Investigation of the Relationships Among Trauma Exposure, Parental Representations, and Post-Trauma Symptoms

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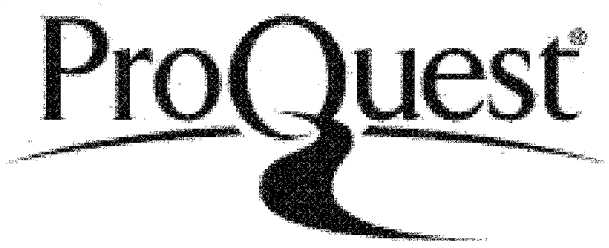

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I dedicate the completion of this project to my grandmother Rae Marks, "the smart one" and to Laney.

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ABSTRACT

According to Breslau (1998), lifetime prevalence of traumatic exposure in community samples was found to range from 36.7% to 92.2% while lifetime estimates of PTSD range from 5.0% to 18.3%. Prior research has identified trauma type and attachment as variables that predict PTSD diagnosis and/or symptom severity. The aim of the current study is to examine symptom presentation across a broad range of traumatic events and by exploring how trauma type influences the relationship between attachment and symptom severity.

Six hundred and nineteen individuals seeking psychological services at an outpatient clinic completed questionnaires assessing their interpretation of their relationship with their parents, exposure to various traumatic events, and PTSD related psychiatric symptoms of anxiety, anxiety-related disorders, depression, traumatic stress, affective depression, cognitive depression, physiological depression, negative relationships, thought disorders, and social detachment. Questionnaires included the Inventory of Parental Representations (IPR) (Hart, 1992), the Personality Assessment Inventory (PAI) (Morey, 1991), and the Posttraumatic Diagnostic Scale (PDS) (Foa, 1995). The majority of participants in this study were young adult females who have been exposed to one or more traumatic events.

Sexual assault was found to be more highly associated with a diagnosis of PTSD than the other trauma groups studied. It was also more highly associated with PAI anxiety-related disorders, traumatic stress, depression, physiological depression, and thought disorders than the remaining five trauma types (accident/fire/explosion, natural disasters, life-threatening illness, sexual contact before age 18, and non-sexual assault).

Results showed generally higher levels of post-trauma symptoms were associated with negative attachments and lower levels of symptoms associated with positive attachments to mother and father. In addition, trauma type was found to partially moderate the relationship between parental representations and trauma symptoms.

CHAPTER I

LITERATURE REVIEW

Introduction

The human response to psychological trauma is described by van der Kolk "as a phasic reliving and denial, with alternating intrusive and numbing responses" (van der Kolk, 1987, p. 3-4). Epidemiological research estimates lifetime prevalence of exposure to traumatic events to be between 36.7% and 92.2% (Breslau, 1998). However, not all individuals go on to develop post-traumatic symptoms. In fact a relatively small proportion of those exposed to trauma are diagnosed with post-traumatic stress disorder (PTSD). Breslau (1998) estimated lifetime prevalence of PTSD to be between 5.0% and 18.3%.

Many researchers have explored factors that may protect people from developing symptoms including external factors such as type of trauma or proximity to the event and internal factors such as resilience and coping. Attachment theory posits that in times of stress people operate on a behavioral system that is laid down by complex interactions with our earliest caregivers. When confronted with stress people seek out internal and external models of protection, support, comfort, and relief. Object relations theorists have emphasized the regulatory role of internal representations of security-enhancing primary caregivers (Greenberg & Mitchell, 1983).

Mikulincer and Shaver (2006) propose that attachment theory is therefore directly relevant to the recovery from trauma. The current paper will explore the protective role of positive parental representations in the development of symptoms after exposure to a traumatic event and how this relationship varies by type of traumatic event.

Psychological Trauma

The study of psychological trauma is traced back by many historians (Wilson, Herman) to the focus on hysteria by such early neurologists and clinicians as Janet, Freud and Breuer, and Charcot. A convergence of their investigations at the time concluded that hysteria was an altered state of consciousness brought on by psychological trauma. As asserted by Herman, the study of psychological trauma came in and out of favor depending upon the political leanings of the time. Between Freud's time and World War I it went out of favor. Then, following prolonged exposure to the stresses of warfare, soldiers primarily in England and the United States, displayed similar syndromes to hysteria (Herman, 1992).

In 1941 Abraham Kardiner, after working in a psychiatric clinic at the Veteran's Administration, published a study entitled *The Traumatic Neurosis of War*. In this work he outlined the traumatic syndrome as it is understood today (Herman, 1992).

The Second World War drew interest again to combat neurosis, however systematic study of the "long-term psychological effects of combat was not undertaken until after the Vietnam War" (Herman, 1992, p. 26). Soldiers themselves were the driving force behind this interest as they returned home and organized themselves within the anti-war movement of the time. They established "rap groups" to provide support for traumatized veterans and to raise awareness of the effects of war. The growth of this movement helped to support the addition of PTSD as an official diagnosis for the first time in the 1980 publication of the DSM-III.

Herman also credits the organizing of the women's movement in the 1970's in the United States for raising awareness about domestic violence, rape, and childhood sexual abuse. Victims of these crimes were legitimized for the first time and in 1980 the pervasiveness of these experiences was finally recognized. Veterans had helped to legitimize the concept of PTSD and it was recognized that the "psychological syndrome seen in survivors of rape,

domestic battery, and incest was essentially the same as the syndrome seen in survivors of war" (Herman, 1992, p. 32).

While there is debate over broad versus narrow conceptualizations of traumatic events in terms of definition and measurement of psychological trauma (Weathers and Keane, 2007), this debate is outside of the scope of the current paper. Herein the DSM-IV-TR criterion A definition will be used. In order to be diagnosed with PTSD today a person must have experienced an extreme traumatic stressor or what is referred to as a Criterion A event. Criterion A states that one must be exposed to, witness, or learn about an event that causes death, serious injury, or threat to oneself or a close other. PTSD is understood to result from a variety of Criterion A events, (DSM-IV-TR lists military combat, violent personal assault, kidnapping, terrorist attack, natural or manmade disasters, learning about the sudden, unexpected death of a family member or close friend, etc.) and a substantial body of research exists which examines variations in the disorder across victims of different Criterion A events. Within the DSM-IV-TR there are possible qualifiers mentioned such as the intensity of and physical proximity to the event, and whether the Criterion A event is of human design. These qualifiers may impact the likelihood of developing PTSD and or the severity and chronicity of the disorder (American Psychiatric Association, 2000).

The original Criterion A in DSM-III was brief and vague with two key descriptors of a traumatic event ("outside the range of usual human experience," and "would evoke significant symptoms of distress in almost everyone") (Weathers and Keane, 2007, p. 108-9). The revisions added to DSM-III-R provided a list of examples of qualifying events and also added language about the "type and severity of distress evoked" stating that the event "is usually experienced with intense fear, terror, and helplessness" (Weathers & Keane, p. 111).

Symptoms

Regardless of the definition, the study of psychological trauma centers on human response following traumatizing events (stressors, Criterion A). After such events individuals are overwhelmed by helplessness and their "ordinary systems of care that give people a sense of control, connection, and meaning" are overwhelmed (Herman, 1992, p. 33).

Threat brings about changes in the sympathetic nervous system. Perceptions are changed and intense feelings of fear and anger are aroused. These changes are normal reactions to threat which allow a person to take action. However, "when action is of no avail, the human system of self-defense becomes overwhelmed and disorganized". The self-defense system remains in effect in an "altered and exaggerated state long after the immediate danger is over." "The symptoms become disconnected from their source (the event) and take on a life of their own" (Herman, p. 34).

Bessel van der Kolk describes the "response to psychological trauma as a phasic reliving and denial, with alternating intrusive and numbing responses" (van der Kolk, 1987, p. 3-4). This aligns with what Herman refers to as the dialectic of trauma and she proposes that the vacillation between these two states may be a way of attempting to restore balance which is lost for the traumatized person (Herman, 1992).

Herman further divides post-traumatic symptoms into the three categories of hyperarousal, intrusion, and constriction. Hyperarousal refers to the fact that the traumatized person remains in a hyper-alert state as if the threat may reappear at any time. The person experiences heightened startle responses, irritability, and sleep disturbances (Herman, 1992).

Intrusion also refers to the continual reliving of the traumatic event which repeatedly interrupts the normal events of everyday life. People experience flashbacks and nightmares and small reminders may evoke traumatic memories "which often return with all the vividness and emotional force of the original event" (Herman, p. 37).

Intrusion occurs not only in people's minds but also in their actions as reenactments of traumatic events. This is observed in children's repetitive play and in adults' actions as well. What Freud referred to as the "repetition compulsion" which may be an attempt at mastery or at integrating the traumatic event. The traumatic event is filtered through altered perceptions at the moment of trauma and encoded in unusual, non-linear, sensory forms in memory (Herman, 1992).

In some traumatic experiences the person has no option of actual physical escape causing shifts in consciousness towards dissociative states. A person may wall off their perceptions of the event and enter a state of calm in which the perception of time may slow and the sense of reality is distorted. While these states of consciousness may be adaptive in the moment of trauma, they continue long after and are even consciously sought out, sometimes through the use of alcohol or narcotics. Maintaining dissociation from the experience of trauma prevents people from integrating the experience which delays or prevents healing. Thus numbing or constriction, along with reliving or intrusion, can prolong post-traumatic symptoms in a self-perpetuating cycle. People restrict their lives in attempts to avoid reminders of their trauma and may diminish or cut off social interactions and reduce their quality of life overall (Herman, 1992).

Prevalence

It was thought in the past that exposure to trauma was uncommon. The first inclusion of PTSD in the DSM-III described traumatic events as "outside the range of usual human experience" (American Psychiatric Association, 1980). We now know that this is not true. In 1998 Naomi Breslau conducted a review of epidemiological reports of trauma and PTSD that were published between 1990 and 1997.

Across the studies reviewed, lifetime prevalence of traumatic exposure was found to range from 36.7% to 92.2% of the populations studied. Lifetime estimates of PTSD range from

5.0% to 18.3% (Breslau, 1998). There is a distinct disparity between portions of the population who have been exposed to trauma and those whose post-traumatic response warranted a diagnosis of PTSD.

Many researchers have explored this disparity, looking at both internal (e.g. coping, resilience, personality) and external (type and severity of trauma exposure) variables to explain why seemingly few trauma survivors develop PTSD. The current study will examine the impact of type of trauma and parental representations on the development of PTSD and on symptoms severity among people exposed to trauma.

Trauma Types

While PTSD is understood to be a single disorder resulting from a variety of Criterion A events, (DSM-IV-TR lists military combat, violent personal assault, kidnapping, terrorist attack, natural or manmade disasters, learning about the sudden, unexpected death of a family member or close friend, etc.) a substantial body of research exists which examines variations in the disorder across victims of different Criterion A events. Within the DSM-IV-TR there are possible qualifiers mentioned, such as whether the Criterion A event is of human design, and the intensity of and physical proximity to the event, that may impact the likelihood of developing PTSD and or the severity and chronicity of the disorder (American Psychiatric Association, 2000).

Another important consideration when studying PTSD is that it is highly comorbid with a number of other disorders. The DSM-IV-TR states: "Posttraumatic Stress Disorder is associated with increased rates of Major Depressive Disorder, Substance-Related Disorders, Panic Disorder, Agoraphobia, Obsessive-Compulsive Disorder, Generalized Anxiety Disorder, Social Phobia, Specific Phobia, and Bipolar Disorder." (American Psychiatric Association, 2000, p. 465).