

Trauma chronicity and assailant type as predictors of symptom presentation in a community-based clinic setting

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Introduction

- The literature suggests that individuals with chronic or multiple trauma histories frequently have severe symptomatology and are often excluded from PTSD research studies.
- Such exclusion compromises the generalizability of the research literature to individuals with chronic and/or familial abuse patterns.
- This study hypothesized that:
 - Those traumatized by family members will have more severe symptomatology than those traumatized by non-family members.
 - Those with chronic trauma histories will demonstrate more severe symptomatology than those with acute trauma histories.
 - The number of traumas experienced will be associated with symptom severity.
 - The majority of the sample will meet exclusion criteria typical of most PTSD treatment outcome research studies.

Method

- This predominantly female sample (N = 262) was drawn from a client population at a community-based outpatient treatment center and had a mean age of 34.7 years old (SD = 10.6 years). Seventy-four percent were Caucasian, 8% were African American, 4% were Latino, 2% were Native American, and 12% were of other or multiple ethnicities.
- Mean number of traumas endorsed = 4.86 (2.6). Over 75% reported experiencing traumatic events over a period of years or of over “weeks and months.” The predominant diagnosis was PTSD (62.6%) and over half of the sample (51%) presented with comorbid diagnoses.
- All participants completed the following measures: the Posttraumatic Stress Diagnostic Scale (PDS; Foa et al., 1997), the Dissociative Experiences Scale (DES; Bernstein & Putnam, 1986), the Brief Symptom Inventory (BSI; Derogatis & Melisaratoros, 1983), and the Beck Depression Inventory (BDI; Beck et al., 1961). These measures demonstrate high internal consistency and test-retest reliability.
- T-tests were used to compare extents of traumatic history between those with and without particular abuse histories and to compare symptom levels between histories associated with different types of assailants (familial or nonfamilial). Analyses of variance were used to compare symptom levels across different levels of chronicity as well as across clusters of number of event types experienced.

Assailant type as a predictor of dissociation across trauma types

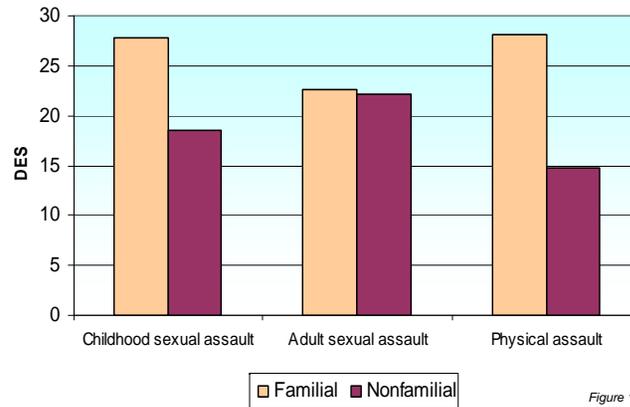


Figure 1.

Chronicity of trauma as a predictor of symptoms

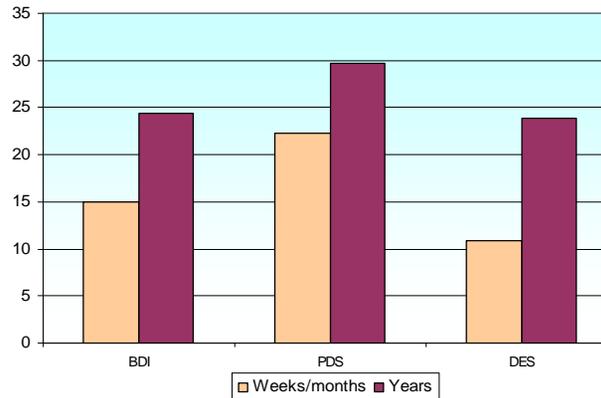


Figure 2.

Results

- Across all measures, having experienced 6-11 event types was associated with significantly greater symptoms than having experienced 1-2 event types (or 3-5 event types in the case of PTSD symptoms): (BDI: $F(2,243) = 7.23, p < .01, d = .72$; BSI: $F(2,240) = 5.31, p < .01, d = .60$; DES: $F(2,237) = 10.2, p < .01, d = .75$; PDS: $F(2,238) = 5.10, p < .01, d = .44$).
- Childhood familial sexual assault histories were associated with higher levels of dissociation when compared to nonfamilial childhood sexual assault history. No differences in adult sexual assault histories.
- Familial physical assault histories (compared to nonfamilial) were associated with greater symptoms across all measures (BDI: $t(99) = -3.67, p < .01, d = .91$; BSI: $t(100) = -3.37, p < .01, d = .83$; DES: $t(55) = -3.28, p < .01, d = .81$; PDS: $t(97) = -2.42, p < .05, d = .61$).
- Chronic histories lasting years were associated with significantly greater symptoms than chronic histories lasting weeks and months (BDI: $F(3, 140) = 3.84, p = .01$; partial $\eta^2 = .08$; BSI: $F(3, 134) = 5.96, p = .001$; partial $\eta^2 = .12$; PTSD: $F(3, 139) = 2.95, p = .04$; partial $\eta^2 = .06$; DES: $F(3, 136) = 2.87, p = .04$; partial $\eta^2 = .06$).
- Foa et al. (1991)'s or Foa et al. (1999)'s exclusion criteria would have excluded 69.1% and 51.6% of our sample, respectively. Specific exclusion criteria impacting our sample include substance abuse/dependence, suicidality, assault by family member or spouse, other psychological diagnoses, and age at which the event occurred.

Discussion

- Our finding that participants having suffered betrayals of sexual or physical abuse at the hands of a family member (as opposed to an acquaintance or stranger) would have greater symptomatology was consistent with theory that suggests that children are particularly vulnerable to such offenses perpetrated by their own family.
- Whereas familial physical abuse histories were predictive of greater symptoms across all measures, only in the case of dissociation was familial childhood sexual assault (as opposed to nonfamilial) predictive of greater symptoms. Dissociation has been proposed as a hallmark symptom of childhood sexual abuse histories (Freyd, 1996).
- Our data did not permit the distinction between adult and minor physical assault so this category includes incidents at different times in the life span. Similarly, some analyses are based on the presence of the event in the participant's history whereas others (i.e. chronicity) are based on the selection of the event as the “most distressful event.”
- Approximately three-quarters of the sample would have been excluded from current studies using “gold standard” treatments. As researchers successfully refine and develop the most efficacious treatments for PTSD from acute traumas, it is critical that these treatments be applied to samples of greater ecological validity. More studies using samples representative of the treatment-seeking populations will yield findings with direct relevance to clinical practice.