Trauma type as a conditional risk factor for posttraumatic stress disorder in a referred clinic sample of adolescents

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Abstract

Introduction: Traumatic experiences that are varied in type and severity may lead to the development of Posttraumatic Stress Disorder (PTSD). Some trauma types present a higher conditional risk for PTSD owing to their nature and impact on growth and functioning. Few studies have investigated the conditional risk of PTSD in clinic referred adolescents in low- and middle-income countries. The aim of the study was to determine the conditional risk for PTSD based on various trauma types (car accidents, other serious accidents, fires, witnessing a natural disaster, witnessing a violent crime, being confronted with traumatic news, witnessing domestic violence, physical abuse and sexual abuse) and to stratify risk by gender.

Method: Adolescents exposed to at least one Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV) qualifying trauma were referred to a research clinic in Cape Town, South Africa (n = 216). PTSD status was assessed using a clinician administered interview. Conditional risk was determined using backwards stepwise multiple logistic regression analysis for 1) the whole sample, 2) females only and 3) males only. Gender differences in exposure to trauma types were determined using chi-square tests and cross-tabulation.

Results: The prevalence of PTSD was 48.1% in the whole sample. Age (β = .16, p = .048, OR 1.17), fire exposure (β = 2.32, p = .036, OR 10.12) and sexual abuse (β = .93, p = .001, OR 2.54) were significant predictors of PTSD in the whole sample with the model explaining 12.4% of the variance in PTSD status. Age (β = .22, p = .041, OR 1.24) and sexual abuse (β = .87, p = .018, OR 2.39) were significant predictors of PTSD in female participants and explained 9.8% of the variance in PTSD status. Being a victim of a violent crime (β = .78 p = .100, OR 2.19) was the only remaining predictor of PTSD in male participants and showed a trend towards significance. The model explained 7% of the variance in PTSD status.

Conclusions: The findings underscore the importance of timely identification of trauma, particularly, sexual abuse and violence. Longitudinal tracking of adolescents exposed to different trauma types may identify those in need of treatment and enhance our understanding of the lasting impact of trauma.

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1. Introduction

PTSD, by definition, can only be diagnosed in individuals who have been exposed to a qualifying trauma according to the Diagnostic and Statistical Manual of Mental Disorders [1,2]. Trauma type is an overarching category for a wide range of individual traumatic events that are precipitants of the syndrome [3]. Epidemiological data, predominantly from the USA, indicate that adolescence is the developmental period that carries the highest risk of exposure to potentially traumatic events [4,5], with traumatic occurrences peaking between 16 and 20 years of age [4].

The prevalence of traumatic experiences is relatively high in general community samples of youth. Trauma prevalence estimates ranging between 30.8% and 40.5% have been reported in samples of German youth, with PTSD rates ranging between 1.7% and 6.9% [6,7]. Higher trauma rates, ranging between 25% and 61%, have been reported in studies conducted in the United States with PTSD prevalence ranging between 5.2% and 7.6% in these child and adolescent samples [5,8,9]. Trauma exposure in South Africa is common with prevalence rates ranging between 73.8% and 83% in youth [10–12]. However, PTSD
prevalence, in relation to trauma exposure, is lower compared to samples from the United States and Germany and ranges between 3.5% and 5.8% in adolescent samples [10,13].

Rates of trauma exposure and PTSD in trauma exposed adolescent clinic samples have been less commonly reported and are generally limited to studies conducted in the United States [14–19]. The average number of traumas experienced ranged from 3.1 to 3.62 [14,16]. PTSD prevalence ranged from 5.3% to 19% in these adolescent clinic samples [14,16]. A study conducted in a clinic sample of school-going Latino immigrants reported an average of 6 traumas of a chronic nature [18]. More than 90% of immigrants reported clinical levels of PTSD based on self-report measures [18].

Interpersonal violence, including sexual and physical violence, has consistently been found to present a higher conditional risk for the development of PTSD in community samples of adolescents and adults [3,5,7,20–22]. The risk of developing PTSD following physical abuse ranges between 25.5% and 32.9% [5,20] while the risk of developing PTSD following sexual abuse and rape ranges between 13.2% and 39.3%, respectively [5,20]. Vicarious trauma exposure, such as hearing about a traumatic event, carries the lowest risk (2.2%) of developing PTSD [4]. A study based on a clinic sample of trauma exposed adolescents found that sexual abuse, physical abuse, exposure to domestic violence and being confronted with traumatic news were significant predictors of PTSD status [14]. The authors also noted that witnessing crime, being a victim of crime and exposure to accidents, fire or disaster, were not significant predictors of PTSD [14].

Various studies have found a link between gender and PTSD risk. Studies conducted in adolescent and adult community samples have found that females are more likely to develop PTSD after trauma exposure, compared to men [4,22]. This is in part due to the nature of the traumatic exposure associated with female gender [3]. Females are more likely to be victims of rape and sexual abuse which carries a higher conditional risk for PTSD in both genders and across developmental groups [3,5,6,21]. Male adults and adolescents are more likely to be victims of physical violence, to witness an injury or death, and be involved in an accident [5,6,21]. Studies conducted in child and adolescent clinic samples have yielded similar findings in terms of gender, namely, that females are more likely to develop PTSD following trauma [15]; females are more likely to be victims of sexual violence [23,24]; males are more likely to be victims of physical assault [25]; and that females experience more traumatic events overall than males [17].

While various studies have considered the conditional risk of PTSD in adult community samples, few have assessed the conditional risk of PTSD in child and adolescent clinic samples against the background of diverse traumatic event exposure [14]. The majority of clinic studies investigating conditional risk for PTSD have been based in high-income countries with few investigating conditional risk in low- to middle-income countries (LMIC) where trauma exposure is highly prevalent [14–17]. Traumatised children and adolescents can experience an array of psychological, emotional, behavioural and cognitive difficulties post-trauma which, in turn, can impact on their relationships, school work and broader areas of functioning [26,27]. Broadening the knowledge base on the conditional risk for PTSD in LMIC clinic-referred youth, overall and by gender, can inform more efficient prevention and treatment strategies.

2. Methods
2.1. Participants

Participants comprised 216 school-going adolescents who had experienced at least one PTSD-qualifying traumatic event, as defined by DSM-IV criteria [1]. Participants were referred to a trauma research clinic based at the Department of Psychiatry, University of Stellenbosch, Cape Town, South Africa. Inclusion criteria were: being between the age of 12 and 18 years old; being able to obtain informed assent from participants younger than 18 and informed consent from a parent or legal guardian or informed consent from participants 18 years and older; and being proficient in Afrikaans or English. Exclusion criteria included: known intellectual disability (based on a prior assessment of cognitive delay and adaptive functioning); current use of sedative psychotropic medication; traumatic brain injury with loss of consciousness; any major medical illness; or current illicit substance abuse.

2.2. Study design and procedure

The study followed a cross-sectional design. Ethical approval was obtained from the Health Research Ethics Committee (Institutional Review Board) of the Faculty of Health Sciences, Stellenbosch University. In addition, permission to conduct the study was granted by the Western Cape Department of Education.

Schools, clinics and non-governmental organisations were informed of the study through recruitment visits, phone calls, emails and the distribution of pamphlets. Recruitment was focused predominately on low income areas and informal settlements surrounding the clinic, however, appropriate referrals from areas outside of the targeted locations were also accepted. Participants made use of public healthcare as opposed to private healthcare due to financial constraints and low socio-economic status. All services were offered free of charge and participants were reimbursed for their travel expenses.

Referring organisations were asked to complete a short referral form indicating trauma exposure, current symptoms, duration of the problem and the contact details of the potential participant’s parent or guardian. Following referral, participants were telephonically contacted and screened for potential eligibility, based on inclusion and exclusion criteria. Potentially eligible participants were invited to
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