (Cloitre et al., 2009; Mueser et al., 2004; Schumm, Briggs-Phillips, & Hobfoll, 2006), we ran additional analyses including lifetime number of trauma types endorsed in order to examine whether relationships between trauma type and outcome variables are accounted for by number of trauma types experienced.

2. Method

2.1. Sample

The NCS-R is composed of adult respondents ($n=9282$) selected from a nationally representative, multi-stage clustered area probability sample of households within the contiguous United States. Participants completed face-to-face, in-person interviews at their places of residence between February 2001 and April 2003. Interviews were conducted in two parts. Part I included all core World Health Organization Composite International Diagnostic Interview (WMH-CIDI, 1990) disorders and was administered to all respondents. Part II assessed risk factors and other correlates of the core disorders as well as diagnosis of secondary disorders and was administered to 5692 of the original respondents and oversampled respondents with existing clinically significant psychopathology. A more detailed description of the procedures used in the NCS-R and complex-sampling weights used in analyzing this data can be found in the reviews by Kessler and colleagues (Kessler et al., 2004; West, 2008).

For the current paper, we examined a subset of responders who met diagnostic criteria for PTSD in their lifetime ($n=398$) based on reported reactions anchored to a worst-event index trauma and completed Part I and Part II of the NCS-R. See Table 1 for demographics.

2.2. Diagnostic assessment

The NCS-R utilized the World Mental Health Survey Initiative version of the WMH-CIDI to assess lifetime anxiety, mood, and sub-

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