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Influence of Trauma Type on Severity of PTSD Exhibited by Children

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Introduction

- Since the diagnosis of posttraumatic stress disorder (PTSD) was extended to minors in 1987, there have been significant efforts to accurately assess how minors react to traumatic stressors (Hawkins & Radcliffe, 2006).
- PTSD is defined as an intense physical and emotional response to thoughts and reminders of the event that last for many weeks or months after the traumatic event (CDC, 2003).
- Interpersonal violence, or trauma, exposure is noted as one of the most common and severe adverse events in childhood with long-term health effects (Margolin & Gordis, 2000).
- Alisic et al. (2014) found that one in ten children developed PTSD after non-interpersonal trauma (non-IPT; e.g., natural disaster) exposure, and one in four children developed PTSD after interpersonal trauma (IPT; e.g., assault) exposure.
- Poly-victimization, or experiencing different types of victimization, has also been a powerful predictor of trauma symptoms, becoming more important in predicting symptom levels than other lifetime adversities in all but one analysis (Finkelhor, Ormrod, & Turner, 2007).
- It was hypothesized that children who were exposed to a combination of IPT and non-IPT would have significantly higher PTSD severity scores when compared to children who experienced either IPT or non-IPT independently.

Methods

Participants

- Participants were 126 children (57 females, 69 males) referred to a trauma specialized clinical program.
- Participant age ranged from 7 to 17 years (M = 10.06, SD = 2.70).
- Children were mainly identified as Caucasian (54.0%) or African-American (15.9%).

Measures

- During assessment, children completed the Child and Adolescent Trauma Screen (CATS), which is a 20 item self-report measuring both trauma exposure and severity of PTSD symptoms per DSM-5 criteria. Each item refers to symptoms occurring over the past two weeks.
- Children rated each item for frequency on a 4-point Likert scale ranging from 0 to 3. A rating of 2 or 3 would denote symptomology. Severity scores, or the sum of their ratings, can range from 0 to 60, with scores of 21+ reaching clinical significance for the presence of PTSD.
- Participating caregivers provided necessary demographic information.

Procedures

- Participants were referred to the University of Oklahoma Health Sciences Center Child Trauma Services Program to have evaluations for mental health treatment needs in relation to trauma exposure. Participants completed intake assessments consisting of a clinical interview and administration of various caregiver and child measures. All data was collected during assessment and treatment sessions and was analyzed retrospectively for this study.
- This project was approved and conducted in compliance with the University of Oklahoma Health Sciences Center Institutional Review Board (#7394). All caregivers of children within the clinical program agreed to participate in the research. Clinical services were not dependent on their participation in the research.

Results

- A one-way analysis of variance (ANOVA) tested the effect of trauma type on PTSD severity in children who experienced interpersonal trauma (n = 28), non-interpersonal trauma (n=15), or a combination of those traumas (n = 83).
- There was a statistically significant effect of trauma type on PTSD severity, $F(2, 123) = 4.02$, $p = .02$, $\eta^2 = .06$.
- Participants from the combination group ($M = 26.8$, $SD = 11.7$) had higher severity scores than those in the IPT ($M = 22.7$, $SD = 11.9$) and non-IPT ($M = 18.3$, $SD = 11.0$) groups.
- A Tukey HSD post hoc test indicated severity scores for participants in the combination group were significantly higher than those in the non-IPT group at $p < .05$.
- There was no significant difference in severity scores between the non-IPT group and the IPT group, or between the IPT group and the combination group.

Figure 1. **PTSD Severity Scores for Trauma Types**

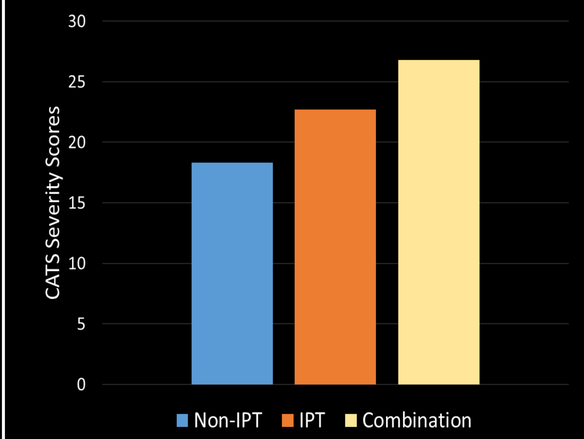

Figure 2. **Rates of Trauma Type Exposure**

Discussion

- Results indicated that participants exposed to both IPT and non-IPT reported significantly higher PTSD severity than those exposed to only non-IPT.
- Previous research supports these findings that higher rates of PTSD are linked to multiple trauma exposures, particularly those associated with shame (i.e., IPT; Nooner et al., 2012).
- Contrary to our hypothesis, there was no significant difference in severity scores between the combination group and the IPT group. However, average severity scores for each group did follow a trend based on the type of trauma.
- Future research should address including CATS caregiver-reports that were not included in this study to observe caregiver-child agreement on severity scores. Caregiver-child symptom agreement across clusters could also be explored.
- Future research may consider using an ANCOVA to control for the number of traumas each child experienced.