

Relation between lifespan polytrauma typologies and post-trauma mental health

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Abstract

Background: Most individuals experience more than one trauma. Hence, it is important to consider the count and types of traumas (polytraumatization) in relation to post-trauma mental health.

Method: The current study examined the relation of polytraumatization patterns to PTSD clusters (intrusions, avoidance, negative alterations in cognitions and mood [NACM], and alterations in arousal and reactivity [AAR]), depression, and impulsivity facets (lack of perseverance, lack of premeditation, negative urgency, sensation seeking) using a web-based sample of 346 participants. Age, gender, race, and ethnicity were covariates.

Results: Results of latent class analyses indicated a three-class solution: Low Experience, Moderate Experience – Predominant Threat/Indirect PTEs (Moderate Experience), and High Experience – Predominant Interpersonal PTEs (High/Interpersonal). Multinomial logistic regression results indicated that ethnicity and gender were significant covariates in predicting Low versus High/Interpersonal Class, and Moderate Experience versus High/Interpersonal Class membership, respectively. The High/Interpersonal Class had higher scores on most PTSD clusters, depression, and the impulsivity facets of lack of perseverance and negative urgency compared to the other classes. The Low and Moderate Experience Classes differed on PTSD's avoidance and AAR clusters (lower in the former).

Conclusions: Individuals exposed to multiple PTE types, particularly interpersonal traumas, may be at risk for more severe post-trauma symptoms.

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1. Introduction

Posttraumatic stress disorder (PTSD) is one of the few Diagnostic and Statistical Manual (*DSM*) diagnoses wherein the experience of a potentially traumatizing event (PTE) is a necessary diagnostic component [Criterion A; 1]. Most researchers and clinicians address the *index event* (most distressing traumatic event) as influencing post-trauma mental health including PTSD symptoms [2] despite the fact that most individuals experience more than one lifetime PTE [polytraumatization; 3]. Hence, one needs to comprehensively assess the influence of all experienced PTEs on

post-trauma mental health symptoms [2,4]. Person-centered statistical approaches are well-suited to accomplish this goal by examining polytraumatization patterns in relation to post-trauma mental health [5,6]; this is the focus of the current study.

Most individuals experience more than one type of PTE (e.g., motor vehicle accident, natural disaster) in their lifetime [7,8]. Relative to experiencing single PTEs, the experience of multiple PTEs relates to poorer mental/physical health [3,8–10]. These results prompt a need to consider potential factors inherent to the experience of multiple PTEs that could explain their greater impact [11–13]. First, the *type* of PTE matters in relation to psychopathology prevalence and severity [14]. As an example, the type of PTE influences the conditional risk of developing PTSD, and PTSD severity [15,16]. Patterns of different PTE types may influence unique distal, proximal, and co-occurring mental health symptom outcomes [5,17–19]. Second, the *count* of PTEs matters in relation to

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psychopathology prevalence and severity. A dose-response effect exists between increasing number of PTEs and poorer mental/physical health [20]. An increasing number of PTEs relates to greater depression and PTSD severity and poorer quality of life [10,21]. A higher count of PTEs may influence sensitization and kindling effects, possibly lowering the threshold for emotional responding to aversive stimuli, and contributing to more severe behavioral and physiological reactions to later traumas [22,23]. Third, the *count of PTE types* is an additional characteristic to consider; this refers to the number of different types of PTEs. There is a positive relation between the total number of different types of childhood PTEs and complex trauma, or the total number of different types of co-occurring symptoms [24–26]. The cumulative and additive effects of PTE types contributes to the development of PTSD, higher PTSD severity, and lower probability of remission over time, referred to as a “building block effect” [27,28].

To account for the count, type, co-occurrence, and interactive impact of all PTEs [8,9,29], Cogle et al. [4] recommended assessing all PTEs and a subset of the index, most recent, and first PTE. The construct of polytraumatization [3] captures the experience of a broad array of PTEs (count and type); it is not restricted to focusing on certain PTE types [9], repeated experiences of a single PTE [30,31], or the count of PTE types [32,33]. Person-centered approaches such as latent class (LCA) and latent profile analysis (LPA) are recommended to examine such polytraumatization patterns. LCA/LPA identify meaningful subgroups of individuals with shared patterns of PTE experiences [5,6] and permit an examination of the nature of meaningful subgroups of individuals based on the type and count of PTEs endorsed.

In the existing literature on polytraumatization patterns, relatively few studies have examined lifespan polytraumatization patterns [34]; rather most studies have examined PTEs occurring in one developmental period such as childhood [35]. Such an approach prevents an assessment of the cumulative impact of different PTEs across one’s lifespan. Studies assessing lifespan polytraumatization patterns (see Table 1) have indicated three [34,36–38] or four [39–41] meaningful subgroups of participants; such results are consistent with a recent systematic review on lifespan polytrauma patterns [42]. The obtained subgroups generally differed both in PTE types (interpersonal versus indirect) and in degree of the amount of traumatic experiences (low, moderate, high). The results have been consistent despite the diversity of samples including type (e.g., university students [40], civilians [37,39], victims of intimate partner violence [34]) and gender composition (e.g., solely females [34,37], solely males [39]).

Among the reviewed studies in Table 1, some limitations of the existing literature are apparent. One, most studies have assessed only interpersonal PTEs [36,37,39]. Second, few studies have used web-based surveys to study community samples, which allow for more anonymity and perhaps an increase in self-disclosure [38]. Third, limited studies have

addressed the heterogeneity in PTSD symptoms clusters relating to polytraumatization patterns [34]. PTSD is a heterogeneous disorder [43] comprising of clusters of intrusions, effortful avoidance of internal and external trauma-related triggers, negative alterations in cognitions and mood (NACM), and alterations in arousal and reactivity (AAR) [1]. The PTSD symptom clusters differentially relate to psychopathology, supporting their discriminant validity [44–46]. Hence, it is beneficial and appropriate to conceptualize PTSD in terms of its different symptom clusters rather than as a unitary construct. Lastly, no study to our knowledge has examined relations between polytraumatization patterns and impulsivity facets. The UPPS Impulsivity Scale conceptualizes impulsivity as a multidimensional construct [47] comprised of four facets: lack of premeditation (tendency to act without careful thought), negative urgency (tendency to engage in impulsive behaviors in the context of negative affect), sensation seeking (tendency to seek excitement), and lack of perseverance (difficulty completing tasks and tendency to become easily bored). Research indicates that different types [48,49] and degrees [50] of traumatic experiences relate differently to the ability to control impulsive tendencies including engagement in substance use [51,52], and aggressive acts [53]. Thus, impulsivity is a relevant yet understudied construct in relation to traumatic experiences.

Accounting for the aforementioned limitations, the current study examined polytraumatization patterns (subtypes) in relation to post-trauma mental health. Using a web-based recruited sample with experiences of at least one PTE, we examined (1) latent subgroups of individuals based on their lifetime PTE type endorsements, and (2) the construct validity of the optimal latent class solution. On uncovering latent subgroups of individuals, we modeled proximal demographic covariates of the optimal class solution (age, gender, race and ethnicity) based on empirical evidence. Studies have shown that increasing count of PTEs (specifically interpersonal traumas) correlates with increasing age [38], and childhood-onset interpersonal traumas are associated with more severe psychopathology compared to traumas at other developmental periods [54]. Further, females are more likely to experience interpersonal traumas, and more likely to meet criteria for PTSD compared to males [55]. Regarding race and ethnicity, the differential exposure and differential vulnerability hypotheses suggest differences in post-trauma severity across racial and ethnic groups. The differential exposure hypothesis attributes between-group differences to differential degrees of PTE exposure [56]. For example, Whites experience fewer traumatic events compared to African Americans [16,57,58]. Conversely, the differential vulnerability hypothesis attributes between-group differences to increased vulnerability to stressors linked to racial and ethnic factors (e.g., history of discrimination, differences in coping styles) [56,59].

Further, we included post-trauma mental health distal outcomes as dependent variables associated with the optimal

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