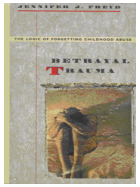


Adult trauma and adult symptoms: Does childhood trauma drive the relationship?

Bridget Klest, MA; Carolyn Allard, MS; Jennifer J. Freyd, PhD

University of Oregon

INTRODUCTION

The current paper attempts to use structural modeling to explain observed relationships between childhood trauma, adult trauma, and adult dissociation and mental health. Many researchers have noted these relationships without attempting to piece apart the nature of the relationships, only assuming that all variables might have causal effects on all others (with the exception of adult variables causing childhood variables). Theoretically, if childhood trauma causes revictimization (adult interpersonal trauma) as well as dissociation and mental health problems, a model specifying paths to revictimization, dissociation, and mental health beginning at childhood trauma should best fit observed data. Conversely, if childhood trauma does not cause these outcomes, and underlying characteristics of the individual cause both traumatization and mental health problems, a model that leaves out paths from adult trauma to outcome variables should not fit the data well. It is hypothesized that a model specifying paths from childhood trauma to adult trauma, dissociation, and mental health, and setting paths originating at adult trauma to zero will most parsimoniously predict observed patterns of association between these variables.

METHODS

The current study surveyed 307 (198 women, 97 men, 2 declined to report gender) undergraduates recruited from the University of Oregon psychology Human Subjects Pool. Participants were compensated with partial course credit. Demographics in this sample were representative of the UO undergraduate population with a mean age of 20.96 years (SD = 4.89), mostly (94%) single, and ethnicity represented as follows: 85.1% Caucasian, 9.3% Asian American, 2.0% Hispanic/Latino/a, 11% other groups.

Questionnaires were computer-administered.

The **Brief Betrayal Trauma Survey (BBTS; Goldberg & Freyd, 2006)** distinguishes between events perpetrated by individuals who are close to the respondent (high-betrayal) and those that involve no or non-close perpetrators, and also between childhood and adulthood events. Events experienced in childhood are those occurring before age 13, and adulthood after 18th birthday. The number of different types of high-betrayal traumas that fell into each age category was summed for each person and used in the analyses.

The **Trauma Symptom Checklist 40 (TSC-40; Elliott & Briere, 1992)** includes symptoms commonly reported in child abuse survivors, including depression, dissociation, anxiety, sleep difficulties, and sexual problems. The depression, anxiety, and dissociation subscale scores are the most reliable, and were used in the analyses in this paper.

The **Dissociative Experiences Scale (DES; Carlson & Putnam, 1993)** is a self-report measure of common and uncommon dissociative experiences. Examples of common experiences include "spacing out" during a lecture and highway hypnosis. Examples of less common experiences include identity confusion and identity alteration related items.

Descriptive Statistics

	Mean	Std. Deviation
TSC Anxiety	4.590	3.3128
TSC Depression	5.749	3.5117
TSC Dissociation	3.831	2.6490
DES Dissociation	10.0260	8.85493
Childhood Trauma	.1227	.20330
Adult Trauma	.0891	.16615

Pearson Correlations (N = 307)

	TSC Anxiety	TSC Depression	TSC Dissociation	DES Dissociation	Childhood Betrayal Trauma
TSC Depression	.690**				
TSC Dissociation	.697**	.663**			
DES Dissociation	.378**	.442**	.563**		
Childhood Trauma	.250**	.280**	.245**	.223**	
Adult Trauma	.279**	.354**	.273**	.272**	.403**

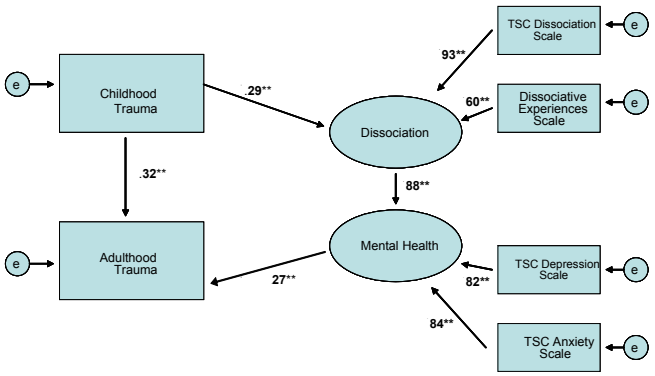
**. Correlation is significant at the 0.01 level (2-tailed).

RESULTS

Upon completing a thorough check of the data's suitability, the hypothesized model was run in Mplus. The model was specified as follows. Scores from the DES and the TSC dissociation subscale were included as indicators of the latent construct dissociation. Scores from the TSC depression subscale and TSC anxiety subscale were included as indicators of the latent variable mental health. Childhood betrayal trauma was included as a predictor of adult betrayal trauma and dissociation, and dissociation was included as a predictor of mental health. Mental health was in turn included as a predictor of adult betrayal trauma experiences. Paths between adult betrayal trauma and dissociation, and child betrayal trauma and mental health were set at zero.

This hypothesized model fit the data very well. The comparative fit index (CFI) was .98, and the chi-square test of model fit was 20.21 ($df = 7$, $N = 307$, $p < .01$). Standardized parameter estimates indicated significant relationships for all estimated paths. See the figure below for a visual representation of the model with standardized path estimates.

A more complex model in which the hypothesized model is nested includes direct paths between adult trauma and dissociation, and child trauma and mental health. This model also fits the data very well, with a CFI of .98, and a chi-square test of model fit of 16.61 ($df = 5$, $N = 307$, $p = .005$). This more complex model tests the hypothesis that essentially all variables are related to all others in any direction that makes sense temporally. This more complex model is not significantly better at predicting the data than the hypothesized model. The chi-square change statistic was 3.6 ($df = 2$, $p > .05$), indicating that the reduced model is equally good at approximating the data as is the full model.



CONCLUSIONS

The analyses conducted provide some evidence to support the notion that childhood trauma is responsible for the bulk of the variance in dissociation and mental health that can be attributed to trauma. Adult trauma does not appear to be significantly related to dissociation when controlling for the effects of childhood trauma, and may have a relationship with mental health such that adult mental health symptoms make adult trauma more likely.

Overall, the hypothesized model is preferable over the full model because it provides a more parsimonious explanation of the data without significantly deteriorating. It is somewhat unclear, however, whether equivalent models that specify different relationships between trauma and the latent constructs might be just as likely. There is not strong enough theoretical grounding one way or another to make this determination.

These data do clearly suggest that childhood trauma is the driving force behind the relationship between trauma and dissociation. Given that most reports are retrospective, and experiencing childhood trauma is correlated with experiencing adult trauma, it is often difficult to determine the nature of observed relationships. However, the model supported by the current analyses has important implications for diathesis-stress models of psychopathology.

Frequently, it is assumed by diathesis-stress researchers that underlying vulnerabilities toward developing psychopathology are biological or genetic in nature. Many researchers talk about a cognitive vulnerability to depression or anxiety, but do not discuss how the vulnerability is acquired, leaving the reader to assume that it is somehow inherent. However, this paper is consistent with a body of research supporting the idea that childhood trauma creates within a person a diathesis, possibly through dissociation, and is itself a stress. It is entirely possible that many diathesis-stress models could be reframed as early stress-later stress models.

REFERENCES

Carlson, E. B., & Putnam, F. W. (1993). An update on the Dissociative Experiences Scale. Dissociation, 6(1, March), 16-27

Elliott, D.M., & Briere, J. (1992). Sexual abuse trauma among professional women: Validating the Trauma Symptom Checklist- 40 (TSC-40). Child Abuse & Neglect, 16, 391-398.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. American Journal of Preventive Medicine, 14(4), 245-258.

Freyd, J. J. (1996). Betrayal Trauma: The Logic of forgetting childhood abuse. Cambridge, MA: Harvard University Press.

Freyd, J.J., DePrince, A.P., & Zurbriggen, E.L. (2001). Self-reported memory for abuse depends upon victim-perpetrator relationship. Journal of Trauma & Dissociation, 2, 5-17.

Freyd, J.J., Klest, B., & Allard, C.B. (2005) Betrayal trauma: Relationship to physical health, psychological distress, and a written disclosure intervention. Journal of Trauma & Dissociation, 6, 83-104.

Goldberg, LR. & Freyd, J.J. (2006) Self-reports of potentially traumatic experiences in an adult community sample: Gender differences and test-retest stabilities of the items in a Brief Betrayal-Trauma Survey. *Journal of Trauma & Dissociation*, 7(3), 39-63.

ACKNOWLEDGEMENTS

This research was supported in part by the Trauma and Oppression Research Fund at the University of Oregon Foundation.

We are grateful to our participants, and our colleagues in the Dynamics Lab for their helpful input.

Please address correspondence to: Bridget Klest, MA
1227 University of Oregon
Eugene, OR 97403-1227
bklest@uoregon.edu

Reprints of this and other Dynamics Lab presentations are available at http://dynamic.uoregon.edu

International Society for Traumatic Stress Studies Annual Meeting 2005